Women In Recovery from Substance Abuse: A Narrative Inquiry of Self and Belonging in Community

By

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live life free of the oppression of addiction - and to know joy and love in their relationships.

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ABSTRACT

TITLE: Women in Recovery from Substance Abuse: A Narrative Inquiry of Self and Belonging in the Community

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This narrative inquiry of the experiences of women recovering from substance abuse was designed to discover how social and health care providers could become more sensitive and effective with these women. Thirty-two narrative interviews were conducted with eleven women who were in recovery from substance abuse and living in the community to elicit their descriptions of their experiences with social and health care system providers. Analysis of the interviews followed hermeneutic principles which involved iterations of review and refinement of textual interpretation. Interpretion lead to a coding scheme, paradigm case, exemplars, and discovery of the meaning of these experiences to the participants.

The women described living in two separate worlds, the addictive and the non drug-using worlds, parallel cultures that isolated their members from the other world. The women's experiences identified contrasting behaviors and attitudes of providers who were helpful and effective and those who were ineffective and not helpful or punitive. The women responded to treatment and its focus on self esteem, parenting, and skill-building. They supported mandated treatment because it provided the continuity and safety necessary to break their addictive relationships, patterns, and lifestyle. Their

transitions to recovery were marked with a mixture of celebration and anxiety. They expressed their desire for ongoing community support from outside the recovery community to assist with parenting guidance and mentoring in learning how to belong to the non drug-using community.

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Chapter One: Introduction and Aims of the Study

In this study, we will consider the relationship between society and substance abusing women, and look at how they are intimately connected over the course of the participants' social and health care experiences. Through its identified institutions, representatives, and customs, society renders a significant influence on the sense of place one feels in terms of belonging to the community. Those individuals and groups who are considered unacceptable to society may be marginalized through the establishment of social constraints, policies, and actions designed to separate them from the community.

Society, as the gathering of the community to meet common needs and to provide the place for social connection and belonging, may include or reject persons or groups. Those who are rejected are marginalized - relegated to the borders of our community's human relationships and with limited access to common resources and social support. Whether individuals are marginalized due to poverty, substance abuse, family dysfunction or other culturally unacceptable conditions, it is difficult to struggle from those margins toward the center of communal life. Changing one's circumstances or overcoming inherited cultural patterns that are unacceptable to the larger community is a daunting task, requiring belief in oneself and encouragement from others. One's self concept is, in great part, encouraged by the sense of acceptability within the community. Being marginalized, therefore, especially as children of marginalized families, can be a barrier that influences one's abilities and motivation to try to change one's circumstances.

Important resources for changing circumstances are the human service systems that are supported by society: the helping professions, schools, churches and social

networks, social service agencies, charitable organizations, and others. Yet because the providers of services are **of** society, their services and their institutional and individual attitudes are shaped by historical social values - in some cases, the values that ultimately marginalize certain individuals, namely substance abusing/recovering women.

Phenomenon of Interest

This study investigated how women who are economically poor and recovering from substance abuse have experienced their encounters with social institutions and providers of care. Many of these women come from abusive or dysfunctional families who, themselves, were not competent in dealing with social systems. These families, therefore, could not have guided their children toward functioning as mature, interdependent adults. Women with substance abuse problems also have children of their own. Services that are available to them as they recover from substance abuse often conflict with their necessary roles as mothers. There are few or no coordinated services which would help them learn the parenting skills which they never experienced as children.

Demands from welfare agencies to meet various conditions in order to sustain public financial support for their families may be frustrating because of the rigidity of the rules or the inflexibility of their case workers. The stress of being financially dependent on the public welfare system combined with the stigma of addiction may contribute to poor recovery stability in this population.

I have chosen this topic as a result of research and clinical experience in psychiatric-mental health and community health nursing over the past 30 years, working

with poor, vulnerable clients in both community and institutional settings. My experience suggests that systems are frequently incapable of adjusting to clients' transitional requirements, as their needs for services and resources change over time. Interventions may be ill-timed, inappropriate, or inadequate to meet needs resulting from the ***changing conditions*** of the clients' lives. As a clinician, I found that I could not access support from the larger system to help clients during critical ***transitions*** from financial, social or psychological dependence to gradually increasing independence. The system was simply not prepared to respond with flexible levels of services and resources.

For instance, women who are known as substance-abusing clients to some of these social service and health care agencies may have been stereotyped as dependent and expected to fail at independence or recovery. If this attitude is commonly held among the provider community it may be an obstacle to facilitating these women's access to treatment and other community resources.

Although such services as the Federal JOBS program are now connected to welfare services, there are still pervasive negative public attitudes and the services may not provide graduated or flexible educational or employment incentives that increase the women's competencies (Houck & Thurston, 1994). The double burden of labeling and discontinuity can be oppressive and discouraging to women who are seeking emancipation from dependency and marginalization. These burdens cause social handicaps that make progress difficult especially for recovering women who are mothers. Until the 1980's, when studies began to show the devastating effects on infants born with drug and alcohol symptoms, there were no appropriate services at all. Programs have only

recently been developed to allow children to accompany their mothers in residential treatment and to include parenting training as part of women's substance abuse treatment.

There continue to be many poor mothers who are still unable to leave their children in order to enter substance abuse treatment because they have ***no safe place or person who will care for their children in their absence.*** Suitable, drug-free housing is lacking for these women, as are adequate health care for them and their children, education and career development, and other supports to assist women in moving toward independence from the social service system. For these reasons, this study explored the women's experiences with social institutions over time in order to discover the critical encounters that were effective and sensitive to their capacities and needs.

In my practice, I have also repeatedly observed a failure of communities to integrate clients after completion of substance abuse treatment. I attribute this problem to the following: life patterns established in childhood and during their drug-using years; psychological and physical dependence on addictive substances; and the lack of an adequate recovery model for women, especially women as mothers. This last condition can be directly addressed through policy changes and care providers' practices.

The traditional recovery model is based on the Alcoholics Anonymous (AA) twelve step program. It may occur in outpatient or residential treatment programs as well as in community support groups with other recovering people. Recovery involves a long-term commitment to abstinence, and cycles of relapse, treatment, and recovery are common in drug-dependent people (Gerstein & Harwood, 1990). These community self-

help groups are mandatory in many treatment programs and are seen as an essential vehicle for maintaining abstinence and recovery in the community.

For single women who are the primary support for their children, the need to establish a new parenting role and relationship with their children may conflict with the requirement for frequent attendance at these groups (several times a week and on weekends). Single mothers need the peer support of other recovering women for their own growth in self confidence and establishing themselves as non drug-using persons.

However, if they have no resources to help care for their children, these women may not be able to attend the required meetings, jeopardizing their commitment to abstinence and peer support while working on recovery goals. Further, they will find that parenting issues in recovery, or family-related recovery needs, have not been adequately addressed by the AA program. Mothers thus find a vacuum in precisely the area of their greatest need: the training for parent-child(ren) relationships with new rules, boundaries, and communication. Since these women were likely not to have been parented appropriately, they require assistance and guidance in the normal developmental needs of children at each stage; and they need encouragement to continue learning how to express themselves effectively and lovingly with their children. The current model does not meet these ongoing and changing needs.

As part of the dissertation development, I conducted a pilot study of recovering women during the year preceding the study. Parenting issues during recovery were raised frequently by the women. They indicated that there were no appropriate resources available to them, and that they felt quite vulnerable in this regard. As a member of a

program evaluation study, I also interviewed directors and staff members of community agencies about community support for women's treatment and recovery. The respondents identified this issue as a major need for women in recovery (Appendix A).

Given the social obstacles identified, the following research goal and aims guide this research toward reforming the paths for women's recovery:

Research Goal

To understand substance abusing/recovering women's experiences with providers and social institutions, especially concerning provider policies and practices as they affect the women's sense of self, their sense of marginalization, and their transition to the non drug-using community.

Aims of the Study

1. To describe shared meanings and common themes in narrative accounts of recovering women's experiences with social and health care systems.
2. To describe the impact of providers' practices and policies as experienced and described by recovering women.
3. To describe the experience of trying to belong to the non drug-using community.

Justification for Studying Phenomenon

Poor women, as single heads of households, are particularly vulnerable to social policies. They lack financial security and resources to manage child rearing and homemaking, unable to provide stable homes for their families. If they are also drug and alcohol addicted, they are likely to experience social stigma, as society has tended to be

extremely critical and judgmental of addicted women who are also mothers. It is true that the federal government has recognized the "stigmatizing" influence of alcohol and drug illnesses on clients, and sought to provide strict protections of their privacy rights. Nevertheless, there continue to be policies and procedures that are punitive and deter women from entering treatment - for example, criminal prosecution and incarceration of women for alleged drug use during pregnancy (Weber, 1992, p. 350). Some states have attempted to expand the interpretation of the child abuse law by prosecuting addicted pregnant women with charges of fetal abuse. Additionally, evidence of drug use and possession may be collected without the mother's informed consent at the time of labor and delivery, and has been found to occur more often in hospitals that serve poor and minority clients (Weber, p. 355).

The stereotype against alcoholic women also can be traced to societal views of sexuality and female drinking (Blume, 1991), leading to both stigmatization and victimization of women who drink: "This stereotype differs from that of the alcoholic male in that it contains a culturally ingrained expectation of hypersexuality and sexual promiscuity" about women (p. 139). Blume identified the historical and contemporary perspectives that form the cultural heritage of a double standard of expectations for men and women who drink. It is apparent that women who drink are viewed as sexual prey by men, and, indeed, are seen as inviting exploitation or victimization. This view was expressed in the coverage of the 1983 Massachusetts rape case of a young, inebriated woman who was gang-raped on a pool table in a bar. Her pleas for help were

unacknowledged, and she was verbally abused by the townspeople during the trial against the men who raped her (Blume, p. 140).

It is not uncommon to hear public comments, both personal and media-based, that stigmatize women with alcohol and drug addictions. These comments are based on the perception that these women chose their addictive lifestyles and, in effect marginalized themselves. Many people thus feel morally justified in stigmatizing and condemning these women.

The process of stigmatizing is society's way of distinguishing who belongs and who does not belong in the larger community. In fact, the marginalization of these women occurs in two ways: 1) a self rejection that was cultivated in childhood from family and others' messages of unacceptableness; and 2) the expression of contempt, ridicule, or indifference by the agents of society's rules and culture. For this study population, **marginalization** thus involves two perspectives: one is the women's subjective feeling of not belonging or not being socially acceptable by the larger community of others; the other is a social experience projected by the general public and some providers of social and health care services and their agencies.

Pilot work with recovering women suggested that, as children and adolescents, these women were not protected by society's laws or promises - neither implicit nor explicit ones. Data analysis revealed five themes from the narratives: chaotic lives/no one notices; threat as motivation for treatment; coping through imagination; loneliness as part of recovery; and parenting in recovery (the report of the pilot study can be found in Appendix A). Case histories of women in treatment suggest that, when help was sought

later in life, the insensitive and punitive practices of workers and health care providers may have contributed to feelings of guilt, anger, and shame.

The women's lack of connectedness to their communities and their personal experiences with abuse and addiction seemed to have provided the medium for what might be seen as a sub-culture of isolation, which is perceptually and experientially remote from society's centers of connection. This disconnectedness may have contributed to their lack of socialization in the mainstream culture where one learns how to deal with social institutions like education, employment and housing. In short, substance abusing women are "multiply marginalized". They are consequently predisposed to self-doubt, confusion, anger, and the erosion of self-esteem.

Therefore, by understanding the women's personal experiences of living with addiction and abuse, and their reflections on their experiences with society's agents of care, we may be able to understand how to intervene more effectively in their situations. Guided by the women's perspectives, we may be able to alter social relationships within our institutions so that providers can change the practices in their organizations for dealing with these women - practices that help to emancipate the women from the oppression of poverty and addiction.

Assumptions and Concepts Woven into the Study

The goal and aims of the study are based on a conceptualization that values the experiential context of the participants' lives since their childhoods. Clinical practice with economically and socially oppressed families, especially underserved women/mothers, stimulated an interest in a philosophical perspective of justice and compassion that is

rooted in social and feminist ethics. The concepts and language stem from the disciplines of philosophy, nursing and social science. The choice of a narrative inquiry method is consistent with my background in psychiatric-mental health nursing with a focus on interviewing and therapeutic communication techniques. The design of this *qualitative* study relies on *narrative inquiry* for interviewing participants and *hermeneutic analysis* techniques for interpretation of the data.

An important perspective is that community embodies moral obligations of members as citizens toward one another (see section on Social Ethics). For this study, society is represented by its institutional agents (teachers, physicians, social workers, police officers, community health nurses, etc.), who are ethically ***responsible*** for their behavior and attitudes toward the women of the study with whom they have professional encounters. To be responsible, in this sense, is to incorporate a professional, interpersonal accountability for practice, and to recognize the role of the provider in facilitating the emancipation of the 'client' from social dependency, including transition to the mainstream community.

This study is also founded in existential-phenomenological beliefs about who beings are, recognizing the social constitution of their nature and development. It also appreciates that substance abusing women may have received disapproving self messages as children, contributing to negative self-concept development.

Clinical work in psychiatric-mental health nursing is focused on the individual's responsibility for self, and much of the alcohol and drug treatment literature reinforces these concepts, encouraging the individual to cope effectively with society rather than

blame others and engage in dysfunctional behaviors. Responsibility for one's actions, beliefs and attitudes is critical and must be supported by a community that provides an appropriate milieu for effective change.

Social Ethics Application for Study

The Moral Value of Belonging

Individuals can function freely in society only when there is equity in both knowledge and accessibility of decision-making for choices. The freedom and ability to make choices to provide for oneself and one's family, and to participate in the community's distribution of resources is basic to our country's social ethic. Walzer (1983) describes this basic principle in terms of ***membership in community*** and what we understand in the social contract between government and citizens. Community membership is crucial to citizens because of the power that accompanies political decision-making which influences their everyday lives. How well members recognize one another's claims for "communal provision of security and welfare" is reflected in the social policies and institutional practices that meet members' needs (p. 64). Belonging to the community is a mutually sustained benefit for all members; belonging is how one accesses the goods and services and participates in the political life of decision making in the community.

If recovering women are to feel they have a stake in their community, they must feel that they belong. Community belongingness reflects a sense of relationship with the people and those processes that affect their lives and their children's lives. It frees them

to express their opinions, to be treated with respect, and gives them the confidence in their ability to acquire needed resources.

Such a social contract is, of course, a two-way arrangement. The degree to which the community acknowledges that all its citizens are entitled to share in the social contract will determine whether the members can participate freely as equals. The culture of the community is shaped by its members' values, beliefs, and attitudes; these determine who participates and with what 'authority' or power. Individuals and groups who are stigmatized and marginalized are *not* considered full members by those in power.

Compassion and justice for the marginalized and a desire to emancipate them from the social conditions that separate them from the community are the principles that undergird social morality. These principles must be in place when policies are developed for the distribution of resources and for the development of an equitable, caring model for all members of the community. The validation of belonging, then, brings both tangible rewards of goods, services, and political empowerment, as well as the psychological benefits of acceptability and respect.

Because marginalization of members and groups from the larger society disconnects them or keeps them from full participation as citizens, marginalization must be scrutinized under social ethical principles that are consistent with the culture. Such scrutiny springs not merely from a rights distributive claim (Freeden, 1990; Walzer, 1988), but also from ethical positions of justice and compassion. Feminists argue further for the establishment of "right relationship" (Heyward, 1982) between those in power and the oppressed. Holland & Peterson (1993) similarly claim that the societally

marginalized possess a higher moral claim for redress of their grievances, and may rightfully demand the fulfillment of justice in their community lives. If the social contract is worth anything, it will serve to connect the privileged with those less fortunate in society, not separate them into isolated self-interested spheres.

Walzer correctly describes the contract as a "moral bond . . . creating a union that transcends all differences of interest" (p. 82). Marginalized people need access to the community's resources as well as education in how to participate in the community decision-making process.

Relevance To Nursing

This study is grounded in nursing: it arises out of the nursing culture of competent caring, justice and equity, and ethical advanced practice. The research tenets are embedded in the justice and compassion of nursing ethics and values. The nursing profession has a distinguished history of providing service and raising up the concerns of the dispossessed for attention to their social and health care needs.

While the study participants are substance abusing women, the application of the study may not be limited to gender-specific or addiction populations. Many patients with medical diagnoses and general health needs have addiction histories, so it is likely that nurses in all settings have contact with patients who have family history or personal experience with addiction. There is ample evidence that people across the lifespan experience addictive problems, either individually and/or as family members. These individuals have passed through the hands of health care providers and not always with positive results. Social stigma within the health professions has existed - and still exists -

against clients with substance abuse problems. This stigma has contributed to attitudes about services that are given to these clients, which undoubtedly affects their caring practices.

Nurses have an ethical responsibility to take care of all people they meet in their professional roles at work and to attempt to meet the needs of their clients equitably and with compassion. However, nursing knowledge is informed through social values and experiences as well as being influenced by previous education. This study will provide greater clarification about women's experiences with their *addictions over their family lifetimes*, and will suggest relevant practices for nurses to use, in all settings, relative to substance abuse care. As a result, nurses may be influenced to greater understanding of their clients' challenges in dealing with an addictive lifestyle. They may be able to be more compassionate and effective in serving their clients' needs. And they may realize an advocacy role within their agencies and institutions that will provide opportunities for these clients to sustain and nourish healthy behaviors and attitudes, in themselves and with their children and families.

The Policy Connection in the Study

Social policies reside in the interface between individual and society: the communicated relationship between recovering women and the social institutions and their agents who provide the services and resources. Given the ultimate goal of this study - to influence policies and practices for social empowerment - the study will have implications for policies and providers of services to recovering women and their children. The providers are the social agents (agencies, institutions) who exercise at least

two important functions for society: 1) they interpret society's expectations and desired conventions to their clients, and 2) they analyze the individual clinical situations, attempting to match the expertise and resources available within the institution. How these social agents mediate the two sometimes-competing demands will depend on their view of their role, and on their creativity and effectiveness in accessing resources and interpreting social policy. These agents must be sensitive to their advocacy role for those who are marginalized.

Acting as a moral 'bridge' between institutions and their clients, providers must first access resources for the women - which is the beginning of the redress of injustice discussed earlier. They are then in a position to help the women learn how to participate in the larger, non drug-using community to acquire the resources independently. Being able to acquire necessary resources for self and family maintenance and growth is essential to the recovery process for the women of this study. Such action must be seen as an *ethical commitment* by society to those who are vulnerable and marginalized. Only through this kind of commitment to its members can society be respected and engage its members through their belonging to the community.

Belonging acts as a social buffer that protects families and individuals from isolation and marginalization. The sense and reality of belonging supports parents in raising their children as members also of a community that cares for them. Individuals cannot experience their autonomy outside the community of belonging which fosters their continued growth and development.

Emancipation - freedom from social and political oppression - should be seen as both a process and an outcome of social policies. Emancipatory policies and practices incorporate both justice and compassion for the marginalized and oppressed because of the recognition of the powerful role society plays toward its members.

Inviting people in from the community's margins sends a message of 'welcome' and acceptance, which is the beginning of their journey toward psychological and social wholeness as community members. Such emancipatory policies would be designed to free marginalized women from the conditions that inhibit their pursuit of the legitimate and socially acceptable goals of all citizens in our society: financial independence from the welfare system, health care for them and their families, drug-free affordable housing, and the pursuit of educational and vocational goals that contribute to their involvement as participating members of the society.

At the same time, welfare and health care policies present economic burdens that heighten our awareness of the need for increasing the timeliness, effectiveness and creativity of approaches to delivery of client services. Managed care has had an enormous impact on the perceptions of available resources, and has led directors of agencies to be particularly concerned with their survival in a newly competitive business environment. These are legitimate concerns. However, to use *only* economic principles to determine which policies will be applied with those who require services is inadequate. And the appearance of changing values at the federal and state levels of government have stimulated increasing pressures on local programs, leaving them vulnerable to mergers, and to loss of prior commitments to clients and treatment philosophy. Without the

support of funding agencies for providing necessary services and expertise in treatment, the agencies may be unable to maintain their own moral commitments.

Backer et al (1993), who identified the role of policy as bridging the two domains of community welfare and individual community members' well-being addresses this issue:

> Public policy is a matter of choices, particularly as resources become scarcer. These choices are driven by the values of those who determine the policies . . . dominant values of the public sphere that have left many communities struggling . . . when policy is developed with a focus limited to bottom line issues at the expense of concern for the growth and development of communities, choices become limited. Caring becomes a lost value. (p.27)

The ethic of caring practices is foundational to nursing values and can provide a significant guidepost in today's management of care systems. Public domain caring, however, must effect a transition to practices that foster emancipation and community membership for recipients of services. This policy would accommodate the political pressure for reducing public funding by shifting government economic burdens of dependency, while also targeting support for recipients to support their gradual independence. Therefore, policies and procedures should incorporate practices that provide recipients with a continuum of services through transitional stages of increasing responsibility. Social-community caring can be both cost effective and emancipatory.

Nursing systems, like other social care systems, are being driven by the same social pressures, and need to meet the challenges of developing policies that help to

liberate clients from oppressive conditions. It is appropriate that nursing policies include both therapeutic and politically relevant language, for the practices that emerge from such documents can direct provider practices toward a socially ethical and competent perspective. From this perspective, marginalization and its remedy, emancipation, become for recovering women the merging of their personal and public worlds. The social agents who interpret policies from an emancipatory, or liberating perspective, carry the ethic of justice and compassion through to a logical outcome, the launching of individuals into the center of community life--in from the borders.

Methodology

Narrative Inquiry and Hermeneutic Analysis

The study is an interpretive phenomenological study that included two interrelated components: 1) narrative interviews of study participants for descriptions of their experiences with social and health care institutions and providers using narrative inquiry; and 2) interpretation of the data according to hermeneutic analysis principles. These will be described briefly to show their relevance to the study, however, an in depth explanation is found in Chapter Three.

Narrative inquiry is one research method of interpretive phenomenology and has been used by nurse researchers and others (Benner, 1989, 1994; Josselson & Lieblich, 1993; Van Manen, 1990; Mishler, 1986; Packer & Addison, 1989) to elicit stories from people about the things that concern them, especially as they relate to health-illness transitions. It is oriented to the context of history, culture, and the world as experienced by the individuals interviewed.

Benner (1994) describes some of the essential elements necessary to understanding the breadth of narrative inquiry and the connection between the personal and the social for humans: "Social meanings and their embodied social postures, stances, habits, skills, and practices are relevant for recovery and rehabilitation, for nursing practice, and for skillful ethical comportment in caring for the ill." (p. xvii).

The interviewer is seen as an interpreter of text through which ". . . the actual study is required to make visible and to challenge aspects of the researcher's pre-understanding that are not noticed prior to engaging in a dialogue with the text." (p. xviii). The researcher engages the informants or participants of the study in such a way to learn from them what their social meanings are for the phenomenon being investigated.

The study intends to influence social policy by giving voice to the critique provided through the narrative interviews of substance abusing women who have multiple experiences with the provider system. Policies often are primarily influenced by statistical presentations that reflect large data sets which are of some relevance, but which do not describe the impacts of various policies on the recipients lives. Narrative inquiry respects the importance of the experience of the people affected by social policy, and argues that a human science is needed to interpret the needs of humans from *their perspectives*, not from a dichotomized view of the world and the people who inhabit it.

Hermeneutic Analysis, as described primarily by Packer and Addison (1989) is a close companion to the existential-phenomenological tradition (Husserl, 1913/1962; Heidegger, 1926/1962; Merleau-Ponty, 1962) that is foundational to narrative inquiry. The subject of analysis is not the participant, but the text produced by the participant,

which is in narrative form. The investigator does not pose 'objective' questions designed by a distanced researcher, but is engaged with the informant's story, and is led to some degree - is open to it - by the telling. The interpreter looks for what lies hidden in the text, knowing that the background of the text is central to understanding the meaning of the informant's expression. Steele (1989) described the unconscious influence within the text:

> Seeming detours or asides, allusions and metaphors become central to such an analysis because they form the unconscious of a work. They are what the text is built on, even though the text would rather have us view its facade than its deeper meanings. (p. 233)

Packer & Addison note that part of what is going on during interpretation is evaluation as the researcher comes to the study with a perspective, and she is constantly in "dialogue" with the text and her understanding. Heidegger described the circularity of understanding as discussed by the authors:

> This means that we both understand it [the phenomenon] and at the same time misunderstand it; we inevitably shape the phenomenon to fit a "fore-structure" that has been shaped by expectations and preconceptions, and by our lifestyle, culture, and tradition. Understanding always takes place within this horizon or framework that is "projected" by human being ("Dasein"). (p. 33)

Some of the measures used to prevent a biased interpretation by the researcher include critical review with colleagues, mentors experienced in the tradition, other texts which provide comparison, extension, or contrasts, as well as traditional literature. The

important consideration for the study is whether the interpretation uncovers an answer to the questions that motivated the research; and whether it is "plausible" and "convincing" to others who read it (Packer & Addison, p. 289).

The concern underlying this study is to sensitize providers to their everyday practices with recovering women, and to influence the policies that govern those practices. More will be said of this, but it is important to note that interpretive or hermeneutic analysis does not intend to answer the question for all time, nor for everyone. It is not based on that kind of supposition. Rather, it eschews a positivist scientific rationality for a search of fact in favor of discovery of the meaning for persons within the contexts of their everyday life. The power of the study is not in prediction but in relevance, so that we can grasp the meaning of recovering women's experiences with their providers of services. For current practice and policy, we can learn much through this method of inquiry/analysis, as the study participants are truly the experts on what providers and their systems conveyed during encounters with them.

Chapter Two: Literature Review and Organizing Perspectives

The literature that is reviewed in this section provides the interpretive framework to understand the social worlds of marginalized, substance abusing/recovering women. The following literature was reviewed: 1) research studies of women's substance abuse prevalence, related health issues, and women's addiction treatment; 2) social ethics and marginalization of substance abusing women; and 3) social policy issues that are relevant for women's access to treatment and community resources along the addiction-recovery continuum.

Studies of Women's Substance Abuse: Prevalence, Health, and Treatment

During the last ten to fifteen years, various research studies have attempted to analyze the large national data sets of drug use, prevalence, trends and patterns of both genders, but with increasing attention to women's addiction data. Previously, little was known about women's patterned drug abuse since most studies, from the 1970s and early 1980s, focused on patterns and prevalence of heroin abuse/treatment for males. In 1985, the National Institute of Drug Abuse (NIDA) reported that approximately 8 million or 15 percent of women between the ages of 15 and 44 were substance abusers. Crack/cocaine addiction along with poly-substance abuse, including various combinations of alcohol, marijuana and opiates (Miller & Hyatt, 1992) has been found to be increasing among women, particularly among poor, urban women (McMillan & Cheney, 1992). Analyzing the National Household Survey on Drug Abuse (NHSDA), NIDA found that by 1994, 31 percent of women over the age of 17 had used an illicit drug at least once in their lives.

Greater than 3.8 million women had used an illicit drug at least once in the preceding month (of the survey). Dramatic changes in the availability of illicit drugs - marijuana, crack/cocaine, opiates, hallucinogens - have been increasing in the latter part of this century, with both men and women using drugs at younger ages.

Adolescent Drug Use Prevalence

Since many people who develop an addictive pattern initiate their drug use in adolescence, or earlier, it is important to include these data in the study. Adolescent experimental drug usage emerged as a pattern in previous surveys and continues through the 1990s. The Institute of Medicine (IOM) Report (1992) indicated that the earlier it begins, "the more likely it is to progress to abuse or dependence; the later it begins, the more likely it is to [diminish] into renewed abstinence without further progression . . . or yield to earlier, more sustained recovery (p.49). These data do not identify "differentiated knowledge" about adolescent women, their initial exposure and reasons for drug experimentation, for instance, but it was recognized that such knowledge would be essential in understanding the nature of vulnerability to problems with alcohol and drugs in that population (p. 153).

Clayton, Voss, Robbins and Skinner's (1986) study, using the NIDA 1982 drug use survey data, also showed that both males and females initiated use of marijuana and cocaine at younger ages. The 1997 Substance Abuse and Mental Health Services Administration (SAMHSA) retrospective analysis of drug use prevalence data (1966-1995) confirmed that there was a "gender convergence" in marijuana initiation between 1966 and 1975 which mimicked the marijuana initiation in the total surveyed population.

For both genders, marijuana use has fluctuated over the 30 or so years of research documentation (p. 12).

Clayton et al believed that "a virtual epidemic" of cocaine use had occurred between 1970 and the early 1980s " . . . in fact, 47 percent of the respondents in the survey who had ever used cocaine used it first in 1979, 1980, or 1981" (p. 95). The NIDA report from 1994 NHSDA estimated that 440,000 women had used cocaine in the preceding month, 188,000 had used crack cocaine, and 245,000 women had used hallucinogens (including PCP and LSD) in the preceding month (1997, p.1).

The recent analysis in the SAMHSA study showed that cocaine use for women aged 12 and older actually had its highest rate in 1985, of 2.1 percent reporting and males, 3.9 percent, also the highest rate since the data of 1979. After 1985, rates for both genders dropped steadily with 1995 data showing women reporting 0.4 percent and men, 1.1 percent use of cocaine (SAMHSA, 1997, p.18). What was also discovered was the dramatic change for women and their younger initiation of alcohol use. There was at least a 31 percent increase of total alcohol initiates of ages 10-14 in females between the periods of 1961-65 to 1991-95. However, rates of alcohol initiation have been similar between males and females since the 1960's.

The Clayton et al study, the NIDA report on women and drug abuse, and the SAMHSA report were initiated to understand more about the prevalence, rates, and patterns of drug abuse by women who use and abuse legal and illicit substances. Analyzing data from the 1982 NIDA survey, Clayton et al showed the importance of ***birth cohorts and societal influences*** on women's use of drugs. Lifetime prevalence rates

for women aged 18-34 years, showed women's use of prescription psychotherapeutics (sedatives, tranquilizers, stimulants and analgesics) and illicit drugs (marijuana, cocaine, heroin, hallucinogens) to be greater than twice as much as younger (12-17 years) and older women (>35 years). NIDA, using 1994 NHSDA data estimated that about 1.2 million women aged 18 and older had taken prescription drugs (sedatives, tranquilizers, or analgesics) for a nonmedical purpose during the preceding month.

The SAMHSA (1997) report also identified differences among age cohorts for prevalence rates of "any illicit drug use" by gender. Adolescents of both genders aged 12-17 have very similar ***rates*** of illicit drug use. ***Patterns of use,*** however, among total population aged 12 years and older show statistically significant differences between males and females, with males reporting much higher use of all substances, legal and illicit than females. The ***trend patterns***, however, are roughly similar between males and females. For instance, in reports on illicit drug use in 1979, males reported usage in the past month of any illicit drug of about 19 percent and females reported about 9 percent. Ten years later (1988), both genders' rates had dropped (males to 9 percent and females to 6 percent), neither to return to the higher rates in 1979. Females and males showed continued decreasing rates of usage, with small fluctuations up or down, ending in 1995 with male rates at 7.8 percent and female rates at 4.5 percent.

In the SAMHSA analysis, there appear to be social and familial correlates with higher rates of illicit drug use for both genders and for adolescents. The variables that were significant for younger adults (ages 18-25, 26-34) included households in which someone was receiving public assistance, being unmarried, and first experimenting with

substances at age 15 or younger. For adolescents (age 12-17), the important variables also included someone in the household receiving public assistance, living with persons who were not biological parents, family relocation in the past five years, being aged 15-17, and emotional and behavioral problems (p. iv).

Clayton et al also were interested in women's usage of psychotherapeutics in relation to women's self esteem and social identity in the changing culture of gender-conscious society in the '80's. Their study suggested that more research was needed regarding 1) young women's use of chemical stimulants as related to weight loss and the relationship to eating disorders; 2) the patterns of drug use and women's changing roles in the workplace; and 3) understanding women's greater use (than men) of physician office visits and use of prescriptions.

Substance Abuse and Women's Health

In their review of women's health literature, Rodin and Ickovics (1990) discussed mortality and morbidity consequences of addiction for women's health. They reported that 70 percent of all psychoactive medications are prescribed to women, and that women are two times more likely than men to become addicted to these prescriptive drugs (pp. 1022 & 1029). Alcohol abuse dramatically increases women's risk for suicide, as they are 5 times more likely than non-alcoholic women to attempt suicide (p. 1022). Since many substance-abusing women combine various drugs, such as alcohol, marijuana, amphetamines, tobacco and caffeine, the risk to their health is substantial.

There are other significant health issues for women that are specifically linked to drug abuse. One of these is an increasing trend for lung cancer deaths for women,

escalating to 44 percent from 1979 to 1986, whereas, for men, the rate of increase is 7 percent. Smoking is believed to explain 85 percent of deaths due to lung cancer (Rodin & Ikovics, 1992). NIDA (1997) estimated that in 1994, 26 million women had smoked cigarettes (p.1). In addition, underemployment for women was significantly related to their physical and mental health, "...women who felt they were in jobs that failed to utilize them fully with regard to hours worked, wages paid, or utilization of skills had poorer health than women with adequate employment" (p. 1024). Recovering women possess these and other health concerns resulting from their years of addiction and the consequent damage to various body organ systems. In addition, they also experience stresses related to maintaining abstinence and managing their recoveries during their transition to the non drug-using lifestyle, making them more vulnerable to stress-related diseases.

Pregnant-Parenting Women and Substance Abuse Services

National public health concern for pre-natal exposure to Alcohol and Other Drugs (AOD) and consequent fetal and newborn effects has increased public attention to the identification and treatment of drug abuse in women (NIDA, 1985). Programs and funding specifically for research and treatment of women who were addicted to substances was finally mandated by Congress in 1990 with the findings and recommendations of the report, *Drug-exposed infants: A generation at risk* (General Accounting Office, 1990). Using data from the National Hospital Discharge Survey (1986-88), this report provided national estimates of the prevalence of infants who were exposed to drugs in-utero, the cost to society, and the impact on the child and social

welfare programs. There were also interviews with experts, providers, and substance abusing women, and medical record examinations of 10 hospitals from five major cities across the nation. One section in the report identified the lack of drug treatment for women and lack of identification of drug abusing women at prenatal care settings. Special attention was given to the following discoveries in the conclusion:

> Preventing drug use among women of childbearing age would reduce the number of infants born drug exposed. Providing drug treatment and prenatal care could significantly improve the health of infants born to women who use drugs and could reduce the risk of long-term problems. Yet in the five cities in our review, drug treatment was largely unavailable and many women giving birth to drug-exposed infants are not receiving adequate prenatal care (p. 10).

Simultaneously, the Office of Inspector General (OIG) produced a report which evaluated the impact of increasing births of "crack babies" on the child welfare system. The summary of findings reported the following data:

> . . . there is no typical crack baby; 8,974 crack baby cases were identified, and the social and health care costs were estimated at $500 million; most crack babies are not identifed at birth - about 50-75% go home with mother/relative - a significant portion gointo foster care, emergency, or congregate care; crack babies are complicated and time-consuming to care for, and face future problems; comprehensive case management is essential to help crack-addicted mothers and their babies; few crack babies have been adopted (OIG, 1990, p.11).

Although NIDA's national surveys have provided the major source of research data on national drug usage estimates, there are problems with the survey method in that it leads to underestimation of the problem for certain populations who are not accessible to surveys (Kaufman & McNaul, 1992). Those who are under-represented in the NHSDA are the homeless (roughly one-quarter are women with children) and those who are temporarily living with friends/family (also many are women and children); people currently in institutions for treatment of mental illness and/or addictions; those who refuse to participate; and people incarcerated in jails (many of whom are there due to drug use and associated criminal activity). Most of the large studies conducted prior to the late 1980's relied on this data set for estimates of funding needs for agencies and programs in alcohol and other drug (AOD) treatment. It is probable, therefore, that underfunding for women's treatment programs also was operative at this time which had direct influence on state funding at the local government levels.

The Office for Substance Abuse Treatment (OSAT) was created by Congress in 1988, in response to the lack of specific treatment programs for women, particularly those of child-bearing and child-rearing status. This new attention has identified promising programs and strategies to change the treatment and outcomes for women, in particular (but not exclusively). Increased funding for innovations in treatment and for increasing access to treatment, combined with outcomes evaluation designs have begun to provide data about women's treatment experiences that can be used by agencies and programs to improve the quality of gender-specific treatment.

The first group of substance abusing women to have increased clinical and research attention in the last 15 years were those who were pregnant and/or parenting. The National Association for Perinatal Addiction Research and Education (NAPARE) conducted a hospital survey to determine the incidence of substance abuse among pre-natal patients. An average incidence of 11 percent was found. The combination of an objective protocol and urine screens identified more women using illicit drugs, with a 16 percent incidence rate when all patients (not just suspected women) were screened with specific protocols (Miller & Hyatt, p. 249).

Ten years later in Oregon, a team of public health researchers, physicians, and other health care providers conducted research on prenatal substance abuse prevalence in the state (Glick, B., Zimmer-Gembeck, Tesselaar, H. & Weir, B., 1996). Findings indicated that prenatal alcohol and other drug use continues to put infants at risk and that hospitals and primary care providers have not adopted effective screening techniques as standard practice. The authors stressed that many of the women who were interviewed in the study did not perceive that there were health messages about the risks of prenatal substance abuse in provider settings.

The women were concerned about risking disclosure of substance abuse in relation to maintaining custody of their children and because of the negative attitudes of health care providers toward substance abusing women, those who were screened for substance abuse were more likely to disclose than those who were not screened. Private providers treated most (86.7%) of the prenatal patients in Oregon in the study year, 1994, but did not screen their prenatal patients for substance abuse, did not give advice

regarding the risks of substance abuse, and, therefore, did not encourage disclosure of substance abuse by their patients. "Thus, failure of providers to screen patients for substance use were missed opportunities to reduce prenatal substance use." (p. 13)

The balancing of recovery and pregnancy is a health concern that requires skill and support from health care providers. Brudenell (1996) studied the issues and experiences of pregnant recovering women seeking prenatal care. The women identified that risk of disclosure of their recovering status with health care providers was a major concern. The concern was expressed in terms of the fear of provider stigma related to their drug by the providers and the potential that the child protective agency would be contacted, with the potential threat of losing custody of their children.

Westermeyer (1992) called for a federal drug and alcohol policy that contains specific goals and objectives which would address prevention, treatment and recovery issues for women as a significant at-risk population. The Communicable Disease Centers reported (March, 1990) that 11,746 women were diagnosed with AIDS (Rodin & Ikovacs, p. 1026) demonstrating certain characteristics that place women at risk for AIDS: women with AIDS who are 13-39 years old, in their reproductive stage (79%); women who are black (52%), are Hispanic or other ethnic minority (20%), or who are white (28%); one-half are or have been IV drug users; and one-third had heterosexual contact with persons at risk for AIDS.

Corrections and Drug Policies' Impact on Substance Abusing Women

These data are particularly relevant for the study population, as poor women in particular who are substance abusing may be dependent for housing and support from

men who are drug abusers or drug dealers. These women, called "drug mules", are frequently placed in high risk situations for delivering illegal substances, and may be sent to jail even for a first-time offense, potentially losing custody of their children. The war on drugs has had a devastating impact on women, as new harsh sentencing laws have resulted in an increased rate of incarceration of 275 percent from 1980 to 1992 nationwide. Between a five year period (1986-1991) there was a 433 percent increase in the number of women incarcerated in state prisons for drug offenses (NIAA, 1997).

Bloom (1997) notes that a study (Mauer & Huling, 1995) demonstrated a disproportionate increase in African American women's incarceration:

> Nationally, between 1980 and 1992, the number of Black women in state and federal prisons grew 278% while the number of Black men grew 186%; and overall the inmate population increased by 168% . . . between 1986 and 1991, the number of African American women in state prisons for drug offenses increased more than eightfold, from 667 to 6,193 (828%). (p.2)

A report on the conditions of arrest and sentencing of drug offense cases (Lindesmith, 1997) indicates that there are several factors that have contributed to the disproportionate increase in women and especially African American women who are incarcerated for drug related offenses. There is a lack of "judicial discretion" in distinguishing between minor and major participants in drug cases, first time offenders are not given any "relief" in sentencing, and there is a lack of attention to mitigating circumstances related to women as mothers or other factors that could be considered in a more careful consideration of the individual case.

These issues weigh heavily on substance abusing women's access to health care. Not only is there stigma attached to mothers of children who abuse drugs, by the public, corrections/judicial officials (Lindesmith, 1997), and health care providers, but women who are fearful of being apprehended for their drug involvements are not likely to present for health care because of the fear of loss of custody of their children. In some states, currently, women who abuse substances and are pregnant risk criminal prosecution for charges that include drug distribution or assault and murder under the theory that they are "delivering" illegal substances to the unborn (Lindesmith, p. 14).

In addition to their dangerous and fragile situations as women who are addicted, their lack of economic stability to acquire safe housing makes poor women particularly vulnerable to prostitution, accompanied by sexual abuse and sexually transmitted diseases. In many reports about barriers to women's treatment (Finkelstein, N., Kennedy, C., Thomas, K., & Kearns, M., 1997; Center for Substance Abuse Treatment, 1994; National Institute on Drug Abuse Research Monograph, 1992; Public Health Service, 1991) the need for stable, safe, drug-free housing for women and their children has emerged as a significant barrier to treatment.

Treatment for Women with Addictions

The Alcohol and Other Drug (AOD) addiction for treatment programs are primarily publicly funded through federal government block grants and research studies, with the money channeled through state offices that manage mental health and/or substance abuse programs. This ties women's treatment access and opportunities to the

political processes that determine the distribution of resources and makes them dependent on current sentiments of government agencies and state legislatures.

The classical literature and research (Winick, 1962; Vaillant, 1973) on cycles of drug dependence-recovery-relapse were reported on male heroin addicts from the 1950's. The CSAT (1994) report on treatment of substance abusing women acknowledged that there continues to be a paucity of gender-disaggregated data and outcomes research on women's treatment (p. 78). Most substance addicted women are poly-drug users, often combining alcohol with the drugs that are most accessible to them. Treatment and recovery for women are influenced by the severity of alcohol/drug dependence, and whether the individual has access to social support (economic, housing, child care, relationships). In Oregon, to determine appropriateness of level of treatment, providers assess incoming clients using various addiction severity assessment instruments, some of which may be standardized and validated, and others have been developed by the specific agency. Based on the intake results, the clinical team assigns level of treatment according to state administrative rules, e.g., intensive outpatient, residential, inpatient, etc. (Thurston, 1996).

Most substance abusers, including women, have lengthy 'treatment careers', with histories of numerous treatment episodes and recovery relapses (Hubbard & French, 1991). But research is lacking on the prognosis of addiction or the relative effectiveness of various treatment models and their client outcomes. CSAT projects have only recently required outcome evaluations in the funded research of the agency. It will be several years before comparative data among treatment models and client outcomes will be

available to guide treatment programs for women clients. Until more predictability among client groups and improved assessments can be assured among treatment programs, clients may continue to experience lengthy treatment careers (IOM Report, 1992, p. 54).

Historically, people with addictive problems have been viewed from cultural perspectives, reflecting the dominant religious, social and political values of the time (Bennett & Ames, 1985). And, according to Bennett and Ames, it is the complexity of our pluralistic society that has caused confusion in the development of a generally accepted explanatory model for alcoholism (Bennett & Ames, pp. 4-6). In the absence of a specific disease-illness rationalization that is grounded in objective, scientific evidence, the public and professional view of alcoholism [and addictions] tends toward a "popular culture knowledge base involving numerous lay stereotypes, of which moral stigma is probably the most important", (Chrisman, in Bennett & Ames, p. 16; Ogborne & Glaser, 1985).

Although it is a fairly recent conceptual turn from a primary focus on moral choices, Alcoholics Anonymous (AA) has embraced the notion of alcoholism as a disease. Hall (1992) believes that this has been a successful strategy to use with AA members, as it relieves them of the moral burden for their disease, and it projects recovery in a time period that has as its goal, cure: "a process that ends or is completed within a specific, if variable, period . . . that moves the individual away from the illness condition." (p. 184).

The difficulty with this 'cure' model in AA programs is that it is inadequate in explaining the dominant experience of most substance abusing people, that recovery is a continual process, much like chronic illness with remissions and exacerbations in which there is no absolute cure. Individuals tend to experience cycles of recovery-relapse-recovery, therefore, it is unrealistic to expect a 'cure' within a specified time period for individuals.

Another problem in the AA approach, according to the researchers, is that there is a tendency to rigidity of program expectations, based on stereotypical beliefs about the treatment-recovery process, irrespective of the individual experience. It is one of the research aims of this study to provide additional evidence to support treatment reforms that include individuals' *experiences* of living with addiction and of their transition needs for continuing recovery. This kind of reform will add flexibility to the policies and practices of providers and encourage creativity in recovery support.

Relapse and recovery in AA philosophy are seen in terms of power and control, emphasizing the will and motivation to change through relinquishing of self-power to a higher power. Brown (1988) explained and argues for the relinquishing self power in the development of the new self of the recovering person, stating that dependency needs are legitimized and vested outside the self or others (through a higher power) and, because this is approved position for all those in treatment, there is less anxiety around the power-control dynamic (pp. 305-306)

For women, especially, the issues of co-dependence (Collins, 1993; Haaken, 1990) and submitting to a higher power (envisioned as male) combine with the influences

of their backgrounds of abuse and violence. These concepts can become counter-productive as a theoretical explanation for their addictive problems, and may function as barriers to treatment.

Hall (1992) challenged some of the beliefs and metaphors in AA through her qualitative study on lesbian images of recovery from alcohol problems. She, also, is critical of the metaphor of "conversion" in AA, which like the notion of cure, has a 'religious' once-in-a-lifetime experience, and is inappropriate for recovery as a process. The women in her study constructed alternate images that included celebration of accomplishments and demonstrated a range of life experiences that ultimately became empowering for them in their recovery. Recognizing social and power issues for lesbians in treatment/recovery, Hall challenges clinicians to change their policies and practices so as to include more strategies that are transition-oriented:

> The notion of recovery as empowerment has not been effectively incorporated into most mainstream recovery programs. . . To be open and supportive of this image of recovery, providers must acknowledge that women are the best authorities regarding their own healing and liberation, a tenet that conflicts with the compliance and control so often used in clinical interaction. (p. 195)

The challenges raised by these women's experiences of treatment and recovery to 'mainstream AA programs' can be mirrored in other marginalized women's experiences. In order to improve access and utilization of treatment for all women, fundamental changes in the metaphors and beliefs of the traditional approaches must occur. One such challenge is to change the philosophy of recovery to one of process and change over time,

which acknowledges that recovery evolves out of the women's progressive personal development and identity of self as a competent individual.

Another challenge is to reformulate the concept of co-dependency for women, into a relational model, that is more consistent with women's socialization and experience. Several authors and experts in women's treatment (Finkelstein, et al, 1997) provide alternative models of treatment for women based on recognition of the socialization to the feminine role in our society. And these cultural influences are understood in parallel with the psychological influences on the developing self of the girl-woman in her family.

The Ethics of Co-dependency and Recovering Women

Co-dependency is one of the traditional concepts in the alcohol treatment literature for describing, particularly, wives of alcoholic spouses who were believed to be dysfunctionally involved with their husbands' addiction. The concept has recently been expanded to include behaviors of various family members and others in relationships who focus on the needs and behavior of others (Whitfield, 1989, in Collins, 1993, p. 472).

Feminist critique of this concept reveals the lack of empirical support for its use, and for "decontextualizing" and depoliticizing the idea of women's relationships in dominant and/or oppressive situations. Rather than blame the woman for lack of responsibility for her situation, feminists suggest that women are socialized and, indeed, develop healthy self concepts through their primary relationships. When these are interrupted, due to unresponsive or abusive parenting and family environments, these "disconnections" result in developmental and relational problems (p. 473-4).

According to the self-in-relation theorists, two essential theoretical and practical differences exist from traditional notions of co-dependency of women:

> 1) a woman's developmental problems are . . . seen as [arising] from difficulties she experiences in trying to maintain connections while also asserting her own needs and desires . . . 2) the woman in a subordinate relationship will likely be personally disempowered or victimized, resulting in negative consequences both personally and in her social world (p. 474).

These self-in-relation theorists caution that empowering women in treatment, thereby encouraging learning interdependence, should not jeopardize either their autonomy or their relational connections. An empowerment treatment philosophy would require a kind of engagement with counselors that could challenge the role and authority they are accustomed to under a traditional 12-step program.

Group therapy, support and education are common among treatment programs and in the community support programs of most agencies. Haaken (1990) recognized the positive value for women in recovery groups and the sharing, comfort and hope offered there, which decreases their sense of isolation and aloneness. "On the other hand", she states, "recovery groups draw on the [co-dependency] literature that pathologizes caretaker dilemmas and vastly oversimplifies problems of human dependency and interdependency" (p. 404). She, too, advocates for a broader, socio-political base upon which to ground women's treatment, that acknowledges gender inequalities, and the development of "new forms of reciprocity and healthy interdependence between men and women" (p. 405).

In another conceptualization of treatment/recovery strategies, Brownell, Marlatt, Lichtenstein and Wilson (1986) specified a separate stage for 'lapse' in the relapse process. "We suggest that lapse may best describe a process, behavior, or event. . . is a single event, a re-emergence of a previous habit, which may or may not lead to the state of relapse" (p.766). Their efforts were focused on preventing relapses and empowering clients to determine the severity of a perceived loss of control.

This model is based on social learning, cognitive skill-building, and social support theories. The issue of loss of control is seen as a central issue for recovery, but in this model, the energy is directed positively toward accepting loss of control as a lapse, a temporary phenomenon. Anticipating lapses and developing strategies for coping with them is a positive, empowering strategy for women, in particular, rather than relinquishing choice or control to a higher power or the recovery group.

Finkelstein and colleagues (1997) concur with these suggested alternatives for women's treatment programming changes. In a federally funded project, these researchers and specialists in women's treatment have written a theoretical resource paper that discusses the conceptualization of a relational, life cycle perspective for treatment programs for substance abusing women. This project was intended to lay out the framework and issues that should be considered in women's treatment-recovery programs. The authors critically reviewed the historical and current literature that identifies needs of the many sub-groupings of women who need specialized addiction treatment, e.g., women of varying ethnic/racial membership, women in poverty, women with co-morbid conditions, such as mental illnesses, women with chronic health conditions such as

HIV/AIDS and other chronic conditions, pregnant and parenting women, and so on. Many women in treatment also have been abused and learned violence as a coping strategy to survive on the streets, have been incarcerated and had other legal problems with the corrections system. This paper presents a comprehensive perspective, comparing traditional substance abuse treatment programs with other systems of care for clients, demonstrating the need for changes in attitudes and practices among the providers of treatment for women.

Another practice that is fairly common in 12-step programs is confrontation about addiction and, when combined with the requisite admission of powerlessness, women may feel disengaged from pursuing treatment. The IOM (1992) study concluded that because of substance abusing women's psychological vulnerability, confrontive techniques may worsen such problems rather than help reduce them.

McMillan and Cheney (1992), in a contemporary study of case management for women recovering in the community, have identified the barriers to development of programs for recovering women in urban, impoverished situations:

Barriers in Recovering Women's Treatment

1) treatment models need to be specifically designed to meet women's needs, especially those who are parenting and establishing homes on their own for the first time;

2) many of the women have histories of child abuse and sexual abuse, making a "confrontational" style of treatment (AA model, applied to males) ineffective or frightening to women; seeing themselves as sexual objects makes them particularly

vulnerable to sexual intimidation, perceived or actual, by male staff in treatment programs;

3) addictive behavior patterns and physiological detoxification continue after treatment, making them susceptible to lapses/relapse;

4) there are too few resources to help women concretely establish their independence in household and financial management;

5) the needs for transportation are heightened, as women in recovery have aftercare appointments, vocational/educational classes, and community support meetings to attend, often with pre-schoolers in tow; and

6) the need for coordinated care through case management that includes targeted, individualized relapse prevention, which includes skill-building and social support in non drug-using friends/family (pp. 274-280).

In another federally sponsored project, the National Drug Control Policy office invited a panel of clinicians, researchers, and administrators to review the outcome studies that have been published for all treatment models: therapeutic communities, pharmacological treatment, outpatient treatment, inpatient treatment (therapy-based, 12-step, and multimodality programs). In closing summary, the expert panel identified certain critical elements believed to be necessary for program effectiveness, regardless of treatment setting or modality: complete and ongoing assessment of the client; a comprehensive range of services, including pharmacological treatment, if necessary; counseling, either individual or group, in either structured or unstructured settings; and HIV-risk reduction education; case management and monitoring to engage clients in an

appropriate intensity of services; and provision and integration of continuing social supports. Adhering to these elements more so than specific treatment models, "will determine whether clients will be successful in their treatment . . . and affecting the broader social or community problems that exist because of drug abuse" (p. 20).

Notwithstanding the above discussion, treatment philosophy, as a reflection of society's values and expectations, has had an impact on the structure and extent of programs. As a consequence, people who are marginalized in a community may experience many kinds of barriers to treatment programs and recovery resources. These barriers exist, in part, because of the lack of research on women's experiences with social institutions which is related to social attitudes and values. As a group, their experiences of marginalization and stigma as addicted women continues in the public consciousness and in provider ambivalence towards them.

Social Ethics and Marginalization of Substance Abusing Women

Social stigma and its impact on belonging to a community is influential in women's lives. Marginalization results from stigma that derives out of the social history of the culture and its ongoing practices towards its members. Thus, over time, stigma and marginalization become legitimated in the values and norms that prevail in the community. It is important to understand the historical perspective in order to appreciate how marginalization influences the treatment/recovery process for women in today's society. As noted previously, treatment program philosophies and interventions reflect the dominant social values and the degree to which society responds to people's needs.

Social stigma is projected onto others by those who enjoy a position or attitude of privilege that is believed to justify their behavior. It is a divisive attitude that disenfranchises the marginalized from community membership by creating barriers to belonging and participation. Stigma is not necessarily obvious to an observer because it is concealed in social norms and respectability. It is often used against those who are economically and socially disadvantaged and the person or institution that is perpetuating the stigma is protected by the force of their social power.

Marginalization that results from stigma and social disapproval contributes to barriers of access to treatment and health care for women. Women of all ages and circumstances can become 'marginalized' in our society in a variety of ways, due to gender, race, income, change in marital status, sexual orientation, illness, disability, or age (Wuest, p.41). Marginalized people, for instance, those who are under-employed, and those in poverty, especially single mothers who make up at least 60 percent of poverty statistics (Wuest, 1993, p. 40), are at particular risk for inadequate health care due to stigma and lack of access. Stevens (1993) asserted that providing access for marginalized people who are underserved or excluded could enhance access for all citizens and should be included in federal policy reform.

The social ethics of the community provides the standards or guide for measuring the community's moral effectiveness in addressing injustice and abuses of power among its members. As a just and caring democracy, our social institutions are supposed to provide moral protection for those who are least well-off in the population. However, since the institutions represent and exist as part of the political processes which fluctuate

in direction and resource capacity, the community's marginalized and dependent recipients of social and health care services need advocates to represent their interests.

Recovering women have been victims of marginalization from society because of social stigma, and their experiences in oppressive social conditions of poverty and abuse have limited their opportunities and sense of empowerment to change their situations. Theirs is not a voice that is heard nor have they been encouraged to speak out because of the shaming of the self that occurs by institutional social abuse. So, while the experience of being stigmatized is accepted by many in society, and is not seen as morally wrong, from the private perspective, it is felt as a personal culpability of unworthiness and hopelessness.

Social ethics in this study is used to critique society's moral effectiveness and commitment to justice for its least well off members, in particular, recovering women and their movement from marginalized status to one who belongs in the community. All of the women who participated in this study experienced periods of financial dependence on the public systems, were stigmatized for their addictive condition, and grew up either in violent families or in emotional environments that exacerbated their susceptibility to addiction. At various points from childhood to adulthood, there were needs for advocacy and support from the providers of social and health care services. The women's narrative descriptions provided the experiential data for social critique of their encounters with agencies and institutions.

The IOM Report (1992) identified the complex of psychological, social and biological factors that relate to the cultural issues which inform the vulnerability to substance abuse and which need to be considered for a wholistic view:

> The overall prevalence of drug use is a poor absolute measure and an imperfect correlate of the extent and severity of problems, probably because different subgroups of the population have different trajectories of drug involvement. . . These differences have much to do with the kind of social advantages and supports available to the individual. (p. 68)

Using the lens of social ethics in this study revealed some of the complex social factors that existed for the study participants. It also provided a moral marker to assess the community's effectiveness in supporting these women as marginalized substance abusing mothers and, later, as recovering women. Considering the influence of stigma on women's access to services, the social ethics framework provides the conceptual link between the personal and public experience of addiction in a society that contributes to addiction-producing attitudes and behaviors in its culture.

Historical Perspective on Social Institutions - Oppression/Marginalization

Marginalization of women who are poor and substance addicted has a long history in our society. Such a claim can be made because of a moralistic and judgmental value system inherited from the Judeo-Christian religious systems, and because of the political and personal oppression of women by a patriarchal social and economic system. It is important to understand 19th century values and the cultural milieu that dominated that

period of our society's moral social history - and that continue to influence social policy and institutions.

Contributions by feminist social researchers and philosophers (Mink, 1990; Gordon, 1990; Mahowald, 1993; and Bell, 1993) provide an ethical perspective that contradicts male-generated philosophical understanding and rationales for the social system and its practices towards women as recipients of services. A feminist ethical interpretation of the history and origins of policies and practices reveals the influences of the relationship between the economically powerful elite (as male-dominated privilege) and the construction of the poor as marginalized classes in our society. Women during this era lived within social boundaries that were organized around their dependent roles in families as caretakers and nurturers, primarily through matrimony and motherhood, both tied to economic dependence and lack of employment and educational opportunities.

Mink (1990) describes the social value related to independence, which was considered to be an essential personal characteristic ascribed to men, and highly valued as a public virtue ascribed only to men. She notes that staking manhood to citizenship made "political life a masculine affair and denied women a public political identity" (p. 93). The associated characteristics of self-reliance, self-ownership and autonomy, became legitimized in the civic domain as public virtues which provided the access to public decision-making necessary for gender, racial and class domination.

According to Mink, these roles and activities existed outside women's social boundaries and contributed to a socio-cultural explanation that justified the perception of women's secondary moral status. *Spheres of belonging* were defined by gendered patterns

of structure, and included class and race prejudice as well. Middle class women were bounded by home and family duties and excluded from the intellectual-political and commercial spheres. They were essentially marginalized even though living in relative comfort. Their service relationship to the immigrant populations was pivotal in the formation of the social response to families in need, and served to establish a classist social policy (Gordon, 1990).

Gordon (1990) noted that origins of child protection agencies grew out of a middle class women's social elite that ultimately victimized the immigrant mothers, who were seen as belonging to minority racial "stock" and/or were poor. The policies that were designed to protect children from abuse or child labor also produced a pattern of racial and class bias that ignored the immigrants' strengths in family and community. Middle class women were, in Gordon's view, acting on the dominant class' ethnocentric values. The unfortunate preoccupation with the perceived need to indoctrinate immigrants with the community's social and cultural values ignored the fact of their poverty - a condition that was directly related to the oppressive prejudice against hiring immigrant labor.

Today, the vestiges of a gendered morality can be seen in the oppression and marginalization of the poor and the feminization of poverty, that is, increasing numbers of women at both ends of the life span becoming poorer and finding themselves further from economic security. Poverty, violence, and social marginalization were revealed by Gordon (1990) in her research on family violence and social control in Boston during 1880-1960. She identified the blurring of victim and victimizer in the mother, herself. If mothers are not given adequate resources and means to provide for their families, they are as

susceptible to perpetrating child abuse as are men. Child abuse is seen as a "gendered phenomenon that comes out of women's rage and abuses of power" against them (p. 183).

In revealing the connection between oppressive social policies/practices and social and family violence, Gordon also showed the devastating consequences of marginalization on these families. Being trapped by the social identity of not belonging or not measuring up to the standards of the community prevented their liberation from the stigma of marginalization. And for some individuals and groups, these demeaning identities instigated the eruption of violence towards family members and/or resistance to social authority. Belonging and feeling included in the community, therefore, seem to be essential for transforming social identity, and for creating the appropriate context for social institutions in their approaches to family violence, poverty, and marginalization.

As part of this historical critique, it is useful to look at the foundation for the patriarchal pattern that was established in our society's earliest social structure. One of its critics and a member of the social reform movement during the 19th century, John Stuart Mill discusses the social-psychological nature of the power-subjection dynamic between husbands and wives that was dominant at the time:

> All women are brought up from the very earliest years in the belief that their ideal of character is the very opposite to that of men; not self-will, and government by self-control, but submission, and yielding to the control of others. All the moralities tell them that it is the duty of women, and all the current sentimentalities that it is their nature, to live for others; to make complete abnegation of themselves, and to have no life but in their affections. (p.31)

This account, written in the mid-19th century, identifies how the society indoctrinated women in their domesticated role and justified it by moral duty. The role was framed within the context of the home as the "social workshop for the making of men" (Mink, p. 97). So, not only her status in society, but her sense of self was seen as inextricably bound to the social role and status of the male head of household. She was primarily connected to him, and therefore to the community, via her biological capacity for reproduction and emotional sentiments for education of the species.

Ophir (1991), in writing about how society will not only distribute goods (the good) which benefit certain groups but, also distributes suffering through its policies that create barriers to services or denies people their right to justice and compassion. When generations of families or categories of peoples have been indoctrinated in a social view of themselves as unacceptable to the community as a whole, and when the community legitimates their marginalized status, suffering has been dispensed through the same means as services and goods intended to alleviate suffering.

The themes of oppression and coercion repeatedly appear in writings about marginalization of women. The feminization of poverty is of particular concern for egalitarian-feminist approaches to social dilemmas. Women's reproductive autonomy, equal access to fulfillment of basic needs and health care, government programs designed to respect the complexity of providing services to individuals in diverse circumstances - all represent a more sophisticated social program that "recognizes human health as dependent on relationships as well as medical condition" (Mahowald, 1993,p. 227). In this example, the social programs are recognized for their capacity to distribute physical and emotional

goods that are palliative in the interim. But, there is still great and increasing need among the women in poverty in this country.

One of the worst forms of oppression is that which is legitmated by the legal system, which takes its jurisprudence history from religious and early cultural doctrines in the origins of social communities. "When the culture normalizes rape, it is women and girls rather than men and boys who are seen to be at fault in cases of alleged rape" (Bell, 1993, p. 169). The difficulty in trying rape cases, according to Bell, stems from Jewish and Christian traditions that bind women to men as property. A crime of rape is one against a man's property. To this day, rape laws remain gender-specific, marital exclusion continues in many of the statutes, and victims' sexual histories continue to be entered into court records (p. 168). In an ironic twist of legal counsel, women may be urged to plead insanity to charges against them for defending themselves from male aggression and coercion, that is, from battering or rape (p. 168).

What has been presented is a feminist social historical perspective on the development of the social institutions and practices of a community that serve to isolate and marginalize certain people who do not fit mainstream values. In chapter one, I argued for a communitarian ethical approach to relieve the social strains from not belonging, and the resultant lack of access to material goods and citizen political participation experienced by oppressed, marginalized peoples. Social ethics, informed by feminist historical critique of women's roles and social boundaries, strengthens the communitarian argument (in this study) for belonging in community as an essential factor for women in recovery.

Relationality and Social Ethics

The social justice issues raised from the historical-cultural review point to origins of power imbalances which form part of the feminist ethical critique of marginalization of oppressed groups. The political perspective of the moral place of women in a just and caring society (Sherwin, 1992, p. 49-51) is essential to understanding how recovering women's personal experiences are shaped by their relationships in community. Sherwin's concerns are particularly relevant for women in addiction treatment/recovery systems because of the socialization of women in our society. Feminist ethics must provide moral criteria that do not further exploit women in the "virtue" of caring as this view tends to support their roles in inferior or subordinate positions. Caring by women has been valued by men because it serves them, and allows them to pursue their interests. Caring without justice for women, in relationships and in health and social care systems is, then, one more evidence of exploitation that is politically expedient to a patriarchal social system.

Sherwin parts with some of her feminist sisters, however, in that she believes that it is in all our interests to work toward a society that reflects gender-neutral perspectives - those that value both men and women taking the virtues of both caring and justice as a mutual responsibility. Caring and justice are both needed in society, and should not be assigned to either gender as a biologic characteristic - for there are many situations in which they act in unison to correct non-compassionate or unjust situations.

Sherwin also discusses women's oppression, which is used as a paradigm for the experiences of marginalization in this study. Oppression is seen as both a personally felt experience in the private relationships with oppressive, or abusive partners/others; and as a

public experience of lack of access to resources, and the stigma of not belonging. Being oppressed prevents one from participation fully in the external community because it disturbs the balance of reciprocity in communal relationships. The erosion of self is felt in both the private and public spheres, leading to increasing feelings of inadequacy and being trapped in hopelessness. Sherwin states that oppression [marginalization] is seen "as an interlocking series of restrictions and barriers that reduce the options available to people on the basis of their membership in a group...[while] the barriers may look innocent when examined on their own; their role as restraints may be easily obscured". (p.13)

Understanding justice and care from a feminist view of social morality, Kittay and Meyers (1987) note that for women, the private and public spheres of their lives cannot be separated; that their relationship orientation to themselves as contributors to family and society is a commonly shared and valued perspective for women. Justice and right are contextualized in their connections with identifiable people and situations - not abstracted as part of and idealized social political position.

An ethical view cannot focus only on the interpersonal oppression that is experienced. We all belong to structures of oppression which have histories and names (e.g., patriarchy, totalitarianism, racism, ageism). We must expose the systems we have inherited through social criticism and analysis. Once we accept that we are caught up in a great web of *relationality*, then to "redress injustice for the oppressed is to increase justice for us all" (Heyward, 1982, in Holland & Peterson, p. 23). Lebacqz (1987), points out that *relationality* is at the heart of the social experience of living life as a female:

> the most important tools for understanding justice will be the stories of injustice as experienced by the oppressed and the tools of social and historical analysis that help to illumine the process by which those historical injustices arose and the meaning of them in the lives of the victims. (p. 150)

It is hoped that this research will contribute to the empowerment of the participants by providing a forum for voicing their stories. The women's public expression of their experiences, both private and public, will not only help in their liberation from the oppressiveness of not belonging, but will speak to and empower others who have experienced similar situations. Finding one's voice and speaking out is a powerful way to integrate internal and external experiences, and is, therfore, therapeutic as well as emancipatory. Their voices will symbolically connect them to others in the community. This research will describe the experiences of women that show the tangible connections needed from providers to the resources of the community - needed also as part of the emancipatory experience of empowerment through recovery and belonging.

Sherwin further discusses principles for feminist ethics that are based on justice, which is understood in terms of its opposition to oppression. Accordingly, injustice cannot be morally understood outside of the context in which it occurs (p.82). Therefore, correction of unjust situations requires attacking the political and social causes that perpetuate the injustice. If our view of current treatment programs for women represents an injustice, then our critical review of how it came to be, and what values need to be confronted, is necessary to a vision of just and compassionate care in AOD treatment for women. And the role of social policy must also be critically and morally analyzed for its

contribution to the exacerbation of injustice, a consequence of economic principles that interrupt the flow of effective provider relationships and resources to the marginalized.

Additionally, because marginalized women have desparate situations and are victimized by oppressive social conditions, their needs should be addressed before other competing claims, and should include all the barriers to treatment and empowerment that have been identified in the research literature. In this way, the society 'reaches out' to these women, and invites them into the community by teaching them and supporting them in their recovery process. Addressing injustices is critical in conveying that oppression will not be tolerated in public spheres for those who belong to the community, and all should be invited to belong. In this way, the community and its people come into a "right relationship" (Hayward, 1991).

Injustice has a personal 'face' as well as the public one, and no less so for recovering women when viewed from the perspective of their childhoods. Because of the complexity of their developmental and family histories, as noted earlier, addicted women's treatment and recovery must reflect their unmet developmental and interpersonal needs. It is important for this study to raise the readers' consciousness to the moral injustice done to these women as children, so that we can begin to recognize the women in their fundamental human role, not only as mothers of children. By focusing on the women in relationship to the community as citizen-members, like others in society, and channeling appropriate treatment and resources for their long term recovery, there is the beginning of a right social and political relationship. Through its provider-representatives, the society can demonstrate its commitment to recovering women. Thus, the institutional policies and

practices will affirm that providers meet their professional and moral obligations to offer the services and resources to meet addicted-recovering women's needs.

Family Social Policy Issues

"Public policy is a matter of choices, particularly as resources become scarcer. These choices are driven by the values of those who determine the policies." (Backer, Costello-Nickitas, Mason, McBride, & Vance, 1993, p. 27). As discussed, the perspective of this proposal is that the policies that affect women who are both vulnerable to and who become drug dependent need to change. The emphasis on communitarian and feminist ethics was deliberately used to expose the relationship between social values and policy decisions that directly affect the personal and social lives of substance abusing women.

Gilchrist and Gillmore (1992), writing for NIDA, note that there is a growing awareness of the environmental factors that influence women's introduction and maintenance of drug use/abuse in their lives. They state that "environments in the form of systems and social networks exert exceedingly powerful direct and indirect influences", and that programs could benefit from intervention and prevention efforts at the organizational and social network levels. Three psychosocial factors important for recovery are: gender and gender role socialization, culture and ethnicity, and developmental maturity (p.5).

The IOM Report (1992) indicated that multiple social missions and "several socially desirable objectives" will continue to determine drug policy direction (p. 56). It is their conclusion that there is an interweaving of different strains of political and pragmatic goals (from agencies representing the justice system, the medical system and civil

libertarians) that will dominate the future of drug policy - and that no "one ideological master" will determine societal response to these problems (p. 56).

In a recent editorial in the American Journal of Public Health, Joseph Califano (1998) speaks to some of the policies that need to change for addiction research and treatment. He believes that the increasing addiction trends in the country have become a public health epidemic that requires new infusions of money for research. As the Chairman and President of the National Center on Addiction and Substance Abuse at Columbia University, he is knowledgeable about the Medicaid expenditures for the physical and social costs of addiction in our society, particularly of the infants exposed to drugs. "Of the 4 million women who give birth each year, some 820,000 smoke cigarettes, 760,000 drink alcohol, and 500,000 use illicit drugs during pregnancy" (p. 9).

Yet, from his current perspective, he is concerned that youth are using addictive substances, legal and illicit, at alarmingly high rates, "..the proportion of teens with friends and classmates who have used drugs such as cocaine and heroin jumped from 39% in 1996 to 56% in 1997." (p. 9). This perspective on the urgency to intervene in teen drug use may shift policies and resources from other programs such as women's recovery programs. These are today's mothers of the children and teens who are being exposed to illicit drugs, and it is important to maintain commitment to supporting these women in their economic struggle to provide for their families, to parent their children, and to bolster their opportunities for relationships with mentors and peers in the non drug-using community.

Policies that continue to direct resources and research towards women's treatment and recovery are necessary in order to maintain access and to improve their prognosis and

clinical outcomes. Information regarding women's experiences and responses to drug addiction in their families and their own lives has begun to inform the development of women's treatment options. While some of the information was gleaned from anecdotal clinical experience and client histories in treatment programs, there is a renewed interest in the use of qualitative research among funding agencies. Patton (1990) remarks that evaluation designs that incorporate qualitative methods improve the applicability of the research for program and policy use. Evaluation research is applied research, and "is judged by its usefulness in making human actions and interventions more effective and by its practical utility to decision makers, policymakers and others who have a stake in eforts to improve the world." (p. 12). It is expected that this study will be applicable to policy reform, and will contribute to aspects of evaluation research for programs that serve women in the community.

Ethics and Policy

Aroskar (1993), a nursing ethicist who writes about public health and policy issues, has suggested that there are ethical concerns appropriate to policymaking that include: our conduct with each other; whether our conduct is right or good; identification of our duties and obligations; and what we ought to do when ethical values conflict with each other or with other vlaues . . . .(p. 201). Earlier in the proposal, I have written that I believe ethical comportment in providing human services is implicit to the competency of a provider's practice. Professional practitioners are obligated to serve clients from an ethical as well as a knowledge-based perspective. Certainly, one of their ethical obligations is to identify

and intervene at various system levels for the emancipation of women from oppressive personal and social conditions.

Emancipatory ethics expose the negative consequences for provider-client relationships when their connections are inhibited by oppressive social policies and stigmatizing social conditions (poverty, addiction, unemployment, age, etc.). Kendall (1992) has created an emancipatory nursing model that conceptualizes provider practices that would help recipients of care become emancipated from a "disjointed health and social service system" (p. 1). In her view, the clinician should facilitate emancipation through helping the clients realize and act upon their awareness of being oppressed - as a clinical intervention. She recognizes that social oppression is counterproductive to therapeutic progress, and envisions a confrontation between clients and providers whereby providers become sensitized to the oppressiveness of their policies, and seek to reform those policies.

A feminist perspective also holds society responsible for its policies for women: "An emancipatory social science [is needed that] would provide women with understandings of how their everyday worlds, their trials and troubles, were and are generated by the larger social structure" (Acker, Barry & Esseveld, 1991, p. 135). For the women in this study, there are many concrete areas of social change that currently exist and act as barriers to interdependence and self-responsibility - improved financial status, employment/educational assistance, childcare, drug-free and stable housing, help with household management, and the many other "barriers" noted in the McMillan and Cheney (1992) article.

An assumption that has influenced family policy is the belief that the social environment is crucially important to human development. Environment, as cultural system, may support or inhibit the family's ability to successfully rear their children. Bronfenbrenner's (1979) description of the parent dyad needing support for parenting from other sources is instructive:

> An effective context for human development is crucially dependent on the presence and participation of third parties, . . . if such third parties are absent, or if they play a disruptive rather than a supportive role, the developmental process breaks down; like a three-legged stool, it is more easily upset if one leg is broken, or shorter than the others. (p. 5)

For substance abusing women, the resources and supports to care for themselves and their children are extremely important, as described earlier. Marginalization is a barrier that society has erected, is oppressive, and prevents access to the community's support and needed resources. Bronfenbrenner's ecological theory is relevant for women as persons and as mothers, and recognizes the importance of the role played by the other systems surrounding the family. It suggests that policies that affect female-head and single parent families should be constructed for flexible and innovative response to address the unique needs of contemporary families. Social policy, as manifested in the practices of recovery systems, must advocate for emancipating families from cycles of poverty, abuse, addictions, and marginalization by their communities.

Providers, Policies and Ethics

As society's agents of care, providers and their agencies occupy the relationship interface between the individual/ family and the external community. They can act as both conduits to and from the individual/family and the community and, as buffers between these two spheres when conflicting demands among systems appear. Seeing their role as an ethical duty to provide services and to help clients emancipate from a marginalized relationship with society is necessary in reforming the policies that govern the distribution of goods and resources to marginalized families. Acting as advocates and interpreters of needs is a particularly important ethical obligation of providers, an activity that is uniquely associated with professional practitioners.

As noted previously, policies are developed and revised as a consequence of multiple forces in society coming together, not the least of these, political, and evolving into sets of "shared ideas" and "conventional opinions" (IOM Report, p. 41). Since commonly held views among the lay public may contain myths and misinformation, or biases that are counterproductive to services, the providers are strategically situated to interpret the needs of their clients and to correct misinformation.

With the influence of managed care organizations, physical health care and behavioral health care (substance abuse and mental health services) have changed in terms of delivery of services, particularly since the beginning of the decade in Oregon. One of the primary reasons for the creation of the Oregon Health Plan (OHP) was to curb Medicaid costs for the poor and uninsured population (Health Services Commission, 1993). There is the belief that improved quality of care is attainable under managed care

systems, and some of that logic arose out of the economic principles for studying cost-benefit and cost-effectiveness of health care.

Hubbard and French (1991) have influenced this recent research effort by recommending comprehensive assessment of benefit-cost and cost-effectiveness studies. Cost benefit/cost effectiveness (CB/CE) studies evaluate costs of treatment in relation to outcomes for reducing treatment careers rather than agencies primarily looking at individual treatment episodes, which has been the standard way of measuring success under state regulations. They also identified the issue of unique needs of clinical sub-populations who would benefit from specialized treatment adaptations as both more clinically efficacious and more cost effective (pp.94-95).

Improvements in gender-specific care for women have emerged out of theory-driven conceptualizations of women's unique biological and social development, not from a primary concern for costs. Whether conducting CB/CE studies would enhance and empower women's treatment outcomes remains to be seen. It is important that funders and researchers carefully design such studies so as to protect and expand treatment options for women, while attempting to provide the best quality of care with the available resources.

Gerstein (1991) discussed the policy implications of cost benefit and cost effectiveness studies of treatment programs. He discussed the prevailing social view of addiction since the founding of AA, that of a moral causality for addictive behavior which has dominated policy and resource distribution for treatment and research of this condition. He points out that the cost-policy question for access to addiction treatment is raised differently by policy-makers than costs for care of other conditions:

> Underlying it [CE/CB] is an uneasiness about the moral qualities of people in treatment and . . . there is the question of the degree to which the illness has been chosen by them rather than visited upon them. Why should the public be asked to help pay for the consequences of their choices? If it is pointed out that alcoholics are not denied treatment for liver cirrhosis and other gastrointestinal ailments, nor smokers denied treatment for lung cancer and coronary heart disease, and that these, too, are the results of choices, the response is that alcohol and cigarettes are legal, and cocaine, heroin, and marijuana are not. This is not a medical distinction, but a moral one. (p. 138)

These beliefs are not limited to policy makers or lay persons, but may also apply to providers of services who are instrumental in the development of policies and procedures for their organizations.

Recipients of services can also contribute to policy reform, although their insights have not been sought until recently. Their experiences with the services and practices of providers add another level of accountability and evaluation to policy reform. Program evaluation (Quade, 1989; Patton, 1990) is an arena where the recipients of services are interviewed for their experiences with programs and providers. Recipients also may be invited to share their experiences and concerns to the legislative bodies that consider publicly funded treatment agencies and their funding by state government. Unfortunately, the confidentiality surrounding substance abusers' identification often prohibits public testimony for recovery programs, unlike those with other illnesses and conditions.

Relationality, belonging, and emancipation in community are dynamics discovered in the literature analysis that are appropriate public health and social ethical principles for policy reform with substance abusing and recovering women. As morally relevant to women in the personal and public domains of their everyday worlds, these dynamics should be reflected in treatment programs and goals for recovery. Policies, informed by providers and recipients, as well as the lay public all have vested interests in community welfare. But what is needed at this time, is the concept that not only does the family raise its children, but the whole community is morally accountable for all its children. How this is worked out is what occurs in the public debate, and in the political realm. Bringing these ethical principles to the "policy table" along with the people who have **primary experience** with the problems (recipients of services and providers) is an important step toward resolving some of the problems that have evolved from the marginalization of the population of women who are represented in this study.

ORGANIZING PERSPECTIVES

The perspectives for this research study have been identified in clinical practice experience and knowledge of vulnerable populations and their relationships with the social and health care systems. This study targets substance abusing and recovering women as a discrete sub-population who may experience similar vulnerabilities in relation to social systems. The following perspectives from the literature provide the blueprint for this research study:

1. Epidemiological data and trends demonstrate the significance of the health and social risks of substance abuse for women.
2. Research has identified promising practices for identifying and treating recovering women.
3. Recovering women must be understood in relation to the attitudes and behaviors of the non drug-using culture.
4. Social ethics with its emphasis on power imbalances, marginalization of oppressed groups, and the moral place of women in society is an appropriate lens for this study.
5. Narratives from recovering women can produce information that is relevant to interventional strategies and public policy.

Chapter Three: Methodology Description and Rationale

Interpretive Phenomenology

This study was designed to understand recovering women's experiences with providers and social systems in order to determine how those relationships can be structured to reduce the women's experiences of marginalization. An assumption of the study is that helping providers to understand substance abusing/recovering women's experiences of stigma will alert them to policies and practices in their organizations that marginalize these women.

There were several reasons for choosing hermeneutic or interpretive phenomenology as the philosophy and method to accomplish those goals. First, it provides a framework for understanding the phenomena of concern, including the ethical and intersubjective nature of this research. Second, hermeneutic phenomenology is concerned with how people experience their practical, everyday realities. This framework includes a social moral dimension that provides a conceptual bridge to the social ethics and policy interests of the investigator. Third, it provides the philosophic foundation for Narrative Inquiry, which is a contemporary methodological research application of hermeneutic phenomenology.

Using the methodology, I elicited detailed accounts of recovering women's experiences with the social system over their lifetimes. These accounts demonstrated the influences of providers of services, families, and others in both cultures, the addict world and the normative society, on the women's self identity and relationships. Use of this methodology facilitated uncovering the meanings of those experiences for the women,

particularly when applied to the practical world of social policy. Interpretation and understanding of the women's experiences described in this study were instrumental in the development of recommendations for changes in policies and practices of the community social and health care systems.

Interpretive Phenomenology as Framework for Understanding

Human Inquiry versus Positivist Science Traditions

It is important to discuss differences between hermeneutic inquiry and the positivist science traditions. Martin Heidegger (1926/1962) and M. Merleau-Ponty (1962/1979) were early 20th Century European phenomenologists who followed Edmund Husserl's original work on phenomenology. Both have written extensively on the perceptual limitations of the positivist science traditions for understanding the essential role of the experiential, everyday world of humans. Merleau-Ponty explains this difference:

> It is a matter of describing, not of explaining or analyzing [relating to the purpose of phenomenological science] . . . All my knowledge of the world, even my scientific knowledge, is gained from my own particular point of view, or from some experience of the world without which the symbols of science would be meaningless. The whole universe of science is built upon the world as directly experienced . . . [and] we must begin by reawakening the basic experience of the world of which science is the second-order expression. Science has not and never will have, by its nature, the same significance *qua* form of being as the world

which we perceive, for the simple reason that it is a rationale or explanation of that world. (p. viii)

In this description, Merleau-Ponty (1979) juxtaposes *lived experience* as the primary focus for understanding beings and their relation to the world, as against positivist science which takes the observations of the natural world as the focus of inquiry and theoretical explanation of phenomena. The focus in this study was on *understanding* and *describing* the *direct experiences* of recovering women - not on trying to establish causality for their conditions or establishing a theory of women's recovery.

Ontological Underpinnings of Phenomenology

The study of lived experience assumes an ontological view that is rooted in the existential-phenomenological school of philosophical thought. Heidegger (1926/1962) thought of human beings as being integral to their worlds, each contributing a constituting capacity in the other that he called *Dasein,* "Being-in-the-world by which every mode of its Being gets co-determined" (p. 153). The I, or the Who of Being, is therefore recognized as one-with and among others - it is significant *because* of its existential, inter-connected relationship with others. Merleau-Ponty (1979) describes this phenomenon of being through the form of body, ". . . our own body is in the world as the heart is in the organism; it keeps the visible spectacle constantly alive, it breathes life into it and sustains it inwardly, and with it forms a system." (p. 203).

Recovering women experience the world through their sensations, perceptions, emotions, and thoughts - in other words, physically and concretely, just as we all do. However, their dependence on addictive substances sets them apart, makes them

unacceptable in the community of others in society. Their experiences are shaped, and paradoxically shape them as beings-in-the-world with others in ways that are unique. From the literature and my clinical experience, we have seen that to some degree, their experience of the social world is shaped by their addiction experiences. It is also shaped by the stigma and marginalization that accompany the designation of their *Dasein* as "Woman-Who-Is-Addicted", a special category of Other that embodies social rejection and unacceptability.

Intersubjectivity. Phenomenological research is not said to be either objective or subjective. Those engaged with one another (the informants with each other and with the investigator) share their intersubjectivity through their relationships and engagement with one another. The relationship between beings, e.g., researcher and informant, and the social environments which surround them results in a dynamic interaction - one of reciprocity, mutuality, and a steady engagement. None of us can arbitrarily disengage ourselves from our being-in-the-world (Heidegger, 1962; Packer & Addison, 1989). It is precisely that engagement in the real world that is the strength of this approach for this study, because both inquirer and informant bring their whole selves to the research encounter.

The relationship that develops between the informants and the investigator becomes part of the research activity. Dreher (1994) states that " . . . the quantity, validity, and reliability of the data are grounded in the skill of the investigator to establish relationships with informants . . . " (p. 286). Part of what I bring to the research is my experience as a psychiatric-mental health nurse clinician. My education and practice in

therapeutic interviewing and in leading therapeutic groups has prepared me for this kind of research activity, which relies on establishing a relationship of trust and rapport between the researcher and the participant.

This approach provides an alternative strategy to the common problem of experimental bias that occurs with quantitative research. Not having to respond to experimental conditions, the informants are able to focus on their experiences, using their everyday language, in a setting of their choice. The inquirer is thus engaged in her informants' experiences as lived by the women, rather than attempting to extract 'data' from a hypothetical, manipulated, and distanced perspective.

Interpretive Phenomenology: Concerns with Everyday Reality

The nature of beings is understood as a social process that involves several aspects: the process is interactive and dynamic; it is essentially a co-creating activity with other beings with their social worlds. And the consequence of this relationship is an organized process that is a socially transmitted quality in humans which allows them to engage in the world, and to recognize self and other in relationship. The existential notion of Being is *body-of* and *body-with* culture.

For this study, the women can be seen as inheritors of a family culture that was in part co-created with the past and existing social systems, so that their development as human beings - their choices, limitations, and opportunities - were bounded by that co-created culture. Thus, their inherited culture influenced how they engaged in the co-creation of their own social worlds with others. The women, as research participants, were invited to describe their experiences of connecting with others and of being

marginalized by others, focusing on encounters and relationships within the personal and social realms of their everyday realities.

The inter-weaving of the personal and the social, of experience and history, as concretely lived out and described by the participants forms the complex of our understanding, even though the initial view is dimly understood. In somewhat parallel fashion, as the women's development has evolved, so does the investigator's gradual ability to interpret the texts at ever deeper levels and beyond the superficial appearance. To borrow from SmithBattle (1994), the study concentrates on the " . . . meanings, contradictions, obstacles, options, and possibilities" of living as recovering women in the community (p. 163). It seeks to reveal the social institutional responses which need to be transformed from obstacles to *recovering women belonging in community* into the reality of participation. This interpretive study has provided recommendations and perspectives to improve social policies for substance abusing/recovering women through the following: 1) accepting that multiple influences on the development of addiction are interwoven with individual and social processes; and 2) examining the discreet influences in selected individual's lives of their encounters with providers and systems.

Interpretative Process

Phenomenological interpretation is historically credited to Heidegger's description of 'phenomenon' , derived from the Greek etymology as 'that which shows itself', or 'is manifest', "visible within itself" (1962, p. 51). Simply it means, what is seen is what is. It is this accessibility through the background of familiar and shared understandings, the "ready-to-hand" mode of involvement (Plager, 1994) that engages the investigator with

the study participants and the texts of the interviews. However, the phenomenon is also more than what is only superficially seen, for it has hidden meanings which are alluded to by the *way* in which the phenomenon manifests itself. For instance, Heidegger uses the analogy of disease symptoms which indicate, or point to the disease itself which must be diagnosed, or uncovered in order to understand the origin and nature of the process. He further states that "all indications, presentations, symptoms, and symbols have this basic formal structure of appearing . . ." (p. 51), implying that nothing can truly be taken for granted as merely what it appears to be.

Interpretation, therefore, is needed to uncover the meaning of the experience for the individual. It is the mediator between the experience and the understanding; and it makes possible the act of noticing the familiar, that which is taken-for-granted, and appreciating it with fresh vision and insight. Packer and Addison (1989) describe the interpretive process as follows:

> Interpretation is the working out of possibilities that have become apparent in a preliminary, dim understanding of events. And this pre-understanding embodies a particular concern, a kind of caring. It provides a way of reading . . . a perspective (a forestructure) that opens up the field being investigated. (p.277)

Heidegger notes that interpretation of the data is " grounded in something we grasp in advance - in a fore-conception . . .” meaning that even before our encounter with our participants we have some conceptualization about the study of women’s experiences in transitioning from addiction, for instance. As a researcher, I also bring something to the study, an "involvement which is disclosed in our understanding of the world", and which

is revealed through the systematic presentation of each step of the interpretive analysis (p. 191). The interpretation does not pretend to be objective because it exists within the meaning and social context of the experience. The process for the investigator is one of uncovering or peeling back the various layers of understanding until the essence of the meaning is revealed. In this study, the women and their narratives and their interaction with me, the inquirer, produced together an interpretive understanding of what it was like for them in attempting to navigate two distinctly separate cultures.

For instance, as the investigator, I brought my concern about the phenomenon of stigma and addiction to the encounters with participants. The phenomenon was not constructed by the investigator's preconceptions or 'fore-conception'; rather the phenomenon of being stigmatized because of the condition of substance abuse exists and was revealed in the lived experiences as described by the informants. The phenomenon was revealed by the woman whose experience it is, and the research relationship presents the possibility to uncover its essential meaning as described in the woman's personal and social experiences. Through the interpretive process, then, the full meaning of the women's experiences are exposed.

Hermeneutics, from Polkinghorne's (1983) view, " . . . provides an exposition of rules to guide successful Understanding so that the interpretive effort is more efficient and so that the validity of its results is safeguarded from the intrusion of arbitrariness and subjective misunderstanding" (p.218). The guidance for conducting this kind of interpretation refers, in part, to the "hermeneutic circle" (Heidegger, 1962), a heuristic device to force continual iterations between insights, repeated interviews, and interpretive

review by others with expertise in the topic. These procedures help to refine the investigator's initial subjective responses to the narratives and, through the iterative processes, to reveal deepening layers of understanding of the phenomena of interest.

Heidegger cautions that although this may appear to be circular reasoning, by which the investigator finds what she anticipates, it is not appropriate to view the circle in this way. The hermeneutic circle must be entered properly, with an expectation of finding the "positive possibility" of the essential characteristic of the knowing; for the "circle in understanding belongs to the structure of meaning...[which] is rooted . . . in the understanding which interprets" (p. 195).

Interpretation is understood to operate in an iterative process that projects in arc-like fashion in a forward and backward manner, moving from early interpretation with the initial interviews to evolving, deepening interpretation with each subsequent interview and reflection upon their meanings. It is a continual process of uncovering layers of meaning, requiring of the inquirer openness and receptivity to the narrative and its embedded meanings. The manner in which this occurs is a combination of thinking and writing, both with computer and by hand, breaking apart and keeping whole the subtle understandings that make up the essence of the particular experience under scrutiny. A consequence of remaining open is that the investigator becomes immersed in the interpretive process, and according to Van Manen (1990), is transformed, " . . . the self, writing and reflecting, is deepened and transformed . . . writing decontextualizes thought from practice and yet it returns thought to praxis" (p. 127-8).

Interpretive Phenomenology: Foundation for Narrative Inquiry Method

Researchers have shown how social science (Josselson & Lieblich, 1993; Reason, 1988), psychology (Mishler, 1986; Packer & Addison, 1989; Van Manen, 1990) and nursing (Benner, 1994, 1993; SmithBattle, 1994; Boyd, 1993; Munhall, 1994; Gadow, 1980) have adapted the assumptions, principles, and techniques of interpretive phenomenology by using narrative inquiry as a research method. Benner (1994) described the phenomenological stance necessary for nursing inquiry, which requires the nursing investigator to be open to challenges to her initial questions in the research (p.105). That is, upon entering the interpretive research encounter - the hermeneutic circle - the researcher acknowledges the assumptions, beliefs, and cultural understandings that she brings to the study. Throughout the investigation, the researcher continues to maintain a stance of openness, inviting challenge and critique from the participants, colleagues and those who have a claim of interest in the outcome of the study. The investigator is thus accountable for the practical implications of her study as well as the conduct of the research.

I chose this methodology because it is grounded in listening to participants about their lived experiences in their worlds. Narrative inquiry not only invites participants to describe their worlds but also exposes the "social horizon" (Merleau-Ponty, 1979) against which their histories and relationships are constituted. Narrative inquiry is particularly sensitive to participant (informant) experiences as they have lived them and as they are accessible for our understanding. It is also a particularly appropriate strategy for in-depth understanding of the social conditions that accommodate marginalization and

stigmatization of recovering women, a phenomenon whose social nature requires "moral imagination" in the interpretive activity (Benner, p. 124).

While the research literature about women with substance abuse has identified their problems in the aggregate, it lacks in helping the society at large overcome its misunderstanding and stereotyping of the women. And because of political sentimentality for the children of substance abusing women, the stigma and marginalization of the women as mothers becomes justified in the public mind, and their oppression is exacerbated by the social condemnation.

Interpretive phenomenology grounds narrative inquiry in the being of the human-in-the-world that s/he experiences, at once recognizing the interrelationship of self to self and self to other - of self to separate social, family, and historical contexts - which requires the investigator to honor the participant as expert of her own experience. This forms the dialogic hub of the interview process, as the investigator opens herself to that which is not hers to know except as one privileged to participate with the informant's telling of her story. The narratives that evolve are thus personal and social by their very nature. These shared encounters are witness to the co-creating capacity inherent in humans as social beings. The intersubjective nature of the conditions of being human is part of the pre-understanding shared by both participant and investigator, each anticipating communicating and being understood in their involvement in the interpretive enterprise. The narratives are built on mutual trust and on acceptance of the uniqueness and commonality that exists for each - the participant and the investigator.

The content that is described in the narratives are those practical, everyday realities that are able to be communicated to another, "their everyday concerns and practical knowledge" (Benner, p. 112). This is no esoteric exercise free of the messiness of the concrete lived experience; rather, narrative inquiry wants to explore and uncover that which is not readily understood by applying the interpretive process to reveal that which is within the phenomenon of interest. The phenomena of interest may be commonly *recognized,* but until the interpretive process is enacted, may be *misunderstood* regarding the meanings of these phenomena for the individuals who experience them. And it is ***understanding*** that is the goal of narrative inquiry.

Another aspect that appealed to me in choosing narrative inquiry for the study is that there is a basic respect for the individuals as research participants. This stance reflects an inherent ethical orientation within the research interview that is consistent with the goals of this study. The research activity itself is seen as an ethical endeavor between investigator and participant within the methodology. The intersubjective relationship between informant and inquirer is guided by an ethical view of self which embodies at least two implications: 1) an equality between the informants' experiences and the investigator's assumptions; and 2) rigorous research practices of data management and interpretation. As a nursing study, the professional practice of caring for others as a practitioner or as an investigator includes moral obligations of conduct.

In her emphasis on not objectifying or disengaging from clients, Noddings (1984, p. 100) challenges providers to make a long-term commitment to the whole-self experience of our clients. Providers as researchers are no less challenged or obligated to

treat their research participants as equal moral beings - who co-constitute the research endeavor with the researcher. Trust and reciprocity between participant and investigator are evidenced in the informed consent procedures and in the ethical and professional conduct of the whole inquiry. The researcher recognizes the participants as the experts on the phenomena.

The experiences and meanings of recovery to women have not been explored adequately for adaptation to policy so that services reflect the everyday lives and struggles of these women in their transition to the non drug-using community. The contribution of interpretive analysis is important to this project because it is founded on a view of being-in-the-world that at once honors the individual woman in her uniqueness while also acknowledging the inter-relatedness of the person in her family and cultural milieu.

In Chapter II the traditional view of co-dependency was reframed for women in recovery using the concept of self-in-relation, or relatedness, within the cultural, gendered socialization of caring-for-others that women in our society are generally expected to assimilate. Relationship and interconnections are central themes for phenomenological ontology. For women with addictions, this belief and approach supplies a powerful alternative framework for evaluating policies that involve recovering women and their families.

Policies are implemented by providers of services. By turning to the women who have experienced marginalization from society, for their critique of services and practices of providers, this research reveals insights that will improve the ethical and clinical practices with women and their families who have been cast in stereotypic categories. A

social-ethical view of service delivery systems has the capability of transforming provider relationships toward 'clients' as people who *belong* to and who should participate in the community. Such a value-driven practice could prevent clients from becoming disengaged and could assist those who have become marginalized into re-connecting to the community. This study, therefore, takes the position that ethical services are synonymous with competent practice by providers who must be supported by sensitive and socially responsive policies in their service organizations.

Study Procedures

Sample Selection.

In narrative inquiry methodology, transcribed interviews are considered the data, and are referred to as texts or narratives. This approach maintains the interpretive focus on the experiences as described by the women, and guides the investigation away from analyses that focus on the psychology or the causality of the phenomena under study. In addition to the narrative descriptions, I have also selected appropriate textual samples from research and literary sources to facilitate the interpretive understanding. In support of using alternate forms of narrative data, Benner (1994) states that, "Multiple data sources and contexts are preferred in order to create a more naturalistic account and to prevent an overly narrow perspective on the situation" (p. 118).

In order to protect the anonymity of the participants in the study, we (the participants and I) have chosen fictitious names for presenting individual data. These

pseudonyms appear in any tables or in references to their narratives in this study. I have maintained the list of identities for accountability of the data sources.

Inclusion Criteria for Study Participants. The criteria for participation in the study included women who were maintaining their recoveries while living in the community, and who may or may not have completed a treatment program. Other criteria were:

1. Recovering women who were at least 24 years of age.
2. Women who were at least one year post-active treatment for alcohol and drug addiction or one year in recovery.

Rationale. The literature review indicates that drug abusers experience multiple episodes of treatment and may, on average, be approximately 30 years of age at the end of drug abuse and treatment experiences. For women, there are additional considerations in establishing minimum age limits: 1) drug abuse is more toxic to women and affects them earlier than men; 2) addicted women with children may be mandated to treatment in order to retain custody of their children resulting in their motivation to enter and complete treatment; and 3) life on the streets is hard for women, in particular, so that the early stimulus toward drug use may recede as they enter their mid-to-late twenties.

Exclusion Criteria for Study Participants. Younger women and teen women were excluded because my clinical experience with these age groups shows that they typically are not ready to quit using drugs until later in their addiction development. In addition, they may also be dependent upon drug abusing significant others for housing and financial support for themselves and/or their children, and cannot see beyond these realities of their existence.

Description of Participants. Eleven women agreed to participate in this study and were interviewed twice, ten women were interviewed three times. One of the women left the study after her second interview and I was unable to locate her for follow-up or debriefing of her participation. The age range of the sample was 25 years to 39 years of age (mean age = 32.9 years). Nine women were Caucasian and two were African American. All but one of the women said that they had criminal records and nine had been in jail at some time in their addiction careers, eight had involvement with the child protective services agency. Three of the women had been involved with the juvenile justice system during their adolescent years. Five of the women were divorced and with no partner at the time of the study; one woman was engaged; four women were married; and one woman was single with no partner. Three of the spouses of the four women who were married were in alcohol and drug abuse recovery.

Summary of Drug Abuse Progression. The women were born between the years 1956 – 1970 placing them within the range of many of the samples of the federal drug use survey populations discussed in the literature review (Table 1). The range of years in which the sample were substance abusing was eight to twenty-three years (x = 14.09 years addicted). The range of years of recovery (clean and sober) was 11 months to five years (x = 29.18 months).

Table 1

Participant Age, First Drug Exposure, Time Clean and Sober, Years of Addiction, and Reported Start of Addiction

Name	Age	Yr Birth	*FDE/Age	*C&S	Yrs Addicted	Report Start
Renee	39	1956	1968/12	11 mos	12 years	1982, age 26
Georgie	39	1956	1971/15	2 years	14 years	1979, age 23
Barbara	38	1957	1967/10	5 years	17 years	1973, age 16
Eve	37	1958	1969/11	1 year	10 years	1984, age 26
Helene	35	1960	1972/12	3 years	23 years	1972, age 12
Theresa	34	1961	1968/7	3 years	22 years	1970, age 9
Sherrel	32	1963	1970/7	2 years	9 years	1984, age 21
Kristine	31	1964	1973/9	2 years	19 years	1974, age 10
Rose	27	1968	1979/11	4 years	11 years	1980, age 12
Betsy	25	1970	1980/10	2 years	8 years	1985, age 15
Ruth	25	1970	1983/13	22 mos	19 years	1983, age 13

*Legend: FDE = First Drug Exposure; C&S = Clean and Sober time

The year of First Drug Exposure (FDE) ranged from age seven to fifteen years of age, but the age they identified as beginning their substance abuse patterns varied from the FDE. Two women said that they began substance abusing with their first exposure at 12 and the other at 13 years of age. Both women described physical and sexual abuse in their families/households, and ran away to drug-using environments. Ten women identified a gap between FDE and patterned substance abuse of from one year to fifteen years.

All the women were first exposed to addictive substances at home with eight of them aware of alcoholism in one or both of their parents (Table 2). Cocaine and methamphetamine were readily available, if the women had the money and access, but because of the potency of methamphetamine most of the women gradually stopped using it. Cocaine, as a rapidly addictive drug, remained the dominant drug of choice. However, as their financial circumstances were compromised in later addiction, they would return to the cheaper and available alcohol, and heroin if possible.

Like the research literature states, however, the women in this study were also polydrug users most of their drug-using years. Some of the participants discussed the depressions they came to recognize in treatment, and realized that they had been medicating themselves through drugs without understanding about their feelings. Only three of the women were incarcerated as adolescents, and one of these was actually diagnosed as bi-polar depressive, although, she frequently refused treatment as a teen, preferring to escape through drug use.

Table 2

Participant Race, First Drug Exposure Location and Drug, Progression of Drug Use, Drugs of Choice, and Criminal Justice System Involvement

Name	Race	FDE/ Location	FDE/A&D	Progression of Drug Use	Drugs Of Choice	Criminal Justice
Renee	African-American	Home, JHS, Friends	Alcohol	Cocaine, Meth.	Cocaine	Juvenile; Prob/Parole
Georgie	Caucasian	Home, Friends	Marijuana; Alcohol	Cocaine; Speed	Alcohol	DUII; Jail; CSD
Barbara	Caucasian	Home	Alcohol	Marijuana; Meth.; Cocaine, IV	Alcohol; Cocaine	DUII; Jail; CSD
Eve	Caucasian	Home	Mescaline; Marijuana	Heroin, IV; Polydrug	Heroin, IV	Jail; Probation
Helene	Caucasian	Home	Alcohol; Marijuana	Cocaine; Polydrug	Alcohol; Cocaine	Jail; CSD
Theresa	Caucasian	Home	Tobacco; Marijuana	Alcohol; Cocaine; Heroin, IV; Meth.	Alcohol; Heroin, IV; Cocaine	Juvenile; CSD; Jail
Sherrel	African-American	Home	Alcohol; Tobacco	Marijuana; Alcohol	Cocaine; Alcohol	Jail
Kristine	Caucasian	Home	Alcohol; Meth.	Cocaine; Meth.; Alcohol	Cocaine; Alcohol	CSD; Probation
Rose	Caucasian	Home	Marijuana; Alcohol	Cocaine, IV Crack	Meth., IV; Alcohol; Marijuana	Jail; Probation
Betsy	Caucasian	Home; Friends	Alcohol; Marijuana	Crack; Crank; Acid	Alcohol; Cocaine	CSD
Ruth	Caucasian	Home	Alcohol; Marijuana	Polydrug; Heroin	Cocaine	Juvenile; Jail; CSD

Text Samples. Poems and other literary works were selected to support the participants' narratives, and also to add different perspectives of women's experiences of recovery and marginalization, e.g., women coping with violence in their lives, women of other racial or cultural groups. Phenomenological research asks for contrasts and variations in order to uncover universally experienced meanings that are expressed in varying and uniquely individualized ways. The expression of extremely complex and intense emotions was difficult for some of the women, so poetic selections that captured the essence of participant experiences were used to aid the readers imaginative and affective connection to the texts.

Access to Participants. Participants were identified and selected through the following agencies who agreed to facilitate this process (Letters of Support, Community Treatment Agencies, Appendix B).

1. Addiction Recovery Association (ARA) is a community-based outpatient and residential treatment program for women and children. ARA also maintains transitional housing while women are completing treatment and awaiting public housing approval.

2. ASAP Treatment Services, Inc., provides treatment for several drug abusing populations of both genders and provides a number of gender-specific programs for women. Treatment is a three-phase process, including community-based recovery support groups.

3. Transition Projects, Inc. (TPI) is an agency that provides shelter and case management for men, women, and children. During the participant selection time, TPI

provided community-based alcohol/drug treatment and case management to women recovering from addiction who lived in an apartment house run by TPI.

General Procedures

Participant Recruitment. Participants were identified through three publicly funded substance abuse treatment agencies in the metropolitan area that provide recovery aftercare services. I approached the agencies to request their assistance in providing access to four to six women (from each agency) who met the selection criteria and who were willing to participate in the study. After the women gave their permission to be contacted, I called them to briefly explain the study and set up the first interview. In the first interview, I fully explained the study, described the expectations for their participation, answered their questions, and acquired their written consent.

One agency provided seven names of women and four agreed to participate; the second agency provided six names and all six agreed to participate; and the third agency provided one name and she agreed to participate. One woman who refused to participate stated that she did not think she had enough time to participate due to the demands of her employment and single parenting. Another woman was trying to find housing while living in the shelter and was not able to return my calls to set up an interview. The third woman said that she did not want to continue focusing on her past addiction experiences as she was trying to move forward in recovery.

Interview processes. Interviews lasted on average approximately two hours and were audiotape recorded. Participants agreed to participate in three interviews to fulfill the

interpretive methodological requirement for iterative discovery. An Interview Guide was prepared to provide structure during the interview (Interview Guide, Appendix C).

The place and time for the interviews was arranged according to the participants' needs regarding transportation access, child care availability, and personal schedules. The interviews generally took place at the end of the workday, on weekends, or in the evening since most of the women were employed. For several women who were primarily working at home or employed part time, the interviews were conducted at their homes. The small group meetings were conducted either at the home of one of the participants or at churches or other public facilities located in a neighborhood that was geographically convenient for the women. After each interview, participants were encouraged to review my understanding of their experiences and to clarify their reflections.

The interviews occurred over seven months, each occurrence taking a month to complete for all participants and with two months between each data collection period. Eleven women began the research and completed two interviews, and ten women completed all three interviews (as noted earlier). Unfortunately, the tape recorder malfunctioned during the participant's second and last interview and her interview was lost. I kept process notes after the interviews, so was able to construct much of the narrative experiences that she described in that interview.

Transcription and preparation for coding. As soon as the interviews were completed on audiotape, I sent them to a transcriptionist who I trained in the Ethnograph formatting process. The interviews were transcribed verbatim and entered into a computer qualitative database software program (Ethnograph v.4). The formatting of the

transcriptions was important to the eventual coding and interpretive process, and was designed in the Ethnograph program. The text was line numbered for use in referencing specific data samples, and ample margins were created to allow for preliminary topical coding of descriptive phrases or helpful quotes in the texts. The transcriptions were returned to me with both a hard and disk copy, along with the original audiotape recording. The transcriptionist was directed to leave underlined spaces of proper names and other potential identifying information about the interviewee on the hard copy in order to protect the participant's anonymity.

Management of tapes and transcriptions. The tapes and transcriptions were maintained in my office at my home. I will continue to retain the tapes for comparison and ongoing interpretive analysis for a brief period following the dissertation report. The tapes, however, will be erased within six months of the completion of the dissertation.

Data Collection

First Interview. The first interview was conducted by the researcher with the individual participant. During this occasion, I explained the purpose of the study and how their experiences would contribute to the research. I encouraged them to ask questions for clarification of their involvement and the purpose of the study, explained the informed consent procedures and the reimbursement arrangement, and answered all questions. I obtained their written consents to participate and gave each woman a copy for her records and kept a copy for the study files. A preliminary interview guide was developed that was semi-structured to focus on the women's family and social histories, helping me to understand some of the cultural and relational contexts of their experiences.

Second Interview. The second interviews were scheduled following transcription and early interpretation of the first interviews. The women were offered the opportunity to participate in small groups of other study participants who completed the first interviews. There are no methodological reasons to prevent the participants from choosing individual or group interviews. The option was created for those participants who prefer the group atmosphere, since this was a common therapeutic practice in all treatment programs. There are both theoretical and methodological reasons to use group interviews in a narrative inquiry. Group interviews provide the investigator with an opportunity to grasp the distinctions between the general and the particular in the narratives (Plager, 1994).

Benner (1994) has used group interviews successfully in her research for the following reasons:

1) they create a natural communicative context for telling stories;
2) ordinary speech is naturally used;
3) they provide a rich basis for active listening;
4) meanings of the stories can be enriched by stories triggered to counter, contrast, or bring up similarities; and
5) the small group may simulate a normal environment for the participants (pp. 109-110).

The last point is particularly relevant for recovering women. All of the treatment-recovery programs use a group model for therapeutic and educational purposes, especially those that are based in the Twelve Steps recovery model. Alcoholics Anonymous and Narcotics Anonymous community support groups are important relapse prevention

strategies recommended by the programs. The women were introduced to these groups early in active treatment and were expected to attend meetings on at least a weekly basis as part of their ongoing treatment, possibly for the rest of their lives. Many of the women maintained their contact with these groups for several years following active treatment.

In the study, three dyads met in addition to the remaining individual interviews. The contingencies of work and family schedules, and transportation availability made the convergence of groups somewhat difficult. When it was possible, and the women were agreeable, a small group was arranged. Otherwise, the interviews were conducted individually. Three women maintained their preference for individual interviews on all three occasions.

The content of the second interviews included clarifications of the previous material, and inviting the women to describe their experiences in more detail. During these interviews, the use of the treatment/AA jargon as the language that the women used to describe their feelings, perceptions, and experiences became an issue for the study. Because I was searching to uncover the personal meanings their experiences had for them, the jargon seemed to interfere because it was generically used by many of the women to describe similar experiences, but it did not provide the level of personal specificity needed for narrative inquiry. So, much of the second interview focused on getting the women to translate the jargon into their own terms. This was difficult, however, because the treatment programs, as noted in the data sections, were where some of them learned to identify and name their feelings and perceptions that had laid repressed or dormant for

most of their lives. At this time, also, the interviews focused on issues of their concern in adapting to the worlds of recovery in the non drug-using community.

Third Interview. The third interview provided the women with the opportunity to expand on previous material, to focus on experiences that needed clarification or that were omitted earlier, and to allow the women to talk about their reflections on their previous interviews. For the investigator, the third interview provided the time to explore in more detail and depth the experiences discussed earlier, and to include descriptive accounts of experiences that the women believed were important to the study. Two groups of three participants each met separately from the remaining four individual interviews.

Interpretive Process

The interpretation of the data took several forms and became more systematic with increasing familiarity with the data. The coding procedures that were developed by Tanner (1994) were employed throughout the study period. These included data management for each iteration of coding for themes, paradigm cases, and exemplars, as well as thoughts and discussions about the interpretive work to date. Data management was also needed for the analytic tasks related to the interviews, identifying recurring themes, unclear or contrasting themes or data, and subsequent coding schemes and/or data management.

I maintained an interpretive process notebook which contained the work in progress of interpreting the narratives over the numerous iterative stages of the reading and coding of data. These notes were useful in designing questions for clarification in subsequent interviews and as early interpretive ideas. As each interview transcription was completed and returned to me, I listened to the tape recording while checking the

transcription for accuracy. Corrections were made on the computer and new transcriptions were printed and the old ones destroyed. Corrections usually involved removing identifying names and/or places that could potentially identify the participant.

Analysis

Interpretation results in paradigm cases, exemplars and thematic analyses (Benner, 1994). *Paradigm cases* are "strong instances of concerns or ways of being in the world, doing a practice, or taking up a project", which are discovered by the researcher within the text. They are made up of everyday language, the language of the participants, and they serve as a strategy in the early interpretive process by which "perceptual recognition and understanding" occur for the researcher (p. 115).

Thematic analysis is also an important interpretive strategy because it prevents the researcher from decontextualizing the narrative into bits and pieces of material. By looking for "meaningful patterns" and inconsistencies, the researcher "confronts all the ways in which real lives and actual practices are not like a literary text . . . " (p. 115). *Exemplars* "convey aspects of a paradigm case or a thematic analysis...and they substitute for operational definitions...they add nuances and qualitative distinctions . . . that establish a cultural field of relationships and distinctions" (p. 117). For the researcher, keeping a record of exemplars helps to maintain focus on her thinking and the progress of the interpretation. Through comparison and contrast among the exemplars, the resulting analysis will produce refinement and clarification of important concepts, relationships, and meanings (pp. 117-8).

Pre-coding. Preliminary coding of each transcription consisted of making notes in the margins of the transcriptions of the topics being described in the narrative. For time one and time two interviews, colored sticky tabs were used to label particular sections that appeared relevant to the research questions and that seemed important in the women's development of self identity during addiction-recovery phases. The labeling scheme was determined in the process of reading transcriptions, based on the unfolding of the narratives and on clinical and literature knowledge. A summary was written for each interview.

Coding. Following the first round of preliminary coding and using the margin notes and the sticky tabs, I developed a coding scheme for labeling the principal topics that recurred in all the texts. Each transcription was tagged with the sticky tabs according to the emerging thematic codes.

The first coding scheme included the descriptive topics under Early coding in the graphic, Coding in Process (Table 3). In the early phases of times one and two data collections, each re-reading of transcriptions produced revised and/or additional codes. This is the work of the interpretive iterative process, because with each reading I was becoming more engaged in the narratives, noticing the veiled meanings embedded in the experiences as the women described them.

The interpretive notebook was very useful in helping to identify, code, and refine interpretations as the investigation proceeded, so that I did not lose track of important themes and could recognize others that were not as helpful or relevant as initially appeared to me. The other important function of the notebook was that it was a place for me to

record my affective responses to the women's stories. Some of the childhood experiences described by these women were so brutal, taking place in families whose own emotional chaos or despair created a milieu of violence, or of apparent disregard for the children. Writing in the notebook was essential in helping me to maintain a balance in perspective, not wanting to lose the depth of significance the experiences had for the women's development nor to misunderstand the complexities in their social and personal histories, while also retaining the perspective and distance of the other as investigator, engaged, yet looking in from the outside.

These first early coding exercises laid out the territory of the participants' addiction experiences before and after reaching young adulthood. Much of the content was laden with treatment-recovery jargon which I recognized as necessary for those women who had not learned to identify and describe their own feelings and responses. Nevertheless, it was sometimes difficult to know what a woman's personal responses were to the experiences she described. In subsequent interviews, I attempted to elicit non-jargon descriptions.

Interpreting Coded Data. As the blending of early coding and early interpretation came together, a second coding process occurred, which shows the fluidity of the interpretive process. Still dealing with time one and time two narrative data, some of the early codes were consolidated and others were expanded as re-reading and continued coding of the transcripts progressed, noted in the box. With continued re-readings and careful attention to the similarities and differences among the women's stories, the paradigm case of "two different worlds" was developed which captured the descriptive

accounts of the separateness between living with addiction (addictlife) and living in the non drug-using worlds (living clean and sober).

After the time two interviews, I reviewed the research questions to determine whether the interviews were yielding the appropriate information and were challenging the study assumptions. There were still descriptive phrases that seemed important, but I was not sure how idiosyncratic they were, nor how they might fit in the interpretive scheme. Consequently, when the time three interviews were completed, there were roughly 31 separate codes that had evolved. Table 3 demonstrates some of the coding development that occurred during interpretation of each interview at each occasion.

The subtitles, Early codes, Additions/Revisions, and Continued Additions are not synonymous with times 1, 2, or 3 interview narratives, but reflect an artificial separation of reading, coding, and reflecting in interpretive process. Use of the Ethnograph software program allowed excerpting of codes from all the transcripts. This facilitated review of groups of codes to check the relevance of the coding scheme as evolving, and allowed me to view the similarities and differences among the selected codes from the narratives. Electronic coding facilitated methodological interpretation processes.

Table 3

Descriptive Example of Early Narrative Coding Process

	Coding in Process	
Early codes	Additions/Revisions	Continued Additions
Recovery, women's issues	Tools of recovery, added more recovery issues	Clean and sober trust self
Childhood, abusiveness, issues affecting self esteem	Feelings, emotional development Grieving experiences	Depressed, lonely Controlled
Stigma (awareness), recovery groups and responses to them	Social system, normative society	Marginalized, Providers (negative) Homeless Oregon Health Plan/insurance and treatment length of stay
Drug use, treatment experiences, treatment motivators	Drugs as escape, hitting bottom, treatment learnings	Providers (positive, negative) physical condition,
Positive self, recognition of worth, related treatment experiences		Not self, self image Adoption, as related to addiction
Parenting now, being parented as child, homelife as child	Connections drawn by women between being parented and parenting, violence in family of origin	
Belonging and community in addiction and recovery		Transition

Electronic coding also helped address the ongoing concern about maintaining a methodological balance in the narratives among uniqueness and shared meanings of similar experiences in the texts.

The clustering and reduction process condensed a number of codes and produced the first of several Code Books, an Ethnograph strategy to help organize and define salient codes under particular 'parent' codes. For example, recovery became a parent code for the text codes, tools of recovery, positive self, clean and sober, transition, and recovery experiences. The Code Book was being revised regularly as interpretive work revealed comparisons and contrasts among the women's narratives, and certain codes were revealed to function more as themes across the narratives.

These procedures of pre-coding, coding, and interpretation were repeated with each transcription. Coding continued until all relevant aspects were accounted for. The final Code Book contains four parent codes: Addictlife, Providers, Recovery, and Social System. Each of these has a cluster of four to five text codes, not mutually exclusive, since the parent codes can also appear as text codes under a different parent code. For instance, the parent code, Recovery, also is a text code under the parent code, Providers. The interview summaries were also used to help focus on the individual narrative and to compare with the other narratives. Careful attention was given to texts that did not fit into the existing codes, and to those that confronted emergent codes because it is important to challenge the interpretations and to avoid pre-mature coding.

The interpretive process notebook included the following: 1) coded text segments with explanations justifying the choice of code; 2) interpretive summaries of the narratives with questions about the meaning of the narratives; 3) sections on the investigators developing understanding and images of the women's experiences; 4) paradigm cases and

exemplars; 5) comparisons among the three interview occasions and the themes that were evolving across the three occasions; 6) code books and developmental revisions; and 7) the relationship among the emergent codes and the study aims and questions. Throughout this process, a record was kept of the challenges from the data to prior opinions and biases and how the changing interpretations influenced my thinking and understanding of the women's experiences. Methodology Flow Diagrams and Interpretive Process Outline can be found in Appendix D which contain the time line and activities for development of interpretation over the study period.

Continuing Evaluation of Interpretations. In accord with established interpretive research guidelines to access as many appropriate critical reviewers as possible, the investigator involved others in reviewing the research and interpretation to date. The investigator's interpretations were subjected to review by participants, colleagues, expert researchers, the dissertation committee, and the literature.

Committee schedule for interpretive review. A systematic schedule for review of interpreted material was followed: the investigator was responsible for initial coding of transcripts, identifying themes, and interpretations. These were initially reviewed by all members of the dissertation committee for accuracy and relevance to the research aims. After the three interviews were completed, the chair and the methodology expert on the committee assumed primary roles in reviewing the ongoing progress of the interpretation. As particular sections of interpretive work were completed, individual members who possessed expertise in a particular topic, for instance, parenting or marginalization,

reviewed those sections carefully, making recommendations for revision. When the revisions were completed by the investigator, the whole committee reviewed the study sections for comment and discussion. The dissertation committee members and the investigator continued to meet to clarify and refine, probe and challenge the texts, uncovering deeper levels of meaning of the experiences as described by the participants. Between the second and third interviews, the full committee was assembled to review the work to date, and to make suggestions regarding the interpretations.

Student review group. Oregon Health Sciences University School of Nursing doctoral students who were trained in interpretive methods, assisted in providing "enriching and corrective voices to augment the interpreter's finite and perspectival grasp" (Benner, 1994, p. xviii). By this time, the investigator was ready to present to the student review group, having completed the narrative summaries, developed the paradigm case of two different worlds, and exemplars and themes through the coding and interpretive process described earlier.

The student group review provided an external critical perspective and raised issues previously unattended to from the investigator's perspectives. The students commented on the development of themes and supporting narrative data and questioned whether a social bias may have been operating among some of the women in their responses to the individual attention provided by the investigator in the interviews. They also made suggestions to continue looking for more discrete descriptions about the

affective component of caring and its relation to connection of the women to the community.

The format for review of the interpretive work was determined by the goals of the review and depending on the persons reviewing the study. In all cases, the investigator had the burden of presenting her perspectives on the data and supporting her conclusions from text citations, describing relevant background information, identifying the paradigm cases, exemplars and thematic material, and documenting the process of thinking and writing used to arrive at the interpretive statement. Several "rounds" of critique and review occurred among the dissertation committee. The participants were involved with every interview encounter in reviewing their contributions and evaluating whether their intentions were conveyed appropriately.

Systematic record keeping is necessary to document the origin and influences on thinking about the narratives and interpretive tasks. The interpretive work was completed when consensus was reached among the external groups about the credibility and relevance of the interpretations, and when the interpretive summaries and conclusions showed pragmatic application to social policies.

Confidentiality and Protection of Human Subjects

This proposal was reviewed by the Institutional Review Board for the Protection of Human Subjects at Oregon Health Sciences University for approval to begin the research (Sample Consent Form is found in Appendix E). Annual review of the progress of the

research was conducted and approved by the IRB. Confidentiality was protected through the following procedures.

Signed Consent Forms. These were stored in a separate location from the data, and codes were assigned to each participant with their names and telephone numbers being stored in a separate location from the transcripts. Transcriptions do not contain any identifying information or way to connect particular women, their stories and current lives. The audio taped narratives were maintained in a file drawer, separate from the transcriptions and signed consent forms. The participants were not able to be linked to the agencies who participated in accessing clients for the study.

The women were advised that suspected child or elder abuse must be reported by the investigator. Confidentiality within the group was discussed and strongly encouraged. Participants were informed that the dissertation committee and selected interpretive researchers were allowed to share in the interpretive process.

Risks and Discomforts of Participation. It was not expected that participants would experience undue discomfort. However, as a psychiatric-mental health nurse clinician, I have been educationally prepared and have considerable experience in interviewing and in making assessments and referrals for people in emotional distress. I informed the participants that if it appeared that any of them were experiencing significant emotional distress or reaction to the interviews, I would refer them to Professor Gail Houck, PhD, a licensed Psychiatric-Mental Health Nurse Practitioner (Letter of Agreement is found in Appendix F). I informed the participants that I was aware that they might experience some

inconvenience because of child care, transportation, and/or the time required to make arrangements to attend the interview sessions.

Costs/Compensation for Participation. There was no charge for participation in this study. However, since they could have incurred expenses related to transportation or child care, for example, I provided compensation of $20 per interview. This compensation was also in recognition of their contribution toward educating providers and the public about the substance abuse recovery and transition process.

Benefits of Participation. There is potential benefit for other recovering women in the future, which the participants said was personally satisfying to them. All of the women acknowledged that they were very pleased to describe their recovery experiences, and felt that it was important in furthering their understanding about themselves, their families, and their communities. They were particularly pleased that their experiences may contribute to providers education and system policies.

Evaluation of the Interpretation

Critics of phenomenological research retain a misconception about interpretive inquiry that it should "proceed by conjectures and refutations" (Popper, 1972, in Packer and Addison, 1989, p. 276) a view that comes out of the positivist tradition. Interpretation is then seen as researcher speculation or conjecture. As noted earlier, interpretation is not arrived at serendipitously, but its result is not some irrefutable outcome either. Packer and Addison note that there are processes for interpretive inquiry, including reciprocity between participant and researcher in the sharing of their understandings; the continual

reviewing of ideas and insights that derive from the thinking and writing processes; and bringing to light, those inadequate interpretations that are unconvincing when critiqued by others (p. 277).

At the same time, one must accept the boundaries of qualitative research methodologies, in general, in that they do not aim at timeless truths in context-free or valueless situations. If the goal is understanding the practical relevant problems in peoples' lives, and if that understanding can be used pragmatically to solve problems, then the research is justifiable. Critics of the methodology should be assured, however, that the method for interpretation is clear, systematic, and should demonstrate how the interpretations were determined. Because of the careful preparation of knowledge and experience that the investigator brings to the research, and with engagement of the participants as co-researchers in the process, Packer and Addison (1990) reply that this method "can hardly be said to foster unsupported speculation" (p. 277).

There are several ways in which to establish the trustworthiness and credibility of the interpretation. Packer and Addison (1989) identify four processes by which to evaluate the credibility of the interpretation of narrative accounts: coherence; relationship to external evidence; consensus among various groups; and relationship of the account to future events (p. 279).

Coherence refers to the "internal character" of the interpretive account. The researcher must build in questions to challenge her interpretations, so that she does not find only what she intends to see. Coherence is closely linked to confirmability, and,

therefore, must be kept in check to prevent circular validation. Packer and Addison (1989) advise that, "Coherence is not, after all, inevitable, and good interpretive inquiry will scrutinize and check an interpretation that appears coherent by searching out and focusing on material that doesn't make sense" (p. 281).

External evidence is another criterion to assess the interpretation. At the follow-up interview, participants were asked to talk about their 'intentions' at the time of their descriptions, e.g., asking what they thought was significant about their experiences when they described them. This certainly has an apparent logic, but with coherence, also has flaws in reliability, because of dependence on individuals' ability to accurately reflect on their perceptions from a later time period. Nevertheless, it does provide another check on the investigator's influence on interpretation.

Participant interpretation is another form of providing external evidence. Again, in the follow-up interview, the researcher probed for what the participants thought their experiences might mean to them now. As with the other two criteria, Packer and Addison assert that there is no objective way to validate an interpretation, since, indeed, participants' views are also an interpretation of their actions. They, too, can be misled by their own intentions or interpretations (p. 284).

Seeking consensus among researchers is another evaluative mechanism. Consensus taken alone also cannot provide an interpretation-free account, because of the fallibility among researchers to either agree with the investigator - and be incorrect - or to disagree, and also be incorrect. Packer and Addison advise that discussion among colleagues is

essential, but that a significant contribution to evaluation would be for the investigator to develop a stronger, more convincing argument than the others in justifying her interpretative account.

Finally, assessment of the practical implications between the interpretive account and future events can be applied to evaluation. Practical implications should be understood from the philosophical assumptions that guide the approach, namely, those pragmatic issues in participants' everyday experiences that are troubling for them, e.g., marginalization and liberation from dependency and social stigma. Lather (1986) described the emancipatory nature of interpretive inquiry, as follows:

> Emancipatory knowledge increases awareness of the contradictions hidden or distorted by everyday understandings, and in doing so it directs attention to the possibilities for social transformation inherent in the present configuration of social processes. (p. 259)

The thrust of this research has been identified in the practical application of the research to policies and practices that can be altered to reflect recovering women's lived concerns. Taken together with the above criteria, I believe that a rational and fair evaluation of this interpretive inquiry study occurred. However, with Packer and Addison, I am cautioned that no interpretation is value-free nor will it last for all time (p. 289).

The next four chapters contain the research data, the narratives of the women who participated in the research and interpretive summaries of each data chapter. When possible, direct quotes are used as chapter titles and section headings. The narrative

experiences are quoted within text boxes to emphasize the women's voices and to separate from the researchers commentary and interpretive remarks. Consistent with the narrative inquiry method, there are occasional uses of poetic or other literary references to provide confirmatory or contrasting examples of related experiences from others.

The data chapters are: Chapter Four: Living with Addiction; Chapter Five: Provider Encounters - Bridge or Obstacle to Recovery; Chapter Six: Parenting and Being Parented - Parallels and Contrasts; and Chapter Seven: Recovery, Transition, and Belonging.

Chapter Four: Living With Addiction

The narrative data in this study are rich with the experiences of what it is like for a woman to live with a drug and/or alcohol addiction from within the culture or lifestyle of addiction. This chapter includes descriptions of the circumstances out of which the habitual use of alcohol and drugs occurred, some of the events and sacrifices they experienced in the course of their addiction, and the experiences of giving up the addiction and its lifestyle. Their experiences took them inside at least two separate social systems, *two worlds*, the drug-using and non drug-using cultures. The following narratives develop our understanding of the differences in living in these contexts.

Two Different Worlds

Over the three separate interview occasions all of the women described experiences which indicated that involvement in either world required survival skills and knowledge that must be learned from the established culture. Ruth provided this comparison between the two different cultures:

> ***It is like two different worlds, but we are all on the same planet.***
> ***It really is like two different worlds.***
> ***I was in my own little world, with my own little people, and my own little behaviors, and my own little actions,***
> ***and my own little trips.***
> ***And now today, I am in another world,***
> ***with my own little behaviors,***
> ***and my own little responsibilities,***
> ***and my own little actions.***
> ***All that stuff that I have to do today is in another world.***
> (Ruth,l. 668-678).

At this point in her recovery, she was involved in paying many fines in various jurisdictions as part of her court-mandated directives for making restitution to society, in

lieu of going to prison/jail. Her view of the contrasts between the two worlds exposed the vast social chasm that separates them. Ruth's description of living in these two distinctly different cultures is the paradigm case[1] of Two Different Worlds, living on the streets and living clean and sober, which were described similarly in several of the other women's narratives.

Two Different Worlds

Living on the Streets	***Living Clean and Sober***
Have to know: **** how to get money for drugs/alcohol*** **** how not to get killed or kill somebody else*** **** how not to get caught by cops*** **** how to be able to pay for hotel room*** **** who you're buying drugs from: someone who's not going to get busted.***	***Had to learn:*** **** responsibility*** **** to be accountable for my behaviors*** **** to pay rent*** **** to use bus pass/tickets*** **** to respect people*** ***Society makes you deal with your past:*** **** clean up driving record*** **** paying fines***
(Ruth1, l. 164-80)	(l. 184-86; 524-45)

She continued by saying that society "*asks a lot*" of her in recovery. However, she is not resentful of the requirements of the criminal justice system or the Children's

[1] Paradigm cases are strong instances of concerns or ways of being in the world . . . (Benner, p.113)

Services Division (CSD)[2] for her. On the contrary, she welcomed the opportunities that she was discovering in the clean and sober life. For example, having never driven with a license or with car insurance, and therefore, having always to be fearful of being caught and incarcerated, she now looks forward to the freedom offered in driving legally. *"It is like, what I did in my addiction I am taking responsibility for in my recovery. And it makes me feel good...I am doing what I am supposed to be doing"* (l. 584-90).

> *It's something about, when you get clean, it's not just stop picking up the drugs. You got to change everything because along with addiction comes criminality, co-dependency.*
> *See, there's a lot of things you got to change about your life. You have to relearn everything.*
> (Renee3, l. 382-90)

Renee wanted to be very clear about not only the particular types of activities that had to stop, but how becoming clean and sober involved re-thinking everything. For instance, she explained how one learns how to think in order to perform criminal acts, as part of the addict world. Therefore, the process of recovery requires changing both thinking and behavior in learning how to live in the clean and sober world.

> *I mean [the dancing scene], that was like opening a door into this other world, that's where there was [sic] a lot of drugs. . .*
> (Eve2, l. 723-25)

Eve described her entrance into this other world that she said she did not know existed. Her interest in dancing grew out of her need to find income after a divorce, but also with an ongoing fascination with alternative culture.

2

Since the data were collected for this study, the agency's name was changed to Services for Children and Families (SCF). CSD will be retained throughout this report as the term familiar to the participants.

Barbara called the addict world a "subculture", as she grouped common activities of many of her drug-using friends: the nude dancing, prostitution, and dealing in illegal drugs (l. 219-21). Her perspective illuminates one of the negative features of this lifestyle, the demand for a personal watchfulness and fear that is part of the early indoctrination for survival in that subculture. She says, like Ruth earlier, that one has to be constantly vigilant against discovery or getting caught. Her use of the term *"expendable"* was more significant than I knew at the time. As she described later in the interview, there are some women who were considered expendable, because they knew enough about the dealers and the business of the illegal drug culture. These women avoid homelessness for themselves and their children by performing household functions or other duties determined by the dealer, in exchange for drugs and shelter.

> *What I saw,*
> *what I heard, what I knew,*
> *didn't need to be known . . .*
> *I was in a very expendable position . . . It makes you leery of trusting people, you don't want to be around newer people. You can become very paranoid.*
> *There was a lot of police infiltration so, I did a lot of observing, more observing than talking. I chose to stay in the background a lot, but I was still good at what I did . . .*
> (Barbara2, l.1483-86; 1516-25)

The culture calls a woman who lives in this situation a *"house mouse . . . they can leave if they want, but they're hooked . . . And they stay there until they die, and if they come to the end of their usefulness, they can be expired"* [sic] (l. 1405-34). Even in her recovery, she retained some anxiety about her knowledge of that previous life and of those who had threatened her, her parents, and her child if she ever revealed their names, activities, or location.

> *. . . everybody was always at my house. I got addicted to the lifestyle, because I wasn't using - all the clothes you get, the people coming to your house - I think the excitement -*
> *So, when I left him, it was like, I'm going to show you, I'm going to do what I want to do. So, I started to going to the after-hours, and I started going to the drug houses, buying dope, so everybody could say they saw me at the dope house.*
> (Renee3, l.1148-55; 1225-32)

Although Renee described living with fear in a later narrative, in this example, she talks about the sense of family or community the drug culture gave her. She loved her addictive lifestyle with her dealer husband. But after several years, she became dis-enchanted with his relationships with other women, and she was angry about his jealousy and control over her (l. 1218-20).

Before she became drug dependent, however, Renee described some of the situations that happened in her marriage. Smiling and shaking her head, she called it *"wild and crazy, madness, insanity, definite insanity . . ."* (l.2146-7). She referred to a time when her husband was in prison and, while incarcerated, sent her large sums of money from his drug deals. In addition, his customers on the outside were continuing the business and sending money to her from their accounts so that she always had lots of money. In a scenario that resembles stories of the loyalty and protectiveness of incarcerated mafia family members, her husband would also support families of his associates who were imprisoned, a kind of *"alternative welfare system"*, as she called it (l. 2134).

Several women were drawn and held in the new addictive culture by the pleasurable or euphoric feelings that the drugs gave them. There also were accompanying psychological factors that the women seemed to find release in drug use. For example,

Betsy was drawn to the drug culture partly because of a belief that she was somewhat predestined to use drugs because of her birth mother's long-term addiction. As far as she was concerned it was only a matter of time, if not at age 10, then later, but she was sure that she would have tried drugs when offered. As she said, in the beginning, she loved the feeling of being out of control.

> *I liked to get higher and higher. I liked that feeling of being out of control - I think it's an important part of it.*
> (Betsy, l. 454-62)

In another description of the euphoria and excitement of her drug use, Betsy tells of the dangerous way in which she used crank, horrifying her friends because of the risk of overdose.

> *. . . that [IV] is the only way I liked to do it, because of the rush . . . I would fall on the floor and I would start hallucinating. I wouldn't know my name for 20 minutes. That's how much I liked to do. If much, I didn't think I was high, and I wanted more. I don't know if a lot of women like that feeling, that rush, that uncontrollable . .*
> (Betsy, l. 911-29)

> *. . and I loved it, I was like, this is awesome, this is so much better than cocaine. I don't know why I wasn't doing this instead of cocaine . . . I just felt happy, I felt good, real comfortable with everybody - I felt non-judgmental and compassionate towards customers [as a wait person] . . . I thought I was just growing up - I didn't think it was the drug making me feel better - but it made me want to do things and that is when I started doing art again, after a dry spell of years.*
> (Georgie, l.2004-08; 2025-50)

Georgie talked also about the early experiences, once she discovered speed. In fact, she was not a little grateful for those experiences because, she believed, she developed an openness toward her art and family relationships, and a growing maturity.

In the following text, Renee describes her own experience as a cocaine addict. She

confirmed the dangerousness of heavy use, and described the frightening side to addiction - how cocaine alters one's perception so that every situation is a bit like playing roulette.

> *With heroin . . . you gonna nod off, go to sleep, or OD. With alcohol, you goin' to drink so much, you gonna be throwing up, be out of it.*
> *But with cocaine, you just keep going, and going, and going. The longer you stay up, the more numb you are, . . .and it's dangerous, because you are not eating, you're not drinking, . . . so you start getting dehydrated, you hallucinate . . . and you could hurt somebody, as well as hurt yourself, and really not know it.*
> (Renee2, l.692-701)

These examples show that there are ranges of enjoyment as well as danger in the women's adaptations to addictive substances and the lifestyle. In accord with Barbara's previous account, the use of illegal drugs contributes to suspicion and cautious behavior toward unfamiliar people and situations, because of the fear of being caught by the police.

Different women handled the fear and threat of discovery and the requisite deception in different ways. For instance, Renee had always protected herself by carrying a gun, so she was already accustomed to that. She ends this narrative by acknowledging that the fear related to being caught was part of the feeling of excitement connected to the whole experience.

> *I was really violent-oriented, even before I met my husband, . . . I was carrying guns because I was always by myself . . . always felt alone. . . . I would do whatever I had to do.*
> *When I got in the lifestyle that became a habit . . . then it got to be where, you know, I had to watch out for the police . . .*
> *I had to watch out for the guys that were going to come that were dope seekers, didn't have money, but they might try to rob me because he wasn't there, and all that. And that became a rush.*
> (Renee3, l. 1157-77)

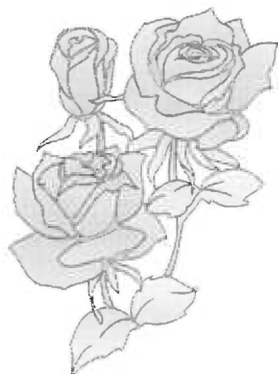
Theresa, who was in a triad interview with Renee and Helene, agreed with her about the excitement of the lifestyle and pointed out the necessity for a criminal lifestyle to maintain living in that world. She gives us a very descriptive feel for the experience of addiction and its criminal behavioral associations. The physiological and emotional needs patterns, for Theresa, became so entangled with criminality as to be mentally inseparable. Both Renee and Helene were adamantly nodding in agreement to Theresa's description.

> *. . . illegal lifestyle, behavior, people, places, and things,*
> *. . . I kept secrets, involved in a criminal lifestyle even though I wasn't getting loaded. I knew people who were selling dope, I was a part of it .*
> *. . . the excitement, living on the edge . . . that thrill - that adrenaline and constant crisis going on, being sneaky . . .*
> *. . . the stomach starts turning, the mouth starts watering, - it's a build-up.*
> *And then you get it ... and it's kind of like an orgasm. It's like foreplay and sex because it's an ecstasy.*
> *When you take that first hit, and then trying to hustle - and not get caught, then that's when fear comes in.*
> *It's not living on the edge, it's fear - you don't want to go to jail, because you don't want to be sick . . . to go through withdrawal.*
> (Theresa3, l. 21-71)

But she took the discussion of the addict lifestyle to its, now, obvious conclusion - the realization that it is fear, not excitement, that ultimately shapes the experience.

Narratives of living with addiction show how fear and excitement are interwoven in the women's daily life. However, there was the presage of disappointment that accompanied the early addictive experiences. As we travel along with these stories, we are shown the increasing loss of control, at first subtly then more violently, as the peer culture and the drugs take over the women's will.

Drugs, Abuse, and Control



The rose is a beautifully deceptive flower with its thorny stem, seductive in the anticipatory pleasure of savoring its loveliness and heady scent. But it is notorious in its capacity to simultaneously inflict pain as one attempts to hold its beauty close. The rose is an appropriate image for this section on the interplay between a woman's relationship to her partner and her drug addiction, both wielding control over her and rendering her prisoner in their grasp.

It is the entrapment in relationships that press the women into compliance which emerges from their stories. One of the messages that repeatedly screams out of the women's narratives is their experience and association between love and hurt. Several of the women learned this association at a young age through experiences of poverty and families in chaos and violence. Others learned it in young adulthood as they became indoctrinated in the ways of the addict-world. All of the women shared the experiences of physical pain and psychological emptiness that are consequences of the oppressiveness of the addiction and the relationships associated with the addict-world.

Barbara described her experience of the hurtful, controlling nature of her relationships with men during her addiction. She had to endure physical and mental abuse in order to hold onto a partner. She craved the feeling of *"closeness*" or belonging to the men with whom she lived, but this craving cost her a sense of herself and it threatened her survival. This deep emotional need for approval and connection that she lived in the

addiction culture, increasingly meant poverty and criminality, and "*led me to staying with them when they began to hit me around*" (l. 445-57).

However, her survival instincts maintained during this treacherous period, and she supplied an analogy that captured her responses to the dangers during her *"drugging and drinking"* years. She said that she was like the punching bag toy, Bozo the Clown. What she meant was that no matter how many times she was beaten down, she would always *"come back up with my fists flying, you weren't going to hold me down. . . keep popping up. I knew, and in my sobriety, my later years of the drug and alcohol, I liken it to a merry-go-round in hell. And I couldn't get off.*" (Barbara2, l.723-33).

> *He beat me, he'd threaten me, he'd threaten the lives of my children.*
> *It's a big, a lot of power.*
> *My self esteem was nowhere because I had lost everything, it seemed like, and I was coming close to losing more having him around -*
> *If I would try to kick him out he would threaten me, beat me, . . . or else try to tomorrow,*
> *after tomorrow,*
> *after tomorrow,*
> *you know . . .*

For Eve, like Barbara, the merging of pain with the need for love created feelings of powerlessness. This sense of powerlessness began to prevade their existence, and underscored the recklessness with which they lived their lives. The control was handed over to the drug, to others for approval, and, in most cases, to both. Eve described the control of the relationship defined by her drug-dealing partner. He manipulated her through her addiction and her dependence on his role as father of one of her children. In the deceptive rationalization of her wounded self, she would put off the eventual confrontation with his abusive behavior.

Later, she could recognize his manipulation of her, and her ambivalence about leaving him.

Renee added another dimension to the role of control in the substance abusing woman's life, and the early perception of being in control. But in this narrative, she admits one of her motivations for drug use - that of not wanting to feel emotionally.

> *. . . I started smoking crack, I didn't feel no more . . .crack gave me control, the more dope I had, the more control I had . . . the more friends I had..*
> *So you can call the shots when you got the sack . . . I would buy a lot of it so I would have lots to control, and I wouldn't feel anything . . .*
> (Renee2, l.1800-25)

Theresa knew about the control issue, too, saying that when *"you've got* [a lot of money] *you go buy a package because then you can be in control . . . I've got the bag . . .* [but] *you end up with the dealer's habit, which is worse*" (Theresa2, l.777-92). In these last narratives, the women express want us to understand that, regardless of the perceived benefit of their drug use, there was always a cost, whether in terms of the continued need for the drug and the ways to acquire it, or to themselves and their relationships.

These descriptions show that the initial feelings of being in control quickly give way to being controlled by the drug and the lifestyle, including the partners who were abusive and manipulative. The control contributed to feelings of being trapped, of not knowing how to get off the 'merry-go-round in hell'. The next section shows the differences between early and later drug usage, and the terror at the end.

In Pursuit of Freedom

As the women revisited their experiences of the first stages of addiction, it was clear that the entry into an active addictive lifestyle was a gradual unfolding over time, encompassing both psychological and social factors that affected their ability to make choices. They certainly did not intend to become addicted nor would they have *chosen* such a life. For several, it meant an early indoctrination into pseudo-adulthood and 'living on the edge'. For others, entering the drug scene later in life seemed to reflect their needs for freedom from relationships or situations that had trapped them in unhappiness, frustration, or meaninglessness.

Although Eve had experimented with various drugs and alcohol during adolescence and young adulthood, she did not become addicted until she was 27, following a very unhappy separation and divorce. She described a gradual sequence of alternate lifestyle changes which lead to her drug use. She believed that if the marriage had not deteriorated and resulted in her having a prolonged undiagnosed depression, she would not have thought of risking her health or her life by exposure to the drug-using world.

> *. . . those people that were there, they see that you need comfort, they don't know how to give it, so they are going to say, 'well here, take this' . . . . . And that was the kind of comfort that they knew . . . So that's what happened, I guess . . .*
>
> *If I hadn't been depressed, I don't generally want to take the kind of risks that mess with my health, because I was really into that kind of thing, being healthy.*
>
> (Eve2, l. 722-754)

She acknowledged that the depression and grief following the divorce left her in a vulnerable state - a psychological numbness that betrayed her deep sadness and hopelessness, which, even now, she has difficulty

admitting. Her new friends in the after-hours club where she began dancing responded with the kind of support they had available, mind and emotion-numbing drugs, particularly heroin.

For Georgie also, drug addiction did not occur until she was in her mid-twenties. A friend introduced her to cocaine, and she gradually began to like it, ". . . *euphoric and happy . . . it was really nice, then it turns on you"* (Georgie2, l.1755-62). In time, she had to use alcohol to "*take the edge off the coke"*. Not liking this kind of life, after about a year, she decided to move away. Within six months, she was back and started using speed which she found made her very happy (p. 6). However, she ultimately recognized that she was trapped and needed help getting out of the addictlife. She acknowledged that if it had not been for CSD, who was notified after a charge of drunk driving and striking her child as she was driving, she would have continued her addiction.

As Betsy's addiction progressed, she described the phase in which the drugs became the controlling influence over her life. As a dancer, she would work at night and this text describes her personal nightmare. (Tweaking is the term commonly used to describe the involuntary neuro-muscular responses to the drug, causing a jittery feeling and uncoordinated appearance). These descriptions present a vivid picture of the demands of maintaining the addictive lifestyle. By this point in the addiction, she was controlled by her need for the crank.

. . . would go out and buy crank, stay up all night. . . and when it was time to get ready for work I would drink a half of a fifth of vodka to lower myself down, or I would be like, really high and tweaking

When I first started drinking, I was not physical. But with the abuse that I was taking, I became meaner and meaner . . . The violent groups that I hung around with, living on the streets - just - I was literally a bag woman.
(Barbara2,l. 380-88)

Barbara described the deterioration she experienced as the drug-using lifestyle increasingly took over her life. Having been raised in a middle class home, her last statement is particularly telling about the impact of addiction on her lifestyle.

Now, totally out of control, the drug which had been such a delightful escape at the beginning turned on them. The women found themselves prisoners of an elusive yet powerful obsession. Always seeking that seductive initial high, they became willing to do anything, regardless of the cost to themselves, their families, or anyone else who otherwise might have mattered to them.

The memories of these feelings - not caring about anyone else, risking so much - were painful as the women talked about their feelings of shame or lack of shame during their addictions. These conscience-driven memories have been important to their recoveries (physical, emotional, and spiritual), as shown in the next section.

Becoming Someone Other

. . . you do not want to be around them - they will stab you in the back . . . they are a different kind . . . you totally lose your conscience.
It did a different thing to me . . . inside
it's like a Satan thing
(Kristine2, l. 740-64)

For several of the participants, living with addiction included the gradual erosion of their values, and the compromise of their morals or consciences. While they may have recognized the moral conflicts on some level [of consciousness], they were inhibited in acting from a morally driven perspective because of the demands of both the addiction and the rules of the drug using culture. There is a

theme I have called, the "not-self", that is embedded in this section. The narratives speak to what happens when one's self as a moral being is compromised within an oppressive relationship or situation, such that one ceases to be the person known as 'myself'.

For Kristine, in particular, she maintained that certain drugs were more devastating to one's moral condition than others, and that the groups who used crank were particularly amoral. As she thought about the comparison between drug-using groups, she pointed out how her own moral condition had been compromised with the use of crank, specifically. She maintained that she would not have stolen charge cards out of a woman's purse had she not been abusing crank.

> *Back then, I didn't care what I did to people. I tried to exclude kids, but I had no conscience at all . . . None.*
> *I was pretty cold-blooded .*
> (Helene, l.953-65)

Helene, who was a woman of few words, used these interviews to continue to "work" her recovery program. Twelve Step recovery work requires a "moral inventory"[3] of one's life, so it was important for her to discuss these issues and memories. Having lived for many years with criminal thinking as the primary guide to her behaviors in the addictive culture, she now reflects on how little morals or conscience affected her life. Unfortunately, she had very little practical help in these matters as a child growing up in a brutal family environment, and learned quickly that survival was the most important rule guiding one's behaviors. But, it was important for her to explain because she retained a parental concern about the effects of her immoral behavior on her children, even during her addiction.

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[3] The Twelve Steps of AA: 4. Made a searching and fearless moral inventory of ourselves. Kasl (1992).

> *Oh, I knew after about 40 days* [of treatment] *I started to get a conscience, I didn't like it...at all.*
> *Because I was scared, I didn't know how I would survive. Here I am, a fifth grade drop-out, how am I going to survive?*
> *That's* [criminality] *all I know. Nobody is going to hire me to be a security guard - I'd probably be one of their better ones, but . . .*
> (Helene2, l. 2777-87)

Her subsequent comments about developing a conscience in recovery are expressions of an anxiety that is peculiar to those who have only 'worked' at surviving. Not knowing or having experience with the surrounding normative culture, she cannot imagine her next steps of transition to this new clean and sober life. And with a wry smile, she noted that her experiences have uniquely qualified her for a position for which she would not be hired.

Barbara also reflected on the fact that her addiction *"cut into my morals . . ."* but she reasoned that she needed the drugs and alcohol every day. She was dependent upon them in order to function, so the criminal activity associated with survival was necessary even though she felt that she was compromising the morals she valued (l. 759-767).

In the following two narratives, Georgie described the ambivalence she felt about her parents' disapproval of alcohol and drug use.

> *It* [drug use] *made me really introspective. It made me realize that I really did feel guilty about a lot of things. . . . So, I felt like I was having my rebellious stage and it felt good . . . breaking away from my parents . . .*
> (Georgie, l. 2186-2213)

> *. . . I had wanted to be like, a little wild in high school, but I was scared to be wild because I thought I would get in trouble, and*
> *- what would my parents think?*
> *- what would my parents think?*
> *. . . I remember that phrase going through my head a trillion times. That just held me back until I was in my 30's.*
> (Georgie2, l. 777-86)

In a variation on the theme of drugs as an escape from family problems, this woman's drug use offered a freedom from her guilt and, thereby, seemed to facilitate her individuation from her parents' authority. Drugs and the lifestyle that they engendered provided an avenue for a rebellion that was unable to surface during her adolescence.

Betsy also had a difficult time with her drug using because of her relationship with her mother, in particular. This was not a rebellion like Georgie's, but was more about having fun and being known as different and wild. However, her mother's disapproval of her drug usage bothered her throughout her addictive years.

> *. . . and that was the conflict in my head when I used. I could never be happy with myself when I used because it was implanted in my head that what I was doing was wrong.*
> *I kept telling myself, you're okay, drugs are okay. . . . You're not doing anything bad -*
> *But I always knew it wasn't okay because of the way my mom raised me. And I hated that.*
> *I wished that that was never implanted.*
> (Betsy, l.1549-64)

These examples show that the women became aware of various moral compromises demanded of them while living with addiction. Sherrel discovered later that all those people with whom she had used during her addiction were not her friends: "*They didn't share any of my innermost values, morals . . . They didn't care about me, they only cared about what I could give to them.*" (l. 1696-1700).

There were not only moral compromises made in addiction. Living the lifestyle also challenged several women's efforts to retain any vestige of who they were at their core being. Eve was found in a motel room by EMTs after someone had called them, concerned that she might be a victim of a heroin overdose. She was very upset when they reported her as a prostitute, however. She said she had never traded sex for drugs, . . .

"and that was really upsetting to me, . . . there are lines that you draw, and, it's just one of those things." (l. 2566-76).

In a subsequent interview, Eve described the ongoing abusive relationship that she had with her partner. He had sabotaged her previous attempts at getting treatment and at becoming emancipated from him. She found that she *"was losing sight of myself. This guy had really done a number on me in five years."* (l. 1266-68). In recovery, she could recognize how much she had lost of herself under his control and abusiveness, but was perplexed as to how she had let it happen.

In yet another example of becoming someone other than who one believed oneself to be, Theresa used several metaphors to describe the control of the addiction.

> *. . . it is like living in a communist country*
> *where your life is controlled*
> *. . . like being in boot camp .*
> *. . . It doesn't let you be, you can't be yourself. You are whatever this thing makes you.*
> *It makes you become a creature.*
> (Theresa, l. 211-225)

All of the women described the gradual physical, mental, and social deterioration that they experienced. The drug and the lifestyle demanded increasingly more from them in terms of survival, and gave them much less satisfaction. Their sad stories describe the oppressiveness of their situations as they searched for ways out and for someone to help. Finally, a way was found to extricate from the addictlife. They described what they went through, an experience called *hitting bottom* which lead them to treatment and to staying in the program.

Hitting Bottom

Hitting bottom was described as a temporal experience by several of the women. It may occur one or more times during the addiction. It may also be experienced as a psychologically spatial experience in that each person's psychological limits were reached in the hitting bottom experience. There was a psychological time and place that occurred for most of the women in the study when/where they wanted out (of the addiction and the lifestyle) by whatever means possible, almost without concern for the consequences. Several women said that they had several 'bottoms' before finally making it out of the addiction. Some of their experiences were blatantly suicidal, in both thoughts and behaviors. Other experiences were framed in the contexts of law enforcement situations, in which they were forced to get evaluation or treatment. The social coercion toward treatment was acknowledged as a welcome rescue and an avenue to leave their drug-using situations and relationships behind.

Having lost or been threatened with losing nearly everything of importance to them, including their children, the women found themselves, often alone, praying for death and deliverance from the addiction.

> *At the very end, I was locked up in my apartment with all the curtains closed, I was so paranoid . . .*
> *I didn't want* [her mom] *to see me that high . . . I was so scared to talk to anybody who would come over . . . that's how low my self-esteem was, I didn't really know how to talk anymore . . .*
> *I was scared of my son, I couldn't talk to him . . .*
> *I remember, we would get some and we would shoot up and as soon as it would hit me, I would start crying.*
> (Betsy, l.1651-81)

Betsy again remembers the impact of her relationship with her mother, even during the worst of her 'hitting bottom' stage. In fact, it was her

mother whom she finally called for help. She described how the drugs had turned on her also, ultimately chasing her to a desperate and frightening psychic place. In describing this incident, she was credulous about her own fear of her son during this time, and expressed her remorse for also putting him through this ordeal.

The next three narratives are from Sherrel, Rose, and Barbara who, together, discussed what it took to finally give up their addictive life. These women, who were not usually 'pray-ers' found themselves asking for insight and deliverance from the abyss surrounding their lives.

> *I went to jail and I prayed to go to jail - straight up prayed.!*
> *I was on a two week run . . . I had actually thought about my life for 25 days; I was able to re-evaluate where my life had been, where was it now, where was it going to be if I continued to use.*
> (Sherrel, l.1769-84)

> *I too had done a lot of praying in the four or five months before sobriety came to me - that I am sick and tired of being sick and tired.*
> *Do something God to get me out of this situation that I am in.*
> *And I went to jail . . . and got involved with CSD.*
> (Barbara, l. 1752-59)

Rose was not the only woman who described at least one, but often, numerous times of trying to overdose with large amounts of drugs, frequently in

> *I was beat. I had nowhere else to go.* [There] *was only one option left, it came in that moment of clarity . . . and I thought, God, what would it take for me to stop this insanity?*
> *Lose my house, lose my kid . . .?*
> *I was so beat and so desperate and so ready to either die or change . . . God knows I was trying, I did an 'x' amount of dope thinking that this will be the one*
> *and it never was . . . there was nothing left,*
> *I was empty.*
> (Rose3, l. 1697-1711)

combinations that they were sure they would not survive.

Kristine described a similar experience, in which, for some unexplained reason, she found herself ready to admit her helplessness. Before this time, she said that she had spent the previous 10 years at a job denying her addiction and inability to stop using drugs. Like the other women, she prayed for rescue and relief.

> *It was the first really genuine prayer I think I ever said, and I just said - prayed for God to make the pain go away.*
> *I said if you are up there, I need you to make the pain go away.*
> *I was falling apart, I was cracking up - and I think that from there, was when my bottom really came up.*
> (Kristine3, l.1483-91)

> *Nuts actually ... began to think I was crazy - but I finally found out that I was okay, and I hadn't totally lost myself.*
> *I was on the way, though.*
> *I had tucked myself so far inside that I had a hard time.*
> *It took me awhile to get back.*
> (Eve3, l.120-26)

In yet another example of feeling alien to oneself, Eve found that she was not able to trust what she had known as reality. She was talking about how much emotional power her abusive partner had over her - how he had manipulated her thinking about herself and her situation.

In a particularly sad account of living in addiction, Ruth described the disconnection she felt from everyone and everything in her life - especially from herself.

> *Just, on drugs and not caring about nothing. Connected to nothing. Nothing meant nothing to me. . . .*
> *Everything meant nothing to me. . . .*
> *I didn't mean anything to myself. . .*
> (Ruth, l. 1487-93)

This section closes with a poignant poem from Neruda that captures the sense of the women's experience of the ending of their lives (as known) - of a desire for

annihilation of self and final closing off of self from all meaning and relation with others.

Cataclysm

Fear envelops bones like new skin,
envelops blood with night's skin,
the earth moves beneath the soles of the feet -
it is not your hair but the terror in your head,
like long hair made of vertical nails,
and what you see are not shattered streets,
but rather, within you, your own crushed walls,
your frustrated infinity, again the city comes
crashing down: in your silence, only water's threat
is heard, and in the water
drowned horses gallop through your death.

Stanza IX

(Pablo Neruda (1996). Ceremonial Songs. pp.97-111)

Interpretive Summary

The women's narratives have described the emotional landscape of living with addiction, from escape, excitement and the *rush* of fear to the emotional isolation from which their desperate calls for help emerged. In their eagerness to escape from threatening family situations or release from despair and loneliness in families with minimal regard for them, some of the women ran away or were sent to juvenile facilities as children/adolescents. Still others drifted towards alcohol and drugs out of a desire for excitement, relief from grief and depression, or for the sense of freedom. All of the

women ultimately were deceived by the promises that the drug-using lifestyle would rescue or liberate them from their situations.

Ironically, the satisfactions and exhilarations experienced in the early phases of drug use disappeared, to be replaced by a controlling and punitive lifestyle that demanded constant attention and servitude. Management of the addict life became oppressive, due to the insatiability of the drug habit combined with the need for vigilence and deception to protect one's self and the addict community.

In both sections, Becoming Someone Other and Hitting Bottom, the experiences reveal the women's disconnections from themselves. These experiences gave rise to the thematic interpretation of 'not being myself'. The women were constantly pushed toward abnegations of self and compromises of their moral self boundaries. They found themselves dealing with people who did not share their values, engaging in criminal behaviors, becoming violent or aggressive, or living and 'working' in unspeakable conditions. None would have chosen this kind of life for themselves and all acknowledged how addiction had contributed to feelings of shame, betrayal, and powerlessness.

When they finally confronted themselves, they typically had become so demoralized, so "other-than-themselves", they could <u>only</u> pray for deliverance. The expression 'hitting bottom' captures the poignancy of the visual associations conjured up by the women's narratives: losing oneself inward to the perception of 'being crazy'; feelings of futility and powerlessness to change life's course; perceptual walls of paranoic and suicidal isolation; and feelings of desperation in the face of the unyielding

grip of addiction. They did not feel worthy to hope for something better, but their need for deliverance from the pain of addiction overcame their doubts and hesitation.

It is apparent that the two worlds described are, on the whole, invisible from inside either one, the drug culture or the normative culture. Except for some of the human services and the criminal justice systems, the people who inhabit either world are relatively invisible to one another. For poor women living with addiction, their invisibility is what marginalizes them from the community that has certain resources and supports they desperately need.

For some of the women, their invisibility to the normative culture, however, was ultimately integrated in their own psyche, in that they became invisible to themselves. That is, the cumulative effects of the drugs and the lifestyle altered their views of themselves, and they increasingly took on the public persona of a junkie, whore, or other degrading character descriptions. In losing contact with oneself - becoming "not-self" - the women became ever more vulnerable to the definition of the drug culture and less valuable to themselves. In the final recognition of self in the hitting bottom sequence, death was preferable to living.

Their invisibility to themselves mirrored, also, the invisibility of the normative culture. Not only could they not imagine what the clean and sober life had to offer, some of them did not believe that they deserved to feel good, or to be responsible, or to belong to the non drug-using society, the 'normies'. Hope and imagination were not yet available to them but would be when they entered treatment. Along the way, the women experienced numerous encounters with providers of services who occupied the boundary

between the normative and marginalized cultures. Encounters between the participants and providers are explored in the next section, using the lens of access to resources and supportive relationships.

Chapter Five: Provider Encounters

Bridge or obstacle to Recovery

The women's narratives provide descriptions of their experiences and relationships with representatives of various human services professions. These include caseworkers from CSD, physicians, nurses, social workers, counselors, police officers, probation/parole officers, and teachers. This broad array of helping professionals are considered providers in this study. Some of the following encounters were initiated by the women because of their need for health care or police safety from domestic violence. Other encounters were initiated by CSD or the corrections system.

This chapter presents the women's descriptions of their encounters and how they were affected by the providers' responses towards them. The encounters were experienced by the women in terms of their perceived effectiveness, sensitivity to their individual circumstances, and ethical practices of providers. The encounters occurred at various points along the women's addiction-recovery careers, including prior to and following active addiction. These included experiences from childhood, adolescence, young adulthood, and recent encounters with providers. They described the contexts in which the encounters or services were provided, their expectations, and the behaviors of the providers as they experienced them.

The women who presented to these providers during their active addictions have changed considerably since beginning recovery. Possessing either a negative or a fragile self concept, the women came to these encounters with heightened vulnerability to probable rejection by the normative culture. Most remembered feeling insecure or

negative about themselves as children, and several had memories of being treated disrespectfully by those in authority. Therefore, they brought some of their past emotional resentments to these encounters. Additionally, because of the fear of being discovered as an addict, their approach to social system providers may have been guarded, defensive, or even hostile. On the other hand, the women's real need for assistance from the providers may have modified their behavior so that their requests could be met positively.

What is relevant for this study is that the women provided examples of both positive and negative types of interactions. This allows for an examination and development of the contrasts of the salient characteristics between providers who were professional, competent and caring with those who demonstrated converse qualities.

The chapter is arranged according to either negatively or positively experienced provider encounters. The negatively perceived encounter narratives have been separated into three clusters: Missed Opportunities, Ineffective Interventions, and Punitive Encounters. The positively perceived encounter narratives have been separated into two clusters: Engagement and Relationship and Walked Me Through. Each cluster is comprised of similar texts' qualities that show distinguishing characteristics of the cluster. While not mutually exclusive, the clusters provide a way to analyze for variation and comparison between the positive and negative encounters. The narrative clusters and qualities are demonstrated in a schematic at the end of this chapter.

Negatively Experienced Provider Encounters

The first cluster, *Missed Opportunities*, represents provider behaviors that ignored rather than confronted, that did not take advantage of the occasion for potential

intervention, or that showed abandonment of a professional response. It is comprised of the following encounter qualities: *Nobody Did Anything; Nobody Said Anything; No One Helped; and No One Paid Attention.*

Missed Opportunities

Nobody Did Anything. Rose described her experience of seeking legal emancipation from her family when she was 15 years old. In tone and in facial affect, she expressed her sense of deep sadness that accompanied this memory, as she had given up on her family and, in a sense, on a life she had hoped would change for the better. At her emancipation hearing, her mother told the judge that she had rented out Rose's room and that she couldn't live with her. In fact, Rose was already fairly independent, living on her own, attending school, working and essentially supporting herself. The counselor, who was present at the hearing, suggested a three month trial period. However, a letter from her high school principal helped Rose to successfully achieve emancipation as a minor.

> *They* [CSD] *failed me for so many years. There was never an intervention - we had such bad violence . . .*
> ***and nobody ever saved us.***
> *I couldn't trust the schools and I surely couldn't trust the legal system. . . . The cops were at my house repeatedly,*
> *. . . Neighbors, the school, they all knew what was going on, what was happening to us kids and*
> ***nobody ever did anything.***
> *So by that time they had lost me.*
> *It was too late then.*
> (Rose3, l. 1060-82)

As she reflected on this pivotal experience in her life, she wondered what might have happened had the judge decided to pursue the counselor's suggestion. With her mother's refusal to accept her back home, Rose said that it was too late for any family re-unification. But she still wonders what might have happened if the trial phase had been

ordered by the judge. In fact, what did happen, is that she acted on her feeling that it was too late, and she gave up caring. In retrospect, she now believes that becoming emancipated eased her absorption into the addict world, and fostered the estrangement from her family.

> *She said she knew I was doing drugs again, I was doing drugs - that's it!. So, I said, 'Fine! If you think I'm doing it then I am going to do it!' And I did.*
> *That is kind of like, if you are not going to give me any credit for what I am doing for my life today, then fuck you. I am just going to go back the way I was anyway.. . . And that was the way it was a lot of times for me.*
> (Ruth, l. 1668-80)

As a teen, Ruth was treated for bi-polar disorder and for substance abuse. At home following drug treatment, her mother did not believe that Ruth was maintaining abstinence. Ruth became angry and belligerent, insisting that she was following her recovery program. In another narrative (Ruth1, l. 1295-1319), Ruth talked about her parents ignoring her, so her comment about having become accustomed to not being believed relates to her childhood experiences in her family. This altercation, then, with her mother became the turning point for her to renounce her family and escape into the world of addiction.

Nobody Ever Said Anything**.** Renee expressed amazement that there were instances in which she was not confronted about her addiction when she clearly could have been. The first example occurred while attending a high risk clinic for prenatal care, where she thought she would be asked

> *Nobody ever said, I mean no doctor, no nothing . . . I was going to a high-risk pregnancy clinic because I have to have a caesarean . . . and I have this rare blood type, and I have breathing problems. . . and I would go to my doctor appointments. I had two kids, using drugs, and* ***nobody ever said anything****.*
> (Renee3, l. 1304-13)

about risk factors, such as use of drugs or alcohol.

The second occurred while she was in the hospital for labor and delivery, when she again expected to be challenged about drug use and was acutely aware of her vulnerability as a practicing addict. However, with no confrontation by the labor and delivery staff, on her way home from the hospital, she stopped at a dope house and got some crack to smoke.

> *. . . I had been smoking all day. I had been to the hospital like 2 or 3 times and they sent me home, and then went home and was smoking and my stomach was hurting. . . I went to the hospital, I had my baby by caesarean.*
> *They never, nothing, I just knew they were going to take the baby.*
> ***Nobody ever said anything to me about . . .***
> (Renee3, l. 1316-50)

She said that she "*gave the baby to my daughter who must have been, maybe 13 or 14 then, went up to my room and started smoking*" (l.1346-7).

In the third example, Renee had been discovered as a substance abusing woman, and was confronted with its effects on her children. She had to relinquish her children to CSD. Now, in this third example, she realizes that this was an opportunity whereby she could have been offered a choice for treatment evaluation. As an addicted mother who was losing her children, she said that she would have been more inclined to accept a referral for treatment because of the impact on her ability to retain custody of her children.

> *They took my kids, and it was better for them to take them than for them to live like they was living. . . But . . . if the person that's got the control issues it in a different manner, . . .*
> *When they took my kids, they* ***never said nothing about you need to get in treatment, or, what can we do to straighten this situation out . . . Never, ever.***
> (Renee3, l. 2299-2347)

Nobody Helped. In this situation, Eve was not offered support in getting her abusive partner out of her house nor was she given the protection she needed for herself and her children. This was an opportunity for the police to investigate the domestic abuse and to provide protection for her and her children. She needed their support so that she could make plans for treatment for herself. Since she owned this home, she was very concerned about his access and use of the house for his drug dealing location if she were not there to protect her home. She had hoped that the police would support putting a restraining order on the partner after witnessing the abuse.

> *If I ever called the cops I was hysterical or crying and upset because I had just been beat on. And the kids were there and they were all crying too, and of course he was always calm: 'Oh, I never touched her'. He'd give me a black eye and then turn around, 'I didn't hit you'.*
>
> *And so, the cops would come and they would say, 'well, this guy seems pretty rational, here she's just on drugs'.*
>
> *And they were supposed to be kicking him out, they were asking to see my arms and wanting to check my house out, when I am trying to just get this guy whose just beat me out . . . And they wonder why these women end up dead.*
>
> *Well the cops don't . . .* ***not only don't they help them****, they all but give these guys the green light to just go ahead.*
>
> (Eve3, 1.42-72)

Although Betsy was not considering providers in this next example, she marveled that no one either in the audience or among the club staff noticed the deterioration of her appearance. Neither were there any offers of

> *. . . but bruises from shooting up. God, I just wonder what I looked like. I'm sure it was obvious to someone at least.* ***Nobody ever said anything to me.*** *Here I am, naked with bruises on my arms and* ***nobody ever said anything****.*
>
> ***Not to try to help me.*** *Not that that is their place, but you would think that if I looked like death so bad,* ***why didn't someone, like, offer to talk to me or something?***
>
> (Betsy, l. 953-64)

support or concern. She seems to be trying to understand why human compassion would not have stimulated concern on someone's part for a person who must have looked so desperately ill.

Didn't pay attention. Rose described several encounters with providers who were meeting her for the first time in her recovery. She was always frightened when having to go to the clinic for health care because of the changes in doctors (those who had completed their residencies, or those who were new and inexperienced students who were beginning their clinic training).

> *I have an anniversary date that comes up every year and I went in to see the doctor, and I tried talking to her and* ***she just blew me off*** *. . . she was very brusque, almost militant I would say . . . and I told her I had post-traumatic stress, and she just looked at me and turned right back around and started writing in the chart -* ***didn't pay any attention to me*** *. . .*
> (Rose3, l. 717-47)

Parents and social system providers are the subject of these next examples, in which these adolescents were able to avoid consequences when adults do not pay attention to their at risk behavior.

> *Me and a friend of mine, somebody said they smelled alcohol on us and we got suspended for three days or something. . . . they* [parents] *fought so much, and hated each other so much, and wanted revenge on each other, so if I got caught skipping school* [while living] *with my dad, and so, if I went to live with my mom, then I wouldn't be in trouble for it.*
> (Kristine, l. 604-85)

In Kristine's narrative about school accountability, she thought that they might have met with a school counselor after this incident, but she did not remember any consequence for the behavior and no school link with the parents. And she acknowledges that she had already learned how to take advantage of her parents' relationship by

manipulating situations to avoid potential negative consequences for her. In spite of these behaviors, however, she managed to graduate from high school.

Although the school system did not pay effective attention, the legal system did when it required her to act as a witness against her father when she was 12 years old. She remembered this time with strong emotion, as her parents were separating and she felt that she and her brother were manipulated by each parent against the other. Having grown up in a violent and frightening home, the attention she needed from any outside system was long overdue. Her needs as a child for protection from violence and for nurturance had not been addressed, so her anger with her parents was intensified by their involving her in their adult problems.

> *My mom's boyfriend puled a gun on my dad and it was kind of a long drawn-out thing, and I was one of the only witnesses besides the three of them.*
> *And so I had to go to court and sit in that court . . . My mom on one side, my dad on the other, and my mom's boyfriend sitting there.*
> *And it took me a really, really long time to get over the resentment I had at my parents for that.*
> (Kristine, l. 514-30)

Ruth also experienced her family not paying attention, which she believes was instrumental to her succumbing to sexual and physical. Somehow, she reasoned, that was the only kind of love she knew and was what she apparently deserved.

> *I remember being about nine years old, standing out in the front yard screaming and crying, 'mom and dad, take me with you, take me with you', and they were. . . going to leave me with one of my sex offenders. . . And I remember going from there,* ***crying for my mom****, into the house, being sexually abused and being put to bed.*
> *. . . So, I think that sexual abuse was a way of receiving love. . . that I made it okay because this is the* ***love that I deserve****, this is what is supposed to happen to me.*
> (Ruth, l. 1295-1319)

This next cluster of encounter qualities shows providers who noticed, said, or did something in response to the women, but they showed a lack of skill or professional expertise in their handling of the situations. The effects on the women had both immediate and long term consequences for their own health and welfare, and for their children's.

Ineffective Interventions

This cluster of encounter qualities is comprised of *Lack of Skillful Attention* and *Trying To Manage Health Care.*

Lack of Skillful Attention. The following two narratives come from two women who were incarcerated at an adolescent girls' correctional facility. Although the providers noticed and responded to behavioral cues of the young women they did not seem to apply skillful knowledge in therapeutically effective ways. As Ruth described the milieu, the staff's approach of medicating the signs of emotional upset among the girls fostered the girls' manipulative responses.

> *. . . you know, you can talk a psychiatrist into almost anything. Believe it or not. They give that stuff away like candy.*
> *. . . 'oops, she's climbing the wall, better give her something' . . . 'oops, she is hyper, we better give her something'*
> *. . . 'oops, she is having bad dreams, we better give her something'*
> *. . . 'oops, she's depressed, she might be suicidal, we better give her something'.*
> (Ruth, l. 1533-43)

Theresa was also sent to that facility when she was a young adolescent because she was becoming increasingly unmanageable by her mother. She did not recall any particular staff response to the drug abuse among the girls. In

> *. . . and I went to my first girls' home. And I was introduced to LSD . . . I thought that was kind of cool, watching things enlarge and stuff. I used to handle, like acid, watch things grow. Things talk to you that weren't there.*
> (Theresa, l. 648-56)

discussing this period of her life, she remembered numerous experiences with caseworkers, special education teachers, and counselors who "*would scream at you . . . just why can't you just get this, you are screwing up your life. . .*" (l.699-706). She described how the child welfare system tried to respond to her by transferring her to different workers every time she moved, finally classifying her as high risk, ". . . *and you would go through 13 caseworkers and they would all do the same thing.*(l. 729-33). She said, about herself, that she was one of the 'throw-away kids' at that time, meaning kids who no one knew how to handle in the system.

> *. . it made a tremendous impact due to the fact that (*treatment agency*) was not acting on the behalf of the clients who were of minority cultures.*
> *We had no interaction with other health providers who could assist us with our issues . . . of **my culture**.*
> (Sherrel, l. 1410-1430)

Sherrel was the only woman who talked about cultural issues in treatment and felt that the treatment agency was particularly insensitive to this as an important issue for ethnic women in recovery. Even though she always had friends from her own and the dominant culture, she said that she wanted mentors or role models from her own culture. With so much of recovery focused on self concept and identity, she felt that the agency lacked an appreciation for the importance of cultural role models for their ethnic recovering women.

> *The doctors said I had a chemical imbalance. They didn't run any kind of tests or anything. . . and they put me on these pills. That was it. The end of it. Released me. . .*
> (Kristine, l.1066-71)

Kristine provided an example of a health care situation that, again, did not result in her having to confront her addictive

disease (recall the previous adolescent situations). This text comes from her reflection on a hospitalization for an attempted suicide. She said she realized, later, that her feelings of desperation that fueled the suicide attempt were, in part, related to withdrawal from a cocaine habit. She said that she had become accustomed to substantial quantities of the drug that had been supplied by her recently separated partner, but which she could not afford on her own. Following the separation, she overdosed on 'speed' hoping to relieve these symptoms. But she became ill and frightened, and was finally taken to the hospital resulting in admission for a brief stay.

Kristine described attempted therapy, but, because she always fell asleep, the therapist told her to return when she could stay awake. There must have been a psychiatric diagnosis since she received antidepressant medication. However, she did not understand what this meant to her nor that she should have medical follow-up upon discharge from the hospital. Although she realized that she was not ready to quit using at that time, she was surprised that none of the staff directly confronted her about drug abuse or offered any treatment options near her home (in the neighboring state from the hospital).

Trying To Manage Health Care. These next two examples demonstrate the proactive role these recovering women had to play with physicians who either did not know how or who refused to treat them for physical conditions. Barbara's experience with physicians in the community health clinics demonstrated her sensitivity to the provider's not managing her physical care within the context of her recovering from addiction. This put more responsibility on her for guarding her identity and also her

recovery gains. As an accomplished addict, she was attuned to doctors who would let drug addicts manipulate them for prescriptions and so she terminated the relationship with the first physician.

Regarding the second physician, Barbara was cautious about prematurely informing him of her recovery status lest it frighten him. She had hoped that giving him a chance to know her as a person would reassure him of her recovery and help to maintain the clinical relationship. Barbara waited several months before telling him of her recovering status. Her strategy backfired and he ultimately refused to treat her.

> *This was a doctor. He has since retired, but he would have written a prescription for anything. The second one that I had, and I had him for several months before I told him that I was in recovery. I immediately got a letter from him saying that your ideas of your health care and my ideas of your health care greatly differ. I suggest you find another doctor. . .*
> (Barbara, l.307-316)

Renee described her experience of attempting to manage her physician's care of her physical health within the context of her recovery needs. In this experience, she was in recovery but her asthmatic condition necessitated health care attention and she had to go to the clinic over a weekend. So she was very open about her situation when she saw the

> *I didn't want any narcotic drugs. They gave me these pills to take, said they weren't narcotic. I found out later they were Tylenol #3. . .*
> *. . . they gave me a bottle of cough syrup to take home with me,* [later] *I looked at it and it says, Robitussin AC. . .*
> [she called the clinic] *'Now, I said that I don't want to take this medicine, because what I know is when I start feeling down, I want to feel up, and what I do to get up is cocaine. I'm going to want to take a hit'.*
> (Renee3, l.2063-92)

clinic physician and nurses. Her abstinence was hard-won, and she said that she did not want to risk her recovery by taking medications that would remind her body of drug abusing patterns. Since she was unable to persuade the weekend staff of these concerns, she had to wait to be seen by the Nurse Practitioner on Monday in order to get safe medications.

In this last cluster, the encounters have a mean-spirited property to them, in that providers did not merely ignore or dismiss the women, but seemed to consciously want to wound the woman's spirit. There is a punitive quality (hence the cluster title) to some of the behaviors and these narratives display negative stereotyping.

Punitive Encounters

This cluster is made up of the encounter qualities, *Trying To Do Right* and *Treated Me Like A Junkie.*

Trying To Do Right. During her years of addiction/recovery, Theresa has had many provider encounters which did not invite collaborative relationship. This example comes from an early recovery time in which she wanted to show that she could act responsibly. However, the provider focused exclusively on the infant and did not recognize that she already felt guilty for how her behavior had jeopardized her infant's health.

> *He was telling me how **I didn't deserve to have my baby,** and that as long as I did drugs, my baby, all his problems were going to be my problems, it's my fault. You know, I'm dealing with guilt,. . .*
> *- tell me I didn't deserve to have my baby, they should take him right away - . . .*
> *No, I was clean, I was in treatment, I was trying to do right, . . .*
> (Theresa3, l.2205-25)

It was upsetting to her that he would not allow her to assume the appropriate mother role and that he also did not appear to give credence to her recovery status. His threatening and hurtful comments served only to infuriate her. She left this encounter in tears, incensed that he presumed she did not care about her baby.

> *CSD has taught me a lot, they've helped me a lot. But when I wanted help for my second daughter I had to threaten physical violence to get attention.*
> *Since I had priors from that [*behavior*] they took her, and **I was looked at as a dirty dog** today.*
> *Last night and right after court, I felt like . . . I wanted a bong so bad I could taste it . . .*
> (Helene3, l. 2437-47)

In an another example of a humiliating provider encounter, Helene expressed her distress in remembering a recent experience with CSD. Her child was acting out and showing other signs of needing psychological evaluation and help. Although not educated beyond the fifth grade, her many experiences with agencies over the years taught her how to get the help if she believed that the system was not being responsive to her children' needs. It is a testimony to her love for her child that she submitted to the disapproval of the workers in order to get the help that was needed. That she could refuse the temptation to find the old, reliable, comfort she knew in her addiction showed her commitment to maintain recovery and her parenting relationship.

Rose, also, has had numerous experiences with providers during her life and in treatment and recovery. And, although she said that she was accustomed to being humiliated, this encounter stands out because of the harshness of the provider's behavior.

> *When I had 30 days clean and I went in and I said, 'I am an intravenous drug user, I need an AIDS test. I have no veins, and I don't want to be traumatized', because they always* ***made me feel bad*** *because they can't find a vein where they want to find a vein.*
> *They will look on my legs, they have to look down my arms, wherever there happens to be one, and I would always get negative [vibes].*
> *I had one lady [lab tech] say, '* ***this makes me sick, I'm leaving'.***
> (Rose3, l. 364-75)

Treated Me Like a Junkie.

> *. . . and he* ***didn't give me my respect****, he treated me* ***like a dope fiend, like a junkie*** *. . .*
> *I said fine, if that's what you want to think of me, then that's what I fucking am, I'm a fucking junkie. And that's the way I come off to people . .*
> (Rose3, l. 484-9)

Having to go to the community clinics meant that Rose would often see different practitioners. Meeting a new provider and explaining her recovering situation was always risky in terms of the unpredictability of the provider's response.

> *. . . even after I had told her that I haven't done anything for so long. . . . She just* ***didn't believe anything*** *. . .* ***pulling my fingers apart, trying to find track marks*** *on me to this day.. . . She was asking me all these questions and they started getting to be out of context.. . . Finally she threw her arms up in the air and she said, fine, I tried to help you. I said, 'Look, I cannot admit to something that I didn't do and I'm not going to say I'm guilty when I'm not' . . .*
> ***She is supposed to be an impartial party****, she's a judge, and here she is telling me that he was doing this - and I was right there with him, and she just knows that is what happened, - so far from the truth that I just couldn't believe it.*
> (Eve3, l. 465-520)

In this next situation, Eve had petitioned the court for a trial in the hope that her side of the story could be told. She was still trying to protect

herself and her children from the violence and abuse that they suffered from her drug-dealing partner. Judges have a great deal of power when it comes to sentencing people who have been charged with possession: they may choose to offer treatment rather than incarceration and they can approve or deny a right to trial. So she realized the importance of this hearing for the ruling on her parental custody rights of the child she shared with this abusive father. It was very hard for her to understand why the Judge would not take into consideration her treatment and recovery status, as well as the abusiveness that she and the children had endured from this man. She was very insulted at not being believed about her recovery status, and felt publicly humiliated by the physical examination of her hands and arms in the courtroom.

Interpretive Summary of Negatively Experienced Encounters

These narratives were clustered into ***missed opportunities***, ***ineffective interventions***, and ***punitive encounters***. In the negatively experienced encounters, the women felt dismissed or ignored (nobody did anything, nobody said anything, no one helped, no one paid attention), believed that providers did not apply sound professional judgment in either assessing or intervening in their situations (lack of skillful attention or trying to manage health care), and/or treated them punitively (trying to do right and treated me like a junkie). The theme of *not being noticed* has again been shown as a constant in the women's lives. These providers did not demonstrate skillful practice and did not seem to care about whether their procedures or behaviors made a difference in the lives of the women. Not listening, not responding, and not doing were experienced by the

women as not caring and, over time, seemed to contribute to their frustration or giving up hope.

Not caring in all these examples prevented the development of relationship between providers and the women and resulted in significant consequences for the women and their children. The consequences of not caring were seen as obstacles for the women's access to treatment (Renee, Kristine, Ruth, Betsy), to justice (Eve, Rose, Sherrel, Ruth), and to other community resources (Theresa, Barbara, Helene, Rose, Eve). Presenting obstacles to resources by not attending, effectively intervening, and not caring are examples of the distribution of suffering that was identified in the literature review (Ophir, 1996). The narratives of themselves cannot label these provider behaviors as intentional or inadvertent - they point to the women's responses and to the consequences for the women, which provides the ethical critique of providers' clinical practices.

<u>Missed Opportunities: Early Intervention Opportunities.</u> The examples of the women as children and adolescents, as well as mothers trying to protect their children from domestic violence, demonstrated the need for community-level support and therapeutic intervention with their families and themselves. Rescue from family dysfunction, violence, and abuse are clearly in the interests of the children, families, and the community. The lack of expert attention seemed to contribute to the overall hopelessness that the women felt about themselves later in life. The instances of avoiding confrontation and intervention with women during their child-bearing and child-rearing times certainly prolonged the ultimate devastation their children experienced when CSD

finally was notified. Providers demonstrated behaviors that the women experienced as not caring enough to do what they were trained to do as professionals in their fields.

Ineffective Interventions: Intermediate Intervention Opportunities. These encounters demonstrated a lack of provider expertise so that even though there were interventions, they were ineffective. And, because the women did not believe or experience concern or help, they were put in the position of trying to arrange for their own help. From the examples of the girls' correctional facility and the ready access to psychotherapeutic medications, the lack of psychiatric hospitalization follow-up, to the inappropriate and harmful prescriptions for a woman in recovery, these provider encounters did not address accurate or appropriate evaluation and intervention needs of these girls/women.

Social and health care providers, whether directly or in supervising others, are trained to evaluate situations and connect clients to appropriate resources. To not do so, given the examples described, is a breach of their professional ethical code. But it is also important as a justice issue, because they are denying their roles as advocates for those who have no voice or standing in the community. The community has the goods and the resources needed for health and welfare of individuals and families. The providers in these examples did not evidence an awareness of the importance of their roles in accessing the resources for their marginalized clients.

Punitive Encounters: Require System-Level Intervention. These narratives describe unethical professional conduct that should not be tolerated within the social and health care systems. These behaviors and attitudes are further examples of the oppression

and marginalization experienced by the women, in this case, by respected representatives of normative society. The previous two clusters of provider encounters also caused various kinds of harms, and may have been products of stigmatizing attitudes in those providers who did not respond or who responded ineffectively. This cluster, however, is qualitatively different, because it is personally oppressive but not necessarily publicly visible. It can only be rectified through education and enforcement of organizational systems' professional values of ethics and compassion.

The control and authority that is vested in the professional provider system is embedded in providers' clinical and legal responsibilities - this gives them considerable power of office. When providers used their power in punitive or stereotyping ways, the women in this study experienced negative consequences: one, it was emotionally destructive and reinforced their negative self image; and two, it pushed the women away and made them less amenable to seeking treatment or to maintaining their recovery.

The negatively experienced encounter narratives showed that the women were disappointed by the attitudes and behaviors of these providers' practices. They expected clinical expertise in assessments and interventions in their situations, and they believed that they should have been treated with more compassion. What they described was a kind of cognitive dissonance - they thought the providers would know more about addiction-recovery processes than they seemed to, and that they would be more respectful and concerned about clients regardless of the cause of their symptoms.

In their active addictions, they were hurt by these encounters because they were so dependent and vulnerable in their need for help from providers. As the women reflected

on these encounters during recovery and abstinence, they were insulted that these providers did not recognize their recovery efforts. And they were angry because they felt that their worth as human beings should not have depended on their addiction-recovery status.

Positive Provider Encounters

These encounters present a marked contrast to the previous ones. Providers who affected the women positively displayed concern and skill in the performance of their practices. Not only did they recognize the complexity of the individual women's situations, they collaborated with them to understand how they could be most effective. Some providers went out of their way to provide services and acted as coaches in helping the women learn the art of maintaining a relationship that fostered self esteem and mutual trust. The clusters of positive provider encounter qualities include *Engagement in Relationship* and *Walked Me Through.*

Engagement and Relationship

This first cluster of positive encounters includes provider behaviors that demonstrated skill and commitment in performance of their disciplines' procedures. These narratives involve several pre-treatment encounters with providers or contacts who were accepting of the women regardless of their abstinence. Other narratives are from experiences during post-active treatment, but early recovery. These providers were clear and direct with the women, were supportive even in confrontation, and demonstrated excellence in their practices. The qualities that comprise this cluster are *Skillful Assessment*, *Authoritative Engagement*, and *Believed in Me*.

Skillful Assessment. In this first narrative, the community health nurse used skillful interviewing in order to determine Kristine's drug of choice, which seemed to impress

Kristine. The nurse found Kristine at a crucial time in which she was financially vulnerable, had lost nearly everything, and was pregnant. She found timely help from the nurse, who was pivotal in helping her acknowledge her addiction and to seek treatment.

> *. . . She asked me if I used crank. I don't know why she asked,* ***she knew, for some reason*** *or another, and I said, yeah.*
> *That's where it happened. I started talking to her,. . . but I was pregnant at the time. So, talking to her and then the girls from the shelter, then one thing led to another. . .*
> (Kristine3, l. 1427-37)

In another example of skillful listening, assessment, and intervention, this physician communicated real understanding of Sherrel's symptoms and began mentoring her in another aspect of maintaining recovery. He was also in recovery and knew how to integrate his care for her physical, spiritual, and emotional recovery. She had been trying, unsuccessfully, for about a year after treatment to get relief from a systemic itch. She knew it was part of the long-term withdrawal process but had been unsuccessful in treatment approaches with several doctors. This doctor treated her as a

> *And when I went in to see him, he didn't want to see where it was, where I itch, he wanted to* ***know where was I at today****. And every time I go into visit him,-* ***one day at a time*** *- . . .*
> *He gave me a pager number where I could reach him, . . . and he would say things I needed to hear. 'One day at a time. If you have to, one second at a time'; 'stop and think'; 'meditate and pray'.*
> (Sherrel2, l. 115-55)

person, and focused on providing for her emotional security as well as her physical symptoms.

Authoritative Engagement. In this next text, Barbara had just about run out of options to continue with her addiction. She acknowledged that she had wanted to stop using, had prayed for help in quitting, but thought that she could not stop without convincing her husband to do so also. Barbara had not had many experiences with providers before getting a DUII (Driving Under the Influence of Intoxicants) citation, a state-mandated alcohol and drug use evaluation. She and her husband were in a violent argument on the highway, so they were jailed and the baby was taken to foster care. The CSD worker's professional and direct approach impressed her. Although there was the threat of loss of custody, Barbara did not experience this as punitive. Rather, the caseworker was convincing and the whole experience engaged her rational thinking, which she had abandoned during addiction. She did not want to risk losing her daughter. In fact, later she could say that this was the answer to her prayers.

> . . . *the evaluation appointment,* [the CSD worker] *you be there, if you're not there I'm going to come get the baby.*
> *You have an intake appointment, you be there, or I am going to come get the baby.*
> *And I* ***knew this woman meant business.***
> (Barbara, l.1113-18)

Renee was confronted with this same reality and potential threat, only it was conveyed by a friend, a former addict who knew that she had relapsed again. He was concerned about her without threatening or shaming her. He was working with a community HIV/AIDS needle exchange program so he was out in the drug-dealing neighborhoods and could try to persuade her to enter treatment, no matter how many times she relapsed. He was effective and persuasive and she said that she often thought about what he said. She was grateful for his 'being there' and reaching out to her when she needed his reminders to change. She credits him with helping her to make this her last relapse.

> *I'd be out there and I was pregnant, and I had a son in the car or in my arms, and he'd come up to me and he'd go, 'You know, they're going to take your baby if they catch you up here' . . .*
> *Then I wouldn't go in the dope house, but be waiting for my boyfriend to bring it to me . . .and* ***he would be there*** *every time, . . . and he would tell me, 'the shame isn't in coming back, the shame is in staying out' . . .*
> (Renee3, l.236-49)

Theresa also received encouragement prior to her decision to quit her drug abuse. She described the support she received from an OB physician who had helped with her babies before. Even though she was currently using drugs, he maintained his primary concern for her well-being and for her pregnancy. Although she repeated this story with a sense of humor about his

> *I had bruises all over my arms. . . he told me that* ***I did it before, and I can do it again*** [get clean] . . .
> *And* ***he was going to see me whether I was using or not****. If I didn't show up for my next appointment, he was going to come to my house, and he knew where to track me down . .*
> (Theresa3, l.1469-78)

following her to her house, she conveyed that he was quite serious about continuing her prenatal care regardless of whether she was abstinent.

> *. . . and **she was my everything**, and to this day is my everything. She's the one that taught me to stand up to doctors. . . nurses, and fight for what I need.*
> *When I relapsed when I was pregnant with* [son], *I went to the OB that I was seeing and her first reaction was, I can't see you anymore.. .*
> (Theresa3, l. 1433-45)

She also was followed by a community health nurse who has maintained a commitment to her for many years, during her addiction, relapses, and now during recovery. Theresa said that '*she was my everything*', in terms of providing some of the nurturing and acceptance that she had not received as a child. And, importantly, she taught her how to interact with the health care system and its providers. After this incident, she talked with the hospital's patient advocate about her experience with the medical student.

Believed in Me. Eve described the importance of the provider's competence and belief in her regarding her custody battles. Eve had initiated numerous court challenges for custody of the child from her last partner, the father of her young son. Her experiences with the corrections and legal systems were usually insulting and she never felt as though she could adequately convince the judge or attorneys of her abstinence and recovery. However, she was tenacious in her quest to keep her children together, even though she had experienced repeated humiliation and disregard in trying to win maternal custody.

Previous public defenders had not acted on her behalf primarily because they were either incompetent (according to her) or did not believe that she was serious about her

abstinence and recovery. The fact that this attorney believed her was refreshing and affirming, which enhanced her courage to continue fighting for custody of her son.

> *For a public defender, he was real good, on top of things, he has his own investigator and stuff.*
> *And he would gladly have taken it to trial for me, because **he truly believed me. . .***
> (Eve3, l. 692-99)

The next cluster of narratives are derived from experiences the women described with providers in and outside the treatment system. These providers were inspirational in helping the women understand their uniqueness and supporting them during difficult challenges in recovery.

Walked Me Through

The emphasis of these narratives is on expertise in knowledge and application of the providers' disciplines, with the ability to guide the woman along new paths toward increasing confidence and competence. These providers encouraged mutuality and collaboration as they taught the women about interdependent relationship. The encounter qualities include *Supportive and Assuring Safety, Mentor and Guide*, and *Caring Confrontation.*

<u>*Supportive and Assuring Safety*</u>. Early in treatment, as Kristine was preparing for her court appearance, she was guided in the process by her counselor and surprised that her counselor would accompany her to court. She was also surprised by

> *. . . **went in with me** and I turned myself in for forgery and she said there was no way I would be able to turn myself in and not go to jail for at least one day. And she prayed and I prayed, and she called in, and I just had to go in to arraignment. I never had to spend a day in jail.*
> *That was when I did the best I could with* [counselor] *help and prayed to make this work.*
> (Kristine3, l.697-708)

the demonstration of caring and constancy of her counselor. This experience established a trust in their relationship that encouraged Kristine to work hard at her treatment and was not something Kristine expected from treatment.

> *My first doctor always* ***made sure I was safe.*** *When she had the psych come in to evaluate me for the antidepressants, she said, "I'll be your go-between - if you don't want him in the room, I'll talk to you, I'll go talk to him, and I'll come back and talk to you'.*
> *And that's the way she treated me throughout*
> (Rose3, l.753-62)

Rose was diagnosed with bi-polar depression during her treatment evaluation and was seen by physicians at the primary care clinic. The reassurance that she was safe was extremely important to her, because of her abusive history, and this physician was both sensitive and skillful in her treatment of Rose.

> *So, I went back to* [program] *and they didn't want to let me go after that because of him, . . . going into that a couple of times with black eyes and they wanted me to stay there because they could* ***kind of protect me,*** *. . . she* [counselor] *knew what was going all the way through - what I was planning on and everything that happened.*
> *She was real* ***supportive****, and she just kind of helped me keep my head about things - and made sure that I wasn't going to relapse. She was amazed that I didn't.*
> (Eve2, l. 897-902; l.1220-28)

Eve discussed her return to treatment after her partner had sabotaged the previous effort, which stimulated another relapse for Eve. This time, she was more receptive to the program and staff, finally accepting that there was no way to continue the relationship with her partner if she and her children were to be safe. She, too, was grateful for her counselor who encouraged and guided her in strategies to prevent another relapse. This provider understood and accepted Eve's vulnerability, and imbued her with strength and confidence in herself.

Georgie enjoyed the fact that her treatment counselor was not in recovery like others in the agency. And the fact that the counselor was compassionate and listened to her, accepting her as a unique person, was essential for Georgie's engagement in the treatment relationship. She said of her counselor that '*she was like talking to a friend'*, and she *'made me feel good'*. Rather than stressing her addiction, the counselor encouraged Georgie to claim her competence as an adult woman, '*it was nice to have somebody recognize that, to reaffirm my own suspicions that maybe I did know what I was doing.'* (l. 349-72).

> *She* ***listened.*** *She didn't have an alcohol problem herself, but her family did. So I felt like she had a slightly different perspective on things. It's one thing to talk to somebody else who has a problem with drinking, which can be a good thing.*
>
> *But it is also very refreshing to me to be talking to somebody who had never had a problem with drinking, who could look at it from . . . because I had* <u>*never*</u> *had a problem with it my whole life, so I felt like she was representing another part of my life. And she was just really* ***compassionate*** *. . .*
>
> (Georgie3, l. 215-30)

In another discussion about the importance of being treated as a unique person, Georgie found support from her counselor in seeking an alternative approach to the traditional twelve-step treatment program. One of Georgie's objections to the AA approach was the requirement to make one's primary identity that of being an alcoholic.

> *She seemed to recognize right away that the AA thing was not something that would work for me . . . that I am intelligent and that I question and analyze things . . . saying things like, 'I wouldn't recommend this for everybody, but I have a feeling it will work for you',* ***made me feel like an individual*** *. . . she really gave me a lot of leeway . . . and let me in on a lot of the decision making rather than telling me what I needed to do . . . I wasn't just another DUII coming through the door.*
>
> *(Georgie3, l. 262-80; 313-36)*

She talked at length about how dis-empowering the

introduction of self as an alcoholic was to her. Since it is part of the standard procedure in the community support groups, Georgie could not understand how women, especially, moved beyond that description into something that represented one's creativity and uniqueness. As an artist, these were very important personal expressions for her, and she did not want to fragment herself into sick and well parts.

Mentor and Guide. Not only are human services providers and other recovering women critically important to women's recovery, but so are employers. Kristine's employer acted as a mentor in helping her to adjust to new roles and responsibilities as she made the transition to the normative society. The employer provided employment security and various opportunities to help her develop independence and competence in the job.

> *My boss tucks me under her wing and has* ***taught me stuff*** *I never would have got the opportunity to do . . .*
> *She* ***sent me to school*** *to get my ____ license, everything. She hired me because I reminded her of her, I kept bugging her.*
> (Kristine2, l. 479-87)

In another example from Rose's experience with her first physician during treatment, she said that she

> *My doctor took me in at 30 days and worked for me for at least a year or year and a half - she ran all kinds of blood tests, helped me try and stay eating nutritious, and helping me with what would agitate me and what wouldn't.*
> *. . . Her thing was I can't believe you lived through it all . . . And with 10 months clean I just lost it. She talked to me about depression, getting on antidepressants, and I battled with her for a long time over it because I didn't want a pill changing my attitude or anything, but it became really severe,. . .*
> *and* ***she walked me through that,*** *and let me know I wasn't crazy, and that I could get off it at any time . . . she got me a scholarship to the Y because she thought I needed more exercise. She just did everything for me. She helped me stay in treatment for as long as I needed, she just really worked with me. . .*
> *And if I wouldn't have had her, I don't know, she was so* ***understanding*** *and* ***loving*** *and* ***compassionate.*** *And I educated her . . . she couldn't understand the streets that I had come from or the things that I had seen.*
> (Rose3, l.390-459)

'*walked me through*' the process of learning about her body and its needs and symptoms. Rose appreciated learning about the radical changes the body experiences over the long term of withdrawal an grateful that she was also learning how to interpret the symptoms so that she would know how to manage them in healthful ways. In addition to managing her physical recovery, this physician provided the kind of emotional support that was highly individualized and collaborative. Like Theresa's nurse, the support and affirmation of worth helped to create a more assertive stance toward the health care establishment and a knowledge of what to expect and how to advocate for one's needs. Her caveat about teaching her doctor about the streets showed the mutuality and collaboration that evolved out of their rapport.

> *She was very* ***inspirational,*** *she taught me a lot about who I am as an individual and what recovery is all about . . . . and I wanted what she had so much that I was willing to go to any lengths to* ***follow in her footsteps*** - [to become a counselor].
>
> (Sherrel3, l. 2619-27)

Sherrel changed her life because of her relationship with this inspirational treatment counselor. This counselor's impact - spiritual as well as behavioral- gave her the career direction she was seeking.

> *She was* ***really mad*** *at me. . . I was really mad, and the rebellious part of me thought how can she talk to me like that? And it stuck with me.. . . she wanted so bad for me to stop being so co-dependent of other people . . . I hated to see other people taken advantage of.*
>
> *That was just life's lesson, I guess. . . and I learned, because I let myself be abused for years. I needed to learn to get out of it . . . to know that somebody that I really didn't know, that she* ***really cared****. I saw a lot of feeling in there, in her. So that was neat.*
>
> (Kristine3, l.1203-28; 1887-97)

<u>Caring Confrontation</u>. Kristine described an exchange with a counselor in a group treatment session, in which the counselor yelled at her. She was both surprised and

insulted, initially, but then realized that it was exactly what she needed in order to face her own self-denial. In her past family experiences, and relationships, she said that she had always '*walked out*' when there were disagreements or unpleasant situations. This was one of her strategies in avoiding responsibility for her actions (Kristine, l.680-85).

Betsy had a similarly emotional experience of self-discovery in treatment through her counselor. Her gratefulness resided in the expertise and relationship of the counselor who 'knew' what she needed and guided her through the transition to self acceptance and recovery.

> *I really bonded with one of the counselors and she would just, like, pick on you. She knew just what to pull out of you and make you cry, every time. And everyday, for like a month, there I was crying everyday in morning group. And I was looking forward to it, too. I was like, all right, cool. I am going to go crying . . . because she would bring it out and you would feel a lot better afterwards.*
> *She* ***really knew what to work on****, type of thing. For me, that was a good experience.*
> (Betsy, l.1913-19; 2011-17)

Interpretive Summary of Positively Experienced Encounters

Positively experienced encounter narratives were clustered into two categories, ***engagement and relationship*** and ***walked me through***. These encounters were characterized by the women in terms of the providers noticing them as situated in particular contexts and caring about the consequences to the women. Providers who were experienced as positive, effective, and professionally ethical used a variety of effective and caring strategies: confrontation, providing timely feedback, showing commitment regardless of abstinence status, and helping to anticipate potential. These providers

extended themselves toward the women, inviting them into a relationship in which they experienced caring and competent practice.

Interpretation of these encounters revealed that the women experienced them as skillfully managed by providers who showed attentive listening and questioning which resulted in appropriate intervention for access to treatment, community resources, and health care. The providers' behaviors and attitudes showed expert understanding of the women's whole situation, engaged the women as particular persons who had addiction problems and required unique treatment, and used timely confrontation of the women to help them understand and accept their options.

Confrontation was always done within the relational context that existed between the woman and the provider. The confrontive encounters showed providers who mediated the discomfort in the situation by providing supportive but direct challenge to the women's usual way of thinking and behaving. The women seemed able to trust these providers with their self disclosures and the providers responded by not abandoning them. They were supportive and understanding of the women's pain, indecision, or rebellion. The acceptance of the woman by the provider was not contingent upon her success in quitting her addiction. In contrast to the negatively experienced encounters, acceptance was unconditionally offered, and the relationship recognized her struggle and desire to achieve recovery, even in the midst of lapses/relapses of the addiction.

Walked Me Through is a beautiful exemplar that was articulated by Rose. It provides the image of the provider who is constant, uses her knowledge to prepare the client for changes and transitions, and does so with care and sensitivity. A number of

providers were represented in this exemplar in the narratives. One of the aspects of this kind of encounter was the collaboration that was shared between the provider and the woman. The women were encouraged to take responsibility for identifying problems and potential solutions, as providers maintained their presence and support. These providers demonstrated their professional intuitive judgment in gauging the women's ability to follow or to take the lead in decision-making. Their competence was their ethical practice and who they were, essentially, in their professional roles.

This chapter is about providers - their practice expertise, compassion, and professional ethics. And it is about the women - their needs for relationship, understanding and acceptance of self, and development of self esteem and competence in managing their recoveries. What the narratives show is the **relational intersection** of these two kinds of persons - substance abusing women as clients and providers of health care and human services.

Providers and the women of this study each are products of their own personal histories and the social milieus in which they were raised. For providers of services, they have been enculturated by their professional training and ethical codes of conduct. Providers in professional clinical disciplines have ethical obligations to use their knowledge and training to assess and intervene in client situations in such a way not to harm their clients but, hopefully, to improve their clinical outcomes. The client-provider encounter is the occasion that prompts a complex dynamic between the provider and the client as they each bring expectations to this relationship.

The women also were enculturated in the beliefs, values, and codes of conduct in the addict-world, influencing their expectations and behaviors towards encounters with providers. Even though they may have needed health care for themselves and/or their pregnancy or newborn, as addicts, they were reluctant to reveal anything about themselves that might have compromised their safety, custody of their children, or their drug addictions. These women brought physical, emotional, and social burdens from their complex personal histories. As addicted women coming to these encounters and accompanied by their self-protective behaviors, they, undoubtedly, were challenging to the providers from both diagnostic and service perspectives.

Providers of human services are often the gateway into systems that have access to or can provide many resources and services for survival and a minimal quality of life, especially for poor and at risk women and children. These clients have histories of obstacles to receiving timely, effective assistance from impersonal service delivery systems. The women in this study appreciated the providers who humanized these systems, making it possible for them to overcome some of the negativity of their social and psychological histories - and opening the gates to an empowered relationship in the community.

Through their successful completion of treatment, they discovered and celebrated their new-found self esteem and were compensating for the personal and social wrongs committed during their addictions. Making restitution to society is their way in to the community, by re-paying the debt owed and acknowledging their respect for the rules and expectations in the community (as noted in Chapter Four). An affirming response is

needed from providers that recognizes the reformed social status the women occupy in their recoveries. When providers did not acknowledge the importance of this aspect of the women's recovery process, they undermined the foundation of the women's engagement and belonging in society.

Cluster Schematic for
Negative and Positive Qualities of Provider Encounters

Negative Encounter Clusters

1. Missed Opportunities
   Nobody Did Anything
   Nobody Said Anything
   No One Helped
   No One Paid Attention
2. Ineffective Interventions
   Lack of Skillful Attention
   Trying to Manage Health Care
3. Punitive Encounters
   Trying to Do Right
   Treated Me Like a Junkie

Positive Encounter Clusters

1. Engagement & Relationship
   Skillful Assessment
   Authoritative Engagement
   Believed in Me
2. Walked Me Through
   Supportive and Assuring Safety
   Mentor and Guide
   Caring Confrontation

CHAPTER SIX: PARENTING AND BEING PARENTED

PARALLELS AND CONTRASTS

The title of this chapter derives from the dilemmas described by the women as they wrestled with their own developmental experiences and those of their children. The women talked extensively about being parented and about parenting issues with their children during their addiction and recovery times. In treatment, these women/mothers were helped to face the consequences of their addiction for their children. The narratives in this chapter manifest the women's grief and guilt over the hurts, fears, and traumatic beginnings of their children's lives.

None of them had intended this for their own children - although they understood how it evolved, especially as they began to appreciate the implications of their parenting practices upon their children. They confronted this painful awareness during treatment as they learned about the role of self esteem in parenting and in comparing their own childhoods with those of their children. The treatment programs helped them to learn about developmental needs and milestones of growth for their children; and they were also instrumental in helping them understand their own family histories - the formation of and expectations for relationships and belonging. For women who had not experienced nurturing in safe and stable families, and for those whose development was not affirmed with care and encouragement, the need for learning about self esteem and parenting skills and concepts was significant. The treatment programs provided not only the didactic education, they also guided the women in new experiences with their little children who attended treatment with them.

As the women began to understand the impact of how they were treated as children in their families, they gradually made the connections to their children's experiences. Learning about feelings and emotional development and the role of self esteem in the development of the self was both frightening and helpful to the women. As they came to understand themselves they also had to understand their children's behaviors - it was at this juncture in their recovering journey that the parallels between themselves and their children emerged.

Some of the women's infants had been adopted at birth due to the mother's young age, because the babies were born with drug effects and required specialized care, and/or due to the mother's continuing addiction abuse patterns. Most of the women had relinquished custody of their child/children for some periods of time to foster care or adoption as a consequence of child protective services involvement. These narratives witness to the women's ongoing efforts at integrating their complex personal histories and their hopes for their children's futures - legitimate and inspiring themes for recovering mothers. The themes identified in the narratives were: Self-esteem and Identity, with sections on the role of adoption and custody experiences, and Belonging and Connection.

Self Esteem and Identity

One of the commonalities discussed by the women upon entering treatment was poor self esteem and a tendency to distrust other women. Their lack of feminine identity was a consequence of their difficult relationships with their mothers and other women. For some, it was first felt in their families, where they experienced abuse or neglect, or

where the emotional distance or lack of caring by their mothers influenced later emotional dysfunction in the women's personal relationships.

> . . . ***she wanted to keep us little.*** *So, not suffocating in the way, it's not like a boundary thing. I just always felt, you know, get a life. I don't want to be your reason for living.*
> *It really bothered me because I didn't feel the same towards her. I know she obviously wanted something from me that I had no experience of giving and didn't want to experience.*
> (Georgie2, l. 223-33)

Georgie's interviews contain many descriptions of family relationships and experiences. They are filled with ambivalence and seeming contradictions. Much of the conversational material indicated frustration with the way her own mother tried to raise her, throughout her childhood.

She thought her mother was distant when she was younger, conjecturing that her mother '. . . *was sad, lonely, and sick and tired of moving for the hundredth time.'* (l. 282-86). She said that her father had to move the family frequently around the country with his engineering jobs. As she approached puberty, her mother initiated a talk about sexual issues, and Georgie said that she felt violated in some way by her mother's invasion of her privacy.

> *I had not been used to talking to her so I felt that I,* ***my privacy was being invaded****. I was really uncomfortable with it. I said 'okay' to her but inside I'm going, 'I will never talk to her about anything.'*
> (Georgie2, l. 163-68)

On the other hand, she and her father have shared intellectual interests and artistic tendencies (Georgie2, l. 640-47). While this relationship appears to be more convivial Georgie, nevertheless, discussed at length how she felt both parents influenced her lack of self identity and confidence, contributing to her search for belonging and affirmation in her drug-using lifestyle (Georgie, l. 2186-2213; Georgie2,

l.777-86).

Rose lived in a violent, unpredictable, and very abusive family throughout her childhood. She described many frightening experiences at home in which she was either wakened from sleep or non-verbally signaled by her siblings to quickly leave the house before her father became more violent towards their mother or, perhaps, turn on the children. She described the fear and ambivalence towards her parents in one of her wakeful nighttime periods.

> *And I remember looking out the window with my dog, thinking, god, I hope they don't come home. And then thinking, oh god, they'll probably get in a car wreck. . . and* ***just fighting with myself.***
> *Not wanting them to come home because I knew what was going to happen, yet wanting them to because of fear of the unknown. . .* ***what happens if they don't come home.***
> (Rose2, l.893-903)

Developing effective parenting was important for Sherrel because she resented her mother for denying her an adolescence, which she described as a period in which she had to perform for her mother - in her eyes, had to meet her mother's needs rather than being valued for who she was as an individual. Unfortunately, a series of family tragedies happened when she was about 15 in which, Sherrel, as the oldest child, had to function as the mother surrogate for the five younger siblings, abruptly suspending her adolescent development.

> *So,* ***who else was going to fill in.*** *And so that's how I learned. And she rewarded me with the gifts. . . so I was doing her needs, neglecting my needs. Got to look good, got to be there, got to be the best for mommy. That's just how it was.. .*
> (Sherrel2, l.2452-60)

Later, because of the addiction that was consuming her life, this pattern was

repeated for her own child who also had to assume parenting responsibility for her younger siblings.

> *I have a nine year old who is about to be ten, and she had to grow up fast in the early beginning because she had to take care of her two little sisters. So* ***when she was five, she was doing mother stuff****. . . she is very mature, and some people mistake her for being 12 or 13. . .*
> (Sherrel3, l.1337-49)

> *A prime example of her enabling trait was the last couple years of my addiction . . . I had moved back with my mother and my siblings due to the fact that I had lost my housing certificate. . .* ***She would never call CSD and report me*** *and that allowed me to continue to use, in spite of the negative consequences.*
> (Sherrel, l. 326-39)

Sherrel described her mother as enabling in their relationship, and also manipulative in getting her to take care of the younger children by giving her gifts. Sherrel said that she did not understand at the time, but, during treatment, she realized that her own identity had been at stake. She recalled that feelings and concerns were not discussed in her family of origin, that other family members were addicted and this was kept as a family secret, and that her mother's inability to confront her addiction had worked against her getting treatment earlier.

But she believed that what she had learned during treatment was having a positive influence on her children and how she was parenting them now. She was studying to become a chemical dependency counselor and she and her husband applied what she was learning in her classes to her family and children (Sherrel2, l. 2412-4). Parenting in recovery was not easy, however, as she discovered the conflict of needs between herself

> *I had to get a sense of what it is like to be normal and interact with my children without the use of drugs. It is very difficult for me at this day and time because I have always had a bottle to drink when crisis* [sic] *came up.*
> *I always drank to escape - So, it is like now at times I feel that my children are very needy, and* ***sometimes I am not emotionally available*** . . .
> (Sherrel, l. 848-58)

and of her children. She needed to make sure that she continued to practice the 'tools of recovery' - which means not thinking or behaving in old addictive patterns. But she also needed to be able to respond to her children's needs as she was teaching them to trust and rely on her as their primary parent.

In subsequent interviews, Sherrel talked about how the parenting was improving, how she and her husband were successfully working with the school to provide a consistent approach with her middle daughter who had developed manipulative tendencies. Sherrel believes that she is breaking a pattern of co-dependency between herself and her mother. She is determined to give her children the freedom to talk about whatever they are thinking or feeling as a means to help them cope better than she did (l. 543-48; 1873-4).

Barbara also talked about how she had applied what she had learned about expression of feelings in her treatment program to parenting her daughter. Specifically, because she had been taught not to talk about feelings and unpleasant subjects in her family, she taught her daughter how to express her feelings directly and immediately.

> . . . *the words for feelings. She never had a hissy fit as a child because I gave her 'frustrated', 'I can't do that', 'that's wrong'.* ***I gave her feelings, words for her emotions.*** *So she was able to verbalize and get it out.*
> (Barbara3, l.1439-45)

Rose, Sherrel, and Barbara all had children who shared the experience of

attending their mothers' recovery meetings, and they agreed that it is important that the children not be ashamed of their mothers but that they understand the progress they have all made as families because of recovery. Rose's daughter started going to recovery meetings with her when she was four years old. At one point, the three women shared a laugh when they discovered that their children had learned to suggest that, "Mommy, I think we need a meeting." For Rose, a central issue is that she does not want to forget her past because " . . . *it's never going to go away. . . and I'm never going to push it under the rug. I didn't have an advocate when I was a child and so I'm my advocate now.*" (Rose3, l.1618-22).

Adoption and Custody Experiences. There were three women who were adopted and who described their difficulties with self identity and the sense of belonging in their adoptive families and the external community, especially during their early through late adolescence. Betsy, Renee, and Barbara separately raised the issue of being adopted, and how important they believed that to be as they grew up, became chemically addicted, and searched for identity and belonging with others.

> *You know, when I was 0-9 months old I never had any motherly attention. I never had that bonding with a mom. When I was little, they* [adoptive parents] *would visit me and I was always left in the crib. The back of my head was bald because I was never picked up, and my diapers were always dirty. I think I lost out on a lot of that. A lot of it.*
> *And then I started using drugs so early, I never had a chance to know who I am and only now, you know,* ***I'm 25 years old and I'm like trying to figure it out.***
> (Betsy, l. 1104-12)

Betsy was told about her early infancy from her adoptive parents, who were related to her biological mother. With each interview, she raised the issue of bonding and the neglect she believes that she received in her early infancy. Her biological mother's history and

continuing drug addiction leads her to believe that she was genetically predisposed to becoming addicted.

Barbara did not know the circumstances of her birth parents. She is unique among the women in the study, in that she remembers a relatively happy childhood until about age eight, when she moved from the eastern area of the United States to the northwest region. She said that she had none of the violence or abuse often associated with women who become addicted to alcohol. But she thinks that being adopted was connected to her subsequent substance abuse patterns - feelings of emotional insecurity, lack of personal identity, and her susceptibility to being attracted to and accepted by a marginalized group, the addiction community (l. 445-57).

> *I was six months old when I was adopted and I had been at the agency for a couple of months. So, I am sure that* ***that lends credence somewhere in my make-up to being insecure. Oh, I'm sure it does.***
> *You know, at birth I was with my parents and then going to the adoption agency, being in foster care, then coming to my parents - now, all this happening in six months' time.*
> (Barbara, l. 411-21)

Renee has several 'families', but does not know her biological family. She has been told little of the circumstances of her birth, primarily that her [adoptive] father and his first wife adopted her. When she was two years old, this woman, her first adoptive mother, died. Her father was in military service at the time, and his brother and his wife took care of Renee for about a year. Her father and his new wife then came to bring Renee back to live with them.

> *I was probably about 3 ½ or so, and I remember them in the kitchen, and her* [her aunt] *saying to him* [her father] *that if you are not going to treat her like she is yours then leave her with me.*
> [her father said] *I am bringing her with me and I will raise her.*
> (Renee2, l.819-830)

> *It's still missing - I still want to know who I am. Especially since I've gotten clean . . . who my parents are and who my family is. That is why I was **really angry with my father**, because he did not think enough to say - he told me the judge asked him 'anything you want to know?' And he said, 'no, seal the records.'*
> (Renee2, l.632-39; 723-28)

She said that she was never allowed to understand the mystery that surrounded her birth and the family's secretive responses to caring for her. She expressed strong emotions about being prevented from trying to discover her biological roots, and, therefore, her familial identity.

Although her adoptive family was financially secure, she said that the money was unimportant to her in comparison to the desire for knowing her biological family and feeling like she belonged to them. Her adoption and being prevented from knowing the reality of her birth-parents colored her experiences as a child and as a mother.

> *. . . everybody always talked about how much I had, and I never felt like I had anything. - **What I saw that I wanted that I didn't have, was that*** **[close family ties].**
> (Renee2, l.1874-77; 1831-4)

Mother-child closeness or bonding was seen as particularly important to these adopted women, because they felt that they had missed out on critical relationships with their biological mothers.

However, for Theresa, it was in her last foster home that she felt like she belonged. She said that in her last foster home she finally had some indication of what a normal family life could be. But she ran from there as well, much to her later regret. As a young teen, Theresa was usually caught running away from her mother's home or foster

> *. . . and I was really okay there . . .*
> *I really felt like I was a part of something.*
> (Theresa3, l.1363-5)

home placements. Finally, as a ward of the state, the CSD brought her case to the court saying that they had no appropriate placements for her. At the last hearing, her biological mother refused to accept her because she said that she could not control her. So Theresa was truly on her own, she was *'homeless for the first time, I mean, totally.'* (l.1375-6).

> *. . . well, my mom, she smothered me, literally, she would hug me until I couldn't breathe. I hated it.*
> (Eve2, l.628-32)

For those women who were raised by their biological mothers bonding did not necessarily occur so they described feelings of insecurity and confusion regarding their sense of self and acceptance in the family. This applied in those families of study participants who were not economically deprived or where there was not abuse or neglect, for example with Georgie (as noted above) and Eve. Eve also described a difficult relationship with her mother. She said that she was aware that her parents had not planned for her birth and thought that she was left alone more than her siblings. Although her mother would play with her she was also strict, and Eve would choose to play alone rather than get into a fight with her mother.

Belonging and Connection

> *Well, I remember the fear watching my parents, it* ***was so much scarier when you are the kid*** *than when you are doing the fighting.*
> *Now that it's over, I remember how I used to feel and I think, man, she was really having a horrible outlook on life to start with. She really did.*
> (Kristine3, l. 1118-25)

Escaping into addiction was not seen as a life choice for the women especially when it occurred during their early and mid-adolescence. What they wanted, to varying degrees, was to find relief from emotional pain and sometimes, to escape from physical and sexual assaults they

endured in abusive environments. The search for safety and security was elusive in the addiction community, but there was an unconditional acceptance by that group of peers who welcomed them as one of their own. Therefore, acceptance and understanding that was missing in their early years was found later among the addiction community, but the price of that association was very high, as noted in Chapter Four.

In these narratives, there is, again, the alternating reflections on themselves as children and as parents of their own children. It is difficult for them when they looked back and realized that similar patterns of relating had been replicated in their own offspring. The theme of belonging and connection arose among the women's stories, whether talking about their path to addiction, parenting their children, or their recoveries in treatment and upon transitioning to the non drug-using community. With few skills for living responsible adult lives, the demands of parenting their children in recovery created additional threats to their self esteem and added stresses in their contacts with the external society.

Often, as in the next narratives by Kristine, the children show through their behavior the depth of their emotional disturbance as a result of what they have encountered during their mothers' addiction lifestyle. For Kristine, parenting education was crucial in helping her to deal with the implications of this for her child; but she had to get there by resolving some of her own childhood abuse effects on her emotional development.

She turned to alcohol by the time she was nine, which she attributed to coping with her parents' violence and addictions (l. 1140). Kristine was able to make the

connection between her experiences as a child with violent, alcoholic parents and her own child's experience when she and her partner were doing drugs and fighting. She has helped her daughter cope with the intensity of her feelings, even though she did not always understand the feelings or the ways her daughter chose to express them.

As she recollected these experiences, she was reminded of a particularly intense experience she had with her daughter, which, ultimately became a turning point in their relationship as mother and daughter. Kristine described a situation that happened while she and her (then) 3 ½ year old daughter were in the treatment program. While she did not know what triggered her daughter's rage in this instance, she realized that the child was venting the accumulated emotional hurt and anger from her early years in an emotionally abusive home: '*We never hurt her when we were angry, but she would go into her room and just sit there and just sing.*' (l. 1743-46). At some level, Kristine also realized that her ability to show her own feelings communicated powerfully to her child about expression of feelings. (She had been taught how to hold her child in a particular manner by the child specialists who worked at the program).

> *. . she got real mad, and I took her in the bedroom and I did the little hold on her and kept telling her I love you* [child's name], *and it's okay to be angry but I love you and this stuff,*
> *and every time I said I love you, she got madder. She was almost growling. She was just, I don't want you to love me. And she would just have a fit of rage.*
> *And this went on for 45 minutes while she screamed. She growled, she screamed, she cried and that is when she turned . . . and* ***saw that I was crying*** *and then she shut down, and that was the first step.*
> (Kristine, l. 1687-1704)

The issues of adoption and custody were also important for those women in the study who were not adopted, but whose children were placed in foster care. Most of them had lost custody of their child/children during their substance abusing years. Helene's first two daughters were adopted by her husband's family because of her sense of inadequacy in the preparation for parenthood. She described how this transpired.

> *. . . it just got really isolating and I had [first baby] and I didn't know how to be a mom. I didn't want to be like my mom and I didn't really know how to ask for help*
> *. . . and really needy because I didn't get a lot of life skills and stuff like that. And then I was pregnant with my second daughter, and* ***I was really overwhelmed -***
> (Helene, l. 666-90)

About a year before the study, her older daughter, who was about 15 years old at the time, had run away from the grandparents' home and tried to come to live with Helene. But Helene's health had been severely compromised by her addiction, and, now in recovery, she was having black-outs and other organic symptoms that had not been treated. She and her daughter had aggressive physical exchanges, so her daughter was placed with CSD. Since that time, Helene has responded to medical treatment for her organic symptoms and recently regained custody of both daughters by the time of the last interview (l. 754-63).

Renee resents her parents for making her give up her first child when she became pregnant at age 13. After she was self-supporting and had completed college, she had a daughter. By the time her daughter was two years old, Renee had become involved with a man who was a drug dealer. She married him and he has taken care of her daughter since then. She had three more children and kept them all together until she got heavily into her

own drug use, which occurred after she left her husband. She lost custody of her children twice to CSD due to her drug usage. Her two youngest children have been adopted by a family but she was working on getting her own place so that her older two children could come back to live with her.

> *I have no excuse except it was stupid -*
> *I don't know if that was to have maybe another issue to remind me what I was doing, . .*
> .(Kristine, l. 55-74)

Kristine also had to relinquish her first child who was born with methamphetamine intoxication. She said she was very ambivalent about her pregnancy, using drugs for the first three to four months. Deciding not to have an abortion, she quit using drugs. But she used again five days before he was born. She felt quite guilty and was disappointed in herself since she had been abstinent in the last two trimesters.

Ruth's first pregnancy ended prematurely by giving birth to a stillborn infant as a result of her drug and alcohol abuse. She became pregnant four months later and this child was also born drug-affected with methamphetamine and marijuana intoxication. He was immediately taken from her and placed in a medical foster home. Her mother eventually adopted him and he is three years old now (l. 316-26). At the time of the interview, she was living in recovery transitional housing with her eight-month old son. Ruth said that she depends on the parenting skills she learned in treatment now that she is on her own.

Theresa also had to relinquish her parental rights for her first child to her mother. She did not describe her situation at that time, nor any of the parenting situations that she must have encountered during her long history of addiction. She had attempted treatment

on several occasions, and CSD had been involved. For the most part, however, she managed to retain custody of her children most of the time.

However, she provides a glimpse of her recollected experiences as a young mother in her description of a 16- year-old cousin with whom she identifies, in terms of her struggles and young motherhood.

> *She doesn't really know how to parent . . . she says she really wants to parent, so I am kind of reliving my childhood through her . . . I can see the parental side of things now where I couldn't before, where I used to put blame I can now see -*
> (Theresa3, l. 1451-63)

The issues of parenting at every stage of addiction/recovery were identified and described by the women, showcasing some of their worst moments in the narratives.

> *. . . He was just demanding, emotionally demanding, and I yelled at him a lot. . . I could say rude things to him and I didn't even care . . .*
> *It was, usually I was mad at* [his father]*. . . like how can I be treating a sweet tempered boy like this, I mean, it's not his fault.*
> (Georgie, l. 2811-2832)

Georgie struggled with motherhood while she was abusing substances and shows the ambivalence between needs of self and of her son which were ramified by the mind and judgment- altering substances. Parallels are apparent between her being parented and parenting her own child. Both she and her mother were alcoholics, although her mother's disease was not apparent until Georgie was in high school. Georgie, however, became addicted to drugs, and later, alcohol, in her

> *. . . he was a real high energy kid. . . he didn't know what drinking was and I always got him in bed and everything. I got him fed.*
> *I was - I don't know how he felt but I know that by the time I was pretty drunk I was not thinking about him anymore . . .I was just too much in my own misery and feeling so drained because he required so much attention . .*
> (Georgie, l. 2793-2805)

late twenties. Her descriptions of her own child's early life include Georgie's own distance and preoccupation, reminiscent of her childhood relationship with her mother.

However, in recovery, she is able to put her son's needs ahead of hers (her desire to move out of state), because he is doing so well in the neighborhood school. She said that he ' *is so much fun to be with now. He's funny, he's smart, he minds, he helps clean up,* ' (Georgie3, l. 866-69).

In recovery for approximately two years by this interview, Kristine was able to see the differences in parenting her daughter from the way that she was parented. Kristine said that her daughter gets confused about anger and what subjects are appropriate for her to express herself. She said that she thinks it is her own fault because of her moods, so the child cannot anticipate her reactions. For example, her daughter was playing with something that was sticky and it got caught in her hair. When her mother broke out laughing, the daughter said that she thought she would be angry with her (l.1152-64).

> *Yeah, she's finally stopped fighting me. It's little stuff now, but that battle is - finally, we have gotten over that hump of her just really not figuring out why I have to make the rules . . . she wanted us to be equals.*
> (Kristine3, l.1002-07)

Kristine said that she was very grateful for the child/parenting therapists from the program who initially were available to her by phone after she had left treatment, especially when she had trouble managing her daughter at home. She said that she had not called them very often but the early transition time was difficult for her daughter who was having to learn about her mother's love as well as her discipline. Kristine had to use the holding technique described above on several occasions until her daughter became more

secure at home.

One of the many things Rose had not learned either at home or during her addiction years was how to dress herself attractively. She had talked earlier about getting clothes from Goodwill, for example, and that she might leave them in a bush somewhere or at someone's house. In recovery, she wanted to learn about those normative things she had missed and found a friend to help her learn about choosing clothing outfits for her child. She valued this kind of learning as it could become overwhelming without help: "*Because I definitely want to do a lot better for my kid than what was done for me.*" (Rose3, l.1245-51).

> . . . *Well, two weeks later* [after recent court hearing] *he* [son's father] *is still pulling the same crap. I haven't seen* [son] *now since the end of June. I knew it was going to happen that way. . . . all of a sudden he wasn't there again and all this other stuff.*
>
> *And so, we have to run in again and fight him again. And I'm so tired of that. I just have dropped it. I'm supposed to have* [son] *four days out of the week. It's just, I can't keep fighting, and be here for the rest of them.*
>
> (Eve2, l. 128-238)

Eve has a number of children, through several marriages and partners. In recovery, she has several of her younger children with her in addition to her fiancé's two daughters and a son. During this phase of her recovery, she has had to spend a great deal of time fighting to regain custody rights for her younger son, as his father would not follow-through with their shared custody agreement. She has been to the court many times (Eve3, l. 465-520). She had begun to despair of ever having any kind of normal life with all of her children with her because of the accumulated stress of trying to maintain a home for the rest of the children.

Interpretive Summary

The narratives in this chapter demonstrate the intimate emotional geography of these selves moving back and forward in time, challenging the reader and the investigator in following these turbulent routes toward healing and growth. The issues of parenting for the women became an important component of the understanding of what it is like to be a substance-abusing woman and a woman/mother in recovery. The narratives speak about the understanding of themselves and their acceptance by their parents for who they were, important factors in the development of the self's identity. The women's self esteem was integrally related to both their addiction and recovering experiences and played a pivotal role in the evolving development of themselves and of their children. The acceptance of responsibility for causing pain in their children's lives cannot be underestimated as a major recovery-of-self issue for these women as mothers.

Personal, relationship qualities were missing in their lives as children. The need to fend for themselves prematurely (developmentally) contributed to their anxiety and fears about not belonging anywhere. The assimilation into the addiction community appeared, initially, to provide what they were looking for. All of the women, in one way or another, discovered a feeling of belonging in the addiction community that they had desired from their families or other relationships. Having not received sufficient warmth, security,, and acceptance as children put them at risk in knowing how to give and receive love as adults and as parents to their children.

<u>Adoption as exemplar in interpretive understanding</u>. The adoption narratives are useful in facilitating understanding about what it means to lose oneself, as one is lost

from one's mother or family of origin. The impact of being adopted and of losing custody of their children was manifested in their descriptions of their ongoing search for identity, for the biological and bonding roots of family, and of the demands of parenting their children in their developmental anxieties. In recalling the narratives in Chapter Four, the women's descriptions of their search for identity through the addiction communities was recognized as a search for belonging. Identity and belonging are integral to the formation of the self which prepares one for the experience of engaging in meaningful relationships.

Those women who were not adopted had experiences with their families that were not so dissimilar from those who were adopted, in that they also felt out of place, unacceptable, and as though they did not belong. For example, Theresa and Rose were told by their mothers, in court, that they could not come home to live; Georgie felt so removed from her parents that she believed she had discovered herself through her addiction community; Eve did not feel as though she could relate to her mother/parents and principally tried to avoid contact with them as a child; Helene's family was so abusive and hazardous that she began trying to leave home when she was eight; and Ruth's parents would not believe her cries for rescue as they left her to the sexual abuse of babysitters. Having become addicted to drugs and alcohol is the common denominator for the women, and was the way they tried to construct a family and self identity of one-who-belongs, one who is attached to a family.

The way these women have talked about the devastation of their lives as adults and as parents was in terms of their responses to some of the powerful, negative experiences in their childhoods. Whether their parents could or would have taken

advantage of marital or family therapy is unknown. But their families did not receive intervention, as remembered by the women, and their experiences as children did not contribute to positive self esteem or feeling connected to others. Therefore, most of the women as adults did not know what kinds of support or resources could have been available to them in their communities. This prevented their awareness of options for personal and parenting support - both during their addictions and in recovery. Rose reminded us that she had no advocate for herself as a child and was determined to do so now - however, she also said that she always felt as though others had a “guidebook” for living and she did not. Not knowing how to manage life and live in ways that help one access services and resources needed for families is a serious handicap for women in recovery. It makes them even more dependent on providers of services to teach them about advocacy, first in demonstrating it in their own systems, and them coaching the women through the process for themselves.

While there are apparently strong linkages between their families of origin and the women’s subsequent abuse of substances, it is difficult to demonstrate a causal relation, since there are significant differences and variable qualities among the families. What is striking are the risk factors that were prominent among the participants in the study. Much more is known in the ‘90's than was available when these women were children. However, even during the middle of this century, it was known in the psychiatric literature that children from dysfunctional and violent homes needed intervention. The community had mechanisms for identifying children at risk for abuse, but in these stories, the systems failed to intervene early and effectively.

The women have learned much about their own emotional states through watching their children during stages of adjustment to their mothers' recoveries. They received support and education in parenting while in treatment which was essential in preparing them for assuming responsibilities upon leaving active treatment. But, the questions and observations they shared in these narratives show how much more is needed for their ongoing development as parents - parents who can help their children adjust to the challenges of normative situations in school, neighborhood, and their own families. Since these are not familiar experiences for the women, it is difficult for them to anticipate for their children without wondering or questioning whether their ideas are appropriate. Several women said that they kept in touch with the programs for guidance in these matters, but one wonders whether the staffs can continue to provide ongoing guidance with the press of continuing new admissions and new needs of those clients. Also the treatment programs do not accept school-age children with their mothers, so the parent education is focused on infant, toddler, and preschooler development.

In addition, the parenting education and therapy the women received during treatment was necessarily limited to what the women could assimilate at that time - a time when they were having to concentrate heavily on their own recoveries as well as meeting obligations for finding housing, jobs, education, etc. for the transition. As the children continue to develop, there may be ongoing adjustment concerns that require the mothers to interpret behaviors and development with limited preparation. Having guides or mentors in the community could be very helpful in traversing these school age to adolescent phases.

One hears in these women's stories their continual search for identity, even though they have made strides in self acceptance and self esteem. They seem to have accepted and for the most part enjoy the parenting identity, wanting to assure that they provide a better opportunity for their children than what was available for them. But what of their identities as women and as persons separate from their children, as interdependent adults in the community? The next chapter deals with the transitions theme and assesses how the women are managing in their recoveries.

CHAPTER SEVEN: RECOVERY, TRANSITION, & BELONGING

The women's narratives in previous chapters have shown that even when the women completed treatment and were in recovery, they may have been stereotyped or treated with suspicion by providers and others who did not recognize their recovering status. They believed, and were encouraged to believe by treatment staff, that before being accepted in the community they had to make restitution for the wrongs committed during their addictions. The narratives in this section describe their experiences in transitioning from the treatment culture to an abstinent lifestyle and learning the skills necessary for participation in the culture of the non drug-using society.

Struggling with Recovery

Treatment programs anticipate the difficulties that people deal with after leaving active treatment and as they learn how to manage their lives in the community. The women talked about the "tools of recovery" which are strategies to change how one thinks, feels, and behaves from old addictive and dysfunctional patterns. Examples of tools are: find a recovery group and maintain your connection; work with your sponsor to learn adaptive skills to the normative community; take care of yourself, physically and emotionally; watch for cues of anxiety and/or addictive thinking and get to a group or call someone in recovery; and so on.

The women described many of the issues that challenge them, issues that may have been obscured in the past by addictive substances, or that emerge in the course of attending school, being a neighbor, maintaining a regular schedule, or in parenting. One

of the strategies is to volunteer at various agencies to reach others who are addicted or trying to stop using. So, they may visit schools to participate in drug use prevention activities with students, or they may volunteer at a detoxification unit to provide support and encouragement to people in withdrawal, or they may be on a speaker's bureau to inform citizens about drug addiction and their recovery experience. The treatment programs usually encourage their graduates to participate in this manner for at least two reasons: 1) volunteering is a way to give back to the community; and 2) it is a means to help recovering people focus on maintaining their abstinence by talking about the destructive consequences that addiction had on their lives and relationships.

Sherrel said that she has organized her whole life around recovery during the past three years. One of the issues that she talked about in each interview was her relationship with her mother which seemed to overshadow the development of her own separate identity. For Sherrel, recovery needed to be her emancipation from that '*co-dependent'* relationship, and she needed to substitute her mother's goals for her with her own. She makes explicit the connection between her addiction and her new-found autonomy - she has found that she can go to parties without feeling any desire to use substances because, "*I have a life today and I have a purpose"* (l. 560-1). Now that she has discovered her own goals and purpose for her life she can move forward with new confidence, not needing the artificial support

> *. . . as far as my schooling is, it's recovery orientated, my job is recovery orientated, my internship is recovery orientated.*
> *The first year I did hospitals and institutions where I went out and I shared my experience, strength and hope, then I did another year of volunteer services. . .*
> (Sherrel2, l.606-16)

of drugs or alcohol.

Several of the women talked about their volunteer work after treatment in which they go to the detox center or emergency rooms and talk with the patients there about treatment and recovery. What Sherrel said echoes other women's sentiments about how detox reinforces their recovery, "*And I needed to see the reality that crack still don't work. . . and I needed that year to do that*". (Sherrel2, l. 632-5).

Renee and Theresa discussed the practice of volunteering as part of living one's recovery from the perspective of one who has 'been there'. On several occasions, various women stated the importance of the trust that is established between two individuals because of the shared experience of addiction.

> (Renee) *It's a difference when they know you can talk to them and they know you've been right where they are and you've changed, and it gives you an example to show you that, 'Look, I did it, I know it's hard'.*
> (Theresa) *Both ways, it helps the person helping. . .*
> (Renee) *Yeah, it keeps you on focus, it keeps you on track. . .*
> (Theresa) *Because you look and go - I ain't going back.*
> (Renee & Theresa, l. 1779-95)

Theresa said that she will always do the volunteering, as she is a strong advocate for treatment and believes that this helps her maintain her recovery. Most of the women talked about not wanting to forget what the addiction experience was

> *I'm talking about a partnership. I do all my stuff free. I don't ask to be paid for anything that I do, and it's about knowing when your advice is going to be heard . . . and you see a patient who is trying to go through withdrawal. . . they don't want to hear about recovery. . .*
> *But when someone . . . calls the hot line and asks for someone to be sent out, right? And this person can sit down and hold their hand, they can talk the talk. See, that's the whole thing - it's a language, that only we understand.*
> (Theresa3, l.1953-72)

like, especially the misery of withdrawal from the drugs. She described the skillful way in which she approaches patients in the hospital or in a detoxification unit. She makes an excellent point in saying that those who have '*been there*' know the language to use with the person, which may have more influence than someone without that experience.

> *Sometimes it takes a few times where you slip and fall, but eventually, if you really want it to, the relapses get further and further apart and they don't last as long and stuff.*
> (Eve2, l. 998-1002)

How it Feels. In Eve's synopsis of the recovery trajectory, she discusses the personal challenges that she faced at varying times in phases of recovery and transition. Her experiences taught her to be open and not apologetic about the failures to sustain recovery. She is speaking from a mature point of view of someone who has not defined herself, principally, as an addict, but as one who experimented and got caught in a relationship that undermined her strengths.

She spoke for some of the other women when she expressed an appreciation for the support that she has received during her several attempts of abstinence. Not all of the participants were fortunate to claim this kind of help in their abstinence efforts.

> *It takes a lot of understanding, a lot of love to get out of the mess with the drugs. **It takes a lot of patience for somebody to hang in with you** while you are going through the transition; help you to make it out of it and wait for you to find yourself again.*
> *Because most people just don't understand it, first of all, and then they just don't have the time, and then, they think it should be this way and she should be over it.*
> (Eve2, l. 985-97)

She said that she had learned a great deal through her addiction and relapse experiences. Now in her 40's, Eve indicates that she was no stranger to letting go, and muses over not only what she has lost, but what she has learned through her struggles for

her own freedom. Her reference to smothering is reminiscent of her description of her mother as someone who smothered her, and how she hated it. As she reflected on the painful experience of her divorce and subsequent depression it may have triggered this insight about smothering and letting go. In the devastating loss of her first husband - the grieving, depression, and subsequent plunge into addiction - she could recognize the desire in herself to hold onto him, and the probable oppressive effect that may have had on him (Eve2, l.746-53).

> *. . . it doesn't have much to do with recovery, necessarily, . . . but how to let go.*
> *You really, when you hang on to something or somebody, all you probably do is* ***smother them.*** *You don't own anybody but yourself, . . .*
> (Eve2, l. 1407-13)

Theresa talked about the feelings of loneliness that assail the early recovering person. Having drugged herself out of emotional awareness during addiction, she now experiences how powerful are her emotions and realizes that she must learn how to accept and cope with them in recovery.

> *. . . the loneliness comes in when you get clean and you realize you have to let go of everybody.* ***It is so lonely***. *Who am I going to have?*
> *It is like moving to another city where you don't know anybody.. . . except that you stay in the same city . . .*
> (Theresa, l. 1134-42)

Theresa knows what Eve also knows, from bitter and painful experiences. In the narrative, she was not worried as much about where she would move, literally, but she was most worried about belonging to someone, someone who would also belong to her. The only friends she has had are no longer available to her, and the loneliness arises out of the fear of being alone in unfamiliar surroundings, both in the literal and the psychological sense.

In the next narrative, she describes an experience that is, unfortunately, rather common for addicted women coming out of detox and hoping to "kick it". Previously, both Renee and Ruth had talked about how warm and welcoming the drug community is, especially for the substance abusing woman who has no home or family to turn to. The drugs mute or obliterate the awareness of the poverty of their situation, both economic and symbolic, that had begun to surface in the detoxification experience.

> *You don't want to use, you can't get into treatment, you've been to [detox center] they kick you out because your 7 days are up and there ain't nowhere to go -*
> *who wants to talk to you?,*
> *who cares about you?*
> *You go back to the streets. ..*
> (Theresa3, l. 1691-98)

Ruth reflected a similar sentiment about the transition from active treatment, "*But once you get out of treatment, it is kind of like you are on your own again. It is kind of like you are in the full world, by yourself again, but you are not actually by yourself*" (l. 468-73). In another conversation about the differences between treatment and recovery, Theresa talked about treatment being very structured and safe, and the woman does not have to spend much time alone because she is living with the other women in treatment (l.1032-35).

> *And I thought that was marvelous - three weeks of no outside contact. Again, you really had to look inside yourself. You had literature to read. You had to evaluate yourself daily. List good positive things about yourself daily, and just start taking an evaluation.*
> (Barbara3, l.110-17)

Barbara was very grateful for the enforced isolation upon entering treatment, where she was safe from all her former abusive and addicted 'friends'. It also helped her make the

permanent break from her former peers in the drug-using world. She enjoyed the structured program of treatment which she carried with her into recovery, as did other women. Structuring one's time, daily, is another recovery tool that is taught and lived in the treatment program.

Not only are the women in recovery susceptible to discovering painful emotional feelings, their bodies wake up, as it were, to physiological conditions that the drugs had mediated over time. Theresa said that she did not know she had allergies until she was clean. Getting effective treatment was quite a relief. She also did not know that she had kidney stones, having passed one during her addiction, she just thought she "*had shot too much dope*". In a humorous aside, she said that she has passed two more stones during recovery and that she would rather give birth to quadruplets (l. 1169-98).

Kristine also expressed her amazement at the time required for her body to adjust to its non-using status.

> *It takes a good year to be fully,* ***a year and a half to let your body, feelings, and chemistry and everything go normal****. Now that they're normal.*
> *I mean you've got to figure, I've never in my life had normal, that weren't* [sic] *chemical, I mean I started drinking when I was nine years old. This is all new to me.*
> (Kristine, l. 1748-56)

Both Theresa and Rose described their experiences in various stages of withdrawal, and they used a term that is part of the treatment vocabulary which helped them understand their bodies' adjustment in the post acute withdrawal process, the HALT system[1]. They explained that these symptoms often accompany the sensation of

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[1] HALT refers to the slogan used in treatment programs that means the recovering person should avoid getting too hungry, angry, lonely, or tired. From Kasl, C. (1992), p. 217.

craving for the drug, and it is one of the tools of recovery to diagnose the symptoms quickly to prevent relapse. They also said that women in recovery need to learn to "pamper" themselves, to take care of themselves, to watch for the signs of relapse, and to use the resources of recovery (Theresa, l. 1069-91; Rose3, l. 28-37).

Joy and Accomplishments in Recovery. Barbara also is very positive about her recovery, and credits both the treatment program and the recovery groups that she attended in her transition phase from treatment to the community. With five years of sobriety, she has a good job, and is proud of having a pension plan and savings, nearly owning her car, and helping to pay for family vacations to Mexico (on a cruise) and Hawaii. She knows the price she has paid for her addiction and recovery, and is clear about her worth and her contributions to family and society.

> *One of the keys for success is to chase sobriety as hard as you chase the bag. One of the things that you would hear at an NA meeting, and it was true,* ***I had to want it.*** *At first, it was for my daughter, to be able to keep her, then as my confidence grew and I learned how to express my feelings, . .*
> *As soon as I learned the tool of 'I feel', 'When You', 'Would You', I was listened to, because I didn't have to yell anymore.*
> (Barbara2, l. 1071-93)

Like Barbara, Kristine expressed joy and pride in her recovery accomplishments. She is excited about her job and the education and mentoring given by her boss, who is very supportive of her recovery. But she is also aware of ongoing issues that need to be dealt with. For instance, she was not as confident as Sherrel about going to parties. She stated that if she were to go to the office party, she would probably take her daughter, just as a little boost to her security that she would not be tempted to drink, "*because alcohol used to be my liquid courage*" (Kristine2, l. 1802-3).

Then, she reflected on her recovery as an achievement that she is very proud of, having been clean and sober for nearly three years. Acknowledging her "*checkered past*", she said that she would feel she had lost everything if she reneged on her recovery. *"I'm 32 years old and I may not have a lot, but I have that. And I know why I don't have a lot"*. (Kristine2, l. 844-57).

> *. . . it's such a peaceful feeling that* ***I wonder if, maybe, you know, if this is the way it's supposed to be*** *or if I have gone completely the other way. . . . . haven't gone out with anybody, not dated, not been interested.*
> (Kristine, l. 1340-49)
> *. . . My tools of recovery, one thing would be that's missing, going to meetings.. . . talking about having to get confronted on the way that I yelled at her* [daughter] - *to me those were tools of recovery. I mean, recovery's not just not using drugs,* ***recovery is changing your whole life around.*** *. . . If you stop going to meetings you're going to relapse, . . .*
> (Kristine2, l. 1456-67)

Kristine has seemed to progress beyond the preparation for recovery that was given during treatment and after-care. In several interviews, Kristine wondered whether she was risking her recovery by not following the standard program of attending the community support groups, as she had done initially. Not finding them particularly useful or encouraging, she had stopped attending regularly.

> *So, now, it's trying to use what I learned. I feel like I've learned a lot, using it is a different thing. But, I feel like I'm actually applying the knowledge.*
> (Georgie3, l. 1075-79)

For Georgie, treatment has helped her mature in her self discovery and individuation from her parents. Now, recovery is an extension of what she learned in treatment but not easy to apply.

> *I mean I feel a lot better and I am really proud of myself. . . I mean I still struggle. . .not worrying about using. . . I know I can make it through a day. . . . It is* ***more like my inner things like my anger and my jealousy and my control..*** *. . . . my son is diagnosed with ADHD and we go to counseling for that. We are trying to learn how to deal with him. . .*
> *. . . it is more of a self-loving, learning problems where I learn and grow from them instead of putting myself down with the drugs and stuff.*
> (Betsy, l. 1486-1513)

Betsy had been very busy in her recovery also. She did many groups during aftercare: parenting classes, one on one with her counselor, and since she was on welfare, she was able to enroll in the JOBS program. She graduated from a skilled trades course at a community college, and has become employed in her field (Betsy, l. 1409-18). She was very upbeat about her recovery even though she continued to deal with some of the emotional issues she had tried to escape in addiction.

Recovery and Relationships

There are many other practical things that are learned in treatment, like how to shop and budget, thinking about housing and monthly utility bills, buying household and personal staple items, etc. It can seem overwhelming, as Ruth said earlier. But how most of the women get through the tough times in treatment and early recovery is in their relationships with one another.

> *. . . but you got your 'mother' . . . your 'daughter' . . . your 'grandmother' in AA or NA, . . I got a 'mama' in NA who is an old Indian woman and I have been calling her mom since I first came in. . . . My mom is always going to be sick and she is not going to be there when I need her. But this mom that I have in NA. . .* ***she is there.*** *She has taken me on spiritual journeys, my mom never even talked God with me. . . . I got a 'sister' that is Native American, and she held my hands through a lot . . .*
> (Rose3, l. 2001-21)

Because of the disrupted family relationships, some of the women, like Rose, found substitute family members in their recovery groups. Having not received appropriate

nurturing in her childhood, Rose learned about closeness and belonging in a family from some of the women in her recovery group. She described how she had substituted her biological family with women in recovery, "*because my family will never live up to my expectations*". (Rose3, l. 2010).

Helene also needed to experience maternal care while in treatment. But she also realized how much she had missed in parenting her children when they were small. She was committed to try to make up for hers and their losses of parenting.

> *And that womanly closeness, I mean they* [daughters] *didn't have me when they were younger, . . . and I grabbed her foot and . . . I didn't get that when you were younger, and then I sat there and hugged her and held her and it was real uncomfortable for her because she didn't get a lot of that.*
>
> *But now she is leaning into it. And I'm thinking that if her needs are met that way at home, she ain't going to look for it in a man right away.*
>
> (Helene2, l. 1888-1909)

Celebrations of Women in Recovery. The women's treatment system/network sponsors women's retreats which encourage women's relationships with one another and foster female identity and self esteem. Rose and Theresa talked about these enthusiastically. The women are charged a nominal fee but many of them cannot afford either the price nor a weekend away from their families. Apparently, the retreats are designed along recovering themes and have a strong affective and spiritual component to the workshops and activities. The women said that women's sponsors will often supply scholarships for newcomers to familiarize them with the importance of relationships with women in recovery.

> *. . . We just sit and hold and we nurture.. . . But it's like doing a mini four-step with your deepest darkest secret. It's scary, its' very scary the first time you do it...but then, now, we did it last year and this year, I'm looking forward to it.. . .*
> *It's like I can let go of something and you don't have to know it's mine.*
> *We listen to meditation tapes . . . there's no TV, . . . it's totally* ***spiritual.*** *. . I'm so jazzed . . . it's just that* ***healing process****, . . . it's like we talked about, you don't build that trust overnight.*
> (Theresa2, l.1828-32;1869-81;1912-38)

According to Theresa, the retreats are usually held at the coast or in the mountains, where the women can take advantage of long, peaceful walks and a beautiful environment. In addition to describing the experience of women nurturing one another, Theresa remembered the impact one of the retreat workshops had on her the last time she attended. The subject was secrets which brought a reaction from Helene, whose first response was that the use of anything with her handwriting could be traced to her. Theresa assured her that the workshop was designed to protect the participants from this. However, for Helene and several other women (Barbara and Renee), their happiness in recovery is side-by side the potential threat of being discovered by former addict-peers who would harm anyone who might jeopardize their addiction/dealing.

> *. . . I would go out to the beach and I would look out to where the sky and the ocean met, that is where my god was. And I would yell, and I would stomp my feet in the sand, and people would think I was crazy, and I would scream. But I left there feeling so good.*
> (Rose3, l.2722-29)

While attending a 'Roundup' of women in recovery, Rose described the catharsis of suppressed emotions that she needed to release. The beach and the supportive women encouraged freedom and self-discovery that contributed to her sense of wholeness and peace. She believes that these kinds of experiences began a spiritual awakening in her that

sustains her in recovery.

> *. . . When I came into the program, I saw beauty, a beauty that I can't explain to you. It was so pure and even now, I am reminiscent about it, . . . but I saw that and that is what convinced me to stay... . . I held onto the Native American in their connection with the Great Spirit . . . and it was just believing that I have a soul, that I have a spirit, and that I am one of god's creatures, and just everything that is good . . .*
> (Rose3, l. 2650-56; 2698-2706))

The spiritual focus of women's treatment began for Rose upon entry to treatment. Her description of those early experiences have an almost mystical quality.

> *I didn't know what loving myself even meant, and that is a big part of being a woman in recovery.*
> (Ruth, l. 352-4)

Although Ruth was not describing the women's retreats, she captured the essence of what several women said about women's treatment programs. Ruth's treatment experience was consistent with the preparation needed for women to be able to trust the recovery retreat process and the staff and peers who would be there.

Comments and Criticisms of Recovery Programs. While all the women were grateful that they had received treatment for their addictions, some were critical of the traditional Alcoholics Anonymous 12-step program. We are reminded of Georgie whose narratives in Chapter Five described her relationship with her counselor during her treatment experience. Georgie knew that she needed something different than the AA approach, and she appreciated her counselor for suggesting an alternative treatment approach (Rational Recovery). She believed that her motivation and successful treatment were due, in great part, to the relationship she had with her counselor who invited her full

participation in the planning and individualization of her treatment.

Oh yeah, when we left that was one thing that they really emphasized was that you can't stop going to meetings. That always scared me . . . (Kristine, l. 1209-12).

As noted before, Kristine expressed her fear of not attending the AA/NA community support meetings following treatment, even though she had discovered that they were not helpful to her recovery.

. . . what I see in meetings is a lot of negativity, I don't see a lot of hope sometimes. . . hearing the same old thing, and all the ***unhappy recovering people****. That gets old, it does.* (Kristine, l. 910-12)

In a subsequent conversation, she said that she could not use the recovery groups for emotional support, but that she found groups who were interested in change, because "*recovery is about change*" (Kristine2, l. 697-700).

Sherrel became angry about her recovery group's peer pressure at their insinuation that she was not managing her recovery well. What was especially irritating was that she felt that the group members were not moving forward in their own recoveries, and that they used one another to justify their symptomatology.

Others will say to you. . . you need to be in a home group, you need to interact with your sponsor, blah-blah-blah, that if you don't do this, or if you're going through that phase, you will use. And they give you an ultimatum.

And that is what I got from this group and it was like: How dare you say this to me? Just because I won't stay sick with you I'm in relapse? I don't think so. So, ***it was really hurtful*** *for me . . .*
(Sherrel3, l. 2306-18)

Eve also acknowledged that there are some recovery groups who are not encouraging or positive, like Sherrel and Kristine talked about. She described one that she

> *I don't know whether it was the 'war stories', or people were just not as up, more depressed. - They just weren't so thrilled about their recovery or something.*
> (Eve2, l.3-19)

decided not to revisit. When asked what kind of group she had looked for, she talked about certain characteristics, and about some of the differences she found between gendered recovery groups. She makes the point that in the co-ed groups there is less fear of confrontation about one's rationalizations, etc., and she found this helpful to her recovery, overall.

> *Someplace where I could relate to the people, where they were pretty down to earth and laid back - and* ***people who weren't discouraged with life*** *- still wanted to live. So, you know, people who were friendly and compassionate and affectionate toward each other, . . .*
> *. . . well, it's kind of fun to have an all women's group, but on the other hand, you don't get to see both sides of things in an all-women's group. Women get. . . going about beating things to death. We don't have that in a coed type group because we keep each other in check and call each other on our crap.*
> (Eve3, l. 805-29)

Where Do We Go From Here?

Kristine wondered what to do if she could no longer rely on her recovery group: "*where to go from there",* after being clean and sober for several years (l. 940). Rose experienced similar questions about how to know whether she was managing her recovery in appropriate ways. Her poignant description shows the anxiety and ambivalence connected with the power of the treatment community as authority for setting the standards for one's life in recovery. Yet she wonders, how it is that she did everything according to the principles of AA and has arrived at the goal of balance in her life, but she feels "*out of place*" ?

Again in this interview, Rose identifies the importance of a "guidebook" for living and feeling that she did not know what others seemed to know about life, until she came

into treatment: *"Everybody had the rules but me. These women give me the rules, even the men do . . . so they give us that guide book"* (Rose3, l. 2094-2108). Even though she acknowledges the essential things she has learned through the 12-step program, she feels a lack in knowing what to do next, or in trusting herself to determine what she needs that will enhance her recovery without jeopardizing her accomplishments.

> *And as I grew in recovery, got all I could out of it, gave all I could to it, and then moved on - but it's not like we were when I was in early recovery . . . now I've learned to balance my life.*
> *And I don't know how to do that. I'm an obsessive person - my life was recovery, dope, or recovery. . . I went from everything being dope to everything being recovery . . . and I'll tell them,* ***I feel out of place, I don't belong here,. . . I don't have a home anywhere*** *. . . I feel like I'm missing something and I keep an eye on myself because I think maybe you're setting yourself up . . . and I don't see myself tricking myself. . . I just feel like I'm at a loss.*
> (Rose3, l.2123-28;2242-72)

> *In early recovery, you are doing lots of group meetings, whatever it takes. And as you begin to grow and your own self-worth comes on you, you find clean and healthy environments in other places. You find church, you find school, you find a job, you find clean and sober family and friends.*
> *But it is still is nice to have the nest to go to.*
> (Barbara3, l. 2393-2402)

Barbara adds a perspective on the process of growth and movement along the recovery continuum. In her descriptive detail about her personal experiences in recovery, she clearly made decisions to move beyond each group as she felt her own growth out-pacing them, as have Rose and Kristine. She is proud of the fact that she looked for recovering mentors who kept expanding their own goals for better employment or education, because it inspired her to do so also (l. 2059-71).

Eve recalled that she had tried treatment-recovery several times before she was finally ready to stay in recovery. And she said that it may take awhile for the individual to find the '*right group, most likely it's out there somewhere, for everybody.*' (Eve3, l.263).

Georgie added an interesting anecdote about being in recovery. She had become irritated by something she had read in one of the recovery books which suggested that it was appropriate, that possibly one 'should' relinquish one's choices and control to someone else in recovery who might know what she needed to maintain her recovery.

> *. . . read something in one of those co-dependence books, that one clue that you are probably not doing, the word 'should'. That's not a good word. . . that should be like a little warning signal, when that word 'should' comes up . . .*
> *Says who? 'should' seems to come from somewhere else, not from your gut. 'Should' is somebody else's standards, who is not dealing with their life. Why?*
> (Georgie3, l. 1343-61)

> *. . . A need I think that women especially coming out of early treatment need [is] to have a place, an apartment setting, a house setting, to go to where they are with other recovering women. The halfway house, the transitional house, an* ***all-sober apartment complex****. It wasn't unheard of in the 30's, the 40's, for an all-women apartment building.*
> (Barbara2, l. 1356-66)

There are other issues that are particularly important for women's recovery and transition to the non drug-using community, namely, affordable, safe and drug-free housing. Barbara pointed this out in one of our conversations. She understood some of the special needs recovering women have, "*women are just more vulnerable out there and are taken advantage of*" (l. 1381-85).

> *. . . I'm still on Section 8 [housing certificate], and. . . I think it's a gift - that is something that is helping me. Nobody owes me that. . . and I appreciate it, . . .*
> (Kristine3, l. 1242-47)

Kristine understood the value of her public housing because, before treatment, she said that she had lost everything, including her apartment and car. She said that she had always had nice cars, had never ridden the bus, and that she also had never been dependent on public funds (AFS). She thinks that these deprivations motivated her to complete treatment quickly (Kristine, l. 1213-25).

Interpretive Summary

From worries about whether they are maintaining recovery appropriately or fighting for custody of their children, to job and relationship transitions and the celebrations of new life, self-discovery, and belonging, the women have journeyed through three extremely different and difficult worlds: the world of addiction, the treatment culture, and, now, their recovery worlds. For most of the women, their recovery experiences show their surprise and delight in discovering a world they did not know or believe could exist for them.

In their narratives can be seen the individuality of their experiences and the unique needs and goals they each projected onto their treatment and recovery. Where several used their treatment knowledge to forge new careers, others discovered a spirituality within themselves that provided meaning and focus to their whole life. Even with the questions they asked of themselves and of the treatment programs, the women tell stories of accomplishment, maturity, and connecting with other women, especially.

But questions persist for some of them. Rose and Sherrel do not feel like they

belong to the recovery community and Rose does not know what should happen next in her life; Kristine is concerned about whether she is duping herself in rejecting the community meetings; Theresa and Eve have struggled with loneliness and letting go of those things they cannot change - the custody issues related to Eve's son are particularly difficult for her; Betsy and Georgie continue to work on what they learned in treatment, about themselves and how to apply their knowledge in ways that help them emancipate from old psychological wounds; and Helene, in particular, tries to make up for her absence as a mother during her children's early development - she and her children are still learning about trust and receiving love.

The treatment-recovery community has contributed substantially to the improvement of these women's lives, and the lives of their families. But have the women been able to branch out to the non recovery-oriented community for their primary support and sustenance? The transition period appears to be continuing for these women, and what we see is a reluctance, on most of their parts, to let loose of their dependence on the treatment 'umbilical cord'. Only a few continue with regular contact with their sponsors and the community support meetings, in part, because the demands of work and family leave them with little time. Several have married since the interviews, and they seem to have found less need to attend recovery groups.

It appears that there are gaps in the community services network which could support the women in their next steps toward full participation in the community. Except for those women who have found church groups that are helpful to their recoveries, or those whose work supplants the support group, most of the women have not replaced

recovery-sponsored activities with non recovery-oriented programs or activities (such as PTA-type activities, career interests, or recreational organizations).

Perhaps it takes longer than their current recovery years to develop skills and the personal freedom to join in with the non drug-using society. Or, perhaps there is not just a stereotyping of the women, but of the treatment agencies by the normative community. In which case, these are larger barriers to overcome than individual recovering women could manage. Since the women have experienced stigmatizing behaviors among the health care and social services providers, it is not unreasonable to believe that other social institutions in the community may possess similar biases against recovering women/mothers who are in transition from the treatment programs. Consequently, the non recovery-oriented organizations and programs in the normative community may not encourage or welcome these women to their groups.

What can be learned from the women is that they responded to structure and guidance in the treatment and community support process. They had only to focus on themselves and their families, not on locating new kinds of experiences with new friends. Numerous recovery groups exist, are accessible, and there are many incentives to attend. There was a women's network, celebration and personal sponsorship to help with the immediate practical things of life. What several of the women confided to me on several occasions was that they had seen various sponsors relapse which created anxiety and stress on the newly recovering woman to maintain stability in her own recovery. The burden is upon the woman to find someone else, but this is emotionally difficult as she feels compelled to help her sponsor get back into abstinence and recovery again.

What can the community learn from these experiences? 1) work is very important in increasing the exposure to non drug-using people and encouraging new relationships; 2) it is really helpful to have a mentor coach the women in appropriate social behaviors; 3) welcoming groups/organizations need to be marketed to recovering women as places where they will meet and be accepted by others; 4) these groups and organizations need to be safe and accessible; and 5) there need to be meaningful and appropriate reasons for the women to consider joining/participating in organizations in the non recovery-oriented community.

Chapter Eight: Conclusions and Recommendations

This research was conducted to understand what substance abusing women's experiences were in making the transition from being identified as an addicted woman to the social identity of someone who belongs to the community. I chose this topic because my research and clinical experience in nursing suggested that social and health care systems were frequently incapable of adjusting to clients' transitional requirements. As clients' needs for services and resources change in their efforts to emancipate from public systems of support, interventions may be ill-timed, inappropriate, or inadequate to meet theirs and their families' needs.

Women with substance abuse problems and histories may have particularly difficult relations with the providers of these systems because of the stigma that is attached to women who are mothers and who are chemically dependent. Therefore, I wanted to understand the women's experiences with the providers of services. And, finally, since the study is philosophically based in a phenomenological view of person - the person as co-creator of experience with its culture - there is a focus on community and social belonging as necessary to the development of the social being of the women in the study.

The **research goal** was to sensitize providers to recovering women's experiences with social institutions, especially concerning provider policies and practices as they affect the women's sense of self, their sense of marginalization, and their transition to the non drug-using community.

The **research aims** of the study were: 1) to describe shared meanings and common themes in narrative accounts of recovering women's experiences with social and health care systems; 2) to describe the impact of providers' practices and policies as experienced and described by recovering women; and 3) to describe the experience of trying to belong to the non drug-using community.

Method. The narrative inquiry method was used to elicit descriptions of substance abusing/recovering women's experiences through interviews. The data were the lived experiences of the women as children, adolescents, and adults and during their lives as substance abusing and recovering women. The interviews focused on their experiences of living with addiction, on their encounters with providers in the social and health care systems, how they experienced addiction treatment, and descriptions of their experiences of transition to the community as recovering women.

Description of Participants. Eleven women who were recruited from local treatment programs agreed to participate in the study which involved three separate interviews. One woman left the study after the second interview and could not be traced. The women's ages ranged from 25 years to 39 years of age (M = 32.9 years). Nine women were Caucasian and two were African American. All of the women had some kind of criminal/correctional system involvement and/or were involved with the child protective service system. Three of the eleven women did not have CSD (Children's Services Division) involvement. At the time of the study, four of the women were married, five were divorced with no partner, one woman was single and had never been married, and one woman was engaged. The average number of years of addiction was

14.09 years (Range = 8 to 23 years). The women's average years of recovery (clean and sober) was 2.4 years (Range = 11 months to 5 years). All of the women were exposed to alcohol and/or drug use in their families, between age seven to fifteen years old. They were all polydrug users, often combining one or more legal and illegal drugs. Cocaine, or its various forms, was frequently identified as the drug of preference in adult addiction.

Analysis. The interviews were analyzed using a hermeneutic approach that sought to uncover the meaning of the women's experiences to them. The interpretive process involved iterations of review and refinement of textual interpretation, using a coding scheme that evolved from early interpretation. Focusing on what meaning the women ascribed to their lived experiences revealed their realities as embodied, sensitive beings living in both the addict world and the clean and sober world. This process gave way to the major paradigm case of Two Different Worlds, which showed the relative isolation, yet parallel systems in which these two cultures reside.

The interpretive work revealed the powerful relationship between the personal and the social experiences of marginalization in the women's descriptions of their encounters with providers of services. Through the women's stories the roots of disengagement from family and community were revealed. Themes of belonging and connection were shown to be very important to the women's sense of self, both during addiction and recovery. The exemplar of adoption was particularly helpful in exposing these thematic processes for both adopted and non-adopted women, and for their issues of parenting their children.

Other themes were discovered in the women's gradual recovery and learning to trust and celebrate relationships with other women, and with treatment program staff.

Struggling to maintain recovery while learning to manage their transitions to the non drug-using world was shown to be highly stressful but also very rewarding over time.

Findings and Recommendations

Living With Addiction

There were four interpretive topics that emerged from the narratives of living with addiction: *Two Different Worlds*; *Drugs, Abuse, and Control*; *In Pursuit of Freedom; and Hitting Bottom.* These topics with key interpretive discoveries are summarized in this section, followed by the recommendations. The women described their experiences of two cultures and how different they were from each other, the addict world and the non drug-using (clean and sober) world. Their term for these two cultures was "two different worlds" which was the major paradigm case for understanding the findings of the study. The paradigm case was important because it exposed the essential separation that the women felt from the non drug-using community. Interpretive analysis revealed the need for a conduit or access between the two worlds, so that the women might be able to cross the boundaries that separated them from the community's resources and treatment for their addictive disorder.

Recommendation #1. Providers may exacerbate a sense of isolation by not understanding their role as bridge to the community.

The women described the gradual unfolding of their addiction experiences from the earlier escape into addiction to be free of emotional pain, crises of identity, physical abuse, or hurtful relationships, to the later stages of degradation and severe personal and social losses. In these later stages, it was apparent to the women that they were not free

but, rather, imprisoned and oppressed by the addiction and its lifestyle. Most non drug-using people do not believe that substance abusing women have consciences or that they care about what is happening to themselves or their children.

Addiction and its lifestyle put them at high risk for violence, criminality, degradation (physical, mental, and emotional), loss of children, and threats to their survival. In the process, they became someone other (or not self) than who they knew themselves to be, finding that they had sacrificed their values and morality to the conditions of the drug culture's demands. Some of the experiences during their addiction showed that they had occasionally risked discovery by making clinic appointments, for instance, when pregnant, or for applying for food stamps, or in reporting abuse to themselves or their children. These encounters with provider systems did not result in assistance with their addictive problems. The use of early supportive and targeted interventions increase the possibility for engagement of the women in recovery-oriented and community support programs.

Recommendation # 2. Community agencies encourage professional relationships between providers and substance abusing/recovering women for connections to the community.

It is known that depression underlies many adult women's addiction experiences and the origin can be traced to their dysfunctional or disturbed families. Tijerina expresses her passionate response to the violence that she felt growing up as a Latina child in the urban poverty of her marginalized community. Childhood depression is one response to overwhelming situations, such as family violence, making diagnosis and

determination of the etiology of the child's behaviors a significant intervention. Most of these women said that they did not know or understand their feelings as children and, indeed, learned about feelings, family dynamics, and self esteem through their treatment programs.

> *Street culture and behavior is a way of surviving in industrial North America. It creates a passionate and violent language. . . . the passion of the language which exploded inside me sprang from the same source. . . . I began responding to the harsh reality that I was worthless in society by broadening my violent actions. And in an odd way, I sought justice.*
>
> From Notes on Oppression and Violence by Aleticia Tijerina

There needs to be more widespread education and treatment for families and children in recognizing the importance of feelings and communication in families. Opportunities for engaging families in parenting enhancement and communication skills development should be abundantly available through the community and school systems, with ongoing positive reinforcements developed to maintain connection with vulnerable families. Working with their families could interrupt dysfunction and the harm done to the young girls, providing opportunity for change in parenting and access to social and therapeutic support for stressed or disturbed parents.

Recommendation # 3. Increase school identification and treatment of children's emotional disorders.

Providers could be trained to intervene at strategically significant points of contact along the continuum of service delivery. The continuum might include these points of contact: 1) county social services which provide food stamps or WIC assistance, housing, child care, or economic assistance; 2) primary care clinics for prenatal or other health care

for self and/or children; 3) police calls for domestic violence or restraining orders on the abuser; and 4) emergency room or urgent care facilities for violence and abuse, alcohol/drug intoxication, and/or suicide attempts.

Regardless of the provider's point of contact with the substance abusing woman, it is necessary to identify the severity of the addiction and to institute/maintain case management. Safety is extremely important to the women from this violent underworld in which they live, so housing and security is essential to prevent their discovery by drug dealers and others with whom they have associated in illegal activities. Taking seriously their desire for help is a first step; but it must be followed by knowledgeable providers who have the resources and authority to respond to protect the women and their children.

Recommendation # 4. Use multiple opportunities for intervention based on stages of addiction and continuing social needs.

Provider Encounters: Bridge or Obstacle to Recovery

This section of findings from the women's narratives revealed qualities of provider encounters that ranged from negatively to positively experienced situations.

Negative encounters. These encounters resulted in three clusters: *Missed Opportunities, Ineffective Interventions, and Punitive Encounters.*

The narratives (and the literature) made clear that women with addictions tend toward very low self esteem and do not believe themselves to be worthy of help. The women in the study did not expect help or understanding, and may have come to provider encounters with resentment as well as low self esteem.

The providers are seen as a primary resource for the women, but they may not have seen themselves in this capacity. The women described those who did not assess and respond appropriately to them. They did not understand why highly trained providers did not perform their professional obligations with efficacy and compassion. To them, there was an obvious connection between being a competent and ethical practitioner. And they especially could not understand the blatant stigmatizing comments and behavior of some providers who seemed to want to vent their feelings onto the women.

> *In Finkelstein's, et al (1997) review of the women's treatment needs literature, several researchers confirmed the reality of negative and punitive attitudes among the providers of care. In particular, women were less likely to be identified as needing alcohol or drug abuse screening, even in the presence of specific risk factors and diagnostic criteria in primary care settings.* (p.10-11)

The systems where substance abusing women will inevitably come into contact with providers of care and services need to develop protocols for addressing the needs of these women. Training and education for all providers who deal with this population should be provided on a regular basis. Women need health services and were found to be reluctant to disclose their drug use patterns to primary care providers (Chang, et al, 1997, pp.183-92). This research also documented the reluctance on the part of physicians to screen women for addictions, at a greater rate than for men who are addicted.

<u>Recommendation # 5</u>. Develop provider protocols to increase substance abuse screening.

Mothers and children need protection and rescue from violence. Several women described experiences with providers from the justice system and community corrections services who did not respond appropriately to extricate or protect them from abuse and violence. Principal health and social care organizations could be more effective through collaboration and in developing greater accountability and responsiveness to crisis situations of safety.

These organizations should conduct outcome evaluations of agency/provider interventions to determine: decision-making patterns; response activity and referrals made; referral agency responses; and effectiveness of interventions. Women in the child-bearing and child-rearing years should be screened for substance abuse to establish their personal and domestic risk for abuse. The women noticed when this was not done and judged the providers as inept or uncaring. Most importantly, when providers ignore recognizing the women's addictive disorder they are also perpetuating the vulnerability of exposure to increased personal risk for the women.

<u>Recommendation # 6</u>. Develop improved accountability and effectiveness for crisis intervention.

<u>Positive Encounters</u>. The positively experienced encounters with providers were clustered according to the following: *Engagement and Relationship & Walked Me Through*. Without exception, the women were very grateful for the demonstration of compassion, helpfulness, ability in astute understanding of their circumstances, and

encouragement given them by these providers. These providers did not give up on the women, and were able to communicate respect and confidence in their finally making it through treatment. Even when one of the women was not able to maintain her sobriety, she knew that her providers would not reject her, but would try to encourage her return to recovery. These providers were committed to the women, not just because they were mothers of children, but for themselves as persons worthy of having a better life. What is not known, is how these providers differ and in what particular ways from those who were encountered as negative by the women. Research should be conducted to understand what are the essential components of education and character development that result in ethical, competent practitioners with this population.

Recommendation # 7. Conduct research on the qualities of "expert" providers.

These positively experienced provider attitudes and behaviors are exemplary, and should be modeled for the emerging professional students in all fields of client care. Their effect on the women was profoundly helpful and life-changing. The providers who stood out in this section seemed to be able to look past the women's shortcomings to their value as human beings, and to accept the contingencies of their difficult lives. Their behaviors provided a practice model for addressing the oppression in the women's lives. By listening and caring for the women, these providers tried to rectify injustices the women had experienced from others. Enhanced ethical training for social and health care services professionals should be required as part of continuing education.

Recommendation # 8. Provide enhanced ethical practice training for social and health care providers.

Parenting and Being Parented: Parallels and Contrasts

Self esteem and Identity and *Belonging and Connection* were the two clusters resulting from interpretative analysis of the narratives dealing with the women as parents and the influences on them as children by their families of origin.

Through their treatment programs and ongoing recovery efforts, the women described their discovery of themselves as persons worthy of being respected and loveable. What they learned about their own needs for self esteem was also learned in multiple ways about the self esteem needs of their infants and children through the parenting programs in treatment.

At the time of the study, all the women described ongoing struggles in parenting that they attributed to their children's early exposure to their addictive lifestyle environments. In addition, the women were not prepared for the demands of taking care of children through their growing and changing developmental stages because their own developmental needs had not been addressed by their parents. These women as parents have special needs as they learn how to balance the demands of their own recoveries and the needs of their children.

Remembered childhood fears relating to family violence and premature assignment of surrogate parent roles were experiences several women unwittingly thrust upon their own children, during their addiction years. Their re-experiencing of their childhoods through their own children was acutely painful, and exacerbated their

disconnection from family and significant others - and increasing their loneliness during transitions to non drug-using community life. These women were typical of many substance abusing women, in histories, length, and severity of addictive careers, therefore, increasing community support for this population could provide may benefits for society.

Recommendation # 9. Expand outreach efforts to identify and support recovering women in their transitions with managing recovery and parenting.

All of the women, in one way or another, discussed their desire for belonging to someone or to a community of caring, accepting people. Narratives of adoption experiences provided an important exemplar of the connection between self esteem/identity and belonging. Being adopted seemed to exacerbate the feelings of lack of attachment and identity, which they connected to their search for belonging in the addict culture. Several women who were not adopted also talked about lack of attachment to their families, to the sense of not belonging because of not being accepted for themselves, or because of the chaos and dysfunction in their parents' lives so that they were not noticed or listened to. The experience of stigma and marginalization by the non drug-using community, therefore, potentiated the feelings of a lack of connection to the community and to their sense of belonging. All of these personal and social fears were activated when they were threatened with loss of custody of their children or the children were actually placed in foster/adoptive care.

However, the women acknowledged that their mandate to treatment through the legal or child protective service systems was crucial to their entry to treatment and

eventual successful completion. The community should adopt policies that shadow this scenario, but provide earlier intervention in women's addictive careers to try to avoid the devastation to the women and their children from the prolonged oppressiveness and cruelty in the addict world.

Recommendation # 10. Develop a range of incentives to encourage treatment that balances needs of the children and supports the mother's custody of her children.

Parenting training in treatment was possible only after the women had completed detoxification and early withdrawal of the addictive substances. During this time, the women required substantial support from staff in relationships. As long as the women are physiologically and psychologically influenced by the addictive substances they cannot make appropriate choices. Identifying and referring women to detox and withdrawal from addiction in a secure, safe, and clinically sound atmosphere should be part of the health care system's strategy for interrupting the harm to the women and to their children.

It was not clear from this study that there was adequate treatment space for women emerging from detox, but several of the women acknowledged that waiting to enter treatment was an obstacle to maintaining early recovery and abstinence. The combination of loneliness and fear of not belonging anywhere except the addiction community, and the lack of immediate treatment enrollment may have precipitated subsequent relapsing by those women with more vulnerability. Following completion of the short term detox program (usually 5-7 days), the women should be immediately entered into an intensive treatment program, and should have access to 24 hour services if the program is outpatient rather than residential.

<u>Recommendation # 11</u>. Construct a seamless continuum of care from detoxification-withdrawal to treatment-recovery programs for women.

As providers come in contact with substance abusing women who may not appear to want treatment for their problems, the providers should know that low self esteem is part of the dynamic that influences the women's interaction with them. Training should occur in particular areas: 1) the neurobiological research of addictive substances on the thinking, behaviors, and attitudes of the addicted woman; 2) the complex and contradictory dynamic of the woman's love for her children and her dependence on drugs, affecting her ability to parent; and 3) interactive education to learn how to establish therapeutic communication skills that engage the women as persons and as mothers.

Pairing of addiction recovery volunteers along with an agency liaison would increase the credibility of the service by *one who has been there* and *who knows the language* - someone from the recovery community. The pairing of volunteer and provider could potentially facilitate phased services that are flexible and delivered in a timely way.

<u>Recommendation # 12</u>. Training for non-treatment providers about addiction influences on the long term recovery and parenting aspects of women.

Following active treatment, the women continue to need support and training in the developmental needs of their children, as there is inadequate parenting expertise within the community. Treatment programs could extend their therapeutic effects by training others in the community about addiction, parenting, and recovery issues. Churches and community groups could work with the treatment consultants to assist the

recovering women in parenting and family activities and provide mentoring support for the mothers.

Child development specialists and others in the health care and educational systems could be engaged as consultants by a consortia of community groups to provide the needed support and education for these women's ongoing concerns. Parenting programs offered at primary care clinics, with child development staff who can assess parenting competence and provide appropriate learning strategies, would provide a therapeutic atmosphere supportive to good primary care and to the needs of this population of clients.

Recommendation # 13. Develop community education and support programs for parenting of children at all developmental stages.

Recovery, Transition, and Belonging

In this last section of interpretive narratives, the women described the mixture of anxiety, endurance, practicing the tools of recovery, and the joys of sharing with other recovering women. The following themes emerged: *Struggling with Recovery, Recovery and Relationships, and Celebrations of Recovery.*

During this phase which began in treatment and is believed to continue throughout the recovering person's life, there is a gradual separation from the domination of the past and a movement toward personal goals that are defined and embraced from a new, positive self esteem perspective. As described in previous sections, the women again expressed their ongoing physical, emotional, spiritual challenges in learning how to manage their recoveries. Not following the program prescribed for recovery in the

treatment agencies would potentially threaten their recovery and could make them vulnerable to relapse.

The 'tools of recovery' were learned in the treatment program and regularly reinforced in the community support groups. However, most of the women continued to have residual symptoms of diagnosed emotional disorders and/or conditions from their years of addiction, for instance, Hepatitis B and C , and body systems damage. These conditions amplified the transition to managing in the community.

Recommendation # 14. Educate providers and shape community programs and clinics to respond to phases of withdrawal, recovery, and relapse.

There are many joys and accomplishments along the path of recovery that the women described, even during times of struggle. Developing relationships with other women was mentioned by many of the women as a positive experience in the study, as they learned about trust, laughter, and comradery with their peers. The relationships were recognized as critical to helping them get through some of the difficult periods with their personal and group therapy treatment. As they moved outward and transitioned into the community, these relationships became more important, and were seen as essential in helping deal with the threats of relapse.

The women also talked about their celebrations of recovery which had tremendous impact on their feeling positive about themselves, and helped them learn about community. Celebration was part of the encouragement that the women talked about that became so important to their acceptance of a relationship with those providers who were positive influences in their lives.

Among the providers in the health care system, there is a need to understand and promote supportive, positive, and celebratory activities within their clinics and agencies for those women who are being successful in their struggles to maintain abstinence and clean and sober lives. Nurse practitioners, in particular, could help to identify those positive avenues of support in their encounters with these women, and to help translate to their workplaces into the practice of celebratory interventions.

Recommendation # 15. Celebrate recovery and success in community clinics and programs.

Addendum: Participants' Experiences and Comments on Community Recovery Support Groups. It seemed to me that those women who had come from families in which they had rather normative experiences in childhood, in contrast from those who experienced abuse or disconnection from their parents, emancipated from recovery programs and moved forward in their lives with more self confidence than did the other women. For instance, Barbara began in the community recovery groups which lasted about five years, and now she is attached to a church support group and does not maintain ties to the 12 step recovery groups in the community anymore. Betsy also did not attend the groups, but was working and dealing with her own family life and feeling that she was no longer defined by her recovery. Georgie and Eve, likewise, also seemed to have moved beyond the community support groups into their children's and their own personal commitments. They were not willing to attend groups where the members were apparently invested in negative thought patterns and were not moving forward in life.

While these women remembered, vividly, what they had survived in their addiction years, they resisted defining themselves primarily, and only, as recovering women.

Other women, notably Rose and Kristine, worried aloud about their current success that did not seem to fit in the range of experiences in their previous recovery groups. It was hard for them to freely enjoy what they had accomplished and to trust themselves in their decision-making about next steps. While the treatment programs provided an atmosphere that nurtured them, and connected them to people and processes that were supportive for their development, the program presented an admonition about the necessity of maintaining recovery by maintaining connection to the recovery support groups. This was a source of ongoing self examination about whether they were risking their current success by, in a way, duping themselves in false security about their recovery stability. Theresa, Sherrel, and Helene, however, maintained their continuing relationship to the community recovery programs and primarily defined themselves as recovering women - everything else about them followed that self definition.

Future Research Directions

I believe that this is an area for future research investigation. It is important to recognize that treatment works for women who have been chemically addicted, and that it works because it has adopted important principles of gender-based knowledge about women's needs for relationship and connection in their lives. For those women who are unable to use the recovery support groups, there need to be readily accessible alternatives so that their recoveries in the community are not threatened. Some of the issues raised by several of the women related to the challenges (from the traditional model) they felt to

their independence and individuality in determining the course of their treatment. Other issues related to the inadequacy of certain recovery groups to offer positive stimulation or challenge to the women and the difficulty in locating new support groups where there is a good fit between the woman and the group.

In addition, there are likely successfully recovered women in the community who may not have attended formal recovery programs, but who used different resources to accomplish their sobriety and maintain a recovery process. These women, and perhaps men as well, could be very helpful to understanding addiction-recovery processes from an alternative perspective. Knowledge about the strategies and resources to help with an alternative to the 12-step recovery group process could be shared with women who may be searching for an escape from their addiction, or who need a different method to help them maintain recovery after treatment.

Another subject for further research is the apparent emerging sub groups of women who have differing conditions or circumstances that affect their treatment, for instance, women with dual diagnoses of mental and emotional disorders, or women with complicated physical disorders that require adaptations to treatment strategies. While these topics were not central to this study, several women raised these issues in terms of their own situations or knowledge of other women, for instance women with HIV/AIDS, organic brain damage, and other conditions that severely compromised their lives. Systematic investigation of how these conditions affect treatment programs and continuity of care for women with addictive disorders is a necessary next step for the discipline.

Several of the recommendations suggested in this chapter have identified the need for continuing training of the provider community about substance abuse and women. Research about the status of knowledge and expertise of the practicing professionals in Oregon would indicate what kinds of strategies should be employed to enhance their practices to improve access to services and treatment for substance abusing/recovering women.

Policy Perspective

From the perspective of this study, there are social problems related to how our society deals with women who abuse substances and, especially, if they also are mothers of children. The identification of the social stigma attached to these women is not original to this study. However, the fact that it continues to this day and that the women are marginalized from the rest of society are serious issues that require knowledge, creativity, and compassion from policy makers. The effect on the women who need help from the social and health care system to quit their addictive lifestyle is that they are prevented from either knowing or believing that there is another 'world' available in which they will learn self esteem, respect and care from others.

There continue to be policy dilemmas that result from ambivalent or punitive approaches toward substance abusing mothers and their ability to retain custody of their children. The fear of discovery of their addiction prevents these women from seeking care. Increased risks of discovery have both personal and social consequences that are counterproductive to seeking and entering treatment.

The child protective system should cooperate with the health care and treatment systems to coordinate mandated treatment and provide appropriate protection of the children while the mother is receiving treatment for her addiction. And the corrections system needs to be involved to protect these mothers and children from abusive and threatening colleagues from the addict world.

The study did not evaluate the systems' efficiency from an organizational or political perspective. Rossi (1993) says that the definition of social problems is ineffective unless it is defined within the context of the political sphere. Since most of the treatment facilities have primary funding through governmental systems, Rossi's point is well considered. Legislative advocacy by those who are best informed about these issues - providers, family members, and the women themselves - should be encourage to change ineffective or hurtful policies.

Social policies are influenced by many forces in the society, such as the social values that influence a community's perception of needs and attitudes, the availability of funding for specific programs and organizational systems, and the direction of research and education in the various health care and social delivery systems. As noted in the literature review, the previous decade saw advances in treatment programs for substance abuse treatment for women and their children, and recognized the importance of gender-based programs to meet the needs of this specialized population. But these issues were not new - they were redefined in terms of a "crack baby epidemic" that was perceived as a threat to society and was a volatile political issue in the treatment community at that time.

The mothers were not the focus of these federal programs except as the biological environment for their babies.

By the mid-1990's, many of those programs in Oregon had disappeared with reductions in funding. This study was an attempt to raise the issue of improving access to treatment and services for the substance abusing woman for herself as a person. The study is an ethical critique of the social system. The women's experiences provide a road map to the intersections of practical changes needed in the system.

The problems of substance abusing and recovering women are complex and, therefore, require responses that are integrated, coordinated, and managed among various agencies from larger systems: health care, social service and public welfare, corrections and justice, education, housing, transportation, and child care and protection services. In this era of managed health care and cost effectiveness of social programs, there is ever more reason to pay attention to the needs of these women whose potential for contributing to society is quite positive, after completing addiction treatment.

In addition, providing early intervention, and continuing intervention and supportive services with these women/mothers improves the chances for their children to live healthier lives with their biological mothers. There would be fewer demands for permanent placement of children out of home, and the women would actually become contributing members of the community. The alternative is potentially keeping these women as dependents of the social welfare system, and/or risking their return to an illegal lifestyle, incurring costs for maintaining the criminal justice systems.

Finigan (1996) provided a significant argument for the benefits of treatment in his economic evaluation research regarding the social costs to society if treatment had not been received by substance abusing clients. Financial data ($14,879,128) provided by the state Office of Alcohol and Drug Abuse Programs for tax money spent on 1991-1992 cohort of treated clients was shown by Finigan to produce the following savings, or avoided costs, to Oregon tax payers:

> With the estimated total of $83,147,187 of avoided costs savings, we calculate that every taxpayer dollar spent on those who completed treatment in 1991-1992 produced $5.60 of avoided costs savings to the taxpayer. Furthermore, additional (unknown) savings presumably accrued from those clients who received a good amount of treatment but who did not complete treatment (p. 26).

Whatever social policy is recommended, those who will carry out the policies are the agency directors and the direct providers of services. Employed by these social and health care systems, providers are required to represent the interests and values of these organizations. However, their professional ethics require that they also represent the interests of their clients. Therefore, they find themselves in a mediating or buffer position between the needs of their clients and the needs of the organization. This is where professional ethical practice, clients' needs, and system policies intersect.

McMillan & Cheney (1992) speak exactly to this point by noting that provider advocacy may be the only way to fill the gaps " in affordable housing, child care, and lack of material goods" for recovering women coming out of treatment (p. 280). Their approach includes both individual and collective advocacy on behalf of their clients. It

can be a very uncomfortable role for professional providers as few providers are educated to cope with the complexity of substance abusing/recovering women's needs nor to take an advocacy role with larger systems or the legislature. Study findings also suggested that providers' personal values may have affected their ability to intervene effectively with these women at critical junctures of need.

As a nursing-oriented study it did not investigate the preparation of nursing providers for their competency and compassion in dealing with this population. Research should be conducted to discover the extent and quality of nursing education in addictions treatment and management, and nurses' experiences with substance abusing women/mothers in their practice settings. Female nurses, as mothers and sympathetic to the needs of vulnerable children, may have a particularly difficult time with substance abusing women who have placed their children at risk for abuse or neglect due to their addictive lifestyles.

In the view of this study, all providers have an ethical responsibility to help substance abusing women access treatment and other supportive services and they should be held accountable by their systems to maintain this policy. Ophir (1991) raised the social ethics standard in the accompanying statement regarding society's distribution of resources or withholding of access. As noted before,

> *Evils are not merely the infliction of suffering or pain . . . evils have a presence of their own; this fact, at once social and moral, should be taken seriously into consideration in ethics and social theory. . . Preventable suffering, . . . is social and political through and through. . . it is not without reason that so often the poor, the unemployed, and the drug addicts have been considered " enemies of the society" by the society that has been their worst enemy.*
> (pp. 102-4)

providers are essential bridges to health/social care because of their access to resources that the women need, and without which, some will die.

Finally, there are social issues related to the nature of addiction, as a criminal lifestyle. Obviously the community has the responsibility to protect its members from violence and unlawful behavior related to drug abuse. But the community has an equal responsibility to intervene to prevent addiction and to provide access to treatment for those women who want out of the lifestyle. As described earlier, using the corrections system as the vehicle for control or intervention has been shown to discriminate against women, especially African American mothers. This kind of system response reinforces socially constructed beliefs that marginalize substance abusing women without helping the community understand the genesis and development of addiction.

Recovering women need women from the non drug-using community to help them with the transitions to their world. The recovering community provides a great deal in the early months following treatment completion to support the women in maintaining abstinence and a clean and sober lifestyle. Mentoring by others who know how to learn, work, parent, and live in the community and to use its many resources effectively can be crucially important to recovering women who need role models and guidance. Being connected and having connections with the clean and sober community should be part of their rights of passage into this new world of hope and opportunities.

Further research is needed to demonstrate the importance of these issues for recovering women, and to compare the outcomes of women who become connected with those who do not. The women in the study had difficulty talking about their transitions to

the community, in part because some of them were still closely tied for support to the treatment and recovery community. The treatment programs reinforce staying connected to the recovery community as a primary strategy to maintain sobriety and recovery. In part, I believe this is because of the recognition of the social stigma against people with addiction histories, which can undermine the success of the recovery program. In that sense, it is a protective stance. But it can be harmful as well, as women need to learn many coping strategies to deal with this new world, and the exposure to non drug-using women who have developed healthy attitudes and behaviors for parenting, relationships, and the many essential skills for living in the community could be very supportive and encouraging.

A related issue is the secrecy that surrounds addiction - because of the stigma, and the very real dangers of having lived in the illegal, criminal world of addiction - the external society is suspicious of people with addictions. And those recovering women may continue to harbor fears of discovery by past drug dealers and others with malicious intent against them, even after having left the addiction community. The women have sensitized me to this condition of their lives as addicted and as recovering women in transition, so the secrecy issue is important to understand when looking at potential community connections.

It seems to me that the connection between secrecy about one's addiction and one's dependence on the recovery community for primary support are intimately related to the stigma and marginalization from the non drug-using society. The remaining question, then, is whether the women have traded the oppression and marginalization of the addict world, for a more subtle marginalization within the non drug-using community that, nevertheless,

still separates them from the real ability to be as one-who-belongs in that community? All of the women would testify to the improvement in their lives by recovery, and are much happier to be living as clean and sober women and mothers. But when asked, the women in the study did not claim to belong to that community; rather, they said that their struggle was continuing as they tried to transition to the non drug-using community.

Perhaps it takes much longer than this study could assess; or, perhaps recovering women have to learn to ignore stigma when they encounter it and to pursue their goals for themselves and their families in spite of others' value judgments against them. This remains to be understood more deeply by nursing researchers in the field of addictions. The experience of those who live the effects of the stigma continues to be the bedrock of understanding. Recovering women continue to be the experts who can guide educators, researchers, and providers about the meaning of marginalization. And importantly, they know where the critical junctures are to make changes in the system that will free them for lives of meaning and worth in the community of those who belong.

References

Acker, J., Barry, K., & Esseveld, J. (1991). Objectivity and truth: Problems in doing feminist research. In M.M. Fonow & J.A. Cook (Eds.), Beyond methodology: Feminist scholarship as lived research (pp. 133-153). Bloomington, IN: Indiana University Press. (Reprinted from Women's Studies International Forum, 1983, 6, 423-435).

Ames, G. M. (1985). American beliefs about alcoholism: Historical perspectives on the medical-moral controversy. In L.A. Bennett & G.M. Ames (Eds.), The American experience with alcohol: Contrasting cultural perspectives (pp. 23-39). New York: Plenum Press.

Aroskar, M. A. (1993). Ethical issues: Politics, power, and policy. In D.J. Mason, S.W. Talbott & J.K. Leavitt (Eds.), Policy and politics for nurses (2nd ed., pp. 200-207). Philadelphia, PA: W.B. Saunders Company.

Backer, B. A., Costello-Nickitas, D. M., Mason, D. J., McBride, A. B., & Vance, C. (1993). Feminist perspectives on policy and politics. In D. J. Mason, S.W. Talbott, & J.K. Leavitt (Eds.). Policy and politics for nurses. (2nd ed., pp.18-31). Philadelphia, PA: W.B. Saunders Company.

Bell, L. A. (1993). Rethinking ethics in the midst of violence: A feminist approach to freedom. Lanham, Maryland: Rowman & Littlefield Publishers, Inc.

Benner, P. (Ed.). (1994). Interpretive phenomenology: Embodiment, caring, and ethics in health and illness. Thousand Oaks: SAGE Publications.

Bloom, B. (1997). Chemically dependent women in the criminal justice system: Hidden victims of the war on drugs. Manuscript submitted for publication.

Blume, S. B. (1991). Sexuality and stigma: The alcoholic woman. Alcohol Health & Research World, 15(2). Washington, DC: National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Boyd, C. O. (1993). Toward a nursing practice research method. Advances in Nursing Science, 16, 9-25.

Brickman, P., Rabinowitz, V. C., Karuza, J., Coates, D., Cohn, E., & Kidder, L. (1982). Models of helping and coping. American Psychologist, 37(4), 368-384.

Bronfenbrenner, U. (1979). The ecology of human development: Experiments by nature and design. Cambridge, MA: Harvard University Press.

Brown, S. (1988). Treating adult children of alcoholics: A developmental perspective. New York: John Wiley & Sons, Inc., A Wiley Interscience Publication.

Brownell, K. D., Marlatt, G. A., Lichtenstein, E., & Wilson, G. T. (1986). Understanding and preventing relapse. American Psychologist, 41(7), 765-782.

Brudenell, I. (1996). A grounded theory of balancing alcohol recovery and pregnancy. Western Journal of Nursing Research, 18(4), 429-440.

Burr, Herrin, Day, Beutler, & Leigh. (1988). Epistemologies that lead to primary explanations in family science. Family Science Review, 1(3), 185-210.

Califano, J. A. (1998). Substance abuse and addiction - the need to know [Editorial]. American Journal of Public Health, 88, 9-11.

Chang, G., Behr, H., Goetz, M. A., Hiley, A., & Bigby, J. A. (1997). Women and alcohol abuse in primary care: Identification and intervention. The American Journal On Addictions, 6, 183-192.

Chrisman, N. J. (1985). Alcoholism: Illness or disease? In G.M. Ames & L.A. Bennett (Eds.), The American experience with alcohol: Contrasting cultural perspectives (pp. 7-22). New York: Plenum Press.

Clayton, R. R., Voss, H. L., Robbins, C., & Skinner, W. F. (1986). Gender differences in drug use: An epidemiological perspective. In B. A. Ray & M. C. Braude (Eds.), Women and drugs: A new era for research (Research Monograph 65, pp. 80-99). Rockville, MD: National Institute on Drug Abuse.

Collins, B. G. (1993). Reconstruing codependency using self-in-relation theory: A feminist perspective. Social Work, 38, 470-476.

Dreher, M. (1994). Qualitative research methods from the reviewer's perspective. In J.M. Morse (Ed.), Critical issues in qualitative research methods (pp. 281-299). Thousand Oaks, CA: SAGE Publications.

Evans, M. E., & Dollard, N. (1992). Intensive case management for youth with serious emotional disturbance and chemical abuse. In R.S. Ashery (Ed.), Progress and issues in case management (NIDA Research Monograph Series No. 127, pp. 289-315). (DHHS Publication No. ADM 92-1946).

Finkelstein, N., Kennedy, C., Thomas, K., & Kearns, M. (1997). Gender-specific substance abuse treatment (CSAP Contract No:277-94-3009) [On-line]. Available: http://www.nwrc.org/respkg.htm

Freeden, M. (1990, April). Human rights and welfare: A communitarian view. Ethics, 489-502.

Gerstein, D. R., & Harwood, H. J. (Eds.). (1990). Treating drug problems: Vol.1. Institute of Medicine, Committee for the Substance Abuse Coverage Study, Division of Health Care Services. Washington, D.C.: National Academy Press.

Gilchrist, L. D., & Gillmore, M.R. (1992). Methodological issues in prevention research on drug use and pregnancy. In M.M. Kilbey & K. Asghar (Eds.), Methodological issues in epidemiological, prevention, and treatment research on drug-exposed women and their children (Research Monograph 117, pp. 1-17). Rockville, MD: National Institute on Drug Abuse.

Glaser, F. B., & Ogborne, A. C. (1982). Does AA really work? British Journal of Addiction, 77, 123-129.

Glick, B., Zimmer-Gembeck, M., Tesselaar, H., & Weir, B. (1996). Oregon prenatal substance use prevalence and health service needs study (Executive Summary). Portland, OR: Multnomah County Health Department.

Gordon, L. (1990). Family violence, feminism, and social control. In L. Gordon (Ed.). Women, the state, and welfare (pp. 178-198). Madison, WI: The University of Wisconsin Press.

Haaken, J. (1990). A critical analysis of the co-dependence construct. Psychiatry, 53, 396-406.

Hall, J. M. (1992). An exploration of lesbians' images of recovery from alcohol problems. Health Care for Women International, 13, 181-198.

Heidegger, M. (1962). Being and time (J. Macquarrie & E. Robinson, Trans.). New York: Harper & Row, Publishers. (Original work published 1926).

Heyward, C. (1982). The redemption of God: A theology of mutual relation. Washington, DC: University Press of America.

Holland, S., & Peterson, K. (1993). The health care Titanic: Women and children first? Second Opinion, 18(3), 10-29.

Hubbard, R. L., & French, M. T. (1991). New perspectives on the benefit-cost and cost-effectiveness of drug abuse treatment. In W.S. Cartwright & J.M. Kaple (Eds.), Economic costs, cost-effectiveness, financing, and community-based drug treatment (DHHS Publication No. (ADM) 91-1823, pp. 94-113). Rockville, MD: National Institute on Drug Abuse.

Institute of Medicine. (1992). Extent and adequacy of insurance coverage for substance abuse services: Vol.1, A study of the evolution, effectiveness, and financing of public and private drug treatment systems. (Drug Abuse Services Research Series, No. 2). (DHHS Publication No. (ADM) 92-1778). Rockville, MD: National Institute on Drug Abuse.

Josselson, R., & Lieblich, A. (Eds.). (1993). The narrative study of lives. Newbury Park, CA: SAGE Publications.

Kalmanson, B. (1992). Family-provider relationships: The basis of all interventions. Infants and Young Children, 4, 46-52.

Kasl, C. D. (1992). Many roads, one journey: Moving beyond the 12 steps. New York, NY: HarperCollins Publishers.

Kaufman, E., & McNaul, J. P. (1992). Recent developments in understanding and treating drug abuse and dependence. Hospital and Community Psychiatry, 43(3), 223-236.

Kendall, J. (1992). Fighting back: Promoting emancipatory nursing actions. Advances in Nursing Science, 15(2), 1-15.

Kilbey, M. M., & Asghar, K. (Eds.). (1992). Methodological issues in epidemiological, prevention, and treatment research on drug-exposed women and their children (Research Monograph 117). Rockville, MD: National Institute on Drug Abuse.

Kittay, E. F., & Meyers, D. T. (Eds.). (1987). Women and moral theory. Rowman & Littlefield Publishers, Inc.

Lebacqz, K. (1987). Justice in an unjust world: Foundations for a Christian approach to justice. Minneapolis: Augsburg Publishing House.

Leonard, V. (1994). A Heideggerian phenomenological perspective on the concept of person. In P. Benner (Ed.), Interpretive phenomenology: Embodiment, caring, and ethics in health and illness (p. 46). Thousand Oaks, CA: SAGE Publications.

Lindesmith Center for Drug Policy Research Institute, The . (1997). The impact of current drug policy on women. [on-line]. Available: http://www.lindesmith.org/

Mahowald, M. B. (1993). Women and children in health care: An unequal majority. New York: Oxford University Press.

Majchrzak, A. (1984). Methods for policy research. Newbury Park, CA: SAGE Publications.

Mason, D. J., Talbott, S. W., & Leavitt, J. K. (1993). Policy and politics for nurses: Action and change in the workplace, government, organizations and community (2nd ed.). Philadelphia, PA: W.B. Saunders Company.

McMillan D., & Cheney, R. (1992). Aftercare for formerly homeless, recovering women:Issues for case management. In R.S. Ashery (Ed.), Progress and issues in case management (NIDA Research Monograph 127, pp. 274-288). Rockville, MD: National Institute on Drug Abuse.

Merleau-Ponty, M. (1979). Phenomenology of perception (C. Smith, Trans.). London: Routledge & Kegan Paul Ltd. (Original work translated 1962).

Mill, J. S. (1971). On the subjection of women. Greenwich, CT: Fawcett Publications, Inc.

Miller, W. H., & Hyatt, M. C. (1992). Perinatal substance abuse. American Journal of Drug Alcohol Abuse, 18(3), 247-261.

Mink, G. (1990). The lady and the tramp: Gender, race, and the origins of the American welfare state. In L. Gordon (Ed.), Women, the state, and welfare. Madison, WI: The University of Wisconsin Press.

Mishler, E. G. (1986). Research interviewing: Context and narrative. Cambridge, MA: Harvard University Press.

Morgan, D. L. (1988). Focus groups as qualitative research (Sage University Paper Series on Qualitative Research Methods, Vol.16). Beverly Hills, CA: SAGE.

Morse, J. (1994). Critical issues in qualitative research methods. Thousand Oaks, CA: SAGE Publications.

National Institute on Alcohol Abuse and Alcoholism. (1990). Alcohol and women. Alcohol Alert, No. 10 PH 290.

Available: http://www.niaaa.n. . .lications/aa10.htm

National Institute on Drug Abuse. (June 6, 1997). Women and drug abuse. NIDA Capsules [On-line], (C-94-02). Available: http://www.health. . . /caps/NCWomen.htm

Noddings, N. (1984). Caring: A feminine approach to ethics & moral education. Berkeley, CA: University of California Press.

Oakley, A. (1993). Women, health, and knowledge: Travels through and beyond foreign parts. Health Care for Women International, 14, 327-344.

Ogborne, A. C., & Glaser, F. B. (1985). Evaluating alcoholics anonymous. In T.E. Bratter and G.G. Forest (Eds.), Alcohol and substance abuse: Strategies for clinical intervention (pp. 177-192). New York: The Free Press, A Division of MacMillon, Inc.

Office of Inspector General. (1990). Crack babies (Office of Evaluation and Inspections Publication No. OEI-03-89-01540). Washington, D.C.

Ophir, A. (1991). Beyond good-evil: A plea for a hermeneutic ethics. In M. Kelly (Ed.), Hermeneutics and critical theory in ethics and politics (pp. 94-121). Cambridge, MA: The MIT Press.

Packer, M. J., & Addison, R. B. (Eds.). (1989). Entering the circle: Hermeneutic investigation in psychology. Albany, NY: State University of New York Press.

Patton, M. Q. (1990). Qualitative evaluation and research methods (2nd ed.). Newbury Park, CA: SAGE Publications.

Polkinghorne, D. (1983). Methodology for the human sciences: Sciences of inquiry. Albany, NY: State University of New York Press.

Popper, K. R. (1972). Conjectures and refutations: The growth of scientific knowledge. (4th ed., rev.). London: Routledge and Kegan Paul.

Quade, E. S. (1989). Analysis for public decisions (3rd ed., revised edition by G. M. Carter), A RAND Corporation Research Study. Englewood, Cliffs, NJ: Prentice Hall.

Reason, P. (Ed.). (1988). Human inquiry in action: Developments in new paradigm research. London: SAGE Publications.

Rodin, J., & Ickovics, J.R. (1990). Women's health: Review and research agenda as we approach the 21st century. American Psychologist, 45, 1018-1034.

Substance Abuse and Mental Health Services Administration. (1997). Substance use among women in the United States (Analytic Series: A-3). Rockville, MD: National Clearinghouse for Alcohol and Drug Information (NCADI).

Schatzman, L. (1991). Dimensional analysis: Notes on an alternative approach to the grounding of theory in qualitative research. In D.R. Maines (Ed.), Social organization and social process: Essays in honor of Anselm Strauss (pp. 303-314). New York: Aldine De Gruyter.

Schatzman, & Strauss. (1973). Field research: Strategies for a natural sociology. Englewood Cliffs, NJ: Prentice-Hall, Inc.

Schon, D. (1983). The reflective practitioner: How professionals think in action. New York: Basic Books, Publishers.

Smithbattle, L. (1994). Beyond normalizing: The role of narrative in understanding. In P. Benner (Ed.), Interpretive phenomenology: Embodiment, caring, and ethics in health and illness (pp. 141-166). Thousand Oaks, CA: SAGE Publications, Inc.

Sherwin, S. (1992). No longer patient; feminist ethics and health care. Philadelphia, PA: Temple University Press.

Stevens, P. E. (1993). Marginalized women's access to health care: A feminist analysis. Advances in Nursing Science, 16, 39-56.

Tijerina, A. (1990). Notes on oppression and violence. In G.Anzaldua (Ed.), Making face, making soul: *Haciendo caras* (pp. 170-173). San Francisco, CA: Aunt Lute Books.

U.S. General Accounting Office. (1990). Drug-exposed infants: A generation at risk (GAO/HRD-90-138). Gaithersburg, MD: Author.

Van Manen, M. (1990). Researching lived experience: Human science for an actionsensitive pedagogy. London, Ontario, Canada: State University of New York Press.

Vaillant, G. E. (1973). A 20-year follow-up of New York narcotic addicts. Archives of General Psychiatry, 29, 237-241.

Walsh, J. H. (1991). The substance-abusing family: Consideration for nursing research. Journal of Pediatric Nursing, 6, 49-56.

Walzer, M. (1988). The company of critics: Social criticism and political commitment in the twentieth century. New York: Basic Books.

Walzer, M. (1983). Spheres of justice: A defense of pluralism and equality. New York: Basic Books, Inc., Publishers.

Weber, E. M. (1992). Alcohol- and drug-dependent pregnant women: Laws and public policies that promote and inhibit research and the delivery of services. In M.M. Kilbey & K. Asghar (Eds.), Methodological issues in epidemiological, prevention and treatment research on drug-exposed women and their children (Research Monograph 117, pp. 349-365). Rockville, MD: National Institute on Drug Abuse.

Westermeyer, J. (1992). Substance use disorders: Predictions for the 1990's. American Journal of Drug Alcohol Abuse, 18, 1-11.

Whitfield, C. (1989). Co-dependence: Our most common addiction-Some physical, mental, emotional and spiritual perspectives. Alcoholism Treatment Quarterly, 6, 10-36.

Winick, C. (1962). Maturing out of narcotic addiction. U.N. Bulletin on Narcotics, 14, 1-7.

Wuest, J. (1993). Institutionalizing women's oppression: The inherent risk in health policy that fosters community participation. Health Care for Women International, 14, 407-417.

Appendix A:

Report of the Pilot Study

APPENDIX A

REPORT OF THE PILOT STUDY

During Summer, 1994, I conducted a pilot study to refine the interview guide and questions and to check on some of the assumptions I was bringing to the study. I gained access to the three women through a public agency that runs a day treatment program for recovering women. Procedures for Protection of Human Subects were completed for Oregon Health Sciences University and for the agency. Both institutions granted approval for the pilot study, including use of any relevant data in subsequent dissertation research.

Sample and Procedures

The agency contacted the women to seek their permission so that I could schedule an appointment for the interview. The women were selected by the agency based on their graduation from the program within the past year, and on their accessibility by current telephone number. The interviews were conducted in a county government building, in a location familiar to the women. Appointment times were set according to the women's schedules and transportation availability.

Participant demographics. Two of the women were either working or attending school full time, the third was in school part time and caring for an 18 month old child at home. Two women were in their mid-twenties and the third was 20 years old. The three women were white. One woman had four children and she had moved out of a house with various adult drug-using friends into her own place. A second woman was temporarily living with her mother and step-father with her two children. The third woman was living with her child and a significant male adult. All of them had

experienced divorce and remarriage of their parents during their childhoods and early adolescence, and had left their homes prematurely. They all had either graduated from high school or completed their GEDs prior to attending the treatment program. One woman's youngest child was born drug-affected, and an older child had some effects that could have been related to the mother's drug usage during that pregnancy. The other two mothers discussed being aware that they were lucky in not having transmitted alcohol or drug effects to their children, as they also had continued drug/alcohol use during pregnancy. All three had been mandated to attend treatment by the court under threat of losing their children.

First Interview. Two women attended the first interview, and the third woman did not have reliable babysitting and lived about 45 minutes out of town and could not make the meeting. I scheduled a meeting with her at another time. After explaining the study and the informed consent, I encourged their questions about their participation. For the pilot, I did not anticipate meeting with the participants more than one time, as I was not testing the interpretive process, only the interview process. They signed the Consent Forms, and were each given a copy.

Interview Questions

The questions were aimed at uncovering information about their relationships with social institutions and their sense of 'connection to the community', as well as about their personal experiences in their families

1. I began the interview with an open-ended question about their decisions to come to treatment, and to tell me what their lives had been like prior to treatment.

2. I then asked them to talk about their encounters with workers, therapists,

probation officers, etc. What was their relationship like, how did they help/not help?

3. Then I asked what experiences could have been helpful - if servics/resources might have been offered differently or at a different time - and what experiences were not helpful.

Data management

During the interviews which were audiotaped, I kept brief notes to remind myself of concerns to note when transcribing later. I did not use their names. I transcribed all the tapes in a word processing program. I kept the tapes and transcriptions in separate locations at my home. I have retained the tapes to compare and possible use in dissertation analysis. Data management followed procedures presented by Professor Tanner (Summer,1994, class handouts) including making margin notes on transcripts with written commentary. On a separate piece of paper I noted my questions about unclear segments, or missing data. I used informant language to capture themes where possible. I kept a journal in which I noted theoretical concerns, challenges to my assumptions, questions about the process of the interview, suggestion for forming questions differently, and affective impressions of my relationship with the women during the interview.

Interpretive Process

I was guided in the analysis process described by Van Manen (1990) in what he calls the "highlighting approach", which is a first level of interpretive analysis aimed at uncovering thematic aspects of the transcripts (p. 94). Because the pilot study occurred within the context of a summer class on Interpretive Phenomenology (Narrative Inquiry), and because I was focused on the interview process rather than

doing the in-depth kind of analysis described for interpretive research, it was appropriate to keep to the highlighting approach. Peer and expert group processing of the analysis took place within the summer seminar taught by Professor Tanner. I took notes from those meetings, and have incorporated suggestions in revision of the interview guide. I also kept a list of further areas to explore in subsequent interviews.

Interpretation

The women in the pilot described their lives during childhood, early addiction experiences and then the more recent treatment and post-treatment times. It was difficult for them to describe relationships with others outside their families while growing up. Their early experiences were so painful or there was so little understanding about what was happening in their families, that whether others were available to them or whether they thought about their circumstances and wanted help had not occurred to them as children or adolescents. One woman still has great difficulty remembering those early years, and has no reliable informants to help her sort out what was going on. She described her childhood and adolescence as constantly feeling "anxious", and all the women described their young lives as being chaotic, with no one "noticing" how they were managing, whether at home or in school.

There were five themes that emerged: Chaotic lives/No one notices; Threat as motivation for treatment; Coping through imagination; Loneliness as part of recovery; and Parenting in recovery.

I was not able to elicit information about their views on the larger social community. Several reasons may explain this: they seemed focused on telling their

stories, which is common practice in recovery groups in the community; they need more exposure to me to establish a rapport of trust; the question of relationship to the larger community does not seem relevant to them; the question is not phrased in such a way as to elicit memories or reflections on experiences; or their personal and familial stresses could not accommodate much awareness of others outside their private sphere. However, all three women talked about their experiences of being drunk or high in school and around their communities during early and later adolescence, and of not remembering anyone confronting them about their attitudes or behaviors. Two of the women remember other youth being very obviously under influence of substances and school personnel ignoring, "not noticing", them. In this small sample, I believe that ***no one noticing*** is a metaphor for their lives - parents were preoccupied with their own issues, were divorcing, or were also involved with alcohol and drugs, there was neglect but it did not seem to matter to anyone, and these young girls had to fend for themselves. Their development and attachments to significant adults were halted and the feelings were buried, for there was no one apparently who cared enough to ask or to respond. They don't even remember wanting help, or that they felt anything except a vague sense of confusion, and anxiety.

Given the complexity of the combination of physical and psychological influences on recollection and on their belief in the worth of themselves and their histories, of attempting to own their pasts through understanding and eventual articulation of their presence in their history, I have begun to journal about my relationship with them as inquirer and co-researcher. Before I returned to check the

analysis with the women, I resolved how to proceed with further questions about their sense of belonging. I realized that it would be important to help them talk more about how they felt about belonging in their families, since belonging in family would precede belonging in community. The questions took the form of, "Have you ever noticed a feeling of belonging in your life?",or can you remember when you first noticed feeling a sense of belonging around others?" .

Second Interview. The women spontaneously suggested that they wanted to get together again to go over my interpretations. We scheduled the meeting at a time and place convenient for them, choosing a church that often has recovery group meetings. I wanted to establish neutral territory for the women, and to begin finding suitable sites for the subsequent dissertation research.

Two of the women could not make it to the meeting, but the third came and I was able to check the interpretations with her. It continued to be difficult to get clarity around the issues of community connections and, I believe, as a beginning researcher, that I did not have the "conversational language" that is familiar to participants which was an obstacle, as noted by Benner (1994, p. 108). And without the other two participants, the woman did not have any help among her peers to push me to greater clarity.

Investigator-Participant Relationship

As we talked, I noticed a feeling of reciprocity between the participant and me. An easing of tension and sense of rapport developed as the second interview progressed, that showed itself in her spontaneous self- reflection and use of light humor. The issue of trust in relationships was discussed frequently by this woman,

and I am aware that it is an ongoing issue for recovering women with other women in treatment (Thurston & Houck, unpublished, 1994). I will continue to be conscious of this concern with these women, and attempt to be as non-threatening as possible, while being myself with them. Providing opportunities for them to make some decisions about the research activities, time, place, etc., and the process of the interviews will be helpful in this regard.

The difficulties that the women had in making arrangements to come to the research interviews has sensitized me to their complicated and busy lives, include childcare responsibility, transportation issues and educational or career obligations. I will provide modest compensation to them to acknowledge their time and inconveniences attached to participation in the study.

Appendix B:

Letters of Support from Community Treatment Agencies

DARD OF DIRECTORS

David Allred
Hillier Associates, Inc.

Charles Anderson
CellularOne

MyChelle Andrews
PacifiCorp

Sherry Boyd
Oregon Health
Sciences University

Michael Burgess
This Week

Constance Crooker
Attorney At Law

Michael Doherty
A.K.A. Advertising, Inc.

Kathryn Grimm
Weiss, Jensen, Ellis, Howard

Otis Hayes
Adult & Family Services

Marsha Heimbuch
Providence Medical
Foundation

Rod Lundquist
Portland General Electric

Andrea Marek
Christian Supply

Diana McNichols
Arthur Andersen & Co.

Tom Murphy
Furrer & Scott

Kathleen Neys
Blue Cross & Blue Shield
of Oregon

Deston Nokes
Northwest Natural Gas

Jerri Noland
Portland General Electric

George Scherzer
Smith Barney

February 28, 1995

Dr. Duane Denney, Chair
Institutional Review Board
Oregon Health Sciences University
Office of Research Services
3181 Sam Jackson Park Road
Portland, Oregon 97201

Dear Mr. Denney:

Our agency has been asked to provide access to women who are in recovery, for doctoral dissertation research by Ms. Christine Thurston, from the School of Nursing at OHSU. We understand that Ms. Thurston will interview the participants in up to three separate interviews, and that this is totally voluntary by the participants. Ms. Thurston has described how the interview material will be managed, and that all identifying information pertaining to the participants and to our agency will be eliminated.

A representative of our Board of Directors has reviewed the description of the project and the Consent Form, and approved our participation in this study and agreed to provide access to clients who meet the study criteria, according to the procedure suggested by Ms. Thurston.

Upon completion of the research, The Board asks that Ms. Thurston prepare a Summary of Findings for our Board.

We endorse and support this research by Ms. Thurston because of our commitment to women's recovery process, and our desire to continually improve the quality of services that we provide.

Sincerely Yours,

Barbara Aho Grider

Barbara Aho Grider
Executive Director

BG:mmg

2130 SW FIFTH AVE., SUITE 100 • PORTLAND, OR 97201 • 503/224-0075 FAX 503/274-7642

ARA *Addictions Recovery Association*
P.O. Box 86640, Portland, Oregon 97286
(503) 235-3546, FAX 235-3791
Alcohol & drug residential treatment program and continuing care services
for poverty-level pregnant women and mothers with young children
❑ Clare House ❑ Letty Owings House

June 15, 1995

Dr. Duane Denney, Chair
Institutional Review Board
Oregon Health Sciences University
Office for Research Services
3181 Sam Jackson Park Road
Portland, OR 97201

Dear Dr. Denney:

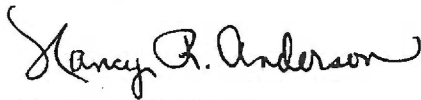
Our agency has provided access to women who are in recovery, for doctoral dissertation research by Ms. Christine Thurston, from the School of Nursing at OHSU. We understand that Ms. Thurston is interviewing participants in up to three separate interviews, and that this is totally voluntary by the participants. Ms. Thurston has described how the interview material will be managed, and that all identifying information pertaining to the participants and to our agency will be eliminated.

We reviewed the description of the project and the Consent Form and have provided access to clients who met the study criteria, according to the procedure suggested by Ms. Thurston.

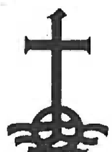
Upon completion of the research, we are asking that Ms. Thurston present the findings to our staff and prepare a Summary of Findings for our funding agencies.

We endorse and support this research by Ms.Thurston because of our commitment to women's recovery process, and our desire to continually improve the quality of services that we provide.

Sincerely yours,



Nancy R. Anderson
ARA Program Manager



Transition Projects, Inc.

Formerly Burnside Projects, Inc.

1211 SW Main Street
Portland, Oregon 97205
503-222-9362
FAX: 503-222-4782

September 17, 1995

Dr. Duane Denney, Chair
Institutional Review Board
Oregon Health Sciences University
Office of Research Services
3181 Sam Jackson Park Road
Portland, OR 97201

Dear Dr. Denney:

I am writing to you to confirm that Ms. Christine Thurston from OHSU's School of Nursing has received this agency's approval to access residents at our Barbara Maher Building as part of her doctoral dissertation research.

I have reviewed a description of the project and the project's consent form. I am satisfied that appropriate confidentiality safeguards are in place. Consequently, I have agreed to provide access to clients who meet the study criteria, according to a procedure suggested by Ms. Thurston.

I understand that Ms. Thurston will inform all potential participants that participation is completely voluntary. Ms. Thurston has described how she will manage all interview materials and maintain all confidential information.

I have asked Ms. Thurston to present her findings to my board and staff upon the completion of her project.

Transition Projects, Inc. endorses Ms. Thurston's research. We are hopeful that Ms. Thurston's findings will help us in our effort to improve the quality of our services for homeless, chemically dependent women.

Thank you for your time and consideration.

Sincerely,

Bob Durston
Executive Director

CC: Jala Waleed, Chuck Currie, Cheryl Bittner, Dennis Clay, Christine Thurston, Marcia Hickman

Appendix C:

Interview Guide

OREGON HEALTH SCIENCES UNIVERSITY
INTERVIEW GUIDE

WOMEN IN RECOVERY FROM SUBSTANCE ABUSE:

A NARRATIVE INQUIRY OF SELF AND BELONGING IN COMMUNITY

Introduction and Description of Study

* Welcome

* This is a special kind of research, because you are really the experts - you are the ones who have had the experiences that I am interested in understanding. When this research is completed, what we have learned from the stories of your experiences will be used to sensitize providers of services to recovering women's needs and concerns. As we discussed before, I will audiotape the interviews, have them written up (transcribed) without your names or other identifying information, and will come back to you later with a summary for discussion.

* The purpose of the study is to learn from your experiences with the social and health care systems in order to sensitize agencies and providers to be more responsive to recovering women's needs. My questions will ask you to think about relationships and experiences you have had with agency providers, professional staffs, and others who represent society to you (teachers, ministers, media presentations etc.).

Participant Role and Interview Discussions

Two basic questions will provide the structure for the interview discussions:
1) what experiences did you have with providers that effected your sense of yourself (your view of yourself)?
2) what experiences or encounters did you have with people that influenced your transition to the non drug-using community?

Probes

(1) **View of Self**

* Try to remember times in the past and *how you felt about yourself* - what were those times like?

* Tell us everything you can remember - who was there, what happened before, and after the experience?

* Describe what people said to you, how did they say it, what were you thinking or feeling at the time - what did you do/think/feel afterwards?

(2) **Transition to Community**

* Try to remember situations and people, [or TV, radio, or news reports] - anything that effected your sense of yourself as a drug-using person; as a recovering person? where were you when you first noticed these feelings/perceptions? [about yourself] [from others outside yourself] - give details.

* Describe your experiences of noticing that you either *belonged or did not*

belong to the non drug-using community - when did you first notice this, who was there, your reactions at that time?

* How did these experiences affect your desire to be part of the non drug-using community? How does *feeling like you belong affect your recovery?* - what does not belonging feel like inside yourself - what do you do to cope with it - give details of the situations and encounters.

* What were your encounters and relationships like with providers during this time - describe in detail what they did or said that influenced your *sense of belonging* to the non drug-using community? How does this differ from your sense of belonging to the support/recovery community? Describe in detail.

Other Topics - These may have relevance to the women - may be used as warm-ups if recall or sharing isn't coming easily:

1. Motivation for treatment - what got you into treatment (threat of losing children, relationships with others)? How did providers influence decision to enter/stay in treatment - what about recovery process? role of providers, family, others.

2. Parenting and recovery - what has parenting been like during recovery? how has your view of parenting changed since treatment? - what was it like before - what happened to get you to look at your role and behaviors as a parent - what did providers do or say during these times?

3. Relationships during recovery - how have these changed since treatment? - what were they like before? - what have you had to do to protect yourself or to separate yourself from drug-using friends/significant others? What are the risks like for you to maintain these contacts? Feelings, behaviors, details.

4. Lapse/relapse issues - describe what happens and how this affects your recovery? how has treatment educated you to dealing with these issues? effective/not effective in terms of your experiences with providers, family and others, and self?

5. Recovery groups - describe experiences with these groups; has your pattern of attendance changed over time? if not attending, what do you do to maintain your recovery? what influences attending/not attending? Describe in detail.

Appendix D:

Research Methodology Flow Diagrams

Methodology Flow Diagram

Pre-Code-Coding

Time: 1

N=11
Develop rapport
Biographical data
Informed Consents

1. Research Notebook
   - Field notes
   - Reflections
   - Ideas to F/U
   - Dev. transcription format
   - Narrative summaries
2. Interpretive Notebook
   - Themes
   - Questions of data
   - Design next interview

Pre-code-Code-Interpret

Time:2

N=11
Increase depth of descriptions
Focus: providers, agencies, clarify time1 data

Interpretive Process

Paradigm Case:
Two Different Worlds
Codes/Themes
Table: Comparison T1-T2 themes
Monitor relevance to AIMS

Code-Interpret

Time:3

N=10
Focus interpretation w/AIMS of study
Challenge research assumptions

Final Codes/Tags

1. Res. verification
   - Student peer review
2. Iterative interpretation
   - Range of examples
   - Refine Interpretations
   - Cluster meanings
   - Identify broad categories: Marginalization, Belonging, Living with Addiction

Interpretive Process

Student Verification Meeting

Focus on Provider Practices

Thematic Responses to Reading Narratives

Questions related to: role of locus of control in the women's narratives; and social bias

The women projected an attitude of "in my face"

Struggle Theme

Recovery as Crusade

Narrative Reviews Iterative Interpretation

Reviewed texts as follow-up to student consultation

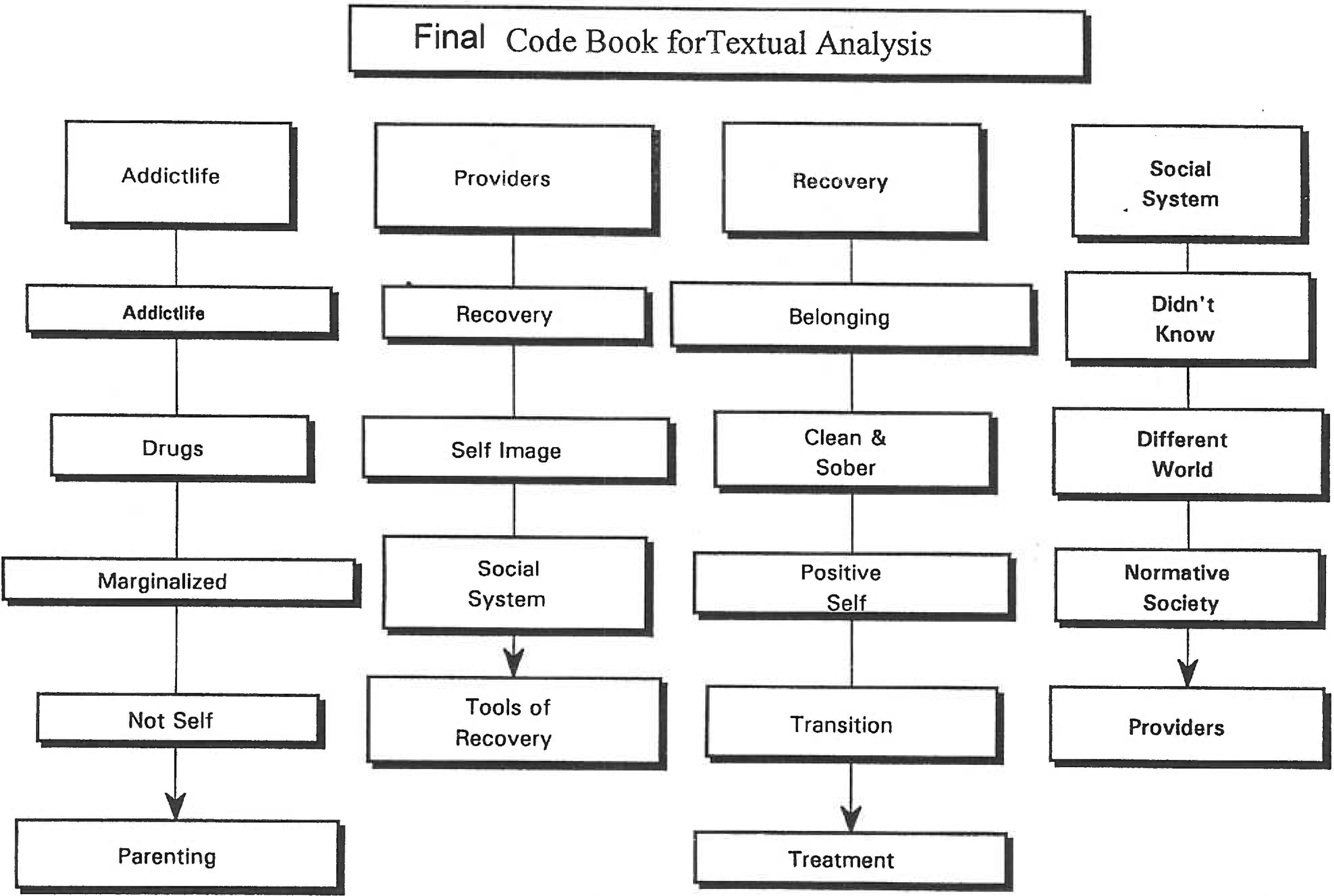
Continue reviewing texts, re-coding/tagging for sampling of ranges

Looking for contrasts, paradigm cases, exemplars, testing earlier themes across cases

Refine Code Book

Select 10 major Tags/Codes w/text examples

1. Addictlife
2. Adoption
3. Belonging
4. Diffworlds
5. Hitbottom
6. Providers Pos/Neg
7. Parenting
8. Soc System
9. Recovery
10. Transition


Women in Recovery
Final Code Book forTextual Analysis
Addictlife
Addictlife
Drugs
Marginalized
Not Self
Parenting
Providers
Recovery
Self Image
Social System
Tools of Recovery
Recovery
Belonging
Clean & Sober
Positive Self
Transition
Treatment
Social System
Didn't Know
Different World
Normative Society
Providers

Appendix E:

Informed Consent Form

IRB# 3844
Approved 3/24/95

OREGON HEALTH SCIENCES UNIVERSITY
Consent Form
WOMEN IN RECOVERY FROM SUBSTANCE ABUSE:
A NARRATIVE INQUIRY OF SELF AND BELONGING IN COMMUNITY

PRINCIPAL INVESTIGATOR

Christine A. Thurston, PhC, MSN, RN, 503-494-1509
Research Advisor: Carol Lindeman, PhD, RN, 503-494-7734

STUDY PURPOSE

You have been invited to participate in this research study because of your experiences as a woman who is recovering from alcohol/drug addiction. The purpose of this study is to learn about the ways social service and health care providers have been helpful in your recovery process. The analysis of your experiences may help to sensitize providers and policy makers to understand how they can improve services for women in recovery.

PROCEDURES

If you agree to participate, you will be asked to participate in three interviews over a two to three month period. Each interview will last approximately two hours. Each interview will be recorded on audiotape.

First Interview. The purpose of the first interview is to answer your questions about the study and the consent form and to gather your personal history as pertaining to chemical dependency.

Second Interview. The purpose of the second interview is for you to review my interpretation of your first interview, and to search for other meaningful information about your experiences. You may choose an individual or group interview, depending on your comfort with sharing your personal information in group discussions. Group interviews are made up of three to four women who have completed the first individual interview. Group discussion can be helpful to individuals in stimulating memories and reflections about their experiences.

Third Interview. The purpose of the third interview is to review the interpretation following your second interview to make sure that it is accurate and says what you intended to communicate. It is your choice whether to meet in a group or individually.

For group interviews, three to four women will be asked to meet together. Meetings will be arranged at a convenient time and place for the participants.

RISKS AND DISCOMFORTS

Some of the topics may be upsetting to you and you are free to refuse to discuss upsetting material. However, if it appears that you are experiencing significant emotional distress or reaction to the interviews, you may request assistance. I have made arrangements for referral, should it become necessary, to a licensed Psychiatric-Mental Health Nurse Practitioner.

BENEFITS

You may or may not personally benefit from participating in this study. However, by agreeing to participate, you may contribute new information which may benefit other recovering women in the future. You may enjoy discussing some of the topics, and may feel that it is useful in furthering your understanding about yourself, your family and your community.

CONFIDENTIALITY

* The interviews will be audio-taped and transcribed, and written notes will be kept. All identifying information will be deleted from the tapes, transcriptions and written notes. The tapes and transcriptions will be stored separately in locked files. Consent Forms will be stored separately from the data files so that it will not be possible to link or connect them in any way. When the analysis is completed the tapes will destroyed.

* The dissertation committee of faculty, selected interpretive researchers who are students and faculty at OHSU, and the investigator will have access to the transcriptions.

* Excerpts of your stories may be published. Neither your name nor your identity will be used for publication or publicity purposes.

* According to Oregon law, I must report suspected child or elder abuse/neglect to appropriate authorities.

COSTS

There is no charge for your participation in this study. Compensation of $20 will be given to you at the conclusion of each interview to help defray potential costs for your participation in the study.

LIABILITY

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 the Medical Services Director at 503- 494-8014.

PARTICIPATION

Participation in this study is completely voluntary. You may refuse to participate or withdraw from this study at any time without affecting your relationship with or treatment at the Oregon Health Sciences University or any agency with which you are affiliated in your recovery process. If you have any questions regarding your rights as a research subject, you may contact the Oregon Health Sciences University Institutional Review Board at 503-494-7887. Dr. Carol Lindeman (494-7734) has offered to answer any other questions you may have about this study. If you agree to participate, you will receive a copy of this consent form.

Your signature below indicates that you have read the foregoing and agree to participate in this study.

__________________________________ Date __________
Participant Signature

__________________________________ Date __________
Witness Signature

__________________________________ Date __________
Investigator Signature

OREGON
HEALTH SCIENCES UNIVERSITY
3181 S.W. Sam Jackson Park Road, SN-ADM
Portland, Oregon 97201-3098, (503) 494-7790

School of Nursing, Office of the Dean

Christine Thurston, PhC
School of Nursing
Oregon Health Sciences University
Portland, OR 97201

February 22, 1995

Ms. Thurston:

I am pleased to serve as a referral resource for the participants in your dissertation study, "Women in Recovery: A Narrative Inquiry of Self and Belonging in Community." I have practiced as a Psychiatric Mental Health Nurse Practitioner for eighteen years in the private sector and have served as an evaluator for an intervention program with substance abusing women. Both my clinical and research experience have contributed to a sensitivity to the complex needs and issues of women with a history of substance abuse. In the event that the interview process triggers emotional distress in any participant, I will be pleased to facilitate referral to an appropriate resource.

Sincerely,

Gail M. Houck

Gail M. Houck, RN, PhD, PMHNP
Associate Professor
School of Nursing