# Alcohol Recovery and Transition to Parenthood

by

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# ABSTRACT

The purpose of this study was to explore women's concurrent experiences of alcohol/drug recovery and transition to parenthood. The study used a qualitative design to explore and understand women's experiences of recovery from alcohol/drug dependence during pregnancy and early parenting up to the first year after birth. Observation, diary entries, and intensive interviews were used for data collection from a purposive sample. Eleven women, who self-identified as recovering alcoholics/addicts and were either pregnant or had an infant younger than 12 months, participated in the study. Findings from descriptive analyses were compared with concepts in the literature about the processes of alcohol/drug recovery and transition to motherhood. Balancing emerged as the core concept, a process that explained how women successfully integrated the recovery and motherhood processes into their identity. The women used strategies learned in the process of alcohol/drug recovery to balance between alcohol/drug recovery and motherhood. They used the strategies in unique ways during pregnancy and in early parenting to incorporate the developmental and relational aspects of both advancing in motherhood and maintaining recovery. Understanding concepts and processes associated with the concurrent experiencing of recovery and parenting will be useful to nursing and other disciplines that seek to improve the health of mothers, infants and families. This study demonstrates the complexity of the women's experiences and suggests implications for practice, theory, research, and policy.

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# CHAPTER 1

## INTRODUCTION

Many studies have documented the effects of using alcohol, either alone or in combination with other drugs, on the health of the mother and fetus during the perinatal period. Use of alcohol during pregnancy has been associated with a range of birth defects generally classified as fetal alcohol syndrome and fetal alcohol effects (Rosett, Weiner, & Edelin, 1983; Stressguth, 1976; Weiner & Morse, 1988; Weiner, Morse, & Garrido, 1989). Alcohol use during pregnancy has also been studied in connection with prematurity, low birth weight, neuro-behavioral abnormalities, and developmental problems (Abel & Sokol, 1986; Chasnof, 1986). During the postnatal period, alcohol and drug use by parenting women can further endanger the health of their children and families through such social and psychological effects as child abuse and neglect (Bushong, 1990; Daghestani, 1989; Fanshell, 1975; Mondanaro, 1989). Awareness of the consequences of maternal alcohol use has prompted a major public health education effort that is aimed at reducing or eliminating alcohol use during pregnancy and the first year after birth (Jessup & Green, 1987; Weiner, Morse, & Garrido, 1989).

Although health education has decreased the use of alcohol during pregnancy, women with a history of alcohol or drug dependency may need additional support to learn strategies to attain and maintain chemical abstinence during pregnancy and early parenting (Weiner & Morse, 1988). For an increasing number of women, the process of stopping alcohol and other chemical abuse is occurring during the time of

childbearing (Weiner et al., 1989). Whether pregnancy is the stimulus for drug recovery or an otherwise concurrent event with drug abuse recovery is unknown. The dynamics of the two processes of drug recovery and childbearing occurring concurrently has had little description in the literature.

## Models of Alcohol Recovery

Recovery from alcohol dependence involves abstaining from alcohol and learning to live a in a drug-free manner (Brown, 1985; Mondanaro, 1989). Brown conceptualizes recovery from alcohol addiction as a developmental process that involves cognitive, psychological and social changes for the individual. Finkelstein (1990) depicts alcohol and drug addiction recovery within a relational model. In that model, the recovery process is described in terms of how the social network and family interact with the recovering individual. Alcoholics Anonymous (AA) is a well established self-help model used to attain and maintain alcohol recovery. AA is compatible with both the developmental and the relational models of alcohol/drug recovery.

## Developmental Process of Motherhood

The months of pregnancy and the first year after birth have been viewed together as a developmental period of parental role transition that involves physical, psychological, social and family changes (Barnard & Eyres, 1979; Mercer, 1990; Rubin, 1975). The process of parental role transition consists of the mother changing from an anticipatory role during pregnancy to a parental role during the first year after birth.

No theorists or researchers have described the concurrent processes of alcohol recovery and parental role transition. An understanding of both processes, as they interact and co-occur, may enable nurses and others who work with recovering women to provide more sensitive care. More informed care may improve mothers' chances for long-term sobriety and thus may improve the health of mothers, children, and families.

## Issues in Alcohol Recovery and Parenthood

### Interpersonal Relationships

Recovery and parenthood are both on-going developmental processes. The transition stages of both processes are often highly stressful periods when supportive interpersonal relationships become important for positive outcomes. During pregnancy and after birth, important relationships change. Mothers and partners have been identified as key people for support to women during the pregnancy and first year after birth (Ballou, 1978; Barnard & Eyres, 1979; Mercer, 1990; Rubin, 1975). Relationships are important to women during alcohol recovery also (Brown, 1985; Finkelstein, 1990). Women in treatment consistently identify key family members like parents, partners, and children as sources of both support and conflict during recovery (Beckman & Amaro, 1986; Finkelstein, 1990). Although these relationships have been identified as crucial for both recovery and parenthood transition processes, they have not been addressed in the research literature for when the two processes occur at the same time. Whether the relationships between a pregnant woman and her mother, other family members, and partner bear the same importance during the

concurrent transitions of parenthood and recovery as that which occurs while in recovery from substance abuse has not been described.

## Legal and Ethical Issues

The literature on perinatal chemical dependence includes two opposing approaches for dealing with this problem. One approach focuses on the need for therapy and treatment for the using pregnant woman. The other approach emphasizes the need for legal intervention and involves looking at the rights and obligations of women in opposition to rights of the fetus. There have been over 50 efforts to prosecute pregnant women who were using drugs or alcohol; these efforts resulted in two convictions. Seven states have legislation proposed to amend child protection laws to include fetal abuse and the delivery of drugs to a minor through the umbilical cord (Chavkin, 1990). However, sanctions enacted for drug use during pregnancy have been reported to be discriminatory with prosecution of poor, minority women being higher than prosecution of caucasian women (National Association of Perinatal Addiction Research and Education, 1991).

Barriers to treatment for addicted pregnant women are encountered frequently. Even when treatment is available, it may not address issues important to parenting and pregnancy. Two articles in medical journals (Connolly, 1991; Evans & Gillogley, 1991) have identified issues related to initiating treatment for chemical dependency during pregnancy. Connolly has discussed the legal issues surrounding assessment of chemical use during pregnancy. Evans and Gillogley have stressed the importance of including drug screening and intervention through referral to treatment

resources in the obstetrical management of chemical dependency. Both articles focused on assessment of chemical dependency and referral during pregnancy but had no suggestions about evaluating long- and short-term effects of chemical dependency treatment on either recovery or childbearing.

Becker and Burke (1988), writing in a nursing journal, analyzed the problem of neonatal addiction from two moral orientations, a justice perspective that focused on the fetal rights versus maternal rights and a caring perspective that focused on the needs of mother and infant. The justice perspective was seen as minimizing contextual variables and applying rules and laws indiscriminately, often separating the rights of the mother and infant. The caring perspective was described as meeting the needs of both mother and infant through relationships and contextual variables.

Pregnant women often report that physicians do not assess alcohol and drug use during pregnancy and that referrals and opportunities for treatment are rare (Nadel, 1991). Criminal prosecution for drug use during pregnancy and proposed legislation to include perinatal drug use as fetal abuse discourage women's disclosure of alcohol and drug use to care providers and may keep some pregnant women from seeking prenatal care. These issues are beginning to be addressed within the context of legal, ethical, and health care practice considerations. However, controversy and conflict continue between moral orientations.

## Alcohol as a Focus

Alcoholism in relation to the transition to parenthood was selected as the focus of this research for four reasons. First, there is a substantial link between health

problems of infants and mothers and alcohol use during pregnancy and the first year after birth. Second, alcohol is a legal drug which is widely available, has few legal restrictions, and is thus consumed by many women during the childbearing years. Polydrug use almost always includes alcohol and alcohol is often the drug of choice even when other drugs are available. Third, in spite of international attention about the effects of maternal alcohol and other chemical use on infants and children, the majority of substance-using pregnant women and mothers with young children do not receive drug treatment services that meet their needs, such as education in prenatal care, child care, and parenting skills in conjunction with substance abuse treatment. Urban and rural areas have similar rates of alcohol use but rural areas have less resources to treat alcohol dependence (Kumpfer, 1991). A knowledge base about substance abuse treatment for women during pregnancy and early parenting can provide a vantage point for understanding the special problems that these recovering women encounter. Fourth, alcohol abuse has been linked with other problems, such as domestic violence, crime, and intergenerational child abuse and neglect. Recovery from dependence on alcohol and other drugs may provide a means to sever this link. Understanding how childbearing and parenting women are able to attain and maintain recovery from alcohol dependence may improve the effectiveness of interventions. Thus, the health of women, children and families may be improved.

## Problem Statement

The purpose of this study was to explore factors related to women's concurrent experiences of recovery from alcohol and other chemical dependency and the

transition to parenthood. This transition begins in pregnancy and continues during the first year after birth. Understanding factors that influence women's ability to attain and maintain recovery, as well as the interactions between the processes of recovery and childbearing and early parenting, should provide a basis for health policy, program planning, research and nursing care. This study investigated two essential research questions: What is the alcohol/drug recovery process for women who are pregnant or parenting an infant less than a year old, and how do recovering women experience the transition to motherhood?

# CHAPTER II

# REVIEW OF LITERATURE

The purpose of this study was to explore factors related to women's concurrent experiences of recovery from alcohol and other chemical dependency and the transition to parenthood. The literature on factors and processes of women's alcohol recovery, transition to parenthood, and concurrent experiences of recovery and transition to parenthood has provided a knowledge base for this study. A review of this literature is given in this chapter, followed by a descriptive summary of concepts addressed in these studies.

## Alcoholism and Drug Addiction

### National Statistics

Alcoholism is a sociocultural, psychological, and physiological problem and is a serious public health problem in the United States (Wallace, 1990). The economic, health, and social costs of alcoholism are great. Health care costs associated with alcoholics were found to be 100% higher than with nonalcoholics, and estimated 20-40% of all U.S. hospital beds are occupied by persons who are suffering from the consequences and complications of alcoholism (Schoenborn, 1991). These statistics do not include the related costs of automobile accidents, family violence, and care for infants and children affected by alcohol.

The results of the 1988 National Health Interview Survey on Alcohol estimates that 10.5 million people in the United States exhibited some signs of alcoholism and another 7.6 million abused alcohol (Seventh Special Report, 1990). Alcoholism

during pregnancy has been associated with a range of birth defects described as fetal alcohol syndrome and fetal alcohol effects. Although the prevalence of alcoholism during pregnancy is not known, the reported incidence of fetal alcohol syndrome is 1.9 per 1000 births (Abel & Sokol, 1987). No safe level has been established for alcohol consumption during pregnancy. An estimated 11% of all infants are born drug affected each year in the Northwest (Horowitz, Nickel, Shaughnessy, & Davis, 1990).

Alcoholism affects not only the addict, but also the nonusing family members. According to a 1988 study by the U.S. Department of Health and Human Services (DHHS), about 43% of the adults in the United States had been exposed to alcoholism in the family, through either a blood relative or marriage to an alcoholic (Schoenborn, 1991). Consequences for family members exposed to alcoholism have been documented. They include economic hardship (Schoenborn, 1991); social isolation; health consequences from physical, emotional, and sexual abuse; increased family violence (Amaro, Fried, Cabral, & Zuckerman, 1990; Hurley, 1991; Swett, Cohen, Surrey, Compaine, & Chavez, 1991); parental failure (Fanshell, 1975); and other dysfunctional family patterns (Black & Mayer, 1980; Cruse-Wegscheider, 1989; Finkelstein, 1986).

## Gender Differences

### Health Effects

Women who are alcohol dependent have significant health problems. Physiological differences between males and females influence the effects of alcohol

and other drug consumption on the body. One difference is the relative proportion of body fat and body water. Women have a higher proportion of body fat and less body water. Because ethanol is distributed in body water, women attain a higher blood alcohol level than do men of the same body weight as the women when an equivalent amount of ethanol is consumed. Although reports about interactions between the menstrual cycle and metabolism of alcohol have been conflicting, both blood alcohol levels and alcohol metabolism appear to vary at different phases of the menstrual cycle (Jones & Jones, 1976). Long-term heavy drinking has been linked to sexual and reproductive dysfunction in women (Wilsnack & Beckman, 1984). An association between alcoholism and cancer of the breast has been documented (Schoenborn, 1991). Some authors suggest that women appear to be more susceptible to the diseases associated with alcoholism and experience adverse health effects sooner than men do, demonstrating a "telescoped" disease (Blume, 1990). Mortality for female alcoholics is higher than for alcoholic males and for the general population of women. Causes of death among women alcoholics that are in excess of expected rates for women in general include cirrhosis, breast cancer, and violence (Schoenborn, 1991).

Drinking Patterns and Social Stigma

Patterns of drinking as identified by male and female alcoholics appear to differ. Women are more likely than men to report that drinking occurs when they experience major life crises (Wilsnack & Beckman, 1984; Finkelstein, 1986); when they feel powerless or inadequate (Finkelstein, 1990); and when they feel shame,

guilt, or depression (Blume, 1990; Finkelstein, Brown, & Laham, 1981; Rosett et al., 1983; Zuckerman, Amaro, Bauchner, & Cabral, 1989). Finkelstein et al. (1981) described clinical experiences of treating alcoholic mothers who reported increased drinking when feeling guilty about their children's problems.

Societal stigma and sanctions about drug and alcohol addiction contribute to denial, a behavior which may reduce opportunities for intervention and treatment especially for women. Drug dependent women, especially when pregnant, have been described as highly stigmatized (Daghestani, 1989; Finkelstein, 1990), partially because of society's focus on concerns about the fetus and partially because of the negative social attitudes about women who abuse alcohol. Social attitudes toward pregnant drug dependent women are reflected in the increased legal prosecution of women without concomitant concern for increasing treatment options for these women.

Stigmatization reinforces women's feelings of isolation, low self-esteem, and powerlessness (Blume, 1990; Finkelstein, 1990). During interviews with recovering pregnant women, Brudenell (1991) found that these women described themselves as different from "normals," i.e., nonalcoholics, and that they worked hard to appear normal while feeling very different. These women felt that nonalcoholics could not understand alcoholics and their struggle in recovery.

# Addictions Recovery

## Models of Recovery

### Alcohol Recovery: A Developmental Model

Alcohol recovery has been conceptualized by Brown (1985) as a dynamic and sequential developmental process occurring over time. Brown identifies three components to the developmental model: (a) the alcohol axis, (b) environmental interaction, and (c) interpretation of self and others. The alcohol axis, representing the continuous focus on alcohol throughout recovery, acts as a central organizing principle. According to this model, abstinence and the transition into recovery is based on the alcoholics' recognition of their loss of control over alcohol use. Recognition of loss of control is essential to the recovery process, serving as the first step in recovery.

Environmental interaction, the second component of Brown's model, is conceptualized as a dynamic process wherein individuals progress through stages of recovery within the context of their environment. As individuals identify themselves as alcoholic and learn skills to remain sober, the focus on alcohol decreases and awareness of other concerns and interests emerges. Recognition of problems other than alcohol occurs. Individuals attending Alcoholics Anonymous (AA) begin to make the distinction between the meanings of "dry" and "sober." "Dry" means being abstinent from alcohol, whereas "sober" means achieving emotional maturity and serenity and growing as a person while maintaining chemical abstinence (Brown, 1985, p. 45).

Brown's third component is the interpretation of self and others. This component involves intrapsychic change and spirituality. Increasing awareness of experiences and problems leads to the development of new coping skills, self-exploration, and the ability to deal with problems. Sobriety entails new experiences, attitudes, and concerns as never experienced before. Learning to live without alcohol must occur throughout the process.

Stages of recovery and developmental tasks within each stage have been described by Brown. Drinking is the first stage, marked by an intense focus on alcohol, social isolation, and self-centeredness. Abstinence marks the shift into transition, the second stage, which is followed by the stages of early recovery and then ongoing recovery. Early recovery is described as a stage of intense focus on learning the behaviors of alcohol abstinence. Ongoing recovery is described as a stage when behaviors of alcohol abstinence are well established and awareness of other problems besides alcoholism emerges. According to this model identification of self as an alcoholic must occur for recovery to progress. Treatment interventions need to be individualized and differ according to stages of recovery and developmental tasks within each stage. The model poses an integrated treatment approach that uses various resources including psychotherapy, Alcoholics Anonymous (AA) and other helping interventions. A key concept in all the interventions is the need for accepting a loss of control over alcohol and learning skills for living without consuming alcohol or other drugs.

Brown's model is based on intensive interviews with 80 abstinent alcoholics

(40 men and 40 women) in AA about their personal experiences of recovery, including relationships with others, personal and interpersonal adjustments, and major life changes. The model is derived from a psychological and developmental perspective with some information about physical health and daily functioning.

Among the array of psychological problems associated with recovery was depression, which was often severe and was reported by all those interviewed as occurring during the first year of recovery. Depression and low self-esteem may occur in cycles throughout recovery, with decreasing intensity, length, and frequency of the cycles as sobriety continues. According to Brown, surviving the first severe depression without drinking alcohol should contribute to a sense of strength and an ability coping. Depression may be a necessary reaction during recovery as emotions previously numbed by alcohol begin to emerge. Depression is reported to occur more frequently with newly sober women than with men (Brown, 1985; Finkelstein, 1990). Brown's theory of recovery has implications for understanding the increased risk of depression among recovering women but does not address the recovery process during pregnancy and early parenting.

Relational Model of Recovery

Finkelstein (1990) conceptualized women's alcohol and drug addiction recovery from a relational perspective reflecting women's social and psychological roles within their particular social, political and economic environments. She based her work on that of J. B. Miller (1976). Women's roles and relationships as mothers, daughters, and spouses are examined in Finkelstein's model and used as a focus for

counseling and change in recovery. Violence in relationships and societal violence against women are identified as important variables that affect all women's lives, but especially those with chemical dependence. In this model, the interactions of social and intergenerational family networks with the recovering individual are seen as important factors in the recovery process. Recovery is tied to forming social relationships that are empowering and non-destructive. Healing of women's relationships was described as crucial for success at ongoing recovery.

Alcoholics Anonymous and Other Twelve Step Programs

For over 50 years, AA has provided the means for individuals to achieve sobriety. The literature from Alcoholics Anonymous World Services includes numerous publications. Two used for resources in this study are Alcoholics Anonymous (1990) (often referred to as the Big Book) and Twelve Steps and Twelve Traditions of Alcoholics Anonymous (1990). The Big Book was first published in 1939 and contains the working premise of the program as well as 44 personal stories that recount experiences with drinking and with using a recovery program that worked. In 1990, over 88,000 AA groups met in 134 countries. One third of the AA members were women and one fifth were 30 years old and under (Alcoholics Anonymous, 1990). The Twelve Steps and Twelve Traditions of AA represent the principles by which individual AA members recover and by which the organization functions. AA's Twelve Steps are a "group of spiritual principles which if practiced every day promise to expel the obsession to drink and enable the sufferer to become happily and usefully whole" (Twelve Steps and Twelve Traditions, 1990, p. 15).

AA's Twelve Traditions apply to the life of the fellowship and is how AA retains its unity, relates to the world, lives, and grows. The Twelve Steps and Twelve Traditions have been adapted by many groups, including Narcotic Anonymous (NA), Cocaine Anonymous (CA), Adult Children of Alcoholics (ACOA), and CoDependence Anonymous (CODA).

AA's Twelve Steps follow a specific pattern. Step One through Step Seven are based on intrapsychic change, for example, coming to the realization of "powerlessness over alcohol--that our lives had become unmanageable" (Twelve Steps and Twelve Traditions, 1990, p. 5). Steps Eight through Twelve focus on relationships with others as well as a spiritual relationship with God. For example, Step Ten, "continued to take personal inventory and when we were wrong promptly admitted it" (p. 88), is used to improve relationships and to achieve emotional balance. Use of early steps facilitates progress in the later steps. The writing inventory in Step Four, for instance, forms a foundation for Step Ten inventory work. Although appearing to be similar, the intentions of the steps are different. Step Four looks at the past and Step Ten examines the present but both represent an internal psychological change. Members of AA/NA practice the steps every day, if possible, in order to achieve and maintain sobriety. In AA/NA groups, the only requirement for membership is a desire to stop drinking or using drugs. There are no fees, and traditions explicitly maintain anonymity of membership. Members assume responsibility for leading meetings, reaching out to new members through sponsorship and twelfth step work and doing their own work to further personal recovery. AA

provides a basis for attaining and maintaining ongoing sobriety, according to Brown (1985).

Key components in the recovery process of AA/NA are working with a sponsor and subsequently being a sponsor. A sponsor is defined as someone who is a member of AA or NA and usually has worked the Twelve Steps at least once. This group member is able and willing to teach a new member of the group how to utilize the Twelve Steps to initiate and maintain recovery from addiction. Healthy communication based on honesty, respect and acceptance of responsibility is modeled in the sponsoring relationship and in the relationships with other AA/NA members.

Brown (1985) discusses the role of sponsors in facilitating the work of recovery. When a person enters AA/NA, sponsors teach them how to set up a support system that can be called on when the alcoholic is going to drink or the addict is going to use. Sponsors teach "babies" in recovery how to work the program. Sponsorees are generally referred to as "babies" or "pigeons." During the transition into abstinence and early recovery, members may "babysit" a person new to recovery to help him or her abstain.

There are some similarities and differences in sponsorship and parenthood. Sponsors and parents do not charge for their help, and both are available 24 hours a day, 7 days a week. Parents and sponsors often make long-term commitments to their "babies." Sponsors and parents differ in several ways. Parents may choose to have children while the one being sponsored chooses a sponsor to meet their needs. Responsibility for asking someone to sponsor resides with the one who needs a

sponsor. Termination, if the sponsor relationship is not working, can be initiated by either one or both parties. Sponsors assume no responsibility for the recovering person but act to facilitate recovery. Parent child relationships may be terminated through legal actions and parents assume responsibility for the care of the offspring.

## Gender Differences in Addiction Recovery

Studies have established that gender differences are significant in terms of what alcohol and drug treatment is used and how recovery is experienced. Women in alcohol and drug treatment face different problems than men do and may require different interventions. According to Brown (1985), independent behaviors, such as attending meetings and going to treatment groups, associated with chemical abstinence may be more frightening and threatening to women and their family members than they are to men.

Beckman and Amaro (1986) investigated the social and personal difficulties faced by men and women entering alcohol treatment. Anglo women ($n$=54) and Anglo men ($n$=54) were interviewed while they were in treatment. Women had less favorable attitudes toward seeking health care and perceived greater adverse social and personal consequences from having entered treatment. Women encountered opposition from family and friends to entering treatment, whereas men rarely encountered such opposition. Almost 50% of the women but less than 20% of the men experienced one or more costs because of entering treatment, such as problems with money and family or friends' opposition to treatment.

Other differences between men and women in treatment include psychiatric

diagnoses and psychological characteristics (Beckman & Amaro, 1986). Women in treatment more often than men are found to have dual diagnosis such as post traumatic stress disorder, depression, and psychosis (Daghestani, 1989). Women alcoholics frequently have marital instability and may have alcoholic or drug dependent spouses (Cruse-Wegscheider, 1989; Finkelstein, 1986; Mondanaro, 1977). Women are more likely to suffer from physical and sexual abuse and to report abuse than are men (Blume, 1990; Hurley, 1991; Young, 1990).

Treatment for drug dependent women may require a new orientation for success. Reed (1987) identified the need for women-sensitive treatment services and the problems preventing the implementation of services. She noted the following factors to be important in women-oriented drug dependence treatment services: a context that is compatible with women's styles and orientations; freedom from exploitation; recognition of women's roles, socialization and relative status within the larger culture.

Evaluation of effectiveness, variables related to matching needs and services, and a theoretical base for services were lacking in the majority of treatment descriptions. In Reed's clinical experience and evaluation of women's treatment programs, women have been more likely to continue in treatment and progress in recovery when programs met needs for services such as family therapy, job skills, child rearing skills, assistance with housing, and health and legal problems. These conclusions have been supported by other clinicians (Finkelstein, 1990; Gomberg, Nelson, & Hatchett, 1991; Weiner & Morse, 1988).

## Transition to Parenthood

Pregnancy and early parenting during the first year after birth have been described as both a maturational crisis and a developmental process (Ballou, 1978; Barnard & Eyres, 1979; Bibring & Valenstein, 1976; Deutsch, 1945; Mercer, 1990; Rubin, 1975; Tilden, 1980). The childbearing period is one of parental role development that moves in sequential developmental tasks from an anticipatory maternal role during pregnancy to actualizing the mother role within the first year after birth (Mercer, 1990).

Developmental changes and tasks within the trimesters of pregnancy and the post partum have been identified (Mercer, 1990; Rubin, 1967, 1975; Tilden, 1980). During the first trimester, the pregnancy is accepted and the growing fetus is incorporated within the self identity of the pregnant woman. Maternal attachment to the fetus begins early in pregnancy and is a result of psychological and physiological events which allow a prebirth relationship to develop between a pregnant woman and her unborn infant (Cranley, 1981; Stainton, 1985). "The extent to which women engage in affiliative and interactive behaviors with the unborn fetus" is defined as maternal fetal attachment (Cranley, 1981, p. 338). Developing maternal fetal attachment has been identified as a critical task of pregnancy and interactive and affiliative behaviors with the unborn have been described for both mothers and fathers (Cranley, 1981; Stainton, 1985). Acceptance of the pregnancy and the fetus by significant others, especially the partner and the pregnant woman's mother is sought. Acceptance may increase available social support for the mother and her pregnancy.

Presence of a social support system of family, friends and professional care givers has been shown to increase maternal fetal attachment while an increase in perceived maternal stress decreases maternal fetal attachment (Cranley, 1981). During the second trimester, there is increasing separation of the self from the fetus after "quickening" or fetal movements are felt by the pregnant woman. She seeks increased dependence on the partner for support, approval and nurturance. The strength of the marital or couple relationship has been shown to increase father's affiliative and interactive behaviors with the unborn infant (Cranley, 1981). Both mothers and fathers report attachment behaviors which include awareness of fetal activity and sleep patterns, calling the fetus by name and identifying characteristics of the fetus which have meaning to the parents. Behaviors indicating attachment are present before and continue into the third trimester (Stainton, 1985). During the third trimester, there is increased separation from the fetus through emotional and physical preparation for childbirth, nesting behaviors, and identification with and self evaluation of the ability to mother an infant (Sherwin, 1987). Increased anxiety, fantasy, and preoccupation with delivery may occur as the mother seeks safe passage for herself and her infant. After birth, the infant and the mother continue to engage in a process of attachment and separation within the environment of their family and community.

Several important themes emerge from the psychology of pregnancy literature. Pregnancy is a period of psychological disequilibrium and intrapsychic change (Bibring & Valenstein, 1976; Deutsch, 1945; Tilden, 1980). The disequilibrium may

be necessary to accomplish incorporation of the maternal role in a first time mother (Ballou, 1978; Bibring, 1976; Mercer, 1990). Relationships with significant others change throughout pregnancy and include the partner, mother's parents and peers, and the fetus/infant. Reconciliation of conflicts within the family may occur especially with important people like mothers or partners (Ballou, 1978). Fantasies, dreams, and anxiety are common and may mimic psychopathology (Deutsch, 1945; Sherwin, 1981, 1987; Tilden, 1980).

Transition to parenthood continues after birth with the role of the mother progressing through phases of parenting during the first year after birth (Mercer, 1990). During the formal role, from birth to approximately 3 months after birth, early maternal developmental tasks include mother integrating her labor and delivery experiences; resolving expectations of pregnancy, labor, and delivery and her infant; assessing the normalcy of her infant; developing caretaking skills, particularly with feeding; and redefining her roles. Informal role attainment occurs between 2 to 5 months after parents have successfully attached with their infant, responded to unique cues of their infant, and developed a sense of accomplishment, competency and pleasure in infant care. Personal identification as a parent occurs when parents have internalized the parental role, see the infant as a central person in his or her life, and feel a "sense of harmony" with the role (Mercer, 1990, p. 35). Time for achievement of the personal level of the parent role is variable with the majority of mothers reporting achievement by a year after birth.

Parenting has been explained through an interactive model with clusters of

variables associated with the parent, child, and environment (Barnard & Eyres, 1979). Development within the parental role occurs over time and is a result of interaction among the parent, child, and physical and social environment. Variables in each area can contribute to dysfunctional parenting or act to cushion the effects from the other areas. An interactive model of parenting is important because it provides a framework for understanding how parents with chemical dependency problems are able to actualize the parent role while in recovery. The social and physical environment may act to buffer effects from parental problems of addiction and recovery on the child. Because interaction occurs over an extended period of time, growth and development continue for all three interacting variable clusters. Parents, as they progress in recovery and their parent role development, could be expected to move toward behaviors similar to other parents but to use different and additional environmental support for their transition of parenting.

## Alcoholism Recovery and Transition to Parenthood

Developmental and relational models of recovery (Brown, 1985; Finkelstein, 1990) and parenthood (Mercer, 1990) can be integrated and used as lenses to critically examine research with chemically dependent pregnant and parenting women. The literature in the combined fields of recovery and childbearing is relatively new and contains primarily clinical narrative accounts with a small amount of research. The majority of articles reviewed do not have an explicit conceptual orientation. Based on this literature, health care and some form of intervention for reducing alcohol and other drug consumption, such as referral to a self help group, appears to improve the

health of mothers and infants, although the effects attributed to the drug exposure were not always eliminated by comprehensive care or by non-use of substances. Mothers were able to reduce or eliminate alcohol and drug use with supportive counseling and assistance with problems such as child care, housing, transportation, and food. However, in none of the studies was recovery examined as a process that evolved over time with different treatment or intervention needs during the different stages of recovery and different trimesters of pregnancy or early parenting. When an integrated developmental model of recovery and parenthood was used to evaluate these studies, little information was available about the process of recovery and relapse occurring concurrently with pregnancy and early parenting. Classic and key studies will be reported in the following sections.

## Difficulties for Women and Their Children

Difficulties experienced by drug dependent women when pregnant or parenting and consequences for their children have been described in the literature (Bushong, 1990; Fanshell, 1975; Weiner & Morse, 1988). Studies on parenting by nonalcoholic addicted mothers are included here because they may have relevance to alcoholic mothers as well as heroin and cocaine addicted mothers. These studies may document common attitudes, behaviors, and experiences of users despite differences in specific chemicals abused, location of study, socioeconomic conditions, and ethnic status of subjects. Many studies relate experiences of low income, minority women with heroin or cocaine addiction who live in the inner city of major urban areas.

In a classic qualitative study, "Difficulty in Taking Care of Business: Women

Addicts as Mothers," Rosenbaum (1979) described women addicts who were also mothers. Using the method of grounded theory for analysis of data, the researcher interviewed 100 women addicts and observed them in their "street society" of San Francisco and New York City. Differences between male and female addicts were noted. For male addicts, "taking care of business" involved heroin-related work; women with children did not have the option of full time pursuit of drugs. Women expressed a conflict of interest between their responsibilities to their children and their desire to obtain heroin. Addict mothers entered pregnancy while experiencing a sense of failure and extreme guilt. Heroin was a way for mothers to cope with the problems of child rearing; however, children were often a controlling and limiting factor on the mother's addiction. Addicted mothers wanted "out" of the heroin lifestyle when their children and the role of mother were threatened. In spite of addiction, mothers wanted to be "good" mothers and valued the motherhood role.

Alcoholism during pregnancy adversely affects the health of mothers and their fetus/infants. Lemoine, Haronsseau, Borteyru, & Menuet (1968), in a French journal, published the first account identifying maternal alcoholism through examination of affected children. In 1969 and the subsequent 4 years, clinicians at the University of Washington examined children whose deformities and development were consistently linked with maternal alcoholism during pregnancy. The complex of growth abnormalities, physical malformation, and mental retardation was identified as a distinct clinical entity that has become known as fetal alcohol syndrome and fetal alcohol effects (Jones, Smith, Ulleland, & Streissguth, 1973).

Researchers have continued to study the effects of alcohol on the developing fetus through animal studies as well as through clinical research using descriptive designs (Streissguth, Landesman-Dwyer, Martin & Smith, 1980). In a computerized literature search by the Office of Substance Abuse Prevention (OSAP) from 1989 to 1991, 21 of 45 articles about alcohol use in pregnancy reported results of experimental exposure of mammalian fetuses to alcohol. All studies confirmed the teratogenicity of alcohol on developing mammals. Because ethical considerations have prevented human experimentation with alcohol exposure during pregnancy, clinical descriptive research and case studies about alcohol use during pregnancy continue to be the only means by which to study adverse health effects of alcohol during pregnancy for both the fetus and mother.

Russell and Skinner (1988) in a retrospective pregnancy outcome study of 531 obstetric out-patients found that alcohol consumption prior to pregnancy affected mothers and infants. Alcohol consumption prior to pregnancy predicted spontaneous abortion and infants' lowered Apgar scores at birth. Problem drinking during pregnancy also predicted intrauterine growth retardation of infants. Day et al. (1990) collected data prospectively on 461 pregnancies through 8 months after birth. All mothers were assessed for alcohol and other drug use during pregnancy through a self-report interview regarding quantity and frequency of alcohol use per day. A significant relationship was found between alcohol consumption during pregnancy and growth and morphology (shape and formation) of infants as observed at 8 months of age. Alcohol use during the second and third trimester, as well as throughout

pregnancy, was associated with decreased weight, body length, and head circumference at 8 months. Minor birth anomalies as well as fetal alcohol effects were statistically predicted based on prenatal alcohol exposure.

Critical periods of alcohol teratogenicity in fetal development have been investigated using Michigan Alcohol Screening Test (MAST) scores (Ernhart et al., 1987). The MAST is used to detect chronic alcohol problems, such as alcohol abuse and dependence. The results from the Ernhart et al. study were based on examination of 359 mother-infant pairs in a matched cohort of MAST positive ($\underline{n}=176$) and MAST negative ($\underline{n}=183$) gravid women. A non-experimental matched cohort design was used. A critical period for alcohol teratogenesis was found around conception. A dose response association between alcohol consumption and craniofacial abnormalities was found. Other malformations were associated to a lesser degree. Risk for anatomic abnormalities was clearly increased with mothers who drank more than 3 ounces of alcohol per day (the equivalent of six drinks).

The Fetal Alcohol Syndrome Prevention Project (Morse, 1991) defined heavy drinkers as consuming 5 or more drinks at one time or 45 drinks a month. A drink was defined as 1/2 ounce of alcohol. In two studies at Boston City Hospital, infants with fetal alcohol syndrome or fetal alcohol effects were born exclusively to women classified as heavy drinkers throughout pregnancy (Rosett et al., 1983). As a result of these studies, precise safe or dangerous levels of alcohol have not been identified. Alcohol effects are thought to be dose related, although subject to individual variation (Weiner et al., 1989).

Individual differences among women's reproductive variables and disease variables may alter the risk of having an infant with alcohol-related birth defects. Rosett et al. (1983) propose that the effects of alcohol appear to be mediated by dose, gestational stage at time of exposure, fetal susceptibility, maternal nutrition, parity and chronicity of alcohol abuse. The risk of having a child with fetal alcohol syndrome may increase with the addition of each mediating risk factor (Sokol et al., 1987). Prevention of alcohol-related birth defects requires abstinence from alcohol from conception throughout pregnancy. Reducing alcohol consumption during pregnancy has been shown to modify effects of alcohol-related growth retardation and to increase the likelihood of having a healthy infant (Morse, 1991; Weiner et al., 1989).

Clinical studies about the effect of alcohol use during pregnancy are confounded by extraneous variables, such as use of other psychoactive chemicals, poor nutrition, and problems with quantifying alcohol use and timing in gestation due to recall bias. In a prospective randomized cohort study of 2,002 randomly selected pregnant women in Western Australia, authors report that confounding variables, such as tobacco use, dietary habits, nutritional intake, and medications, must be examined before conclusions about the effects of maternal drinking in pregnancy can be validated (Walpole, Zubrick, & Pontre, 1989). In spite of limitations of research studies, it is estimated that almost 5% of all congenital anomalies may be attributable to perinatal alcohol exposure (Ernhart et al., 1987).

An area of concern for addicted women in treatment is exposure to and

infection from human immunodeficiency virus (HIV) through sexual behaviors and drug use. Suffet and Lifshitz (1991) examined women addicts' responses to the threat of AIDS. Data were obtained from pregnant women and mothers who had been addicted to heroin. Most had been intravenous (IV) drug users. Thirty patients enrolled in a comprehensive health care program in New York City were interviewed. All interviewees feared AIDS, and consequences of infection for themselves and their children and used strategies to deal with the threat. Past IV drug use was considered by some to be a risk and receiving methadone had curtailed this risk. Other strategies to reduce risk included assessment of the male partner for use of IV drugs, reduction in the number of sexual partners, the practice of monogamy and celibacy, and condom use. Most male partners did not use condoms and women acceded to this. Vigilance and avoidance were manifested by women who chose to be tested for HIV (Suffet & Lifshitz, 1991).

## Pregnant and Parenting Women in Treatment

Results of studies have demonstrated that pregnant women with addictions do respond to efforts to decrease their use of alcohol and other drugs, while comprehensive services support efforts by mothers to improve the health of their children. Interventions that helped pregnant women reduce alcohol/drug use were found to decrease the likelihood of alcohol-related birth defects as well as child abuse and neglect. Understanding the etiology of drug use is key to developing interventions for prevention, early detection, and treatment and rehabilitation during pregnancy (Lindenberg, Alexander, Gendrop, Neniciollo, & Williams, 1991).

In two quasi-experimental studies, therapy for heavy drinking was integrated with routine prenatal care for 791 women through the clinic at Boston City Hospital and 464 women at maternal health centers in Stockholm, Sweden (Rosett et al., 1983; Weiner & Larsson, 1987). Identification and classification of alcohol use were standardized through a three-phase classification system based on motivating factors for drinking rather than quantity or duration of consumption. The phases were not necessarily progressive, although some women had moved from one phase to the other.

Women who drank because of social pressure, the first phase, were able to decrease their alcohol consumption after receiving information about effects of alcohol on the fetus. For these women concern by the father of the baby and other family members was an important motivating factor in reducing consumption.

In symptom problem drinking, the second phase, women used alcohol consumption to relieve a range of psychological symptoms and depended on alcohol to alter their mood and perception. Some women used alcohol to blur feelings of loss, fear, confusion, and depression. Pregnancy often exacerbated an already stressful life situation, and women often experienced ambivalence toward motherhood and its added physical and social responsibilities. Women in this group often were more sensitive to staff comments, frequently misinterpreted comments, and required repetition of information about pregnancy and the birth process. All the women in this group required extensive counseling and support for social problems and the normal developmental crises of pregnancy. They were able to decrease alcohol

consumption through the additional support and counseling by the staff.

Women who were alcohol dependent, the third phase, exhibited physiological tolerance and dependence on alcohol. Eleven percent in the Boston sample and 4% in the Stockholm sample were diagnosed with alcoholism. Many consumed .5 to 1 liter of alcohol a day. Several had medical complications related to alcohol use, such as hepatitis and pancreatitis. Health care, assistance with social problems, and child care were required by all women in this group. Alcoholism treatment centers, halfway houses, and AA groups were used to supplement therapy and support from the clinical staff.

Interventions of counseling and education were designed based on the classification phase of alcohol use. An alliance was formed among the woman, therapist, and clinical staff. The therapeutic alliance focused on having a healthy child. Two-thirds of 49 problem drinkers who attended three or more counseling sessions reduced their drinking. Age and parity were two factors that distinguished women who were able to reduce their drinking from women who could not. Younger women without other children were more likely to reduce alcohol consumption or to abstain completely, while women who reported they drank to relieve depressive or nervous symptoms had a less favorable outcome. Quantity of alcohol use was not a significant predictor of success in reduction of alcohol use. Women who drank heavily, and whose offspring were at greatest risk, responded by reducing alcohol consumption when supportive counseling was included in prenatal care.

Halmesmaki (1988) summarized the experiences of a program of intensive

alcohol counseling and prenatal care given to 85 problem drinkers in the University Hospital, Helsinki, Finland. Findings from this study suggested that intensive counseling and prenatal care reduced the incidence of fetal alcohol syndrome and fetal alcohol effects among infants born to alcoholic pregnant women. Other findings were that the most severely damaged infants were born to mothers who continuously abused alcohol while pregnant. A control group was not used and subjects' alcohol use level in this study at initial assessment ranged from moderate drinking (defined as 10 drinks at one time) to a 5- to 20-year history of alcoholism. Measurement of alcohol use was based on self-reporting. Little information was provided by the authors about the intervention of intensive counseling. Other variables that may have affected alcohol use, such as residential treatment of mothers, were not reported. Criteria for the diagnosis of fetal alcohol syndrome were described by the author and are similar to those in the United States.

Chan, Wingert, Wachsman, Schuetz, and Rogers (1986) compared the birth and maternal characteristics of 87 first year drop outs with 103 active participants of a pediatric clinic that provides long-term follow-up care to children exposed prenatally to substance abuse. Compared to the dropouts in this descriptive study, the active participants were more likely to be Hispanic and to receive prenatal care, were less likely to smoke, and delivered babies who were heavier and older at gestational age. Drop outs were less likely to have received a detoxification treatment. Both the mothers and infants in the drop out group were high risk for continuing health problems.

## Depression and Mental Health Concerns

Depression and mental health concerns of women during pregnancy and early parenting may be linked to the developmental transitions of pregnancy, post partum effects and alcohol recovery. Depressive symptoms and associated health behaviors in women during pregnancy may have been an important connection with the socio-emotional environment provided by the mother and with infant outcomes (Zuckerman et al., 1989).

In the Zuckerman et al. (1989) descriptive study, 1,014 low income, minority women who attended a prenatal clinic at Boston City Hospital were interviewed and asked to provide urine samples for marijuana and cocaine metabolites. Scores for depression were obtained on the Center for Epidemiological Studies-Depressive Scale (CES-D) and ranged from a low of 0 to a high of 57 with a median score of 16. Depressive symptoms were more likely to occur in pregnant women who had high life stresses, decreased social support, and poor weight gain and who used cigarettes, alcohol and cocaine. The researchers concluded that assessment of a woman's affective state, social context, and mental health is important in planning health interventions to prevent adverse pregnancy outcomes.

The Zuckerman et al. study had important limitations, including the narrow sample of predominantly low income, minority women; no differentiation of depressive symptoms that may be a consequence of adverse behaviors rather than a cause; measurement of depression with the CES-D that was not specific for pregnancy and did not differentiate between clinical depression and symptoms related to

pregnancy and the living experiences of poor inner city, minority women. However, based on the association of depression during pregnancy and poor health behaviors, such as, the use of tobacco, alcohol and other drugs, the researchers believed it would be prudent to address mental health concerns, especially depression, when intervening with health behaviors. Depression may add to the likelihood of alcohol and other drug use, although its placement as a cause or effect of substance abuse has not been determined.

Characteristics of pregnant and parenting women in treatment for chemical dependence have been identified in clinical observations. Daghestani (1989) has written a description based on a review of the literature and clinical experience gained through the Perinatal Center for Chemical Dependence at Northwestern University in Chicago. According to Daghestani, psychopathology in the pregnant addict population stems from a number of sources and may include dual diagnoses. The pregnant addict often has multiple social, family and interpersonal losses that result in feelings of grief. Women often report feelings of anxiety and depression as well as suicidal thoughts and attempts. Psychological concerns are brought to awareness during both pregnancy and alcohol recovery. Underlying psychological issues related to intimacy and sexuality, if not dealt with in counseling, may increase the likelihood of relapse. Alcoholic mothers who drank while pregnant but were in treatment described themselves as feeling guilty and blaming themselves for any of their children's problems. Guilt and low self-esteem have been found to be associated with renewed drinking when there were no counseling interventions (Finkelstein et al.,

1981).

Interventions for alcohol/drug dependence during pregnancy are important because they foster healthy behaviors that may continue after birth. In spite of limited evaluation data from programs that serve addicted mothers in recovery, the consensus is that the majority of mothers who participated in prenatal care and received counseling and drug treatment are able to have healthier babies and parent their children more effectively.

## Preliminary Study

In a preliminary study, Brudenell (1991) explored how women viewed their simultaneous experiences of alcohol/drug recovery and pregnancy or post partum period. Concepts about recovery in the literature were compared with concepts that emerged from the data on a sample of women. This comparison led to both refinement and generation of tentative new concepts and ideas about recovery and relapse for women at this stage of life.

Data were collected from interviews, medical records, and observations of six self-identified recovering women either in the third trimester before childbirth or within the month after delivery. All participants received prenatal care and had been "clean and sober" from 6 months to 2 years. They had been recruited from a prenatal care program that served low income patients. Participants were interviewed either at their home or a health care provider's office. Of the six women, three had partners who were drug free and attended AA/NA groups and three did not have partners. There were no racial or ethnic minorities among the six women.

Using the method of constant comparative analysis (Glaser & Strauss, 1967), Brudenell formulated some preliminary recovery process concepts for childbearing addicts. Results were validated with one participant who was willing to review findings. From the analysis of the participant interviews, a recovery process described as "breaking a cycle of abuse" was identified. Substance abuse was connected by the mothers to family violence, child abuse, and neglect. Women identified the importance of their alcohol/drug recovery as a way to become mothers who did not repeat familial patterns of child abuse and neglect. The recovery process during pregnancy and post partum for this group of women was interactional and involved breaking through several cycles of behaviors and thought patterns that were destructive. Learning and maintaining new patterns of behavior and thinking and developing spirituality were intensified during pregnancy and were portrayed as an ongoing daily struggle. Mothers reported continuing difficulty with memory and depression that made learning difficult.

Episodes of relapse occurred during this process when one mother drank after losing her job and again to cope with fear when her infant was in NICU for several days. The meaning of relapse for women changed with a longer period of sobriety. Early in recovery, relapse was viewed as renewed drug or alcohol use. With an increase in length of sobriety, negative emotions and resentments were also described as relapses. However, length of sobriety was not related to risk of relapse and one participant said "it doesn't get easier with time." Understanding relapse has many implications for nursing care to facilitate both recovery and maternal role transition.

Findings from this preliminary study were used to identify areas of future investigation, limitations to address in a subsequent study, and recruitment strategies for participants. Subsequent studies could elaborate more fully on how the stages of the recovery process interact with the stages of maternal role and with family and support changes. Such studies could contribute to the development of a conceptual understanding of how women experienced both the recovery and childbearing processes. Limitations of the preliminary study included the use of a small, homogeneous sample drawn from one low income prenatal clinic and the single interview with all but one participant. Subsequent studies could yield more if the sampling included women from a variety of sources and different backgrounds. The interest and enthusiasm of participants suggested that women might be willing to have several interviews if the researcher negotiated convenient times and places to meet, maintained confidentiality, and established a relationship.

## Methadone Studies

Methadone-maintained women are frequently included in studies of drug-addicted pregnant women because of the women's availability and concern about the health effects from their high risk life style. Wellisch and Steinberg (1980) investigated parenting attitudes of nonaddicts and of female heroin addicts receiving methadone maintenance. A single factor design was used in the study with age and race as covariates. Twenty-five women in four groups were compared on the Parenting Attitude Research Instrument (PARI). The four groups consisting of: (a) addict mothers receiving methadone, (b) addict women who were not mothers,

(c) women who never were addicts but were mothers, and (d) women who were neither addicts nor mothers. A parenting style of "Authoritarian over Involvement" as measured by the PARI significantly differentiated addict mothers from the other groups. The 1980 study appeared to confirm earlier clinical observations of addict mothers in a parent training program who viewed their babies as objects to meet their demands.

Wellisch and Steinberg (1980) suggested that assessment of the addicted mother's feelings, attitudes, and behaviors toward parenting while receiving methadone was necessary. In addition, they felt that assessment of the mothers' perception of her own nuclear family experience should be included in comprehensive care. Findings from this study suggested three approaches for treatment of addict mothers: (a) education, including child development, (b) skills training, such as communicating with infants, feeding, and bathing, and (c) psychotherapy in a small supportive group that would focus on recognizing what was maladaptive in the mother's own nuclear family. The goal of the therapy would be to assist women to not repeat previous dysfunctional parenting patterns.

Mondanaro (1977, 1989) has provided two clinical descriptions of patient behavior at the Pregnant Addicts Program in San Francisco, a methadone maintenance program where she was the medical director. The mothers' behaviors were seen as products of the mothers' battering as children and continued battering as adults. Although the mothers were often unrealistic in their expectations of their infants, themselves, and their partners, they valued the mother role.

Suffet and Brotman (1984) described results from a comprehensive care program for pregnant addicts and addicted mothers associated with the New York Medical College. Enrolled in the program were 278 pregnant women who received methadone for heroin addiction and delivered 218 infants. A greater length and amount of prenatal care received by the mothers directly related to higher birth weight, older gestational age, and lack of complications at birth for mother and baby. Mothers continued in the program for 2 years or more and participated in parenting classes, pediatric care for their children, and counseling and received assistance with social and economic problems.

Drug addicted mothers' parenting behavior and their children's development were the focus of a study by Bauman and Dougherty (1983). Two groups of 15 mothers on methadone maintenance and their 15 preschool age children were compared with 15 nonaddicted mothers and their 15 children. Aspects evaluated included the mother's personalities and parenting attitudes, the mother-child interaction, and the children's intelligence and developmental level. Methadone-maintained mothers were less adaptive in their personalities and parenting behaviors. Parenting attitudes did not differ between the two groups of mothers. Children of the methadone-maintained mothers performed more poorly on measures of intelligence, development, and socially adaptive behavior. Findings suggested a disparity between parenting attitudes and parenting behaviors of addicted mothers. Recommendations from the study included parenting skills training for mothers and evaluation and referral of children of methadone-maintained mothers for remedial education.

In contrast, evaluation data based on clinical observation by staff members from the Pregnant Addicts/Mothers program at the New York Medical College (Leif, 1985) demonstrated that simply providing comprehensive health care, parenting support, and chemical dependence treatment could improve the parenting behavior of the mother and the health and development of the mothers and their children. Addicted mothers were able to provide competent child care if they received comprehensive care and drug treatment.

## Summary of Literature

Two prominent areas of interest in the literature on chemically dependent pregnant women and mothers of infants have been addiction treatment outcomes and parenting issues. In the area of treatment results, studies have documented that comprehensive care combined with counseling, treatment, and education decreased women's alcohol/drug intake and improved the pregnancy and neonatal birth outcomes. Mothers were motivated to decrease alcohol/drug use to improve the health of their babies (Weiner & Larsson, 1987).

Although factors that affect alcohol/drug use by mothers have been identified, a theoretical explanation of women's recovery combined with transition to parenthood is missing in the research studies. One clinical account used Brown's developmental model of recovery (Kaplan-Sanoff & Rice, 1992). None of the studies looked at the effects of key interpersonal relationships, such as with a partner, or other family members, which have been shown to be important to women during both pregnancy and early parenting (Ballou, 1978; Rubin, 1975). All the studies reviewed utilized a

limited sample of women, many from large urban areas, who were low income. Many of the women came from impoverished living situations where violence and fear confounded the effects of alcohol/drugs and made recovery even more of an effort. Only two accounts of clinical experiences with addicted mothers (Kaplan-Sanoff & Rice, 1992; Rosett et al., 1983) reported the use of support from AA/NA groups for recovery of pregnant or parenting women.

The literature has identified motherhood attitudes and intergenerational abuse as factors affecting the parenting abilities of drug dependent mothers. The researchers agree that motherhood is "psychologically loaded" (Jessup & Green, 1987) for addicted pregnant women. Many addicted women believe that motherhood is the only socially acceptable role remaining to them and thus the only way to achieve feelings of self-worth. These insights about the value of motherhood, the mothers' concerns about mothering, and the mothers' own experiences of being parented as a child are important considerations in treating women with chemical dependencies who are pregnant or caring for their children.

Comprehensive care programs oriented toward improved parenting are now addressing parenting issues and child rearing skills in recognition of the intergenerational abuse experienced by many drug dependent women. However, the influence of psychological, physical, and social changes during recovery are not described in parenting interventions or prenatal care. During recovery, continuing functional problems and difficulties with memory, attention, and recall appear to affect learning. Although the consequences of childhood abuse and the role of family

violence on parenting ability are recognize, their effect on the transition to parenthood combined with recovery has not been addressed.

## Definition of Terms

Integration of the developmental models of drug use recovery and parenthood with incorporation of relational changes provides a possible conceptual framework for understanding recovery during pregnancy and early parenting. Brown's developmental model (1985) identifies recovery as a process that occurs over time and involves psychosocial, physical, cognitive, emotional and spiritual changes. Finkelstein (1990) depicts women's recovery from addiction within a relational model of interaction between the recovering woman and the social and intergenerational family network. Mercer (1990) has identified the developmental transition of parenthood as a process that involves physical, psychosocial and role changes over time. These three models have contributed concepts that helped frame the tentative conceptual map for this study and allowed the researcher to further define the concepts.

The life experience of recovery from alcohol abuse during childbearing and early parenting from the perspective of the recovering woman has not been studied systematically. Theoretical concepts based on women's descriptions of recovery and motherhood, rather than on partially relevant models of recovery and models of transition to parenthood or clinicians' perceptions, are essential to understanding the process of recovery from alcohol abuse during childbearing and early parenting. Knowledge about the concurrent processes of alcohol/drug recovery and parenthood

transition may be used to increase the sensitivity and effectiveness of interventions to help women attain and maintain alcohol/drug recovery. The purpose of this study was to generate a descriptive, conceptual framework of women's recovery process during the transition to parenthood. Concepts already identified in the literature were used to guide this study and were refined through the research process and results. The working definitions of concepts are given below:

Alcoholism. As adopted by the American Society of Addiction Medicine (ASAM News, 1991):

> Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic: impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences and distortions in thinking, most notably denial. (p. 9).

Sobriety. "A condition of being abstinent or temperate with alcohol and achieving a sense of emotional maturity and serenity; growing as a person" (Brown, 1985, p. 45).

Dry. A term used by alcoholics to denote a condition of being abstinent from alcohol.

Chemical abstinence. Nonconsumption of psychoactive substances.

Alcohol recovery. A long-term developmental process of healing from the

effects of alcoholism. Recovery is not a mirror image of alcohol addiction but a construction and reconstruction of a person's identity and world view. Persons in recovery are in a process of learning to live without chemicals. Individuals experience physical, psychological, and relational changes over a period of time. Stages in recovery include drinking, transition to abstinence, and early and ongoing recovery (Brown, 1985).

Relationships. The state of being connected through kinship or alliance (Clarke & Summers, 1981). Interpersonal connections are identified as important in both the transition to parenthood (Barnard & Eyres, 1979; Mercer, 1990) and the recovery process of addicted women. Building relationships is an important part of maintaining recovery for women (Finkelstein, 1990).

Relapse. An intense focus on alcohol and other drugs with renewed chemical use. Relapse prevention rests on the individual's desire to remain abstinent, a knowledge and demonstration of how to remain abstinent, and a supportive environment of family and friends (Brown, 1985). A slip, sliding backward, or a fall are terms used by alcoholics to describe relapse.

Transition to parenthood. Development of the parent role through a phased process beginning with the anticipatory mother role during pregnancy, followed by a formal role after birth, an informal role from 2 to 5 months after birth, and finally integration of the personal maternal role achieved by a year after birth (Mercer, 1990). The process described by Mercer was based on a developmental model of interaction between the parent and infant within a social and physical environment

(Barnard & Eyres, 1979).

Early parenting. The parent-child relationship in the period after birth until approximately 1 year after birth.

Adjusted gestational age. The corrected age of the infant when the number of weeks premature are subtracted from the chronological age.

Index pregnancy. The participant's current pregnancy during the study period.

Spirituality. According to the AA model of alcohol recovery and Brown (1985), a change from viewing from the self as center of the world to viewing the self as part of a larger whole; a belief in a higher power.

Transformation. A process by which an individual shifts beliefs and constructs a new personal identity with compatible behaviors, thoughts, and emotions (Brown, 1985).

# CHAPTER III

## METHOD

The purpose of this study was to explore and describe factors related to women's concurrent experiences of recovery from alcohol dependency and the transition into parenthood, which begins in pregnancy and continues through early parenting during the first year after birth. The study focused on understanding these concurrent experiences from the perspective of the recovering women. An attempt was made to uncover and describe a process of alcohol/drug addiction recovery for women that incorporated the developmental and relational aspects of pregnancy and parenthood as well as those of recovery. Two research questions were addressed: (a) What is the alcohol/drug recovery process for women who are pregnant or parenting an infant less than a year old and (b) how do women experience the transition to motherhood?

### Design

The study used a qualitative design whereby some tentative concepts about alcohol recovery and the transition to motherhood were explored and other relevant concepts were developed. The developmental and relational concepts of Brown (1985), Finkelstein (1990), and Mercer (1990) were included in the results to the extent that they were present in the material generated from the data collected and analyzed. A naturalistic approach was used so that women's alcohol recovery was examined within the context of their daily lives. Participant observations, intensive interviewing, and diaries (Bogdan & Taylor, 1984; Glaser & Strauss, 1967; Lofland

& Lofland, 1984) were used for data collection from a purposive sample of recovering women alcoholics who were also in transition to parenthood. The goal of the analysis was to identify and/or further define empirically grounded concepts for a theory of women's alcohol recovery while in transition to parenthood.

Grounded theory was proposed by Glaser and Strauss (1967) as a method to generate theory in areas where little research has been done and when a fresh perspective is needed. Inductive and deductive reasoning processes are used to guide the process of building theoretical concepts and relationships from the data. A combination of inductive and deductive approaches was used for this study because the models of recovery and transition to parenthood, although providing some deductive guidelines, were insufficient to explain the experiences of this population of women. Grounded theory is a form of field methodology used to develop theoretical concepts grounded in the substantive phenomena in order account for the social context under study (Stern, 1980). Theory is said to be "grounded" when it is inductively drawn from and supported by the data. Data may come from a variety of sources, such as interviews, observations, and documents, from which concepts are inductively developed and then compared deductively with literature sources (Stern, 1980).

Grounded theory originated in the discipline of sociology and is guided by assumptions underlying the theory of "symbolic interaction" of human behavior. These assumptions are: humans act toward things, which can be people, objects, or institutions, on the basis of the meaning that things have for them; meaning arises out

of social interaction; meaning is formulated and modified through an interpretative process of interaction; and patterns of social life may be discovered that describe basic social processes (Blumer, 1969; Chenitz & Swanson, 1986). The emphasis of grounded theory is on understanding the process and meaning of human interaction in a social world (Chenitz & Swanson, 1986). The philosophical assumptions of this method, therefore, fit with the relational and developmental aspects of the models by Finkelstein, Mercer and Brown.

## Overview of Research Plan

Data were obtained through semi-structured in-depth interviews using an interview guide that elicited descriptive responses. Other data consisted of the researcher's observations during the interview and diary entries by recovering women. Diary entries were used to write perceptions and experiences of recovery and pregnancy during the study period. The question format of the interview guide encouraged women to discuss their experiences. The purpose of using the interview guide, observation, and diary was to provide multiple sources of data to describe in detail experiences of recovery and transition to parenthood. Theoretical sampling of the data from informants and other sources like the literature and diary entries of participants continued as the emerging categories of concepts guided development of a substantive theory of alcohol recovery during childbearing and early parenting. Sufficient data were collected to achieve the saturation of most categories necessary for the development of a substantive conceptual framework.

Data collection included both cross sectional and longitudinal data from

individuals at different developmental phases during the transition to parenthood. Originally, repeated interviews were planned with pregnant individuals during three developmental time periods -- the last 3 months of pregnancy, the 6 weeks after birth, and 5 months after birth. These developmental time periods were planned to capture transition points during the process of becoming a mother. Although the actual availability of the same women in each of these developmental time periods was less than needed, other women did enter the study in different periods of pregnancy and early parenting.

The study sample consisted of 11 pregnant and parenting women. Points of induction into the study for the women are given in Table 1. The researcher attempted to adjust the interviews to correspond to the above identified developmental time periods. Each participant was interviewed at least twice, and five participants were interviewed three or four times. Over 1,000 pages of transcripts and a total of 29 interviews were completed over a period from September 1992 to May 1993. In addition to individual interviews, two small group interviews were held to confirm and clarify findings with participants.

## Setting and Study Group

### Setting

The setting for the study was a metropolitan area in Idaho surrounded by rural areas and farming communities. The metropolitan area is a small city of 150,000. All participants lived in different areas within the city limits. Idaho has no statewide statistics on prevalence of alcohol use during pregnancy. However, information from

Table 1

Stage of Pregnancy or Parenting, Total Pregnancies, and Length of Chemical Abstinence at Initial Interview

| Pregnant | Participants (number) | Total Pregnancies (number) | Length of chemical abstinence (years) |
|---|---|---|---|
| First trimester | 1 | 3 | .75 |
| | 1 | 3 | 5.00 |
| Second trimester | 1 | 1 | 1.00 |
| | 1 | 1 | 2.00 |
| Third trimester | 1 | 2 | .50 |
| | 1 | | 3.00 |
| | n=6 | | |

| Early parenting | Participants | Length of chemical abstinence (years) |
|---|---|---|
| Birth to 2 months | 1 | 5.5 |
| 3 - 5 months | 1 | 5.5 |
| | 1 | 5.5 |
| 6 - 8 months | 1 | 1.5 |
| 9 - 12 months | 1 | 7.0 |
| | n=5 | |

birth certificates about alcohol use during pregnancy and about fetal alcohol syndrome is collected and published in an annual report issued by Idaho Department of Health and Welfare. Illicit drug use is not included on the birth certificate information. Trends from 1989 to 1990, as reported in this Annual Report (1990), included an increasing proportion of unmarried mothers reporting both alcohol and tobacco use during pregnancy. No infants born with fetal alcohol syndrome were reported during the same 2-year period.

Study Group

Recruitment of sample. Three difference approaches were used to recruit participants for the study. The varied approaches were used to reach as diverse a group of women as possible. The three approaches were: soliciting through health agencies, advertising in the major local newspaper, and posting fliers in selected public areas.

Several health agencies were contacted for permission to recruit participants from among their clients. Help was sought directly from agency staff, and fliers were also displayed on bulletin boards and in public areas at these agencies. One agency contacted was a community hospital where childbirth education classes are conducted and the majority of the area births occur. A description of the study was presented to the hospital supervisors and permission to recruit was obtained (see Appendix A). About 200 fliers about the study were distributed through the childbirth education classes and through the hospital perinatal care staff. In addition, physicians and nurse supervisors at the district health department and family practice residency program,

which provided prenatal and pediatric care to low income women and families, were contacted and agreed to distribute fliers to clients attending the prenatal clinic. Another health agency contacted ran a drug/alcohol treatment program that provided drug treatment to state-sponsored clients. Clinical supervisors of the program gave approval to distribute information about the study to clients attending treatment groups. At each agency, staff were requested to inform clients of the study and to distribute fliers through personal contact. These fliers were also displayed on bulletin boards and in public areas at these agencies.

Recruitment for study volunteers through the local newspaper, The Idaho Statesman, consisted of advertisements in two regularly published columns entitled "Someone Needs You" and "Health Events." The third recruitment methods was through fliers posted in public areas that might be likely sources of participants. Permission to post the fliers was obtained from the appropriate offices. These locations and organizations included, among others, buildings where AA meetings occurred, the local university campus, women's organizations, and supermarkets. A sample recruitment flier is in Appendix B.

Interested women contacted the researcher for a complete description of the project. The criteria for participation were explained. To participate the woman had to be age 18 years or older, in alcohol recovery, and either pregnant or mothering an infant less than 12 months of corrected gestational age. Participants who were pregnant had to be receiving prenatal care. Recovery status was by self-report at the initial screening.

During the recruitment and early interview period, it soon became apparent that all women reporting alcoholism were also reporting addiction to other drugs. The original focus on women in alcohol recovery was therefore broadened to include women in recovery from other psychoactive chemicals as well as alcohol.

After the initial telephone contact, an interview was arranged between the researcher and the participant at a mutually agreed upon time and place. The women were asked to agree to participate in interviews, to be observed, and to record experiences in diaries that would be read by the researcher. Prior to the first interview, the study was again explained to the prospective participant. Once the woman agreed to be a participant, she signed an informed consent form (see Appendix C). At the subsequent interview during the study, the researcher re-explained the study and verified continuing consent for participation.

Characteristics of study group. The 11 participants in the study were recruited through the following methods: 2 through fliers at AA meetings, 4 through health department prenatal clinics, 1 through a local acute care hospital, 3 through newspaper announcements, and 1 through "snowball" effect. Fourteen women were screened initially and included in the study, but three of them could not be included because they did not meet all the alcohol/drug recovery criteria once the data were examined more closely. Two did not identify themselves as alcoholics but were currently abstaining and the other identified herself as an alcoholic but was drinking, according to data collected during her interview. Of these three women, one was recruited from the newspaper, one from the health department prenatal clinic, and one

from a community flier.

Of the study's 11 participants, 6 women were pregnant at the initial interview. Three of these were primigravidas. As required by the study criteria described above, all six pregnant women were receiving prenatal care either through a low income clinic or through private care providers. At the initial interview, two women were in the first trimester of pregnancy, two in the second trimester, and two in the third trimester, as summarized in Table 1. Five of the 11 women were parenting infants younger than 1 year adjusted age at the initial interview. One infant was 5 weeks old; two were between 3 and 5 months old; and one infant had been born at 32 weeks. For the mother of this preterm baby, the initial interview occurred when the infant was approaching his first chronological birthday. Three of the mothers, all pregnant at induction to the study, were also parents to older children and two of these three women reported alcohol/drug use during previous pregnancies.

The range for the length of chemical abstinence and/or sobriety from alcohol and illicit drugs at the initial interview was 6 months to 7 years. The time between the beginning of chemical abstinence and the current pregnancy or the most recent pregnancy varied. Two women reported having used only alcohol during the current pregnancy but did not continue it after the first trimester. The other nine women had been chemically abstinent for 1 to 7 years before the current pregnancy. Table 1 summarizes this information. All but three women were nonsmokers at the time of the study. One of these woman had decreased her use of cigarettes and was "trying to quit before the baby came home from the hospital." Another smoker had stopped

and then restarted before delivering her child. One participant continued to smoke a pack of cigarettes a day throughout her pregnancy. Concerning consequences of their past substance use history, six women reported having received citations for driving under the influence (DUIs) and four reported jail time on drug-related charges. All but two participants reported intergenerational substance abuse in their immediate family, including parents and grandparents, or in their extended family, such as aunts and uncles.

Demographic characteristics of the participants were obtained through questions during the interviews and are displayed in Table 2. Ages of participants ranged from 18 years to 39 years (M=28.6 years). Two had completed tenth grade in high school, five participants had completed high school, one had attended 3 years of college, and one had completed college. One participant was currently attending twelfth grade in high school and one was attending college. All 11 of the women identified their race as caucasian. Participants reported a range of socioeconomic status from "low income" to "upper middle class." Economic status had improved for all women since beginning recovery. Many were buying their own home or had comfortable apartments.

Three of the mothers reported having one or more chronic illnesses or conditions such as arthritis, lupus erythematous, asthma, depression, and mobility alterations that required ongoing health management in addition to their alcoholism or addiction. Nine women had received either outpatient or inpatient alcohol treatment and eight were current members of an AA or NA twelve step support group. Two

Table 2

Characteristics of Study Group at Time of Initial Interview

| Characteristics | Women (n=11) |
|---|---|
| Age and education | Years |
| Age (years) | |
| Range | 18 - 39 |
| Mean | 28.6 |
| Education Completed (Years) | |
| Range | 10 - 17 |
| Mean | 12.9 |
| | |
| Other characteristics | Number of women |
| Current marital status | |
| Partnered or married | 10 |
| Non-partnered | 1 |
| Ethnicity | |
| Caucasian | 11 |
| Employment status | |
| Working full-time outside the home | 1 |
| Working part-time outside the home | 1 |
| Student - high school | 1 |
| Student - college | 1 |
| Homemaker (for income or as mother/wife) | 7 |
| Socioeconomic status by self-report | |
| Low income | 7 |
| Middle income | 3 |
| Upper middle income | 1 |

women did not currently attend a support group, and one still attended an alcohol treatment after care group.

Among the 11 participants, 10 women were in partnered relationships. Nine of the ten were married or living with a male partner; one maintained a relationship with the father of her baby but lived at home with her own parents. The one non-partnered participant lived alone and did not have a relationship with the father of her baby. That father was reported to be alcoholic. Eight of the couples were married. Six for a second time. Only 2 of the 10 male partners were reported to have been married previously. Participants considered the relationship with their partners as very important to their recovery and parenting. The one participant whose partner relationship had ended continued attempts to reconcile with the father.

Two of the partners had no alcohol and drug problems, while the other nine partners were currently "in recovery" themselves from alcohol/drug addiction. All but one of these male partners were cross addicted to alcohol and other drugs. Five of the partners were reported to be attending AA/NA, and five had received outpatient or inpatient alcohol/drug treatment. All of women's partners were employed. Two partners had been recently released from prison and were getting re-established with work and family. Participants reported that four of the partners had experienced intergenerational alcoholism and seven had experienced childhood abuse and/or neglect.

Three women reported having had a sexual partner in the past who had been an intravenous (IV) drug user. Among the 11 women's partners, 6 had tested

negatively for HIV exposure and two had not been tested. The other three partner's HIV testing status was unknown to the women.

## Protection of Human Subjects

This study was approved by the University Institutional Review Board for Oregon Health Sciences University (see Appendix D). In addition, approval was sought from cooperating agencies in Idaho as needed: including a local hospital and the district health department (see Appendix A). Each participant either read or was read the informed consent agreement and signed a consent form after explanation of the study. Consent forms were maintained by the researcher in a locked file and office.

Efforts were made to ensure anonymity and confidentiality of participants. Transcripts were coded and kept separate from identifying information, and all tapes were erased or returned to the participants at the conclusion of the study. The diary entries were identified by neutral identifiers and read into the tape recorded interview. Non-identifiers were used in all field note entries. All journals, notes, transcripts, and tapes were kept in a locked drawer in a locked office to help maintain confidentiality.

All identifying and person-specific information have been removed from this study. Each participant was sent a summary of the findings at the conclusion of the study. An opportunity was provided to the participants to meet as a group with other participants or to discuss the findings with the researcher individually.

Participants were advised at the beginning of the study that the researcher was

mandated by law to report suspected abuse and neglect. If current abuse was suspected, the researcher would discuss the situation with the participant and a designated person at the referring agency. The women were told that in these emergency situations only information that was needed to protect life and health would be shared with the referring agencies. No suspected cases of abuse or neglect were reported by the researcher during the study period. Participants were referred to their health care providers, counselors, or AA/NA sponsors as appropriate for other types of problems that emerged during the study. During the interviews, no psychological or physical distress was reported. Data concerning the suspected or current abuse of illegal drugs were erased from the tape and deleted from the transcript for further legal protection of participants' confidentiality.

## Data Collection Procedure

### Interview Guide and Process

An interview guide was developed by the researcher and modified through a preliminary study (Brudenell, 1991). The guide used open ended questions to elicit descriptive responses and was revised throughout the interviewing process to reflect the developing conceptual material (see Appendix E). Through an emergent process, new questions were added to the interviews as new information and areas of concern developed for each woman. The dialogue pace was set by both the researcher and participant. Each interview was tape recorded with permission of the participant and lasted about 1 to 2 hours.

### Other Data Sources

Before, during, and after the interviewing, the participants' behaviors and family interactions were observed. Observations of nonverbal behaviors, actions, the settings, and the contexts of the interviews were made systematically in field notes and were used to enrich, supplement and clarify the interview data. Interviews and observations occurred at a location of mutual agreement between the participant and the researcher. These interview locations were the participant's home, the researchers's office, or another location that provided privacy and a nondistracting environment.

As an additional source of data, participants were encouraged to write entries in diaries about their experiences, thoughts, and feelings related to recovery and/or childbearing so that the data would also reflect the context of their daily lives (Murphy & Hoffman, 1992). Each woman's diary was to be shared with the researcher to generate additional questions and insight into the woman's experiences of recovery during pregnancy, and early parenting. Use of a diary has been reported as an effective strategy for developing questions for later interviews, validating information with participants, and identifying a chronological pattern of events (Bogdan & Taylor, 1984). In this study, although all participants liked the idea of writing in a diary, only one woman actually made any entries in her diary.

## Data Analysis

### Data Analysis Process

Data collection and analysis continued concurrently until redundancy occurred,

or no conceptually new information was elicited from participants. Data analysis was based on the technique of constant comparative analysis (Glaser & Strauss, 1967; Stern, 1980). Coded data were compared and contrasted to categorize them and develop mutually exclusive conceptual categories that reflected the empirical data and the context. In the constant comparative analysis, every piece of data whether from interviews, diaries, or observations was compared with every other piece.

The steps for data collection and grounded theory analysis as described by Stern (1980) were used in this study. The series of overlapping steps are: collection of empirical data, concept formation, concept development, concept modification and integration, and production of the research report. Theoretical sampling of data, combined with the criterion of saturation, enabled the researcher to sample and describe concepts relevant to the phenomenon being considered. The inclusion of observational and diary data was used to increase the validity of the findings from the interview data. Diary data from the one informant was used to enhance understanding of her interview data. The interview and observational data were weighted equally unless they differed in their results. Then the researcher discussed the discrepancy with the participant to clarify the divergence. Memo notes were used during analysis to track the researcher's thinking about emerging descriptions, concepts, and ideas. Theoretical notes about tentative conceptual relationships were recorded and put aside until categories of concepts were developed. A computer software program named Ethnograph, Version 3.0 (Seidel, Kjolseth, & Seymour, 1988), was used to facilitate physical management of data as they were substantively coded and sorted into

conceptual categories.

## Scientific Adequacy of Findings

Criteria and procedures described by Lincoln and Guba (1985) for insuring scientific adequacy of qualitative findings were used. Procedures were used to achieve the following four standards for scientific adequacy: credibility, confirmability, dependability and transferability.

### Credibility

Credibility has been defined as the truth value of findings (Lincoln & Guba, 1985). Credible findings can be enhanced through data collection that is reliable, consistent, and a valid indicator of reality (Goodwin & Goodwin, 1984; Lincoln & Guba, 1985). The meaning and intent of all findings was validated with participants during return interviews. Genograms, fishbone diagrams, ecomaps, timelines, and drawings were used to validate information provided by participants. Because data collection was continued with participants over a period of time, repeated samples were provided. Prolonged engagement with participants, a procedure recommended by Lincoln and Guba (1985), leads to greater validity of findings. The prolonged engagement led to rich descriptions of experiences and perceptions that were more consistent with the daily life context over time of the recovering women.

The researcher ensured confidentiality and established rapport with participants, other procedures recommended so that informants will feel safe in sharing personal information (Lincoln & Guba, 1985). Maintenance of rapport and engagement was facilitated in several ways. Telephone calls were used to maintain

contact with participants between interviews. Thank you notes and assorted cards were sent to encourage continued participation and to acknowledge important milestones like weddings and births of babies. Women participated in the study with interest and commitment to keeping appointments for scheduled interviews.

Another procedure to enhance credibility is the provision of an audit trail, persistent observation, and rereading of the data (Lincoln & Guba, 1985). Procedures for data collection and analysis have been described in this study report so that others may critique the study (Brink, 1991).

Validation of results of the analysis was done with two participants individually and a small focus group. Members of the focus group were two participants in the study who had infants and another woman who was a member of an AA group and the mother of an adopted infant. She had been invited by one of the participants in the group and all agreed to her presence; however, she was not one of the original informants. All three women in the focus group were well acquainted through their concurrent activities in AA and motherhood. The meeting was held to discuss tentative findings from the study and to clarify the social process of balancing recovery and motherhood. Index cards with conceptual categories and definitions were presented for confirmation and clarification. Participants confirmed the social process of balancing and also provided negative examples to illustrate when balancing does not occur.

Confirmability

Confirmability, or neutrality of the findings was enhanced by several

strategies, (Lincoln & Guba, 1985). Transcripts were reviewed while listening to the interview tape and corrections were made. Field notes, diary entries, and transcripts were used to cross check and confirm data. Transcripts and data analysis were reviewed with research committee members. The results of the data analysis were also reviewed with professional nurses and doctoral student colleagues familiar with the process and content of qualitative data analysis as well as experiences of recovery, pregnancy, and parenting. Categories were developed through extensive rereading of transcripts, data coding, and data analysis in collaboration with the research advisor. With the research advisor an audit of data collection and analysis was used to document accuracy and fairness of findings (Lincoln & Guba, 1985). If discrepancies were determined, then the analysis strategies were reviewed, agreement was secured, and appropriate changes were made.

Dependability

Dependability or consistency/reliability, is concerned with the repeatability and stability of the participants' accounts (Lincoln & Guba, 1985) as well as the researcher's ability to record and collect information accurately (Brink, 1991). Verification and clarification of transcripts with participants, repeated interviews, asking equivalent or alternate questions of the participant during the interview, and discussing observations and diary entries were strategies to ensure that material was both reliable and valid to women's experiences. Triangulation with multiple methods of data collection such as interviews, observations, and diaries within a longitudinal design, as described in this study, is an additional way to enhance validity and

reliability of the findings.

Transferability

The theoretical sampling, conceptual development, and strategies to increase credibility through triangulation of data sources provide a base against which other samples may be compared in the future for transferability of findings (Lincoln & Guba, 1985). Transferability, or generalizability, refers to the extent that findings from one context will be similar in another. Although all the exact findings from this study may not replicable for another study, the concepts and tentative hypothesis generated in this study may be tested and possibly replicated by using a different sample in a similar context.

## Summary

This was an exploratory study in which a qualitative method was used by the investigator to uncover the social process of women's concurrent experiences of the transition to parenthood and alcohol/drug recovery. A purposive sample of 11 women volunteered for the study. All were 18 years or older and self-identified as an alcoholic/addict in recovery and pregnant or newly parenting. Participants' stories of their experiences provided a narrative that revealed the complexity and richness of their daily experiences, insights, and fears and hopes for achieving motherhood and ending a cycle of chemical abuse. Data were collected from interviews, observations, and one woman's diary entries. Constant comparative analysis of the data resulted in the identification of concepts relevant to understanding the process of adjustment to both addiction recovery and transition to parenthood. Credibility of findings was

enhanced through prolonged engagement, validation of data with participants and the use of multiple data sources. Confirmability of findings was obtained through the use of an audit trail, review and correction of transcripts with interview tapes and notes, and discussion with the research advisors. Dependability or consistency was maintained through triangulation of data collection methods over a period of time and clarification of data with participants both individually and in a focus group. Theoretical sampling, conceptual development, triangulation of data sources, and a detailed account of the methods used addressed transferability of the findings for use in other studies. Thus, use of these methods helped to produce a conceptual understanding of the combined experiences of addiction recovery and pregnancy and early parenting.

# CHAPTER 4

## RESULTS

The purpose of this study was to explore women's concurrent experiences of alcohol/drug recovery and transition to parenthood. Data analysis resulted in identification of a unique process of balancing that incorporated the developmental and relational aspects both of recovery and of pregnancy and early parenting. The findings were in keeping with the developmental and relational models of recovery described by Brown (1985) and Finkelstein (1990), respectively, and with the developmental process of transition to mothering described by Mercer (1990).

Balancing was identified as a process that had two dimensions. The first dimension was balancing the adjustments to adapting to the alcohol/addict identity and the mother identity. The second dimension of balancing was the flexible adapting and shifting of strategies that maintained both identities during the transition to parenthood. During the transition to parenthood, three developmental periods were identified as points at which the balancing strategies and recovery and motherhood transition processes reported in the data changed in substantive ways. These periods were pregnancy, birth to 3 months, and 4 months to 11 months.

Although balancing is descriptive of the relative attention given to the developmental transitions of motherhood and recovery, the process of recovery did not require that motherhood be initiated a priori. In fact, all women had initiated recovery efforts at least once prior to the motherhood transition. Prior to the pregnancy event 10 of the 11 study participants had begun the recovery process. The

remaining participant entered recovery during early pregnancy after several previous unsuccessful attempts to achieve sobriety. All participants described their own recovery processes that had begun before the index pregnancy and continued during the transition to parenthood through the use of recovery strategies. For this reason, the set of recovery strategies that began prior to the index pregnancy are described here first. The balancing of these strategies is then described here as they were used alone or in modified form in each stage of transition to parenthood.

## Recovery Prior to Event of Index Pregnancy

Strategies developed by participants to maintain the addiction recovery process prior to pregnancy were continued throughout the index pregnancy and early parenting. Three categories of strategies were identified by participants: protecting, progressing and non-progressing.

### Protecting Strategy

Protecting strategies were those efforts developed to safeguard recovery by preventing renewed drug use and preventing thoughts of drinking or using drugs after a period of abstinence. According to mothers in this study, protecting recovery through relapse prevention is part of maintaining recovery.

#### Preventing Relapse

Preventing relapse is a goal or outcome of maintaining ongoing recovery (Brown, 1985) and is frequently the focus of treatment for addictive behaviors (Young, 1990). Relapse has been defined as a focus on renewed alcohol/drug use after a period of chemical abstinence and is one part of the disease of alcoholism

(Brown, 1985). Learning due to actual or potential relapse experiences is thought to be a necessary part of developing increased self-understanding and results in behavior change during recovery. Learning may involve identification of triggers for drug use, situations to avoid, and positive ways of responding to potential relapse (Brown, 1985; Gorski & Miller, 1986).

Participants who had been sober for more that 5 years described relapse as a "return of thoughts about drinking/using." They had developed coping strategies to deal with the thoughts as well as actual use. Learning to manage the risk of relapse by use of a protecting strategy was part of maintaining recovery used by all women in this study.

Consequences of potential relapse episodes varied among participants and included activation of coping strategies. One participant viewed relapse as a way for the now sober person to gain an understanding of what others go through, an understanding that would assist the individual in giving service to others as well as having greater self-understanding. Another participant emphasized that she "would rather be dead than start drinking" again. Through membership in AA/NA groups, several participants had noticed the deterioration in parenting of an infant that occurred when a parent relapsed. Identification as an "alcoholic/addict," with or without relapses, may lead to increased surveillance by health care providers.

Relapse prevention required ongoing awareness because preoccupation with alcohol/drugs remained an issue among all women in the study, even those with many years of sobriety. In spite of long periods of abstinence and well-developed coping

mechanisms, the threat of relapse remained for all women. This is consistent with the alcohol recovery model that includes the continuing focus on alcohol as a central feature of recovery (Brown, 1985). All the participants continued to state that they were unable to drink alcohol or use any drugs without jeopardizing their recovery. They felt that their drinking and using were uncontrollable even though they had maintained sobriety for years. A familiar sentiment was:

> I've got so much time [sober] but I really have a lot of time when you think about it. I have a lot more than other people. So I start to think, "Well, I've got time I can have a drink...." That's kind of like a thought of suicide because you are going to kill yourself and watch your family and your friends mourn you and be sad. That's such an extreme. These are alcoholic thoughts.

Family and friends had adjusted to the nondrinking alcoholic but, as one woman noted, complacency about recovery can be risky:

> I don't think they [parents] even think about it [when daughter was drinking] anymore. I think it's been so long, it's been 7 years, and they know that I've had no slips, because we've reached a certain level of honesty that, had I slipped, I would have told them. I would have asked them for their help to get back. I think that all of us are a little complacent with my sobriety...don't think about the possibility of my getting drunk or using drugs again, but as we all know, [it] is just a drink away.

Conditions Leading to Relapse

Participants identified stressful times as factors leading to relapse. At times of

increased stress, the focus on alcohol became more intense and then various coping strategies were initiated to prevent relapse. During prolonged periods of stress, coping strategies might regress or return to ones used earlier in sobriety, such as "being babysat" (having a member of a Twelve Step support group stay with them), "calling my sponsor," or "getting to a meeting." All these strategies could be used as well as "going out on a service call to save another suffering alcoholic." Even women who did not regularly attend an AA group used the support of that group as a "safety net" to prevent relapse. Another woman who never used the fellowship or tools of AA did spend more time with her individual counselor at stressful times and reported trying to "get away from her problems" by taking a trip or shopping. Several women reported that partners were helpful in differentiating the effects of medical treatment with the "crazies" of relapse. Sober friends and other AA members were sought as support persons during times of increased stress with medical procedures. Through a protective strategy, the women believed they could maintain ongoing recovery.

Many conditions were identified by participants as high risk situations for relapse. Some of these conditions had been identified and prepared for by participants, but some had not been foreseen. Anticipated conditions included avoiding people, such as drug using friends, and places where relapse might occur, such as bars. Examples of unanticipated events identified by participants were emergency admissions to hospitals for illness or accidents and guilt about effects of previous drug abuse on children.

Participants reviewed hospitalizations and medical procedures and treatments for their effect on recovery. Several women were fearful that relapse could occur with taking any medication for any reason. The majority of participants were careful to read labels and avoid medication with alcohol. The belief of "hard liners" was that antibiotics, bronchodilators, and cold remedies should be used only if absolutely needed. Yet another woman with 7 years of sobriety felt she could take what was needed without relapsing. All participants feared hospitals and medical procedures as potential triggers for relapse.

Brown (1985) addresses the problem of using medications such as tranquilizers in early recovery to either relieve symptoms of abstinence or to remove the desire to drink. According to Brown, before abstinent behaviors are well established the use of medications may delay abstinent behavior or shift addiction to prescription drugs from alcohol. AA literature encourages cooperation with medical treatments and procedures but cautions about using prescription medications or over the counter preparations. For newly abstinent women, the risk of relapse due to misuse of medications was greater than for women with longer sobriety who continued to evaluate the risk of relapse with medical procedures and medications.

The protecting strategy of preventing relapse was developed and used to maintain recovery effectively in a variety of situations and conditions by participants. Having a repertoire of ways to respond to threats of renewed drug use, or thoughts of use, provided a base to maintain ongoing recovery. This repertoire could then be used during subsequent life events including the index pregnancy.

## Progressing Strategy

The progressing strategy has eight dimensions that demonstrate forward movement of personal change and potential for growth during the recovery process. Each of the eight dimensions is described and illustrated in the following section. The eight dimensions are: establishing an alcoholic/addict identity, developing spirituality, dealing with emerging feelings, keeping intimate relationships, reordering family ties, reaching for maturity, using professional help, and creating a fellowship.

### Establishing an Alcoholic/Addict Identity

Participants stated that establishing an identity as an alcoholic/addict was the first and most important step in their recovery process. This identity was established over a transition period that resulted in a total transformation of self-identity. The transformation occurred in a variety of ways. Women in this study reported seeing others who were addicted, like their mothers, relatives, or friends, or experiencing the consequences of addiction. Sometimes participants knew people who were "powerless" over the drugs and couldn't stop even to save their marriage and their children. Although they did not want to be like that person, they realized that they indeed were.

At the time of their transformation to an alcoholic identity, all participants felt desperate and alone. They were "hitting bottom." The eight participants who attended AA/NA meetings felt that "people come to AA when they don't have any place else to go." Several women reported feeling increasingly lonely and isolated while using drugs. One was hospitalized with a suicide attempt. Three were

involved with arrests due to driving under the influence (DUIs) and drug charges, resulting in "jail time." These legal consequences initiated a series of events that culminated in identity transformation. One participant, with 5 years sobriety, said, "I came to AA to get the shit off my back and to get my life in order and to quit causing harm to people. I didn't come to stay sober for the rest of my life." This woman realized that she was an alcoholic only through attending AA meetings and interacting with members of the group, and her identity transformation occurred over that period of time.

Participants noted that the purpose of recovery behaviors like attending meetings or going into treatment changed over time for them and for people they knew in recovery. One woman reported that "Some people come to AA to get their lives back, or husband back, or kids back....Some people, their purpose will change. My purpose changed." Only two participants in the study went to treatment and AA as a result of intervention by their family. Two women entered treatment "for their parents" and several months later realized that their recovery was for themselves. One example is a participant who entered treatment to keep a trust fund given by her parents. After several months of complying with abstinence, she reached a turning point in her recovery when she realized that recovery was for her, not her parents. All of the women acknowledged that their purpose in beginning recovery had changed during the period that they stayed sober. All participants had accepted the disease concept of alcoholism/addiction and had recognized their loss of control over drugs/alcohol.

Stigma. Involved in acceptance of the alcohol/addict identity is awareness of the stigma associated with addiction. Stigma is a social phenomena that deprives a person of full social acceptance (Goffman, 1963). Stigma is an intervening variable that affects accepting the disease of addiction. Cultural beliefs about female alcoholics/addicts delayed some women's acceptance of the unwelcomed identity of alcoholic/addict. All participants in this study recalled their transition to recovery retrospectively. One participant said she "used to be bothered by the stigma of alcoholism." The daughter of a prominent physician, she grew up in a small town and did not want to be known as an alcoholic. None of the women "wanted to be an alcoholic." Other consequences of stigma were identified by participants as "being denied life or health insurance" because of a history of alcohol or drug abuse and family members "disowning them or their child."

Brown (1985) describes the transformation of identity during early recovery. She states that breaking through denial about addiction by reinforcing the identification is important at every stage of recovery. Participants believed that talking about the "secret" (alcoholism or addiction) helped to reduce the stigma and promoted the honesty necessary for recovery from the effects of addiction. Consistent with the data, Brown (1985) discusses confirming and building the new identity as an alcoholic and reinforcing new behaviors to maintain recovery which is made more difficult for women who are newly abstinent due to the effects of stigma. Participants in this study recalled the difficulties encountered during the transformation in identity.

Telling others the new identity. Telling others the new identity was defined as

communicating one's alcoholic/addict identity to significant people. Communication of that identity reinforced the identity change needed for recovery. Telling others helped to confirm the alcoholic/addict identity and reinforced the new behaviors that accompanied the changed identity. Telling others was constrained by the stigma associated with belonging to a stigmatized group such as alcoholic/addicted women. Telling, however, appeared also to be one method to elicit crucial support for recovery. Telling usually occurred in the context of a relationship that was significant. Participants reported telling their alcoholic/addict identity to health care providers, counselors, family, friends, and members of Twelve Step groups.

Disclosing to health care providers was defined as communicating one's identity as alcoholic/addict to professionals who deliver health care services. Communicating one's identity solidified the identity of an alcoholic or addict and elicited needed professional care providers' support in meeting health needs. Nurses in public health clinics, hospitals and home nursing staff, family practice residents, private physicians, midwives, and nurse practitioners were among the variety of health care providers involved with participants.

Participants viewed health care providers' support as essential in managing health conditions. One participant explained:

> I think when you are honest with them right up front that they receive you better than if it's like a deep dark secret. I don't tell just everyone that I'm a recovering addict. I think that health professionals need to know. Some of them don't treat you any different anyway.

Developing Spirituality

Spirituality, the second dimension of the progressing strategy, was defined as the emergence of beliefs and practices for contact with God, or a "higher power." Spirituality was the core of the recovery effort for all the women who participated in AA or NA. Brown (1985) states that spiritual factors and a reliance on a higher power are important throughout recovery, beginning with the identity transformation. As abstinence continues there is a "move away from a self-centered view of the world to one which places the individual in relation to a larger universe" (Brown, 1985, p. 37). Spiritual belief about one's relationship with God is a center point from which other relationships move outward in concentric circles. Brown (1985) addresses spirituality as a change in world view, or paradigm shift, during the transformation into recovery.

All the participants who had been sober for 5 years or longer or who attended AA or NA meetings talked about the spiritual focus of their recovery. Nine of the eleven participants practiced AA principles and two participants worked with their church principles. Several spoke about how they developed a conscious contact through prayer and meditation with a higher power and how that had changed their lives. One participant stated:

> The whole program is based on spiritual principles. It's based on things like truthfulness and honesty and the golden rule, things like that. That's why I work the steps. I get rid of my selfishness and self-centeredness. I get rid of my character defects so that I can live a more spiritual life so that I can have

constant contact with God.

Another participant said:

I have this emptiness inside of me I've had for as long as I can remember. This emptiness. Nothing I have ever used or tried to use filled that emptiness. Now I believe that emptiness can only be filled by God. God is, God has, I have to be seeking my relationship with God like the Big Book talks about and like it shows me how to do in here in order to have that emptiness filled.

Thankfulness, as an expression of spirituality, for having another day clean and sober and an appreciation for how far they had progressed in recovery were expressed by all the participants.

Dealing with Emerging Feelings

Dealing with emerging feelings is the third dimension of the progressing strategy. According to Brown (1985), emergence of affect is a feature of ongoing recovery that involves integrating new emotional elements into expressions of the personal identity. Consistent with Brown (1985), participants attributed suppression of emotions and physical sensations during drinking/using due to various factors, such as effects from addiction, emotional neglect in childhood, or use of suppression as a survival mechanism. While using, their feelings are numbed or expressed as anger and aggression. In experiences growing up, survival meant not feeling anything so the child never learned to correctly identify and express feelings. Feelings become prominent throughout early recovery and a major task of recovery is learning to recognize, express, and deal with feelings (Brown, 1985). Depression also has been

found frequently during the first year of recovery (Brown, 1985).

Participants reported experiences with learning how to express their feelings. Four women said they "needed to learn how to cry and that it was okay to feel emotional pain, hurt, and sadness." A mother with 5 years sobriety described a poignant story to illustrate coaching by her male partner on how to cry:

> I have had to learn how to cry because "big girls don't cry." I've had to go out and learn to be a kid. Trust is a big issue....[Husband] taught me how to cry. He coached me, "Okay, here it comes, just let it happen. Let it happen." I'm sure there are times now that he regrets that. Anger was how I deal with everything. Anger was acceptable in my family and everything else was not. When I was sad you turned it into anger because that was okay [in her family].

One participant reported depression in her second year of recovery after giving birth, and another woman reported having a continuing depression throughout life. Three women reported depression during the years of alcohol and drug use but not in recovery.

Methods used by participants to deal with their feelings were talking things over with their partner, friends, support group, or sponsor (if involved with AA or NA); working through the inventory process; reading self-help books; getting individual counseling; writing in a journal; getting in touch with a higher power; praying; and writing letters. Participants who were involved with the support that a Twelve Step program offered or who had the tools of a Twelve Step program and a

supportive partner reported being able to progress with the release of emotions and had improved their relationships. Building trust and learning to express feelings of love and tenderness were identified as being important to developing a later attachment to their infant.

Keeping Intimate Relationships

Keeping intimate relationships, the fourth dimension of the progressing strategy, was defined as developing and maintaining healthy interpersonal connections. The process is learned and experienced through close emotional involvement with significant people. Characteristics of intimacy are respect, caring, and interdependence (Cruse-Wegscheider, 1989). Finkelstein (1990) has stated that women's intrapsychic and interpersonal development in recovery occurs through establishing and maintaining healthy relationships. The ability to form and maintain relationships is a result of alcohol/addiction recovery (Brown, 1985). The results of this study, agreeing with Brown and Finkelstein, describe the building of relationships, especially those with a partner, as important work of recovery.

Brown has noted that at some point in early recovery the focus on the alcohol/ drugs shifts to awareness of other issues that need to be explored. As the behavioral and cognitive framework of abstinence becomes well established, work on the other problems and issues can be emphasized. Major adjustments are made in relationships with others. Experiences are interpreted and reinterpreted within the framework of the alcoholic/addict identity. Participants' data confirmed the description by Brown.

Developing trust. Developing trust is defined as a process of developing

confidence in the behavior of another person to meet needs. Trust is a basic component in keeping intimate relationships and is the basis of all positive relationships. Trust is a consequence of a predictable, caring relationship between people. Implicit within trust is a sense of vulnerability to another person who is trustworthy and caring. All the participants identified that they had great difficulty in trusting people but had at least one person whom they felt they could trust completely, usually the partner or a sponsor. Participants had learned to trust first others and then themselves through relationships with a counselor and/or a sponsor in the initial stage of recovery.

Forming a team. Forming a team involved methods used by participants and their partners to communicate and work together to meet joint goals such as continued addiction recovery. Through communication between partners, common values were developed and experiences and beliefs were shared in an atmosphere of respect. Trust and the existence of intimate relationships enabled forming a team. Being in a partnership together with joint goals required being able to balance the give and take of the relationship with individual needs.

Support by partner. Support by partners was an aspect of the progressing strategy that assisted participants to maintain recovery and was an outcome of having formed a team with the partner for recovery. Partners, boyfriends, or spouses have been reported to be key support persons during recovery (Ericksson, Steneroth, & Zetterstrom, 1986).

In this study, all partners were either in recovery or nonaddicted and were

employed. As one participant explained, her partner support situation was different from that of friends whose drug-using partners were not supportive:

> It helps a lot to have my husband. At least in my case, usually relationships that come from, if you used together, it's really hard for two people to recover together. When you're using together for years you learn to enable each other to use. I think that we've been together for so long and his going back to prison again and getting clean in prison, and me getting clean out here, we weren't together when we got clean, I mean not living together when we got clean. He was inside and I was outside. I think that helped make the difference of why we made it [together now].

Partners were viewed as support persons even when they were in prison. Prison was seen by some participants as a "reality slap" that helped them and their partners become clean and sober. Participants and their children continued to visit and remain connected to partners who were incarcerated.

Maintaining a relationship with a partner was an integral part of recovery and permitted additional relationships to form. One participant who met her husband through AA said:

> It amazes me sometimes because....we've come so far. So many things have changed and even just having a relationship with anybody, much less to have a married relationship, is foreign for both of us. A relationship was not possible before. Neither one of us could handle that or even maintain a relationship.

Another woman expressed her thoughts as follows: "our relationship is a lot

more open than a lot of people's are just because we're both in recovery." Some participants felt that having a partner in recovery made it easier to do their own recovery. A mother who was pregnant again said:

> It's hard for people that aren't addicts to understand what addicts go through. If I need to go to a meeting and leave the kids, that's like okay because he understands that meeting. I need to do something for myself.

Although partner support was perceived to be important, all women described their partners as "knowing" them well yet not understanding, or asking them, what type of support was needed. Sometimes listening was the most valued type of support rather than "doing."

Participants identified ways that partners supported each other in meeting their joint goals. Some of the ways were helping with children and household tasks, doing Bible study or spiritual work together, providing financially for the family, being nonsmoking, and abstaining. Participants wanted spouses to listen to them and try to meet their emotional needs, "to be there for them." Some participants spoke about "trying to balance" and "give and take" what they did for spouses with the help they received.

Previous studies have portrayed relationships with partners of addicted women as abusive, dependent, or nonexistent (Bushong, 1990; Deghestani, 1989; Mondanaro, 1977). Contrary to findings in other studies, partners of this study's participants were either in the process of recovery or were nonusers/drinkers and most of the partners supported efforts to maintain ongoing recovery. The partner relationships formed

during the process of recovery were described by participants as "healthy and supportive" in contrast to what the partner relationships were like when they were using drugs. The difference in findings may be due to the participants' ongoing recovery status, whereas previous studies of substance using pregnant women and mothers may have focused on women not yet in recovery.

Reordering Family Ties

Reordering family ties, the fifth dimension to the progressing strategy, is defined as a process of change in familial relationships that begins with transformation of identity and continues throughout all stages of recovery (Brown, 1985). Only through changes in families can the pattern of substance abuse end. In recovery for over a year, one participant expressed the hope of being able to "break the chain of substance abuse." Her mother had also been an alcoholic. Participants in this study recognized that the reordering and forming of relationships had been the bench mark of their personal recovery process as well. All participants stated that first forming a central relationship with God and then forming and reordering relationships with a partner, support group, parents, and friends were the means and goal of recovery.

Despite supportive relationships with the partners, women reported that they had to manage conflicts in the partnership. A major area of conflict was addiction and recovery. In one woman's marriage, the partner's social drinking was a source of conflict because his wife had cross addictions and could not drink. She was angry with him for this behavior, which was not supporting her recovery. Another participant had recently divorced her husband, who did not continue his sobriety.

During recovery from addiction, family members, including partners, need to progressively relinquish control of the alcoholic and focus on themselves and their own recovery from the effects of addiction (Brown, 1985).

Parenting in recovery. All participants with older children were hopeful that they had changed significantly through recovery efforts and pregnancy so they would not repeat previous dysfunctional parenting with the index infant. Both Brown (1985) and Finkelstein et al. (1981) describe difficulties that parents face when they enter recovery. Guilt for child neglect or abuse may precipitate relapse. Feeling inadequate as parents is common. Recovery exposes other problems in the family besides alcoholism and confuses the roles and patterns. All this requires family adjustments. Finkelstein (1990) emphasizes the importance of including a women's children and partner in recovery programs.

All participants with children reported that parenting in recovery entailed having to find ways to deal with the negative effects of behaviors from alcohol/drug addiction on the parent-child relationship. During recovery, children and parents learn new ways to relate (Brown, 1985; Cruse-Wegscheider, 1989; Finkelstein, Duncan, Derman, & Smeltz, 1990). For parents, it is one of the issues that must be addressed. Guilt, regret, and anxiety about drug use during pregnancy and while parenting emerge during recovery (Finkelstein et al., 1981; Finkelstein, 1990). While a mother is drunk or using, older children may adopt a pseudoparent role. This role reversal has to revert to normal when a mother enters recovery (Brown, 1985; Cruse-Wegscheider, 1989). Mothers report in the data that when they are sober and clean they can attend to their children and their needs. This change in parent roles as

described in the data and literature may be difficult, and mothers may feel guilt, remorse, and fear about assuming this role (Finkelstein et al., 1990).

One illustration of parenting in recovery comes from a mother who had two children and was 7 months pregnant with a third child. She had been clean and sober for 1 year and evaluated her year of being clean by saying:

> I think that a year at home has been really important to me making it [recovery]....My husband works and I had the opportunity to stay home with my family and to get good at that....There's all this stuff that I wanted to be good at but just wasn't able because of the dope....It was important for me not to have a job, to stay home for a year or however long. It was important for me to stay home and make amends, get to be a good mom and get involved with what they were doing and pay attention to what they said instead of "Don't bother me," which I did for years. We went to family counseling with my son and helped him with his problems and let him know that his stuff is [as] important as our stuff. I think it was important.

All the mothers placed a high priority on caring for their older children. This caring focused on attending to the older children's needs and not their own. Attending to children was a consequence of maintaining early as well as ongoing recovery. Guilt and the opportunity to "make amends" or try to make up to children for the past was a powerful motivator for the participants to change behaviors and relationships.

The mother in the previous illustration expressed the need for healing family

relationships as follows:

> So it's a recovery I think if there's even one addict in the family; recovery involves the whole family. It's just like addiction. You can't have an addict in your family and not have it affect you if you are living with them. 'Cause my husband was in prison for years. And during the worst part of my addiction, it was just me and my older son. And he [the son] had to be the parent.... Last year he got really desperate because he felt the world on his shoulders. And then all of a sudden, Mommy and Daddy were clean and they're together and they're being parents. My son wonders where do I fit in because he took care of me for so long, literally. And all of a sudden his job was absorbed. And he has no clue how to be an 11 year-old kid....And we are the parents now. We are learning to do this job. We tell him "its not your job anymore," kindly without hurting him. So our kids have more chance to be kids now. When your parents are using you [the child] have to be an adult.

Another participant described a role reversal with her son that had occurred for years. Upon returning from school, he would care for her when she was drunk or passed out in the living room. The participant was now clean and sober but had been previously unpredictable and dependent on her son.

Dealing with parents. Dealing with parents was defined as psychosocial methods used by the woman to cope with the behavior of her own mother or father during the process of recovery. The parent-child relationships had changed in

recovery, prior to the index pregnancy, among all the participants and their parents.

In this study, seven women expressed highly ambivalent feelings toward mothers in the family of origin. Participants whose mothers were alcoholic/addicted used the principles of AA, described as "relinquishing control" and/or "responsibility" for their mothers' behaviors, such as drinking or violence, to work through their feelings of ambivalence. Some of the women avoided contact with their parents who were still drinking. Three of the participants' mothers and two fathers continued to drink and were unable to provide support in their daughters' recovery or subsequent pregnancy. The women found alternate sources of support through their Twelve Step group and sponsors or other female relatives. One daughter commented about her mother's drinking, "It's obnoxious to be around. I try to avoid my mother after a certain hour of the day. I don't like to talk with her."

In recovery, some participants worked on accepting their parents through "doing inventory," a strategy from AA, rather than a true reconciliation. Conversely, one of the study participants said, "My relationship with my parents has done a 360 degree turn since I started into recovery."

The change in one relationship between a participant and her father over a 5-year time period while she "worked her program" in recovery was recounted as follows:

> When I was growing up my father and I were very bitter towards each other. When I got sober, I started looking at my part of the relationship with my father and I saw that I was in the wrong a lot where I had caused it a lot and

> caused him a lot of pain and how I started a lot of these fights. My Dad and I have a great relationship now. When I first got sober I didn't tell him. When I was in recovery, I didn't tell him what had happened. I didn't tell him until 2 to 3 years ago when we [the women and her partner] were making plans to get married, that's when I told him. He didn't know what the change was; he just knew there was a change. He had no idea.

Another participant, sober 5 years, used tools from AA to help heal a family relationship. She said:

> My relationship with my mother and my sister along with my father has really calmed and gotten much better in the time I've been in recovery. I was not close to my family at all. I've had the opportunity to take the past through the steps and make amends for the damage that I did in the past. I'm closer to my sister now than I ever have been and with my mother too.

Another participant with 5 years of sobriety described the way that her perception of relationships with others has changed in recovery, "It's all about taking responsibility for the stuff in my life, like stop blaming others for my misfortune and behaviors. I'm a whole lot less self-centered."

In the family of origin, loss of parents through death or divorce with abandonment had occurred for a majority of participants. Only two women reported a close relationship with their fathers. Several said they hated their fathers or felt as if their fathers had died. One woman said:

> I can understand that he went through hell. But the way he handled it was all

wrong. He just locked himself up [from all emotion]. I think that I frightened him because I was bringing out the emotions. I pissed him off, and I made him hurt.

Several participants had severed relationships with a parent when abuse had occurred. "It was just fine for him to stay away from me and my kids." None had prosecuted or reported a parent for child abuse.

Reaching for Maturity

The sixth dimension of the progressing strategy is reaching for maturity. Brown (1985) has stated that during the woman's movement from the stage of chemical abstinence toward working with concerns about emotional maturity and adult developmental tasks, she has to deal with various issues, one being maturity. As recovery and chemical abstinence continue, there is a steady movement from the intense focus on the behavior of not drinking and using drugs toward adult development and relationship concerns, according to Brown. A consequence of reaching for maturity is developing self-value and responsibility. Reaching for maturity provides the context for processes of recovery and adult development.

All participants in this study confirmed working on other problems and experiences, that were underlying or a consequence of addiction, while maintaining chemical abstinence, regardless of the length of time of sobriety. One participant in the study said:

It's been a lot easier to quit drinking and doing drugs than it has been to deal with some of the other stuff. I've been seriously working on the other issues

> for about 3 years now and I've just about gotten most of them licked. It's been a lot of work.

Another woman traced a change in her thinking when she said:

> I used to think that drinking was my problem. Now, I don't think that that's the problem. I think it's a symptom of the problem. I think that my selfishness and self-centeredness is the problem. When I stopped drinking, my life was not wonderful. It was just the opposite, it was horrible.

Another mother said she was motivated to maintain her recovery to "Be a better parent to her older children. A better spouse. Just to have better relationships."

A participant with 5 years sobriety and 10 years abstinence from illicit drug use said:

> The thought of me doing drugs and being in that lifestyle scares the hell out of me. And I am so glad that I don't have to worry about it. I am so happy with my life. My husband drives me crazy, my child drives me crazy, I drive myself crazy sometimes, but I wouldn't trade it for the world. And I would never return to drugs and alcohol to solve my problems.

Being an adult. One method to achieve reaching for maturity was to act as an adult in spite of feeling uncertain about knowing what the expectations were at the adult level of development. Learning adult behaviors has been described in the literature as an activity for recovery despite the uncertainty about what constitutes normal adult behaviors (Brown, 1985; Cruse-Wegscheider, 1989). Experiencing arrested adult development during alcohol and drug abuse years was cited by a

majority of participants. For eight participants who were raised in abusive families, development was further compromised through traumatic events, emotional abandonment, and the inability to trust significant others. During recovery, all participants felt they were moving toward adulthood. One participant, who was a mother of two older children, was 28 years old and had been clean for one year. She said:

> I know a little bit more about being an adult now. I'm sure somebody's going to pull my cover one day and say, "You're an adult imposter, you're not an adult." I'm sure that in a big [NA] meeting, they ask you to speak when it's your birthday and it's a huge meeting. I said, "I think my greatest fear in life today is that I'm learning how to be an adult for the first time and I just know that everyone knows I'm faking it and somebody is going to pull my cover." Emotionally you stay young. Emotionally you don't mature when you use drugs. You can't. I've had a couple of recent small crises in my life and my sponsor said, "You handled that like an adult." I said, "Is that what this is?" and she said, "Yes." I thought, "That's why it feels so different."

Participants in early recovery reported exploration of their adult identity. One participant said, "I'm feeling more inquisitive about me. I used drugs for so many years and I started so young that I have no clue who I am." Another participant assessing her own development in the context of cultural expectations said:

> We got married and we had kids and I've never had to go it alone. I guess my life was kind of planned out for me early. It took a long time for me to

> grow up. I'm 27 years old but in my mind I'm so much older. It's taken me a long time for my brain to catch up with my [physical] maturity level. Not too many 18-year-olds have gone through what I had.

Processes of adult development that had been aborted or subverted by drug use had reemerged as women progressed in their recovery. As one participant said, "I have survival skills. Now I'm learning how to live." Preparing for adult roles and doing adult behaviors was important to participants. Three were college students and a fourth was planning to return for vocational education. Another example of learning to live was managing financially and acting responsibly. The women were learning to plan a budget, pay bills, buy houses and cars, seek health care, communicate with teachers about their older children, and make and keep friends.

Being comfortable alone. Being comfortable alone was defined as learning how to be alone without feeling lonely or overwhelmed with psychological pain or indecision, an experience associated with well-established abstinence and an ongoing recovery effort. It is a condition or experience associated with progression in ongoing recovery (Brown, 1985). Learning to be alone is a necessary part of maturity.

Several women used the words "increasing comfort being alone" to describe their status as their recovery continued. One participant with 5 years sobriety said:

> I've learned to be alone. I can find things to do. I can occupy my time.... I think I like me and I don't have so many overwhelming problems that the thought of being alone is frightening. I don't have to worry about sitting and wondering about them all the time.

Other participants described learning how to be alone without feeling lonely as being the outcome of using several strategies. The strategy of "going to God" through writing inventory, praying and meditating was used. Another strategy was accepting that friends were available by phone, or to visit, when needed.

Using Professional Help

Using professional help, the seventh dimension to the progressing strategy, was defined as appropriate engagement of professional care providers to enable recovery progression. It has several dimensions, including managing health conditions, appropriately using medications, and seeking and using counseling. For six participants, managing chronic conditions required utilizing health professionals to manage conditions like asthma, limited mobility, arthritis, and pancreatitis. Meeting counseling needs was a strategy for dealing with individual and family psychosocial problems during recovery by using a therapist. Purposes of therapy include improved coping with relationships during recovery.

All participants using therapy considered it one way to improve their ability to cope with their relationships in ongoing recovery as well as issues other than drug addiction. Participants had engaged in individual and group therapy. The therapy relationship was described by one woman as follows: "She [therapist] is like a rubber wall. And she gives me feedback every now and then. She helps put things in perspective."

All the women who had individual counselors appreciated confrontation by their counselors about drug use and "playing the rehab game." Playing the rehab

game is a kind of deception used by alcoholics/addicts to meet expectations for discharge from a drug rehabilitation program without actual change.

Other women desired both individual and family counseling, but both were not always available. Availability and affordability factors influenced a woman's decision to use therapy. Conditions affecting counseling availability were employment, availability of high school or college counseling and involvement with a case worker from a health and welfare agency.

Creating a Fellowship

Creating a fellowship was the definition for a set of strategies to establish a social network of mutually supportive chemically abstinent members who would help the participant maintain recovery. Rebuilding a social network and developing friendships provides a way to progress in recovery and in relationships, according to Finkelstein (1990).

These benefits of creating a fellowship held true for the women in this study. While drinking or using drugs, the women reported experiencing erosion of every relationship and becoming increasingly isolated from friends, family, and colleagues. The women described how they formed new support networks. A shift from drinking to abstaining was concurrent with a shift from dependence on family support to AA/NA support. Two women found church groups helpful. Three dimensions of fellowship were evident in the data: practicing celebrations, use of sponsorship and "passing it on."

Participants stated that creating a fellowship was another way to balance the

ongoing recovery process. All the participants emphasized the importance of ongoing support to maintain abstinence. Social networks offered an opportunity to engage in fellowship and to learn the skills of communicating, practicing different roles, identifying, and finding personal values and relaxation without alcohol. Fellowship extended beyond the AA/NA meeting into activities with AA/NA friends like going to movies, having barbecues, going out for coffee after meetings, and going to each other's houses. Five women created their network through AA/NA and described these groups as "family." A participant with 5 years of sobriety in AA said, "I don't think I could make it without the fellowship. The [Big Book of AA] talks about creating a fellowship and I had a part in creating that fellowship."

Creating a fellowship is one major strategy for a "comfortable sobriety," according to Brown (1985). Brown distinguishes between a "comfortable sobriety" and being "dry" or abstinent without social companionship. Individuals may experience the "dry drunk" throughout the recovery process. It is characterized by nondrinking, but with an emphasis on control, self, and power (Brown, 1985). By creating a fellowship and achieving balance in their lives, participants were able to maintain an ongoing comfortable sobriety.

Practicing celebrations. One part of the AA/NA fellowship involves celebrations, use of rituals to remember and commemorate special events. Special events were identified as holidays, turning points in recovery, and "first birthdays" (12 consecutive months of sobriety). Birthdays in AA are discussed by Brown (1985) as a ritual to commemorate year long periods of sobriety. The end of the first year

marks a transition from learning concrete abstinence behaviors to internalizing abstinent thoughts and behaviors and beginning to explore other issues, according to Brown's developmental theory of alcohol recovery.

One of the study participants celebrated her first year of being clean in NA. Although at the time she was pregnant with her third child (the index pregnancy), it was, in a sense, her first birthday, a milestone of recovery. Among her birthday presents she received a weekend trip with other recovering women and a new copy of the NA book. Her sponsor paid for her trip. Her husband, mother, and children celebrated her progress and facilitated her trip. At her Twelve Step meeting she received a cake and a medallion; and she had the opportunity to tell her "story." Other participants who belonged to an AA or NA support group told similar accounts of rituals and traditions to commemorate progress in recovery.

The practice of sponsorship. The practice of sponsorship was defined as using the assistance of another recovering person to help with alcohol/drug recovery. A recovering woman may be a sponsor to someone else and/or may use a sponsor to assist her own recovery. Sponsoring is a method of creating a fellowship that encourages a comfortable sobriety, enabling personal growth and intimate relationships (Brown, 1985). A turning point in recovery is reached when a woman finds a sponsor and an AA/NA group that work well with her. At that point, the tools of the Twelve Step program are synergized with the fellowship of the program for a successful and meaningful recovery.

The study participants described their sponsors as facilitators for recovery.

One participant described the sponsor as follows: "It's not a person that tells you what to do with your life, that gives you answers for your problems; but its a person who can show you how to get to God for the answers." Another participant said:

> I talked to my sponsor about it, she's got six kids, and what does she do to educate her kids so that her kids are aware [of sexual abuse]. It's like I go from one extreme to the other. I used to never ask anything because you can't talk about stuff. Now my mouth just goes all the time and if [the sponsor] don't answer it, I'll go to somebody else.

One mother described how her sponsor helped her with beginning sobriety, "I can't stay clean forever but I can stay clean today, or I can stay clean for one hour. One hour at a time was a long time for me in the beginning."

Sponsors provide honest appraisal of relationships. One participant who divorced a drinking spouse said:

> I believe a sponsor needs to be able to, in my opinion, to do those types of things, to be able to come to you and say, "Listen, you're dying here. This is killing you and you need to look at it." And then help me, sit down and help me.

Each of the participants with sponsors had chosen female sponsors with children. One mother concentrated her first year in recovery on recommendations by her sponsor that were healing her relationships with her two children. Two of the participants with infants acted as sponsors to other women as well as had their own sponsors. One woman started sponsoring others when she "was 2 years old" [had two

years of sobriety]:

> Simply because my sponsor and I were the only women in this group and she was overwhelmed with women to work with and she needed someone else to sponsor. Her opinion is that its better to sponsor when you are 5 years sober at least. Deciding if you are ready to act as a sponsor is...kind of like "How do you decide if you're ready to have children?" It's one of those things that " If you wait until you're ready you're never going to do it."

Passing it on. Passing it on is defined as strategies for assisting others with their chemical abstinence and other needs. Passing it on is also the service component of personal recovery. It is a way to reinforce identity in recovery, to work the "steps" through sharing what has been accomplished in recovery, and to help others (Brown, 1985). Passing it on occurs in group meetings and individual calls as well as in the performance of duties at meetings.

Passing it on was "absolutely vital for some alcoholics," according to one participant. A participant remembered that from the first days that she had been told, "You do have something to offer. You're doing this exercise in the book for your first step. You've been sober 30 days. You do have something to offer."

Another way that members helped each other was through "not giving answers to problems but showing how to find" your own answers. Members found support in knowing they were "not the only one" and could share their experiences with others. All the women who attended AA/NA reported that both men and women attended and shared experiences at the meetings. Sharing experiences was a way to pass on what

had or had not worked for recovery.

Several participants noted that there were differences in what men and women seemed to talk about at meetings. One participant said:

> Men seem to have a harder time relating with other human beings than women do. They seem to have harder time learning what to do with anger. And so they spend more time talking about it. Women talk about everything when there's no men around. If it's just a women's meeting then we talk about really deep issues: molestation when they were children, rape, loving, inadequacies, gay issues, sexual relationships with their husbands.

Summary

Eight dimensions of the progressing strategy were identified by participants in this study. These were: establishing an alcohol/addict identity; developing spirituality; dealing with emerging feelings; keeping intimate relationships; reordering family ties; reaching for maturity; using professional help; and creating a fellowship. All these dimensions continued to be used during the subsequent index pregnancy and early parenting. The progressing strategy facilitated identity development and change, maturity, and adult development.

## Non-Progressing Strategy

The non-progressing strategy is a coping method used during periods of time when there is little progress in recovery. This coping method was identified by participants as helpful when allowing the recovering person to consolidate gains already made or to adjust to other life changes. Three different examples from the

data illustrated this coping mechanism, "blocking," "being stuck" and "cutting recovery short."

Blocking was described as a coping mechanism characterized by a period of limited recovery efforts. It was a time or experience that could occur during recovery and adult development when recovery efforts stop but there was not renewed drug use. These periods may lead to renewed drug use or they mark a stage when other personal events preoccupy the recovering person, who may stop participating in their fellowship group and quit using recovery tools. Blocks can provide a time of reassessment and renewal. They might represent the quiet refocusing of energy before or after a major life event such as birth or marriage. Blocking is similar to the plateau in physical growth before a growth spurt occurs. This period of time has not been described in the literature about the recovery process and requires additional data to saturate its description, consequences, and conditions.

Three participants described periods of blocking. One woman described her block in recovery as periods of time coinciding with divorcing her husband and ending a violent relationship, beginning a relationship with a new man, getting pregnant, and having a baby.

Being stuck in recovery can occur if chemical abstinence is maintained but new means to cope with emotional, family, vocational, and other problems are not addressed. Blocking and being stuck are similar but have different focuses. In blocking there may be intense focus on concerns other than recovery efforts. In being stuck there may be intense focus on specific recovery efforts related to chemical

abstinence without work on other concerns. It is not clear whether these strategies are best described as transitions in recovery, possible long-term failure to progress in recovery, or suggestions of impending relapse if sufficiently lengthy. One participant did not attend AA or any other support group for addictions. She had support primarily from a partner, a counselor, and health care providers and a fellowship network exclusively from family members. She had behavioral strategies to not drink but did not identify cognitive or emotional strategies or specific plans to avoid relapse.

Cutting recovery short meant beginning abstinence but not dealing with other issues of recovery like emotional pain, family problems, and communication. Behavioral components of chemical abstinence are in place but emotional and personal growth does not occur. This dimension was used by a participant to describe her partner's recovery.

The non-progressing strategy was developed prior to pregnancy. These methods had been used by all the participants or their partners. They could recognize signs of non-progressing in themselves and others.

## Summary

Prior to the index pregnancy, all participants could describe protecting, progressing, and non-progressing strategies to maintain recovery from addiction. These strategies were balanced to meet the requirements of recovery and maintain the identity of alcoholic/addict. All the strategies were then preserved and later adapted for use during pregnancy and early parenting. The following sections present how

these strategies were used to balance each other and the identity and roles of being an alcohol/addict and a mother.

## Pregnancy

The index pregnancy event led to the need to balance the two identities of alcoholic/addict and mother. During pregnancy, the focus shifted from maintaining recovery to balancing a focus between recovery and parenthood. Strategies developed prior to pregnancy were continued and modified to support both the recovering alcoholic/addict and motherhood identities. The three categories of strategies of protecting, progressing, and non-progressing were variously employed during the pregnancy period. The shift during pregnancy was toward increased use of progressing strategies with adjustments made between protecting and non-progressing mechanisms.

### Psychosocial and Physical Factors Surrounding the Special Pregnancy

Various psychosocial and physical factors made the index pregnancy very special to each of the participants. These factors are the context within which the pregnant alcoholic/addict identity change and recovery process occurred.

In this study, every participant valued and desired their current pregnancy, planned or not. This attitude is indicative of Gara and Tilden's (1984) concept of adjusted control. All participants told about adjustments and reactions that helped them resolve ambivalence at the confirmation of pregnancy, leading to a positive perception of the current pregnancy. Conditions leading to the positive valuing of the pregnancy included feeling emotionally ready and stable enough to have a child,

feeling social acceptance and support especially from a partner, timing of the pregnancy with established sobriety, and being physically and financially capable of having a child.

The importance of being in control and having choices in pregnancy was supported by data in this study. For women in alcohol/addiction recovery, having options and being able to make responsible choices is a sign of progress and leads to healthier behaviors. Having a sense of control may be an important factor in women's positive experiences of pregnancy especially after experiences of lacking personal decision-making, as in addiction, fetal loss, and infertility.

Experiencing Fetal Loss

Six of the eleven mothers reported at least one previous fetal loss that they viewed as significant and devastating. Consistent with the literature (Peppers & Knapp, 1981; Stack, 1984), grief about pregnancy loss affected the participant's experience and contributed to the specialness of the index pregnancy. One mother reported a previous pregnancy termination due to her heavy drug use as a loss that she had felt guilty about for years until her present pregnancy. She viewed her inability to conceive for 12 years as a punishment for that pregnancy termination. Another mother reported that she decided to keep her baby and not adopt out because of having had a previous miscarriage. Yet another mother with two earlier pregnancy losses and an older son described her reaction of drinking to cope with her earlier losses:

I got a couple of DUIs during all this. I started going to DUI classes after I

lost the first baby. I just kind of absolutely went nuts. I was so depressed I was going to a psychiatrist and he wound up giving me antidepressants.

Another participant described an earlier pregnancy loss as follows:

It's the only thing about my first marriage that will bring tears to my eyes. For me that baby was a baby for me, that was my feeling at the time. It was like losing a child. That's always affected me. That's always been a great loss. My alcoholism was in full swing by then but I did not drink or anything during the pregnancy. It really went bad after that.

One mother feared the loss of her pregnancy so much that she needed to deny the pregnancy to protect herself. She explained why, after confirmation of the pregnancy, she delayed telling other people:

See, I found out on this pregnancy, the results, at 3 weeks and there was already a bulge. I didn't feel it until I was 6 or 7 months pregnant. Even though I was seeing the obstetrician every other week. Even though I was eating right. It was better for me mentally to be in denial. Right, especially during the first trimester because I was really going off the deep end. So I just put myself in denial to get through it. I was afraid I was going to lose the baby. If I didn't lose it, how was it going to be genetically?

This mother had lost several previous pregnancies while drinking heavily and being sexually involved with an intravenous heroin user.

Infertility

The participants who had a prior infertility diagnosis experienced an enhanced

appreciation of conception but also apprehension about an unplanned pregnancy. One mother explained, "I was diagnosed as not being able to bear children about 8 years ago. When I got pregnant it was like we were really surprised." Another mother who had been told by her physician that she could not conceive and, therefore, was not using any contraception when she did become pregnant said, "It was really a big surprise but both [partner] and I are really glad. [Partner] was really glad from the beginning."

Uncertainties of Pregnancy and Parenting

Evaluating risks from sexual violence, possible HIV exposure, and the potential to parent contributed uncertainty in the special pregnancy and influenced the women's identity as pregnant alcoholic/addicts. Although these concerns may reflect normal ambivalence toward pregnancy (Rubin, 1970), they added uncertainties due to the risks of prior drug/alcohol use also being present for the study participants.

Evaluating Risks From Drug/Alcohol Exposure

Study participants described concerns about the effects of prior alcohol and drug use on the current pregnancy. The concerns centered around potential physical and emotional effects, experiences of sexual violence, and subsequent guilt about these effects. These concerns, associated with years of drug/alcohol use by either themselves or the father of the baby, prompted some participants to seek more information. As one participant questioned:

> Why did I lose the first two [pregnancies]? Something obviously was wrong so the body gets rid of it. So, was there going to be something wrong with

> this one?... I had two miscarriages with him [partner]. That was before they decided that the father's use would have affected a pregnancy. He was doing speed, PCP [phencyclidine], and he drinks. So I'm glad to see they're finally doing the fathers, you know. That last little bit of me that said it was my fault is gone. I can get rid of it now, it's all gone now. It used to beat me up mentally [with guilt].

Another participant worried, "If all the bad things that I had done to my body, if that was going to affect my child because of all the alcohol abuse.... Am I going to pay for that now?"

One study participant faced unresolved issues about sexual assault and possible effects from IV methamphetamine use during a prior pregnancy. Talking about this painful experience she said:

> I'd been in trouble with the law about 5 years before that and I finally got sentenced on it and I had to go to jail. I was probably 2 months pregnant when I went to jail, ...months that I could have chosen an abortion.... It became kind of like denial.... That would be preferable to being pregnant [from the rape] at that time.... The doctor gave me a physical and he said, "You are aware that you are 5 months pregnant aren't you?"... I spent more time working on that [rape and pregnancy] when I was in treatment than my drug problem. With [son] I was so upset that I was pregnant that I used drugs when I was pregnant.

The experience of feeling guilty about the use during pregnancy did not stop the

addictive use of IV methamphetamine. She continued even at the time of the study to evaluate the effects of prenatal drug exposure on that son. The index pregnancy was another opportunity to evaluate these effects.

Finkelstein et al. (1981) describes maternal guilt about drug use during pregnancy and parenting as a factor in relapse for recovering mothers. Brown (1985) does not examine pregnancy as a factor in recovery. Evaluating risks from past or current drug use may affect recovery during pregnancy. Mothers may need to work harder at their recovery when pregnancy is complicated by guilt and fear about the effect of prior drug exposure. Maintaining hope that a healthy baby is possible provides motivation for recovery (Rosett et al., 1983; Weiner et al., (1989).

Sexual Violence

Experiences of victimization in sexual violence are associated with pain, humiliation, and stigma. Pregnancy, as a time when sexual awareness, sensual feelings, and exposure of the body occur, can raise these issues again. One mother in this study with a history of being sexually abused as a child described how frightening the sensations of pregnancy were and feared being touched or examined, especially by males. Among the women in this study, six described sexual and physical violence with a previous partner while they abused drugs, and three women reported having been raped, two as a child and another as an adult. Each of the women had disclosed abusive experiences to their partner, a sponsor, or a counselor before the interviews of this study. These data confirm the role of violence in addicted women's lives as described by many authors (Amaro et al., 1990; Finkelstein, 1990; Finkelstein et al.,

1990; Hurley, 1991; Swett et al., 1991; Young, 1990).

Evaluating Risk of HIV Exposure

Evaluating the risk of HIV exposure entailed appraising risky sexual behaviors, partners, and drug use related to HIV. In this study, all but one participant considered themselves at risk of AIDS because of past drug and sexual behaviors. Two had used IV methamphetamine and two had partners who were former IV methamphetamine or heroin users. Appraisal of the risk of exposure was a continuing issue for these women, which included deciding whether to seek testing. When both the participant and the father of the baby were former IV drug users, mothers sought testing and considered themselves and their babies at high risk. They believed that negative test results and repeated testing were ways to monitor their health.

Avoidance of testing also occurred for participants; they were fearful of being HIV positive and what it would mean. Many of the participants had friends who had tested HIV positive or were acquainted with someone with AIDS or with someone who had died from AIDS. Anticipatory grief of a positive HIV test results caused some women to avoid testing. Evaluating risks from past lifestyles continued during recovery and appeared to contribute to the perception of a "special pregnancy."

Fear of exposing their partner and their fetus to the HIV virus and other blood borne pathogens was present for eight women. They reported that they and their partners had tested for HIV status at the time when they were committed to each other. Another time of testing was during early pregnancy. A participant who was

evaluating her risk said:

> AIDS was a big concern for me when I got pregnant. I was tested and I'm keeping up on the testing. I was never a needle user....God knows that I've probably been with somebody that was....I keep tested. That's something that keeps me on the straight and narrow too is the fact that I want to be the one to raise her.

Mothers expressed relief that they had tested negatively but planned to have subsequent tests. One said, "Now that AIDS is out, I worry.... I have been tested and am negative. I've been very fortunate. Because I was with people you consider high risk." Another young woman who was a former IV drug user and prostitute explained, "I've been tested [for HIV] since I was 14 years old....it scared me...so I made sure I got tested."

An intervening condition for IV drug users is that needles used to withdraw blood for testing may trigger a relapse episode or stimulate drug cravings. One participant had developed a strategy to manage blood testing and protect recovery. She minimized the number of "needle sticks" by having concurrent blood tests drawn. She described her strategy:

> I had tests for HIV about six months before I got pregnant. They say it can take years to show up or something. Each time you have one and it's negative it's better especially if you've waited. Maybe after a couple of years I'll quit having them...I have these anxiety attacks. We put the AIDS test off because I have between the 26th and 28th (weeks) there's a diabetes test that they do

that requires them to draw blood, so we put the AIDS test off until then so they'd only draw blood once.

Another mother evaluated her risk of exposure as low. She explained:

I did worry about AIDS when I was using. When you settle down with one partner and you've been together for a long time you start not to think about it. Especially when you're not using. I never used needles and neither did my husband.

All the participants were aware of strategies for prevention of infection and had changed behaviors since becoming clean and sober, yet fear of infection as a result of previous behaviors remained a source of uncertainty. The findings of the present study about HIV threat perception were similar to those reported by Suffet and Lifshitz (1991).

Debating the Potential to Parent

Debating the potential to parent is defined as an ongoing thought process of weighing past and present experiences and expectations in relation to one's self and one's partner for the ability to parent. Debating the potential to parent was an issue of recovery for all women in this study. This debating process took place during pregnancy but was also reported to be most intense before conception, at confirmation of pregnancy, and again before birth. Initially after confirmation of the pregnancy, it was one factor that contributed to the "special pregnancy." At birth it became a source of planning for parenthood. A consequence of this debate was seeking and negotiating additional support from the partner, counselors and planning for child

caretaking responsibilities. Review of one's own parenting and concerns about parenting have been reported to occur among nonaddicted pregnant women and their partners (Ballou, 1978; Rubin, 1970) as well as among addicted mothers in recovery (Wellisch & Steinberg, 1980).

Some mothers in this study described debating if it were possible for themselves and their partners to become parents and to care for their children. Growing up in alcoholic/addictive families and experiencing abuse as a child made them very leery of their own potential to parent. One participant said:

> When I was 25 I was going to have my tubes tied because I knew I would be the worst parent there ever was. That's why I told [Partner] when we met, "I"m not having kids. I didn't want to be, as much as I love my parents, I'm not going to be like my parents." I didn't want to be a bad parent and I was afraid I would abuse my child. That was one of my biggest fears is that I would be an abuser.

Remembering and evaluating how they were parented as children was painful for some of the study participants, similar to the memories reported by nonaddicted women. One of the issues in the women's recovery, however, was dealing with their childhood experiences. Some of their parents had been alcoholics, addicts, or mentally ill. Several participants reported being abandoned physically or emotionally as children. Four participants repeated several times in interviews that they did not "have a clue" as to how to parent. Two women reported that neither they nor their spouses could remember portions of their childhood; their memories were blank.

Others recounted feeling their parents were unpredictable, cruel, unfeeling, critical, and not caring about them. Five reported that as children they reversed roles with their mothers or become adults at an early age. Even though sexual and physical abuse occurred in nine of the women's families of origin, only two women reported that their family had been involved with child protection services. None of their parents was involved with family therapy.

Participants who were physically and sexually abused as children were fearful of becoming an abusive parent. Many of the participants' partners were also raised in abusive families. All but one of the participants had a partner involved in parenting of the infant. Awareness of the potential for family violence was the motivation for some participants to seek information, support, and self-understanding from individual counseling, family therapy, groups such as Alanon (a Twelve Step group for family members of alcoholics/addicts), Adult Children of Alcoholics (ACOA) groups, or Adults Molested as Children (AMAC) groups.

Parental failure already had been experienced by one mother in the study who had adopted out her 4 year-old son and explained her action,

> I couldn't give him what he needed. I couldn't be what he needed. And I had another son to think about. My husband and I were split up at the time and I had to think about our future you know, if we were to have one. It was an open adoption but his adoptive parents aren't very good at contact. So I just kind of don't deal with it....I had a tendency to abuse him.

This mother had subsequently remarried her husband after the adoption and had two

additional miscarriages before the index pregnancy. She continued to evaluate their potential as parents and as spouses. Both had grown up with abusive parents and with alcoholic mothers. They remained together and worked at "forming a family" and caring for their remaining child.

> A mother with a chronic condition, left by the father of the baby, wondered:
>
> When I was pregnant, as much as I wanted the baby and everything, towards the end I just wondered if I was going to be good enough at being a Mom to deal with it. There was a time right before I had her that I even considered to give her up for adoption because I didn't feel like I had it together enough to give her a good life.

Mothers approached this debate about whether they could be parents by using a number of strategies. Seeking more information about parenting and pregnancy was one way. Several mothers sought information from books and authorities like counselors. As described by one mother, "I was reading in one of the books, it said early in pregnancy and late in pregnancy you tend to really think about your own parenting skills and compare them to your parents." Another way of seeking information was talking and comparing experiences with partners, friends, and siblings after the pregnancy was established. One participant described a change in her partner's attitude:

> He'd always talked about how he was never going to have children and he wasn't going to bring children into this world. When we found out I was pregnant, he was tickled to death and excited. Then it was, "We're not going

to have any more children. We're not going to bring any more children into this world. This is the only one." Just right after I had her, he said, "We'll have another when she is 4." He's really changed his view of the world and parenting.

Debating the potential to parent continued throughout pregnancy and after birth for these women, especially for participants who had been abused or who had abused or neglected their children. Often this led to planning strategies to manage parenting; developing crisis plans if abuse was likely; additional monitoring of their parenting by professionals, partners, and friends; and seeking support and information.

Several sources (Bauman & Daugherty, 1983; Bushong, 1990; Leif, 1985) recommend assessment of substance addicted women's parental attitudes with parental attitude instruments as well as interview questions about how the women were parented as children (Wellisch & Steinberg, 1980). The literature on transition to parenthood is replete with descriptions of normal parents' evaluation of their own parenting as children as well as the implications of those experiences for their ability to be good parents. The differences for addicted women appeared to be the degree of concern before conception and whether the woman continued to feel inadequate or questionable about parenthood after birth, even after using strategies to check on and improve their parenting ability. The specialness of the pregnancy, past failures at parenting, the identity of alcohol/addict mother, and awareness of abuse histories appeared to interact, contributing to the seriousness of concern about potential to parent.

## Protecting Strategy

Previously developed dimensions of the protection strategy to prevent alcohol/ drug relapse were activated and modified to cope with the new situations of pregnancy. A new protection strategy dimension added to the pregnancy period was that of being careful. The spirituality dimension developed previously as a progressing strategy was used as a protecting strategy during the index pregnancy.

### Preventing Relapse

Many conditions during pregnancy were identified by participants as high risk for relapse. Some of these conditions had been identified and prepared for by participants, but some had not been foreseen. Prior to childbearing, the stress points identified and anticipated by women included hearing confirmation of the pregnancy, sharing the news and events of pregnancy with a partner or father of the baby, deciding to maintain the pregnancy, being given needlesticks for blood samples, and receiving a diagnosis with a condition that required increased monitoring and hospitalization. One participant recalled telling her partner about the pregnancy, "I was little apprehensive, when I started to suspect that I was pregnant, about what his feelings were going to be about that because the relationship was so new."

Brown (1985) and Gorski (1986) address relapse as part of the learning process to maintain recovery. However, neither of these authors identified the potential threat associated with pregnancy. Similarly, Mercer (1990), Bushong (1990), and Mondanaro (1989) do not discuss relapse as a problem during pregnancy and transition to motherhood. However, Finkelstein et al. (1981) described maternal

guilt for drug use during pregnancy as a factor in relapse.

Being Careful

Being careful was a new dimension of protecting developed by participants during the pregnancy to protect both recovery and the health of the fetus. It included "staying clean and sober"; maintaining abstinence from psychoactive substances; and taking steps to improve health such as smoking cessation, resting, exercising, and eating nutritious foods. Being careful was used by all the participants in this study.

All the participants identified nutrition as a significant way to promote the health of both themselves and their babies. During past periods of methamphetamine or alcohol addiction, poor nutrition and malabsorption of nutrients had been common and were acknowledged by participants. Improved nutrition was viewed by participants as a way the body could heal from effects of malnutrition and meet the increased needs for pregnancy. One participant said:

> Staying clean doesn't feel like a threat right now. I don't feel threatened in any way. I want to be real careful. I've eaten better than before I got pregnant. I've been real careful. I 'm planning to have a tubal after this baby. I have three children (already). This will be my husband' and I's [sic] only baby together and so I'm really careful not to put myself in places that make me feel like I might want to use, not to do that kind of stuff; and to eat, try not to get to fat and eat the right stuff; this is the first time that I've had a baby with someone that I loved because I chose to.

Threat of relapse, with a slip or renewed drinking, continued unless there was

continuing "vigilance" as well as "healthy decision-making." Decision-making or vigilance were terms used by three mothers to convey control over alcoholism/ addiction. Decision making meant making decisions for continued recovery and good health and vigilance meant focusing more on the threats to recovery.

In this study, the majority of women had experienced depression during periods of drug abuse and when beginning recovery, but only two mothers reported clinical depression during the time of childbearing and early parenting. Relapse with thoughts of renewed drinking and depression were linked by these two participants. Both these women reported a history of physical abuse beginning in childhood, abandonment by the father of the baby, and difficulties coping with pregnancy and early parenting.

Both mothers sought professional evaluations and were prescribed antidepressants after birth. One mother received ongoing individual therapy for severe depression prior to pregnancy. Although hopeful that "things were improving but still stressful," she attended AA meetings when "her ass was falling off." She had 5 years of sobriety and felt that she would sooner die than drink again. The other participant with a diagnosis of depression wrestled with thoughts of renewed drinking and self-doubt about coping with single motherhood. Protecting recovery while managing depression remained a challenge for these two participants, even though depression had been an anticipated condition.

Nine other women described "dysphoric distress" during postpartum, (Affonso, 1991), a general feeling of depression, anxiety, and restlessness (Clarke & Summers,

1981). Symptoms included fatigue, worry, obsessive thoughts of drinking or drug use, loneliness, guilt, and lack of joy. The need to protect recovery from these feelings is important because maternal depression has been associated with relapse (Zuckerman et al., 1989). These symptoms need further investigation to differentiate the normal maturational experiences of childbearing from depression during recovery or childbearing that requires mental health interventions.

Participants also recognized the need to protect their recovery from the stresses of childbirth. As a consequence, all attended childbirth classes. A major concern was managing the pain of childbirth without medication. Participants felt that relapse would occur if any psychoactive drug was taken. One mother was very upset by the "pushing of drugs in a childbirth class." Another mother chose a home birth in order to avoid procedures and medications she felt would alter her recovery and spiritual bonding with her baby.

Spirituality

Spirituality was identified by all participants as a significant dimension to both maintain recovery and to meet expectations of the maternal role during pregnancy. Spirituality in pregnancy appeared to be used as a protective strategy rather than as a progressing strategy as it had developed prior to the index pregnancy. Spirituality continued to be used throughout pregnancy especially to cope with difficult or frightening experiences, such as hospitalizations or "everyday hassles." Participants reported use of prayer, daily contact with a higher power, Bible study, and church and Twelve Step meetings as ways to use spirituality.

Summary

Dimensions of the protecting strategy were used successfully by participants to maintain recovery during pregnancy. These efforts were directed at protecting the mother and the fetus. None of these women reported actual drinking or drug use, but three described thoughts about drinking as a way to cope with pain, fear, and depression.

## Progressing Strategy

The progressing strategy was used throughout pregnancy to maintain recovery and also achieve the motherhood transition. Some dimensions of the strategy were used more intensely or frequently during pregnancy than at other times. Balancing was achieved by altering emphasis to focus more on the mother identity and less on the alcoholic/addict identity. Thus, dimensions of the progressing strategy that supported the mother role were used predominantly. Nonuse of a strategy previously used in recovery did not indicate its absence but rather a lower priority for its use at this time of transition to motherhood.

### Establishing the Dual Identity of Alcoholic/Addict Mother

The first step in taking on the dual identity was acceptance of motherhood. Motherhood identity transformation has been defined as a turning point that occurs when pregnancy is confirmed and accepted and motherhood is anticipated, a developmental task of early pregnancy (Rubin, 1975). During early pregnancy, the mother begins to develop a sense of her unborn child through accepting the pregnancy as part of herself (Ballou, 1978). As pregnancy continues, developmental,

intrapsychic, and interpersonal changes support a changing sense of self and of the unborn child (Ballou, 1978; Rubin, 1975).

During one interview, a study participant described that "finding out that she was pregnant and becoming a mother was as transforming [an] event as when [she] accepted the identity of an alcoholic." Another participant viewed "being responsible for myself as well as a baby as a big change in thinking and behaving." All participants stated that early pregnancy was a turning point. Identification as a pregnant woman changed the meaning of recovery for all participants.

Acceptance of the dual identities of a mother and alcoholic/addict resulted from the woman's recognition that her pregnancy was a special pregnancy that was indeed a wanted pregnancy. Experiencing the processes of recovery and the transition to parenthood concurrently required reinterpretation of both experiences with use of coping strategies to manage this pregnancy and maintain ongoing recovery. An essential stage for all participants was when they redefined themselves as pregnant alcoholic/addicts.

Telling others the new identity. As discussed earlier disclosing an identity as an alcoholic/addict reinforced the identity change. Rubin (1967) describes disclosure of pregnancy as essential to acquiring the motherhood role by eliciting support for the pregnancy.

Participants had different approaches for disclosing the news about their pregnancies. Seven mothers who attended AA support group meetings told members of the group whom they regarded as family. One participant said:

> I've been with the group for 3 years. We announced, [when] my husband and I first found out that we were pregnant; we announced to the group and we wanted them to know. Our group was like a family. I don't have any family out here so it's a wonderful family to be part of. They've been very helpful and very supportive, especially members with children.

For three participants, the Twelve Step group was not a place to receive support for a pregnancy even though they sought addiction recovery support from the group. Another participant who attended NA meetings and had been clean for a year said:

> I haven't even noticed many pregnant women in recovery. I met one a couple of weeks ago at the big Tuesday night meeting. There was a pregnant woman there that was new to the program. We were the only two pregnant women. This was like 50 people. This was her first child. She wanted to talk "baby talk," and so I talked with her. I didn't get much chance to know her.

Recovery and pregnancy needs were not met through the Twelve Step group meetings for some participants, but they did continue to use the support from sponsors and other members.

Disclosing the dual identity to health care providers was important to the participants. To disclose solidified the identity of a pregnant alcoholic or addict and elicited needed services to meet health needs. All participants told their providers about their past or current drug addiction at the time prenatal care was begun. Participants viewed health care providers' support as essential in managing the special

pregnancy. Participants were aware that if drug and alcohol use were suspected during pregnancy that child protection services might be contacted and their infants would be tested at birth for drug residuals. They knew there was a possibility of losing custody of an infant if there were indications of renewed drug use.

Bushong (1990) has stated that women who remain in denial about alcohol/ drug use are at the greatest risk of not moving through the stages of maternal role attainment. Telling others was a way to confirm and acknowledge addiction, and thus prevent denial. All participants acknowledged the identity of pregnant alcoholic/ addict and explored the meaning of that dual identity. For mothers in this study, telling others about the dual identity of addiction and motherhood served to facilitate maintaining recovery and establishing motherhood.

Mothers who had parented a previous child during their drug/alcohol use had not accepted this dual identity at that time. They now retrospectively described some of the previous pregnancies and parenting as not fully experienced, having gone through them "in a fog" or "numb."

Stigma. Stigma was an intervening variable that affected both accepting the disease of addiction and acquiring the maternal role at the same time. Consequences of stigma can be denial of addiction, dishonesty that threatens recovery, and reduced social support that may limit adaptation to the pregnancy and mother role (Mercer, 1990). Lacking full social acceptance may also decrease a woman's positive perception of her pregnancy (Gara & Tilden, 1984). Mothers in this study reported that acceptance of the identity of alcoholic/addict mother resulted in their experiencing

stigma. Participants were sensitive to critical comments and sometimes misinterpreted remarks that they felt were demeaning from professional helpers. As a consequence of the acceptance of the pregnant alcoholic/addict identity, a set of conditions emerged that affected both their recovery and transition to parenthood. The need to balance between these two processes was a constant challenge to participants.

Dealing with Emerging Feelings

Emergence of affect, defined earlier as a dimension of ongoing recovery that involves integrating new emotional elements into expressions of the personal identity (Brown, 1985), was expanded during pregnancy to include the emotions involved with the pregnancy and motherhood experience. The coping strategy developed prior to pregnancy helped to prepare the participants for the emotional upheaval, increased range and depth of feelings, and reactions to feelings and new physical sensations of pregnancy (Ballou, 1978; Rubin, 1975).

Emotional disequilibrium. All participants described emotional disequilibrium during pregnancy similar to that described in the literature (Ballou, 1978; Benedek, 1956; Rubin, 1975). The study participants, however, also reported unique expressions of this emotional upheaval. These included learning to differentiate between feelings associated with recovery, or possible relapse, and pregnancy and developing ways to cope with emotional distress without using drugs or alcohol. Partners helped to differentiate between the emotions of pregnancy, feelings associated with recovery, and feelings that might contribute to relapse. A mother with 3 years of sobriety described her process of coping in relation to her partner's

response:

> It's hard for him to understand and it's like I've been real well lately, but the first few weeks, emotional as all hell. I started bawling one night and couldn't stop and he couldn't figure out what was going on. Even if it took me awhile to go," Oh yeah, I'm doing this because I'm pregnant. I'm not going crazy."

One of the mothers described her difficulty in balancing the feelings of becoming abstinent and receiving confirmation of her pregnancy:

> There's a lot of emotions involved, emotional outbursts and everything else. I don't know. They're so raw. Your feelings are so raw because they are not numbed from alcohol any more. As far as pregnant women go, your hormones are in such a flip when you're pregnant and trying to be sober at the time, you're like a basket of raw emotions. It's something really hard to deal with and not make everyone around you nuts. I'm surprised that anybody in my family or my close friends even talks to me anymore. If I wasn't crying, I was throwing a temper tantrum.

Participants identified that pregnancy was a period that accelerated the emergence of feelings begun prior to pregnancy. Once pregnant they required new understanding and management plans.

Feeling love and attachment to the fetus. Rubin (1975) describes "binding in with the child" that results in the mother investing in "making a good baby, providing a good home for him, in utero now and in her household later, and in protecting and safeguarding that which she has and is so precious" (p. 150). Consistent with the

literature, all participants expressed feelings of love and attachment to the fetus and awareness of patterns of fetal movements and development (Cranley, 1981; Rubin, 1970; Stainton, 1985). This was demonstrated in their descriptions and behaviors.

One mother described her awareness of baby movement in relation to her own activities:

> Well he lets me know that he's hungry because he'll kick me. After I eat, he'll mellow out. He moves into a situation where he's real comfortable and goes to sleep. There's times when I hurry up and eat and he doesn't have to kick me.

One 18 year-old mother was faithful about writing in her diary about her feelings and experiences during pregnancy. She noted many comments about baby movement and reactions. Some of these are: "My baby is moving right now. She feels so great. I am getting excited. I can't wait and I imagine a beautiful baby. I love having a baby. I have no regrets and am in love with it."

Mothers reacted positively to any information about their unborn babies. Three displayed ultrasound photos of their babies' first picture. They commented on watching the babies suck their thumbs and move legs and arms during the procedure. Support persons like partners, children, and sponsors accompanied mothers to these procedures if possible. Knowing more about the fetus appeared to strengthen the attachment that mothers felt toward the fetus.

Fetal movements were associated with fetal health and characteristics, for example "being a strong baby." All mothers wanted a strong baby who moved and

interacted with them as well as with other family members and friends. A mother described her involvement and interpretation of the fetal movements:

> ...the baby, at night every time I crawl in bed, kicks. It will kick my partner. [Partner] has had his head on my tummy and he's got kicked in the nose. My girlfriend gotten kicked in the nose because she will get down and talk to him and stuff like that. The baby's kicked her in the face like three times, hard. This kid packs a punch. He's not a weak child.

Some mothers anticipated increasing fetal movement as a way to involve partners and children in the pregnancy. Feeling movement was a way to make the pregnancy real for the fathers. One participant said, "I can't wait for the baby to move. My husband is scared. It's not a reality yet." In spite of hearing the baby's heart beat and doing the ultrasound together with her partner, one mother said, "It was so tiny and it didn't look like a baby yet. I think it will be exciting for [Partner] when the baby starts moving." Siblings stroked and talked to their mothers' tummies and "their baby brother or sister." The family and close friends were increasingly aware of the new baby as a member of the family with unique characteristics and behaviors. These findings are similar to those from Stainton's study (1985) of couples' relationships with unborn children beginning in pregnancy.

Mothers in this study formed attachments and relationships with their unborn child in a way similar to nonaddicted mothers (Cranley, 1981; Rubin, 1970; Stainton, 1985). Attachment and binding in with the unborn occurred with each participant in this study. Only one participant reported delayed feeling of fetal movement until late

in her pregnancy due to her fears of fetal loss. Each mother sought information about her baby; interacted with the unborn baby through touch, conversation, and an "inner voice"; and encouraged family and friend involvement with the fetus. In addition, each participant demonstrated a unique form of attachment by maintaining recovery.

Keeping Intimate Relationships

Keeping intimate relationships was previously defined as a dimension of the progressing strategy that continued during pregnancy. Ballou (1978) and Rubin (1975) both identify pregnancy as a period of change in social roles and relationships, especially with the mother in the family of origin and the husband or partner. Necessary to keeping intimate relationships were three methods: developing trust, forming a team, and reordering family ties. Each of these methods has been previously described as ways to progress in recovery.

Developing trust. During recovery, participants had concentrated on developing a sense of trust of others and themselves. While pregnant, participants focused on becoming a trustworthy mother. As one participant in the her last trimester explained:

> The only thing that you can say when you're having a kid...you've got to do the best that you can do. Go out of your way to make sure that you're giving everything that you can to the child. To let that kid know that you can be depended on and you can be trusted. That's a point I'm going to make to my child....there are going to be things that he will experience out there that I'm really not going to like but I'm going to be here for him.

This mother had spent her first 19 years in abusive relationships, foster care, jail, or a drug treatment center. At the time of the study she was 21 years old, married, and pregnant, and had been clean and sober for 8 months.

All mothers mentioned the need to help their babies develop trust. Every participant identified trust as the most important element of the parent-child relationship and expressed their desire to be a trustworthy parent.

Forming a team. Forming a team is defined as methods used by participants and partners to communicate and work together to meet their joint goals of a healthy pregnancy and continued addiction recovery, as described previously. In this study 10 of 11 partners were either in recovery or nonaddicted, a key factor in supporting their partner's recovery. These men were able to act as both "father and mother" to their partners as described by Ballou (1978).

An important role for the partners was helping their spouse with the emotional turmoil during pregnancy. They needed to help women "sort out" reactions and feelings of pregnancy or recovery. For some women who had been physically or sexually abused, pregnancy intensified their feelings about past abuse. Spouses or partners often wanted to help with these feelings but did not know how. As noted earlier, all the partners were unsure of how to provide the support needed by the participants, who wanted their partners to listen more than to do things. The majority of women depended increasingly on their husbands as the pregnancy continued, a phenomenon described by Ballou (1978).

Reordering Family Ties

Reordering of family ties, a previously described process of change in familial relationships, began during recovery and intensified during pregnancy. Part of reordering family ties was learning how to deal with and separate from parents. In addition, the participants' relationships with their older children changed during pregnancy.

As noted earlier, seven of the participants had ambivalent feelings toward their mothers. As pregnancy continued, six of the women were more positive toward their mothers and reported a "much better relationship." In addition, participants whose mothers were alcoholic/addict worked through their feelings about their mothers by using AA principles described earlier in the chapter. This is consistent with the reconciliation themes described by Ballou (1978) for all pregnant women.

If unable to reconcile with their mothers, participants worked to build new relationships with parents. One participant felt like she was beginning to have a relationship with her mother and that she could see a link between her feelings towards her mother and her own child. Her story links her experience of abandonment as a child, her relationship with her mother, and the parenting of her own child. This participant had been abandoned as a 3-year-old and was found by her mother when she was 17 years old. She had many questions about what had happened. As she approached childbirth, her changing relationship with her mother was described:

She's made such an effort to make a relationship between us two....She is my

> mother, whether I like it or not. There's been times when I thought, "I wish I never ever would have seen her face." I just wish she would never have showed up. It would have been better if I just still never had a mom. That's not the case anymore. I enjoy her company. I like talking to her. There's got to be a point in our relationship where we sit down and talk about what happened and why and how come I feel this way, because I'm going to have a lot of problems with my Mom and my kid until this is resolved.

The recollection of childhood as a positive experience was not possible for nine women in this study. Even when there was reconciliation with a mother or father, many women felt anger and hurt when thinking about their experiences. Their ambivalence about their own unmet needs as children hampered their fantasy, planning, and actual ideas about parenting their own children. The assistance of an AA/NA support group or counseling helped some women address these problems.

Forming an adult relationship with one's parents was another example of the integration of recovery and motherhood. Ballou (1978) describes this process of adult relationship formation as dependent on a successful outcome of the "reconciliative process," which involves developing a more adult sense of self by confronting the mother as an adult equal and resolving feelings of ambivalence about the mother and recollections of childhood.

One participant, 30 years old with 3 years of sobriety, described the shift that she anticipated through the birth of her first child, as a way that she could "kind of separate from, make our family the priority instead of Mom." She expressed hope

that this separation process would continue:

> I'm hoping that comes more with having a child too. It already has. Us moving into this house and having our own home. Now all of us will get along on a much higher plane. I'll stop being the little girl. That's the expectations I have. Whether it comes true or not will be another thing.

Another participant described how pregnancy may have affected her family relationships: "Pregnancy brings a lot of things to a head. I know things with my family have been closer. Family is important. Your priorities and your values change. It started to change in pregnancy. Family became much more important."

In this study, participants described separating from parents though the changing relationships that occurred during pregnancy and recovery. The particular challenge for these women described by Bushong (1990) and others (Leif, 1985; Mondanaro, 1977; Wellisch & Steinberg, 1980) is that substance abusing mothers are more likely than other mothers to have been abused, neglected, abandoned, or exploited. Many have not been nurtured as children and have been "pseudoparents," through role reversals, to their own parents (Brown, 1985). As these participants approached becoming parents, some described caution regarding the need to continue to work on these relationships. They realized that substance abuse during prior pregnancies had diverted them from working on these developmental tasks usually addressed during a first pregnancy.

All participants described forming and reordering relationships with a partner, support group, parents, and children. Balancing reordering among these relationships

appeared to be a major task.

Reaching for Maturity

Reaching for maturity was a process begun during recovery, the dimensions of which changed during the index pregnancy. The dimensions of being an adult, being comfortable alone, creating a fellowship, and using professional help were ways participants demonstrated their adulthood and dealt with the normal developmental tasks of pregnancy. By accepting the identity of pregnant alcoholic/addict, women were able to work on adult developmental tasks, such as those of pregnancy and motherhood. Flexibility in using the dimensions of the progressing strategy of recovery to meet the developmental tasks of pregnancy was an indicator of the personal growth of participants. They were able to modify the strategy by shifting focus from recovery to motherhood. All participants accomplished the developmental tasks of pregnancy in a similar way to nonaddicted mothers. What is unique about mothers in this study was that they adopted the strategy developed in recovery to master these developmental tasks of motherhood.

Preparing for motherhood. Participants described the following activities and preparations for becoming a mother: maintaining recovery to ensure "safe passage"; establishing a fellowship and reordering family ties to "secure acceptance of the child"; developing the capability for emotional attachment and intimacy for "binding into the fetus and later child"; and "giving of oneself" to the fetus child (Rubin, 1975, p. 153). By accomplishing the maternal role in pregnancy the participants were developing competencies that would strengthen their process of adult development.

Being comfortable alone. Another method of reaching for maturity was being comfortable alone, a dimension developed during recovery. Use of this method permitted pregnant women in this study to become self-reflective and to engage in the intrapsychic/intrapersonal work of pregnancy (Ballou, 1978; Rubin, 1975; Sherwin, 1987). Although this developmental work is assumed to occur for all pregnant women, some participants described how this was the first pregnancy during which they were able to complete this work. By having developed the method of learning to be alone during recovery, they were now comfortable for the first time with the intense intrapsychic experience of also being pregnant.

Similarly, the fantasy or dream work of pregnancy considered essential to the process of attaining the maternal role (Benedek, 1956; Rubin, 1975; Sherwin, 1987) was a new and sometimes frightening experience for participants. In addition to the "normal" fears that emerged in these dreams, participates also described dreaming about drug use. As childbirth approached, all mothers reported difficulty sleeping and had night dreams about childbirth and their babies as well as drug use. Some examples from the data illustrate fantasy work by participants. A newly clean and sober mother reported how her dream included the birth, the special baby, and family members:

> Please give it a rest. The dreams that I have are like going into labor, having the baby. I had a cool dream that I was in labor and I had the baby. Everybody and their dog was looking at the baby and I wanted to see him and I wanted to hold him so I snuck out of my room and I ran down there and I

> was looking at the baby. Their grandma, all she says to me is basically the whole time, "Bring me your baby. Baby that Baby. He's our special Baby." ...She gave me a kiss and told me I had a beautiful baby.

The intense preoccupation with and fear of labor and birth were demonstrated by "drug dreams" by one participant, a mother who was helping a friend to "stay away from crank." This participant began to have dreams about relapsing herself while pregnant. She said:

> I have had a couple of dreams lately and I think the reason is my friend....I had a dream that my partner and those guys were partying together and they were doing some and they offered it to me and it made me really, really angry. I couldn't believe that my husband was like offering it to me because [partner] is really, he's afraid that I might relapse....Then three or four nights ago I had another dream that I did it; I had a bag of crank in front of me; I had my little spoon and my glass kit; I was stuffing it up my nose; I could taste it; and it made me sick. It made me sick. I woke up and was like "I think I'm going to puke."

For this woman, dreams about using drugs had occurred early in recovery and pregnancy but had stopped until close to delivery and the arrival of her drug using friend. Other participants related night dreams about "being sick after drinking," or dreaming about alcohol use that made them angry at themselves or another person.

Day dreams by mothers in this study during the third trimester included fantasies about the characteristics of the baby and were similar to those reported in

the literature (Rubin, 1975; Sherwin, 1981), with the exception of including fantasies about the reactions of AA members to the baby.

Drinking dreams during recovery occur in early sobriety and may serve a variety of functions according to Brown (1985). They may act as an unconscious warning of a desire to drink and alert the newly sober person to increase behaviors protecting abstinence, much as in the illustration of the woman dreaming of using crank. Instead of being a warning, the dream may indicate progress in preventing relapse. Day dreams may also provide imagined ways to manage situations where relapse might occur.

What is unique in this study is the beginning exploration of fantasy among women who are both pregnant and in addiction recovery. Content of both day and night dreams revealed the integration of both recovery and motherhood processes.

Using Professional Help

Using professional help, a dimension defined earlier, was used to manage a special pregnancy and mothering while maintaining ongoing recovery through a specialized social network. Participants incorporated the strategy of using professional help to achieve the developmental task of seeking safe passage for themselves and their babies. Using professional help was reported by participants as a consequence of their increasing maturity during recovery and transition to parenthood.

Ways to manage health during childbearing included intervals of monitoring, education, and treatment by health care providers and other professional helpers. As

described in an earlier section, use of professional help was influenced by external factors, such as assistance through health insurance, change in medicaid eligibility, transportation problems, and availability of child care. Unexpected alterations in health, such as preterm birth and gestational diabetes, increased contact with providers, and participants relinquished management decisions to providers.

All the women in the study received comprehensive prenatal care. All sought care within the first 12 weeks of pregnancy. The majority reported that part of the prenatal assessment included screening for current drug and alcohol use. When one woman was asked about previous alcohol and drug use, she felt she had finally found a nurse practitioner and physician that understood recovery as a life-long process. All the women had tried to explain that they were alcoholics or addicts and what they perceived as added risks for themselves and their babies. They wanted to have a healthy baby and entered into a relationship with a provider to reach that goal.

The majority of the women had some experiences with health care previous to their index pregnancy. The mothers' own low level of trust in people, combined with what they perceived as lack of understanding from providers, sometimes caused women to express anger at providers, withdraw from traditional care, continue care tentatively, or minimize contact with physicians and nurses. Three women required hospitalization during their pregnancies. Two of these delivered a preterm baby. One mother withdrew from prenatal care with an obstetrician because she felt her recovery would be endangered by the hospital procedures and medications. She sought care from a midwife and had a home birth attended by the midwife. Another

mother wrote an explicit plan for her delivery that could be used to plan her care. All the participants suggested ways to improve the care for recovering women. These suggestions included "understand their situation;" "be there for them;" and "be gentle."

Health care for mothers was seen as limited with a planned phase out 6 to 8 weeks after birth. Negotiating a plan of care with the care provider facilitated monitoring, education, and treatment. Providers were able to facilitate a plan if they were familiar with addiction recovery. If a plan was not negotiated, then women withdrew from care, renegotiated with a different provider, turned control of their care over to the provider, or maintained minimal contact with providers.

Nurses and physicians were instrumental in women acquiring some self-care skills. All women reported eating better and knowing more about nutrition; seven were using a Women, Infant and Children nutrition program if entitled. One woman, who had gestational diabetes, had radically changed her nutrition and was feeding her family more fruit and vegetables. Another change was that three participants had decreased cigarette smoking while pregnant, and six had quit completely either before pregnancy or within the first months. One woman quit smoking but started again in the last weeks of pregnancy. Realizing that smoking was an addiction, she said, "I can't believe I came out [of the hospital for asthma treatment] and smoked again. You would have thought I would have quit. I think to me that's switching addictions and stuff."

Participants continued visiting their health care providers throughout

pregnancy, monitoring the health of their babies and themselves, and having multiple tests and medical procedures in order to " have a healthy baby." These tests were those usual to pregnancy assessment plus HIV testing. One participant said, "I think nurses treat people as people and they are compassionate." All of the mothers valued nursing care and the opportunity to discuss sensitive questions with the nurses, particularly in the prenatal and pediatric clinics.

Professional helpers were part of the support network that participants used to help them balance the needs of recovery and motherhood. Counseling and health care were used as well other professional help. All participants described a continuum of professional support. Other authors have noted that mothers in recovery do seek and continue with professional care to meet health and counseling needs (Kaplan-Sanoff & Rice, 1992; Rosett et al., 1983; Suffet & Brotman, 1984).

Creating a Fellowship

These recovering alcohol/addict mothers used the dimension of creating a fellowship to facilitate both transition to parenthood and recovery by assembling and maintaining a support network of chemically abstinent members. The dimension, previously developed in recovery, was expanded such that through fellowship, they obtained professional care for the pregnancy to secure safe passage, one of the developmental tasks of pregnancy (Rubin, 1970). They also used their fellowship to help them work through other developmental tasks.

Fellowship members such as sponsors were important. The use of sponsors, described earlier, facilitated both processes, recovery and transition to parenthood.

As will be recalled, finding a female sponsor who had children or who was pregnant was of paramount importance for participants especially if they were unable to resolve ambivalence towards their own mothers.

Summary

Seven dimensions of the progressing strategy enabled the participant to master the tasks of pregnancy and prepare for the major life transition of becoming a mother. These dimensions were: establishing the dual identity of alcoholic/addict mother, dealing with emerging feelings, keeping intimate relationships, recording family ties, reaching for maturity, using professional help, and creating a fellowship. All of these dimensions had been previously developed for recovery and were now adapted for the parenthood transition process.

## Non-Progressing Strategy

Two dimensions of the non-progressing strategy, blocking and being stuck in recovery, were evident to a limited degree during pregnancy, often apparently due to the intensity of energy focused on the motherhood transition rather than recovery. Participants at times blocked recovery efforts in order to concentrate on the transitions and crises of pregnancy; however, none of the women blocked efforts to attain the maternal role. All the women had established a comfortable repertoire of protecting and progressing strategies for recovery that enabled them to move forward in their personal development during pregnancy.

### Summary

During the developmental period of pregnancy, participants in this study found

ways in which to balance the dual processes of recovery and transition to parenthood. A balance of the protecting, progressing and non-progressing strategies was used. Recovery strategies developed prior to pregnancy were adapted and used during this special pregnancy. Participants reported an increased focus on motherhood rather than recovery during pregnancy. Recovery was described as a means to achieve a healthy pregnancy and baby. All participants were preparing themselves for mothering, a process discussed in the two subsequent sections of this chapter. Mothers with older children remarked at the differences between the index pregnancy and earlier pregnancies during which these strategies had not been well developed or used.

## Transition to Mothering: Childbirth to 3 Months

Transition to mothering was defined as the developmental period from childbirth to approximately 2 to 3 months after childbirth during which time the focus changed from the "special pregnancy" to parenting a desired child. The identity shift moved from "I am a pregnant alcoholic/addict" to "I am an alcoholic/addict mother." Participants reported continuing to balance between two identities associated recovery and motherhood, with an increased focus on the mother identity. Reliance on protecting and non-progressing strategies of recovery increased as mothers recovered from the physical and emotional challenges of childbirth and entered early caretaking with their infants. Participants temporarily suspended many of the recovery activities, like going to AA/NA meetings, as they focused on becoming a mother and caretaking for the new baby. All, however, maintained some recovery activities, such

as talking to their sponsor or reading the Big Book.

Mothering while maintaining ongoing recovery brought forth fears and anxiety beyond the uncertainties that all new parents experience. Additional support from partners, professionals, and friends assisted with maintaining ongoing recovery during the transition period after birth. Participants described this period of transition as a relatively short and intense period, although in some cases it was delayed due to infant condition.

## Protecting Strategy

The protecting strategy used in recovery prior to and during pregnancy was activated as a way to cope with the perceived threats of childbirth and early parenting without relapsing. This strategy was used for both anticipated and unanticipated conditions.

### Anticipated Conditions

As described earlier, women anticipated issues related to pain in labor and had prepared strategies during pregnancy, such as childbirth classes and birth plans, for dealing with pain and possible medication. If nurses and doctors read the history or asked about the history of alcoholism and addiction, then participants were able to negotiate appropriate use of medication. If providers understood recovery and relapse, the chance of protecting recovery was even better. The mothers suggested using the least amount of medication or using it less frequently. None of the mothers relapsed during labor and delivery.

Unanticipated Conditions

Unanticipated conditions were situations or events not foreseen by mothers that required efforts for relapse prevention. Among first time mothers, few had specific plans for the day-to-day demands of caring for an infant and for the physical and emotional changes after birth. None of these women reported actual drinking or drug use, but three described thoughts about drinking as a way to cope with fear or depression.

Bushong (1990) and Mondanaro (1989) have described the period after birth as "the crash of reality" for substance using mothers receiving methadone maintenance. Although many new mothers find the transition after birth stressful, additional difficulties may be faced by recovering women as they try to implement the tools learned in recovery for coping. These tools may not be specific or adequate for this period of motherhood transition.

These circumstances were true for the study women. Assuming caretaking responsibilities during the transition after birth presented many challenges to the mothers and their partners. Physical exhaustion, not eating well, emotional ups and downs, and feelings of inadequacy were described. High levels of stress were reported by many mothers. One said, "Stress. Major. I know there is no such thing as the perfect parent, but I want to avoid as much as I can. The stress, and a half hour to change a diaper, is sad." Some of the most stressful times occurred when the "baby wasn't nursing well," was sick, received first shots, or had colic. Mothers had not anticipated the challenge to sobriety and reported sometimes feeling inadequately

prepared for the experience. One participant with 7 years of sobriety said:

> I think women who are in recovery have one or two things going in their life: (a) They are either supremely prepared for the stress of having a child or (b) they are extremely susceptible to the feelings of fear and being overwhelmed, anxiety, and all those things. The quality of the joy a recovering woman experiences, I think, almost has to be even more acute than one who has never had to go battle with this thing [addiction]. Because it means so much and you know where you were.

Three participants experienced an unexpected preterm birth or condition of the baby that required hospitalization in the Newborn Intensive Care Unit (NICU). During this crisis, physicians and nurses responded with information, emotional support, reassurance, and encouragement, as well as highly technical care. The mother of one infant recounts:

> They monitored me very carefully at the hospital. They were wonderful to me. My son was born at 32 weeks, about a week after my water broke. I had a whole week to lay in bed and worry about the health of this child. On one hand, it was exceeding alcoholic behavior and there was nothing I could do about it. I'm a worrier. That's me. On the other hand, caring that I got at the hospital and the reassurance that I felt that if anybody could help, the professional medical staff there could. That also deflated a lot of the alcoholic demons.

The mothers identified that having a preterm baby admitted to the NICU or

fearing a baby's death could precipitate a relapse into addiction. The same mother remembered:

> The thought crossed my mind, what would have happened to me if the baby had died. The thought crossed my mind that I probably would have been drinking again. I remember distinctly having the idea go in my mind that if this baby died I was going to be out there for awhile.

For 6 years this mother had been clean and sober with a repertoire of coping skills for many situations. The crisis of the preterm birth was a period of instability; but through care and support from professionals and her family, the child survived and the mother maintained her sobriety.

In addition to the normal processes of adjustment after birth, several participants reported having to cope with exacerbations of existing chronic disease and injuries during birth, cesarean births ($n=3$), as well as separations from preterm or ill infants. These conditions added to the stress and adjustments after birth.

Physical Challenges of Parenting

Balancing ongoing recovery while exhausted from caring for an infant was a challenge. Participants reported extended recuperation and exhaustion, which may have been due to coexisting chronic illnesses for some as well as coping with a baby. One participant described difficulties from physical exhaustion:

> I think that what you have to understand is that the sleep deprivation, I think, is a big factor in not being able to be in touch with the tools you were taught in recovery. I think the sleep deprivation is really a crux to my problem.

> Plus I'm a 39-year-old. This is the single most important thing that has ever happened in my life is having this baby.

Frequent respiratory infections, tired feelings, sore nipples when breast feeding, frequent feedings, and no sexual relations with spouses were all identified as problems that persisted past the 6 to 8 weeks when care after delivery is typically terminated. Obtaining adequate food was another problem of one mother when she no longer received supplemental foods from the Women, Infant and Children food program. Brown (1985) or Gorski (1989) do not address threat of relapse during early parenting. These mothers reported little anticipatory preparation for the challenges of early parenting and protecting recovery.

In this study, the majority of women had experienced depression during the period of drug abuse and beginning recovery, but only two mothers reported clinical depression during the time of childbearing and early parenting. Relapse with thoughts of renewed drinking were linked by these two participants to the depression. Both of these women had reported a history of physical abuse beginning in childhood, abandonment by the father of the baby, and difficulties in coping with pregnancy and early parenting. Both mothers sought professional evaluations and were prescribed antidepressants after birth. Protecting recovery while managing depression remained a challenge for these two participants in the study. One participant with a diagnosis of depression wrestled with thoughts of renewed drinking and self-doubt about coping with single motherhood.

Nine other women described "dysphoric distress" a term denoting general

feeling of depression, anxiety, and restlessness along a continuum of symptoms, such as fatigue, worry, obsessive thoughts of drinking or drug use, loneliness, guilt, and lack of joy (Affonso, 1991; Clarke & Summers, 1981). These symptoms need further investigation to differentiate between the normal maturational experiences of childbearing and depression during recovery or childbearing that requires mental health interventions.

Protecting recovery and assuming the new role as a mother were the focus for all participants during the transition after birth. Participants continued with previously developed strategies but found that infant caretaking and recovering from childbirth required more reliance on individual, at-home activities of recovery. Mothers had to be flexible in their recovery efforts as well as their parenting and self-care. In becoming a mother, each of the participants encountered unanticipated and challenging situations. By protecting their recovery, they were able to attend to these events and conditions.

## Progressing Strategy

The progressing strategy was those methods that enabled personal growth and adult development. Participants reported in the period after birth a heightened emphasis on establishing an identity as a capable mother. This emphasis resulted from the use of the dimensions of the progressing strategy. These dimensions are: dealing with emerging feelings, keeping intimate relationships, reaching for maturity, using professional help, and creating a fellowship. Other dimensions, although present, were not as frequently used.

Establishing an Identity as a Real Mother

Establishing an identity as a real mother was a method used to reach maturity. Data from mothers in this study were similar to findings described by Mercer (1990) during the first months after birth, a period called formal role attainment by Mercer. Women used the real mother identity to help movement toward adulthood, to express attachment and emotion, and to reorganize family relationships. During this time period, the mother integrated the birth experience with what was expected, comparing the actual infant to the expected one, and began caretaking of her infant as well as possibly caring for other children.

In addition, each participant had to change her identity from pregnant alcoholic/addict to alcoholic/addict mother. One method used to help establish this identity was to develop and recount the birth story, an account developed by each participant to explain the transition experience of her child's birth and to communicate the meaning of the experience to others. This method was important to integrate the meaning of the identity change from pregnant alcoholic/addict to alcoholic/addict mother and included the effect of the birth on sobriety. One mother wrote in her diary, "January 2, 1993 at 4:40 pm I gave birth to a beautiful baby boy. He's wonderful. I love him so much. I love [Partner] and am happy to have his child." All the participants who gave birth during the study period felt that the birth was successful in spite of some unexpected events. Success was defined by them as having a healthy baby and maintaining sobriety.

Dealing With Emerging Feelings

The continuing emergence of affect permitted women to form an attachment to their newborns and experience feelings of love, which had begun during pregnancy. Prior to pregnancy, recovery had allowed the emergence of previously numbed emotions. One participant whose newborn son spent a brief observation period in NICU said, "I want to be totally there for him." This was in contrast to a previous pregnancy when she was addicted to methamphetamine. Reciprocal attachment between the mother and infant with complementary interaction validates a woman's sense of being a mother and being in an adult-child relationship with her infant (Ballou, 1978; Rubin, 1975). Each of the participants validated positive regard and attachment for the newborn. The participants related their caretaking of the infant to their new level of adult development.

Mothers with older children were well aware of sibling reactions to the newborn. One mother with a 3 year-old remarked that now that she was clean, she could see how difficult it was for her older son to accept the new brother.

Keeping Intimate Relationships

Participants and their partners now focused on the new or continuing role as parents, and experienced a strain on their relationship with each other, as has been described for nonaddicted patients. As one participant said, "Dealing with another person as in a husband: he's got his own ideas and has to deal with you and your postpartum and your sleep deprivation because let's face it, men can't nurse." Or as another said, "I just don't feel like there's enough of me to go around. It's been

emotionally demanding."

Parenting methods were another area of possible conflicts between partners. Participants set limits and priorities on how their partners were to interact with their babies. In one situation, a mother acted to end the involvement of the father of the baby; she referred to his relationship to the index infant as "the donor." Participants usually placed a high value on the benefits of both a mother and father to child development. Mothers valued "hands on dads" and a consistent caring behavior. One participant told her partner, "Think hard and heavy on this. I will be mad. Decide now, either you have contact and you keep it up forever or you have no contact. I will not have yoyo's."

Reaching for Maturity

Because they had developed through recovery, women were able to achieve the maternal role in a manner similar to that described by Mercer (1990). First time mothers reported that approximately 3 months after birth, they "felt like the baby was really theirs;" "there was no one to come rescue them or the baby;" and they were "real mothers." By this age, babies were described as "starting to play...really becoming people." A mother said, "They start to smile, you're getting a real sense of their temperament."

Mothers began to fully assimilate the identity of being a mother. Participants realized, "We're not just babysitting here. We're not taking care of some child, she's ours, she's ours for life." Another mother expressed how her identity included real responsibility when she commented, "I am somebody's mommy. I have a whole

bunch more responsibility now."

One area in which participants demonstrated their maturity and competence as a mother was in obtaining health care for their infants. The seemingly routine event of baby's first immunizations, however, presented special challenges to participants because of the shots. After the first time, each mother had to develop a plan for "getting shots without losing it themselves." Members of AA/NA brought a support person with them to take the baby to the nurse for shots while they stayed in the waiting area. If another AA mother was bringing her child to the immunization clinic, they would go together: "We're all going to do her shots together. It's hard to watch your child get pricked. Even though you know its good for them, it's hard to do."

Another mother enlisted the help of the receptionist and explained:

> I did the first one thinking "what should I expect? What's going to be right?" Oh, I was in bad shape. The next time I took her, the receptionist took her back. We stayed in the waiting room. So tomorrow somebody will take her back. It's "like I can't deal with it. It's cruel." ...So you compromise and stay in the waiting room....I told my AA sponsor that I can do it, although they [sponsor] offered to go with me.

Using Professional Help

The mothers' physiological and psychological return to normal and adjustments after childbirth were monitored by health care providers and the women themselves. Two participants reported having visiting nurses to assist them with parenting.

Although recognizing the need for help, participants were ambivalent about referrals. They believed that referrals were a result of their history and identity as an alcoholic or addict. Learning to use help for the baby involved learning to face and deal with the social meanings of their identity.

One participant, sober for 5 years and a college student, was referred to a child health clinic to evaluate her 8-month-old daughter for failure to thrive and torticollis. In her words, "Baby started out right there at the first at the top [of the chart]. Then she went to the bottom and that's when they sent me to the check girl. She went to the clinic referral but was uncertain about the meaning of "giving the baby blocks" during the evaluation, taking the history, and what the "check girl" and the "little doctors" were doing and saying. She came away from the evaluation with the impression that everything was fine but that she should complete some questionnaires that would come in the mail about the baby. Although she felt like the baby was fine, the clinic visit was sought for reassurance and monitoring. She wasn't worried and said "pygmies run in the family." Her description of the evaluation appointment indicated that in her perception, the visit was disjointed and the assessment tests were not understood.

Meeting health needs of the mothers was anticipated to phase out at 6 to 8 weeks after birth. A consequence of the transition phase after birth was a change in focus to the infant's health needs rather than participant's continued health needs. Completion of the ongoing pregnancy care indicated to mothers that a new phase of health care and parental responsibilities was beginning. Participants sought

professional help to meet their own and infants' health needs, including contraception, treatment for chronic conditions and counseling. Participants remained cautious in making health decisions that might affect their recovery process.

### Creating a Fellowship

Participants relied on previously initiated fellowship groups and networks to support them in the transition from birth to 3 months. Participants called sponsors and members of AA/NA for recovery support and parenting information. The majority of mothers were not able to go to the Twelve Step and church meetings until at least a few weeks after birth and then didn't attend as frequently as during pregnancy.

### Summary

The progressing strategy was adapted to focus on developing and attaining an identity and role as a mother, with lessened emphasis on the alcoholic/addict identity. Methods that supported the mother identity were most frequently emphasized and were balanced with those which protected recovery.

## Non-Progressing Strategy

The non-progressing strategy was used as a means to maintain recovery yet allow maximal energy to focus on developing the identity of mother.

During the first 3 months after birth, participants used the non-progressing strategy for recovery in order to assimilate and adjust to the changes of having a new baby and the day-to-day demands of motherhood. During this time, the balance of maintaining recovery and becoming a mother shifted more to becoming a mother.

The choices by participants to concentrate energy and resources into the mother identity may represent flexibility in their recovery efforts. One participant reported feeling overwhelmed as a new single mother. When she had not yet returned to her AA group, they had warned her that the baby could not keep her sober. She said:

> I think if nothing else, the baby kept it [addiction] in check. I'm so paranoid of going back out, that I would do something and end up losing her. I never thought I would have her, so she's very important to me.

## Summary

As part of their mother role, participants reported learning and trying to meet health care needs for their infants. They sought information and adapted techniques learned from books, classes, and authorities. Participants all indicated an increased sensitivity to infant cues and a greater knowledge of themselves and their infants. This focus on motherhood was a result of having well-established sobriety, having worked on adult maturity, and having working through the developmental tasks in pregnancy and new motherhood.

Participants used a variety of methods to cope with the stress of infant caretaking, maintaining recovery, and maintaining their relationships with others. Some of these techniques were "writing inventory" and talking with sponsors, partners, or mothers.

The use of the three strategies developed prior to pregnancy continued and allowed participants to balance the identities of alcohol/addict and that of mother. All participants experienced this brief period as intense and demanding. Depression,

along with suspended or diminished recovery efforts, contributed to vulnerability for two mothers. The majority viewed this period as a consolidation or regrouping of their resources and energy. By the end of the 3 months, mothers reported a greater sense of comfort with the role of mother. In the subsequent months, participants identified additional needs to balance identities and strategies toward maintaining both recovery and motherhood, as described in the following section.

### Becoming Real Mothers: 4 to 11 Months

Becoming real mothers was defined as the developmental period from 4 months until the conclusion of the first year after birth. During this period, participants continued to use the strategies developed in recovery and adapted through pregnancy and the transition after birth to complete the transition to motherhood and achieve the maternal role much as nonaddicted mothers do (Mercer, 1990). They balanced and used the protecting, progressing and non-progressing strategies to achieve balance between the alcoholic/addict identity and the mother identity. For the first time since pregnancy, however, participants identified that their focus was beginning to shift from the mother identity back toward the alcohol/addict identity.

The mothers demonstrated achievement of the maternal role and the mother identity in many ways. Some of these were responding to infant temperament and behavior, relying less on professionals but continued consulting with sponsors, friends, and their own mothers for advice on infant caregiving. The participant felt like parenting was "on the right track" with increased play and emotional satisfaction and competence in infant care. These have all been described in the literature as

indicators of achievement of the maternal role (Mercer, 1990).

## Protecting Strategy

The protecting strategy was used to prevent relapse and maintain recovery while parenting an infant. Participants reported that at times caring for an infant can be overwhelming, tiring, and frustrating. Mothers who debated whether they could be capable parents and how they would deal with their own children were often stretched to the limit. A mother with 7 years of sobriety said:

> I think that the experience of having a baby reactivates all the old stuff. I really do or at least in my experience that's what happened. All the irrational fears, all the questions of ability to cope, if you learned your lesson in life.

One participant who had been sober for 16 months and was a parent to a 10-month-old infant described her experience "as the most trying period" of her life. She compared her experience as a recovering mother to an accident that left her with a chronic health condition:

> I don't feel like I went through this much crap when I got in my accident. I don't feel like I went through this much turmoil and stuff when I became disabled....I don't feel like I went through as much of an emotional stress with that as I have with recovering and trying to be a good mother, figuring out the day to day, make sure she has everything that she needs, diapers, roof over her head, and attention.

This mother also experienced a nonsupportive father of the baby and remained unpartnered.

All mothers identified that one consequence of relapse was the inability to care for their infant. Participants used a variety of ways to cope with the stress of infant caretaking, maintaining recovery and maintaining their relationships with others. Some of these techniques were "writing inventory"; talking with sponsors, partners, or mothers; and attending meetings of AA.

Three mothers identified that "working the steps" every day and "writing inventory" were ways to maintain recovery and thus become effective parents. Both felt that these strategies replaced the use of drugs. In one mother's words,

> It's like alcohol and drugs were my anesthetic and once that anesthetic was gone what I needed was a solution for the pain that I was anesthetizing. If I don't have a solution for that pain, of course I'm going to anesthetize again because I can't stand the pain.

The tools of AA continued to be used as part of the protective strategy to prevent relapse on a daily basis. According to participants, understanding how to use the tools deepened through experiences of pregnancy and parenting.

## Progressing Strategy

### Maintaining the Dual Identity

The progressing strategy was used by participants as they continued adult development by maintaining the dual identity of alcoholic/addict and mother during the first 4 to 11 months after birth. Balance shifted from an emphasis on motherhood toward an equal emphasis on the two identities of alcoholic/addict and mother. The mothers resumed their activities in AA/NA and church groups. Many of the

participants began to make and implement career and educational plans for the future. Dimensions of the progressing strategy were used more frequently than they were immediately after birth and with more intensity to balance both identities and to continue recovery and motherhood.

Balancing was described by one of the mothers as the "keystone in the arch" that connects the foundations of alcohol recovery and transition to parenthood. Clarke and Summers (1981) offer a useful description of a keystone: it is "the stone at the apex of the arch that locks the whole. A part of something on which the other parts depend" (p. 526). The adjustment to becoming a real mother was accomplished by using the strategies of maintaining recovery under the conditions of the special pregnancy and later mothering. Balancing required management of multiple demands on the self to maintain sobriety while pregnant or parenting.

In a small group, the women discussed the emergent themes resulting from the individual interviews. One of the participants said:

> The work that I've done and the readjustment and stuff that I did while I was pregnant helped make the readjustment when I had the baby easier....It was like building on itself....The way the book [Big Book of AA] talks about it.... You're starting with a foundation and you're building on it, you have to have a solid foundation [principles of AA and the Twelve Steps] and then you're building upon that. Building with the cornerstone and the keystone.

Another participant added how the work she did was like "making an arch in a building. So that you are able to do that [build the arch between recovery and

parenting]. The balancing process was further explained as "making a connection between recovery and becoming a parent and there's an arch. And they both have to be solid, otherwise its not going to work."

For these women, balancing was the connection between the dual processes of recovery and transition to parenthood. Protecting, progressing, and nonprogressing strategies were used to maintain ongoing recovery with the special pregnancy and actual mothering.

Six participants validated the process of balancing the integrated the alcoholic/addict identity and the mother identity. Making connections between the two concurrent processes of recovery and transition to motherhood resulted in personal growth and achievement of a new level of function for many of the participants in this study.

Spirituality

Spirituality continued to be a way to balance recovery with motherhood. As one mother explained:

> I wouldn't have her and I probably wouldn't be able to keep her if I wasn't doing this [AA activities]. I don't by any stretch of the imagination, feel that, on my own power, that I would be a fit mother. I know that only through the Steps and through God am I going to be able to be a mother to this baby....I love her more than I've loved anyone else ever in my life but that loving her does not control my anger, and it doesn't control my selfishness and my inability to see what is going on and what's best for her. I believe that only

God can do that for me.

Each mother expressed the effect of spirituality on motherhood in different ways but shared the same meaning. Thinking about the spiritual gift she had received through membership in AA, one mother eloquently said, "One of the things that I would really like to do for my baby is to give her a sense of spirituality....I didn't know much about it until I was introduced to A.A."

Dealing With Emerging Feelings

Emotional development continued in a new way as mothers found a reciprocal attachment with their infant. They took pleasure in being together. Participants described a change in the relationship with their infants. This change was depicted by comments from two mothers about infant attachment: "About six months, definitely preferential treatment. The babies know who they want. No one else will do but me." The mothers with infants older than 6 months expressed their feeling attachment to their infants in such terms as "knowing the baby's cry"; feeling a "special bond"; "spending time playing and caring" feeling like the "baby is the apple of my eye."

Keeping Intimate Relationships

Participants and partners continued to negotiate and work on joint goals and behaviors that would support recovery and parenthood. Four of the women's partners also worked a program of sobriety through AA. One participant said:

> My boyfriend, like me, can't stay home with the baby all the time. He's got to be out there doing this too. Where we both have to be out there doing this,

it's a whole new readjustment that we have to do in our relationship with him being in recovery too.

Keeping intimate relationships with a partner was a continuing dimension that began prior to pregnancy but had a different meaning as new parents.

Reordering Family Ties

Reordering family ties was demonstrated as mothers decided to prevent future alcohol and drug problems in their children. Each of the mothers expressed how awareness of possible alcohol/drug problems for her children grew out of her own exposure to such problems as an adult and as a child.

The idea that the next generation might be affected by alcoholism was a fear of many mothers. For some mothers, remaining active in AA was one way to break the addiction cycle and to help prevent addiction. All of the participants wanted to break the cycle of their own addiction and provide a better life for their children. One participant had taken a course in preparing for "drug free years." As a consequence of this course, she held weekly family meetings with her spouse and infant daughter. The couple had drawn up a family "no drug policy" and were working on developing a partnership for child rearing.

For some mothers who had not attended AA or thought about alternate strategies, thoughts of family violence reoccurred as a way to enforce abstinence. A participant with 10 years of drug abstinence and 5 years of alcohol sobriety thought about what she would do when her 6-year-old son was older if he should become addicted. She stated, "I would beat the holy living shit out of him, put him in rehab

where he won't get out. I won't deal with it. I won't have him go through what I know is there." She said she is trying to teach her son to talk about problems. She realizes that "drugs knock out the hurt" and wants to teach her son other ways to deal "with emotions" besides drugs. Behavioral indicators and strategies were used extensively by this mother for her own recovery and for interacting with her son.

Reaching for Maturity

Reaching for maturity was a predominant dimension of the progressing strategy for participants in this study. Assuming adult roles and responsibilities was important. As part of adulthood, mothers placed a priority on becoming caring parents.

Participants described this period of parenting as a time of integrating the baby and its needs with existing needs and problems of themselves and the family, a phenomena described by Mercer (1990). They had become real mothers to their infants by trying caregiving strategies with their infants. As has been described for all mothers, these mothers reported that caring for their infant required learning what works and being sensitive about when and how things work with their babies (Mercer, 1990). What is unique about mothers in this study was that success with parenting added to progression of recovery through increased confidence and self-esteem.

Another way that participants demonstrated maturity was by developing alternate ways to relax and relieve stress that involved their children. Relieving stress and relaxing were evidence of achieving balance in life. One participant said:

I have had a hard time since having the baby. I operate under a high level of

> stress a lot of times. A lot of that is residual alcoholic behavior resulting from perfectionism. I obsess. I do all that. I get a lot of relief from playing with my child. That one-on-one interaction gives me such joy, that in itself is a relief.

Other methods of relaxing included "getting together with friends in AA," exercising and praying. These methods supported both recovery and motherhood.

Creating a Fellowship

Fellowship and support were essential to these mothers as parents and as alcoholic/addicts in recovery. Each of the mothers required the continuing support from partners, Twelve Step members, church groups, and friends. The experiences of the mothers in this study confirmed the importance of family and community support to facilitate the transition to parenthood and the process of recovery (Barnard & Eyres, 1979; Brown, 1985; Mercer, 1990).

Celebrations continued to be a part of maintaining ongoing recovery and parenting. As new parents, all the women in the study were developing new family rituals and celebrations to mark special occasions. As recovering alcoholic/addicts, the women had to have celebrations that were alcohol/drug free. Holidays like Christmas, Thanksgiving, and New Year's Eve were identified as stressful times by all the participants. Those with infants expressed the most frustration over the holidays. Holidays presented difficulties in family reunions, pressure to drink at family gatherings, and often conflicts with relations. The mothers developed their own ways to celebrate and commemorate special occasions.

First birthdays were celebrated for infants. Two mothers were planning one-year-old birthday parties for their children during the study. They were pleased at the thriving toddlers. Through celebration a milestone was noted for the child and the parent. Mothers had been able to use creating a fellowship and celebrations to strengthen their identity as an alcoholic/addict and a mother.

"Passing it on" was practiced as mothers rejoined their AA activities and meetings. In one AA group, members rotated as babysitters during meetings:

> What we do is rotate two at a time to babysit all the children....That way all the parents can enjoy the meeting and a lot of us don't work or are very low income people in this group who can't afford to pay a babysitter every night of the week to go to a meeting, so that's what we're doing. That way the new people that we find with children and the new people that we're working with can come to our meetings and not have to pay a sitter.

Attending meetings helped participants in their parenting in another way, as described by one mother: "If I need to talk...if I need help with it, I'm there [as a way to help] for me....I talk about parenting issues with young people and maybe they have fresh ideas. Maybe they can help me."

Summary

Dimensions of the progressing strategy continued to be used in balancing the requirements of maintaining recovery and motherhood. During the developmental period from 4 months to conclusion of the first year, participants achieved the maternal role much as described in the literature about nonaddicted mothers. The

strategy developed in recovery, as modified through the experiences of pregnancy and early parenting, provided the base for balancing parenting an infant and maintaining recovery.

### Non-Progressing Strategy

The non-progressing strategy was used by participants during this period in a new way. Participants identified for the first time in balancing motherhood with recovery that motherhood would have to take a lower priority at times. Previously, a mother had reported a block in recovery efforts during pregnancy and after childbirth. She later returned to her fellowship and her AA work as her baby approached 5 months, which is a time when many women integrate the parent role into their personal identity (Mercer, 1990). Another participant examined her commitment to staying sober during the initial alcohol recovery period 5 years ago and compared its effect now that she had an 8-month-old daughter:

> At the very beginning they asked me like it says in the Big Book "Are you willing to go to any length to stay sober and to help other recovering alcoholics?" And I said "yes, yes, yes." Having a baby puts that in a whole new light. As an example, I'm not going to be able to spend as much time with her as I'd like to because I need to help another alcoholic. There are going to be times when my relationship with her, in my eyes, is going to suffer and, in her eyes, suffer. It always looks to me like a horrible thing.

Several other participants identified that they also were moving toward an increased emphasis on implementing recovery activities while blocking motherhood.

The, participants knew if they did not maintain recovery they would not be able to parent. Participants expressed a need for continued balance between conflicting demands of recovery and parenting in their lives.

## Summary

As the first year after birth concluded, each of the mothers were able to achieve the maternal role through the adaptation and continued use of balancing the protecting, progressing and non-progressing strategies. Participants continued to seek balance in the identity between alcohol/addict and mother. Yet for the first time, there was a shift in focus back toward the alcoholic/addict identity. This shift was a result of participants' need to balance the demands of parenting the index infant while maintaining recovery. Participants described balancing as the key stone between the two processes of addiction recovery and parenthood. Balancing required strategies developed during recovery and modified through earlier life events of pregnancy and childbirth.

## Summary of Results

Prior to the index pregnancy, participants in this study reported the development of recovery strategies used to attain and maintain their identity as an alcoholic/addict. These were protecting, progressing and non-progressing strategies. Dimensions of the protecting strategy involved relapse prevention and being careful, an essential element in maintaining recovery. The progressing strategy had eight dimensions that involved identity change, personal growth and adult development. These dimensions were: establishing an alcoholic/addict identity, developing

spirituality, dealing with emerging feelings, keeping intimate relationships, reordering family ties, reaching for maturity, using professional help, and creating a fellowship. The non-progressing strategy included methods of either blocking, being stuck, or cutting recovery short. These three strategies were balanced to meet the requirement of recovery and to maintain the identity as an alcoholic/addict.

The index pregnancy elicited a change in identity that required balancing between the alcoholic/addict identity and becoming a mother. This new identity of becoming a mother changed the use and focus of the previously developed strategies of recovery. The strategies used in recovery were now used to achieve the developmental tasks of pregnancy. The strategies were preserved, adapted, and refocused as the women progressed into early parenting.

Participants identified three developmental periods when the focus between alcoholic/addict and mother shifted and required rebalancing. These developmental periods were pregnancy, childbirth to 3 months, and 4 months to 11 months. Balancing the focus between the dual identities of alcoholic/addict and mother after childbirth required the use, modification, and adaptation of the strategies developed and adapted previously in recovery and pregnancy. Each of the participants in the study was able to apply the understanding and skills learned in recovery to the successful transition to parenthood, as has been described in the literature (Brown, 1985; Finkelstein, 1990; Mercer, 1990).

What is unique to the findings in this study was the way in which the women integrated recovery with motherhood by shifting their focus between the two identities

of alcoholic/addict and mother during specific developmental periods. They used various combinations of protecting, progressing, and non-progressing strategies to balance between their dual identities. Participants described how the process of balancing addiction recovery and transition to parenthood can occur on a good foundation of recovery and motherhood.

# CHAPTER V

# DISCUSSION

The purpose of this study was to explore women's concurrent experiences of alcohol/drug recovery and transition to parenthood. This study used a qualitative design with intensive interviews, diary entries, and observations to gather data from a purposive sample. Eleven women, who self-identified as recovering alcoholics/ addicts and were either pregnant or had an infant younger than 12 months, participated in the study. Findings from this study were compared with concepts in the literature about the process of alcohol/drug recovery and transition to parenthood. Strategies developed in recovery were modified and adjusted by women at key points to make the transition to parenthood. Women were found to use strategies learned in the process of alcohol/drug recovery to balance between alcohol/drug recovery and motherhood. Strategies were used by the women in unique ways during pregnancy, and in early parenting to incorporate the developmental and relational aspects of both advancing in motherhood and maintaining recovery. Balancing emerged as the core concept, a social process that explained how women successfully integrated the recovery and motherhood processes into their identity.

## Alcohol/Drug Recovery

### Developmental Model of Alcohol Recovery

Brown (1985) has presented a dynamic developmental model of alcohol recovery with three components: an alcohol axis representing the continuous focus on alcohol; interpretation of self and others; and environmental interaction, which

includes changes within the family system during the recovery process. These three components are described as dynamically interacting throughout the following four stages of recovery: (1) drinking with an intense focus on alcohol; (2) transformation of identity when denial about addiction is broken and the transition to alcohol abstinence begins; (3) early recovery when abstinence becomes established and awareness of other problems emerges; and (4) ongoing recovery when abstinence is well established and work continues on problems and psychological growth. Brown reported that a "comfortable sobriety" during long-term chemical abstinence is possible through the combination of fellowship and a spiritual conversion, described as a radical shift toward a belief in a "higher power" or God. More information about the model is presented in this report in Chapter II.

Findings in this study are similar to ones identified by Brown in the development of her model. Evidence of the three components of recovery defined by Brown were found in the data gathered from this study's participants. In this study, women with more than 1 year of sobriety confirmed the continuing focus on alcohol/ drugs. Recovery efforts learned and practiced for chemical abstinence, i.e., living without the use of alcohol/drugs, continued as an underlying base with ongoing sobriety. Participants identified and counted time sober as starting from a specific date when they stopped drinking and using drugs.

Reinterpretation of self as an alcoholic and reinterpretation of relationships with others were reported by all women in this study. Identification as an alcoholic and belief in a spiritual power marked the beginning of recovery. Developmental

aspects showing reinterpretation of self and others were seen as recovery efforts and became well established, and other issues began to be explored. As discussed by Brown, increased self-awareness during recovery is commonly accompanied by the emergence of a variety of symptoms and mental disorders. In both this study and Brown's research, depression in particular was frequently reported in recovery work, especially in the early stages. Although the women in this study remembered depression around initial chemical abstinence, they recalled having even more depression when drinking and using. All reported having to learn how to live with their feelings and reactions without the use of psychoactive chemicals. A majority of participants in this study, as well as participants in Brown's research, reported the benefits of AA/NA support groups, sponsors, and principles for developing ways to maintain long-term sobriety.

The aspects of recovery identified as changes in environmental interaction, as discussed by Brown, account for the alcoholic family as well as the individual alcoholic (Brown, 1985). Difficulties making and keeping relationships for adults raised in alcoholic families are attributed to child rearing experiences.

Addressing these concerns is a task of ongoing recovery when abstinence is well established according to Brown. The Brown model, however, is not specific to pregnancy or parenting during recovery. Women in this study actively reviewed their parenting and their relationships with their parents, siblings, and extended family. Many had addressed concerns about their family relationships earlier in recovery and did so again with renewed emphasis during pregnancy. In this study, all participants

evaluated and expressed concerns about how they were reared as children and had difficulties in making healthy relationships. The majority of participants were raised in alcoholic families. All participants evaluated and discussed their childhood and its effect on their anticipated and actual parenting. The difference between this study and Brown's is that this study examined anticipated and actual changes in parenting as a result of recovery strategies and experiencing pregnancy. Mothers in Brown's study did not describe the central place that parenting had in their lives.

The difference in the two studies may reflect either the ages of the participants or the priorities of the women in each study, or the differing focus of the researcher. In Brown's study, the participants were both male and female and were older, with an average age of 42 years, compared with an age of 28.6 years in this study. All participants in this research study were either pregnant or mothers to infants younger than 1 year. None of the subjects in Brown's study were pregnant or had young children. Length of sobriety varied among Brown's subjects (0 months to 5 or more years) as it did among participants in this study (6 months to 7 or more years).

The first stage of Brown's model is drinking with a downward spiral of addiction. In this study, participants who were drinking or using drugs were excluded thus, stage 1 of Brown could not be addressed. Data about drug use prior to recovery were collected retrospectively. Data about relapses were included in the study as they occurred. In Brown's research, some participants were in the earliest stages of recovery, which is described as a stressful, unstable period. In the present study, all participants had been "clean and sober" for a minimum of 6 months and past the

earliest transitions of recovery, which may account for where the women were having to focus their energy. All participants in Brown's study were alcoholics with no report of cross addiction to other drugs. Among participants in this study, the majority were cross addicted to alcohol as well as other drugs, many of which were illegal and highly addictive. Features of polydrug recovery may be similar to as well as different than the features of alcohol recovery alone. The effects of the combined drugs and accompanying lifestyle may have exacerbated conditions of recovery for women in this study.

## Relational Aspects of Recovery

The relational changes experienced by women in recovery in this study were consistent with Finkelstein's model (1990), which focused on healing and building relationships in recovery. Participants reported "being a better spouse, a better parent, a better daughter" as a result of recovery efforts. During the transition to parenthood, participants used the dimensions of the progressing strategy, as described in this study, of reordering family ties, reaching for maturity, and keeping intimate relationships to specifically address relational concerns. Pregnancy was a time when participants anticipated and made changes in relationships with their own parents, older children, and partners. After birth, mothers continued to use strategies developed in alcohol/drug recovery to parent an infant, and in some cases older children, and to keep intimate relationships. Relational changes were a priority in both the transition to parenthood process and alcohol/drug recovery process.

The role of violence in addicted women's lives (Finkelstein, 1990) was

corroborated by participants. All women in this study had been involved with interpersonal and community violence, both as victims and perpetrators. As recovery efforts continued, these behaviors had changed and alternatives were practiced, such as negotiating and "talking things over." Women reported that they had left violent or destructive relationships with a partner and were able to recognize dangerous situations while sober. Painful memories and experiences of rape and childhood abuses were explored by several participants with hope of resolution. The history of violence recalled by the study participants is consistent with published reports of incest, childhood abuse and neglect, sexual crimes, and domestic violence experienced by alcoholic/addicted women (Blume, 1990; Cruse-Wegscheider, 1989; Hurley, 1991; Mondanaro, 1977, 1989; Young, 1990).

Participants also reported attitudes comparable to those described in other research, such as by Beckman and Amaro (1986). These included negative beliefs about seeking health care and personal and social costs when admitting alcoholism or addiction. Families intervened with alcoholism/addiction treatment with four women in this study. The other seven had received neutral, or limited support or opposition to treatment from family members.

Drinking behaviors for women in this study, recalled retrospectively, confirmed reports that women drank in response to life crises (Finkelstein, 1986; Wilsnack & Beckman, 1984) or when feeling powerless, ashamed, guilty, or depressed (Finkelstein et al., 1981; Finkelstein, 1990; Zuckerman et al., 1989). Women in this study reported thoughts of renewed drug use at times of loss. A

benchmark of recovery for participants in this study was being able to abstain from drinking alcohol when they perceived negative feelings and events. The women reported using alternative coping means, including use of AA/NA and the use of programs and services that provided family therapy; counseling; parent effectiveness training; and assistance with housing, health and legal problems. The adopting of healthy coping mechanisms was reflective of the developmental progress of the women and was consistent with reports about responsiveness of women to assistance (Finkelstein, 1990; Gomberg et al., 1990; Reed, 1987).

What is different from the published reports for participants in this study was the way the women assembled the services that were needed. No comprehensive, one-stop program was available. Participants created a supportive network that included professional care providers as well as the AA/NA fellowship. The women reported, however, that seeking and obtaining needed services from professional care providers was often difficult, time consuming, expensive and frustrating. They frequently encountered barriers to services, such as changing regulations, provider's negative attitudes, and lack of health insurance.

## Transition to Parenthood

Pregnancy and early parenting in the first year after birth has been described as both a maturational crisis and a developmental, interactive process. Factors related to the parent, child, and environment interact through time to influence the parent-child relationship (Barnard & Eyres, 1979). The transition to parenthood involves physical, social, psychological, and family changes (Ballou, 1978; Barnard & Eyres,

1979; Bibring & Valenstein, 1976; Cranley, 1981; Deutsch, 1945; Mercer, 1990; Rubin, 1975; Tilden, 1980). Parental role development moves sequentially in stages from an anticipatory maternal role during pregnancy to actualizing the maternal role within the first year after birth (Mercer, 1990). As a social change, motherhood is a means to achieve adulthood for women in this culture, and success in this area translates into feelings of competence in other areas of life (Ballou, 1978; Rubin, 1967).

During pregnancy, intrapsychic changes help women prepare to become mothers. Acceptance of the pregnancy is the first step in preparing to become a mother. Fantasy, in the form of both day dreams and night dreams, is an experience common to most pregnant women and assists in intrapsychic accommodation of the role of mother (Sherwin, 1987). Attachment and feelings of love to their unborn child emerge for mothers, fathers, as well as other members of the family (Cranley, 1981; Rubin, 1970; Stainton, 1985). After birth, feelings of love and attachment continue and intensify as the parents assume caretaking, the infants respond to parent's interaction, and social and physical conditions in the environment support the relationship (Ballou, 1978; Barnard & Eyres, 1979; Mercer, 1990). More information on characteristics of the transition to parenthood is provided in chapter II.

Results from this study support many of the findings from previous research on the transition to parenthood. Pregnant and parenting women who have already successfully maintained alcohol/drug recovery appeared to be similar to other mothers in their experiences in becoming mothers. The transition to parenthood, however,

also differed between recovering and nonrecovering mothers. Both the similarities and differences may be explained by several factors: 1) the progress of the alcohol/addict mother in the alcohol/drug recovery process; 2) the degree of resolution of childhood abuses and losses through counseling; 3) the level of support perceived or real, from partners, professionals, fellowship groups, and sponsors; 4) and the value placed on the motherhood role as way to achieve both "normalcy" and maturity.

In this study, participants who were first time mothers and entered the study with an infant (n=5) progressed through the motherhood stages as described in the literature (Mercer, 1990; Rubin, 1975). These mothers were interviewed until the conclusion of the study when infants were between 8 and 12 months old. The other participants, who were pregnant when they entered the study, appeared to follow a similar progression but the study period ended before final attainment of the role. All participants placed a central focus on their role of becoming a mother or actual mothering. Childbearing women in this study, as depicted in the literature, experienced important changes in their relationships with their own mothers, partners, peers, and children (Ballou, 1978). As is common among nonrecovering pregnant women, all the study participants had positive feelings toward their pregnancy and viewed it as special. These positive feelings were related to a sense of having options and choices, as was similarly reported in a study of nonaddicts by Gara and Tilden (1984). The idea of having choices has a heightened positive significance for recovering women who are in the process of regaining control over their lives. For

the recovering mothers in this study, other unique factors contributed to the appraisal of the pregnancy as special. These factors included fears associated with previous fetal losses, infertility diagnoses, effects from alcohol/drugs use, risks from HIV exposure, and perceived ability to nurture an infant. Greater awareness of these factors through recovery work increased the importance of the pregnancy to the study participants.

The recovery work of the alcoholic/addict mothers in this study also affected how they experienced the normal fantasy and attachment aspects of becoming a mother. Fears of relapsing into drug use are common in the recovery process and often come out in night dreams. The study participants reported mingling relapse fantasies and pregnancy and childbirth fantasies usually in night dreams. Attachment and feelings of love to the unborn child and later infant was as described in the literature was true for this study group also. An important difference is the extent to which participants reported that they had learned to recognize and express emotions, in regard to not only the pregnancy, but also their love for a partner.

The pregnant woman's reconciliation with own mother, her acceptance of her own dependency as a child, and her dependency on a spouse to prepare for the dependency of a new born have been described as tasks for mothers without chemical abuse problems (Ballou, 1978; Bibring & Valenstein, 1976; Rubin, 1975). The resolution of childbirth issues with parents by participants in this study were sometimes hampered. For example, reconciliation with some mothers in the families of origin was not possible due to the dysfunction of their mother's alcoholism, the

mother's death, or parent divorces. Participants depended on spouses to meet their needs and sought nurturing from partners. They also found supportive maternal substitutes like sponsors in AA/NA, grandmothers, aunts, and friends. Nurturing a recovering woman during pregnancy and early parenting by maternal substitutes, support persons, as well as the spouse may be a crucial element in recovering women's ability to mother their own children.

The influence of the social and physical environment on the development of motherhood and the parent-child relationship was evident in the findings in this study. Mothers sought and interacted with fellowship groups and selected advisors who would support their sobriety and motherhood. They developed and used community resources of professionals to meet health, child rearing, counseling, and other needs. Construction of a professional and personal support network revealed the progress and value the mother had made in achieving maturity and motherhood. The use of environmental support appeared to buffer some of the effects of addiction and intergenerational abuse on the parent-child relationship.

All but 10 of 11 participants had a partner or spouse who was a significant source of love and assistance during the pregnancy and first year after birth. The men were chemically abstinent and provided financial, emotional, and instrumental support to their partners. Although fathers were not the focus of this study, many were closely involved with their spouses and infants. Mothers in this study sought and valued approval from their spouses for pregnancy behaviors and caretaking of the infant. The importance of the relationship with the spouse is consistent with Ballou's

(1978) findings. For the mothers in this study, even if the spouse were in prison, they were still viewed as a source of support.

Motherhood as a means to achieve adulthood and maturity was recognized and accepted by women in this study similar to that reported in the literature (Ballou, 1978; Rubin, 1975). Accomplishing the maternal role was evidence of personal success and competency, as reported by mothers in this study. Maternal failure, however, through abortion, child abuse, or prenatal drug use contributed to feelings of inadequacy and guilt. Several mothers in this study contended with feelings of failure and guilt about prior parenting behavior. These feelings added pressure to protect the unborn and provide for the infant by assuring a safe environment and meeting the infant's physical and social needs (Ballou, 1978; Mercer, 1990; Rubin, 1975).

Participants in this study were progressing through the process of maternal role attainment. They experienced the emotional and physical upheavals of pregnancy and early parenting; worked to strengthen or accept relationships with their family of origin and children; and created supportive relationship networks with partners, peers, and professionals. Many of their accomplishments were similar to those of other mothers in pregnancy and early parenting without concurrent alcoholism/drug recovery. Participants reflected on and appreciated their own personal progress in motherhood and recovery. The differences between mothers who were addicted and mothers without alcohol/drug addiction problems were the use of recovery strategies to accomplish the maternal tasks, the need to balance the dual identity of alcoholic/

addict and mother, and the emphasis on evaluating life events from the perspective of the drug recovery process.

## Alcoholism/Drug Recovery and Transition to Parenthood

Studies have investigated the effects of interventions on alcohol/drug use during pregnancy and early parenting to improve the health of mothers, infants, and the parent-child relationship (Ericksson et al., 1986; Finkelstein et al., 1990; Halmesmaki, 1988; Morse, 1991; Reed, 1987; Rosett et al., 1983; Weiner & Larsson, 1987; Weiner et al., 1989). Maintaining addiction recovery has been found to improve child development through effects on the parent-child relationship and home environment, even among children prenatally exposed to alcohol/drugs (Chasnof, 1992).

Programs that integrate addiction recovery with parent training, counseling, and remedial education for mothers and children have reported improved parent functioning and decreased incidence of substance abuse and child abuse, neglect, and abandonment (Bauman & Dougherty, 1983; Finkelstein, 1990; Wellisch & Steinberg, 1980). Pregnant and parenting women in recovery have been found to be motivated to break a cycle of intergenerational child abuse and neglect through maintaining recovery and learning more about parenting (Brudenell, 1991). Findings of past studies are confirmed by the present study in which women sought and used resources to assure healthy children and to establish a positive relationship with their children. The way in which recovering women were able to integrate alcohol/drug recovery with pregnancy and parenting had not been explained previously. The present study

provides insight into how pregnant and mothering women used strategies from their alcohol/drug recovery and integrated them to balance recovery with motherhood.

Differences between women who participated in this study and those described in other research studies add to an understanding of how the processes of addiction recovery and becoming a mother interact and connect. Participants in this study were not methadone maintained and did not receive comprehensive care or require alcohol/drug treatment, as described in some published studies. Many had years of sobriety and none were in the stressful period of detoxification or earliest recovery. Participants coped with the crises of pregnancy and early parenting by using recovery strategies but were remarkably stable in many ways. For example, none of the women moved residences until the end of the study period (7 months); all had telephones and read newspapers; and all received health care and other professional help. They had homes, even on low incomes, and a family car. Ten of the women had partners. The women functioned as a recovery resource for other women as well as received support themselves. They were successful in many areas of their life in spite of an alcohol/drug problem. Participants were able to articulate aspects of integration of the alcohol/drug recovery process and transition to parenthood while experiencing it. Through analysis of the study data in comparison with published research findings and clinical accounts, a unique process of adjustment between recovery and motherhood became evident. This process was identified as balancing and was the core factor to emerge from the data analysis.

# Balancing

Concepts generated from this study and from the literature have been used to create a conceptual model of the concurrent processes of alcohol/drug recovery and parenthood. Understanding the relationships between the two processes is required to deal more effectively with the dual phenomena.

The results from this study begin to explain how the processes of motherhood and addiction recovery can be integrated. Balancing was the term developed from the data to explain the process used by mothers who had successfully combined an alcohol/drug recovery process with pregnancy and early parenting. Although each individual had unique experiences, the process of balancing captured the predominant themes.

Balancing was described by participants as the "keystone in the arch" that connects the foundations of alcohol/drug recovery and the transition to parenthood as illustrated in Figure 1. As described earlier, a keystone is the "stone at the apex of the arch which locks the whole" (Clarke & Summers, 1981, p. 526). The keystone itself is made up of protecting, progressing and non-progressing strategies. Balancing requires a firm foundation in alcohol/drug recovery prior to pregnancy. Balancing was the process used to integrate the dual identities of alcoholic/addict and mother as well as the core way of using the keystone strategies for working through the concurrent processes of alcohol/drug recovery and parenthood. Achievement of the maternal role and identity was accomplished through the balanced use of these strategies during the transition to parenthood.

In this dual process model, transformation of identity as an alcoholic/addict and commencement of recovery has begun to take place prior to pregnancy. For the study participants, breaking through denial about addiction offered hope for recovery but also exposed the fears and consequences of acknowledging alcohol/drug dependency. While continuing in alcohol/drug recovery, participants developed a repertoire of strategies to protect, progress and non-progress in recovery. These categories of strategies were then continued, adapted, and used in new ways throughout pregnancy and parenting.

The protecting strategy served to protect recovery and prevent relapse and provided a base on which motherhood could continue. The progressing strategy moved the woman forward in recovery and adult development. The non-progressing strategy accommodated a plateau in recovery without relapse or progress.

Pregnancy precipitated the need to balance recovery with the transition to parenthood. Acceptance of the dual identities of addict and mother was the first step. All the participants valued and described their pregnancy as positive and special. The balancing process entailed the dynamic use of strategies learned in recovery that were adapted during pregnancy and parenting. Balancing between the alcoholic/addict and mother identities as well as balancing between the use of the three keystone strategies, and their various coping dimensions continued throughout the developmental periods of becoming a mother. Strategies were used to shift the relative focus between the alcohol/addict identity and mother identity as needed as the woman progressed from pregnancy to childbirth and finally to early parenting. Participants flexibly used the

strategies learned through recovery to achieve the maternal identity and role.

Dimensions of the protecting strategy, such as preventing relapse and "being careful," were those efforts used to protect alcohol/drug recovery throughout the transition to parenthood. The protecting strategy was evoked to deal with the increased stress, fear, and anxiety involved with pregnancy, childbirth, and early parenting. Women reported using protecting methods during anticipated conditions that could precipitate a relapse, such as childbirth and depression. Because mothers could not prepare for all contingencies they might encounter, they also had plans to protect recovery during unanticipated conditions. Although vigilance and decision making were important to prevent relapse, control was not always possible. Coping with unanticipated conditions of pregnancy and early parenting required the use of a variety of efforts from the principles of AA/NA, such as contacting a sponsor and negotiating professional help.

Dimensions of the progressing strategy, such as developing spirituality and being comfortable alone, were used to balance between the dual identities of alcoholic/ addict and mother. Eight dimensions were identified and complemented and accelerated emotional growth and maturity, as well as the ability to form healthy relationships. For example, the dimension of dealing with feelings involved learning to recognize, interpret, and express feelings and was key to coping with the emotional disequilibrium of pregnancy. Partners were important to the mothers to help them discriminate between the emotional responses of recovery and pregnancy. Developing the ability to form attachments and enjoy emotional closeness to the unborn child and

# Balancing Identities and Strategies

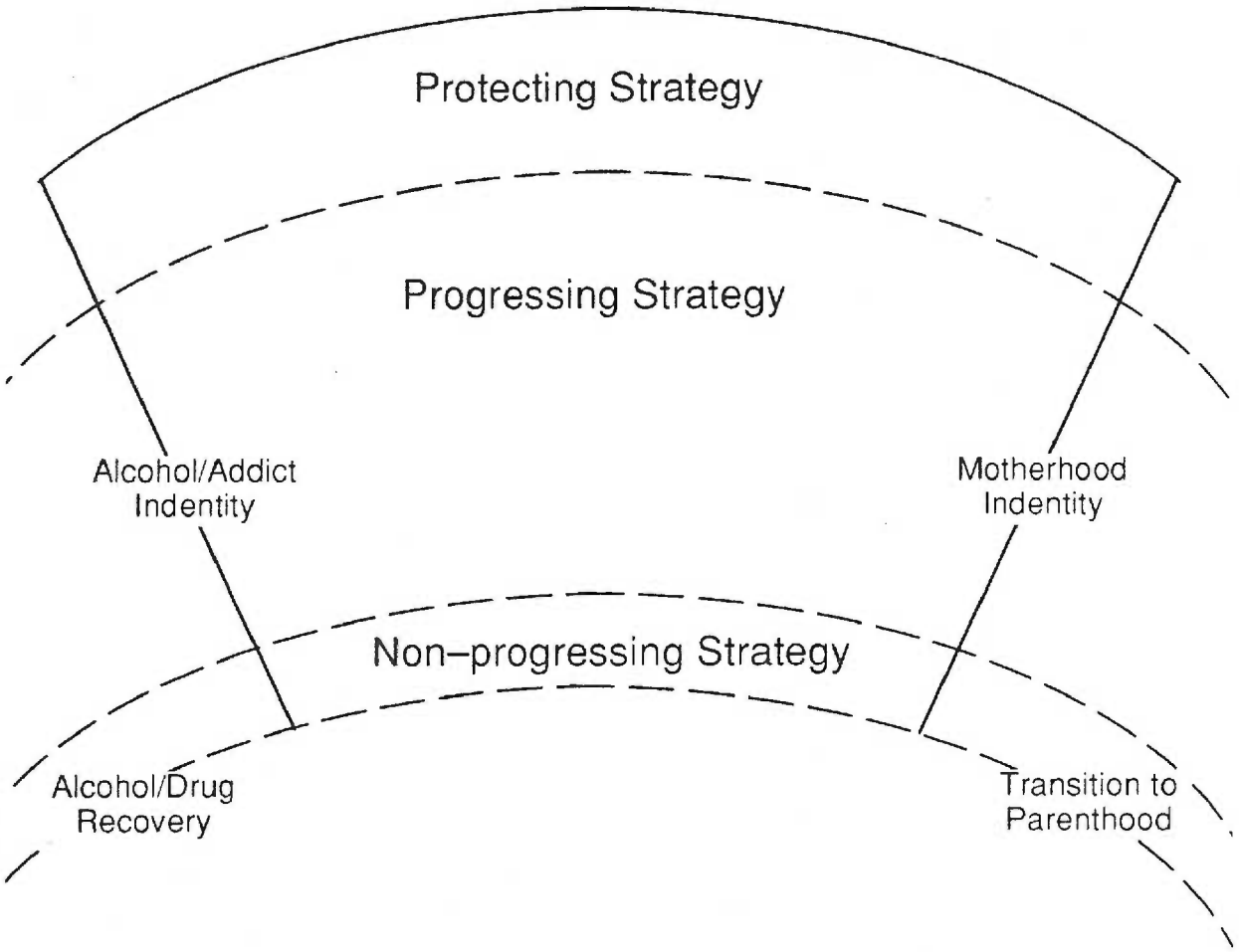



Figure 1: Balancing as the keystone of alcohol/drug recovery and transition to parenthood.

then the infant was based on work begun in alcohol/drug recovery. Reaching for maturity through developing adult competencies and achieving adult roles and abilities, such as seeking and using professional help to manage the special pregnancy, was another progressing dimension. The dimension of becoming comfortable with adult roles, themselves, expectations, and responsibilities permitted women to achieve the mother identity and accelerated a sense of competence through success with pregnancy and parenting.

Dimensions of the non-progressing strategy were identified as methods that permitted a "holding pattern" in the adjustments between recovery and parenthood. Mothers reported different dimensions such as "blocking," "cutting recovery short," and "being stuck." Factors that may influence the use of non-progressing strategies include achievement of a stable sobriety, competence in coping with crises, and presence of adequate support. Consequences of the non-progressing strategy may be resumption of recovery efforts, relapse with alcohol/drugs, or movement toward another stage of recovery or personal development.

The dual process model presented in this study explained how women can successfully manage both the recovery and parenting processes concurrently. Research in this study provided insights into consequences when balancing of these processes does not occur. Three women from an AA group told the story of a young mother who was a former member of their group and could not balance recovery and mothering. She eventually lost custody of her child, even though she was chemically abstinent at the time. Experiencing parental failure rekindled guilt and low self-

esteem which eventually led to renewed alcohol/drug use for this woman. Conditions, like depression, during the transition to parenthood that decreased a mother's energy and ability to seek and use available resources interfere with the ability to balance both processes. Balancing recovery with motherhood is demanding and exacts commitment from mothers.

## Strengths of the Study

### Prolonged Engagement

A strength of this study was the prolonged engagement with the participants, a factor that increased the likelihood of credible findings (Lincoln & Guba, 1985). Another aspect of the prolonged engagement was the willingness of participants to talk about their experiences. They volunteered to share their experiences and sensitive personal concerns. The diversity of participants' experiences in recovery, parenting, and pregnancy gave in depth descriptions of strategies used in balancing. As a group the women were articulate in describing their experience, and insights. Over 1,000 pages of transcripts were generated by the interviews, providing and intensive amount of data to develop concepts about the addicted mothers' experiences.

### The Nature of Addiction

Another strength of the study was the serendipitous finding that these alcoholics were polydrug users. The unplanned inclusion of participants who were polydrug users provided insights into recovery and helped to generalize findings beyond those of alcohol recovery. The initial plan had been to sample only women who identified themselves as alcoholic. Although the advertising and fliers focused

on recruitment of alcoholic mothers, the women who did volunteer first identified themselves as alcoholic and then, as the interview data were gathered, as cross addicted. Only one women, one of the later volunteers, was addicted only to drugs although she represented herself as eligible (an alcoholic) for the study.

## Method

A qualitative design using the grounded theory of analysis was employed to generate a substantive theory about the concurrent processes of addiction recovery and transition to parenthood. Grounded theory, a useful method to develop and describe relevant concepts in areas where little research has been done (Stern, 1980), provides a way to uncover processes embedded in social interactions, as described by Glaser and Strauss (1967). A naturalistic approach was used so that women's alcohol recovery and motherhood could be explored in the context of their daily lives. Intensive interviews, observations, and diary entries were used for data collection. The intensive interviews and observations were the best sources of data. Only one participant wrote in a diary. Interview data were rich with detail and meaning.

Interpretation of the data and the literature were incorporated into the deductive and inductive reasoning used in building theoretical concepts and hypothesized relationships among concepts. For example, deductive reasoning was used to compare the strategies that emerged from the study with those from the alcohol/drug recovery models (Brown, 1985; Finkelstein, 1990) and the developmental model of motherhood (Ballou, 1978; Mercer, 1990; Rubin, 1975). Inductive reasoning was used in the process of identifying from the data the three

strategies of protecting, progressing and non-progressing and their specific dimensions. The inductive method provided the means for intense description of emergent concepts and their integration into a combined model. Premature closure of data collection before a category is saturated may limit the description of categories and their relationships (Brink, 1991; Glaser & Strauss, 1967). Premature closure may result if the data are redundant due to a lack of variability of the participants' experiences. To avoid premature closure, efforts to recruit participants and to collect and analyze data were continued over a longer time frame than originally forecasted. Moving beyond description of experiences and into theory generation required additional analysis of the data, interpretation, literature support, and review by the participants to validate findings and secure their interpretations of the potential dual model.

## Limitations of the study

### Sample

Transferability of the findings from this study will be limited by the all Caucasian volunteer sample. The economic and living conditions of the sample also may be unrepresentative of addicted women's experiences in recovery. As a group they may not reflect experiences of other addicted women, minorities, or other women with fewer or greater resources.

Another possible limitation of the study was the self-reported current status of alcohol/drug use. Recovery status of the women's partners was also reported by participants. Even though the mothers talked about relapse, those who participated

did not identify any actual relapse episodes during the study. One participant withdrew from the study after the second interview and her baby's preterm birth. Whether her recovery status had changed is not known. Also no volunteers were in the transition stage of recovery, as described by Brown (1985). The majority of participants were in the stage of maintaining ongoing recovery from polydrug addiction.

## Methods

Data collection and management were impeded by several factors. During some interviews in the home when a partner or children were present, the women were more guarded in their responses. Also, although the participants were for the most part clear in the information they gave, some of the interview data needed careful interpretation of their meaning. Validation of interpreted meaning was used. For example, one participant often explained her ideas by using "sick humor," making it difficult to follow her train of thought.

Although all but two of the mothers agreed to write in a diary about their day-to-day events, feelings, and ideas, only one participant actually did so. Mothers were willing to interact verbally but did not follow through with writing in a diary.

# Implications of Study

## Implications for Research

The interaction of recovery with pregnancy and parenting is a complex phenomenon that is fertile for new research. Additional research is needed in several areas where data from this study indicate inconclusive findings or provided no

information.

One area that needs further research is the impact of eating disorders and body image problems on pregnancy and post-delivery experiences. Although Finkelstein et al. (1990) identified eating disorders and a distorted body image as a problem with some addicted women, concerns about body image, eating disorders, and amphetamine abuse were not found in this study's data. Changes in body image as part of pregnancy and after birth for nonaddicted women have been investigated (Fawcett, 1978). Only one participant in this study, during a brief telephone exchange 3 months after the birth of her baby, made comments that indicated a possible body image problem with a related eating disorder. The absence of data may reflect lack of investigation. Additional research could investigate body image and its relationship to choice of drugs (the above participant had abused amphetamines), pregnancy, changes after birth, and relapse.

Depression during the perinatal and recovery process needs additional research to understand etiologies and consequences to both the parent and infant. Only two women identified themselves as depressed during this study, although the majority described having had transitory periods of feeling sad, overwhelmed, and exhausted while pregnant and later while parenting. These participants also described more depression during the years when they were using chemicals. Understanding the depression experience more completely may improve the ability of clinicians to more finely discriminate about when interventions are appropriate, especially since depression may be linked to drug and alcohol use.

Future research may investigate the experiences of all the family members. If, as the study mothers say, "recovery is a family affair," a variety of future research questions could be addressed. For example, what are the differences and similarities in recovery and parenting experiences between the mother and her male partner. What is it like for the children of parents who are former practicing addicts/alcoholics? How does the emergence of affect in recovery effect the ability to build relationships with a partner, an infant, or friends? What contextual factors make it harder? Women's past experiences of sexual and/or physical abuse, emotional neglect and abandonment need to be examined for their impact on the ability to cope with pregnancy and parenting while in recovery. What contextual factors during recovery, pregnancy, and parenting help women cope with the experiences of past abuse?

The mother's uncertainty about the impact of the HIV epidemic and the possibility of having to cope with AIDS is another aspect of the combined recovery and parenting experience where little is known. Mothers consistently were aware of and threatened by the fear of having had HIV exposure and being HIV positive. More research with addicted women who are high risk for HIV exposure may provide information about coping with the threat of disease.

Research is needed on the hypothesized relationships between the balancing strategies and phases of the transition to parenthood as parents cope with events and conditions during pregnancy and early parenting. Do differences exist between women who are becoming abstinent during pregnancy and early parenting and women

whose abstinence behaviors are well established prior to pregnancy? This study had no volunteers who were concurrently in detoxification or alcohol/drug treatment while pregnant or parenting.

Policy research is needed to assess how women's experiences of the concurrent processes of recovery and parenting are affected by our legal, ethical, social, and health care "rules," practices, and policies. Rural, urban, and ethnic differences may affect availability of programs and services to women. How do women cope with these differences and manage these two processes? Women and men in recovery from addiction may have experiences with the criminal justice system. How can women and men be better prepared for resuming or beginning parenting and recovery during parole? How does the incarceration affect their self-concept as they take on the new role of parenting?

Additional research needs to examine women's recovery from multiple addictions, which may be very different than recovery from a single substance like alcohol. Treatment programs classify alcohol as only one of many drugs and view little or no difference in the recovery processes. In addition to evaluating effects of alcohol and other drugs on fetal and child development, researchers and clinicians need to consider the effects of multiple chemical substances interactions and effects on the mother's recovery, pregnancy, and mothering.

## Implications for Practice

A theory about how mothers manage addiction recovery and mothering has implications for clinical practice, counseling, and education. The data from this study

demonstrate that transition to parenthood is a period of dramatic changes. These changes necessitate adaptation in all areas of self and relationships.

Women appear to need and want help with the recovery process when they are pregnant or parenting children. During the recruitment process for this study, many women volunteered to participate who did not fit the study requirements. Several women wanted to participate in the hope that they could control their addiction through participation; some women were making lifestyle choices and were not alcoholics in recovery but questioned their use of alcohol. Some of the volunteers who could not be included were parents of children older than 1 year of age. Many women were anxious to talk about their experiences. The interest expressed by all these women may indicate an unmet need in the community for a support group specific to mothers in recovery. Perhaps these women were trying to create a fellowship for support in examining and changing their behaviors, much as did the recovering mothers.

Because the transition to mothering is a time when mothers are not well prepared to protect their recovery, additional support from professional providers as well as AA/NA sponsors should be planned. Twelve Step support groups were under-utilized by the study participants but are a valuable resource for the mother in recovery. Twelve Step groups could accommodate pregnant and parenting women by providing child care and welcoming members with newborns and infants. Several mothers expressed a desire for more opportunity to talk about pregnancy and early parenting experiences in their support groups. Perhaps a group for recovering

mothers would be beneficial. Interventions that encourage women to engage in recovery processes that forge connections between recovery, pregnancy, and parenting will help meet the needs of mothers and their families.

Relapse prevention needs to be specific for women who are pregnant and parenting. The developmental periods of pregnancy, the first 3 months after birth, and from 4 to 11 months after birth emerged as times when participants' relative focus on the alcoholic/addict identity and the mother identity shifted. The shift in focus was accompanied by the use of a different strategy. All pregnant women should be asked about alcohol and drug addictions to help establish the dual identity of alcoholic/addict and mother.

Participants identified that during pregnancy their focus was more on becoming a mother than on the alcoholic/addict identity. The progressive strategy of recovery was used to a greater extent than either the protecting or non-progressing strategy to achieve the developmental tasks of pregnancy. During childbirth and the 3 months after birth, participants reported a continued focus on the mother identity but more use of the protective strategy for maintaining recovery, rather than progressing or non- progressing strategies. Efforts on maintaining recovery decreased, however, as the mothers adjusted to the nurturing of a newborn and the physical changes after childbirth. This may be a period of increased risk of relapse. In the 4 to 11 months after birth, participants noted a renewed focus on the alcohol/addict identity and recovery efforts with a decreased emphasis on mothering. Participants reported a priority placed on recovery efforts over mothering an infant. Progressing and

protecting strategies were used in contrast to the non-progressing strategies for motherhood.

This shifting emphasis between the identities of the addict and mother during the various developmental periods indicates where additional support for recovery may be needed. During pregnancy and after birth, mothers may require a different type and timing of recovery support as they invest in the mother identity. Professional providers need awareness and understanding of the importance of protective strategy, such as preparing for childbirth, to maintaining recovery and the mother identity for progress in recovery. The study women had little professional help or advice in figuring this need for protective strategy, but some did do it. In the 4 to 11 months after birth, mothers may need assistance in meeting the continuing needs of parenting an infant while maintaining recovery efforts.

Professional care providers need to be aware of the psychological and social factors that influence pregnant/parenting recovering women. These factors include debating the potential to parent, uncertainties of pregnancy due to risk of HIV exposure, effects of alcohol/drug use, and sexual violence. The factors should be explored with pregnant women. These concerns need to be addressed through multi-disciplinary counseling and education. The introspection and the intrapsychic changes during pregnancy explain why this is a sensitive time. By addressing these issues at a sensitive time, progress in connecting recovery and motherhood can be made. Education and interventions to promote attachment, understanding of infant and child behaviors, communication, discipline, and physical caretaking could assist each parent

to break a cycle of abuse and neglect, especially those most at risk because of their own experiences of abuse and neglect (Wellisch & Steinberg, 1980).

Dealing with emerging feelings is a dimension of the progressing strategy of balancing ongoing recovery with the transition to parenthood. It represents an area in which mothers may need the most care during pregnancy and parenting. For the majority of the study mothers, emotional healing and development of affective expression were necessary to establish not only the parent-child relationship but also a foundation for meaningful adult relationships. This dimension was begun in recovery and adapted during pregnancy for attachment with the unborn child. It was continued after birth in the forming of a reciprocal parent-child attachment. Learning about affect and expressing emotions has been found to be a serious challenge to persons in substance abuse recovery (Brown, 1985). All who work with mothers in recovery need to assess them for depression, mental health, and anger control problems. Counseling on individual and family problems may be indicated, especially since changes in one person will affect family homeostasis. Consistent caregivers who are empathetic and yet able to establish expectations about behavior are important to building trust and modeling trustworthy behavior.

Concerns about adult development with movement toward maturity should direct program planning for women in recovery. Learning ways to become independent and develop their potential are important to recovering women. Vocational training, general education degrees, and other educational programs are ways for mothers to gain control of their lives. Providers who give health care to

mothers should be aware that the mother's experiences of managing the special pregnancy or a chronic illness are connected to her sense of self as an adult. Mothers in this study reported that assuming responsibility for their self-care boosted their self-esteem and feelings of being "in control" of their lives. Respect for autonomy, personal growth, and self-care will nurture the recovering woman's development.

Surprising findings from this study were the high proportion of women who were successful in maintaining recovery over a prolonged period and the large proportion that had partners or spouses. A majority of the partners also had similar family backgrounds of abuse and neglect. Partners, or spouses, were described as drug free and struggling to become fathers. Including these partners in the management of the special pregnancy, recovery, and parenting would facilitate making the connections between parenthood and recovery. Helping mothers and their partners learn to meet the basic needs of food, shelter, and transportation, as well as health care is another way to nurture recovery and parenting. Consideration of how best to meet the needs of children whose parents are in recovery also merits careful assessment based on research and will require interdisciplinary communication.

## Relationship with Nurses

The relationship of addict mothers with nurses is addressed separately because of the importance of this relationship to recovering mothers. As a profession of primarily women, nursing can do great good or harm to recovering mothers. The mothers in this study viewed nurses in a variety of settings as a source of professional support, information, and guidance. Progress in recovery and mothering can be

facilitated through provision of adequate support. Through establishing a relationship based on mutual trust and respect, nurses may be able to provide the coordination of care that mothers need to continue their recoveries. Coordination of care is necessary to provide the array of resources, such as health care and education, needed by mothers in recovery. Building trust with addicted mothers in recovery occurs over a period of time marked by the nurse expressing acceptance and "being there" when needed. Finally, nurses are in a unique position to case manage and do long-term family follow-up.

Mothers working through the transformation experience and beginning to redefine their identity in terms of mothering and recovery need encouragement and acceptance. Nurses must deal with the seeming dichotomy of the mothers' disease of addiction and desire for healthy children and family. Acceptance by the nurse of the mother as a person who is "sick, not bad" allows the mother to admit her addiction as well as reveal the effects of the addiction on herself, her children, and her relationships. Breaking though denial is a step in a mother's recovery. Nurses' actions that emphasize control of addiction may thwart the woman's breakdown of denial and beginning transformation steps. Understanding the nature of addiction and communicating awareness of the disease help establish trust between the mother and the nurse. Behaviors of nurses that express understanding facilitate the mother in breaking through her denial of the disease. Nurses, as well as all professional providers, need to examine attitudes and behaviors that may convey condescension, condemnation, or hopelessness. Addicted mothers in recovery are a stigmatized

group. The addicted mother is sensitive to these attitudes and may withdraw from contact with health care providers to protect her fragile self-esteem.

As the recovery and mothering processes continue, the mother requires more and more autonomy and control over all aspects of her life. Mothers want to participate in decision making about health care and may withdraw from nurses or other health care providers who do not recognize their need for decision making and accountability.

Relapse is part of the disease of addiction (Brown, 1985). Mothers who relapse either during pregnancy or as parents need support in learning from the experience and regaining their sobriety. Nurses should learn that the addiction recovery process requires ongoing strategies to maintain recovery while mothering.

Nursing care of addicted mothers in recovery, although built on a therapeutic relationship with the mother, needs to include her family. In this study, recovery affected the entire family system, including children, partners, and the participants' parents. Children in a family where parents are recovering need assistance in coping with the changes in their parents and the family. Counseling for children and families is helpful in this process. Parents and their children who are alcohol/drug affected need education and support. Nurses need to work with mothers to get help for their children to cope with effects of addiction and recovery.

Because accountability is a feature of recovery, it may act as a motivator for the combined processes of recovery and parenting. Guilt and shame are part of the addiction cycle, not the recovery cycle and, if not dealt with, they can undermine

recovery and parenting (Finkelstein et al., 1981). Nurses may assist parents and children in recovery by helping them form alliances and negotiate for support from other professional disciplines. A multi-disciplinary approach that is coordinated and co-operative can assist mothers to progress in meeting demands of recovery and mothering.

## Implications for Policy

This study confirms reports in the literature that addicted mothers in recovery require programs that are sensitive to their needs as women and as mothers (Finkelstein et al., 1990, Kaplan-Sanoff & Rice, 1992; Mondanaro, 1989; Reed, 1987). Mothers in recovery need to be part of the planning and evaluation of these programs, as well as the recipients of care. Support for basic needs and vocational, educational, and parenting programs need to be made available to mothers as they progress in recovery. Prevention of the adverse effects of addiction on the fetus and prevention of child abuse and neglect can be accomplished best through a comprehensive approach that supports recovery and mothering by addicted women. Interventions need to address the developmental process as a whole from the perspective of the mother's needs.

Finkelstein (1990) concludes that women's psychological development is linked to the social, political, and economic environment of women's lives. Violence in relationships as well as societal violence in the form of sexism is identified as a factor affecting women's recovery and development. All participants in this study were able to identify forms of violence that they had experienced, such as sexual assaults and

discrimination in vocational training. Nurses who are advocates of women's recovery need to contribute to policy development about issues like violence which affect women in their social environment.

## Summary

The purpose of this study was to explore the concurrent experiences of women's alcohol/drug recovery and pregnancy and/or early parenting. Eleven powerful narratives about women's experiences of addiction recovery and transition to parenthood were told by women in the study group. These narratives were told over a period of weeks and months. Each of the participants was motivated to share their hopes, strengths, and experiences to assist other women undergoing similar transitions. Telling their stories through the research was one way for these recovering mothers to be heard as well as to help others understand how women can successfully integrate recovery from alcohol/addiction while becoming mothers.

Through the process of constant comparative analysis of data, concepts from models of alcohol/drug recovery and transition to parenthood were expanded and a distinct process of recovery for women during pregnancy and early parenting was described. This process incorporated the developmental and relational aspects of both recovery and parenting. Balancing emerged as the core factor for explaining how these women successfully integrated the recovery and motherhood processes into their self-identity and a unique ongoing recovery process. Balancing involved using protecting, progressing, and non-progressing recovery strategies. Various combinations of these strategies were used to balance between maintaining

alcohol/addiction recovery and meeting the developmental tasks of the transition to parenthood and to balance the alcoholic/addict and the mother identities.

Findings from this study have implications for future research, theory, clinical practice, and policy about women's alcohol/drug recovery during pregnancy and early parenting.

References

Abel, E.L., & Sokol, R. (1986). Fetal alcohol syndrome is now a leading cause of mental retardation. Lancet, 2, 1222.

Abel, E.L., & Sokol, R. (1987). Incidence of fetal alcohol syndrome and economic impact of FAS related anomalies. Drug and Alcohol Dependence, 19, 51-70.

Affonso, D. (1991). Postpartum depression: A nursing perspective on women's health and behaviors. Image: Journal of Nursing Scholarship, 24(3), 215-221.

Anonymous. (1990). Alcoholics Anonymous. New York City: Alcoholics Anonymous World Services (37th Printing).

Amaro, H., Fried, L., Cabral, H., & Zuckerman, B. (1990). Violence during pregnancy and substance use. American Journal of Public Health, 80(5), 575-579.

American Society of Addiction Medicine News. (1991). 1990 definition of alcoholism. 9.

Annual Summary of Vital Statistics. (1990). Boise, ID: Department of Health and Welfare.

Ballou, J. (1978). The significance of reconciliative themes in the psychology of pregnancy. Bulletin of the Menninger Clinic, 42, 383-413.

Barnard, K., & Eyres, S.J. (1979, June). Child health assessment, Part 2: The first year of life, (DHEW Publication No. HRA 79-25). Hyattville, Md.: US Department of Health, Education, and Welfare, Public Health Service, HRA, Bureau of Health Management, Division of Nursing.

Bauman, P., & Dougherty, F. (1983). Drug addicted mothers' parenting and their children's development. The International Journal of Addictions, 18(3), 291-302.

Beck, C. T. (1993). Teetering on the edge: A substantive theory of postpartum depression. Nursing Research, 42(1), 42-48.

Benedek, T. (1956). Psychobiological aspects of mothering. American Journal of Orthopsychiatry, 26, 272-278.

Becker, P., & Burke, S. (1988). Neonatal drug addiction: an analysis from two moral orientations. Holistic Nursing, 2(4), 20-27.

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

Benedek, T. (1956). Psychobiological aspects of mothering. American Journal of Orthopsychiatry, 26, 272-278.

Bibring, G., & Valenstein, A. (1976). Psychological aspects of pregnancy. Clinical Obstetrics and Gynecology, 19, 357-371.

Black, R., & Mayer, J. (1980). Parents with special problems: Alcohol and opiate addiction. Child Abuse and Neglect, 4, 45-54.

Blume, S. (1990). Chemical dependency in women: Important issues. American Journal of Alcohol Abuse, 16, 297-307.

Blumer, H. (1969). Symbolic interactionism: Perspective and method. Englewood Cliffs, NJ: Prentice Hall.

Bogdan, R., & Taylor, S. (1984). Introduction to qualitative research methods. New York: John Wiley and Co.

Brink, P. (1991). Issues of reliability and validity. In J. Morse (Ed.), Qualitative nursing research: A contemporary dialogue (2nd ed., pp. 164-186). Newbury Park, CA: Sage.

Brown, S. (1985). Treating the alcoholic: A developmental model of recovery. New York: Wiley and Sons.

Brudenell, I. (1991). Breaking the cycle: Drug/Alcohol recovery and transition to parenthood. Unpublished paper.

Bushong, M. (1990). When parents have a chemical abuse problem. In R. Mercer (Ed.), Parents at risk (pp. 125-141). New York: Springer.

Chan, L., Wingert, W., Wachsman, L., Schuetz, S., & Rogers, C. (1986). Differences between dropouts and active participants in a pediatric clinic for substance abuse mothers. American Journal of Drug and Alcohol Abuse, 12, 89-99.

Chasnof, I. (1986). Alcohol use in pregnancy. Drug Use in Pregnancy. Boston: Kluwer.

Chasnof, I. (1992, December). Nature versus nurture: Improving outcomes for prenatally drug exposed children. Paper presented at the National Association for Perinatal Addiction Research and Education Annual Meeting, Chicago, Illinois.

Chavkin, W. (1990). Drug addiction and pregnancy: Policy crossroads. American Journal of Public Health, 80(4), 483-487.

Chenitz, W., & Swanson, J. (1986). From practice to grounded theory: Qualitative research in nursing. Menlo Park, Ca.: Science and Behavior Books.

Clarke, H., & Summers, L. (Eds.). (1981). New Webster's dictionary. United States of America: Delair.

Connolly, W.B. (1991). Drug addiction, pregnancy, and childbirth: Legal issues for the medical and social services communities. Clinics in Perinatology, 18(1), 147-186.

Cranley, M. (1981). The roots of attachment: The relationship of parents with their unborn. Birth Defects: Original Article Series, 17, 59-83. New York: Arlen R. Liss.

Cruse-Wegscheider, S. (1989). Another chance: Hope and health for the Alcoholic Family (2nd ed.) Palo Alto, CA: Science and Behavior Books.

Daghestani, A. (1989). Psychosocial characteristics of pregnant women addicts in treatment. In I. Chasnof (Ed.) Drugs, alcohol, pregnancy and parenting (2nd ed., pp. 7-17). Hingham, MA.: Kluwer Academic Publishers.

Day, N., Richardson, G., Robles, N., Sambamoorthi, U., Taylor, P., Scher, M., Stoffel, D., Jasperse, D., Cornelius, M. (1990). Effect of prenatal alcohol exposure on growth and morphology of offspring at 8 months of age. Pediatrics, 85(5), 748-752.

Deutsch, H. (1945). The psychology of women. Volume II: Motherhood. New York: Grune and Stratten.

Ernhart, C., Sokol, R., Martier, S., Moron, P., Nadler, D., Ager, J., & Wolf, A. (1987). Alcohol teratogenicity in the human: A detailed assessment of specificity, critical period, and threshold. American Journal of Obstetrics and Gynecology, 156, 33-9.

Ericksson, M., Steneroth, G., & Zetterstrom, R. (1986). Influence of pregnancy and childrearing on amphetamine addicted women. Acta Psychiatria Scandinavia, 73, 634-641.

Evans, A., & Gillogley, K. (1991). Drug use in pregnancy: Obstetric perspectives. Clinics in Perinatology, 18(1), 23-32.

Fanshell, D. (1975). Parental failure and consequences for children. American Journal of Public Health, 65(6), 605-612.

Fawcett, J. (1978). Body image and the pregnant couple. Nursing Research, 3, 227-233.

Finkelstein, N., Duncan, S., Derman, L., & Smeltz, J. (1990). Getting sober, getting well: A treatment guide for caregivers who work with women. Cambridge, MA: The Women's Alcoholism Program of CASPAR.

Finkelstein, N. (1990, September). Treatment issues: Women and substance abuse. Presentation for the National Coalition on Alcohol and Drug Dependent Women.

Finkelstein, N. (1986). Effects of parental alcoholism, family violence, and social support on the intergenerational transmission of alcoholism in adult women. Unpublished doctoral dissertation, Brandeis University.

Finkelstein, N., Brown, K., & Laham, C. (1981). Alcoholic mothers and guilt: Issues for caregivers. Alcohol Health and Research World, 6, 45-49.

Gara, E., & Tilden, V. (1984). Adjusted control: An explanation for women's positive perceptions of their pregnancies. Health Care for Women International, 5, 427-436.

Gelles, R. (1988). Violence and pregnancy: Are pregnant women at greater risk of abuse? Journal of Marriage and the Family, 50, 841-847.

Glaser, B., & Strauss, A. (1967). The discovery of grounded theory: Strategies for qualitative research. New York: Aldine.

Goffman, E. (1963). Stigma. Englewood Cliffs, NJ.: Prentice Hall.

Goodwin, L., & Goodwin, W. (1984). Nursing research, 33(6), 378-380.

Gomberg, E., Nelson, B., & Hatchett, B. (1991). Women, alcoholism, and family therapy. Family and Community Health, 13(4), 61-71.

Gorski, T., & Miller, M. (1986). Staying sober. Independence, MO: Independence Press.

Halmesmaki, E. (1988). Alcohol counseling of 85 pregnant problem drinkers: Effect on drinking and fetal outcome. British Journal of Obstetrics and Gynecology, 95, 243-247.

Horowitz, S., Nickel, P., Shaughnessy, J., & Davis, A. (Fall, 1990). Idaho drug and alcohol needs assessment final report. Portland, OR: Northwest Regional Educational Laboratory.

Hurley, D. (1991). Women, alcohol and incest: An analytic review. Journal of Studies on Alcohol, 25(3), 253-268.

Jessup, M., & Green, J. (1987). Treatment of the pregnant alcohol dependent woman. Journal of Psychoactive Drugs, 19(2), 193-203.

Jessup, M., & Roth, R. (1988). Clinical and legal perspectives on prenatal drug and alcohol use: Guidelines for individual and community responses. Medical Law. 7, 377-389.

Jones, B., & Jones, M. (1976). Women and alcohol: Intoxication, metabolism, and the menstrual cycle. In M. Greenblatt and M. Schuckit (Eds.) Alcohol problems in women and children (pp. 103-136). New York: Grune and Stratten.

Jones, K.L., Smith, D.W., Ulleland, C.N., & Streissguth, A.P. (1973). Pattern of malformation in offspring of chronic alcoholic mothers. Lancet, 1, 1267-1271.

Kaplan-Sanoff, M., & Rice, K. (1992). Working with addicted women in recovery and their children: Lessons learned in Boston City Hospital's Women and Infants Clinic. Zero to Three, August/September, 17-35.

Kumpfer, K. (1991). Treatment programs for drug abusing pregnant women. The Future of Children, 1(1), 50-60.

Leif, N. (1985). The drug user as a parent. International Journal of Addictions, 20(1), 63-97.

Lemoine, P., Haronsseau, H., Borteyru, J.P., & Menuet, J.C. (1968). Les enfant de parents alcoaliques. Quest Medicine, 25, 477-82.

Lincoln, Y.S., & Guba, E.G. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage.

Lindenberg, C., Alexander, S., Gendrop, S., Neniciollo, M., & Williams, D. (1991). A review of the literature on cocaine abuse in pregnancy. Nursing Research, 40(2), 69-75.

Lofland, J., & Lofland, L. (1984). Analyzing social settings: A guide to qualitative observation and analysis (2nd ed.). Belmont, CA: Wadsworth.

MacGregor, S., Keith, L., Bachichia, J., & Chasnof, I. (1987). Cocaine abuse during pregnancy: Correlation between prenatal care and prenatal outcome. Obstetrics and Gynecology, 74, 882-885.

Mercer, R. (1990). Transition to parenthood: The process of parental role attainment. In R. Mercer (Ed.), Parents at risk (pp. 18-37). New York: Springer.

Miller, J.B. (1976). Toward a new psychology of women. Boston, MA: Beacon Press.

Miller, W.B. (1974). Relationship between the intendedness of conception and the wantedness of pregnancy. The Journal of Nervous and Mental Disease, 159(6), 396-406.

Mondanaro, J. (1977). Women: Pregnancy, children and addiction. Journal of Psychedelic Drugs, 9(1), 59-68.

Mondanaro, J. (1989). Chemically dependent women. Lexington, MA: Lexington Books.

Morse, B. (1991, March). Identification and prevention of fetal alcohol syndrome. Presentation of Fetal Alcohol Education Project at Perinatal Substance Abuse Training Program, Sun Valley, Idaho.

Murphy, S., & Hoffman, A. (1992, May). An empirical description of maintenance of abstinence from alcohol use. Presentation at the Annual Communicating Nursing Research Conference, Western Society of Research in Nursing, San Diego, California.

Nadel, M. (1991). HRD-91 ADMS Block grant for women's set aside, Government Accounting Office. Washington, D.C.

National Association of Perinatal Addiction Research and Education (1991, Fall). State by state legislative review. Chicago, Ill: Author.

Peppers, L., & Knapp, R. (1981). Maternal reaction to involuntary fetal/infant death. Psychiatry, 43, 155-159.

Reed, B. (1987). Developing women sensitive drug dependence treatment services: Why so difficult? Journal of Psychoactive Drugs, 19(2), 151-164.

Rosett, H., Weiner, L., & Edelin, K. (1983). Treatment experience with pregnant problem drinkers. Journal of the American Medical Association, 249(15), 2029-2033.

Rosenbaum, M. (1979). Difficulty in taking care of business: Women addicts as mothers. American Journal of Drug and Alcohol Abuse, 6, 431-446.

Rubin, R. (1967). Attainment of the maternal role. Nursing Research, 16(3), 237-245.

Rubin, R. (1970). Cognitive style in pregnancy. American Journal of Nursing, 3, 502-508.

Rubin, R. (1975). Maternal tasks in pregnancy. Maternal Child Nursing Journal, 4(3), 143-53.

Russell, M., & Skinner, J. (1988). Early measures of maternal alcohol misuse as predictors of adverse pregnancy outcomes. Alcoholism: Clinical and Experimental Research, 12(6), 824-30.

Schoenborn, C. (1991, September 30). Exposure to alcoholism in the family: United States, 1988. Advance Data from Vital and Health Statistics of the National Center for Health Statistics, 205. Hyattsville, Maryland: National Center for Health Statistics.

Seidel, J., Kjolseth, R., & Seymour, E. (1988). The ethnograph: A user's guide. Corvallis, OR: Qualis Research Associates.

Seventh Special Report to Congress on Alcohol and Health from the Secretary of Health and Human Services. (1990). Rockville, Maryland: Public Health Service. Alcohol, Drug Abuse, and Mental Health Administration. National Institute on Alcohol Abuse and Alcoholism.

Sherwin, I. (1981). Fantasies during the third trimester of pregnancy. MCN-American Journal of Maternal Child Nursing, 6, 398-401.

Sherwin, L. (Ed.). (1987). Psychosocial dimensions of the pregnant family. New York: Springer.

Sokol, R., Ager, J., Martier, S., Debanne, S., Ernhart, C., Kuzma, J., & Miller, S.I. (1987). Significant determinants of susceptibility to alcohol teratogenicity. In Annals of the New York Academy of Science (pp. 87-102), New York: The Academy.

Stack, J. (1984). The psychodynamics of spontaneous abortion. American Journal of Orthopsychiatry, 58, 162-167.

Stainton, M. (1985). The fetus: A growing member of the family. Family Relations, 34, 321-353.

Stern, P. (1980). Grounded theory methodology: Its uses and processes. Image, 12, 20-33.

Stressguth, A. (1976). Maternal alcoholism and the outcome of pregnancy. In M. Greenblatt and M. Schuckit (eds.) Alcoholism problems in women and children. New York: Grune and Stratten.

Streissguth, A.P. (1989). Fetal alcohol syndrome: Public health implications and recent findings. Washington Public Health, 7(1), 5-7.

Streissguth, A. P., Landesman-Dwyer, S., Martin, J. C., & Smith, D.W. (1980). Teratogenic effects of alcohol in humans and laboratory animals. Science, 209, 353-61.

Suffet, F., & Brotman, R. (1984). A comprehensive care program for pregnant addicts: Obstetrical, neonatal and child development outcome. International Journal of the Addictions, 19, 199-219.

Suffet, F., & Lifshitz, M. (1991). Women addicts and the threat of AIDS. Qualitative Health Research, 1(1), 51-79.

Swett, C., Cohen, C., Surrey, J., Compaine, A., & Chavez, R. (1991). High rates of alcohol use and history of physical and sexual abuse among women outpatients. American Journal of Alcohol Abuse, 17(1), 49-60.

Tilden, V. (1980). A developmental conceptual framework for the maturational crisis of pregnancy. Western Journal of Nursing Research, 2(4), 656-675.

Title, B., St. Claire, N. (1989). Promoting the health and development of drug exposed infants through a comprehensive clinic model. Zero to Three, 9(5), 18-20.

Twelve Steps and Twelve Traditions. (1990) (43rd Printing). New York City. Alcoholics Anonymous World Services.

Wallace, J. (1990). The new disease model of alcoholism. The Western Journal of Medicine, 152(5), 502-505.

Walpole, I., Zubrick, S., & Pontre, J. (1989). Confounding variables in studying the effects of maternal alcohol consumption before and during pregnancy. Journal of Epidemiology and Community Health, 43, 153-161.

Weiner, L., & Larsson, G. (1987). Clinical prevention of fetal alcohol effects--A reality. Alcohol Health and Research World, Summer, 60-65.

Weiner, L., Morse, B., & Garrido, P. (1989). FAS/FAE: Focusing prevention on women at risk. The International Journal of Addictions, 24(5), 385-395.

Weiner, L., & Morse, B. (1988). FAS: Clinical perspectives and prevention. In I. Chasnof (ed.) Drugs, Alcohol, and Pregnancy, Boston: Kluwer.

Wellisch, E., & Steinberg, M. (1980). Parenting attitudes of addict mothers. The International Journal of the Addictions, 15, 808-819.

Wilsnack, S., & Beckman, L. (1984). Alcohol problems in women. New York: Guilford Press.

Woodhouse, L. (1992). Women with jagged edges: Voices from a culture of substance abuse. Qualitative Health Research, 2(3), 262-281.

Young, E. (1990). The role of incest issues in relapse. Journal of Psychoactive Drugs, 22(2), 249-259.

Zuckerman, B., Amaro, H., Bauchner, H., & Cabral, H. (1989). Depressive symptoms during pregnancy: Relationship to poor health behaviors. American Journal of Obstetrics and Gynecology, 160(5), 1107-1111.

Zuravin, S. (1989). Severity of maternal depression and three types of mother-to-child aggression. American Journal of Orthopsychiatry, 59, 377-389.

# Appendix A

## Agency Agreements in Idaho

MEMO of AGREEMENT

DATE: July 30, 1992

TO:
Dr. Blackman, Director
Family Practice Medical Center
777 N. Raymond
Boise, Idaho 83706

Kathy Holley, Director
Nursing Services
Central District Health Department
1455 N. Orchard
Boise, Idaho 83706

FROM:
Ingrid Brudenell, RN, PhC
Associate Professor, Nursing Department
Boise State University
Boise, Idaho, 83709

SUBJECT:

During the 1992-93 year Ingrid Brudenell will be completing a research dissertation in nursing from Oregon Health Sciences University. As part of the dissertation, the researcher will be contacting clients in the prenatal care program offered by the Family Practice Residency Program and Central District Health Department. Clients will be asked to participate in a research study about their experiences of alcohol recovery during pregnancy, post partum and early parenting. Recruitment of subjects will be done by the researcher through fliers and personal contact. Participation is voluntary and will not effect care through the program. Periodic meetings are anticipated with the case managers to discuss recruitment of subjects and update staff on progress of the study.

This study was approved by the Human Subjects Committee at Oregon Health Sciences University on June 6, 1992. All information from the subjects will be kept confidential and a signed consent form will be placed in the clients medical record. At the conclusion of the study, findings about alcohol recovery during the transition to parenthood will be shared with the program staff.

Ingrid Brudenell is a registered nurse and faculty of Boise State University. She is not employed by either Central District Health Department or the Family Practice Residency Program. She is currently enrolled in the doctoral nursing program at Oregon Health Sciences University. She has malpractice insurance. For more information or questions about the doctoral program or the

dissertation research please contact Ingrid Brudenell (at 377-1237 or 385-1670) or the dissertation committee chairman, Margaret Imle, PhD, RN (503-494-3823).

Thank you for your cooperation and support of recruitment of subjects from the prenatal program. Your signature below indicates that you have agreed to recruitment of subjects from your agencies for the dissertation research.

[redacted]

J. Blackman, MD, Director of Family Practice Residency Program

[redacted]

Kathy Holley, RN, Director of Nursing Service

190 East Bannock
Boise, Idaho
83712

208-386-2222

Edwin E. Dahlberg
President

St Luke's
Regional Medical Center

August 12, 1992

Ingrid Brudenell
10892 Bridgetower
Boise, ID 83709

Dear Ingrid:

Your request to access patients participating in Birth and Parenting classes conducted by St. Luke's Regional Medical Center and patients on the 2 East/2 North units has been reviewed by the Nursing Research Committees, the OB/GYN Committee, and approved as stated in your research proposal, "Alcohol Recovery and Transition to Parenthood".

It is understood you will contact patients by means of a "flyer" distributed during the classes or on the nursing unit. You will not personally distribute the flyers.

Since the research does not occur at St. Luke's Regional Medical Center, approval by our IRB Group is not needed. This has been confirmed by Nan Hart, IRB Coordinator.

Judy Cross will be acting as your liaison with the Research Committee. Please keep her informed on the progess of your project.

I look forward to hearing about your findings and am pleased that St. Luke's can provide this support.

Sincerely,

[redacted]

Sarah Jean Cooper, R.N., M.N
Administrative Director
Clinical Nursing Support Services

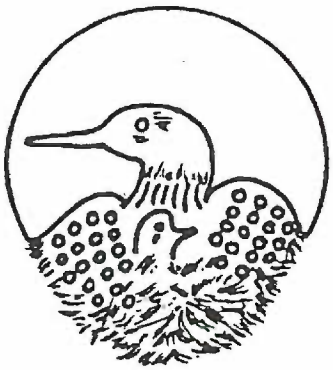
vmg

Enclosure

# Appendix B

## Recruitment Information

## Volunteers Needed for Research Study
## Alcohol Recovery and Transition to Parenthood



*Are you a sober mother?*
*Would you like to help other mothers stay sober?*

Mothers who are sober now but have had an alcohol problem are invited to share their story. How women become and stay sober through all the changes of childbearing is important information and should be shared. Just as understanding how " slips" or "relapse" occurs is important. The more nurses, and other health care professionals understand about recovery and parenting, the more we can assist mothers to remain sober and to have healthier children. I would really appreciate talking with you if you would share your experiences. There are no costs to participate, and all information is confidential and private.

I am a registered nurse who works with parents, and their children as well as teaching student nurses at Boise State University. Also I am a graduate student at Oregon Health Sciences University and completing research for a doctoral degree. My research is about alcohol recovery during pregnancy, and parenting an infant.

Please call me and I will explain more about the study. If you would rather be contacted by mail please fill in the form below and send it to me, or give it to your case manager. Thank you and I look forward to meeting you.

Ingrid Brudenell, RN, MS.
Department of Nursing, Boise State University
1910 University Drive • Boise, Idaho, 83725
Phone 385-1670.

---

Yes, I would like more information about participating in this nursing research study.

Name _____

Address _____

City _____ State _____ Zip _____ Phone _____

Best time to reach me... _____

Ingrid Brudenell, RN, MS.
Department of Nursing, Boise State University
1910 University Drive • Boise, Idaho, 83725
Phone 385-1670.

# Appendix C

## Consent Form

Oregon Health Sciences University
Consent Form (Approved 6/30/92)

Title. Alcohol Recovery and Transition to Parenthood

Principal Investigator. Ingrid Brudenell RN, MS (1-208-377-1237 or 208- 385-1670) Faculty Advisor: Margaret Imle, RN, PhD (503-494-3823)

Ingrid Brudenell is a registered nurse and graduate student at Oregon Health Sciences University. This research project is part of a graduate nursing program requirement.

Purpose. You are being asked to participate in a research study of women's alcohol recovery during pregnancy, post partum, and early parenting. This project explores changes women experience when alcohol recovery occurs at the same time as pregnancy, post partum and parenting an infant. The study will involve at least two interviews over a period of two to twelve weeks. The time, date and place will be something which you and the researcher agree about.

Procedures. You will be asked questions during individual interviews about your experiences in recovery while pregnant, or after birth, or while parenting a baby. The researcher will also make observations during the interview. After the first interview you will be given the opportunity to write in a diary about your experiences and feelings about your pregnancy, recovery and parenting. At later interviews the researcher will want to talk with you about what you have written down. The first interview will last about one to one and a half hours. Later interviews will vary in length of time.

Confidentiality. Every effort will be made to keep your name and identity private. Neither your name nor your identity will be used for publication or publicity purposes. The interview will be tape recorded with your permission to help the researcher remember the conversation. The tape will either be erased or returned to you at the end of the study. Only non identifiers like a flower or place name will be used for any tape, transcript, note, diary or correspondence. All materials will be kept in a locked drawer in a locked office, and your name will not be used. Names will not be connected to the tape and what is said will be used only to describe ideas about recovery during childbearing and parenting. The diary will be returned to you at the conclusion of the study or destroyed.

Risks and Discomfort. Risks associated with participation in this research study include possible social, emotional or physical distress. You are encouraged to discuss only the information that you are comfortable sharing. If you feel distress during the interview please tell the researcher, and she will either stop the interview, reschedule the interview for a later time or continue if you wish to do so. The researcher is required by law to report

suspected abuse and neglect to child protective services. In an emergency situation, only information which is needed to protect life and health will be shared with the referring agency, your health care provider, or child protection services.

Benefits. Benefits of participating in the study are the opportunity to discuss experiences, thoughts and feelings associated with recovery, childbearing and parenting. Increased self awareness and insight may result from talking with the researcher and participating in the study. Findings from the study of recovery and childbearing may increase nurses' understanding and improve the health care available to mothers, infants and families when alcohol abuse is a problem.

Costs. There are no costs to participate in this study.

Liability. It is not the policy of the U.S. Department of Health and Human Services or any agency funding the research project in which you are participating to compensate or provide medical treatment for human subjects in the event the research results in physical injury.

The Oregon Health Sciences University, as an agency of the State, is covered by the state liability fund. If you suffer any injury from the research project, compensation would be available to you only if you establish that the injury occurred through the fault of the University, its officers or employees. If you have further questions please call Dr. Michael Baird at (503) 494-8014.

Other. Participation is completely voluntary. You may refuse to participate, or you may withdraw from this study at any time without affecting your relationship with or treatment at the Oregon Health Sciences University. Your health care or counseling in Idaho will not be affected by your decision to participate or not participate in this study.

Please ask any questions regarding this study prior to agreeing to participate. Ingrid Brudenell (385-1670) or (377-1237) has offered to answer any questions you might have.

Your signature indicates that you understand the above explanation and agree to participate in this research study of women's experience of alcohol recovery and pregnancy, post partum and early parenting. You understand that you will receive a copy of the consent form and that the researcher will keep one in a locked cabinet. Your signature below indicates that you have read the foregoing information and agree to participate in this study.

Name _____ Date _____

Witness (if available) _____

Appendix D

Approval for Study from OHSU

OREGON
HEALTH SCIENCES UNIVERSITY
3181 S.W. Sam Jackson Park Road, Portland, OR 97201-3098
Mail Code L106, (503) 494-7887 Fax (503) 494-7787
*Institutional Review Board/Committee on Human Research*

DATE: June 30, 1992

TO: Ingrid Brudenell, M.S., R.N.
c/o Margaret Imle, Ph.D.

SN-FN [redacted]

FROM: The Committee on Human Research

SUBJECT: ORS#: 3092
TITLE: Alcohol Recovery and Transition to Parenthood.

This confirms receipt from you of the revised consent form(s) and/or answers to questions, assurances, etc. for the above-referenced study.

It satisfactorily meets the recommendations made by the Committee on Human Research at its recent review. The proposal to use human subjects is herewith approved. It is requested that the date of this memo be placed on the top right corner of the first page of the consent form. This is the approval date of this revised consent form.

Investigators must provide subjects with a copy of the consent form, keep a copy of the signed consent form with the research records, and place a signed copy in the patient's hospital/clinic medical record (if applicable).

Approval by the Committee on Human Research does not, in and of itself, constitute approval for implementation of this project. Other levels of review and approval may be required, and the project should not be started until all required approvals have been obtained. Also, studies funded by external sources must be covered by an agreement signed by the sponsor and the Oregon Board of Higher Education.

If this project involves the use of an Investigational New Drug, a copy of the protocol must be forwarded to the Pharmacy and Therapeutics Committee (Pharmacy Services - Investigational Drugs, OP-16A).

Thank you for your cooperation.

xc: MARGARET IMLE, Ph.D.
wp:rcfapp 3/92

OREGON
HEALTH SCIENCES UNIVERSITY
3181 S.W. Sam Jackson Park Road, Portland, OR 97201-3098
Mail Code L106, (503) 494-7887 Fax (503) 494-7787
*Institutional Review Board/Committee on Human Research*

DATE: April 28, 1993

TO: Ingrid Brudenell, M.S., R.N. SN-FN

FROM: Kristie Williams, Clerical Specialist
Committee on Human Research L-106 [redacted]

SUBJECT: ORS#: 3092
TITLE: Alcohol Recovery and Transition to Parenthood.

This confirms receipt of your memo dated March 25, 1993 and new addendum consent form for the above-referenced study. The consent form has been reviewed and approved.

It is recommended that the date of this memo (the consent form approval date) be placed on the upper right hand corner of the new addendum consent form for easy future reference.

Thank you for your cooperation.

OREGON
HEALTH SCIENCES UNIVERSITY
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*Institutional Review Board/Committee on Human Research*

DATE: November 22, 1993

TO: Ingrid Brudenell, M.S., R.N. SN-FN
c/o Margaret Imle, Ph.D.

FROM: The Committee on Human Research
Mail Code...L-106

SUBJECT : ORS#: 3092
TITLE: Alcohol Recovery and Transition to Parenthood.

This confirms receipt of your memo and/or questionnaire dated/signed 11/19/93. It has been reviewed and determined that the above-entitled study should be terminated.

Accordingly, we have closed our file.

Thank you for your cooperation.

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# Appendix E

## Interview Guide

Code: Interview: Date:

Demographic Data Sheet

Age: Birth date: Marital Status:
Ethnic Group: Education: Employment:

Health Condition:

Health Care Provider:

Length of Sobriety: Treatment:

Baby due: Trimester: Born:
Baby's Health:
Other Children: Health:
Comments:

Family history of health problems and/or drug addiction :

Tentative Guide

Description of Sobriety:
How long was alcohol or drugs a problem before you stopped using?
How long have you been sober?
Since becoming sober have you experienced major changes in your life?
How would you describe your sobriety?
what do you consider problems you have worked on since becoming sober?
What kind of support did you need at first and what kind now ?

Have you experienced depression, or menta health problems since becoming sober?
Were there critical events or turning points leading you to become sober?
Who or what persons were most influential in your decision to become abstinent?

Has anyone opposed your becoming abstinent? what has it cost you to become sober? What have you gained?

What adjustments have you made since becoming sober?
what are you doing for recovery?

Have you experienced any barriers to recovery? Describe them.

Pregnancy:
How do you feel about being pregnant or having a new baby?

How do people close to you feel about your pregnancy and coming baby? Or how do people feel about the baby?

Have you noticed any changes in relationships with people close to you since becoming pregnant and in recovery?

Have you noticed changes in yourself as your recovery has continued? As your pregnancy has continued?

how do you think your recovery has been affected by your pregnancy or by having a baby?
How do you see becoming a parent as effecting your recovery?
Relapse:
Have you ever had backward steps in recovery? How did you recognize them? what did you do? What did people close to you do? Have you experienced these during your pregnancy or after having your baby?

How can nurses be of most help to recovering alcoholics who are pregnant, just had a baby or are parents to a baby?

Do you want to add anything that you think nurse should understand about what its like for you?

Thank you.

Follow Up Phone Interview (brief conversation)
Is this a good time for us to talk?
I have gone over the tape and my notes and need to check some things with you.
Do you have any additional ideas or questions about what we talked about?
Have you had any discomfort from our talk ?
Could we set up a time to talk again? Thank you.