

Choosing Family: One Mother's Journey Through Recovery from Cocaine Addiction

by

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ABSTRACT

The purpose of this inquiry was to explore recovery from drug abuse from a mother's perspective. Women's experiences of treatment and recovery are unique from men's and mothers' experiences have been studied little (Poole & Dell, 2005). A series of three interviews were conducted during which the participant was encouraged to deeply explore her experience of recovery as a woman and a mother. This project was carried out using both Consensual Qualitative Research (Hill, Thompson, Hess, Knox, Williams, Ladany, 2005) as well as The Wish and Fear List (Perry, 1997). These two types of analyses complemented one another and provided two complementary views of the participant's experiences as both a woman and a recovered drug user within the context of her parenting. The themes of mothering, recovery and identity development, and respective sub-themes are discussed. The proportions of wishes and fears expressed at two phases in the participant's recovery journey are also discussed.

RESUME

Le but de cette enquête était d'explorer le processus de réhabilitation d'une mère ayant fait usage de cocaïne. Bien que le processus de réhabilitation des femmes diffère de celui des hommes, il y a un manque de recherches traitant de leur expérience, surtout lorsque ces femmes sont aussi mères. La présente recherche présente une série de trois entrevues ayant permis à une mère d'explorer son processus de guérison, en tant que femme et en tant que mère. Le projet a été fait en utilisant le Consensual Qualitative Research (Hill, Thompson, Hess, Knox, Williams, Ladany, 2005) et The Wish and Fear List (Perry, 1997). Ces analyses complémentaires permettent d'obtenir deux portraits différents de la participante, un comme femme et l'autre comme ex-toxicomane et parent. Les thèmes de la maternité, le processus de réhabilitation et le développement de l'identité, ainsi que des sous-thèmes associés sont discutés. Ainsi, les désirs et les craintes exprimés durant les deux phases du processus de réhabilitation de la participante sont aussi discutés.

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CONTRIBUTION OF AUTHORS

The following authors have contributed to the article included in this thesis.

Adriana Sorbo

As principal author she collaborated with Dr. Martin Drapeau and Peigi Beveridge in the design of the study and obtained ethical clearance from McGill University and the Salvation Army Children's Village. She transcribed all interviews and conducted all CQR analysis. With the direction of Martin Drapeau she performed statistical analyses save for the interrater reliability calculations, conducted by Martin Drapeau. She conducted a literature search and wrote the article.

Peigi Beveridge

Ms Beveridge assisted in the conceptualization of the study, conducted the interviews and provided direction in the qualitative analysis. In addition she provided editorial assistance and feedback in the writing of the article.

Dr. Martin Drapeau

Dr. Drapeau provided significant direction in the design of the study and provided financial support to hire research assistants to code the transcripts using the Wish and Fear List. He also acted as auditor in the CQR analysis. Dr. Drapeau provided considerable background information on the Wish and Fear List and assisted with the analysis of the Wish and Fear results. In addition he conducted calculations for interrater reliability tests. Finally, he provided significant editorial guidance.

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INTRODUCTION

The following Master's thesis describes the complex relationship between one woman's experiences of recovery from cocaine addiction and her identity as a mother. Although research about women's drug and alcohol addiction is abundant, little is known about the experience of mothers. Mothers who abuse drugs and alcohol are similar to most women with children in their investment in their mother identity (Brudenell, 1996) and as they journey through recovery they must negotiate the integration of their identity as a woman, as a substance user and as a mother (Brudenell, 1996). As of yet, very little is understood about this negotiation process and of how motherhood affects recovery and recovery affects motherhood.

The present investigation sought to shed light on this complex process by exploring the experience of a woman who chose to pursue recovery and reclaim her role as a mother. Three interviews with the participant were analysed qualitatively using Consensual Qualitative Research (Hill, Thompson & Williams, 1997; Hill, Thompson, Hess, Knox, Williams, Ladany, 2005) and quantitatively using The Wish and Fear List (Perry, 1997). It was expected that the use of these two methods would compliment one another and provide two lenses from which to understand the story.

This thesis is written in a manuscript-based format. First, a comprehensive literature review will be presented, followed by a manuscript, and a general conclusion.

2. LITERATURE REVIEW

2.1. Historical Considerations

The use of mood altering substances, including alcohol, has been common in North American society throughout history. In Native American, Native Canadian, European, and subsequent immigrant cultures mood altering substances were used as part of spiritual and social rituals (White, 1998). Over time, the use of drugs and alcohol has experienced varying degrees of social acceptance and as more attention to the problems associated with overuse increased, scientific literature began to include research and discussion on addiction to and recovery from drugs and alcohol. Although the history of mood altering substances, alcohol in particular has been well documented, most of the discussion of the subject has reflected the experience of men. Until recently women's use of drugs and alcohol has been largely unacknowledged (Brown, 2002). Women's substance use was contrary to socially acceptable behaviour for women. With the sexual revolution of the 1960s and 1970s women's use and abuse of substances has slowly become more visible (Brown, 2002) and as women have increasingly made their way into academia research on women's substance use has increased dramatically, particularly since the 1980s (Bushway & Heiland, 1995).

Despite this increase in attention, models of addiction and treatment have remained largely based on the male experience and only recently has a call to study and design models particularly reflective of women's needs and experiences been heard (Brown, 2002). Describing women's experiences in Alcoholics Anonymous, Brown (2002) states that although women were accepted from the beginning of the movement, they were either subsumed within the male experience or viewed as a deviation from the "normal" course of male addiction.

It is largely agreed upon that women's experiences of substance use, addiction and recovery differs in many ways from those of men (Brown, 2002; Nelson-Zlupko, Kauffman, & Morrison-Dore, 1995; Poole & Dell, 2005; Poole & Isaac, 2001) and yet little is known of the relationship between one of the most significant roles women maintain in society, motherhood, and addiction (Collins, Grella, & Hser, 2003). Except for the focus on pregnant and postpartum addicted women, Bushway and Heiland (1995) suggest that research on women and addiction remains under-funded and under-supported

and although attention has been given to alcohol use among women less is known about drug use, particularly drug use among women with children (Powis, Goddop, Bury, & Griffiths, 2000).

2.2 Current Patterns of Use

There are several challenges in attaining accurate estimates of drug and alcohol use. Cormier, Dell, and Poole (2001) explain that survey data often under-represent prevalence of use due to such factors as inconsistent definitions of dependence and abuse across survey methods and under-reporting of behaviours that are not socially acceptable. In addition, they state that surveys fail to reach certain populations that are likely to be greatly affected by substance use, such as users living on the street and institutionalized users, and specific populations such as elderly people, rural women and people with disabilities.

Despite these limitations surveys, in addition to other research methods, can provide general estimates of prevalence rates and trends in drug and alcohol use among broad samples of the population. According to a study conducted by Tjepkema (2004) for Statistics Canada, in 2002, 9.4% of women surveyed had used an illicit drug in the past 12 months. This rate was significantly lower than that for men (15.9%). Approximately 7% of women drug users reported daily use and this was also significantly less than the reported use for men (10%). Half of one percent (0.5%) of women surveyed was considered to have a dependence on an illicit drug. In a recent survey by the Canadian Centre on Substance Abuse (CCSA, 2005) 1.1% of women over the age of 15 reported cocaine use in the past year. The survey noted that the lifetime use of cocaine among women has increased from 2.7% to 7.3% from 1994 to 2004.

2.3 Male and Female Drug Users

Research on women's substance abuse largely agrees that the differences between men and women's substance use exist beyond the variations of prevalence rates (Brown, 2002; Poole & Dell, 2005; Nelson-Zlupko et al., 1995). Research suggests that drug dependent women differ from male counterparts in patterns of drug use, psychosocial characteristics, and psychological, social and physiological consequences of drug use (Poole & Dell, 2005; Nelson-Zlupko et al., 1995). Women are more likely than men to be in an intimate relationship with someone who is also using drugs (Sun, 2000) and are

more likely to have been introduced to substances and injecting-drug use by their partner (Powis et al., 2000; United Nations Office on Drugs and Crime [UNODC], 2004). Unlike male addicts who often organize their day around drug acquisition, use and recovery, the female addict's daily organization often also includes children (Hardesty & Black, 1999).

According to their review of gender differences in addiction and treatment Nelson-Zlupko and colleagues (1995) found that women are more likely to use drugs in isolation and in private areas such as in their home rather than in public places. Women tend to be more economically disadvantaged, have less education, fewer marketable skills and fewer work experiences than their male counterparts. Although they are more likely to be primary caregivers of children, women are often dependent on family members or public assistance for economic survival.

It has been suggested that women are affected differently than men both physically and psychologically by drug and alcohol use (Poole & Dell, 2005; UNODC, 2004). Although the information on gender differences in drug effects and health consequences is limited, research has demonstrated that women are more vulnerable than men to both the acute and long-term effects of alcohol (UNODC, 2004) and drug use (Poole & Dell, 2005). Women also experience unique psychological and social consequences of substance use. Compared to men, female substance users tend to report greater rates of psychiatric symptoms and suicidal ideation (UNODC, 2004).

Women experience a greater stigma associated with their drug and alcohol use than do men (Poole & Dell, 2005). Societal attitudes towards women's substance use tend to be negative, judgemental, and punitive and have an important influence on women's misuse (Brookes & Rice, 1997; Brown, 2002; Cormier et al., 2001; Greaves & Poole, 2004; Poole & Dell, 2005). Addicted mothers, in particular, are condemned as selfish and uncaring, and unfit to parent. Media representations of drug using women portray them as highly sexual and likely to behave immorally. They are often characterized as impulsive, dangerous, selfish and impure (Alicea & Friedman, 1999). This stigma is in large part to blame for the feelings of guilt and shame that are characteristic of female substance users (Brookes & Rice, 1997; Ehrmin, 2001).

2.4 The Female Addict

From their literature search Gustavsson and Rycraft (1994) describe substance abusing women as having a history of sexual and physical abuse, being involved with a drug-abusing, battering male partner, abusing more than one substance, suffering from nutritional deficiencies, depression and lack of medical care, living in inadequate housing and having few social supports. Many other studies report a troubled and traumatic history in the lives of female addicts. Childhood traumas, violence and multiple stressors and losses are commonly reported in the lives of these women (Hardesty & Black, 1999; Nelson-Zlupko et al., 1995; Sun, 2000). Cormier and colleagues (2001) report on a study of female drug users seeking treatment in Ontario, Canada that found that 85.7% of the 98 women surveyed reported having been victimized (Cormier, 2000 as cited in Cormier et al., 2001). Similarly, a survey of residents at a women's drug and alcohol treatment centre in British Columbia, Canada found that 65% of the women reported a physical assault as an adult, 38% a sexual assault, 47% reported physical violence in childhood and 53% reported sexual abuse as a child (Poole, 2000). A survey by the National Center on Addiction and Substance Abuse (CASA) at Columbia University identified sexual and physical abuse as an important risk factor for girls and women, as girls who have been abused are more likely to use substances and to use them earlier, more often and in greater quantities (CASA, 2003).

2.5 Treatment

Recent research has begun to reveal reasons for which women tend to seek drug treatment less often than men and are less likely to complete treatment (Sowers, Ellis, Washington, & Currant, 2002). It has been suggested that several of those characteristics that distinguish female drug abusers from their male counterparts are the same that pose barriers to their seeking and completing treatment (Nelson-Zlupko et al., 1995). Both internal and external factors influence women's decision to seek treatment. Such issues as personal denial, responsibility for care of dependent children, family denial, lack of early identification by professionals, lack of safe, drug-free housing, inadequate public funding, lack of transportation to and from treatment facilities, lack of woman-centered treatment facilities and negative staff attitudes have all been identified as barriers to

treatment for female substance users (Brookes & Rice, 1997; Poole & Isaac, 2001; Powis et al., 2000; Nelson-Zlupko et al., 1995).

In many ways women's central role as caregiver is the source of several of the barriers to treatment faced by female substance users. For instance, women are less likely to have someone actively supporting them in treatment and in fact might be discouraged from seeking treatment by family members who identify their participation as interfering with their ability to care for their family (Nelson-Zlupko et al., 1995; Poole & Isaac, 2001). Most treatment programs require a significant time commitment that would take women away from their family both physically and psychologically. The emotions that often surface in the recovery process from a drug addiction can be powerful as women are faced with intense feelings of guilt, shame, depression and anxiety (Brookes & Rice, 1997; Ehrmin, 2001). This emotional turmoil can be demanding and exhausting and may lessen women's emotional availability to their families. Women may feel selfish for putting their own needs to seek treatment ahead of their families' and therefore downplay the impact of their drug use on their lives (McMahon, Winkle, Suchman, & Luthar, 2002).

Women who are the primary caregivers of children face unique obstacles to seeking treatment (Poole & Dell, 2005). Although children can be a source of significant motivation for seeking treatment, they typically also represent the main obstacles. Female substance abusers communicate powerful feelings of guilt and shame about themselves as woman and especially about themselves as mothers (Ehrmin, 2001). Poole and Isaac (2001) reported that 66% of study participants described shame as a barrier for accessing treatment. Women express the desire to become emotionally and financially independent to raise their children and strive to regain the respect and trust of their children (Sun, 2001). But for many women, without the intervention of social services they are incapable of finding their way out of their drug-using worlds (Sun, 2000).

However, child welfare policies that pit the welfare of children against that of mothers place pregnant and parenting women who abuse substances in a difficult situation (Greaves & Poole, 2004). Mothers who want to seek help for their drug use hesitate to do so because they fear having their children taken away from them solely because of drug use (McMahon et al., 2002; Poole & Isaac, 2001; Powis et al., 2000).

Research suggests that this fear is not unfounded. Sun (2000) reported that 40-80% of families involved with the child welfare system have alcohol and drug problems connected with the abuse and neglect of their children. In their study of barriers to treatment for substance-abusing mothers, Poole and Isaac (2001) reported that 36% of the women they interviewed had lost custody of one or more children, 36% had given up custody, and 30% had custody issues at the time of the study.

Research suggests contradictory consequences of the loss of children to child welfare. In many cases the removal of children can spiral women into even greater depression and increased drug use (Ehrmin, 2001). However, in other cases the loss of custody can act as a motivator to seek treatment (Poole & Isaac, 2001). Carten (1996) and Ehrmin (2001) report that the threat of removal of children was a motivator for seeking treatment. The participants in Poole and Isaac's (2001) study described that the desire to regain custody of their children determined their entry into treatment. For other women the grief over the loss of their children was too great to overcome and lead them into deeper drug use (Hardesty & Black, 1999). For those women who are able to maintain custody of their children the lack of childcare options prohibits them from participating in treatment because they often have no one to look after their children while in treatment (Poole & Isaac, 2001; Powis et al., 2000). Very few treatment centres offer childcare facilities and many women do not have the support from family and friends to allow them to enter treatment. For some, giving up custody of their children and placing them with child welfare is their only option.

Finally, women's perceptions and past experiences with treatment providers frequently determine the likelihood of future attempts to seek help. Women report the importance of not being judged for their drug use (Ehrmin, 2001) and the positive quality of relationships with staff (Carten, 1996) as essential to their success in treatment. However, the belief that social service providers have a negative image of women drug users proves to be a barrier for many women (Powis et al., 2000). Unfortunately service providers are not immune to damaging stereotypes of female substance users common in society (Greaves & Poole, 2004). Policies that punish women for their drug use serve only to promote stigmatization and inhibit help-seeking behaviour (Akin & Gregoire, 1997).

Researchers have suggested that drug treatment programs specifically designed to meet the needs of women dependent on drugs, including especially the needs of mothers, will result in increased participation in treatment and greater treatment success (Poole & Dell, 2005; Sowers et al., 2002). Programs that integrate the developing understanding of the unique situations and experiences that propel women into drug abuse, that maintain them in that world and that prevent them from getting out can lead to greater retention rates and greater recovery rates for women who seek treatment. Such programs would harness the ingenuity of these women and encourage familial involvement and would offer childcare facilities, parenting support, life skills and employment training, and counselling in addition to drug treatment (Carten, 1996; Killeen & Brady, 2000; Kissin, Svikis, Morgan, & Haug, 2001; Sowers et al., 2002).

2.6 Motherhood

Being a woman today means negotiating one's identity in a time when society's understanding of what a woman is seems constantly under revision. While it is true that women have made strides toward equality in the last century they still carry the bulk of the burden for their family's health and welfare, being responsible for both the care of their children and, as necessary, their parents (Statistics Canada, 2000). Mothers still encounter strong societal messages to put aside their aspirations, careers, at least for a time, and devote themselves to their children, despite the fact that women and children can be plunged into poverty as a result of that choice if the relationship with a partner ends (Hays, 1996; Johnston & Swanson, 2004; Woollett & Phoenix, 1991).

In defining their identity, women face another dilemma. The Western definition of a psychologically healthy, mature individual is one that is differentiated and independent (Caplan, 1995). However, this is in direct opposition to the Western definition of a good mother as someone who always puts her family's, especially her children's needs ahead of her own. Women are raised to be connected to others. They are taught that caring for others should be their main goal in life (Hays, 1996; Miller, 1986) and children are to become the greatest focus of their care.

Despite the perception that mothering is innately known and rewarding, women have ambiguous feelings about becoming a mother. In their study of how motherhood changes women's lives Weaver and Ussher (1997) reported that motherhood was

burdensome in terms of the workload involved and isolating, tying women to the home. The women described a loss of identity related to their perceived need to consider their children and spouses before themselves. However, motherhood also gave them enormous enjoyment and pleasure. They described the gratification felt in watching their children grow and make new developmental gains. These contradicting feelings were reflected in the themes that the authors identified as important in the discourses of their participants. These themes included self-sacrifice, reflecting the societal image of the mother as selfless and prepared to sacrifice her own needs for those of her children; overwhelming love, which described the joy and pride the women felt in watching their children grow and develop; just a mother, reflecting the women's sense that society's image of mothers is of people without intelligence and without a past; the real me, the acknowledgement that the women had not changed and were fundamentally the same people they were before having children. Several authors discuss the evolution of identity as an important aspect of motherhood that is often overlooked (Brudenell, 1996; Smith, 1999; Weaver & Ussher, 1997). Womanhood is frequently conflated with motherhood and some researchers dispute the traditional view that motherhood is a natural component of being a woman (Weaver & Ussher, 1997). However, in their study Weaver and Ussher (1997) found that for the women they interviewed motherhood did not equate with womanhood as expected, it engulfed it.

Women who use drugs and alcohol are no different. Pregnant and parenting women who have successfully maintained alcohol and drug free lives appear to be similar in their experience of becoming mothers to mothers who have never experienced drug or alcohol dependence. For all these women motherhood is perceived as a means to achieve adulthood and success in mothering leads to feelings of competence in other areas of life (Brudenell, 1996). In her study of pregnant and parenting women recovering from alcohol dependence Brudenell (1996) describes the importance of balancing as the core concept in the discussion with her participants. This balancing involved integrating the recovery and motherhood processes into the women's identities. They had to develop flexibility to maintain their identity as a mother and a recovering alcoholic as they transitioned to parenthood. For these women, the identification of oneself as a pregnant women changed the meaning of recovery.

Despite the intense negative social stigma they face (Boyd, 1999; Poole & Dell, 2005; UNODC, 2004), many women who abuse substances continue to value their roles as mothers and seek to fulfill their mothering duties while still actively using drugs (Boyd, 1999; Hardesty & Black, 1999). In a study of Puerto Rican female substance abusers Hardesty and Black (1999) describe motherhood as an identity outside of their participants' drug using selves and the women developed strategies to preserve the sense of themselves as "good mothers". Motherhood was a lifeline and survival strategy throughout addiction and recovery and a line of work that grounded the participants amidst disruption. It became their anchor. Despite this, they described that as they fell deeper into addiction children were neglected. The removal of children from the home produced damage to their mother identity and resulted in extreme guilt. However, even when children were removed from a woman's custody she continued to keep a hold of her identity as a mother and her children remained central in her life. For the mothers in this study the loss of children to child welfare authorities either propelled them into self-destruction or became the seeds for recovery. For female addicts recovery means more than "getting clean", it is about recovering the role of mother and creating a new life for themselves and for their children (Hardesty & Black, 1999).

Mothering brings a challenge and opportunity to recovery like no other circumstance. Children are invariably affected by their mother's substance use and therefore by her recovery and conversely, a mother's substance use and recovery is affected by her children. Just as children affect women's decision to enter treatment, they also affect their recovery process in distinct ways. In a qualitative study of female residents in a recovery home Kunkel (2003) describes the complexities of the influence of the mother-child relationship on recovery. According to Kunkel children observe and respond to their mother's change in behaviour (change from substance use to abstinence). They compete for their mother's attention and test her recovery and although children are primary motivators for recovery they may also be resented because of the demands they place on their mother. Kunkel also describes potential risks for women of focusing their recovery on their children. Children may become a mother's sole identity and as a result she may project issues onto her children. In addition, if children are the primary

motivators for recovery should they be taken away a mother has no other reason for continuing in her recovery.

Brooks and Rice (1997) describe the complexities of recovery for families. They explain that for the mothers they interviewed, recovery was not just a return to their pre-using selves but a complex and active process of growth that allows people to function drug free. This process included connecting with one's sense of self and accepting the "addict", but importantly developing a new understanding of one's identity. The change process can be terrifying and challenging for the entire family and family members, including children, can sometimes unknowingly attempt to interfere with the woman's recovery. Children may challenge their mother and test the new found stability of the family, initially waiting for their mother to fall into old and familiar patterns of drug use. These are all things that a mother must consider and be aware of as she journeys through recovery. It is evident that mothers' recovery is complex because they do not go through the process alone. Whether they are in their care or not children will affect and be affected by their recovery process.

Motherhood is an identity that shapes a woman like no other. A woman is deeply affected by her children and women who abuse substances are no different (Ehrmin, 2001). The study of how women manoeuvre their identities as mothers and as recovering substance abusers is only just beginning. Despite this, research is suggesting what is intrinsically believed; that children influence their mother's substance use and her recovery and that her experience of recovery is necessarily different because of her inherent responsibilities to her children (Brookes & Rice, 1997).

2.7 Purpose of the Current Study

This project seeks to explore one mother's experience of recovery and how her understanding of herself as a mother has been affected by that recovery. Interest in this subject arose out of my work with the research participant. It became clear early in my work with this woman that she had done what many others have not; she chose her children over her drugs. This choice became the subject of numerous discussions between my clinical supervisor and myself. As an in-home support worker contracted by child welfare, I assisted and supported the participant as her children transitioned to living with her on a full-time basis. This process unfolded during approximately three months. As my

supervisor and I discussed how well this woman was doing despite all that she had to work through, again and again questions arose. “How did she make this choice?” “What did she do to convince others that she could do it?” “What and who supported her as she carried it out?” “How has her recovery affected her understanding of herself as a mother?” Perhaps because the choice is such a difficult one to make and follow through on we felt that this woman’s story was one that should be explored and shared. The research on recovery from substance abuse is extensive. However, few inquiries have deeply explored mothers’ experience of recovery. This inquiry is a first step to address this absence. Through a series of interviews it considered four main questions: a) what was this woman’s experience of recovery, b) how did her understanding of herself as a mother affect that recovery, c) how did having children influence her process of recovery, d) what motives were involved in her process of drug use and recovery.

PART 3: MANUSCRIPT

ONE MOTHER'S EXPERIENCE OF RECOVERY FROM ADDICTION

Choosing Family: One Mother's Journey Through Recovery from Cocaine Addiction

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ABSTRACT

The purpose of this inquiry was to explore recovery from drug abuse from a mother's perspective. Women's experiences of treatment and recovery are unique from men's and mothers' experiences have been studied little (Poole & Dell, 2005). A series of three interviews were conducted during which the participant was encouraged to deeply explore her experience of recovery as a woman and a mother. This project was carried out using both Consensual Qualitative Research (Hill et al., 2005) as well as The Wish and Fear List (Perry, 1997). These two types of analysis complemented one another and provided two complimentary views of the participant's experiences as both a woman and a recovered drug user within the context of her parenting. The themes of mothering, recovery and identity development, and respective sub-themes are discussed. The proportions of wishes and fears expressed at two phases in the participant's recovery journey are also discussed.

Keywords: Mothers, Women, Addiction, Case Study, Consensual Qualitative Research, Wish and Fear List, Cocaine, Recovery.

Choosing Family: One Mother's Journey Through Recovery from Cocaine Addiction

Despite the increase in awareness and prevention campaigns, it would appear that drug use among women, and in particular cocaine use, has been on the rise in Canada. According to a study conducted by Tjepkema (2004) for Statistics Canada, in 2002, 9.4 % of women surveyed had used an illicit drug in the past 12 months. Approximately 7 % of women drug users reported daily use. Half of one percent (0.5%) of women surveyed was considered to have a dependence on an illicit drug. In a recent survey by the Canadian Centre on Substance Abuse (CCSA, 2005), 1.1% of women over the age of 15 reported cocaine use in the past year. The survey noted that the lifetime use of cocaine among women has increased from 2.7% to 7.3% from 1994 to 2004.

Research suggests that drug dependent women differ from male counterparts in several ways. According to their review of gender differences in addiction and treatment Nelson-Zlupko, Kauffman and Morrison-Dore (1995) found that women have unique patterns of drug use, psychosocial characteristics and psychological, social, and physiological consequences of drug use. They are, for instance, more likely to use drugs in isolation and in private such as in their home rather than in public places. Women are more likely than men to be in an intimate relationship with someone who is also using drugs (Sun, 2000) and unlike male addicts who often organize their day around drug acquisition, use and recovery, the female addict's organization often also includes children (Hardesty & Black, 1999). Although they are more likely to be primary caregivers of children, women are often dependent on family members or public assistance for economic survival (Nelson-Zlupko et al., 1995).

The lives of women who abuse substances are commonly characterized by disadvantage. Female addicts most often represented in the literature are characteristically economically disadvantaged, have less education, and have grown up in troubled, frequently abusive families. Many studies report a troubled and traumatic history in the lives of the female addicts who have contributed to current research (Gustavsson & Rycraft, 1994; Hardesty & Black, 1999; Nelson-Zlupko et al., 1995; Sun, 2000). Although many female addicts have been exposed to drug use in their families of origin (Nelson-Zlupko et al., 1995), women are often introduced to drug use by a male

significant partner (Bushway & Heiland, 1995; Powis, Gossop, Bury, Payne, & Griffiths, 2000).

In many contexts women are often defined by their relationships with partners, parents, children and others. In part because of their roles as caregivers, women experience greater stigma associated with their drug use than do men (Powis et al., 2000; Roberts & Ogborne, 1999, as cited in Poole & Dell, 2005; Zilberman, Tavares, Blume, & el Guebaly, 2003). This stigma presents a barrier to treatment for many women (Akin & Gregoire, 1997; Poole & Dell, 2005). Numerous additional obstacles result in women substance abusers being less likely to seek treatment and less likely to complete treatment than male users (Nelson-Zlupko et al., 1995; Sowers, Ellis, Washington, & Currant, 2002; Zilberman et al., 2003). Recent research has begun to reveal reasons for which this is the case (Sowers et al., 2002; United Nations Office on Drugs & Crime [UNODC], 2004). For example, women are less likely to have someone actively supporting them in treatment and in fact might be discouraged from seeking treatment by family members who identify the women's participation in treatment as interfering with their ability to care for their family (Poole & Dell, 2005). In addition, women report more feelings of depression, anxiety and particularly of guilt and shame about their drug use and treatment seeking than do men (Brookes & Rice, 1997; Nelson-Zlupko et al., 1995). This guilt and shame is often largely related to their roles as mothers and caregivers in their families (Erhmin, 2001).

Children can act as both motivators and barriers to treatment (Powis et al., 2000). Lack of alternate childcare can prove to be a major barrier as can the fear of facing feelings of guilt and shame (McMahon, Winkel, Suchman, & Luthar, 2002). Also, the fear of losing children to child welfare authorities may be too great to risk seeking treatment (Erhmin, 2001). However, in some cases the intervention of child welfare can act as a motivator for mothers to seek treatment (Sun, 2000). The intervention of social service authorities, although often viewed as negative, can provide women with the support needed to complete treatment. Sun (2000) reported that women wanted to become emotionally and financially independent to raise their children, but that if it were not for the intervention of authorities they would still be actively using drugs. For these

women, having the respect of their children was a significant motivator to completing treatment.

It is evident from the research that women's drug use and treatment seeking is influenced by whether they have children. For all women who have children, motherhood is an identity that shapes a woman like no other. A woman is deeply affected by her children and women who abuse substances are no different (Ehrmin, 2001). The study of how women manoeuvre their identities as mothers and as recovering substance abusers is only just beginning. Weaver and Ussher (1997) discuss the transformation of identity as an important aspect of motherhood that is often overlooked. Womanhood is frequently conflated with motherhood and some researchers dispute the traditional view that motherhood is a natural component of being a woman. However, in their study they found that for the women they interviewed motherhood did not equate with womanhood as expected, it engulfed it.

Despite the intense negative social stigma they face, many women who abuse substances continue to value their roles as mothers and seek to maintain a home for their children and fulfill their mothering duties (Boyd, 1999; Hardesty & Black, 1999). The participants in a study of Puerto Rican female substance abusers describe motherhood as an identity outside of their drug using selves and that they developed strategies to preserve the sense of themselves as "good mothers". This study describes motherhood as a lifeline throughout addiction and recovery and a line of work that grounded the participants amidst disruption (Hardesty & Black, 1999).

In contrast to the image of female substance abusers as "bad mothers" who are out of control and a danger to their children (Boyd, 1999), studies have found that women still manage to provide for their children's basic needs of food, clothing, shelter and discipline and that they view mothering as a central role in their lives (Boyd, 1999; Hardesty & Black, 1999). However, it is also reported that as addiction progresses this role becomes harder and harder to fulfill (Hardesty & Black, 1999) and children are often neglected or abused. It is therefore crucial that best practices continue to be developed for pregnant and parenting female substance users.

It has been suggested that pregnancy may be an optimal time to intervene with women who abuse drugs and that delivering a baby can be an opportunity to embark on a

recovery process (Sun, 2000). One study found that women often reduced their alcohol and drug use during pregnancy even before entering formal treatment (Kissin, Svikis, Morgan & Haug, 2001). It is crucial at these points that women are assisted in broadening their motivation to stop using drugs because if pregnancy remains the only reason for getting clean women run the risk of returning to using drugs once their baby is delivered (Kissin et al., 2001). For those women who continue to identify strongly with their mothering role, a caring, non-judgemental environment can be pivotal in nurturing a mother's commitment to recovery and to her children.

Brooks and Rice (1997) describe the complexities of recovery for families. In their discussion they explain that for the mothers they interviewed recovery was not just a return to their pre-using selves but a complex and active process of growth that allows people to function drug free. This process included connecting with one's sense of self and accepting the "addict", but importantly developing a new understanding of one's identity. The change process can be terrifying and challenging for the entire family and family members, including children, can sometimes unknowingly attempt to interfere with the woman's recovery. These are all things that a mother must consider and be aware of while in recovery because she does not go through the process alone. Whether they are in her care or not her children will affect and be affected by her recovery process. In her study of pregnant and parenting women recovering from alcohol dependence Brudenell (1996) describes how balancing emerged as the core concept in the discussion with her participants. This balancing involved integrating the recovery and motherhood processes into the women's identities. For these women, the identification of oneself as a pregnant women changed the meaning of recovery.

Mothering brings a challenge and opportunity to recovery like no other circumstance. Children are invariably affected by their mother's substance use and therefore by her recovery and conversely, a mother's substance use and recovery is affected by her children. Little is yet known about the complex relationship between recovering mothers and their children and research in this area is noticeably lacking. The literature that does exist mostly explores specific aspects of mothers' drug use, pregnancy, and treatment experience. This project sought to explore one mother's experience of recovery and how her understanding of herself as a mother has been

affected by that recovery. The research on recovery from substance abuse is extensive. However, few inquiries have deeply explored mothers' experience of recovery and none have explored their motives using the method presented here. This inquiry is a small step in addressing this absence. Through a series of interviews it considered four main questions: a) what was this woman's experience of recovery, b) how did her understanding of herself as a mother affect that recovery, c) how did having children influence her process of recovery, d) what motives were involved in her process of drug use and recovery. These questions allowed for the exploration of the participant's experience in an open-ended fashion, while allowing to focus on specific issues.

METHOD

Researchers

The principal author (A.S.) was a Master's student in Counselling Psychology at a large urban Canadian university. As a Caucasian woman from an immigrant family the politics of feminism have become important in her research and clinical development. A.S. worked with the participant as a support worker before the research was conducted. P.B. was A.S.'s clinical supervisor. P.B. is currently a clinician and identifies as a feminist researcher and clinician. M.D. is an assistant professor and A.S.'s research supervisor for this project. He identifies as a psychodynamic clinician.

Participant

The participant in this study, Tina, is a Caucasian woman in her mid-twenties living in a mid-sized Western Canadian city. At the age of 14 she left her parents' working-class home to live with her male partner, who was three years her senior. Tina was introduced to cocaine by her partner and they began using the drug regularly after the birth of their second child. Tina describes not having used any drugs while pregnant with her two first children and stopped using some time during her third pregnancy. Tina's two eldest children, then aged approximately six and seven, were removed from her custody by child welfare authorities while she was pregnant with her third child. Shortly after the children were removed, Tina's partner completed suicide.

Approximately two weeks after his death Tina, then eight months pregnant, entered a four-week women's residential drug treatment program at the request of child

welfare. Her third child was subsequently removed from her custody approximately six months after his birth. Nearly one year after completing the residential drug treatment, at the recommendation of child welfare authorities Tina voluntarily participated in the same treatment program as an outpatient. In the year between drug treatments Tina participated in personal counselling, and attended Cocaine Anonymous meetings. She has remained sober, save one lapse, from the time of her third pregnancy. Her children, ages nine and eight years, and 18 months at the time of the interviews were returned to her custody after approximately two years of living with relatives and with foster parents.

It is important to reiterate that Tina had a previous professional relationship with one of the researchers who provided in-home support for her and her family. This provided the basis for the research relationship and the recognition of how this relationship affected both Tina and the researcher was held in awareness during the interviewing, analysis, and writing.

Procedure

The participant, Tina, was approached to participate in the study once her in-home work with the principal researcher was completed. It was clearly explained that participating in the research was in no way related to and would have no consequences on previous work associated with any social agency with which Tina had worked. Three interviews were conducted varying in length from 45 minutes to 2.5 hours during a three-month span. Each interview was recorded and transcribed verbatim by the researcher. During the first meeting the interviewer read the researchers' definition of recovery: "What we mean by recovery is simply your journey from substance abuse to a life without drugs." The goal was to ensure that both the interviewer and the participant understood the other's frame of reference.

For the first meeting, the interviewer was prepared with several open-ended questions based on the research questions to guide the commencement of the interview. Subsequent questions reflected the content and themes the participant discussed and every effort was made to follow the participant's lead while keeping the research questions as a framework for the interviews. At the end of the first two interviews, the participant was encouraged to pay attention to her continuing experience of recovery and mothering in the time until the next interview. Between each interview the tapes were

carefully listened to and transcriptions read in an effort to uncover information to be explored in the next interview.

Upon reflection of the data gathered it was decided that it had reached sufficient saturation and therefore participation was completed after the third interview.

Ethical Considerations

Tina was fully informed of the purpose and procedure of the study and gave informed consent before beginning the first interview. Arrangements were made for a trained counsellor, who had an established rapport with Tina and was aware of the goals and details of this project, to provide counselling if needed.

The participant and any other person mentioned during the interviews were assigned a pseudonym that was used on tapes, transcripts, notes and in the final report. To ensure that the participant is accurately represented and comfortable with the quotes used in the reports, she was given the opportunity to read the parts of the final document in which she is quoted or described, prior to its publication. She then had the right to request the deletion of information or quotes that she felt could identify her or that she was uncomfortable with. She did not, however, object to any part of the manuscript that she reviewed.

Tina did not receive any financial benefit from her participation in the project.

Data analysis

The data was analysed in two distinct ways: qualitatively and quantitatively. It was initially thought that the quantitative analysis would triangulate the qualitative analysis of the interview data. However, upon further investigation of the data it was realized that using two diverse lenses to view it provided two separate but complementary snapshots of the data and helped explain it at varying levels.

Qualitative: Consensual Qualitative Research, CQR. (Hill, Thompson, & Williams, 1997; Hill, Thompson, Hess, Knox, Williams, & Ladany, 2005). This methodology developed by Hill and colleagues (1997, 2005) involves an inductive process by which conclusions and theories are built up from the data. This methodology allows the themes and conclusions drawn from analysis to be derived directly from the participant's interview data. In addition, the consensual process helps to reduce the risk of researcher bias.

The analysis is conducted by a team of researchers who each code the transcripts individually and then meet to discuss their codings until consensus is reached for each one. Hill and colleagues (1997, 2005) suggest that teams be composed of three to five people. However, because of the small scale of this study the research team consisted of the principal author and a research assistant who had been uninvolved with the study until that point, as well as one auditor. Both researchers and the auditor were involved in training lead by an experienced qualitative researcher with extensive knowledge of CQR in which a transcript unrelated to the current study was analysed using the CQR methodology.

Firstly, the data was separated into broad categories called domains. Hill and colleagues (1997, 2005) have made suggestions for preset domains, which came from Strauss and Corbin's work on grounded theory research (1990). Researchers started with preset domains but they were modified to fit the data as analysis progressed. Once the researchers reached consensus on the domains, the data within each domain was then abstracted to obtain the core idea for each segment of the transcript. An auditor (M.D.) who was involved with the study but not with the coding process reviewed the codes of the first and second transcripts and suggested changes which were discussed by the research team. At this point Hill and colleagues (1997, 2005) suggest a cross case analysis during which the domains and core ideas identified for each participant are analysed and then combined to form categories representing the entire sample. Those categories are then rated in terms of their frequency across the entire sample. However, because the present investigation involved only one participant at three points in time, this methodology was altered. The principal researcher first combined the core ideas for each domain, as is described by Hill and colleagues (1997, 2005). The core ideas within each domain and then across domains were reviewed in an effort to "capture the essence of the phenomenon in the words" (Hill et al., 1997, p. 550). From this process a series of categories or themes were created which were then analysed and refined until a set of themes and subthemes were determined. These themes were determined based on the apparent importance (prevalence) of core ideas within and across domains.

Wish and Fear List (1997). The Wish and Fear List (Perry, 1997) is an observer-rated instrument based on the premise that behaviours, feelings, perceptions, and thoughts

are driven by motives. In their basic form these motives can be divided into wishes and fears, which may occur at varying levels of awareness. The Wish and Fear List comprises a standardized list of 40 wishes and 40 fears. Details about the method can be found elsewhere (e.g. Koerner, et al., 2004; Perry, 1997).

Two independent raters experienced in the use of the instrument and blind to the study purpose, each rated the transcripts, which had been randomized. They then met to discuss their ratings. The consensus ratings were used for the present analysis. Neither of these raters was involved in the CQR analysis. The transcripts were then separated into two time phases: pre-treatment/treatment (Phase 1) and post-treatment (Phase 2). This allowed for an examination of the participant's motives once she had completed her treatment and had fewer professional influences in her life compared with the time when she was heavily involved with treatment professionals. Because the focus of the study was the participant's recovery process, from the time she stopped using to the time of the interviews, it was decided not to include the time she was actively using drugs as a distinct time period. Phase one represented any of the discussion that referenced the time when Tina was a young adolescent, her using days, her first drug treatment experience, the year of counselling she did, and her second experience of drug treatment. Phase two represented discussion of the time after her second drug treatment was completed. For the purpose of this study the proportion of the individual wishes and fears were considered.

RESULTS AND DISCUSSION

Qualitative Analysis

The first part of the analysis involved a thorough, line-by-line, examination of the transcripts which resulted in the development of 10 broad domains: Self: Tina's description of herself; her characteristics, her likes and dislikes; Using/Addicted parent: statements that described Tina's situation, thoughts and feelings about the time when she was actively using drugs; Introspection: Tina's expressed thoughts and feelings; Good parent: Tina's descriptions of herself as a good parent and descriptions of what a good parent should be; Reasons for change: internal and external motivators that facilitated Tina's ongoing recovery from addiction; Action: any active behaviour initiated by Tina; Consequences of action: any direct consequences of Tina's actions; Intervening

conditions: any events that occurred in Tina's life that were not directly initiated by her; Consequence of intervening conditions: any consequences of events that were not directly initiated by Tina; Context: information about Tina, her past, and others in her life that did not fit into any of the above domains.

From the core ideas in these domains a series of themes and sub-themes were determined. Figure 1 is an illustrative representation of the themes and related sub-themes described in detail below and of the relationship each theme has to the others. Each theme is intimately related to the other and none can be described without taking into account the influence of the others. The theme of motherhood enveloped Tina's story and therefore seeped into the discussion of both her identity development and her recovery, which in turn, are related to each other.

Motherhood

"Oh yeah, it's true. I'm just completely consumed in motherhood right now. Yeah everything is like the kids... it's kind of what I needed now too." In listening to the interviews and reviewing the transcripts it became clear that motherhood pervaded Tina's story and that her process of recovery from cocaine addiction was entangled with the process of redefining herself as a mother. She described the ongoing development of her identity as she builds on the person she was before she met her partner, before she became addicted, using as building blocks all the experiences she has had since. This development has included the redefinition of herself as a woman who had an addiction to cocaine but more importantly, as a mother. As the analysis delved deeper into Tina's story it became clear that the theme of motherhood could not entirely stand on its own because it is inextricably connected to everything she spoke about. Identity development and recovery were two themes that developed as important parts of Tina's story and are discussed in relation to her experience of motherhood.

Identity Development

Interrupted Development. Tina's story reflects a process of developing and discovering a new self that has elements of who she was but that has incorporated the lessons learned from her relationship, her addiction and her recovery. She uses the words "sober parent" and "addicted Tina" to differentiate herself from the person she was when using cocaine. It was clear that Tina thought of herself as a different person, a different

parent then when she was using drugs. “I mean I was this wonderful person before the addiction, and I knew that I was better than the addictive Tina”. It is as though the time she was using drugs was a blip in her identity development, an anomaly that interrupted the natural unfolding of her self that she has since taken up again. Paris and Bradley (2001), in their study of adult development and recovery from alcohol dependence, described this disruption and renewal of identity development and how it provided insight into each participant’s alcohol abuse and change through recovery.

In talking about her identity development Tina spoke mostly about herself as a mother. Talking about the way she is with her kids now Tina said:

I sit on the floor and play with them and joke like, it’s I feel like a kid and I just love that like I love being with them because like I had no time for them at all, and it’s just the best feeling...I really like that about myself now that I want to play with my kids and be with them.

During the time that she was using Tina described periods of sobriety where she was actively parenting.

Well I mean I knew that I was more the family loving person than I had been when I was using. I mean I was yeah when I was sober for times I was at picnics with the kids, going to the park. Really a good parent really involved with them like, I cared where they were I cared what they were doing. I wanted to be with them I wanted to parent. And when I was using I couldn’t care less where they were.

After her partner died Tina began to work through her grief, and her focus began to shift from him to her children and she was able to pick up the pieces of her identity and construct herself as a mother to her three children. During this process she began to discover that there were aspects of herself that had been hidden by her drug use.

Who I am, What I am becoming. There were certain adjectives that arose and were repeated over and over throughout the three interviews. Being dependable, reliable and strong appeared to be characteristics that closely describe Tina. Those characteristics that she has been discovering about herself are related to her being a good parent and are also what helped her recover successfully. Some of these qualities Tina realized were always part of her and some she is discovering for the first time.

I didn't make a decision to be dependable I think that was just, I think I must be a dependable person because as soon as I became sober like it was like you could count on me for anything you know.

This dependability has become very important as she regains the trust and respect of those around her, especially her children. While she was using Tina describes being erratic and unreliable and that was part of what made her a "bad mother" during those times. Today it has become important for her to demonstrate her reliability and dependability.

Other characteristics that evidently assisted Tina in the recovery process were her strength and her commitment to her children. Commitment and strength, in addition to her constant positive outlook, helped her to overcome not only her addiction but also the uphill battle of convincing child welfare authorities that she is a fit mother. Despite constantly being told that her children would probably not be returned to her, she remained determined and pressed forward and succeeded at regaining custody of her children. As she reflected on that success she said: "I don't know, I guess I guess that I'm a strong person, (because it's a) strong drug to beat".

Recovery

That strength, determination and commitment were essential for Tina's recovery.

If I didn't have that determination I don't think I would have continued.

Like so many times they (child welfare) said 'why don't you just sign the kids over, don't you think they would be better?' I was just, no. I couldn't give up. I don't know where it came from...

This determination to succeed seemed to come from her commitment to her children and to herself as a mother. The longer she remained sober and the more support she received from those around her, the commitment she had always had to her children seemed to evolve into a commitment to being a mother. Despite the importance of external supports it seems certain that Tina's internal strength was essential in her recovery.

Obligation and taking responsibility. Tina's commitment to her children may have come partly from a sense of obligation she felt because of her role as a woman with children. She matter-of-factly reported that she remained sober for all three of her pregnancies even while her partner and friends continued to use drugs in her immediate

surroundings. When asked why this was important she simply stated that she wanted a healthy baby. What is striking about her decision is its opposition to the common situation for pregnant women reported in research who abuse drugs and alcohol (Kissin et al., 2001). The participants in a study by Akin and Gregoire (1997) described the power of their drug of choice as being impossible to refuse explaining that one didn't just 'say no'. Tina did not have this experience. Despite remaining in a using environment she refused to use drugs while she was pregnant. Tina explains, "the only reason I did quit using was because I was pregnant not because I wanted to."

While addicted her priorities were her partner and her drug habit and although she had a level of dedication to her children it was not until she turned her focus to them and to truly becoming a mother for her children that she began to turn her life around. This concept is congruent with the findings of a study by Hardesty and Black (1999) who report that even as women struggled with their own addictions, meeting their children's basic needs remained important. It seems that in the midst of the often chaotic drug using lifestyle women hold to their role as parents. Even when they are not able to provide their children with a stable and safe environment, attending to their children's basic health may provide women with the sense that they are fulfilling their responsibility to their children. However, there comes a point in the mothering addict's life when her addiction escalates to the point where she can no longer maintain her responsibility and her children are neglected (Hardesty & Black, 1999). She may continue to deny the harm to her children or choose to recognize it. It may be at this point that mothers seek help for their addiction. As Tina explains:

T: Because at first I was totally in denial like I you know especially they first, the kids first got apprehended I, I was like why are they gone? Why did they take them? What was the problem? You know.

P: Even though you'd seen your friend lose hers.

T: Exaclty. Yeah. I thought that we were still better parents then...

Once Tina began her recovery process her focus shifted to motherhood. Despite this striking change in her commitment to mothering the sense of obligation as a woman remained. The idea of "doing what needed to be done" came up several times in the interviews. In talking about her partner Tina explained:

I'm happy I made all the decisions I did but, it's almost like... I don't know if, I don't know if it is a woman thing or if it's just the way that I was raised and kinda what I learned growing up but I'm the one that took on the responsibility like I'm still here raising the kids and I think that's because of I think a lot women feel responsible for the kids more than the husbands I think. So, it's almost like he didn't even wanna quit using and get the kids back but I did because that's just the way I think women feel. Um...So I guess it's a I don't know I'm happy that I have that instilled in me whether it's a woman thing or whether it's...

Part of doing what needed to be done was persevering with her recovery despite the hardships because for Tina recovery was more than just getting sober; it was a process of taking responsibility, taking responsibility for herself and subsequently for her children.

And then gradually through everything that happened it just, I just saw the light or whatever it was and I just realized that yeah like you know no one forced me to do it it was my own decision and, and I just took on my own, my responsibility in it instead of always blaming everyone else...I just realized that it was me taking part too.

Tina describes this point of taking responsibility as occurring quite literally overnight. She explained waking up one day and realizing that she was an active participant in her drug use and could blame no one else for her addiction. Paris and Bradley (2001) talk of this kind of turning point in women who are recovering from alcohol dependence. They explain that a turning point of some sort often sparks an initiation of some treatment and the beginning of recovery. This event is often accompanied by a profound internal recognition and awareness that leads to commitment to recovery or to abstinence.

This taking responsibility for her own behaviour seemed to translate into taking control of her life. She said: "like it was so nice to, to have every all my priorities straight and you know like I didn't want, like I wanted to see the kids and I wanted to do this and I wanted to do that I didn't want to just go hide and get high and shut the world out you know." This idea of making the kids her number one priority arose several times in the

conversations and it seems that for Tina this is a large part of what it means to be a good mother for her children. It became important to put the children first and to do what she needed to ensure that all their needs were met. Spending time with her children and being emotionally available to them has become a hallmark of mothering for Tina.

Children as ultimate motivators. When first asked how her children influenced her recovery Tina immediately said that they were the whole reason she recovered but quickly re-thought her answer and said that she recovered for herself as well, but that ultimately it was for her children. She kept fighting so that she could become a better mother for her children and for that reason her children were the ultimate motivation for her recovery. She described how her children were involved throughout her recovery process. While they lived with their grandmother they visited Tina at the treatment centre and once she completed treatment the first time she had regular visits with them. She believed that it helped both her and her children to maintain that constant contact throughout the years that the children remained out of her direct care.

Contradictions

Despite the fact that Tina was sober, child welfare would not return her children to her because her partner continued to use drugs and they remained together as a couple. Tina described that she was faced with the decision to either remain in the couple and lose the children likely forever, or leave her partner and work towards regaining custody of the kids. When her partner completed suicide the decision was made for her.

Because the decision was made for me you know I recovered. But like I said I think if he had been still here, and if I...oh I guess, I don't know. I guess I really can't say for sure but I, I do think that I would still be with him using and that we would have lost the kids. Which is hard to say.

'Cause the only reason I did quit using was because I was pregnant and not because I wanted to.

This statement is completely contrary to Tina's story of commitment to her children and to her recovery. Although she did not emphasize it, it seems that Tina's partner's death was a major catalyst in her journey to recovery. It complicated her recovery process because when she first entered treatment she was grieving his death, which inhibited her

ability to focus on the treatment process. However, it also facilitated her recovery because it removed a potentially impossible decision- did she choose him or her children?

It is unclear how Tina fits this contradiction into her story of recovery and why she did not spend more time discussing and processing it. The interviewers did not focus on her relationship with her partner nor was Tina encouraged to expand on this particular issue. It is likely that this influenced the flow and direction of Tina's discussion. Perhaps she was not comfortable discussing the issue in detail. It is also possible that it was not the right time in Tina's recovery journey to process this issue. The complicated and seemingly opposing relationship between Tina's commitment to her partner and her commitment to her children remains unclear and is an important topic which future research should explore. Research has suggested that being in a couple with a using partner is a barrier to treatment for many women (Poole & Isaac, 2001) and that addicted women are more likely than men to be in a relationship with a drug using partner (Nelson-Zlupko et al., 1995). Similarly, many women are first introduced to drug use by an intimate partner (Bushway & Heiland, 1995; Powis et al., 2000). However, more information is needed about how these relationship issues influence women's drug use and treatment seeking.

A second issue that stood out during the analysis of the story was not a question about a topic discussed but rather the absence of one. In much of the research literature on women's addictions a main theme that emerges is the intense feelings of shame and guilt that characterize female addicts. Although Tina alluded to these feelings they were not a main focus of her story. She described being embarrassed and disappointed about having to enter treatment because she was the only family member who had ever experienced a substance dependence, and her tone and body language suggested feelings of guilt when she spoke about the kind of parent she had been while actively using drugs. However, these feelings were not overtly expressed nor did they become a focus of discussion. It is possible that because the interviewer did not explicitly ask about such feelings Tina chose not to dwell on them.

Quantitative Analysis

The Wish and Fear data provide a different look at the story. In many respects this analysis complements the qualitative data, providing support to the themes, and

sometimes raising new questions. There were two steps to the analysis of the Wish and Fear List (Perry, 1997). Firstly, the transcripts were coded by two independent, blind raters using the standardized Wish and Fear List. Interrater reliability was good with a median ICC (2,1) = .74 for the Wishes, and .72 for the Fears. Consensus ratings were used. Secondly, each wish and fear code was assigned to either Phase 1 or Phase 2 by two raters. Reliability for this was good (Kappa = .76). Again, consensus ratings were used. The proportion of wishes and fears were then calculated for each phase. The most prevalent wishes and fears can be found in Table 1.

Phase 1 represents a long and complicated time for Tina and includes the time before her children were returned to her (pre-treatment and treatment). During this time Tina spoke about herself as an adolescent, her using days, and the tumultuous two-year recovery period. The Wish and Fear List provides some insight into what motivated Tina during this time. The wish for fair treatment and reparation (22.9%) represented the greatest proportion of wishes in Phase 1. Fair treatment and reparation represents a desire to have access to the same opportunities as others, to have reparation for past injuries or deprivations, to have a right to a life of one's own, to be treated fairly and respectfully and to treat others the same way. It may also represent a desire to seek justice for oneself or others and to get the truth for oneself or someone else who has been wronged, and to get over past grudges.

During this time Tina was struggling to come to terms with her addiction, she was grieving the death of her partner and trying to put her life back together. In recovery she was forced to face the consequences her addiction had had on her children, her friends and her family. She described it as an emotionally gruelling and draining time. In addition, she was fighting to prove to child welfare that she was a suitable parent for her children. The situation with child welfare was a constant battle where she forced herself to remain positive and focused on her goal despite the unremitting negative feedback she received from child welfare workers. She described being angry at the system that held her children and felt wronged because she saw herself as having made a "night and day" change in her recovery. She was sober, she had a job and an apartment, was still going to counselling and felt strong and confident and yet she didn't feel that her accomplishments were being recognized. Akin and Gregoire (1997) have suggested that parents involved

with child welfare because of a substance dependence experience feelings of anger, sadness and powerlessness and consistently express feeling that child welfare professionals have little understanding of how much is being asked of them and that they do not give credit for the parents' accomplishments.

The wish to succeed and achieve one's goals (14.3%) represented the second largest proportion of wishes in Phase 1. It consists of the desire to do one's duty, to carry out one's responsibilities, to develop and to take pleasure in one's talents. Tina described feeling like she was making progress and was proud of the giant leaps she had taken. She spoke with pleasure about reconnecting with old friends and having them tell her how much she had changed from her using days. Above all else, Tina began to take responsibility for her actions and for her children. Her goal was to recover from her addiction and regain custody of her children and her entire life was focused on this goal. This wish relates to the wish for fair treatment and reparation. It is possible that part of Tina's determination to regain custody of her children came from wanting to prove to child welfare and perhaps to her friends and family that she could be successful and to prove that she deserved what was rightfully hers-the opportunity to parent her children.

The most prevalent fear that motivated Tina during Phase 1 was the fear of being dominated and controlled (26.2%). This fear includes the fear of submitting to others, of being taken advantage of by others, of being trapped by others and of losing one's freedom. It is likely that this fear relates closely to Tina's involvement with child welfare and the feeling that she had very little control over her life. Child welfare was holding all the cards and the fate of her children's future lay in the hands of the provincial youth and family courts. Tina described her frustration at having to fulfill all of the requirements that child welfare had put before her and how overwhelming their demands on her were.

The fear of criticism and punishment (14.3%) involves fears of being punished, not being liked, being ostracized, being at fault, and of losing face for one's misbehaviour or infractions. It is likely that this fear is related to Tina's feelings of shame for having become addicted to a drug, to the risk of being permanently separated from her children as a result and of having to reintegrate into a mainstream society where she was beginning to reconnect with old friends. Tina began to reconnect with childhood friends but she described awkwardness when she first began to spend time with them. She may

have been feeling embarrassed for the lifestyle she had led for so many years and was afraid of being judged for her choices.

An ultimate criticism of one's parenting abilities is having one's children removed by child welfare. Although Tina only described fleeting moments of doubt in her own ability to parent she was constantly faced with the reminder that she had been judged unfit. Perhaps she felt like she was being punished for her mistakes by having to work so hard to regain custody of her children. However, in the end that work paid off and Tina's children were returned to her care. Phase 2 begins at the point when Tina finished her second participation in drug treatment and her children were transitioned back to her care. Although child welfare was still part of Tina's life during this time their involvement became less and less intrusive and Tina was given more and more power until finally she regained her full parental rights and responsibilities. It is unsurprising that Tina's motives shifted somewhat but remained similar in many respects.

Table 1 displays the proportion of wishes and fears during Phase 2. The most prevalent wish during this Phase 2 was the wish to cooperate and be helpful in response to others (20.8%). This wish, which represents the wishes to be good, compliant, and cooperative, in essence describes a wish to be helpful to others. In their narrative study of female alcoholics Paris and Bradley (2001) report that as women recover from their alcoholism they deepen their intimate relationships and become more generatively caring towards others. Whether this reaction is a result of a renewed attachment to the women's role as caregivers and passive members of society who avoids conflict and aims to please or an attempt to compensate for their lack of caregiving while they were addicted, it seems the end result is the same.

For the women in Paris and Bradley's study (2001) and perhaps for Tina, recovery resulted in a strong motivation to "do good" and to please others. This wish is a change from the wish for fair treatment and reparation prevalent in Phase 1. It seems that Tina's motives shifted from an inward focus for justice to a more generative, outward focus on others. By this time Tina did not have to fight so hard to prove her worthiness and could instead turn her attention to building a life with her children and her family.

The wish to be a good parent and the wish to be perfect and avoid shame were equally prevalent (12.5%). The wish to be a good parent only became important in

proportion to others after Tina was reassured that her children would return to her. Before this time, although Tina's ultimate goal was avowedly to be a good parent, her immediate motivations came from many other things that she had to work through before she could focus entirely on her parenting. The wish to succeed and achieve goals may have been replaced in importance with the wish to be a good parent since Tina had achieved her main goal and could now focus on the every day tasks of parenting. The increased importance of the wish to be a good parent could also suggest that Tina's wishes were less precise or specific during the time captured by Phase 1. As she progressed through recovery, her wishes became more defined and the importance of her role as a mother became clearer. In addition, the focus on the more specific goal of parenting is an indication of being driven by her own personal desires.

The wish to be perfect and to avoid shame was equally prevalent as the wish to be a good parent. This wish involves the desire to be beyond criticism, to be perfect and to avoid shame. The importance of this wish may be related to Tina's sense of always being on guard about her parenting and her current lifestyle. She said that part of her felt like she was always being monitored. One can extrapolate from her experience that perhaps she feels like she cannot fail, like she has had her chance and if she fails this time she will lose her children for good. Akin and Gregoire (1997) report that feelings of fear and powerlessness linger for parents even after children are returned to their care.

The two most prevalent fears in Phase 2 remained the same two from Phase 1, the fear of criticism and punishment (20%) and the fear of being dominated and controlled (20%). Criticism and punishment increased in proportion while being dominated and controlled decreased. It is likely that the fear of being criticized or punished is closely related to Tina's wish to be perfect and to avoid shame, as described above. It seems that even after Tina's children were returned to her and her life moved on in a positive and secure manner she continued to be driven by the feeling that she had to continue to prove herself as a parent and perhaps as a daughter, a sister and a friend. As discussed above even though her children had been returned to her, child welfare remained involved in Tina's life and she continued to live with the fear that they could be taken away from her again, perhaps for good this time. It is not surprising that the ongoing presence of child welfare authorities gave Tina a sense of still not quite being in control of her life.

During Phase 1 63% of motives were wishes and 38% were fears. These proportions changed to 71% wishes and 29% fears in Phase 2. Once Tina's children began to return to her care she was driven more by wishes than by fears. This shift allowed for the increase of wishes to drive Tina's thoughts, feelings and behaviours. As fears decreased there was more room for personal growth and for motives to originate from wishes.

CONCLUSION

Both research and clinical experience paints a poor prognosis for women who have a drug dependence (Bushway & Heiland, 1995; Kissin et al., 2001; Larkin & Griffiths, 2002; Poole & Dell, 2005). What makes Tina's story so unique and so important is it's glaring contradiction to this stereotype. Tina admits herself that she has been fortunate in that she came from a relatively stable family, has a strong and healthy support and role model in her mother, and did not have the kinds of trauma that so often lurk in the childhood of female addicts. However, what is clear in her story is her personal strength, perseverance, commitment and plain stubbornness as she puts it, that she drew on to achieve her goals. This story, not without its struggles, is a story of success. Tina drew on her personal resources and on the experiences she accumulated along the way to journey through recovery from addiction. Her ultimate goal all along the way was to be a mother to her children. A goal she achieved.

This project has a number of limitations that must be taken into consideration. It is inevitable that the researcher's existing relationship with Tina influenced the flow of the interviews and the kind of information that was shared and not shared as well as the analysis of the transcripts. The changes in the procedure of the Consensual Qualitative Research (Hill et al., 1997; 2005) present potential limitations to the validity of the methodology. The applicability of this methodology to a single case analysis has not been discussed elsewhere.

Because this is a study of only one case the information gathered here cannot be generalized to other mothers' experiences. There are many factors that make Tina unique and unlike many women who are addicted to drugs. Despite this, the discussion of one woman's experience is invaluable in contributing to this area of research and encouraging further research.

It is essential that future research focuses on the particular treatment needs of mothers and examines the influence of children on the recovery process in addition to the developmental issues that may arise as a result of sobriety. Additional research with larger samples can begin to determine whether Tina's experience is an exception or a common untold story. One area not explored in this study was the influence of the type of treatment that Tina participated in on her recovery process. An exploration of how working the steps of a 12-step treatment model is related to both the experience of recovery as a mother as well as the motives described was beyond the scope of the current study but would be of interest for future research.

In addition to adding to empirical research this case study has implications for the clinicians who work in the area of women's addiction. Although Tina described child welfare's intervention as being one of the best things that could have happened to her, she also spoke bitterly of their lack of support and negative, pessimistic attitude while she went through recovery. This experience is reported elsewhere in the research (Akin & Gregoire, 1997; McMahon, et al., 2002) and should be considered when planning treatment plans for mothers with an addiction. Tina described how she surrounded herself with positive and supportive people and talked about how important those peoples' influence was in her journey. Professionals working for child welfare agencies have a unique opportunity to be a supportive and positive influence in the lives of mothers trying to kick the habit and put their lives in order again. Other research has demonstrated that positive and supportive relationships with professionals are crucial in recovery success (see for example Carten, 1996).

For Tina the process of constructing her identity was integral in her recovery process. It is important to consider how identity development might influence or be influenced by women's addiction and recovery, and how the attention to identity by clinicians might be of benefit to working with these women. Other researchers have identified the importance of drawing on women's strengths while supporting them through recovery. Kissin and colleagues (2001) discuss harnessing the ingenuity that helps women survive and support their children while using drugs. Tina's story is a strong example of the abundant resources mothers' in recovery possess.

Finally, the literature in this area suggests that it is crucial that service providers make a fundamental commitment to providing woman-centered treatment for women who are dependent on drugs and alcohol. These services must integrate the knowledge of women's particular needs and must consider the impact of including children in the recovery process.

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Figure Caption

Figure 1 Themes and sub-themes identified in qualitative analysis

Figure 1

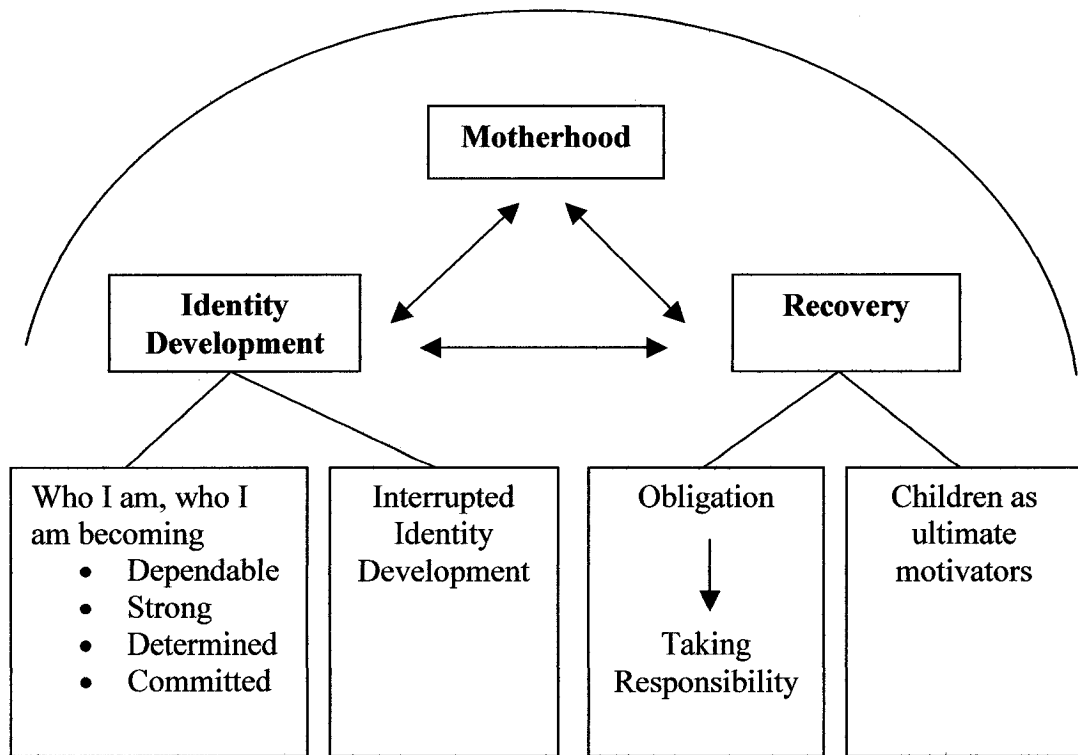


Table 1*Most Prevalent Wishes and Fears (%)*

	Wish	Fear
Phase 1	Fair treatment, reparation (22.9 %)	Being dominated, controlled (26.2%)
	Succeed, achieve goals (14.3%)	Criticism, punishment (14.3%)
Phase 2	Cooperate, help others (20.8%)	Being dominated, controlled (20%)
	Be a good parent (12.5%)	Criticism, punishment (20%)
	Be perfect, avoid shame (12.5%)	

Note. The two most prevalent wishes and fears were chosen for discussion except for the phase 2 wishes because both the second and third wishes were equal in proportion.

PART 4: CONCLUSION

CONCLUSION

This case study was designed to allow for the exploration of the relationship between mothering and recovery from addiction. Through the use of both qualitative and quantitative methods a multifaceted picture of the participant's story was investigated. Consensual Qualitative Research (Hill, Thompson & Williams, 1997; Hill, Thompson, Hess, Knox, Williams, & Ladany, 2005) was used to analyse the three interviews conducted with the participant. Three main themes emerged from the participant's story. Mothering was an overarching theme that permeated the entire discussion. It was a theme that could not stand alone because it was spoken about in relation to each of the other themes. However, it was clear that motherhood was central to the story.

Identity emerged as a second theme. The participant spoke of her addiction and her relationship with her partner as an interruption to her identity development. Once she began recovery she was able to pick up the pieces of her identity and continue to develop and discover herself as a person. She did not identify with the person she was while using and used phrases like "addicted Tina" and "sober parent" to identify the person she was during and after her addiction. Paris and Bradley (2001) point to the lack of research investigating the influence of drug and alcohol use on developmental tasks. In their study of recovered alcoholics a clear theme of reworked development emerged in their participants' retrospective accounts. Each of them described an interrupted and renewed identity development that provided insight into their alcohol use and decision to change and seek sobriety.

Congruent with this study's aims, the participant's view of herself as a mother was discussed at length. It became clear that she identified herself primarily as a mother and not as an addict-recovering or not. Nor did she have a clear conceptualization of herself as a woman. Weaver and Ussher (1997) examined how motherhood changed a woman's life by interviewing mothers of young children. The participants in their study shared contradicting feelings about becoming mothers, describing their contention about the stereotypes they perceived being imposed on them and the joy and pride they felt for their children. For these women motherhood felt like a duty that had been imposed on them and yet motherhood overwhelmed their identity. Unlike the participant of the current study Weaver and Ussher describe the women in their study as maintaining a core

part of their self that had not been affected by motherhood. Finally the participant described the discovery of characteristics, many of which were present in her early adolescence, that assisted her in succeeding in her recovery and that helped her to be the kind of mother she wanted to be. Dependability, reliability, strength and commitment were all important to her journey.

The theme of recovery was discussed. The participant's recovery process was intimately linked to her commitment to her children. She described having always been committed to her children, even while using cocaine but being unaware at that time that she was not a "good mother". This commitment was illustrated by her decision to stop using cocaine during each of her pregnancies. She explained that she ceased use not because she wanted to quit but because she wanted her baby to be healthy. Her subsequent recovery was influenced by a number of events, including the death of her partner and the removal of her children by child welfare authorities. For the participant, her decision to persevere and fight for her sobriety and her children's custody was in part due to her belief that women are more committed to their children than men are.

This obligation to the care of children evolved over the course of her recovery and eventually became a deep devotion to not only her children's well being but to herself as a mother. Part of this process was a turning point at which the participant took responsibility for her own addiction and began to recognize her agency in her recovery. At this point she was able to put her troubled using days behind her and move forward to her goal of rebuilding her family. Paris and Bradley (2001) introduce the turning point as a crucial element in the lives of female alcoholics. Each of their participants described a point in their lives that represented a critical moment that catalyzed movement towards recovery.

Finally, the participant described how her motivation to persist in her recovery came from her children. She wanted to improve herself as a person so that she could be a better mother for her children. Her children were actively involved in her recovery from the beginning as they visited with her and encouraged her. Collins and colleagues (2003) found that parents who were more involved with their children had less addiction severity and less psychological distress. Further research is required to understand whether this is because parents who are less distressed are most available to their children or whether

being more involved with children is a protective factor against increasing substance use. In addition, more research will improve understanding of whether the benefits of involvement with children continue during treatment. Similarly, more research is required to understand the impact of including children in treatment and recovery and the risk factors of out-of-home placement of children while mothers attend treatment programs (Kissin et al., 2001).

The Wish and Fear List (Perry, 1997) was used to investigate the motives that drove the participant before and after treatment. Phase 1 represented all the time before the end of her second experience in drug treatment. Phase 2 includes the time after treatment was completed. The proportion of wishes and fears in each of these phases were explored and compared. During Phase 1 the most prevalent wishes were those of fair treatment and reparation and of wanting to succeed and achieve goals. The highest proportion of fears included the fear of being dominated and controlled and of criticism and punishment. Because the Wish and Fear List is a standardized observer-rated instrument it may have captured motives that were not in the participant's awareness and therefore not identified in the CQR (Hill et al., 1997, 2005) analysis.

During Phase 2 the wishes that motivated the participant changed. The most prevalent wishes were to cooperate and help others, to be a good parent and to be perfect and avoid shame. The fears, however, remained largely the same though the proportions changed slightly. The fear of being dominated and controlled and of criticism and punished remained most prevalent.

Overall, the proportion of wishes increased in Phase 2 and the proportion of fears decreased. Once Tina's children began to return to her care she was driven more by wishes than by fears. This shift allowed for the increase of wishes to drive Tina's thoughts, feelings and behaviours. As fears decreased there was more room for personal growth and for motives to originate from wishes. This in line with findings of Koerner, Drapeau, and Perry (2004). The participant in this case study is unique in many ways when compared to other women in similar circumstances. Poole and Dell (2005) emphasize the importance of recognizing the variation within girls and women who use and abuse drugs and alcohol. Unlike most research reported thus far, the participant in this study gave a different account of her childhood. She did not recount any form of

abuse in her childhood and in fact described her family as generally close and supportive of each other. This support extended to her experience in treatment and throughout her recovery. Poole and Isaac (2001) conclude that having the support of family, friends and helping professionals is a significant ingredient for success for women seeking treatment for substance abuse. In this case the participant's children were placed in the care of her mother by child welfare. This provided her with the reassurance that despite not being in her own custody, her children were being well cared for. In addition she was able to have close and constant contact with her children during the time that she was in treatment. However, this is not the case for most women who wish to seek treatment for drug and alcohol dependence. This has been identified as a significant barrier to treatment for women (Nelson-Zlupko et al., 1995; Poole & Isaac, 2001; Powis et al., 2000).

The participant also had the opportunity to attend a woman-focused treatment centre. This continues to be a rare opportunity for most women who desire to seek treatment. Bushway and Heiland (1995) state that there is virtual agreement in the literature that programs provide the best quality treatment when they are based in a "woman-centric" model rather than a traditional model of drug and alcohol abuse. Part of being woman-focused is the awareness of the barriers to treatment for women and the provision of services that assist in removing those barriers. Poole and Isaac (2001, pp 25-27) make the following suggestions, based on their research, to improve opportunities for mothers to access drug and alcohol treatment and to experience successful recovery: Address stigma, shame and prejudice; ensure that information on treatment programming is widely available; support the role of "gatekeeper"-the front line professionals who are likely to be the first contacts with mothers who abuse drugs and alcohol-, families and peers in helping women to get care; develop and enhance alcohol and drug treatment programming that serves mothers and children; ensure comprehensive care for women and their families; and conduct research into successful strategies for engaging and retaining women in care.

The experience of the participant in this case study has shed light on the subject of mothering through recovery in many ways. An important conclusion made in this investigation is the crucial need of more research attention to this matter. It is essential

that mothers who abuse drugs and alcohol continue to be given a voice in the literature and that researchers and clinicians harness the lessons garnered from their experiences.

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Appendix
Certificate of Ethical Approval