‘Being a Mom’ in a Mixed-Gendered Residential Substance Abuse Treatment Program: A Phenomenological Study

by

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Abstract

Children are often the primary reason women enter a substance abuse treatment program. Women-centered treatment programs have done well to address women's roles as mothers; however, it is unclear how women attending traditional, mixed gender substance abuse treatment programs that have not adopted a women-centered approach experience motherhood within the treatment context. To this end, a phenomenological study was conducted to explore the lived experience of six mothers attending a mixed-gendered residential treatment program in Alberta, Canada. Four meta-themes, alongside twenty-two subthemes, embody the phenomenon in which, s*elf-forgiveness* was both expressed and served as the conduit through which the women experienced *looking back* and *looking forward,* and ultimately, for some, a *sense of closure*. Drawing on attachment theory, psychodynamic theory and self-forgiveness theory, the author discussed how the women's increased awareness and acceptance of self, facilitated a merging of past experiences with the mother she wanted to be.

Dedication

Within every addicted parent, there is a child who experienced a relationship with a parent. And in every child of an addicted parent, there is an enduring reflection of the parent…

(Suchman, Pajulo, Mayes, 2013)

To the women who graciously shared their journey with me,

To my mother and my daughters,

And to all the voices heard and unheard,

… "We know that in all things God works for the good of those who love him,

who have been called according to his purpose"

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Drug-dependent mothers sit at the intersection of idealized images of motherhood, the social efforts to protect children from abuse and neglect, and the dehumanizing social problems of drug and alcohol abuse

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Introduction

A significant number of women presenting for substance abuse treatment are mothers with children both in and out of their care. Of those who have lost or relinquished custody of their children, many hope to fully and/or partially regain their mothering role. Women are three times as likely as men to report their parenting concerns as a motivator to stop using substances (Gerstein Johnson, & Larison, 1997, as cited in Knis-Matthews, 2010). In fact, children are often the primary reason women state for entering a treatment program. Many women enter treatment to increase the chances of having their children returned to them and/or begin to redevelop relationships with their children while in recovery (Baker, 2000; Carten, 1996; Hardesty & Black, 1999; McIntosh & McKeganey, 2000; Sorbo, Beveridge, & Drapeau, 2009).

Notwithstanding these issues, substance abuse treatment has historically neglected the mothering experience. Health care services have often taken a child- or fetus-centered approach in their response to substance-dependent mothers, with little regard to the health and well-being of the mother-child unit (Greaves, et al., 2002; Rutman, Callahan, & Swift, 2007). Women in substance abuse treatment often feel like they have to prove their worthiness (e.g., abstinence) before their health needs are considered in conjunction with their child(ren) (Greaves, et al.,

2002; Sorbo, et al., 2009).

Once a woman decides to enter into treatment, it is unlikely that the program is able to appropriately deal with her parenting needs (Moore & Finklestein, 2001; Niccols, et al., 2010). Few programs emphasize family issues and even fewer allow women to care for their children during treatment (Baird, 2008; Etherington, 2007; Poole & Greaves, 2007). On the contrary, traditional substance abuse treatment programs tend to focus on the individual and drugrelated behavior (Finklestein, 1994; Lafave, Desportes, & Mcbride, 2009); parenting concerns are often only addressed, if ever, after treatment is complete. Although there are an increasing number of women and/or mother-centered programs across Canada, there are gaps in their availability and accessibility (Greaves, et al., 2002; Niccols, et al., 2010). Mothers with substance use problems face multiple barriers in accessing appropriate support and treatment services.

Feminist mothering theorists argue that the dominant discourse on mothering in North America has socially constructed a 'good mother' as

> white, heterosexual, able-bodied, married and in a nuclear family… altruistic, patient, loving, selfless, devoted, nurturing, cheerful… put[s] the needs of their children before their own…[and] are the primary caregivers of their children (O'Reilly, 2004, p. 4).

This dominant social image of mothers delegitimizes the mothering experience for those who do not fit within these social expectations (Litzke, 2004; Middleton, 2006). This is especially true for mothers who abuse substances as they often do

not meet these standards; legitimizing the neglect of mothering issues in traditional addiction treatment programs.

Purpose

Over the last twenty years there have been encouraging increases in the amount of research exploring the lives of substance-dependent mothers. However, research relating to the experiential aspects of maternal drug use, such as perceptions of parenting, the process of mother-child reunification, and the treatment process has occurred primarily within the context of women and/or mother-centered treatment programs.

Despite evidence supporting the utility of a gender-responsive treatment approach to substance abuse, the reality is that most women do not have access to these specialized services. Many studies point to the effectiveness of integrating pregnancy, parenting, and child-development services with addiction services (Ashley, Marsden, Brady, 2003; Niccols & Sword, 2005; Orwin, Francisco, Bernichon, 2001). However, Niccols, et al. (2010) recently reported that approximately half of the addiction agencies surveyed in Canada do not provide any of these integrative services. Of those that do, most are located in British Columbia and Ontario, and the majority of these services consist of referrals to other agencies. Moreover, the absence of any provincial and/or national systemlevel policy for implementing and/or integrating gender-sensitive interventions within substance abuse treatment, even in programs specialized to address the service needs of women and mothers, has resulted in a highly variable treatment experience for substance-dependent mothers across Canada.

Women-centered programming that does exist has benefitted immensely from exploring the treatment experiences of women. Listening to the voices of substance-dependent mothers has allowed service providers to creatively design and deliver services that can be more effective and relevant to the women and children they serve. It is in this light that the neglect of mothers attending less specialized programs is especially problematic, since it continues to marginalize a considerable proportion of substance-dependent women, but it also has the potential to exacerbate the gap that exists between traditional and women-centered substance abuse treatment programs within Canada. The current study attempted to bridge this gap by describing the lived experience of mothers attending a traditional mixed-gendered substance-abuse treatment program in Alberta, Canada.

Definition of Terms

Substance Use, Abuse, & Dependence: The experience of substance use can be best understood to exist on a continuum that ranges from *abstinence* to *dependence*. Both substance abuse and substance dependence differ from substance use in that they are defined by maladaptive patterns of substance use. Substance abuse is defined by factors such as failure to fulfill role obligations, repeated use in situations that are physically hazardous, multiple legal problems, and/ or recurrent social and interpersonal problems in the past 12 months. Substance dependence includes the same maladaptive patterns of use as substance abuse, but also includes tolerance, withdrawal and/ or a pattern of compulsive use in the past 6 months (American Psychiatric Association, 2000).

Addiction is a broad term used to describe maladaptive patterns of substance use, abuse, and dependence. The terms *abuse*, *addiction* and *dependence* will be used interchangeably in this paper, with the understanding that although they represent a range of substance use patterns, they are depicting the experiences of women engaged in maladaptive patterns of substance use.

Relapse refers to the process of returning to the use of alcohol or drugs after a period of abstinence.

Recovery refers to the process of voluntarily working toward and maintaining a lifestyle characterized by sobriety and personal health.

Gender-Based Analysis: Gender-based analysis (GBA) is an analytical tool that examines the differences in women's and men's lives, and identifies the potential impact of policies and programs in relation to these differences. The GBA framework recognizes how bio-psychosocial experiences of men and women are influenced by a variety of factors, including class, socio-economic status, age, sexual orientation, gender identity, race, ethnicity, parenting status, geographic location, education and physical and mental ability (Health Canada, 2003).

Gender-Responsive- Gender-Sensitive- Women-Centered- Mother-Centered-: these terms indicate that a GBA framework has informed the program, intervention and/or treatment approach. While there is no universal definition of substance abuse treatment programming for women, the above terms will be used

interchangeably in this paper, with the understanding they refer to the delivery of services and treatment that reduce women's barriers to entering substance abuse treatment and/or address their specific substance abuse treatment needs.

Literature Review

Problematic substance use has historically been viewed through an androcentric lens; this has had profound implications for prevention, treatment, research, policy and practice. Responses wrapped in gender-neutral rhetoric, often result in services most relevant to adult men, while the unique needs of specific sub-groups, such as women, are underappreciated. In recent years, Health Canada has asserted that population health services and supports should be informed by gender-based analysis in order to be responsive to the ways in which people's particular needs, choices and service engagement are influenced by the interaction of factors such as gender, parenting status, ethnicity, socioeconomic status, disability, and age (Health Canada, nd). In 2008, as part of the National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada, the National Treatment Strategy Working Group also recommended that gender and diversity analysis be reflected in Canada's National Substance Abuse Treatment Strategy (National Treatment Strategy Working Group, 2008). The following section highlights how substance dependent women differ from their male counterparts in their substance use patterns and the biological, psychological, and social risk they experience during their addiction and treatment career.

Prevalence

Sex differences in rates of substance abuse have been consistently observed in the general population and treatment seeking samples, with men exhibiting higher rates of substance use, abuse, and dependence (Greenfield, Back, Lawson, Brady, 2010). However, recent epidemiological surveys conducted in Canada and elsewhere suggest that this gap is narrowing. Findings from the 2004 Canadian Addiction Survey (CAS), one of the most comprehensive and detailed addiction surveys ever conducted in Canada, reveal that alcohol is the most common substance used by women, and its use among women has risen steadily over the last fifteen years (Canadian Centre on Substance Abuse [CCSA], 2004). Women's rates of past year alcohol use increased significantly from 66.7% in 1994 to 76.8% in 2004, as did their rates of heavy drinking (i.e. five or more drinks per occasion) jumping from 6.2% in 1994 to 8.8% in 2004 (CCSA, 2004). Data from the United States suggests that the male to female ratio of alcohol use disorders reduced from 5:1 in the 1980s to 3:1 in the 2000s (Hasin, et al., 2007, as cited in Greenfield, et al., 2010). However, this may be considered modest in light of a 2003 US national survey suggesting the past year male to female ratio of alcohol dependence as closer to 1.9:1 and of any illicit drug dependence as 1.5:1 (Brady & Ashley, 2005).

According to a study conducted by Tjepkema (2004) for Statistics Canada, 9.4% of women surveyed in 2002 had used an illicit drug in the past year. Approximately 7% of those women reported daily use. Although Canadian men remain twice as likely to use illicit drugs as their female counterpart, both genders

report increasing rates of use. The 2004 CAS data reveal that women's lifetime use of illicit drugs has virtually doubled since 1994. The increases are as follows: cannabis 23.1% to 39.2%; cocaine/crack 2.7% to 7.3%, LSD/speed/heroin 3.6% to 9.0% (CCSA, 2004). While there is limited information on methamphetamine use in Canada, 2005 data from British Columbia reveal that of those seeking substance abuse treatment 53% of men and 47% of women sought help for methamphetamine use (Poole & Dell, 2005).

Rates of benzodiazepine use have been consistently twice as high for women than men since the 1970s (Currie, 2003, as cited in Salmon, et al., 2006). A study in British Columbia revealed that 9% of the population received at least one prescription for a benzodiazepine in 2002, and despite potential for harm and little evidence of clinically meaningful benefit, benzodiazepine use steadily increased between 1996 and 2002 (Therapeutics Initiative, 2004, as cited in Poole & Dell, 2005) The study also indicated that considerably more females (12.2%) were prescribed a benzodiazepine compared to males (7.1%). This gender gap held across all ages, with the highest prevalence rates among elderly women. Statistics Canada reports that women also use other prescription and non-prescription drugs, including painkillers, sleeping pills, tranquillizers, antidepressants, and diet pills, at consistently higher rates than men (Statistics Canada, 1996, as cited in Poole & Dell, 2005).

It is estimated that one-quarter to one-third of injection drug-users in Canada are female (Wiebe & Reimer, 2000, as cited in Poole & Dell, 2005). HIV rates in this population remain disproportionately high. It is estimated that

between 2,300 and 4,300 new HIV infections occur in Canada each year (Public Health Agency of Canada, [PHAC] 2010b). Females have comprised an overall increasing proportion of HIV cases reported since 1985. In 2009, injection drug use (IDU) was the third most frequently reported exposure category, accounting for 21.6% of HIV reports among adults that year; women had a higher proportion of HIV attributed to IDU than men (PHAC, 2010b). A number of studies highlight the decreased ability of female injection drug users to negotiate safe injection and sexual practices compared to their male counterparts (Bennet, Veleman, Barter, Bradbury, 2000; Golub, Rey, Obadia, Moatti, 2000; MaCrae & Aalto, 2000). Moreover, patterns of high-risk injection behavior, such as increased frequency of injections, earlier initiation into injecting, injecting in high-risk environments (e.g. shooting galleries, crack-houses), injecting with used syringes and poly-drug use, are more likely to be observed in female injection drug users who are homeless, young, Aboriginal and who trade-sex (Paone, Cooper, Alperen, Shi, Des Jarlais, 1999; Spittal, et al., 2003).

Biological Risks

Overall women experience and perceive significantly more health problems related to substance use than men (Brady & Ashley, 2005). Females are particularly vulnerable to the physiological effects of alcohol and other drugs even at substance use rates lower and/or similar to males. For example, compared to men, females develop alcohol-related liver disease after shorter periods of use, and are more susceptible to cardiac problems, hypertension, osteoporosis, breast

cancer, gastric ulcers and brain and reproductive impairments (Brady & Ashley, 2005; Substance Abuse and Mental Health Service Administration, [SAMHSA] 2004). Greater vulnerability to the physiological impact of substances makes females more vulnerable to dependence and other problems associated with substance use (Brady & Ashley, 2005).

Women who enter treatment typically present with more medical, behavioral, psychological, and social problems than men, despite having used less of the substance and having used the substance for a shorter period of time (Arfken, Klein, di Menza, Schuster, 2001; Greenfield, Brooks, et al., 2007; Greenfield, et al., 2010; Kay, Taylor, Barthwell, Wichelecki, Leopold, 2010). Telescoping is a term used to describe an accelerated progression from the initiation of substance use to the onset of dependence and first admission into treatment; this phenomenon has been observed among women across substance type (i.e. alcohol, opioids, and stimulants) (Greenfield, Brooks, et al. 2007; Greenfield, et al., 2010; Kay, et al., 2010). For example, in a study of 546 men and women addicted to heroin, Anglin, et al. (1987, as cited in Kay, et al., 2010) found that women were more likely than men to become addicted to heroin within 1 month of initial exposure. This study also found that women escalated their use of heroin more rapidly, became addicted in a shorter period of time, and sought treatment earlier in the course of addiction than did men. Similarly, Haas & Peters (2000) observed in women a shorter duration between first cocaine use and cocaine abuse, and found they reported more cocaine use-related problems.

Psychological Risks

Research suggests that as many as two thirds of women with substance use problems may have a concurrent psychiatric disorder, such as depression, post-traumatic stress disorder (PTSD), panic disorder, generalized anxiety and/or an eating disorder (Chander & McCaul, 2003; Poole & Greaves, 2007; Kovalesky, 2004; Zilberman, Tavares, Blume, el-Guebaly, 2003, as cited in Cormier, Dell, Poole, 2003). A large proportion of substance dependent women are victims of domestic violence, incest, rape, sexual assault and child physical abuse (Conners, et al., 2004; Poole & Greaves, 2007). Victimization is more common among women, and has been linked to a variety of these negative outcomes, including PTSD, depression, anxiety, suicidal behavior and low self-esteem. The rate of women seeking substance abuse treatment who meet diagnostic criteria for PTSD, often stemming from childhood physical and or sexual abuse, is higher than men (Brown, Recupero, Stout, 1995) in the range of 30% to 59% (Gose & Jennings, 2007). Chander & McCaul (2003) found the prevalence of substance use disorders in individuals with PTSD ranges from 21.6% to 43.0%.

Similarly, lifetime rates of mood and anxiety disorders are significantly higher among women than men, with and without substance use disorders (Greenfield, et al., 2010; Kang, 2007). Chander & McCaul (2003) found that women are more likely than men to report the onset of anxiety or mood disorders before alcohol dependence. Gender differences in rates of depression emerge in adolescence and continue into late middle age, with women twice as likely to be

diagnosed with major depression as men (Koehn & Hardy, 2007). In alcohol dependent populations Tjepkema (2004) found that females were twice as likely to experience depression as men; moreover, women who were dependent on illicit drugs in the previous year were approximately eight times more likely to experience depression than their male counterparts. These findings have significant implications for women who abuse substances, as comorbid psychiatric disorders have the potential to exacerbate the health and social consequences of substance abuse and negatively affect treatment outcomes (Chander & McCaul, 2003; Greenfield, Brooks, et al., 2007; Kang, 2007; Miles, Svikis, Kulstad, Haug, 2001).

Social Risks

Substance dependent women have lives that are often characterized by stark disadvantage, including few financial resources, low educational attainment, and unstable housing and employment (Conners, et al., 2004; Poole & Greaves, 2007). They are more likely than men to be the primary caregivers of children, despite being less financially secure, and more dependent on family member and social welfare systems for financial support (Conners, et al., 2004; Oggins, Guydish, Delucchi, 2001). They often have life histories replete with emotional, physical, and sexual violence (Bernal, Galera, O'Brien, 2005; Galera, et al., 2005; Poole & Greaves, 2007), increasing the probability that they will use substances, use them earlier, more often, and in greater quantities (National Center on Addiction and Substance Abuse [CASA], 2003). However, in a cruel twist, substance use puts women at a greater risk for experiencing further abuse, often

creating a vicious cycle for female substance users. The emotional interconnections associated with substance use greatly shape the lives of women, as they are more likely to use substances to regulate affect than males (MacLean, Paradise, Cauce, 1999).

Substance dependent women often grow up in troubled and abusive families, where they are exposed to drugs and alcohol early in life (Bernal, et al., 2005; Conners, et al., 2004; Harmer & Sanderson, 1999). Although substance abuse is common in their families of origin, female substance use initiation often occurs within the context of sexual or interpersonal relationships. This is different than males, who are more likely to report experimentation or peer-influence as the context for substance use initiation (Frajzyngier, Neaigus, Gyarmathy, Miller, Friedman, 2007; Hser, Anglin, McGlothlin, 1987, as cited in Grella, Scott, Foss, Dennis, 2008).

Women are often defined by their relationships with others, such as their partner or children. This in part has fuelled misinformation, harsh media representations, and stigma associated with women's substance use (Kandall, 2010). Consequently, women report more feelings of guilt and shame about their substance use than men. These feelings are typically related to their roles as mothers and caregivers (O'Connor, Berry, Inaba, Weiss, Morrison, 1994; Ehrmin, 2001). And unlike male drug users, who organize their days around drug acquisition, use, and recovery, women's daily organization typically also includes child-rearing responsibilities (Baker & Carson, 1999; Hardesty & Black, 1999; Richter & Bammer, 2000). Women are also more likely than men to be in an

intimate relationship with someone who also uses drugs (Conners, et al., 2004; Poole & Greaves, 2007). Considerable power imbalances commonly characterize these relationships, often manifesting in interpersonal emotional, financial, physical, and sexual violence.

Substance dependent women often feel isolated and lack social support from family and friends (Conners, et al., 2004; Kelley, 1998; Poole & Greaves, 2007). They have a greater risk for substance use during key transitions in their life such as moving one neighborhood to another (CASA, 2003). They typically experience poor mental and physical health, and tend to use substances to improve mood, increase confidence, reduce tension, cope with problems, lose inhibitions, enhance sex or lose weight (CASA, 2003; Poole & Greaves, 2007). Women are more likely than men to be poly-substance users, use substances in isolation, and use in their homes rather than in public places (Back, Payne, Waldrop, et al., 2009, as cited in Greenfield, et al., 2010; Sorbo, et al., 2009; Lex, 1992, as cited in Greenfield, Manwani, Nargiso, 2003). Gender differences have also been observed in the situations that are associated with relapse. For females, conditions connected with relapse are living apart from one's children, being depressed, having a stressful marriage, and using within the context of a sexual relationship, whereas for men they include living alone, positive emotional affect, and social pressures (Grella et al., 2008; Rubin, Stout, Longabaugh, 1996, as cited in Grella, et al., 2008; Saunders, Baily, Phillips, Alsop, 1993).

Substance-Dependent Mothers

An estimated 5.5% of women living with children under the age of 18 have abused or been dependent on alcohol or an illicit drug (SAMHSA, 2004).

Canadian trends reflecting the number of substance dependent women who have children is unavailable, however CAS (CCSA, 2004) data suggest that most women who use substances in Canada are of child-bearing age. Data that have been collected in substance abuse treatment samples across North America suggest that most women entering into treatment have minor children (Grella, Needell, Shi, Hser, 2009; Luthar & Suchman, 2000); usually fewer than half are living with all of their children at the time of treatment admission and up to one third have lost their rights to at least one child (Grella, et al., 2009; Kissin, Svikis, Morgan, Haug, 2001). The following section highlights trends and biological, psychological, and social risks associated with maternal substance abuse.

Pregnancy

The Canadian health promotion and public health system has long situated the issue of substance use during pregnancy as a major public health concern. However, there is still a sizable segment of women who use alcohol while pregnant. While any amount of alcohol is proscribed in Canada, data from two recent large-scale Canadian studies indicate that approximately 20% of newborns have prenatal exposure to alcohol (Tremblay, 2003, as cited in Niccols, et al., 2010).

The teratogenic potential of drugs and alcohol has been well established, and is understood to span all areas of children's development. Common physical outcomes include low birth weight, physical withdrawal, obstetrical complications, irritability, growth retardation, sleeping and eating problems, poor coordination, and difficulties with self-regulation (Conners, et al., 2004;

Roussotte, Soderberg, Sowell, 2010; Schempf, 2007; Shankaran, et al., 2007). The effects of substance exposure on cognitive development include lower intelligence, delayed language development, and academic difficulties (Fitzgerald, et al., 1993; Kolar, Brown, Haertzen, Michaelson, 1994; Schempf, 2007). In the socio-emotional domain, internalizing problems such as depression and poor social responsiveness have been observed. Behavioral problems are also common, including hyperactivity, impulsivity, distractibility and restlessness, and physical aggression (Chronis, et al., 2003; Johnson, Boney, Brown, 1990; Schempf, 2007; West & Printz, 1987).

Substance Use & Mothering

While the risks associated with prenatal substance exposure necessitate continued efforts aimed at reducing substance use among pregnant women, experience has shown that fetus-centered approaches that do not address the health and well-being of the mother-child unit have limited long-term impact. For example, a recent study released by Substance Abuse and Mental Health Services Administration ([SAMHSA], 2009), reports that many postpartum women rapidly resume substance use. When compared with women in the third trimester of pregnancy, non-pregnant women with children under three months old in the household had much higher rates of past month alcohol use (6.2 vs. 31.9%), binge alcohol use (1 vs. 10%), cigarette use (13.9 vs. 20.4%), and marijuana use (1.4 vs. 3.8%). Moreover, it is thought that the greatest impact of perinatal substance use on children may be the increased postnatal risks of neglect and maltreatment, foster care placement, and other disruptions in the home environment (Frank,

Augustyn, Knight, et al., 2001, as cited in Schempf, 2007; Schempf, 2007; Wells, 2009). These factors have much stronger effects on cognitive and behavioral outcomes than fetal drug exposure (Hans, 1996, as cited in Schempf, 2007; Wells, 2009).

The effects of maternal substance abuse are quite variable according to the type and extent of the substance used, the child's developmental level, and the presence or absence of other risk or protective factors (Luthar & Sexton, 2007; Suchman, McMahon, Slade, Luthar, 2005). Substance abuse shapes the mother-child relationship through several mechanisms. Some of the effects occur as a result of maternal ingestion of drugs and/or alcohol during pregnancy, whereas others manifest as a result of the impaired parenting commonly associated with substance use. Parents under the influence of alcohol or drugs may experience physical and/or mental effects that inhibit them from providing adequate care to their children (Wells, 2009). Substance use can limit the financial resources available to raise their children, and substance users typically spend a significant amount of time seeking drugs; the time away prevents effective monitoring of, and engagement in, their children's activities (Brown & Hohman, 2006; Coyer, 2003; Kelley, 1998). As well, the chaos and unpredictability that is characteristic of the substance abusing lifestyle is opposed to the structure and consistency necessary for children's development (Bauman & Dougherty, 1983).

Ammerman, Kolko, Kirisci, Blackson, and Dawes (1999) suggest that substance abuse results in low frustration tolerance, increased anger reactivity, disinhibition of aggressive impulses, and interference with appropriate judgment,

all of which impact parenting. The physiological effects of substances can cause erratic sleep-wake cycles, loss of appetite, distorted perceptions, and other substance-induced psychiatric symptoms that impede substance abusing parents' ability to respond to their children in ways that promote optimal psychological and physical growth (Brown & Hohman, 2006; Knis-Matthews, 2010). Substance abusing parents are challenged even further, and the risk of child maltreatment increases, if their children have been exposed to substances in utero. For example, cocaine-exposed infants tend to be more irritable and more sensitive to stimulation, making them more difficult to soothe and calm than non-exposed infants (DiPietro, Suess, Wheeler, Smouse, Newlin, 1995; Hawley & Disney, 1992).

Substance abuse is also thought to interrupt normative personality development. Lief (1985) notes that substance abusing parents may not exhibit the basic understanding of reciprocity in interpersonal relationships. Reflective functioning plays an important role in reciprocity within the mother-child relationship (Fonagy, Gergely, Jurist, Target, 2002; Mercer & Ferketich, 1994); this is the ability to recognize that a child's mental experience is influencing their behavior. Recognition of a child's mental states and their influence on behavior involves recognition of one's own mental states and their influence on behavior. If this is impaired distinction between the mothers' and children's mental experiences is not possible (Suchman, DeCoste, Leigh, Borelli, 2010), making it difficult for a mother to meet her child's emotional needs. Reflective functioning among low and high-risk samples of mothers is associated with maternal ways of

thinking about the caregiver relationship, with maternal behaviors in mother-child interactions (e.g. flexibility and sensitivity), and with children's felt security (Akerjordet & Severinsson, 2010; Suchman, et al., 2010). Both low levels of reflective functioning and substance abuse have been associated with insensitive and emotionally unresponsive maternal behaviors (e.g., withdrawal, hostility, intrusiveness, and distorted perceptions of affective communication) (Harris-Brit, Thakkallapalli, Kurtz-Costes, Martin, 2010; Suchman, et al., 2010; Suchman, Mayes, Conti, Slade, Rounsaville, 2004; Suchman, Rounsaville, DeCoste, Luthar, 2007).

Mothers who abuse substances are often unaware of their child's developmental state, and have unrealistic expectations about their child's behavior, expecting behavior too developmentally advanced for the child's chronological age and skill level (Hohman & Butt, 2001; Velez, Jansson, Montoya, Schweitzer, Golden, 2004). This distorted view often leaves the mother feeling like her child's behavior is unmanageable, and that the behavior is either personally directed at her and/or she has failed, producing increased feelings of guilt and inadequacy (Colten, 1982; Laughinghouse, 2009). Substance dependent mothers often vacillate between authoritative and permissive styles of parenting (Laughinghouse, 2009; Suchman, et al., 2004), possibly compensating for their feelings of failure at each end of the parenting spectrum.

Solomon and George (1996) suggest that a substance-dependent mother's "preoccupation with interpersonal loss and trauma, feelings of shame, defiance, and neediness are readily and repeatedly activated by children's everyday

emotional demands" (as cited in Suchman, et al, 2004, p. 183). Harmer, et al., (1999) explored the relationship between childhood abuse experiences, psychological distress, parenting stress and use of problematic parenting behaviors among substance dependent and non-substance dependent mothers. They found that substance dependent mothers reported significantly higher levels of aversive childhood experiences, psychological distress, parenting stress and use of problematic parenting behaviors along with lower levels of social support. Low levels of social support can result in substance dependent women feeling overwhelmed and being more likely to seek inappropriate nurturing and emotional gratification from their children (Kroll, 2004; Laughinghouse, 2009).

Many of the early child development problems associated with maternal substance use have negative implications for the development of attachment in very young children, especially when combined with the co-occurring problems observed in substance-abusing mothers such as low self-esteem, guilt, poor responsiveness, PTSD, anxiety, depression, social isolation, and anger (Luthar & Walsh, 1995; Lyons-Ruth & Block, 1996; Suchman & Slade, 2005; Turney, 2011). Attachment research has shown that the capacity of a mother to facilitate attachment by recognizing a child's emotional needs and respond to them in an emotionally available way is an important predictor of children's psychological development (Mercer & Ferketich, 1994). Moreover, the child's response to care serves as a source of the mother's confidence or uncertainty, and has been positively related to the mother's perceived competence (Bullock & Pridham,

1988). Maternal competence is recognized as a basic determinant of a woman's capacity as a mother because it affects her ability to respond to her child (Bullock & Pridham, 1988; Mercer & Ferketich, 1994).

Substance Abuse & Child Maltreatment

A number of studies report associations between child maltreatment and parental substance abuse (Wells, 2009; World Health Organization, 2006). For example, The National Institute of Mental Health (NIMH) Epidemiological Catchment Area Study, a community-based survey of 18,000 adults, 11,662 of whom were parents or acting as caretakers for children, in five communities across the United States, compared the frequency of substance abuse and dependence between adults who report having abused or neglected children and those not reporting child maltreatment (Kelleher, Chaffin, Hollenberg, Fischer, 1994). Respondents reporting abusive or neglectful behaviors were individually matched on socio-demographic variables with respondents not reporting child maltreatment. A total of 169 respondents (1.4%) reported abusive behavior, whereas 209 respondents (1.8%) reported neglectful behavior. Sixteen respondents (0.1%) reported both physically abusive and neglectful behavior. The lifetime prevalence of alcohol or drug disorders among subjects admitting physical abuse or neglect of children was markedly higher than that among their matched controls. Adults with an alcohol or drug disorder were 2.7 times more likely to have reported abusive behavior toward children and 4.2 times more likely to have reported neglectful behavior. In a similar study, data from the Ontario Mental Health Supplement (OHSUP), allowed researchers to examine the

relationship between self-reported exposure to child abuse and a history of parental substance abuse in a community sample of 8,472 respondents living in Ontario. Parental substance abuse was associated with a more than a twofold increase in the risk of exposure to childhood abuse (Walsh, MacMillan, Jamieson, 2003)

Neglect is the most commonly observed type of child maltreatment in substance abuse-related cases (U.S. Department of Health and Human Services [DHHS], 1999). Although it is impossible to know how many substance dependent women neglect their children, the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS) reports that neglect has consistently been among the most frequently reported type of child maltreatment since the CIS started collecting data in 1998 (Public Health Agency of Canada [PHAC], 2010a). Of the 85,440 confirmed cases of child maltreatment in 2008, 34% involved exposure to intimate partner violence and 34% involved neglect as the primary maltreatment category. While other forms of reported abuse more often occurred as single incidents, neglect most frequently occurred more than once or was chronic (PHAC, 2010a). In 2003 CIS reported, of all caregivers involved in substantiated cases of neglect 42% were single-mothers, 34% were financially dependent on social welfare, 52% lived in a rental accommodation, 16% relied on public housing, and 22% lived in unsafe housing conditions. Moreover, investigations where neglect was the primary form of substantiated abuse at least one functioning issue for female caregivers was identified in 80% of cases. Most frequently noted concerns were: 51 % of female caregivers had few social

supports, 35% were victims of domestic violence, 33% suffered from mental illness, and 33% had a childhood history of maltreatment. Alcohol and drug abuse by a female caregiver were each noted in more than a quarter of these investigations, 29% and 26%, respectively (Trocmé, et al., 2005).

Similar contextual patterns emerge in findings depicting the relationship between individual and family risk factors and recurrent child-welfare referrals and family reunification. Wolock, Sherman, Feldman, Metzger, (2001) examined the New Jersey Division of Youth and Family Services reports of 238 families who were investigated for child maltreatment. The average family was reported just over four times over an almost five-year period and slightly more than a third of a family's reports were substantiated. Poorer family functioning, parental substance abuse, and poverty were predictors of subsequent reports of child maltreatment, regardless of substantiation. Similarly, poorer family functioning, parental substance abuse and a poverty related indicator, number of children, were related to the substantiation status of a report. The findings also demonstrated that children who were removed from homes due to reasons of substance abuse experienced lower reunification rates than children whose families had neither alcohol nor other drug involvement.

Summary

It is difficult to disentangle the effects of substance abuse on the mother-child relationship from the larger high-risk context in which they exist. These families tend to have a host of other difficulties that are associated with maladaptive parenting, substance abuse, and poor developmental outcomes in

children, including poverty, single parenthood, intergenerational maltreatment and numerous other stressors, such as unsafe housing, homelessness, domestic violence, criminal involvement, and inadequate health care and social supports (Conners et al., 2004; Poole & Greaves, 2007). And as previously discussed, comorbid mental health problems associated with substance dependence, such as depression, anxiety, and PTSD, greatly impact the parenting experience (HarrisBritt, et al., 2010; Lyons-Ruth & Block, 1996; Suchman & Slade, 2005; Turney, 2011). As such, the relationship between parental substance use and parenting is complex and may best thought of as interplay between many contextual factors, supporting the need to both understand and address these issues concurrently.

Voices of Substance-Dependent Mothers

For all women who have children, the mothering experience shapes them like no other. Motherhood is central in defining a woman's identity, and is likely to be very important for her even if her children are not living with her (Colten, 1982; Hiersteiner, 2004). Women are deeply affected by their children, and women who abuse substances are no different. Despite society's demonized view of substance-dependent mothers, researchers who have listened closely to these women reveal they have the same hopes and dreams for their children as those who do not use substances (Brown & Smith, 2006; Colten, 1982; Hardesty & Black, 1999; Sorbo, et al., 2009), and are in fact deeply burdened with feelings of inadequacy, guilt and shame about their mothering experience (Colten, 1982; Coyer, 2001; Ehrmin, 2001; Hardesty & Black, 1999). The following section

highlights qualitative literature on the experience of substance-dependent mothering.

Being a Substance-Dependent Mother

Many women who abuse substances continue to value their roles as mothers, and seek to maintain homes for their children and fulfill their mothering role. Qualitative research in this area has only begun to reveal the complex relationship that exists between substance-dependent women and their children. Studies describe motherhood as being vital for these women. It not only provides them a central valued identity, but has been characterized as a *lifeline* through their addiction and recovery career (Hardesty & Black, 1999; Stenius, Veysey, Hamilton, Andersen, 2005). Sorbo, et al., (2009) explored the recovery process of a substance-dependent mother working to regain custody of her child. They emphasized that the "theme of motherhood could not entirely stand on its own because it is inextricably connected to everything she spoke about" (p.73). Likewise, Baker & Carson (1999) explained that during their research with substance dependent women in treatment, mothering was *not* initially the topic of interest, however "it soon emerged as central to the participants' lives" (p.350).

Despite the enormous contradictions inherent in the maternal and substance-user roles, many women attempt to maintain both roles by juggling mother- and addict-work (Brown & Hohman, 2006; Hardesty & Black, 1999; Knis-Matthews, 2010). Although the balance of work typically shifts toward the addiction as the women's substance use progresses, mother-work does not halt. In fact, even if a woman loses or relinquishes custody of her child(ren), motherhood

remains relevant. The mother-work changes; the *lifeline* is characterized by hoping, dreaming, and thinking about their child(ren) (Brown & Smith, 2006; Ehrmin, 2001; Hardesty & Black, 1999).

An interesting study by Richter & Bammer (2000) identified strategies heroin dependent mothers employ to protect their children from drug-related harm. The women spoke about attempting to stop using completely, typically during pregnancy and/or when they recognized their children were affected by their drug use. Some women initiated methadone maintenance or other form of treatment, although this was paradoxical because although they wanted to enter treatment for the sake of their children they feared losing their children because they required treatment. Mothers who continued using heroin attempted to maintain a smaller habit, which required less financial resources, and worked to shield children from drug related activities by carrying out activities, such as purchasing drugs, injecting, being too high, and going into withdrawal while the child was away or occupied. They attempted to keep the home environment stable by maintaining a day-to-day routine and reducing exposure to drug-related behavior and violence, staying out of jail by committing less serious crimes to obtain money and holding small quantities of drugs. When they were unable to maintain these strategies the women placed their children with a trusted caregiver. An important aspect of this final strategy was to maintain as active a parental role as possible, and was not viewed as permanent.

The pursuit of balance between the maternal and addict roles is echoed throughout substance dependent women's stories. For example in Baker &

Carson's (1999) ethnographic study, they describe women who fervently work to reconcile their drug using and mothering experiences, by continually renegotiating their notions of a "good mother." As they failed to fulfill their *felt* commitment to their children during their addiction, they refocused their mother-work where they deemed they could be successful, such as meeting practical needs (e.g. food, clothing), engaging in harm-reduction strategies to reduce exposure to drug related behavior, and/or using drugs not to "party", but rather to "maintain emotional and physical well-being to effectively function for their children" (Baker & Carson, 1999, p. 358).

Being a Substance-Dependent Mother in Recovery

While there is no doubt that substance abuse imposes many challenges onto the mother-child relationship, most substance-dependent women who enter into recovery want to parent differently, and experience great amounts of guilt and shame about how they have parented their children (Grief & Drechsler, 1993; Coyer, 2003; Hiersteiner, 2004; Ehrmin, 2001; Hardesty & Black, 1999). In fact, for many substance-dependent women feelings of guilt, grief, and shame engulf their mothering experience, regardless of their custodial status (Coyer, 2001; Ehrmin, 2001). Ehrmin (2001) indicates that a critical issue and possible barrier to treatment for African American women residing in an inner-city transitional home for substance abuse was unresolved feelings of guilt and shame associated with perceptions of failure in the maternal role. Raskin (1992) also reports, in a sample of fifteen female substance abusers, all had clinical symptoms of grief related to past or anticipated custody loss. The women's grief was characterized by

preoccupation with the lost child(ren), sadness, rumination, and yearning for reunion. The women felt that the loss of custody of their children, whether to the state or to a family member, was a great personal tragedy. Substance-dependent women who no longer have custody of their children often have ongoing fantasies about the child(ren)'s activities and development, and about parenting. However, these fantasies are typically embedded in feelings of guilt and shame (Ehrmin, 2001; Hardesty & Black, 1999). The feelings of guilt and shame associated with the consequences of substances use, particularly with respect to their perceptions of failure in the mother-role, and/or the experience of temporary or permanent child custody loss can markedly influence a woman's recovery efforts, with resultant pain, guilt, and sorrow leading to relapse and/or increased substance use (Knis-Mattews, 2010; Raskin, 1992).

Many women enter treatment to increase the chances of having their child(ren) returned to them and/or begin to redevelop relationships with their child(ren) while in recovery (Baker, 2000; Carten, 1996; Hardesty & Black, 1999; McIntosh & McKeganey, 2000; Sorbo, et al., 2009). However, they also generally have mixed-feelings about parenting. While it is a primary motivator for many women to seek treatment, it also elicits powerful feelings of fear and being overwhelmed (Carlson, Matto, Smith, & Eversman, 2006; Ehrmin, 2001). It has been suggested that unless women are encouraged to explore the negative and/or challenging aspects of their mothering experience they will likely be ill-prepared to resume the mother role, regardless of recovery status (Maluccio & Ainsworth, 2003; Tracy & Martin, 2007; Wells & Guo, 2006). Hardesty & Black (1999) note

that “mother work in the recovery stage can set into motion a cycle of great expectations, failure to meet those expectations, and then drug relapse” (p. 617). The interrelationships between parenting stress and relapse are understudied. The substance abuse literature suggests that likely mechanisms are low self-efficacy regarding parenting, negative emotions regarding how past drug use has affected one's children, and strong beliefs that one's drug use will have negative consequences for their children (Baker, Piper, McCarthy, Majeskie, Fiore, 2004; Greenfield, et al, 2000). Carlson, et al. (2006) further highlight the complex relationship substance-dependent women have with their maternal role. They found that mothers’ “positive feelings associated with reunification, such as happiness and relief, are often experienced within a larger chaotic context” (p. 890), and suggest that both positive and negative emotions may be experienced simultaneously. This emotional conflict often stems from a fear of failure in their own parenting ability and in their concern over dealing with their children's intense anger and hurt (Carlson, et al., 2006; Grief & Drechsler, 1993; Hardesty & Black, 1999). Moreover, meeting the day-to-day parenting needs of their children, such as providing food and recreation, and providing a safe and protective environment as well as emotional support to help them work through their anger and hurt, is often difficult for these mothers (Bernal, et al., 2005; Carlson, et al., 2006; Hiersteiner, 2004). Complicating these emotional challenges further, women often have competing perceptions of how their drug use impacted their parenting. While most women do recognize the negative impact substance-abuse had on their ability to parent, they also feel that it made them more able to

cope with parenting stress, and engage in parenting tasks, such as cooking, cleaning, and playing with their children (Baker & Carson, 1999; Brown & Hohman, 2006; Hardesty & Black, 1999; Knis-Matthews, 2010).

Kunkle (2002) conducted a phenomenological study of women's lived experience of participating in an integrated substance abuse treatment program in British Columbia, in which mothers resided in treatment with their pre-school children. The program included a fully licensed day-care, parenting support group, parent training, individual counseling, psycho-educational groups, and an exercise group. The study's findings emphasized that the theme of motherhood was integral in the women's treatment experience. The women spoke to how "facing the erosion of their image of motherhood" and then being able to resurrect a new image within the safety of the program, was central to their recovery (Kunkle, 2002, p. 51). The women revealed that their perceived value of themselves as mothers not only provided motivation to face the challenges of recovery, but eventually it allowed them to experience themselves as valuable beyond motherhood. While women who believed they had no value as mothers and/or were detrimental to their children, lost their motivation for recovery and became self-destructive. Similarly, Brudenell (1997) reported that for women becoming mothers in recovery, perceiving their value in both roles (i.e. recovering addict and mother), and achieving balance between the responsibilities associated with parenting and recovery, was necessary to successfully integrate recovery and motherhood into their identity.

Summary

A woman's addiction and recovery are deeply connected to her mothering experience. The findings presented above emphasize the central role that motherhood plays in women's sense of self and suggest that their recovery efforts benefit when it is considered and integrated within the recovery process. Even when a woman loses or relinquishes custody, motherhood continues to be relevant in her life. Despite the challenging and complex relationship substance-dependent women have with their mother-role and the great amount of guilt and shame they experience, most women continue to value their roles as mothers, seek to maintain homes for their children, and want to fulfill their mothering role.

Substance Abuse Treatment

Strategies for treating substance use disorders can involve self-help approaches, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) or programs run by professional clinicians. Substance abuse treatment may be long-term or short-term, inpatient or outpatient, and can involve individual therapy, group therapy, family therapy, pharmacotherapy, or a combination of several approaches (Health Canada, 1999).

Substance abuse treatment literature suggests that treatment with adequate intensity and duration can improve addiction recovery rates (Prendergast, Podus, Chang, and Urada, 2002; Simpson, 2004). However there are performance variations between programs and patients within programs, which raise questions about how to achieve improvements in treatment effectiveness and efficiency (Simpson, 2004). Simpson, et al. (1997) suggest even among programs within a

particular therapeutic orientation their ability to retain patients varies tremendously (as cited in Simpson, 2004). Simpson (2004) stresses the importance of considering the broader context of social institutions and cultural patterns as influences on the outcomes of patient, and recommends that more attention be paid to questions of treatment 'process' rather than outcomes in order to better understand both how treatment works and how it can be improved.

Although a full review of current substance abuse treatment models is out of the scope of this literature review, the following section highlights program components and the respective theoretical underpinnings of traditional residential substance abuse treatment and women-centered treatment.

Traditional Residential Treatment

Typically, traditional substance abuse treatment programs are mixed-gendered and include medically supervised detoxification, education, group therapy, 12 Step programming, and a drug/alcohol free living environment. They tend to focus primarily on the individual and drug-related behavior, and as such interventions are commonly aimed at individual-level factors, such as improving communication and coping strategies, and identifying drug-related cravings and triggers (Finklestein, 1994; Lafave, Desportes, Mcbride, 2009). Most residential treatment programs limit an individual's contact with the 'outside world'. The rationale is that 'distractions' should be kept to a minimum, in order for individuals to 'work on themselves'. Traditional treatment approaches have been regarded as confrontational, isolating and individualistic, incongruous with women's treatment needs (Kauffman, Dore, Nelson-Zlupko, 1995; Suchman,

Luthar, McMahon, DeCoste, Castiglioni, 2008). Feminist critiques argue that this is because most substance abuse treatment programs were designed initially for and by men and little attention has been paid to the different and unique needs of women, including the distinctive etiology, disease progression and the larger relational context of women's lives (Finklestein, 1994, 1996; Lafave, Desportes & Mcbride, 2009; Suchman, et al., 2008).

Traditional Substance Abuse Treatment Theory

Historically, traditional addiction treatment was based on a bio-medical model of substance abuse that viewed the 'disease' of addiction as lying within the individual; accordingly, interventions were aimed at the person. This model views substance-dependence as a progressive, irreversible disease characterized primarily by denial of a problem and a loss of control over substance use. The disease is thought to be influenced by many factors including genetics, environment and social factors, and without intervention, is progressive and fatal.

As our understanding of addiction has evolved and broadened to include the intricate and complex interaction between an individual's biological status, psychological state and social dynamics it has become clear that treatment models borne out of earlier understanding are inadequate. Despite this, many treatment programs continue to neglect the social aspect of addictions, framing relational issues, as a distraction from the 'real' issues of sobriety, and outside the appropriate scope of work for the program. This can be especially detrimental for mothers accessing treatment, as the "the lives of pregnant women and of women with children are intimately entwined with multiple individual and 'systems'

relationships that may include social agencies, hospitals, courts, and schools, among others" (Finklestein, 1996, p. 28).

Women-Centered Treatment

While there is no universal definition of substance abuse treatment programming for women, it is generally accepted that this term refers to the delivery of services and treatment that reduce females' barriers to entering substance abuse treatment and/or that address their specific substance abuse treatment needs (Health Canada, 2006; Brady & Ashley, 2005; United Nations, 2004). Ashley, Marsden, & Brady, (2003), who conducted a review of women's substance abuse treatment for the Substance Abuse and Mental Health Services Administration (SAMHSA), suggest that such programming include the following core components, which may be delivered individually or in combination:

1. *Ancillary services intended to increase female clients' access to substance abuse treatment, such as child care or transportation services;*
2. *Services intended to address the specific needs of females, such as prenatal and baby care, psychosocial education focusing on issues relevant to women or parenting, human immunodeficiency virus (HIV) prevention and risk reduction that targets women, and mental health services that address a woman's history of abuse and trauma;*
3. *Programs and services provided for women only, creating a unique treatment environment that is more focused on women's issues than are mixed-gender services.*

Treatment programming for women may also emphasize a comprehensive service approach to address psychosocial problems, pregnancy education, parenting, employment, housing, and trauma services. This approach should reflect *treatment principles* (see sidebar) that serve to empower women and provide a supportive, non-confrontational approach to treatment (United Nations, 2004). Within the core components, Niccols, Dell, & Clarke (2010) indicate that pregnancy, parenting, and child-development services can vary along a continuum from fully integrated (i.e. including on-site child development and parenting services with women-specific addiction services) to non-integrated (available, but separate, services) to limited (some services exist, but not others) to non-existent (no services available) (p.325).

Delivery options for providing gender-responsive programming for women include*:*

> 1) a women-specific program that is autonomous with its own governance structures; 2) a women-specific program that is part of a larger organization; or 3) a program that serves both women and men but has some components for women only (Health Canada, 2006; Brady & Ashley, 2005; United Nations, 2004).

Women-Centered Theory

Gender-responsive approaches to women's substance abuse treatment have been influenced by theories of women's psychological development, and recognition of the central role that relationships and connection to others play in women's sense of self (Finklestein, 1994, 1996). One of the most important contributions to a more woman-centered treatment approach is the 'self-in-

relation theory' developed by Jean Baker Miller and her colleagues at the Stone Center for Developmental Studies in the early 1980s (Finklestein, 1994, 1996; Jordan, Kaplan, Miller, Stiver, Surrey, 1991; Surrey, 1985). They challenged the assumption that principles of male development are universal principles of human development. Historically, developmental literature considered the formation of a sense of self a differentiating process involving the separation of one's self from others (Miller, 1991; Surrey, 1985). These theorists emphasize autonomy, self-reliance, independence, and self-actualization as part of the development of a healthy, mature self (Gilligan, 1982; Miller, 1991; Surrey, 1985). Miller and her colleagues contend these developmental 'truths' do not reflect the experience of women. They propose that connections are fundamental to a woman's psychological growth and healing; forming and enhancing relationships with others is central to women's sense of personhood and is critical to a sense of worth, pleasure and effectiveness (Finklestein, 1994, 1996, Jordan, et al., 1991). Self-in-relation theory speaks to qualities of relatedness, intimacy, mutuality, and empathy as being highly valued and central throughout women's development. The emphasis shifts from separation to the 'relational self' as the core self-structure in women and as the basis for growth and development (Surrey, 1985). Feminist scholars, such as Chodorow (1978), have supported this position, critiquing traditional notions of human development, arguing that although boys in this culture are encouraged to dis-identify with their mothers and suppress certain 'relational sensitivities' in order to gain acceptance, value, and prestige in the eyes of other males, the direction of growth for girls is not toward greater

degrees of autonomy or individuation, but toward a process of growth within relationships (Gilligan, 1982; Zelvin, 1999). Gilligan (1982), who studied moral development in young women, suggests that "the elusive mystery of women's development lies in its recognition of the continuing importance of attachment in the human life-cycle" (p. 23). She found that, for women, moral and ethical decisions are embedded within the context of responsibility.

> In other words, women make moral choices by considering and weighing the interests of all persons involved… Gilligan characterizes this ideology of care and responsibility as one that recognizes differences in needs and is based on compassion and a belief that no one should be hurt…she contrasts this with a male ideology of rights or justice that is based on 'certain truth' and the assumption that everyone, including oneself, should be treated equally (Gilligan, 1982; as cited in Finklestein, 1996, p. 25).

These authors suggest the female self is organized and developed in the context of important relationships and the primary experience of self is relational. They assert that women's psychological development must be reframed as a struggle for connection rather than difficulty achieving separation (Gilligan, 1982; Jordan, et al., 1991; Surrey, 1985).

Within the context of self-in-relation theory, a person's failure to form attachments and make connections is called 'disconnection' (Finklestein, 1994, 1996). However, in practice, particularity in substance-abuse treatment, women's relational qualities have often been framed as pathologic or have been phrased in regressive terms such as *co-dependent,* making it difficult for women to maintain

relationships and value their relational capacity (Finklestein, 1994, 1996; Zelvin, 1999). This often leads to feelings of powerlessness, anxiety, low self-esteem, and depression, as women's self-worth is intricately tied to their perceived failure and/or success in sustaining mutual relationships (Gilligan, 1982; Jordan, et al., 1991). Finklestein (1996) suggests the incongruity between their relational and connected experiences and an androcentric clinical definition of maturity can cause women to feel "disconnected from their experiences, compromise their ability to act on their perceptions, and, as Gilligan states, to lose ''their own voices''" (Gilligan 1982; as cited p. 26). Surrey (1985), contends that the deepening capacity for relationship and relational competence is the basic goal of women's development, and should be supported, as other aspects of self (e.g., creativity, autonomy, and assertion) develop within this primary context. That is, other aspects of self- development emerge in the context of relationship, and there is no inherent need to disconnect or to sacrifice relationship for self-development (p. 2).

Rationale & Study Aims

The literature reviewed in this chapter suggests that many mothers entering into substance abuse treatment programs present with trauma histories, co-occurring mental health issues, few social supports, low income, and complex and difficult mothering histories that often include child-welfare involvement and/or loss of their children in addition to their substance dependence. Women-centered treatment programs have done well to recognize these challenges and work to address them while acknowledging and honoring women's roles as

mothers. However, it is unclear how women attending less specialized substance abuse treatment programs experience motherhood within the treatment context. Substance abuse treatment literature stresses the importance of considering the broader context of social institutions and cultural patterns as influences on the outcomes of patient (Simpson, 2004). That is, "treatment outcomes are impacted by social institutions (including organizational attributes of the treatment agency), role-related interactions with family and friends, and normative pressures from society and culture" (Simpson, 2004, p. 100).

The relational nature of the self makes the definition and expression of self a difficult psychological issue for women; this is true particularly for women who are mothers (Chodrow, 1978; Rabuzzi, 1988; as cited in Varcoe & Doan, 2007). Whereas discourses around healthy self-definition, particularly in relation to substance abuse recovery, stress the importance of autonomy, differentiation, and separation of the individual from others, discourses around mothering emphasize selflessness, and self-sacrifice (O'Reilly, 2004, p.4, as cited in Middleton, 2006). For substance-dependent women who are mothers, these conflicting discourses offer an ambiguous and potentially confusing context for experiencing, defining and expressing oneself. Traditional substance abuse recovery rhetoric emphasizes the need for a 'selfish program' and treatment programs typically encourage individuals to 'distance' themselves from relationships in order to work on themselves. Gender-responsive approaches to women's substance abuse that have been influenced by theories of women's psychological development, specifically 'self-in-relation' theory, would argue that

this is incongruous to women's treatment needs. They maintain that women's self develops through the processes of social interaction and must be reframed as a struggle for connection rather than difficulty achieving separation (Finklestein, 1994, 1996; Zelvin, 1999).

If this is so, how do substance-dependent women who are mothers experience, define and express self when they are potentially being influenced by and participating in conflicting discourses while in a traditional treatment program? And what influence does this have on mothers' overall recovery and/or treatment experience? The author conducted a phenomenological study exploring the lived experience of mothers attending a mixed-gendered residential treatment program in Alberta, Canada, in order to explore these questions and to gain an understanding of what it's like for these women to experience, define, and express 'self as a mother' within a traditional residential treatment program.

Chapter II

A phenomenological research approach was used to explore the lived experience of mothers residing in a mixed-gender substance abuse treatment program. The goal of the study was to describe what it's like for women to define, express, and experience 'self as a mother' within the program.

Overview of Methodological Approach

Phenomenological research is the study of people's lived experience, as such it is "well suited for locating the meanings people place on the events, processes and structures of their lives… and for connecting the meaning to the

social world around them" (Miles & Huberman, 1994, p. 10). Phenomenology emphasizes subjectivity over objectivity as it focuses on description and interpretation more than upon analysis and measurement of a phenomenon. Thus phenomenology does not aim to provide causal explanations; it is concerned instead with providing systematic descriptions of how people perceive things, understand situations and interpret various occurrences, in order to reflect on the meanings that may inhere in the experience (Moustakas, 1994; van Manen, 1984, 1990; Denscombe, 2003).

An interpretive research design assumes that social reality is locally and specifically constructed by humans through their action and interaction (Annells, 1996; Charmaz, 2006). Rather than assuming and prioritizing the existence of an objective world, interpretivists see the world as strongly bounded by particular time and specific context. As such, phenomenology cannot be defined as a science of objects or subjects, but rather the science of experience. Phenomenology intends to elucidate the essence of experience as it occurs in the *lifeworld* - that is "the world as we immediately experience it rather than as we conceptualize, categorize, or theorize about it" (van Manen, 1984, p.1). This methodology does not reduce the phenomenon into identifiable variables in a controlled environment, but rather seeks to accurately capture the phenomenon within the context that it occurs (Smith, 2003).

Phenomenological researchers generally agree that the "central concern is to return to embodied, experiential meanings aiming for a fresh, complex, rich description of a phenomenon as it is concretely lived" (Finlay, 2006). Wertz

(2005) describes phenomenology as a "low hovering, in-dwelling, meditative philosophy that glories in the concreteness of person-world relations and accords lived experience, with all its indeterminacy and ambiguity, primacy over the known" (p. 175, as cited in Finlay, 2008). Although there are differing views of how best to carry out phenomenological research, there is consensus that the research methods need to be "responsive to both the phenomenon and the subjective interconnection between the researcher and the researched" (Finlay, 2009, p.7). The methods used in this study are located in experiential phenomenology, also known as phenomenology of practice, and draw heavily on van Manen's (1984, 1990) lived experience human science inquiry. This particular approach is a variant of phenomenological *lifeworld* research that has a reflective and practical focus on *lived experience.* It has been adopted by many in the pedagogic and health care fields (see van Manen, 2002).

Exploring the Phenomenon

van Manen (1984) suggests that personal experience is a good starting point for phenomenological inquiry. He proposes that awareness of the structure of one's own experience of a phenomenon may provide the researcher with clues for orienting to the phenomenon and thus to all the other stages of phenomenological research. As the purpose of this study was to explore the phenomenon of being a mother in a traditional mixed-gender substance abuse treatment program, it is important to acknowledge that my interest in this phenomenon is grounded in my personal experience. van Manen (1984) speaks to the importance of 'phenomenologically' orienting oneself to the phenomenon. This is more than simply recalling experiences, but rather focusing on the nature

of the experience. I have 'spent time' with my experience. I have reflected upon: "What it was like to be a mother in treatment?" "Was I mom during that time?" If so, "How did I be one?" What did it feel like?" "What did it look like?" "What was the meaning of the experience?" I will try to briefly describe my experience as much as possible in experiential terms, without offering causal explanations.

I was in treatment because of my children, yet it really wasn't talked about. Nobody asked me about being a mom; I'm not sure who even knew that I was a mom. There was a part of me that was okay with this. Thinking about my kids was difficult. I can't remember if I had photos of them. I remember I had made a craft for one of my daughters during a recreation class. I was connected to my child in the moment of its creation – and yet after, the thought of giving it to her felt small, insignificant – even stupid. I didn't know how to be with my children. Visits were difficult. I was always aware of the conversations of others in the room – aware of their 'inappropriateness.' Yet when my kids would go I would become a part of those conversations –'being a mom' disappeared. It always felt like I failed somehow. There were other mothers in the program. I think people felt sorry for their kids; I think people felt sorry for mine. Silently, ashamed, I understood both. I was given a poem during my time in treatment. The poem was about being a mother. I felt it. In that moment I was a mom; the woman who gave me the poem was looking at me, and she saw a mother. Something happened. No matter how brief, it mattered. I mattered; I was my daughters' mother. 'Being a mom' in treatment was fleeting; moments of connection within a state of 'disconnect'. This small, frayed, fragile string, reminding me I was a

mom, was threaded through me, through the experience; I knew on some level that if I could hang on to it, it would hold me together, shakily intact…and how easy it could slip away.

As I move away from this reflective stance, I wonder, "what is the extent that my experiences are the experiences of others, of other mothers in treatment?" I am drawn into, compelled toward, this phenomenological question. My own experience is not enough to uncover the essence, the meaning, of being a mother in a substance abuse treatment program. Although my initial research question intended to explore the experience of mothers who are engaged in "potentially conflicting discourses" often inherent in traditional treatment, I find the closer I am to the research, I am intrinsically challenged to put aside any assumption that may predetermine the women's experience, and question whether the study design in fact allows me to answer this specific a question. Does my presence alone not alter the traditional treatment experience? Within every interview I will see a mother; she will experience me "seeing a mom." Within this new light, the research study broadens its original question and seeks to deeply understand what it's like for a woman to define, express, and experience 'self as a mother' within a substance abuse treatment program. My intent is to give voice to the experience of substance dependent moms, as such, I will 'borrow' other mother's experiences in order to capture the essence of "being a mom in treatment". In van Manen's words, I "gather other people's experiences because they allow [me], in a vicarious sort of way, to become more experienced ... We are interested in the particular experiences…since they allow us to become "in-formed," shaped or

enriched by this experience so as to be able to render the full significance of its meaning" (1984, p. 18).

Gathering Experiences

Qualitative research is the best strategy for discovery and exploring complex phenomena that are presently unexplored in the literature by focusing on social practices, discourses, processes, and the meanings individuals attribute to their experiences (Miles & Huberman, 1994). Cresswell (1998) emphasizes that a qualitative researcher builds a "complex, holistic picture… [that] allows the reader into the multiple dimensions of a problem or issue and displays it in all its complexity" (p. 15). As the aim of this study was to capture the essence of being a mother in treatment, semi-structured, in-depth interviews were used because of their inherent ability to connect "an external world of events to an inner world of thoughts and emotion that constitute a person's subjectivities [meanings]" (Nunkoosing, 2005, p. 704). In essence the phenomenological interview is a guided conversation in which the interviewer uses the interactive process to uncover the meaning of what is being communicated. van Manen (1984) suggests that it is imperative for the phenomenological interviewer to stay "close to experience as lived" (p. 17). The interviewer must always remain orientated to the phenomenological question of 'what is the nature of the phenomenon'. He proposes that "whenever it seems that the person being interviewed begins to generalize or opinionate about the experience you can insert a question that turns the discourse back to the level of lived experience" (p. 17).

Interviews are viewed as appropriate for, investigating sensitive or personal issues, and research that requires detailed information regarding emotions and experiences from a small number of participants. Moreover, they enable the researcher to address specific areas of interest while allowing for flexibility during the interview process (Denscombe, 2003). The evolving and flexible semi-structured interview design of this study ensured that mothers were able to include and discuss experiences they deemed relevant and/or significant. This approach fosters a more holistic portrayal of the phenomenon, rather than the researcher overlooking valuable information by imposing her worldview on the participants and/or stripping data from its social context (Marshall & Rossman, 1999). An interview guide for the present study (Appendix A) was developed according to pertinent areas identified through a review of literature and by maintaining a phenomenological stance toward the phenomenon of interest.

Artistic Expression

van Manen (1984, 1990) suggests that artistic expression is a valuable source for experiential material because the products of art give shape to artists' lived experience. He further suggests that the act of creating requires a reflective mood, wherein the artist recreates experiences by transcending them. These expressions of art are believed to "transcend the experiential world in an act of reflective existence" (p. 23).

Women in this study were asked to 'give shape' to the experience of expressing, defining, and experiencing 'self as a mother' in treatment through

artistic expression, if they chose. Women were encouraged to explore artistic mediums, such as poetry, collages and/or drawing.

Participants

Typical sample sizes for phenomenological studies range from 1 to 10 persons (Starks & Brown Trinidad, 2007); this study intended to gather multiple detailed accounts from three to five women over a 3 month period. The number of participants were determined to depend upon the number of women enrolled in the host substance abuse treatment program during the study period who meet the study criteria. Six women were enrolled into the study over a six month period; full participant descriptions are provided in Chapter III (see Participant Profile).

Purposeful sampling was used to identify potential participants. This technique denotes a strategy in which particular settings, persons or circumstances are deliberately selected because of their inherent ability to provide important information that cannot be obtained as well from other choices (Maxwell, 1993).

Criteria for inclusion in this study were women who: 1) were currently in treatment for a substance abuse disorder; 2) were currently residing in a mixed-gender substance abuse treatment program; and 3) have at least one child aged 16 years or younger.

Exclusion criteria from the study included women who: 1) were deemed by a treatment professional to be psychiatrically unstable (e.g. exhibiting symptoms characteristic of a Psychotic Disorder); 2) were severely cognitive impaired and deemed unable to understand and give informed consent; 3) were non-English speaking and would require a translator, and/or 4) were acutely

hearing-impaired and would require assistance from another individual to communicate with the interviewer.

Setting

Qualitative research takes place in natural social settings, is interactive, emergent and interpretive (Marshal & Rossman, 1999). Accordingly, I met study participants while they were enrolled in a mixed-gender residential substance abuse treatment setting, thus allowing the data to be collected in close proximity to the specific phenomenon. A review of relevant documents including procedural and program manuals and policy documents, and informal interviews with program staff informed a full description of the treatment program, which is included in Chapter III (see Treatment Setting).

Procedure

Personal contacts were used to gain access to an inpatient mixed-gender substance abuse treatment facility. Initial contact was made with the program's Executive Director and Director of Clinical Services. Subsequently, a formal letter (see Appendix B) introducing myself and the nature of the study and a working draft of the proposal was emailed to the Director of Clinical Services. I met with the Director of Clinical Services and Program Coordinator to discuss the study and address any concerns the organization had.

An application to the Human Research Ethics Board was submitted in February, 2012. I appeared in front of the Human Research and Ethics Board Panel B on April 13, 2012, and received ethics approval on April 25, 2012. On April 28, 2012 I met with the Program Coordinator of the host organization.

Thereafter, I met with appropriate program staff to discuss the research project. Program staff were informed of the inclusion and exclusion criteria for the study and were given a research packets containing a study-flyer (see Appendix C). Program staff were asked to identify potential participants among their case-load, and give a research packet to potential participants during their first week of the treatment program. Program staff were directed to inform potential participants that participation was completely voluntary, and that their decision would not impact their relationship with program staff and/or access to the program. Program staff invited me to introduce myself and describe the study to female clients in the women's primary group. Thereafter, two women approached me to join the study. All prospective research participants were asked to review the research packet, and schedule a time to meet with me to further discuss the study. On May 15, 2012 the first two participants enrolled into the research study. The first interview was conducted on May 18, 2012. Over the next four months, four more women approached me to join the study. All meetings occurred at the center, and did not conflict with treatment programming.

During all initial meetings, I discussed the purpose of the study and described fully what participation entailed. The Participant Information Letter and Consent Form (Appendix D and E) were reviewed, which covered issues such as study purpose and procedures, confidentiality, freedom to withdraw, and potential benefits and risks, and ensured that any questions or concerns were fully addressed. Thereafter the women determined whether or not to participate in the study. All women agreed to participate.

Study participants signed and received a copy of their signed Participant Information Letter and Consent Form. Women were asked to identify a pseudonym to be used in the reporting of the research. For those that did not, I arbitrarily chose a pseudonym to be included in transcriptions and final manuscript. Each participant was informed of a process she was able to engage if any concerns arose as a result of the study. Thereafter, an initial interview was scheduled. The participant's assigned Primary Counselor was consulted to ensure scheduling did not conflict with treatment programming. All interviews occurred within the treatment center. Subsequent interviews were scheduled approximately two weeks apart.

In addition to interviews, I spent a significant amount of time at the center orienting myself to the program. The women enrolled in the study would often spend time with me informally; I grew to know them more during these interactions and developed more intimate relationships. I was frequently invited by the women to attend their primary group when they would be presenting therapeutic assignments they completed, such as grief and loss graphs, trauma eggs, and relationship graphs. Group facilitators approved my attendance, with the approval of other women in the group. All the women who completed treatment invited me to attend their "coin out", which was a primary group dedicated to honor her program completion, and allowed her to share her aftercare plan with her group members. I was approved to attend all of the participants' coin-outs.

Dropping out

As the occurrence of drop-out is relatively common among women in substance abuse treatment, decisions regarding the use of data if a participant should leave treatment early were made during the initial meeting between the researcher and the participant. We discussed whether the participant would prefer to remove herself and her data if she left the treatment program early, or if her information would remain as part of the study. All women agreed that their data remain a part of the study if they left treatment early. I had asked to be contacted by the participant or a staff member from the program if a participant left treatment early and/or that participants were given an opportunity to meet with me prior to leaving the program; however this was not feasible. Two study participants left unexpectedly; I was informed during my following visit to the center. I was not contacted by either participant prior to or following her discharge. However, both women had agreed prior their data remain in the study if they were to leave treatment early; as such their data was included in analysis. All participants had been given my contact information at the outset of their enrollment and were invited to contact me if they chose. No one did.

Interview Protocol

Interviews were conducted at the treatment center in a private meeting room. The Participant Consent Form was reviewed at the beginning of the initial interview session. Participants were given an opportunity to ask any questions they had. I briefly reviewed the purpose of the interview, encouraged participants to only share what they were comfortable with, and reminded them that they

could refuse to answer any question they chose, and/or withdraw from the interview and/or study at any time.

The number of times each woman was interviewed varied. Although I intended to interview each woman on three occasions; two women left treatment earlier than expected, which resulted in fewer interviews, and two other women requested more opportunities to meet, which was accommodated. The interviews ranged from 45minutes to 120 minutes in length, and occurred approximately two weeks apart. Eighteen interviews in total were conducted; however during one interview the audio recorder malfunctioned. I made notes of my overall impressions of the interview and noted any salient themes, however an interview transcript was unable to be included in analysis. At the closing of each interview the participant had an opportunity to 'ground' herself and bring up any questions, concerns, or thoughts she had about the interview process before leaving the interview space.

Memos

I used memos to record aspects of the interviews and my personal reflections throughout the research study. Memo writing encourages the analyst to become thoroughly engaged in the data. Memos typically "grow in complexity, density, clarity, and accuracy as the research progresses" (Strauss & Corbin, 1998, p. 218); it was important that, as the researcher, I maintained a balance between descriptive notes and reflective notes. Strauss & Corbin (1998) emphasize that memos must be dated so that the researcher can later correlate them with the data. The use of memos helped me to tease out and explicate any

personal assumptions and/or experience I had related to the phenomenon. This reflective process assisted in 'bracketing' (see Bracketing).

Data Management Protocol

All hard copy materials were kept in a locked filing cabinet in my home office. I am the only person with access to this filing cabinet. Signed Participant Consent Forms were stored in the filing cabinet. I intended to make copies and/or take photos of all artistic expressions; however no participants provided any. This will be further discussed in Chapter IV (see Study Limitations). All digitally compatible data were transferred onto my personal computer. The qualitative research software program, NVIVO 9, and subsequently, NVIVO 10 facilitated data management and analysis.

Interviews were audio recorded. All audio recordings were transferred onto my personal computer and an external hard-drive located in my home office. Audio recordings were transcribed within the qualitative research software program. Audio recordings and interview transcripts were identified by a pseudonym and the date of the interview. A backup copy of each transcript was maintained on an external hard drive. Hard copy transcripts were occasionally used for reference during writing; however they were immediately destroyed after use. Memos were hand written in a 'thesis journal', and occasional audio-recorded. All study materials and data will be destroyed after no less than five years after I complete my Master's of Science Degree.

Analysis

At the root of phenomenology "the intent is to understand the phenomena in their own terms — to provide a description of human experience as it is experienced by the person herself" (Bentz & Shapiro, 1998, p. 96). When thematic analysis and determination of essential themes are complete, they should allow the essence and meaning of the phenomenon to emerge (Moustakas, 1994; van Manen, 1984, 1990). van Manen's (1984, 1990) lived experience human science inquiry method guided analysis. van Manen has four concurrent procedural activities involving eleven steps as presented below (adapted from van Manen, M.,1984, 1990).

Concurrent Procedures

Turning to the Nature of the Lived Experience

The Existential Investigation

Phenomenological Reflection

Phenomenological Writing

Steps

1. Orienting to the phenomenon
2. Formulating the question
3. Exploring assumptions and pre-understandings
4. Exploring the phenomenon: generating data using personal experience, tracing etymological sources and idiomatic phrases, experiential descriptions from participants, literature, arts, etc.
5. Consulting phenomenological literature
6. Conducting thematic analysis – uncovering themes, isolating statements, composing linguistic transformations, gleaning description from artistic sources
7. Determining essential themes
8. Attending to spoken language
9. Varying examples
10. Writing
11. Rewriting

van Manen (n.d., 1984, 1990) discusses two general processes used in the identification of the thematics of a phenomenon: 1) macrothematic analysis, and 2) micro-thematic analysis. The macro-thematic process, also known as the 'wholistic reading approach', looks at the text as a whole and allows for researcher's interpretation. He suggests as we read over a text we ask "How does this text speak to the meaning of the phenomenon under investigation?" "What sententious phrase may capture the fundamental meaning or main significance of the text as a whole?" We can then try to express that meaning by formulating such a phrase.

Micro thematic analysis includes two distinct, yet complementary approaches: (1) the selective or highlighting approach; and (2) the detailed or line-by-line approach. The selective or highlighting approach identifies words,

phrases, and sentences that appear to stand out as essential to the experience. The detailed approach looks at every sentence or sentence cluster asking what it reveals about the phenomena of study. Both macro and micro thematic analysis approaches were used.

Essential themes are those that "make a phenomenon what it is and without which the phenomenon could not be what it is" (van Manen, 1990, p. 107). They provide guidelines for discovery of the larger dimensions of the lived experience. van Manen suggests that the "phenomenological themes are not objects or generalizations…they are more like knots in the webs of our experiences, around which certain lived experiences are spun and thus lived through as meaningful wholes" (van Manen, n.d.a). They are the actual description of the structure of a lived experience through which we can capture the meaning of the experience. (van Manen, 1984, 1990).

To this end, all the interviews were read a number of times until a good grasp of the phenomenon being investigated was developed. The selective or highlighting approach and the detailed or line-by-line approach was used to begin identifying codes in the data. Early readings of the transcripts focused on identifying sections of text related to the experience of 'being a mom'. Initial coding was focused on identifying material that was determined to be included or excluded as it related to the experience of being a mom. Preliminary codes were then developed in which sections of relevant, included text were placed. Relevant text sections included within selected codes were then repeatedly reviewed and compared across participants and interviews, moving back and forth between

micro and macro approaches to analysis. Themes were subsequently developed to describe the essence of groupings of codes that seemed to be related to each other. All interviews were repeatedly read with these themes in mind; during this process codes and themes were reworked a number of times to ensure they were capturing the essence of the experience.

In addition to the analysis methods outlined above, analysis was both shaped and informed by my clinical experience. Over the last year and a half I have transitioned into a therapist role at the study's treatment centre, and have worked primarily with substance dependent women and family members of program clients. During analysis I drew on both clinical language and theory to explore and explicate the data, and have incorporated knowledge gained throughout analysis into my clinical work.

Bracketing

Bracketing is a deliberate and purposeful opening by the researcher to the phenomenon "in its own right with its own meaning" (Moustakas, 1994). It speaks to a suspension or 'bracketing out' the researcher's own presuppositions and not allowing the researcher's meanings and interpretations or theoretical concepts to enter into the experience (Creswell, 1998; Moustakas, 1994). The process is akin to the practice of meditation. Meditation is a disciplined practice in which all external and internal influences are set aside, the mind is emptied for a time, and one goes to a space of unknowingness in order to discover new knowing, understanding, and insight. Accompanied by continuous reflective writing and rewriting, this introspective process can heighten the researcher's

critical awareness of possible bias in interpretation and description and "simply let what is there stand as it appears, from many angles, perspectives, and signs" (Moustakas, 1994, p. 86; van Manen, 1984). "When we perceive straightforwardly, we focus on the object itself and not the perceiving experience;" bracketing can deepen reflective thoughtfulness about the seemingly trivial, taken-for-granted aspects of everyday life (Miller, 1984, p. 177, as cited in Moustakas, 1994, p. 92). Wertz suggests this process can be used during the interview and analysis process, as it allows researchers to recollect our own experiences and to empathically enter and reflect on the lived world of other persons…as they are given to the first-person point of view. The psychologist can investigate his or her own original sphere of experience and also has an intersubjective horizon of experience that allows access to the experiences of others (Wertz, 2005, p. 168).

However it should be noted, in the context of this study 'the researcher' was not seen as a threat to validity; instead I considered myself to be embedded in the research process. The practice of 'bracketing' was not intended to result in a viewpoint devoid of values or biases; instead it was recognized as a tool manage the presence of 'self'. In order to set aside and/or utilize 'self' in the research process, a researcher needs to engage in active self-reflection. As researcher, I endeavored to maintain transparency in the process and explicitly claim the ways in which my position or experience relates to the issues being researched. For example, self- reflection and interpretation were integral for exploring the structure of my own experience and provided me with insight for orienting myself

to the phenomenon (See Exploring the Phenomenon); whereas, bracketing personal experiences, and the assumptions and biases that lie within, was necessary to obtain descriptions from others without preconceived notions about what would be found in the investigation. This was especially utilized during interviews. As the experiences shared by participants were closely reminiscent of my own experience as a substance dependent mother it became evident early on that I needed to bracket my understanding of the experience in order to seek and allow the women to explicate their own understanding. For example, when a woman would share it was "hard" to see her child during active addiction, because I understood the depth of "hard" through my own experience, it was insidiously easy to stop exploring the concept there. However, I needed to allow the woman to describe and give meaning to the experience through her own words. I often thought, what would someone who knew nothing about what it's like to be a substance dependent mother ask. What would 'they' need to know to capture the experience of, for example, "hard"? It was within mine and the participants' closely shared understanding of the experience individual nuances were, paradoxically, at risk of being lost; it was to this end that bracketing my own understanding and experience encouraged and allowed me to seek an understanding of the women's experience that wasn't limited by what I "knew".

Trustworthiness

Qualitative researchers think in terms of trustworthiness as opposed to the conventional, positivistic criteria of internal and external validity, reliability, and objectivity (Denzin & Lincoln, 2005; Lincoln & Guba, 1985). When considering

the range of evaluative criteria available to qualitative researchers Finlay (2006, 2009) argues that our choice of criteria needs to be compatible with the special nature of the research in question, that is, its methodology, aims and assumptions. I decided to heed Finlay's words and attempted to address my choices in a transparent and thoughtful manner. Finlay (2006, 2008, 2009) suggests that researchers need to be reflexive about their position and values when evaluating their research. To this end, I will try to explicate my position and values in order to help me walk through the process.

Positivist-inspired research has taught me that impersonal, neutral detachment is an important criterion for good research (Corbin & Strauss, 2008; England, 1994; Nielsen, 1990). In these discussions of "detachment, distance, and impartiality, the personal is viewed as a mere nuisance or a possible threat to objectivity" (England, 1994, p. 242). My undergraduate degree extolled the virtues of neo-positivist empiricism, leaving me unsure where my life experiences fit within the research process, if they fit at all. However, the truth is my personal life has had a profound impact on the choices I have made in my academic and professional career. In fact, the questions posed in this research proposal have in large part evolved from my own journey with substance abuse and parenting.

As a novice researcher I find myself looking to make sense of my 'position and values' through the ideas of others. Moving my way through what seems like endless journal articles and texts that speak to ontological and epistemological assumptions, ethical research practice, trustworthiness and rigor, passionate-participant, voice, validity and the list goes on, I am overwhelmed by

the range of views and 'strategies'. Yet I am keenly aware that I am drawn toward some…and 'repelled' by others. Does this 'instinctual force,' so to speak, reflect, speak to, my ontology, my epistemology, my values? It certainly challenges me to consider, and attempt to unravel, my 'taken-for-grantedness.' It has confronted me with questions like: What is *truth*? How do I *know* what I know? What truth can I claim? What truth can *my* research claim? Is it *my* research? What truth can I claim about another? What relationship do I hope to have with participants? How will I establish, maintain, and end those relationships? Whose story do I want to tell? What are my responsibilities to the research, to the research participants, to me, and to my audience? Where am I - the researcher, the substance-dependent mother, the woman- in the process?

Initially this conversation seemed to be nothing more than academic haughtiness, but as I have 'spent time' with, and reflected upon, the experiences of others I have come to grasp the intent (value) of asking these questions. In the following section I will highlight a few authors and their ideas, which embody the values I hope to have brought into this research experience. It is these 'positions and values' that guided, and speak to, the trustworthiness of my research practices.

Campbell's (2001) conception of the emotionally engaged researcher resonates with me.

> Emotionally engaged research is guided by an ethic of caring: caring for the research (or the issue/topic itself), the research participants, what becomes of the research (including the eventual narrative,

> research notes, all of the data), and the researcher and the research team. Quite simply, caring, in this context, involves an emotional connection and concern for an issue, person, or persons (Blakely, 2007, p. 4).

This challenges the methodological hegemony of neo-positivist empiricism, questioning whether the researcher must, or is even able to, to exist within the research process with complete neutrality (Corbin & Strauss, 2008; England, 1994; Nielsen, 1990). Moreover, it enters into uncharted territory, asking if we should. Most qualitative researchers suggest that a researcher's particular paradigms, including perspective, training, knowledge, experience and biases, are "woven into all aspects of the research process" (Corbin & Strauss, 2008, p. 32), and it is these aspects that can enhance a researcher's sensitivity by "having insight, being tuned in to, [and] being able to pick up on relevant issues, events, and happenings in data" (Corbin & Strauss, 2008, p. 32). It is in this context that reflexivity on the part of the researcher is essential. Therefore I gave thought to my own social role and that of the participant and entered into the research relationship intending to deconstruct any perceived power differential that may or may not have existed between us through relationship building based upon partnership and humility on my part. Although the research relationships were in fact developed within the structure of the interview, which inherently delegates the interviewer and interviewee roles, in my view, the relationships that were formed would not be defined by those roles, but were at the core two women who were mothers, with the shared experience of being substance dependent; each

woman, including myself, sharing our personal experience, with the belief that our individual stories would give voice to an issue that mattered to us.

Reciprocity

"Klockars (1977) suggests that the measure of the ethical quality of any interview study is whether or not the researcher suffers with the participants. Reiman (1979) further suggests that the outcome of interview research should enhance the freedom of the participants more than it enhances the author's career" (as cited in DiCicco-Bloom & Crabtree, 2006, p. 319). As a researcher, I hope to embody these values, and behave in ways, that reflect these statements. Some tangible acts of 'reciprocity' I engaged in were as follows: 1) I addressed the realities of my participants' lives by responding to their requests for help and/or information, 2) I provided emotional support; 3) I facilitated access to psychological support if needed; 4) I addressed the immediate needs of study participants prior to meeting the research agenda; and 5) I provided honoraria to the women. Through my time with the women I learned to know them very well, and was able to provide gratitude gifts that reflected their journey, and I hope, expressed the emotional connection we experienced. One woman received a scrapbook, because she spoke a number of times about how she felt like she "quit" being a mom when she quit working in her child's baby book; another received a book about parenting that related specifically to her situation; another received a book that related to issues she was working on, along with "love coupons" she could share with her child; another received a journal with a butterfly on it, because she often referred to herself as a butterfly breaking out of

a cocoon. I was unable to provide honoraria to the two women who left treatment unexpectedly.

Relationship

Colleen Larson (1997) writes of the importance of researchers' engaging in dialogue with those whose lives they are studying. Dialogue makes understanding the life world and lived realities of others possible.

> When researchers share their ways of seeing, understanding, and interpreting life events with story-givers, they surface the fissures between their own life worlds and those of the people they portray. Disparities between the meaning that researchers make of the lives of others and the meaning that story-givers make of their own lives become points of entry into understanding human experience. . . . By failing to engage in deliberative dialogue and inquiry, researchers put themselves at greater risk of not seeing, not understanding, and misinterpreting people whose lives and life experiences differ from their own (p. 459).

Jane Harrison talks about how her hesitance to engage in dialogue with women she interviewed increased her 'othering' of the participants and it ignored the relationship she had with the women outside the research setting, which was in fact informing her analysis and understanding of the participants' lives (Harrison, MacGibbon, Morton, 2001). She suggests that "through judicious use of self-disclosure, interviews become conversations, and richer data are possible"

(Harrison, et al., 2001, p. 323). As a researcher, I am more than a collector of 'others' stories, and believe that 'authentic' engagement in the interview process is essential. Through the 'judicious use of self-disclosure' *we* (the participants and myself) created a safe and honest sharing environment. I openly shared about my personal experiences with substance abuse and parenting, and the women often asked me about my recovery journey, to which I shared honestly. The women regularly expressed feelings of validation through relating, which seemed, in many ways, to help them give voice to their own experience in richer and deeper ways. It was in this open and honest dialogue, that I believe I was able to bear witness to their lived-experience.

Credibility

Lincoln and Guba (1985) argue that addressing credibility is one of the most important factors in establishing a study's trustworthiness. This involves the consideration of how the research design will be responsive to issues such as: 1) whether findings accurately reflect the evidence; and 2) how knowledge claims are tested, to ensure that a true picture of the phenomenon is being presented.

Member checks were a part of the study design. The participants in this study were recognized as co-constructers of knowledge. As the researcher, I acknowledge that my understanding of the experience of substance-dependent mothers in treatment will emerge through, and with, the mothers. I am not the 'all-knowing' expert; I recognize that I am imperfect, thinking and feeling and my understanding of others' experience can be only partial. Van Maanen (1983) suggests that "analysis and verification. . . is something one brings forth with

them from the field, not something which can be attended to later, after the data are collected. When making sense of field data, one cannot simply accumulate information without regard to what each bit of information represents in terms of its possible contextual meanings" (as cited in Shenton, 2004, p. 69). To this end I solicited feedback from participants about their interpretation and understanding of the experience during the interviews.

Although I took authorial control, and the final thesis was largely my creation, participants were informed during enrollment, and again prior to leaving treatment, that they could receive a copy of the final draft and provide any feedback they have, if they chose. However, because of the complexities that often inhere in the lives of substance-dependent women, it was understood that extended study engagement may not be possible. Although all participants indicated they *would* contact me after treatment, and were interested in receiving a copy of the final manuscript, none did. Blakely (2007) suggests that, "caring within emotionally engaged research enables researchers to express their emotional connections and concerns toward the issue and research participants without expecting them to form unattainable research relationships" (p. 4). In consideration of this potential limitation, a peer reviewer was recruited, to debrief the experience and bring a fresh perspective to the analysis and challenge assumptions held by me. The peer reviewer reviewed themes and sub-themes alongside sections of text, and provided feedback regarding the resonance and meaning of themes that emerged during analysis and writing. A summary of her

personal, academic and career history, and overall impression of the analysis is included in the appendices (see Appendix F).

Triangulation is commonly used to address the issue of credibility. It may involve the use of different data collection methods to compensate for a method's individual limitations (Denscombe, 2003; Lincoln & Guba, 1985). In the current study, women's artistic expressions were intended to serve as an additional data source to the interviews; however none were provided.

Another form of triangulation may involve the use of multiple informants. Individual viewpoints and experiences can be verified against others and, ultimately, a rich picture of the experience may be constructed based on the contributions of a range of people. Van Maanen (1983) urges the exploitation of opportunities "to check out bits of information across informants" (as cited in Shenton, 2004, p. 66). In this study, such corroboration took the form of comparing the expression of 'self as a mother' described by one individual with those of another mother in treatment.

Transferability

Lincoln and Guba (1985) suggest that it is the responsibility of the investigator to ensure that sufficient contextual information about the fieldwork site is provided to enable the reader to make transferability inferences. To this end a full description of the substance abuse treatment program is included in Chapter III (see Treatment Setting).

Representation

Finlay (2006) suggests that a qualitative study can, and should, be judged on its ability "to draw the reader into the researcher's discoveries allowing the reader to see the worlds of others in new and deeper ways" (p. 12). Language used in the final representation "offers the emotionally engaged researcher the possibilities for extending texts, finding alternative ways for representing data and research, and infusing emotions into the study, for instance by using nonacademic language or writing emotion into the narrative" (Blakely, 2007, p. 5). van Manen (1984) suggests that 'attending to the language' is essential if a description is to be phenomenologically powerful, as it acquires a certain transparency; "then it permits us to "see" the deeper significance, or meaning-structures, of the lived experience it describes" (p. 25). Similarly, Bochner (2001) argues the need to bring in more artistry while also attending to ethical dimensions. He proposes this can be achieved through

- Detail, of the commonplace, of feelings as well as facts
- Narratives that are structurally complex and take account of time as it is experienced
- A sense of the author, their subjectivity and 'emotional credibility'.
- Stories that tell about believable journeys through the life course.
- Ethical self-consciousness: respect for others in the field, and for the moral dimensions of the story.
- A story that moves the reader at an emotional as well as rational level (as cited in Finlay, 2006, p. 11).

Moreover, these authors suggest the creation of transparent, powerful, emotive texts requires us to also turn our attention to issues of 'voice'. Devault (1999) points out that "in our concern for representing the voices of others, we sometimes fear to explore and develop our own voices" (p. 190; as cited in Blakely, 2007, p. 5). Ferguson, Ferguson, Taylor (1992) view attending to the constructions of our texts as an opportunity to drop the pretense of the invisible author voice and replace it with a more active and flexible narrative voice. As soon as we, as researchers, become involved in telling *our* stories of *their* stories, we present our interpretations of their interpretations. Not only are there multiple perspectives, then, but there are multiple *layers* of perspective as soon as one enters the reflective process of research (p. 299).

It is these dimensions of 'representation' that guided me throughout the writing process, and hopefully resulted in final texts, which are rich in-depth descriptions, reflect the complexities of experience, are credible to the experience, evocative, emotive and lack deception.

Final Review

All participants were invited to remain engaged in the study after they had left treatment. Women were provided my contact information in order to receive a copy of the final draft and give feedback if they chose. No one did.

Dissemination

The final thesis will be submitted to the University of Alberta to fulfill the requirement for the degree of Masters of Science. van Manen suggests the end of phenomenological reflection is

> the achievement of a personal, formative knowledge, and suggests that the practical significance of phenomenological knowledge is formative in nature: It enhances our perceptiveness, it contributes to our sense of tact in human relations, and it provides us with pathic forms of understanding that are embodied, situational, relational and enactive (n.d.).

It is thought that the formative knowledge gained in this study will increase practitioners' sensitivity to potential conflicting discourses that may shape the treatment experiences of substance-dependent mothers, and moreover, a deeper understanding of the lived-'treatment'-experience of substance-dependent mothers will increase their ability to provide a '(w) holistic' healing environment for these mothers and facilitate a positive recovery process. Therefore, I will provide a copy of the final manuscript to the hosting substance abuse treatment program and present the findings in-house, if they request.

Chapter III

This chapter is comprised of a description of the: 1) treatment setting; 2) participant profiles; and 3) analytic themes, which include a clinical impression, alongside a unified descriptive account, through the explication and integration of structural and textural themes that emerged among the mothers.

Treatment Setting

The treatment center is located in Blackfoot, Alberta, which is small rural community situated just outside the city of Lloydminster, Alberta. The program was established in 1975 as a detoxification unit that was run out of the nurses' residence of the local hospital. Within six years, the centre expanded to a full

treatment centre that offered a fourteen day recovery program and outpatient counseling. In 1988, the centre relocated to a new facility and expanded its programming to include the additional service of a youth and adolescent outpatient office. Over the years the program has continued to evolve; the fourteen day program was extended to twenty-one days, twenty-eight days and then to forty-two days in 2011. In January 2012 the program moved to its current location and currently offers a forty-two day and ninety day residential addictions program.

The treatment centre is a 72 bed facility that provides adult medical detoxification and residential programming. At the time of the study, there were forty adult beds, ten youth beds, twelve transition beds, and twelve detoxification beds. The program is a co-ed integrated program, with adult men and women residing in the same area of the facility. Men and women share common living areas, such as the cafeteria, work-out facility and library. However, in late 2012 the youth program was closed, and the women were moved into the former youth side of the facility, which has since enabled gender segregated living and recreation.

The center is a not-for-profit organization that receives private and corporate donations, and limited government funding from Alberta and Saskatchewan. Under the current funding structure, the Alberta government funds approximately five individuals per month, and Saskatchewan funds approximately two individuals per month. The vast majority of treatment beds are paid for by corporations who either mandate and/or support employees entrance

into treatment. The remaining beds are fee-for service; the current cost for the 42 day program is $17,500.

The program offers a rolling admissions that utilizes a three phase transitional approach. Within each phase of treatment the intent is to care for the client on four basic levels: biological, psychological, social and spiritual. The initial detoxification phase is designed to stabilize and assist individuals in addressing acute withdrawal symptoms. The length of stay in the detoxification program varies, but is typically 7-10 days. Clients seeking residential treatment subsequently enter a 2-5 day transition period. During this time individuals are assigned to a clinical team member for assessment. The transitional assessment involves a two to four hour clinical interview, most often taking place over two to three days, in which the client's bio-psycho-social and spiritual health and functioning are assessed. Individuals are also assessed for gambling and sexual addictions. During the transition period, clients are expected to attend two daily group sessions, in which they are provided psycho-education about addiction and an opportunity to share with other clients. Clients are also encouraged to begin daily morning activities (i.e. walk or meditation and "Daily Reflections") which are part of the general programming for all program clients. In the final stage the client enters the residential addictions program.

The residential program is based on the Minnesota Model of addiction treatment. The model uses a disease concept of addiction that includes four key elements:

1. The conviction that people struggling with addiction can change what they believe, their attitudes and behaviors. Initial motivation is not necessarily important as this model believes that its interventions are effective at breaking resistance and denial.
2. Addiction is believed to be primary, chronic, and multifaceted and characterized by a loss of control in regards to the addiction. Multifaceted refers to the bio/psycho/social/spiritual impact of addiction.
3. Long and short term treatment goals are specified. The long term goals are abstinence from the substance and all drugs of abuse and a better life-style characterized by improved mental health and emotional states. Abstinence does not necessarily define success. The short term goals of treatment are:
   i. To help clients recognize addiction and the implications
   ii. To help clients admit that they are in need of help and concentrate on living a constructive life knowing that addiction will not ever be 'cured.'
   iii. To help people identify the behaviors that need to change so that they are able to live with the disease of addiction
   iv. To assist clients to translate new knowledge into action by developing a new life style.
4. 12 step involvement is fundamental to recovery. The principles involve growth of spiritual awareness, recognition of choice and

> personal responsibility and acceptance of peer relationships. Resources for recovery lie within each person. Treatment helps people discover how to use these innate resources and to construct an atmosphere that is conducive to change.

Within this model, there are standard components that include:

1. Group Therapy
2. Lectures
3. Multi professional staff
4. Recovering alcoholics or addicts as counselors
5. Therapeutic milieu
6. Assignments
7. Family counseling
8. AA/NA attendance
9. Daily reading groups
10. Life history
11. Twelve step work
12. Recreation

Within this framework, the organization promotes a client-centered approach to treatment planning, and work to support clients according to their individual needs. They have a working relationship with a local psychiatrist to better support individuals with concurrent disorders. Upon entrance into program, residential clients are assigned a primary counselor works with them throughout the length of the program. They support the client in developing an initial

treatment plan and an after-care plan, and provide regular weekly individual counseling sessions.

Clients are encouraged to work through the first three steps of their respective 12 Step Recovery Programs (i.e. Alcoholics Anonymous, Narcotics Anonymous, Sex Anonymous, and/or Gamblers Anonymous) and are expected to attend a combination of three in-house and/or outside 12 Step meetings per week. Daily lectures and activities are provided to assist clients in gaining insight into themselves and skills related to emotional, intellectual and social functioning. Topics include:

> Self-Awareness; Mental Health; Rational / Irrational Thinking; Emotions / Guilt /
>
> Shame; Self Esteem; Relapse Prevention; Emotional Freedom Techniques (EFT);
>
> Family Dynamics; Priorities & Values; Letting Go; Reinventing Yourself;
>
> Mindfulness and Emotional Regulation;
>
> Relationships; Addictive Disorders; and Communication.

Depending upon need, clients may also be referred to specialized in-house groups focusing on post-traumatic-stress disorder symptom management, sex addiction, gambling addiction and smoking cessation. Clients also take part in a gender specific primary group that meets five times per week, in which they can share more intimate details of their life. Additionally, there are co-ed groups that explore a variety of topics such as: balance in life, use of money and time, assertiveness, boundaries, and art and music group-therapy. A monthly four-day Family Program is also offered to family members to help them learn new ways

to cope with addiction by developing skills that will promote recovery within the family unit as a whole.

Clients are allowed two 15 minute phone calls per week; however a limited number of additional calls may be facilitated by their primary counselor. Outside visitors are allowed for two hours every Sunday. Outside visitors must be approved by client's primary counselor. After a client has been in program for twenty-one days they are able to attend activities outside the center, such as church, SPCA, and swimming. All outside activities are supervised by staff and/or an approved community member. In house recreation includes: yoga, tai chi, crafts, massage and organized gym activities, such as basketball and floor-hockey. A weekly bible study is also offered in-house by a community member. While in program clients do not have general access to television, internet, cell-phones, and/or unapproved music. Internet access to manage personal matters such as banking requires approval of their primary counselor.

Participant Profiles

A total of six women were enrolled the study. All of the women entered into treatment by their own choice, and were not mandated by legal order. None of the women lived with their children prior to treatment, except for Chloe who lived with two of her five children. None of the women were currently involved with Child Protective Services. All of the women's children lived with the biological father and/or maternal grandparents. All of the women indicated they intended for their children to eventually live with them, and to resume the mother-role following treatment.

A summary of the main characteristics (i.e. age and number of children) is provided in Table 1. A full description of each participant follows.

Table 1. Summary of Main Characteristics of Participants

Name	Age (years)	Number of Children
Chloe	35	5
Betty	33	1
Faith	33	1
Karen	29	1
Trish	26	1
Amaya	30	2

Table 1

Chloe

Chloe is a 35 year old Metis woman, who entered into treatment to for alcohol, crack-cocaine, and marijuana use. This was her first time seeking help for addiction. Chloe began using marijuana at the age of nine and drinking when she was 10 years old. She has five children; she drank and used drugs throughout all her pregnancies; one of her sons has been diagnosed with fetal alcohol spectrum disorder (FASD).

Chloe left home when she was thirteen and lived with a man who was in his twenties. She had her first child with him when she was sixteen, and her second child when she was eighteen. Four years later she left the relationship; her third son was born from a brief three month relationship. Her cocaine use started

shortly after her third son was born. During this time Chloe began to use cocaine intravenously and she gave up custody of her three eldest children to her mother. Chloe discontinued using intravenously later that year, but indicated she "pushed that addiction aside for another addiction" and never returned for her children. Currently she is in a common-law relationship with a man twenty-eight years her senior and who has two children, aged three and six, with him. Although she often talked about being treated like a "piece of garbage" by her partner and identified the relationship as very turbulent and "codependent", she struggled with "letting go" and remained hopeful that he would change when she returned home.

Chloe was diagnosed with depression six months prior to entering into treatment. She describes experiencing periods of severe depression and extreme mood swings throughout most of her life, and becomes extremely agitated and experience episodes of anger and rage primarily directed toward her children and partner. While in treatment Chloe received a provisional diagnoses of posttraumatic stress disorder (PTSD).

Chloe has an extensive history of childhood neglect, and physical and emotional abuse. While in treatment she disclosed she was sexually abused in the past but was reluctant to speak about it. She identifies both her parents as alcoholic and often talked about the emotional and physical abuse she experienced from her mother. During interviews she would often slide into narratives about her mother when being asked about her relationship with her children. She frequently spoke about only being shown affection when her mother

was drunk. She never knew her biological father, but was close to her stepdad. She has two brothers; however she currently has no relationship with them and does not speak to her stepdad.

As treatment progressed Chloe was able to identify how her substance use was connected to her early life experiences; in one interview she shared,

> My childhood wasn't the happiest childhood either, I was going through a lot in childhood wondering why, what did I do to deserve everything that I got, I used to wake up at night wishing I wasn't even there, blaming god as to why, why am I still here, just take me away, so to deal with all that pain and anger I started off with drugs and alcohol, it progressed over time and I didn't think it was a problem, but it helped me with the pain, I just push everything away, all my memories, the pain and all the feelings I just suppressed down, it's the way I dealt with them, I didn't want to deal with them, I didn't want to remember them, over the years it just progressed.

Initially Chloe presented as reserved and distrusting; she would wear a baseball cap pulled down over her eyes, and had a closed off manner when she interacted with others. However, she was very open during interviews and frequently became very emotional. She often spoke about her struggles with trusting other women in the program; she related this to issues she had with her mother. She identified her early life experiences as the reason why she had great difficulty trusting people and feeling safe; she began to recognize that she keeps her distance from everyone, including her children, for fear of getting hurt.

Initially Chloe found it extremely difficult to open up during group sessions and stated a number of times she only wanted to share on an individual basis with counselors and myself. She would often berate herself after sharing her history in group settings; this was most notable when she would talk about the abuse she experienced by her mother, stating she felt like she had "betrayed" her mother's confidence. However, she was able to challenge this belief throughout treatment, and eventually became more trusting of the process. She began to open up and engage with the other ladies; she wore her baseball cap less and appeared much happier and open during these times. By the end of treatment she frequently vocalized the benefits of sharing her experiences in a group setting, although she identified this would be something she would need to continue to work on. She completed treatment after 42 days.

Betty

Betty is a 33 year old Aboriginal woman who entered into treatment for substance dependence to crack-cocaine. She has been using marijuana and alcohol since she was 13 years old and began using crack-cocaine three years ago. This is her first time in treatment; however she quit using substances for five months a year ago. She often feels depressed and hopeless and has a history of suicidal ideations; she recently attempted to shoot herself but was intervened. She has struggled with anxiety and panic attacks for most of her life, and eats compulsively to soothe negative feelings. She was physically abused as a child and has an extensive history of sexual trauma. She was recently diagnosed with post-traumatic stress disorder (PTSD) and was assessed for, and endorsed patterns of sex addiction.

Betty has an 11 year old son who was born out of an affair she had with her best-friend's boyfriend. When she told the man she was pregnant he threatened to kill her if she told anybody. Because she felt enormous guilt and shame about what had happened she kept the affair a secret. She had her son, and has for the most part raised him on her own. She describes a very difficult parenting experience that was characterized by repeated emotional and physical separation from her son. When things were difficult in her life, she would emotionally withdraw and send her son to live with family or friends for extended periods of time. Her son currently lives with friends of hers who he identifies as his family. Her son is aware that his she is in treatment for a drug addiction. She intends for her son to return to live with her when she leaves treatment.

Betty was adopted by her maternal great-aunt and uncle when she was a week old. She describes growing up in a traditional northern native family; they were very isolated and "lived off the land". Both her aunt and uncle were residential school survivors; she had five older adoptive siblings who also attended residential school. As a child she was physically abused by her older brothers and believes it was tied to the abuse they experienced at the school. She disclosed that she had been sexually abused as a child outside the family, but was reluctant to speak about it. Her adoptive father was an alcoholic who was physically and emotionally abusive when he drank; she describes her adoptive mother as generally "nice", and only "mean" if she was stressed. Most of her siblings have struggled with alcoholism; her older brother, who she viewed as a father, froze to death while drunk when she was 8 years old. Not long after, her

adoptive mother had a stroke which affected her physical and cognitive functioning. This had a huge impact on Betty; she describes feeling very alone and scared during this time. Feeling lost, she sought out her biological father when she was 11 years old. He violently raped her when they met; she never told anyone. In the years that followed she experienced numerous sexual and physical assaults; none of which she's received counseling for until now. She recently left a six year common law relationship with a woman, who had been very controlling and emotionally abusive. Betty seemed to understand that her tendency to bond with people who hurt her was linked to the abuse she experienced in early life and spent a lot of time in treatment working on issues related to self-esteem and learning about healthy relationships.

Generally she was very quiet and had a difficulty regulating her emotions in group therapy session. She required a lot of one on one support from her counselor to help her deescalate and process overwhelming emotion. Although she had approached me to join the study, it often felt like she wasn't overly invested in its purpose, as she would appear irritated, or bored, when I would interject with "interview" questions, and would quickly move back into her narrative. It was clear that the interviews became an emotionally safe place to tell her story. She spent a lot of time talking about her ex-partner and their relationship history. Over time she became more open to talking about her son and parenting experiences, but seemed to have difficulty connecting emotionally to that part of her life. Closer to the end of treatment, she received a letter from her son that seemed to allow her to explore their relationship in a deeper way.

Betty unexpectedly left treatment shortly after; she completed 64 days of a 90 day program.

Faith

Faith is a 33 year old woman who entered in to treatment for crackcocaine and alcohol dependence. She has been to treatment five times prior and has spent a significant amount of time in detox and psychiatric units over the last seven years. She has received a number of mental health diagnoses, including bipolar, borderline, post-traumatic stress disorder, major depression and anxiety; however both bipolar and borderline diagnoses have been questioned by various mental health professionals. She has been homeless for much of her drug using career and has supported herself primarily through criminal activity, sex-trade, and a myriad of menial jobs. She has struggled with depression and feelings of hopelessness for much of her life, and has attempted suicide three times. Her addiction has perpetuated a high risk lifestyle in which she has endured horrific acts of violence including being sold for an ounce of cocaine and held against her will in a basement where she contracted MRSA and was repeatedly raped for two weeks. Although she was a broken woman in many ways, there was a strength and determination that seemed to lie within her. There was something in her brokenness, a desperation that allowed her to face the ugly realities of her life without refrain. I often felt like she didn't only "tell me" about her life and her feelings, but that I was witnessing her grapple with the pain that was her life.

Faith has a nine year old daughter who she gave up to her ex-partner, her daughter's biological father, when she was two years old. Early in treatment she appeared to almost writhe in pain when talking about her daughter and all that she

has missed in her life. Although she has yo-yoed in and out of her daughter's life over the last seven years she has tried to maintain contact and spends time with her when she is able. Her ex-partner recently threatened to remove all access to her daughter if she continues to use drugs. He obtained full custody three years earlier and denied her access to her daughter. At that time she entered into treatment and fought for access; her ex conceded as she remained drug free for nine months, but she relapsed shortly after. She understands and accepts her daughter will not be in her life if she continues to use drugs.

Faith was raised by her mother who was a severe alcoholic and emotionally abusive. She has a brother who is ten years younger, who she took care of because her mom was unable due to her addiction. He was apprehended by Children's Protective Service when he was four years old. Faith describes being "hurt beyond repair" when he was taken; she has struggled with feeling enormous guilt because she felt it had been her job to take care of him. Her mother drank herself to death three years later. Faith has been basically alone in the world ever since. Her biological father has had little to do with her, and her grandmother who she was close to as a child, died shortly before her daughter was born.

Since leaving her daughter's biological father, who is also an alcoholic, she has repeatedly been in abusive and exploitive relationships. Her current partner is a crack-cocaine addict, and has proven himself to be emotionally and physically dangerous to Faith; however she struggled throughout treatment with taking steps to end the relationship. She continued to work on this and by the end

of treatment her focus was, for the most part, on herself and her daughter. She appeared to be coming to terms that she could not be the woman or mother she wanted to be if she remained in the relationship. She completed treatment after fifty days and looked forward to building a healthy relationship with her daughter

Karen

Karen presented as a very attractive and intelligent 29 year old with a sixteen year history of substance use; her primary drug of choice is crack-cocaine; she also uses powder-cocaine, alcohol and marijuana regularly. She was diagnosed with post-traumatic stress disorder (PTSD) and a cocaine-induced mood disorder with depressive features and a seasonal pattern of recurrence (seasonal mood disorder). She has an extensive history of childhood sexual trauma, and reported she was recently physically and sexually assaulted by two men just prior to entering into treatment. During treatment she was assessed for, and endorsed patterns of sex addiction and disordered eating characterized by binge-eating followed by purging, caloric restrictions and excessive exercising. This was her second time in residential treatment; she completed a 28 day program two years earlier, during which time she had a relationship with another client who was married. After treatment she remained sober for four months; however she relapsed after he returned to live with his wife and children.

Karen has a 4 year old son. At the beginning of treatment, she minimized and barely acknowledged she was a mother. Over time she was able to recognize why she was having difficulty admitting to being a parent and began to speak more openly about her son and put up pictures of him in her room. She had been engaged to her son's father, who also uses crack-cocaine, until he had an affair

with her best-friend and left her shortly after their son was born. He has been virtually absent from his son's life and has continued to be emotionally abusive toward Karen. She is lonely as a single mother, but feels she is unable to love anyone, including herself. Although she has been solely responsible for her son, she has received a significant amount of financial and parenting support from her parents. They have been increasingly involved in his day-to-day parenting especially over the last two years. He currently resides with them, although she intends for her son to return to live with her after she completes treatment.

Karen was raised by her mother and father; she has one brother who is five years older. She describes her family as being quite affluent and feels that while growing up she received material possessions in place of emotional or physical affection. Karen's father was an active alcoholic until she was 3 years old, at which time he quit drinking and became immersed in work. She describes him as a "*work-oholic*" who was not there for the family in any meaningful way besides financial support. She has a very difficult conflict-based relationship with her mother in which she has never felt good enough.

Growing up her family never talked about personal issues or admitted there were problems in the home. Karen had been sexually abused by her brother starting at a very young age until she was 15 years old; when she disclosed the abuse to her parents her brother was charged, but later her parents never acknowledged what had happened and directed Karen to keep the abuse a secret. She felt her parents bought her expensive things to make up for the abuse she suffered. Although she feels she has come to terms with the sexual abuse, and

describes a good relationship with her brother, while discussing her brother she would often position him as a victim who she felt sorry for, and attribute, what she vaguely refers to as "all those issues", as coming from her dad's side of the family.

Overall Karen was very well-spoken, although she had a tendency to speak rapidly and would often forget to breathe. When we initially began to meet she presented with somewhat limited affect and had a tendency to intellectualize emotionally activating experiences. She had a difficulty identifying what she was feeling and did not appear comfortable with emoting. She had been unable to cry for years and felt frustrated by the expectation that she needed to cry in order to heal. As our sessions progressed she became more aware of her emotions and was better able to identify what she was feeling. Although she presented a tough "put together" persona for the most part, there were moments during the interviews, especially when talking about relational difficulties with her son, she reminded me of a hurt little girl. During these times she would intellectualize less and acknowledge her pain and vulnerabilities in relation to her son. She began to express her emotions privately through journaling and somewhat with others, however it remained difficult for her to be emotionally vulnerable. She felt she had developed meaningful relationships and healthy boundaries with other clients of both genders, which she described as "huge", because of her tendency to shutout women and conversely, enmesh herself with men. Karen completed treatment after 60 days; she felt she had received as much from treatment as she could and wanted to leave so she could be with her son.

Trish

Trish presented as a bubbly and outgoing 26 year old who entered into treatment for cocaine, marijuana and alcohol addiction. She had not sought help for her addiction prior; she has a thirteen year history of alcohol and marijuana use and describes a pattern of increasing cocaine use over the last three years. Trish has had much success academically; she completed two university degrees, but has not been employed in her profession and has been unable to maintain steady employment for some time. She recently became involved in the sex trade to support herself. She disclosed she frequently engages in self-harming behavior (i.e. cutting) as a way to relieve the emotional pain and depression she feels when coming down from cocaine. She has no formal mental health diagnoses, but describes feeling very depressed, overwhelmed and hopeless over the last few years. She has attempted suicide on one occasion; and has sought help two times over the last three years for symptoms related to depression and suicidal ideation following the separation from her child's father, and later, an abortion. She has also struggled with bulimia since her teen years; although she does not identify it to be currently problematic as it has been inactive for the last three years.

Trish has an 8 year old son who has been living with his father for the last three years. Trish had lived with her son and his biological father until her son was four years old. She recalls that time with fondness, and spoke about how being a mom had given her a sense of purpose and helped her to stop purging. However, in our discussions she was often vague when discussing her life during that time, which left me feeling like I had little sense of what it really looked like or the finer details of her relationship with her son and partner. She experienced

an enormous amount of guilt when she separated from her son's father, but describes the relationship as being physically and emotionally abusive and felt like she had no other choice than to leave. When she initially left the relationship her son lived with her for seven months; however she was struggling financially and was unsure where she was going to live, so she made the decision for her son to return to live with his father until she became more settled.

Trish has continued to have visits with her son over the last three years, most often with the support of her mother, but describes a pattern of decreasing contact. Prior to entering treatment she had not seen her son for three months. She became quite emotional when discussing her son, and appeared overwhelmed whenever we spoke about the future of their relationship. Trish recognizes her drug use has caused her to neglect her son, which she feels immense guilt for, but believes her son is unaware of her drug use because she would not use when they were together. Trish had kept her addiction a secret from her family until recently when she asked her father for help. He assisted her in accessing treatment.

Growing up her family was characterized by significant conflict and emotional distance between her parents, which ultimately resulted in their divorce when she was in grade six. Her father worked away for most of her childhood, sometimes for months at a time; when he would return home, her parents would fight frequently and be verbally abusive toward each other. Trish remained living with her father after the divorce. Trish described not being upset when her mother left; although she felt close to her as a young child and has fond memories of her mother reading her bedtime stories, she feels they grew apart as she got older.

Trish's mom smokes marijuana and drinks alcohol frequently; she believes her mom also addicted to pain killers, but is not sure because her family doesn't talk about it. She describes feeling close to her father although she has always been scared of him. He had exceedingly high expectations for her, and a "terrible temper" when she did not perform to his standards academically or in the home. She felt her father expected her to take on her mother's role in taking care of the house after the divorce, which left her, at 11 years old, feeling very overwhelmed. Trish often felt scared and "sought refuge" at her grandparents' house during her childhood; she was exceptionally close with them and viewed them as second parents. After her grandmother's death two years ago Trish became very depressed and her substance use escalated as she distanced herself from the rest of her family.

During treatment Trish had difficulty expressing negative affect in the presence of others; often times it was difficult to know whether she was authentic in her presentation. As a child she would diffuse difficult situations by being happy and jokey, and began to recognize that this tendency had carried into her adult life. Early in our sessions, I frequently got the impression she was saying what she thought I wanted or expected her to say and would often apologize after sharing. There was a childlike quality about her that seemed to be yearning for acceptance. Her willingness to explore some of her more difficult shame-based experiences seemed to be facilitated by the fact that there was a peer-acceptance she experienced as she opened up with other clients.

She struggled with setting healthy boundaries with men, as she felt more easily accepted by them; this was an ongoing issue as she was often asked to distance herself from men in the program. As treatment progressed she recognized her tendency toward emotional dishonesty, and challenged herself to become more emotionally integrated despite her fear of rejection. She carried a lot of pain and unresolved feelings related to the death of her grandmother, her abortion, and things she had done in her addiction; by the end of treatment she felt like she had worked through many of her issues and was moving toward a place of selfacceptance. She completed treatment after 42 days.

Amaya

Amaya is a 30 year old woman who entered into treatment for a crack-cocaine addiction; she also uses alcohol and sedatives regularly. She has been in over ten different detox and treatment facilities over the last four years but has been unable to maintain any long term sobriety. Her drug use has caused significant deterioration to her health including substantial weight loss, and she reports having three strokes in the last year. She has been unable to maintain employment due to her physical and mental health and has supported herself primarily through shoplifting and the sex-trade.

She has struggled with extreme depression for most of her adult life, and regularly engages in self-mutilation. She has attempted suicide on two occasions, and feels that she is unable to cope with life. She has been sexually and physically abused, but was reluctant to talk about it. She has been diagnosed with bipolar and attention deficit hyperactivity disorder (ADHD), and has received a

provisional diagnoses of post-traumatic stress disorder (PTSD) since entering into treatment.

Although her family of origin was "picture perfect" from the outside, she felt alone and unloved during childhood. She describes her parents as emotionally distant, and feels her mother was more concerned about their appearance in the community than their relationship. Her mother showed her little affection and often was stressed; however both her parents have become more emotionally engaged in her life since her addiction has progressed, and have tried to support her attempts at recovery. They have attended a number of support groups and classes for families with addiction, and have recently stopped giving her money and/or other resources that support her addiction.

Amaya has two children, a daughter aged ten and son who is seven. She married her daughter's father a year after her daughter was born, but feels she was never happy in the relationship. She describes him as controlling and verbally abusive toward her and her daughter. Feeling trapped and unloved, she began to drink frequently and look outside the marriage for affection. She had an affair and became pregnant, but didn't tell her husband the baby was not his. Although she remained in the marriage for three years after her son was born, she continued the relationship with her son's biological father. Throughout this time she struggled with feeling any connection or love for her son, and became increasingly detached from her family. She continues to feel guilty about this and is confused by her feelings toward her children, especially her son. She remains in

relationship with her son's biological father, although she acknowledges that the relationship is centered on drug use and is extremely abusive.

Both children live with her ex-husband; she has limited access to them but has continued to spend time with them at her parent's home over the last four years. She hopes to become more involved in their life, although she knows it will not happen as long as she remains with her current partner. She sees this as her greatest barrier to achieving sobriety and becoming the woman and mother she want to be. Amaya left treatment unexpectedly after three weeks.

Analytic Themes

Data analysis produced four meta-themes that embody the essence of 'being a mom' in mixed-gendered residential treatment. These include, (1) SelfForgiveness, (2) Looking Back, (3) Looking Forward, and 4) Sense of Closure. Within these four dimensions, 22 sub-themes offer structural meanings revealing *how* the phenomenon was experienced, alongside textural descriptions that provide the reader a rich understanding of *what* the participant experienced. A clinical impression, alongside a unified descriptive account, will be offered through the explication and integration of structural and textural themes that emerged among the mothers.

Meta-theme: Self-Forgiveness

All of the study participants described the mothering experience as involving self-forgiveness, the first meta-theme revealed in the analysis.. Within this broad dimension of experience, five sub-themes emerged, each describing different aspects of self-forgiveness reported by the women in the study, as depicted in Table 2.

Table 2. Self-forgiveness Meta-theme and its sub-themes represented in participants' lived-experience

Themes **Participants**						
	Chloe	*Betty*	*Faith*	*Karen*	*Trish*	*Amaya*
Meta-Theme **Self-Forgiveness**	x	x	x	x	x	x
Sub-Themes						
Escaping Guilt & Shame	x	x	x	x	x	x
Backdoor or Bridge	x	x	x	x	x	x
Should I or Shouldn't I Internal Negotiations	x		x	x	x	
Testing the Waters Social Connection	x	x	x	x	x	
"Fake it till You Make it" Decision	x		x	x	x	
What I did isn't Who I am Externalizing	x	x	x	x	x	x

Table 2.

Note: Themes that were represented within the participants' lived-experience are indicated with an x.

Escaping Guilt & Shame

Feelings of guilt and shame that are prolonged may cause people to feel overwhelmed, hopeless, and depressed. These feelings may make it less likely or even impossible for people to take the necessary actions to improve their situation. Feelings of guilt and shame may also be detrimental to physical and mental health and result in the internalization of a negative self-image, which often perpetuate the use of substances as a way to cope with negative feelings. Research has established links between feelings of guilt and shame and substance use, via a positive feedback loop in which intense feelings of guilt and shame are

managed through substance use, decreasing an individual's self- efficacy and selfesteem, which in turn, promote further feelings of guilt and shame (Ianni, Hart, Hibbard, & Carroll, 2010; Scherer, Worthington, Hook & Campana, 2011, Webb, Robinson, Brower, & Zucker, 2006). The cycle insidiously entangles the individual in a downward spiral of addiction. The women in the current study describe feeling trapped within this cycle. Despite their desire to be "better mothers," the need and desire to use substances to manage emotional and physical discomfort continually overrode mothers' good intentions. As Trish explained, although she wanted to be with her son,

> Every time I'd see him I'd feel bad about something, it made me want to rush the weekend that much more because as soon as the visit was over then I could go back and drink and use again and get it out of my head, and just push it aside. (Trish, interview 1, lines 406-408)

All of the women in the study felt desperate to find a way out of the guilt and shame, because they identified this as one of the main reasons they continued to use substances despite their desire to stop. Shame is an intensely unpleasant emotion, one that involves negative emotion directed at the whole self, whereas feelings of guilt result from behaving in a flawed or bad way rather than a flawed or bad self (Brown, 2006). People experiencing shame often report feeling small, worthless, isolated, trapped and powerless (Brown, 2006). Because shame can be so distressing, people experiencing shame often become more concerned with finding emotional relief than with empathizing or repairing relational harm. In

their pursuit of relief, the women found themselves in "situations in which options are reduced to a very few and all of them expose one to penalty, censure, or deprivation" (Frye, 2001; as cited in Brown, 2006, p.46); essentially, they felt they were "damned if you do and you're damned if you don't kind of thing." (Trish, interview 1, lines 414-415)

> That's why people with no kids will throw out do it for your kids, it's like you don't think we thought about our kids. That's the main reason we use, the guilt and the shame. It didn't stop my addiction from totally ten folding. (Karen, interview 1, lines 445-447)

> It's so hard to not have them but it's so hard to see them, what do you do, you just want to pull your hair out. (Trish, interview 1, lines 413-414)

> Those guilt and shame feelings I think that's when they became really real …so I'm like 'god this has got to change my daughter needs me', so all this panic, guilt and shame started coming up, it was really hard, like I said I left treatment, started using a week later. (Faith, interview 1, lines 326-341)

Backdoor or Bridge?

As the women began to seek new ways to escape guilt and shame, all of them expressed a sense of reaching toward self-forgiveness. It was unclear how

the idea of self-forgiveness emerged; initially, for some it seemed to be shaped by recovery vernacular, and almost sought after as a backdoor out of the dead-end of shame they felt trapped in. Tangney, Boone, and Dearing (2005) propose that shame makes self-forgiveness tremendously difficult because of its global devaluation of the self. If one feels guilt about a specific action, one can alleviate the guilt through reparations and amends; but if one feels shame, it is difficult to make up for a global sense of being a bad person. For Amaya this challenge was evident as she expressed a sort of resignation to what is; there seems to be no escape, or way to move across the emotional chasm, despite her attempts. Well I worked a lot on it last time I was here, forgiving myself, even if I haven't, I say I have, cause don't know what else to do,

> I've cried about it enough, I've let it go somewhat, I can't dwell on it or else I'll just be stuck there, so ya….I can't change anything. (Amaya, interview 1, lines 373-378).

In this text, the language of forgiveness has become a backdoor of sorts, which she takes, not because she expects any effect, but because she doesn't see any other options. Tangney et al., (2005) suggest because psychological defenses protecting against underlying shame can be quite strong, self-forgiveness efforts could lead to acts of *pseudo self-forgiveness*, thereby, feeding the defensive cycle, in a further attempt to hide shame. Authentic self-forgiveness is understood to result in an increased acceptance and belief that certain behaviors must and can change, while seeing the self as worthwhile; without these elements, "self–forgiveness is considered irrelevant and pseudo self–forgiveness becomes likely"

(Hall & Fincham, 2005, p. 626). As an individual engages thoughts and attitudes of self-worth and is repeatedly overcome by the self's objective failures, it become more likely they will rationalize, or in the case of some of the women, allay and/or circumvent difficult feelings through the language of self-forgiveness.

> I have to forgive myself, I just put it that way… it's hard, I know I've missed a lot, I don't know. (Amaya, interview 1, lines 364-365)

> [C*rying*] sometimes, oh, I just want to go home and hug them and them hug me and tell me it's going to be okay, it's okay, it's going to be okay [*whispery*] not being able to do that, I want go home I just want to go home to know it's going to be okay, maybe I don't need to do this, if I can forgive them and move on that's all I need, right [*crying*]? (Chloe, interview 1, lines 521-525)

However, over the course of treatment, most of the women seemed to explore and express a more authentically felt sense of self-forgiveness that was viewed as a way to break out of the cycle of negative emotions that perpetuated their absence from their children. Self-forgiveness offered them a way to manage, or contain, the overwhelming guilt they anticipated would emerge as they faced their past. The idea of self-forgiveness was experienced as a bridge that would allow them to move through their past toward who they want to be.

I think for me I'm going to have to work through that guilt and shame surrounding him and what I've done and the things I've missed, and I'm going to have to deal with that because I've missed so much …I was looking at his baby book the other day, my mom had brought it in, and you can see where I fell off as a mom, cause all of a sudden after his five year picture, I have his one month picture, one year, two years, three year, all of a sudden you see where I fall off as mom, that's where I stopped working in his baby book, that's when, I've missed that and I can't get it back and I have to deal with that and learn how to accept that and forgive myself for that and I know that's going to take a lot for me cause I feel like a bag of shit. (Trish, interview 1, lines 346-360)

I just need to let go of all that stuff, I need to be able to forgive myself because my daughter is forgiving me right now and I need to accept that, and I need to really think that it's not too late, but it's getting to the point where it will be too late if I continue, like after I get out of here and I just go back to drinking and using, *I am going to lose my daughter* [emphasized], and that should be like *light bulb* [emphasized] like *hello* [emphasized] stop doing these behaviors, but then again I think oh my god well I haven't

been there, all the negative emotions that come from not being there, I really need to let them go somehow, I don't even know what that looks like, and I guess I really haven't really dealt with it if I think about it cause all the treatment stuff I've ever done is thinking about me, me, me, but never in regards to me as a mother, just me as an addict, so there needs to be a whole different perspective this time, I know that I have to do it for myself but I also have a young child who is counting on me. (Faith, interview 1, lines 527-536)

I have resentment toward my own child, I know that sounds sick, but that's the brutally honest truth, that's the stuff I got to say, and that's the stuff that it's okay, you know, cause that's the past, that's the stuff I need to self-forgiveness, and you know let go of some of that shame and guilt, (Faith, interview 3, lines 60-63)

What I did in the past I can't change it, what I've done is what is done, all I can do is go out with an open heart saying I'm sorry for what I've done in the past, and I hope that you know that I'm changing, becoming an honest, whole woman now, I want them to know that I'll always be there, I got to let go of all the hurt, regret, the grudges, self-pity on myself, got to let it go in order for me to be me,

> cause I always felt like I phony, like I wasn't real, cause I didn't know how to be real, it's letting a lot go, it's starting to feel good to be able to not hold on to anything anymore. (Chloe, interview 2, lines 150-158)

Should I or Shouldn't I? (Internal Negotiations)

Although the women identified self-forgiveness as the way through the guilt and shame that perpetuated their addiction and absence from their children, early in treatment there was no sense of how to begin building this bridge. It was clear that self-forgiveness would not be experienced as a single event; from the beginning the women anticipated it would be a process but had little idea of what it would entail. The women appeared to be emotionally and cognitively negotiating both how to begin and whether in fact they should begin. [*Crying*] It's a lot, I know it's going to be a long road, I just got to take it a day at a time, a step at a time; first step for me is to get myself mentally to a place where I can start working on self-forgiveness. (Trish, interview 1, lines 378-380)

> I know that [self-forgiveness] will make me feel better, but at the same time just not quite being able to do it yet. And I don't know if that means I still just have to talk more or if I need to let go more. (Trish, interview 3, lines 631-633)

> All the negative emotions that come from not being there, I really need to let them go somehow, I don't even know what that looks like. (Faith, interview 1, lines 531-533)

Internal negotiations of their worthiness "to begin" were powerful in the sense that the emotional deadlock became almost tangible as they questioned whether forgiving themselves would make them worse mothers because it would somehow diminish what they had done to their children; although guilt and shame were literally killing them, they questioned whether a good mother would continue to pay an emotional penance for the hurt she caused.

> I just feel like I'm the worst mother on the planet, so if I don't get it this time she's going to be gone for sure… but sometimes I'm just like, well I'm her mother I have a right to be there, but really I don't if this is the way I'm going to be…because I'm giving up my rights left right and center. How then can I say I'm a deserving mother? [*Sighs*] It's confusing. (Faith, interview 1, lines 515-523)

> That's what I can't even fathom, I can't wrap my head around that, cause this is real stuff that really happened, how do you be just like, ok well I'll just let that go [*nonchalant voice*], I'm not sure how to do that. (Faith, interview 1, lines 606-608)

> I remember it was hard for me to even look at [her son] in the eye, especially at the beginning. I felt I wasn't worthy to be his mom.

> He's better off without me… I had a lot of shame around that. I felt like, like I already felt moral-less for the abortion, then after I started [working as an escort] I felt like I had tossed everything aside, there's no me anymore, so who cares kind of thing. (Trish, interview 3, lines 305-309)

> I felt like a bad mom because I had done that, like do I even deserve, I had questioned myself, do I even deserve [her son] because I've done this, and things like that. (Trish, interview 3, lines 555-556)

> Starting with my son, my addiction, my whole entire life, has been since becoming a mom. It blows my mind like how did I become an addict after becoming a mother? I wasn't a crack head before and it's just crazy to me… I felt really brutal, it's been brutal, it would be good for me to write it out cause I don't think I'm fully connecting with it. (Karen, interview 1, lines 510-518)

As they moved forward in treatment, much of their internal negotiations were shaped by other mothers in the program. Other mothers who shared honestly about their mothering experiences provided a model and an avenue to learn how to

self-forgive that seemed to give the women permission to begin exploring their own self-forgiveness.

> I didn't think white people had problems like us, until I came here, and then all the people here are white, where are all the Indian people [*laughs*] am I the only Indian here, they are just as fucked up as I am [*laughs*] okay cool I'm not the only one, I'm not the only lost soul here, and talking to everybody, all the counselors too, it's just like wow, addiction is everybody (Chloe, interview 2, lines 503-506)

> I was so open, but I think it's because we were so much closer in age, we understood each other, we all have little kids, I think it was that, the fact that we had this understanding. (Chloe, interview 3, lines 545-546)

> I didn't see a lot of other women. I had only ever met two other girls in the city that I had used with, so to me I was like, well this is a guy's thing and stuff like that and I'm like being a total fuck up of a mom and a person for this, and being here and being able to hear the stories of other people who are mothers who have been through this really helps me to be able to be open to talk about it, and to be able to get it off my chest and to get me facing that I do

> have to deal with that guilt, and it's okay to forgive myself, because these women are doing the same thing and they are forgiving themselves and it's okay to, for a long time I thought it's not ok to forgive myself for that, just even in a few short weeks I've really come to realize that it's ok to forgive myself, I still have to work on that, I still don't forgive myself, but I'm starting on it, and at least now I know it's okay to do that. (Trish, interview 1, lines 429-437) Because there's other moms that have so many similarities, like me and [other client] right, lots of similarities, like when you feel those similarities I think that also helps with your self-forgiveness, cause you think to yourself, I'm not the only person that's done this, I'm really not that evil, other people makes mistakes too, I'm not a big fuck-up. (Trish, interview 3, lines 670-673).

Testing the Waters (Social Connection)

Although the emotional honesty modeled by others in the program allowed the women to consider self-forgiveness, it did not immediately bring all the women to a place where they were willing to open up. All of the women had histories characterized by emotional, physical and/or sexual abuse which caused them great difficulty trusting people, feeling safe and being emotionally vulnerable. Although the women shared a tendency to isolate and a desire to keep things to themselves, there seemed to be an inherent understanding that this was not "good" for them and they pushed themselves to connect with others. This was

not an easy effort; the women's life experiences had proven people to be unsafe especially in times of vulnerability and most found themselves retreating into themselves for periods of time. For Chloe and Karen this was an especially slow and deliberate process that began with "testing the waters" so to speak. Chloe would often talk about how her early life experiences contributed to her having great difficulty trusting herself and others; she began to recognize that she keeps her distance from everyone, including her children, for fear of getting hurt. She appeared to struggle throughout treatment with trusting the therapeutic process and continually questioned the validity of what she was being asked to do. I keep thinking after six weeks what happens, so I go through all these courses , I do what I got to do, I talk about what I got to talk about, I'm still skeptical, I don't even trust myself to trust anybody else, especially women because of what happened right. Like I'm not even ready and I've been here for two weeks, and I'm not ready to share anything. I can share it with you because it's held in confidentiality like it is with the counselors, but with the other women, the ones in the group, I've never had friends, I've never had anybody close enough, no best friends because I didn't trust, I've got to learn that to, I've got to learn to trust myself before I can trust anybody. (Chloe, interview 1, lines 364-370)

Although she began to test the waters within her therapeutic relationship, she continued to find it extremely difficult to open up during group sessions and stated a number of times she only wanted to share on an individual basis with counselors and myself. She would often berate herself after sharing her history in group settings; this was most notable when she would talk about the abuse she

experienced by her mother, stating she felt like she had betrayed her mother's confidence. Her forays into emotional honesty and her past challenged and contradicted everything she learned about being safe as a child. I have so many years in my childhood that I have suppressed, memories and feelings, cause I didn't want to have to deal with it, I asked them how is this supposed to be helping me, bringing up these memories that I have suppressed for so long and those are the things that made me the person I am today, but how is that supposed to help me in healing, how is it that I am supposed to share my story and the pain that I went through when I was a little girl with these women, she [her counselor] goes 'just relating', I don't want anybody's pity I don't want anybody's comfort, I don't want anybody knowing what I went through [*crying*] nobody has to know, just me and my counselor, they are all a bunch of strangers, it's just like pulling a stranger off the street and say come in here I'll tell you what happened to me when I was a little girl, my whole childhood I'll tell you everything, then what, how is that supposed to help me through. (Chloe, interview 1, lines 271-280)

Similarly, although Karen recognized the value of connecting with others, she found it extremely difficult to be emotionally vulnerable, and would protect herself with aggression and a put-together façade.

> I'm trying to [heal] on my own, I'm praying, just mostly in meetings and stuff, trying to help one alcoholic helping another out, I'm getting more support through the other clients, because

> I'm not a vulnerable, I'm not going to let somebody in, so I've been doing my own therapy by trying to let people I normally wouldn't let in, I'm trying to have more personal conversations, and do stuff like that, just to try to feel different emotions and it has been working. (Karen, interview 1, lines 385-390)

> Isolating is really bad for me, I'll get in my head and who knows what, right, I still have to go outside and smoke and I hate when everyone's like you've been so quiet the last few days, I hate answering, I try to socialize a little so I'm not completely, yeah I'm o.k. but and after a while I'm like no I'm not o.k., so fuck off. (Karen, interview 2, line 154-157)

However, as the women challenged their isolating behavior and worked at connecting with others they began to value and experience a sense of relief when they opened up and shared their life experiences with other group members. A growing sense of empowerment emerged, in which they were able to speak to why they emotionally and physically isolated, and identify how it perpetuated self-destructive behaviors.

> I find the longer I'm here and the more I share, it's still hard but it gets easier as you go through it, I've been facing a lot of my things, and been forcing myself to face them, also

another thing, I usually isolate myself when I get depressed, that's a big thing, I think that's why I used to cut, I'd just go by myself and that would be my release and here I've been trying to push myself, even if I'm crying or something I'll go sit common area, and usually I'm just like *ahh* [emphasized], I don't want to be around people and I don't want them to see me that way and the more I do that the more I feel like yay me [*laughs*]. (Trish, interview 2, lines 3-8)

I don't know, I always felt like, maybe this comes from childhood things, as well because my relationship with [ex-partner] was abusive, I always felt like I had to shut down those tears, I was supposed to be the one to make things happy and smooth, with [expartner] I was the mom, I had to keep it together, if I was crying, he'd be like, 'stop your fucking crying', kind of thing, 'fucking woman', so it feels good, almost powerful to be able to do that, and push myself, and the more I do it the easier it gets. (Trish, interview 2, lines 12-16)

I stay in my room, my safe little world, my safe little haven, I stay to myself, cause there it feels safe to me because it's

> something I know, nobody can take that away from me, that's why I was feeling the way I was, then in class they say that 'we do really need each other' but after laughing there it felt good, I felt a little bit light hearted, something just lifted off of me, so that's why I said my wall came down a little bit. (Chloe, interview 1, lines 512-115)

"Fake it till You Make it" (Decision)

The sense of relief that came with listening to the experiences of other mothers in the program seemed to give the women permission to self-forgive. Worthington (2003) posits there are two dimensions within the process of self-forgiveness; decisional and emotional. He suggests, intertwined within an act of decisional forgiveness, there is a conversion of self-condemning, unforgiving emotions to more compassionate self-talk. These dimensions were evident during the women's move toward "deciding" to self-forgive. In what appeared to be a period of self-forgiveness preparation, the women continued to strengthen their decision to self-forgive by challenging negative self-talk and cognitively reinforcing their "worthiness" to self-forgive.

> I'm starting to get to a point where I just feel, I don't forgive myself yet, but at the same time I feel ready to start working on that, I don't feel like, I'm not bashing myself all the time anymore, I'm not going to myself and saying, you fucking whore, you worked at a parlor, you awful bitch you neglected your son, I'm not saying that stuff to myself anymore, So I think I've kind of come to a point where I've

leveled out, I'm not bashing myself but I'm not forgiving myself, I'm kind of just... nothing really right now, I'm starting to try to tell myself its ok to forgive you, but I'm not feeling it yet. You know what I mean? I'm talking myself into, ya you can forgive yourself for these things [*high pitched artificial sounding*] you're working on this, but I don't believe myself kind of thing. (Trish, interview 3, lines 615-625)

Trying to speak it [self-forgiveness] but not quite believing myself yet, but you know I am a good person, and that was my addiction, and telling myself these things, and I think the more I tell myself these things the more I'm going to be able to self-forgive, and start believing, kind of a fake it till you make it kind of thing. I need to push my mind into that you are a good person thing, cause I had just over the past two years, that's all I've done to myself, it's hard to get your mind out of that.(Trish, interview 3, lines 648-652)

So now my work is affirming myself, so I'm really working in my positive affirmations, like I am a good mom, I deserve recovery, and forgiving myself, like I forgive myself, even though I just want to laugh when I say that,

but saying it till I actually feel that; it's that whole thing just repeating until you believe. (Faith interview 3, lines 33-36)

This time I wrote it out, and at the end I said I Chloe forgive everything, everybody, in my past for what they had done to me and I will overcome this and I will move on, no more letting anybody or anything hold me back from what I want to accomplish, this is about me, and I signed it and dated it, and that was my commitment to myself. (Chloe, interview 1, lines 567-570)

Now I definitely know it's one day at a time; I'd always do that not too bad, but for certain things I would I would jump ahead of myself and then I would set myself up for a failure, then I feel so guilty; as long as I do the best I can every day, then I can't feel shitty; since I've been doing that I haven't had any negative self-talk. I might as well keep doing what works right, I'm going to stick to that, I'm probably up to four to twenty times a day I'm praying take my will, take my day, cause [sic] I definitely seem to get back in my head. (Karen, interview 1, lines 406-412)

However, the women vacillated in this process; at times, there was an emotional resistance to move forward in their self-forgiveness work. Because their sense of worthiness did not align with, and at times outweighed the permission that was being offered in the other mothers' experiences, they experienced an internal conflict that would continually pull them back into feelings of unworthiness.

> You know I've cried more here than I ever did throughout my whole life, and I've only been here for two weeks, it seems like there's not a day that goes by that I don't cry; I'm learning to forgive myself for what I've done in my past, what I've done to people, the people I've hurt in my life, the people that love me, and I love, being able to forgive myself is the hardest thing I've ever done, cause [sic] I still beat myself up every day, thinking well if I would have just did it this way, if I didn't give up so easy. I don't know, it's so mind boggling, like I said how is this place supposed to help you with that? Cause [sic] I got to be the one inside myself to be able to do it first, and not have a bunch of people tell me it's *okay* [emphasized] [*flippant*], now you can forgive yourself, ya well I know I can, but I don't need a bunch of women telling me, you know [*laugh*s] I don't know [*questioning her own attitude*]

> it's just my way of thinking. But that's where I am. (Chloe, interview 1, lines 527-536)

What I did isn't Who I am (Externalizing)

As they wrestled their way through internal negotiations to self-forgive, they engaged cognitive arguments that emotionally separated their behaviors during active addiction from their feelings toward their children and desire to be a mom. For some participants, positioning addiction as more powerful than her role as a mother facilitated self-forgiveness work because it validated that she didn't do this on purpose and challenged her negative beliefs and feelings about herself.

> When I first came here I thought, fuck I am an awful nasty, *eeww* [emphasized] I'm a terrible mom, I'm this and that, I'm starting to see the light, that this is my addiction, and it's almost like I'm two different people. There's Trisha and there's addict Trisha, you know I'm the same person, so I have to take responsibility for the same things but at the same time I was sick, so I'm starting to see the difference between that, whereas before I could only see the, I'm terrible. [Her counselor] has really been helping me differentiate that I am sick, it's a disease, and I think that's what I was struggling with when I first came in. (Trish, interview 2, lines 164-169)

> I was never there for [her son] before, I always said I'll never do this and never do that and then end up doing it,

but I understand now, I can see it… I understand why I was doing it, I was stuck; the devil got a hold of me. (Betty, interview 2, lines 286-291)

Anytime I was away from [her daughter], I don't know, it was this detachment that I could just have and just put her out of my mind, as sick as that sounds, it just shows how strong the addiction was on me, how strong a hold the addiction had, still has on me, that I could just, as soon as I do my first drug or first drink how [*snaps her fingers*] quickly she could just leave my mind. (Faith, interview 1, lines 347-351)

Drugs are more powerful than I am; anytime they are introduced the part of me that's a mother just shuts off. (Faith, interview 1, lines 465-466)

It's not like I'm doing this on purpose to hurt my daughter, you think I want to be like this, hell no, I grew up in an environment like this and like I'm way beyond even my mom's, what she was doing, you know I've gone over and above what she has done, and I don't want it, but it's just so much more powerful than I am. (Faith, interview 1, lines 555-558)

Alongside this, the women began to challenge the expectation that they should "just know" how to be mothers. Amaya recognized that this assumption had been a reason she hadn't sought support in her mother-role prior, "…until someone mentioned it, I hadn't even thought about it, like I just know how to be a mom, but I don't, just sometimes." (Amaya, interview 1, lines 299-300)

A woman's knowledge and attitudes toward mothering develops as a result of the interaction between biological and environmental variables in her life. In particular, her own experience with being nurtured provides a template from which the maternal role develops (Rubin, 1967a, 1967b); in light of the women's childhood experiences it made sense why they "didn't know" how to be a mom, or more accurately, how to parent their children differently than they were parented. As they made sense of their own childhood experiences they were able to create a life story that offered a reason for their felt challenges in the mother-role. This in turn, allowed them to re-evaluate their sense of failure and make sense of how, why and when they behaved in ways that conflicted with their values. Within this self-reflection the women experienced an increasing sense compassion for themselves, which moved them forward in their self-forgiveness work.

> I had [her son], he was premature, he was medevac'd to Edmonton, he had under developed lungs because I was using when I was pregnant… I didn't know how to be pregnant, I didn't know what to do at that time, and then when I had him I didn't know how to be a mother, nobody

taught me anything, so I just learned mostly everything on my own. (Betty, interview 1, lines 2-6)

So then I have her, it was rough [*laughs*] cause [sic] I didn't have any women to phone and to talk to, cause my aunts gone, my mom's gone, and my grandmas gone… I was in the hospital carrying around this baby in the cart, pushing her around and bawling and crying, and all the staff are not even helping me, and I just felt so alone, like what am I supposed to do with her, like I didn't know, I didn't have a mom to phone, or anybody to say what do I do with this baby. (Faith, interview 1, lines 95-100)

How do I even be a mom, because I didn't have the best role model right, like me and [her counselor] were talking, and she's like 'how would you know what to do if you were never exposed to it in the first place' **…** which make sense, I don't know, I tend to give myself a hard time I guess. (Faith, interview 1, lines 583-589)

I don't know what healthy relationships look like, so it's hard for me to give in that sort of way, or have love and compassion and all this stuff, this healthy stuff, when I'm

> just used to everything being about me, like what can you do for me…I'm not sure, I don't really have any example to go by, like realistically I've never been in a healthy relationship my whole life, like even starting with my relationship with my mom, or my dad, so how do I just all of a sudden be changed, right. (Faith, interview 2, lines 112-123)

> There are a lot of things I don't know; I was never a babysitter as a teenager, I was the youngest on both sides of my family, so I was the kid, and I was the baby. I never spent time with children, I don't like kids [*laughs*], I do to a certain degree, but I always was like a waitress or this or that, so I don't know all the answers, my parents weren't disciplinarians, not at all… where my son he needs the smack down [*laughs*] he really does [*serious*] cause he is very strong willed. (Karen, interview 3, lines 265-271)

Meta-theme: Looking Back

Looking Back describes how the women "made sense" of their mothering experiences alongside their addiction and childhood experiences. This process was pivotal within their internal negotiations to move forward in self-forgiveness work because the women were overwhelmingly baffled by their behavior. As Karen explained, "it blows my mind like how did I become an addict after becoming a mother. I wasn't a crack head before and it's just crazy to me."

Within this dimension, six sub-themes emerged that highlight the participants' lived experience. These themes are depicted in Table 3.

Table 3. Looking Back Meta-theme and its subthemes represented in participants' lived-experience.

Themes	**Participants**					
	Chloe	*Betty*	*Faith*	*Karen*	*Trish*	*Amaya*
Meta-Theme **Looking Back**	x	x	x	x	x	x
Sub-Themes						
(Not) "Becoming My Mom" Intergenerational Trauma	x	x	x	x		x
Seeing it Within the Cycle Affectively Experiencing Self & Child	x	x	x			
No "Feeling of Momminess" Exploring Maternal Identity	x	x	x	x	x	x
I Did Something Right Strengthening Ego	x	x	x	x	x	x
Blurring the Past to See the Future Avoidant Defenses	x	x	x	x	x	x
Facing the Past to See the Future Challenging Avoidant Defenses	x	x	x	x	x	x

Table 3.

Note: Themes that were represented within the participants' lived-experience are indicated with an x.

(Not) "Becoming My Mom" (Intergenerational Trauma)

The mothers began to link their addictions to their pasts, and were able to move toward self-forgiveness as they began to make sense of their mothering experiences in light of how they were parented. All of the women recalled

multiple traumatic events that they experienced as children and believed had a profound effect on their adult lives and subsequent drug use. They all described growing up in a family environment that was, at times, unpredictable, volatile, and erratic. As children, they were constantly exposed to poor role models, high stress levels, and contradictory messages. They believed that these events were the foundation for feelings of pain, disappointment, anger, guilt, confusion, rejection, and sadness that they attempted to deal with by using drugs. Many of the women were fearful of "becoming" their mothers, and were determined to parent differently than their parents; however they often found themselves repeating similar patterns with their own children. The re-enactment of trauma from generation to generation is extensively documented. In a comprehensive review conducted by Oliver (1993) he found the crude rates of intergenerational transmission of child abuse are as follows: one-third of child victims grow up to continue a pattern of seriously inept, neglectful, or abusive parenting; one third do not; and the other one-third remain vulnerable to the effects of social stress on the likelihood of their becoming abusive parents. As Faith explained, I always did all the opposite things that my mom did to me, that's how I based myself on being a mother, but then when I get into my addiction then I'm exactly like my mother and now it's hard for me to go back to that other way. (Faith, interview 2, lines 94-97)

Although Faith, and many of the other women, had consciously determined to not do what their parents did, our understanding of *re-enactment* in relation to attachment trauma provides us insight into this pernicious pattern.

Pioneers in trauma research, suggest those "who can't remember the past are condemned to repeat it" (Allen, Fonagy & Bateman, 2008, p.244). Although this may seem contrary to the women's conscious decision to parent differently, in actuality the women had drowned their memories in drugs and alcohol, leaving them unable to face the reality or meaningfully experience the emotions of their past. The resulting emotional disconnect, compounded with the social stress inherent in the chaos of addiction embroiled the women and their children in the intergenerational perpetuation of trauma. The women felt helpless as they repeated the neglectful and abusive parenting practices they experienced as children.

> At this point this is where I'm like holy shit I'm turning into my mother, and what am I doing to my daughter, those guilt and shame feelings I think that's when they became really real , age twenty-seven, and I mean I guess I already knew it in the back of mind but I was still in real denial, so I'm like what am I doing to my kid, this is bullshit I don't want to be the mother I had, but I'm exactly doing the same thing right. (Faith, interview 1, lines 325-329)

> I have issues showing my feeling too, I respond sometimes I snap at him or whatever, I've never had an issue like I don't beat on him or anything like that, thank goodness, I

> feel like I get really short tempered, really irritated and stuff, it's just my own block, my own thoughts, I guess I'm fearful and stuff too, I definitely know I need help. (Karen, interview 1, lines 249-252)

> In my addiction I was angry for something, I didn't know what, but I always had to be angry, I didn't have the patience to listen to kids talk or my kids talk, I didn't have the patience to even go and play with them, there was more of a frown on my face than ever a smile, I didn't know how to laugh, unless I was drunk, playing with my kids unless I was drunk or high. (Chloe, interview 2, lines 208-211)

Seeing it Within the Cycle (Affectively Experiencing Self & Child)

However it was often within these narratives they began to "see the cycle", which was an important step in moving toward self-forgiveness. As each woman explored feelings about her childhood, there was an increase in awareness and acceptance about what she didn't receive as a child that allowed her to safely explore how she had treated her own children. It not only reinforced the idea that "she didn't do this on purpose", but gave reason to what the women could not understand themselves. A deeply intertwined relationship between the women's childhood experiences and that of their children began to emerge.

As Faith poignantly explained,

It's like it so weird cause I have these different angles going on, like here I am still the hurt child in there, not getting love and acceptance myself, and then I'm doing the exact thing to my daughter what my mom did to me, at the same time living out my mother's life as punishment, like that's how I punish myself is by living her life, however my daughter is getting the shitty end of the deal, cause she's getting taken down because of it, like it's twisted, but it's like ever since she [her mom] died and I figured out when I came into recovery and I started noticing my behaviors and like how I was with my own child, how everything was similar, and how I just so easily fell in, like after my mom died, how even before my daughter was born, how I fell into her life, because I needed some kind of understanding of why she lived her life like that, like in a way, as sick as it sounds, it's like I needed to be an alcoholic, I needed to be self-sabotaging for some reason I needed to be that way, so I could try to understand why she was like the way she was, but then it just, I just took it and totally went overboard, because the addiction just got me, then there was no anything after that, rationale or any justifications I could really put to it, it was just straight up addiction, so now it's

> like holy crap what did I do to myself and what am I doing to my child. (Faith, interview 2, lines 229-241)

Within this "remembering", an awareness of their children's pain began to emerge. In the following excerpt, Chloe begins to explore and empathize with her children's emotional experience, as she is able to identify how and why she has been unable to talk to her children about their feelings. By "remembering" the pain she experienced as a child when her parents were emotionally and physically unavailable for her, she began to "feel" her children.

> I don't talk to them about their feelings, cause nobody ever talked to me about my feelings, and I never told anybody about my feelings, I just pushed it down pushed it down, sucked it up, and just that's it, so I know how my kids felt, growing up without having a mother and a father, crying late at night wanting your mommy and she wasn't there [*crying*] just that hurt, that feeling of being alone, and you don't think anybody loves you [*crying*], and all you want is your mom [*really crying*]. (Chloe, interview 1, lines 330-335)

Pain that had been initially unbearable to face because of the feelings of guilt and shame it activated, became "containable" as they explored it within "the cycle", because it separated the mother's behaviors from her being.

No "Feeling of Momminess" (Exploring Maternal Identity)

For many of the women their children were a constant reminder of all they had failed at. Chloe explained how during her addiction she pushed her children away because their presence increased the risk of emotional pain.

> I didn't want to hurt them, I didn't want them to hurt me, I didn't want to be hurt no more, but I knew I hurt them because I was never there, they say I was there, but I was never there [*crying*] even though I was physically there I wasn't mentally there, you know they had to grow up looking at me and seeing the way I acted, but I pushed them away. (Chloe, interview 1, lines 324-327)

Although the women experienced enormous guilt and shame about their physical and emotional absence from their children, it became clear that being with their children did not allay these difficult emotions; rather it often magnified feelings of failure and incompetence. The women's stories depict a cycle wherein the pain they experienced with their children became as unmanageable as the pain they experienced being away from their children; which ultimately locked them into a cycle of "you're damned if you do and you're damned if you don't;" as Trish articulated, "It's so hard to not have them but it's so hard to see them, what do you do, you just want to pull your hair out" (Trish, interview 1, lines 413-414). Chloe describes how her fears of knowing what her children were feeling about her, perpetuated her emotional and physical distance from her children.

> Fears of knowing what they are going through and not wanting to know, the struggling with questions that they want answered but yet at the same time I'm too scared to ask, and how do you go about asking, cause I never gave them that feeling, that way of how to express what you want, the fear of being a mother, taking on the whole responsibility of being there for them, and talking to them, the only time I ever talked to them was when I was drunk or under the influence of drugs, it was the only time it ever came easy, but it was just the whole aspect of being a parent. (Chloe, interview 3, lines 252-257)

For Chloe, there appeared to be an inherent responsibility attached to "knowing" how her children were, and without the ability to provide a solution, "knowing" was unbearable. The women's perceived level of incompetence to manage their children's emotional pain, along with her lack of ability to manage her own emotional pain, made it difficult for the women to experience any "feeling of momminess" that would facilitate her re-engagement in the mother-role. As Amaya explained, "when I went in December, I took care of them and stuff, but I didn't have that whole feeling of momminess, I think they didn't either" (Amaya, interview 1, lines 264-265).

Maternal identity encompasses both the mother's perceptions of her role competence and the child's response to her action (Rubin, 1984; Walker, Crain, & Thompson, 1986). This is greatly disrupted in the context of addiction because

the mother holds predominantly negative perceptions of her experiences in the role, and moreover, children will often act-out, or conversely, withdraw to manage the hurt, confusion and fear evoked by their mother's presence. At the core of this disruption is the mother's inability to recognize her own mental states and their influence on behavior, which extends to difficulty in recognizing the child's mental states and their influence on behavior. When this is impaired, the distinction between the mothers' and children's mental experiences is not possible (Allen, et al., 2008; Fonagy, Gergely, Jurist & Target, 2002; Suchman, et al., 2010). This dysfunction, understood as a disruption in "mentalizing," is reflected in the women's belief that their children's behavior was solely intended to make them "suffer" for the hurt they caused, rather than a complex expression of the child's feelings.

> [Her daughter] is over the fricken top… and it's like it takes all my power and energy not to freak out, and if I even do a little bit, [another person] will be like 'it's okay it's okay, she's just a kid', I'm like no she's not, she's a devil [*laughing*] she's doing this on purpose…It's like a punishment thing, I don't know, on some kind of level whatever level a kid can think about getting back at me, it's her way to get back at me, right, definitely, [*laughs*] and she's a master at that.
>
> …if people are around it's like game over, then all of a sudden 'I got to do everything possible to make my mom suffer', you know what I mean? (Faith, interview 2, lines 166-178)

> Cause [sic] how she is disrespectful of me, she doesn't want to listen, she pushes my buttons, things like that, on purpose to hurt me because I've hurt her, so she wants to hurt me back, I get that, I did the same thing to my mother. (Faith, interview 3, lines 46-48)

> He won't talk to me, he's like I'm busy… he disconnects from me, he won't even look me in the eye… I'm scared to phone my son, scared of emotional pain; it hurts me when he doesn't want to talk to me. (Karen, interview 1, lines 241-244)

> He's trying to hurt my feelings…cause [sic] I hurt his feelings by leaving him with grandma and grandpa all the time. (Karen, interview 3, lines 341-342)

In a similar vein, the women perceived that their children desired to exploit their felt parental incompetence.

> When I have small visits with her, she challenges me every which way, she tests my boundaries, she picks at me cause she knows, obviously she can feel the negativity from me, so she buys into that, right, then she just picks and picks until I explode, and then she goes and she's crying in the corner, so then I'm like awe crap I feel bad, but at the same

time I don't want to give into her because she is the child and I'm the adult right, so if I give into her then that's letting go of my control and my role as a mother and I'm just being walked over, and s*he knows* [emphasized], I know she knows. [Interviewer: What does she know?] She *knows* [emphasized], [*sighs*] she knows that I'm struggling, she knows I'm struggling and she knows, I think she knows I'm not exactly sure how to be a mom, like she has an idea, like even though she loves me to death, she knows what my downfalls are, she knows if I push mommy like this she's going to act a certain way, and [*sigh*] god, it's like she knows [*silence*] she knows how to get what she wants out of me, you know, I don't know, *I don't know what she knows* [emphasized], but I know she knows it [*laugh, sigh*] it's so, I don't know how to explain it in words, [*sighs, silence*] she knows. (Faith, interview 2, lines 139-152)

…I've been parenting in [guilt], then I give into every little thing he ask for, then you feel like you are failing again, I feel like my kid is wearing the pants in this relationship, not me, and I know he's going to be *just* [emphasized] pushing me when I see him. (Karen, interview 3, lines 771-772)

When feelings, such as fear, conflict, inadequacy, or desire cannot be consciously accessed by an individual (i.e. mentalized), they are often defensively projected in such a way as to evoke in the recipient precisely the thoughts or feelings projected (Psychological Projection (n.d.) In Wikedpedia online. Retrieved from http://en.wikipedia.org/wiki/Psychological_projection). Essentially we attribute something inside ourselves to someone else. Within parent-child relationships, Lieberman (2004) expounds on this concept, suggesting that, what he refers to as '*maternal attribution'*, becomes a conduit of intergenerational transmission of trauma, as the mother's parenting behaviors are continually being shaped by beliefs she develops about the child based on her own fears and wishes about the child and the child' function in her life (as cited in Allen, et al., 2008, p. 252).

The lack of maternal identity and sense of inadequacy fuelled within this destructive cycle of disrupted mentalizing, left the women feeling ambivalent about their mother-roles and struggling to feel emotionally connected to their children. As Trish explained, when she was with her son, she often felt like "a baby-sitter" (Trish, interview 1, line 215). The other women expressed similar sentiment.

> It's just on the deeper level I guess there's no respect and no trust, no deeper emotional connection I guess you could say, it's all very surface stuff, going through the motions, like that's how I feel anyway, before I was really struggling to be a mom, like I couldn't I was too addicted and not

knowing how, or not wanting too even, as sick as it sounds it's the brutally honest thing, I didn't want to really have her around because she infringed on my using, so then I have resentment toward my own child, I know that sounds sick but that's the brutally honest truth. (Faith, interview 3, lines 56-61)

I had no communication, it's just like we were friends, no mother and son bond, just I don't know, I just felt like I was in a, I don't know how to say it, like jail or something, not allowed to talk or anything, it felt like residential school, but it was my own residential school [*laughs*]. (Betty, interview 2, line 23-25)

I find I'd get annoyed with him, you know I wouldn't really deal with him at times, like when I was too tired or just fighting with his Dad and stuff; he looks just like his Dad, he looks nothing like me at all, he looks just like his Dad; I don't really notice that anymore but I really did then. At times I really didn't want to be a mom, I loved him but I didn't want to be a Mom or if I was being a mom, then I feel guilty for that cause [sic] I was like, what's wrong with

> me, I have this beautiful baby. (Karen, interview 1, lines 82-86)

The lack of connection was compounded by the women's extended absences from their children. Like many substance dependent mothers, the women put their children in the care of others, for both practical and emotional reasons. Unfortunately, such actions tend to further weaken mother-child bonds and strain the parent-child-relationship (Kunkle, 2002). Many of the women had difficulty connecting with who their children were today, as if time had stood still for them while they were actively using, and they had expected when they returned their children would be the same as when they left. They struggled with how to be close, or mother, their children in a way that responded to the child's ongoing development.

> I've missed a lot, I don't know, it seemed like at some point those aren't my kids, cause [sic] they are *old* [emphasized], what I remember, [her son] was like a little peanut, he still is, he was so tiny, and now they are *old* [emphasized], my daughter is into boys and wants a training bra [l*aughs*], it's so weird, she doesn't need one but her friend has one so she wants one, she talks like a little lady, and my son knows how to write, and do math, he shouldn't be able to know all that stuff, I forget that they are old. It's really weird. (Amaya, interview 1, lines 365-369)

It's just like they are growing up so much, I haven't seen them, they are my babies, my baby three year old, he is talking a lot clearer now, and saying full sentences, it was like where is my baby [*high pitched*], and my six year old is telling me everything what's going on around the house, what happened here and what happened there…I'm going to go home to little men here; no more babies. (Chloe, interview 2, lines 365-369)

I just couldn't take it anymore, he was getting lonely for home, I was too, we decided to move back home, I sent him home earlier than I did…it was getting harder cause he was growing up more and he wanted to go places and I didn't know if it was safe or anything like that, and I started distancing myself from him. (Betty, interview 1, lines 111-114)

It's hard because he's getting much older, and it's harder to discipline him, like he knows right from wrong but he tests me sometimes. (Betty, interview 2, lines 194-195)

I've *missed so much* [emphasized] like I've basically been absent since the start of grade one, all the way up to now,

> it's almost the end of grade two, where mom's mind has been with her addiction and not with him, cause [sic] even when I seen [sic] him read his first words to me, like he started reading, and all of a sudden he shows up with a book and I'm like how did that happen, but you know a month, time flies by so fast when you're always messed up. (Trish, interview 1, lines 348-352)

I Did Something Right (Strengthening Ego)

Drawing on experiences they felt they had "done right" seemed to be important as they explored their past parenting experiences. All of the women spoke about times when they had felt close to their children and/or actively made decisions to protect, or reduce harm to, their child. The pursuit of balance between the maternal and addict roles is echoed throughout substance dependent women's stories. Similar to women in Baker & Carson's (1999) ethnographic study, the women engaged in narratives that sought to reconcile their drug use and mothering experiences, by continually renegotiating their notions of a "good mother" and challenging their feelings of incompetence. It was common for the women to highlight how as they failed to fulfill their *felt* commitment to their children during their addiction, they refocused their mother-work where they deemed they could be successful, such as meeting practical needs (e.g. food, clothing) or engaging in harm reduction strategies.

> Then I got pregnant with my other son, he's three, same thing, I didn't do crack as much though, but it was my rails

> and my drinking, but I made sure I took my multi vitamin every day, and made sure I ate three meals a day and snacks, I gained a lot of weight. (Chloe, interview 1, lines 140-142)

> Even though I drank lots at night time, I was still a really, really good mom, I was there in December trying to stay clean at my parents, but I wasn't, I was using when they were in bed. (Amaya, interview 1, lines 71-72)

> So I felt really for the most part I'm a good mom because he was clean and had nice clothes, he was well fed, I always had a clean house and lots of food in the fridge and that kinda [sic] stuff, all those kind of needs. (Karen, interview 1, lines 78-80)

> Our relationship [her and her children] was always strained, we never talked about our feelings or how we felt towards each other, but I always made sure I said I love you and how you doing and gave them a hug and kiss before I left and every time I saw them I always hugged and kissed before when we met. (Chloe, interview 3, line 53-54)

Moreover, recalling times when they had experienced a "feeling of momminess" [sic] appeared to further confirm that the difficulties they

experienced in the mother-role were not a reflection of something inherently flawed in them, but rather an outcome of poor parental modeling and addiction. Overall, exploring the relationships with their children evoked painful, difficult emotions, however as they were able to connect to mother-child moments when they were not using drugs that felt "good", a sense self-compassion arose that seemed to allow them to challenge their overwhelming feelings of maternal incompetence and continued to move them forward in their self-forgiveness work.

> Ever since I've left nobody's read them stories or anything like that, or bath them, like they bath themselves ever since they were little, so they are very babied when I'm around [*laughs*] cause I still think of them as little and they love it, I put their socks on and stuff, even though they are old enough [*happy proud tone*] they just wait for me cause they know I'm going to do it. (Amaya, interview 1, lines 239-243)

> We were doing awesome stuff, I have so many pictures on my Facebook from my nine months sober, we'd go to the zoo and park and everywhere, I took her wherever she wanted to go, cause I had money and I felt good, we'd go shopping and I'd buy her clothes, just do mom and [her daughter] stuff, that's what she calls it, [her daughter] time, still. (Faith, interview 1, line 462-465)

I raised him there, through one to five years old, it was hard, but there was lots of times just watching him grow, with his little smirks and all that, I started to adjust to being a mom, I started to feel much more calmer and loving, patient with him, and I enjoyed that part. (Betty, interview 1, lines 35-38)

I remember I loved packing his lunch when he started kindergarten… I remember we'd sit and I'd be like well what kind of fruit, what kind of veggies, we'd have to cover all the food groups and we'd make up his lunch and go through his homework at the end of the day' and I just felt like pride and joy and happiness out of that. (Trish, interview 2, lines 350-354)

He's such a wild kid and I've always been so surprised that he loves stories, cause [sic] it's like he'll actually stop and lay there, he gets right into it, sometimes he'll just lay there but most of the time he's reading me the story, cause [sic] usually he's like zoom, zoom, and he's actually like I want to read a story, then we'll read like fricken [sic] so many sometimes, it's like you have to go to sleep buddy [*laughs*]…he really likes bedtime stories, we've been doing

> that since he was forever… [Interviewer: What does he like about it?] Just me being there, the closeness I think. (Karen, interview 3, lines 411-419)

Within these narratives a feeling of pride emerged when they were able to identify when they succeeded at doing the "opposite" of what their parents did. In these moments they seemed to find hope in who they were as mothers, which provided them a source of strength, and a belief in and motivation for change.

> My mom wasn't there, she was there, but not really, she wasn't the cuddly or play with us type… so I've always been extra cuddly with my kids, like I tell them I love you eight hundred times a day. (Amaya, interview 1, lines 317-327)

> My family and my dad were really workaholics so that's what I've only really ever known, I definitely gave my son a lot of love considering the way I was raised, I gave him lots of hugs and kisses and told him I love him every day because I never got that so I've always tried to do that. (Karen, interview 1, line 98-101)

> But he [son] would always do opposite [*laughing*] so I just give up talking and let him be a kid, cause [sic] when I was growing up I can't remember being a kid, I grew up too

> fast, I never got to enjoy being a little girl playing with her dolls or whatever, I never had that life, I can't remember, I never had little friends, because I was growing up in the bush, there was just me and my cabbage doll, so
> I just let him be a kid, let him go. (Betty, interview 1, lines 80-83)

Blurring the Past to See the Future (Avoidant Defenses)

However, a fine line emerged between what they had "done right" and narratives that appeared to protect them from "facing" their past. Research suggests that substance dependent mothers often utilize avoidant defenses to manage the internal conflict that arises while she is actively using drugs (Baker & Carson, 1999; Richter & Bammer, 2000). For example, women may attempt to separate the children from their drug use by not using in front of their children, or asking other people to care for their children, thereby allowing them to deny any impact of their drug use on their children and maintain a separation between their identities of drug user and mother. Although the women in this study were not actively using drugs, there continued to be a powerful tendency to use avoidant defenses when talking about their children. Early on in the interviews it was common for women to minimize the impact of their drug use or absence from their child. In the following excerpt, Karen describes the events leading up to her entering into detox. In her description she appears to have no sense of the fear and confusion her son likely felt about her behavior or leaving, and only reflects on his emotion within the positive aspect of the experience.

> [Her mother] and [her son] drove me here, because I phoned her. I was being a bitch, I was horrible… I slept for a few days before I came here, I only got up to eat something then I'd pass back out, to wean myself down I'd do like a gram or whatever and then eat or sleep, the drugs weren't even keeping me awake that's how exhausted I was, just done. *Then we had a good time driving to Edmonton, spent the night in the hotel and watched movies and stuff.* (Karen, interview 3, lines 671-676)

Avoidant defenses were especially salient in Amaya's interview. Amaya had been in and out of her children's lives for the last four years; she knew on one level that her children had been deeply affected by her addiction, suggesting that her children "need counseling", yet she would often shift attention away from the emotional aspect of events by rationalizing the lack of impact on her children. The depth of her rationalization is epitomized in this excerpt where she is talking about her seven year old son,

> Well I hadn't seen them for 6 months, I saw them four days before I got here, they stayed at my parents, they are pretty happy, my son's very quiet, he can go a whole day without saying anything, but I think he doesn't care cause he's just so little, well used to it, cause I think I left when he was 3, not even 3, that's when he lived with his dad, and I wasn't

around, so its normal for him for me not to be there.

(Amaya, interview 1, lines 65-69)

During the interview, it often felt like she could only turn toward her children's experience for a moment, before she grabbed onto a rationalization or positive ending that spun her back into neutral, where she didn't have to "feel" her children. In her description of last Mother's Day the power of her addiction and inability to "feel" or mentalize her children became palpable.

> When I'm not there, like last year when I'd call, and he's [her father] like 'the kids are here, [her daughter] has been crying all night' because she'd sleep with my picture I guess and be bawling every time, and every time she'd go there for some reason would think I'd be there cause sometimes I am and sometimes I'm not, so when I'm not there, which is [*laughs*] a lot of the time, she'd just be crying, I think Mother's Day was the worst for them last year, cause my dad had given me money the night before mother's day and said 'do your thing just make sure you are here for mother's day, cause the kids are coming, just be here okay', so I did, I got all ready the next day, ready to go, I was walking out the door I checked the mail and there was a check in there for nine hundred dollars, and right there I knew, I'm like fuck, I'm not going, they were so upset, I saw pictures on my mom's computer like a couple months ago, it was of

> the kids on Mother's Day, they were waiting in the backyard with presents and they were hiding waiting to surprise me, and I never came, so ya, I'm over that now, I've forgiven myself, cause if I would have brought them along for this ride it would be way worse, I'm just grateful of where they've been able to be with their dad and people loving them, so ya. (Amaya, interview 1, lines 349-360)

It's hard to understand how she could recount this and not express any emotion, whereas I think I cried when she told me and each time I've read it since. My heart ached for her and her children; however, drawing on my own experience and resting awhile in her words I understood why she "couldn't" feel it. I understood why she "needed" to tell herself her kids were okay. This was Amaya's tenth time in treatment; history had convinced her that she would never recover and that she would relapse again. She couldn't bear to enter into her children's feelings without protection. She needed a way through her reality that she could emotionally survive. Her positive-endings and language of self-forgiveness protected her; it allowed her to be "over it" and allowed her kids to be "okay" in the midst of all this pain that may never end.

Facing the Past to See the Future (Challenging Avoidant Defenses)

As treatment progressed, the women continued to orient themselves toward the past; as they began to make sense of their mixed-feelings and behaviors within the "cycle" it created the possibility for change. Their children's pain no longer reflected an inherent unchangeable quality of her, and a new sense of empowerment emerged.

It feels good to be able to understand now that it [the abuse she experienced in her childhood] wasn't my fault and I didn't deserve this, it wasn't me, it was [her mother], I think she was just scared cause she didn't know how to show me, and I keep going back to try and justify it for her, well just because she was brought up that way, she was beaten and everything, her parents were alcoholic, and that was the only way she knew, but I put a stop to that cycle, cause I didn't want to put my kids through that, but I was still an alcoholic, I didn't beat them but I still verbally abused them, emotionally and mentally right. (Chloe, interview 2, lines 101-106)

So here I am, all this time I'm thinking what a terrible mother I am, all these things I've done to [her daughter] and ways I've hurt her, and I can empathize with them being a child of an alcoholic myself, so he [a counselor] turns around and says 'but what resources do you have already' I'm like I don't know, he's like 'well what are you doing right now' and I'm like I'm in recovery, I'm working on myself, he's like 'I'm working on myself' and he's like 'well what is she going to see' and I'm like she's going to

> see I'm changing and I'm in recovery and I'm not acting out. (Faith, interview 3, lines 16-21)

> It's changing what I feel, cause after realizing what I've been doing to my own family and myself in the process of my addiction, not being able to live with myself the next day, feeling really shitty, having to live with that by myself, it just hurts, knowing that I can put a stop to that now, I can show my kids that there is more to life than this, cause my family and my mother and my old man cause of my addiction, and my kids have went through cause of my addiction, I can't even imagine what I put them through, them not knowing where I was for how many days, and all I gave a shit about was my addiction, I'd come home I'm so sorry [*highpitched, flippant*] ya okay, but not knowing the damage I already done. (Chloe, interview 3, lines 162-169)

Within the "possibility for change", there was a sense they needed to boldly acknowledge what was, in order to continue moving forward. This included the women's many references to feelings of guilt and shame, particularly related to their perceptions of mothering during their active addiction; moreover they began to identify how they had used avoidant defenses to protect themselves from their children's hurt. Because substance abuse is in direct conflict with most women's desire to fulfill their mother role, it's understandable why mothers tend

to minimize and deny the impact of their addiction, especially on their children, as a way to manage the internal conflict. Most mothers had told themselves that their children were not aware of their substance use because they were too young or they didn't use around the child. The women recognized these rationalizations as backdoors to continue using and/or relapse, and were determined to shut these doors despite the emotional pain it evoked. The following excerpts exhibit the women challenging their avoidant defense strategies, and further identifying how these strategies impacted their substance use and children.

> I'd be using coke when she was there, letting her run around in her diaper, and I'd be sleeping, I would be grouchy and snappy, and put the same movie on over and over, just for her to be quiet and stay out of my face, at first I thought it was perfectly normal, she'd be okay because she's not going to remember anything, which now makes me *sick* [emphasized] to my stomach to think about it. (Faith, interview 1, lines 248-251)

> Anytime I was away from her, I don't know, it was this detachment that I could just have and just put her out of my mind, as sick as that sounds, it just shows how strong the addiction was on me, how strong a hold the addiction had, still has on me, that I could, as soon as I do my first drug or first drink how [*snaps her fingers*] quickly she could just

leave my mind; then I see her again, and I'd be like oh my god what am I doing right, but I always think she's young she'll get over it, she's young she won't remember, and that's what was able to keep me going cause I thought she's too young now she won't even know, so I used that as an excuse, I'm going to quit this thing before she's old enough to realize, to remember, and that's what I always told myself, but it doesn't work that way [*small laugh*], unfortunately. (Faith, interview 1, lines 347-359)

I'm scared it's going to be a fight every day to be a mom, and be clean, be normal, whatever that is, it's almost easier to give up than to try, and then I always think I can leave and go use cause it's just normal for them if I do it, so I try and trick myself into thinking that they are okay, but they are not. (Amaya, interview 1, lines 128-131)

I felt guilt as well from the abortion, I felt like I had taken something from [her son] because I knew he had always wanted a sibling, and then later on in that year [her ex-partner, son's father] had started seeing someone who had

> two girls and so I think it was the drugs kind of playing tricks on my mind, I used that as an excuse, well he's got two sisters now on [his father's] side, and he's happy and he's stable, and that's what I would tell people when I'd be out doing drugs, they'd be like 'why aren't you with your kid' and I'd be like well he's got his dad, he's moved in with this women she's got two kids, they're a happy family kind of thing; but all the time it was fucking killing me inside cause I miss the hell out of him. (Trish, interview 1, lines 172-178)

As they acknowledged how they had utilized avoidant defenses to protect themselves from the realities of their addiction, they became more willing to explore how their drug use had impacted their parenting and their children. Initially the women had a tendency to speak in broad terms of how they "failed" or hurt their kids; however as they progressed in treatment they were more likely to identify specific parenting experiences that they now recognized as hurtful to the child. There was a significant shift in the women's ability to concretely think about their children. Within the parent-child relationship, Slade (2007) refers to this ability as *parental reflective functioning*; which plays an important role in reciprocity within the mother-child relationship (Fonagy, et al., 2002). It is the ability to recognize that a child's mental experience is influencing their behavior; which in turn guides the mother's parenting behaviors. It is within this "give and take" that the "feeling of momminess" lies, and the seeds of maternal identity and

maternal competence take root. It is well understood that substance-dependent mothers' preoccupation with interpersonal loss and trauma, feelings of guilt, shame, and neediness are readily activated by children's everyday emotional demands, making it difficult for parenting behaviors to be shaped by the child.

This is reflected in the women's difficult parenting experiences wherein they describe overwhelmingly reactive parenting practices guided by their own emotional state. This greatly decreases the likelihood that the mother will be able to consistently or effectively meet the child's emotional needs. As a result, children will often "dial up" their behavior in an attempt to get there needs met. This leaves the mother feeling like her child's behavior is unmanageable, and that the behavior is either personally directed at her and/or she has failed, producing increased feelings of guilt and inadequacy, which was observed earlier in the women's perceptions that their children's behaviors were intended to hurt and/or persecute (Colten, 1982; Laughinghouse, 2009). This ultimately perpetuates the cycle of "disconnect' within the mother-child unit. However, as treatment progressed the women began to reflect on their child's mental experience or "hold the child's mind-in-mind" (Slade, 2007; Suchman, Decoste, Roosa Ordway, & Bers, 2013), when discussing specific parent-child interactions and overall relational dynamics; this seemed to guide the women toward identifying ways to parent differently. This was significant, as it was a powerful indicator in their shift from "looking back" to "looking forward".

> I used to always ridicule him; I'm going to make you wear a pull up when you go to school in the morning, better quit

pissing your bed [*angry voice*]; I never had the patience with my addiction, constantly washing blankets and sheets, but I always ridiculed him, and that wasn't doing anything, not doing any good to him, I was *hurting* him more, by making him feel *ashamed* of himself, that he would get up in the morning when he did pee the bed he would change before he would come and see us; did you pee; 'no'; *don't lie to me* [emphasized]; now I'm seeing things so much clearer now, I just got to start make him pee before he goes to bed, wake him up in the middle of the night to get him used to it. (Chloe, interview 2, lines 433-440)

I started understanding it more… I didn't think to the extent that when they were younger as they were growing that maybe they *blamed themselves*, for my problems and their dad's addiction, and not being able to stick around and talk to them and make them realize it wasn't their fault, although they grew up and they still love me and everything, I can still see the pattern in them as they are growing to be teenagers that they are starting to turn to drugs and alcohol, it's a cycle, I can see that cycle repeating itself …but I can go back and seeing that I want to go back and start going to counseling with my family and my kids to make them

hopefully open their eyes to show that it wasn't their fault. (Chloe, interview 3, lines 36-45)

I think that's better for my son and me because I think that there are too many parents going on right now. I'll get him on to a routine, then he goes stays with them for a few days or a week, obviously grandparents are there to spoil, but since they're such a big influence in his life since they're with him half, a lot of the time, it's *confusing* him and it's just not healthy for all of us cause we're not on the same page for disciplining. He's got beyond everything materially, just like I always did, but he needs more than just material things. (Karen, interview 1, lines 134-14)

He's *afraid* of me leaving, he's got separation anxiety with me, really bad, and it's my fault, so I think the more I'm with him and he realizes I'm always there to pick him up, I'm always the one who is dropping him off, I'm always the one that's cooking him meals now, he's going get more comforted and it's going to slow down, it's just going take a little while, I just have to have patience with him and not take it to heart cause he will grow past this. (Karen, interview 3, lines 350-354)

> I think we need a lot of patience with each other, I think all he *wants is love* and understanding from me, and just to be there for him, it's all he wants, I was never there for him before, I always said I'll never do this and never do that, and then end up doing it, but I understand now, I can see it. (Betty, interview 2, lines 258-287)

Meta-theme: Looking Forward

This meta-theme reflected the overall experience of the women taking responsibility as a mother; which included connecting with one's sense of self and developing, considering and "trying on" their new constructions of the mother-role. It encompassed the seven sub-themes included in Table 4.

Table 4. Looking Forward Meta-theme and its subthemes represented in participants' lived-experience.

Themes	**Participants**					
	Chloe	Betty	*Faith*	*Karen*	*Trish*	*Amaya*
Meta-Theme **Looking Forward**	x	x	x	x	x	x
Sub-Themes						
Who I want to be Identity Development	x	x	x	x	x	
Meaning & Purpose Identity Development	x	x	x			
What does my Child Need? Maternal Identity Development	x	x	x			

What do I Need? Supporting Developing Maternal Identity	x	x	x	x	x	
Skills, Social Support & Information Practical Resources	x	x	x	x	x	x
I Need to Feel good about Myself Emotional Resources	x		x		x	
Balancing & Protecting Recovery & Mother-role	x		x	x	x	x

Table 4.

Note: Themes that were represented within the participants' lived-experience are indicated with an x.

Who I want to be (Identity Development)

Over the course of treatment, the women began to develop a sense of who they wanted to be as mothers. Although their construction of a "good mother" in many ways underscored how they had failed in their mothering roles, it did not appear to evoke the feelings of self-condemnation one might expect. They seemed to be empowered by being able to name who they were striving to be. There was a hope that emerged within these descriptions, which seemed to give the women, who had previously felt lost, a direction.

> Being a mom means everything, being able to talk to your kids to let them know that you're there for them, to talk to them, to love them completely, and not just pretend, or just half love them, being able to talk to them, to let them know I'll be there for them, structure in their life, you are supposed to be the teacher of your children's future, their

lives, show them how to grow and become an adult, a responsible adult, and if you don't portray yourself well they are not going to have that structure in their own life, they are going to think, this is how my parents were so I might as well turn out like that; being a parent, to be there for them, show them, guide them, talk to them, let them know I'll be there for them and don't be scared; I got to learn to be un-judgmental with them and what I say goes, do it my way or no way, I got to be open, I got to listen where they are coming from, and not just say well that's the wrong way, but understanding, understanding and let them be who they want to be, like if they are going to choose who they want to be it's not for me to tell them that they can't, but just to be there to guide them and help them along the way. (Chloe, interview 3, lines 261-
272)

I want to love her, I want to support her, I want to be caregiver, provider, parent-teacher interviews, like school things, I want to be a volunteer, be disciplinary in her life, like everything, like there I go, I have a picture of what it can look like now, and that's amazing, I never thought

about it or made the connection. (Faith, interview 3, lines 37-41)

Being there emotionally for him, actually listening and seeing what he's saying and what he wants, instead of, oh okay lets go to the park [*flippant, disengaged*], I mean of course I'm going to do those things with him, but I was doing them more before just to keep him happy, not to really, I don't know, I wasn't really there, like I was there physically, but I mean, I did do lots of stuff with him, but I wasn't there as much as I could have been, I wasn't being responsible, plus I was letting my mom be the enabler, enabling my addiction to go on, or I would just put the responsibility on to her all the time, like pick [her son] up, I'm too busy doing this, then I wouldn't get back till 9pm at night, then all I had to do was bath him and put him to bed, I'd do that all the time, even when I wasn't using, like when I was sober for quite a while, like oh I'm going to work an extra hour at work, so she's like the second mom, I want her to be a grandma, and my dad to be a grandpa, not secondary parents. (Karen, interview 3, lines 303-312)

Meaning & Purpose (Identity Development)

In reflecting on their past offenses, the women began to find new meaning through exploring positive aspects in events previously viewed as mostly

negative. They began to incorporate experiences of their past-selves within their new constructions of motherhood in which they were able to be an "example" and "role-model" for their children. They began to identify how their past experiences could add value to their roles as mothers and allow them to support their children in a meaningful way. Addiction was being re-framed; it no longer exclusively represented a wedge that would tear their relationships apart, but rather it was viewed as a vehicle to "uniquely" support and understand their children.

> He knows what I'm doing [treatment] is right… he doesn't want me to go back to that other lifestyle, he doesn't like people drinking, he doesn't even like me smoking, he says 'I wish you could quit one day mom' [*laughs*], I always talk to him about it, not to be around people who does drugs or drinking, don't smoke, so he understands…I just sit down with him and tell him this is why I don't want you to do it. (Betty, interview 2, lines 196-204)

> They are drinking and still doing drugs right, even if I can just send them to a treatment center for a couple weeks, or however long it takes, just for them to understand, they can say 'well I don't have a problem' well that's what I used to say too. (Chloe, interview 3, lines 279-282)

> I do feel I am an example because I went back for my education, I did get my job, keep my job too, so hopefully that's something I've done in the past that they would learn, and going to treatment and coming back a better person. (Chloe, interview 3, lines 300-303)

> It starts with me just being those things, being respectful, being, setting my boundaries with her and following through on consequences, like same thing with my relationship, showing respect, showing honesty, showing loyalty, showing I'm going to be there on time, I'm not going to miss appointments, I'm going to keep my promises, it's the actions that go behind the words, it starts with being a role model, I think is how it would have to look like, as she's seeing these things then hopefully her attitude will change according, like that's the picture of how it could be. (Faith, interview 3, lines 48-54)

What do my Children Need (Maternal Identity Development)

Alongside their constructions of the mothers they want to be they began to express a genuine desire to "be there" for their children and "know" how their children are. Despite the fact that being a "good" mother appeared to be a huge responsibility, they expressed a determination to be there for their children. As

Faith expressed, “I was responsible enough to bring her into this world I need to be responsible for her all the days she's on this planet and that I’m on this planet” (Faith, interview 1, lines 536-537).

Some research suggest that substance-dependent women attach their personal value and well-being to their children and ‘being a mother’, leaving them with little sense of self (Baker & Carson, 1999; Kunkle, 2002). In a sense they “become-one” with the child , which lends itself to emotional reasoning that assures them ‘if the children are okay, they are okay’ (Kunkle, 2002). This faulty reasoning perpetuates the use avoidant defenses in relation to evaluating their children’s well-being, which was consistently observed in the current study. However, as treatment progressed the women displayed an increased cognitive and emotional acceptance that their children had in fact been deeply impacted by their addiction, and were likely not “okay”. As they grew in self-acceptance and self-forgiveness, there appeared to be a shift from “if they’re okay, I’m okay” to “I’m okay enough to know if they aren’t okay”. Chloe captures this “shift” in the following excerpt,

> I don't want to know [how my kids are] because I’ve already felt it with my parents, what they put me through when I was a child, and growing up with my mother saying every time I tried to remind her when she was using, 'oh I don’t want to talk about it never mind, it’s over and done with, just leave it alone’, so I never did get to talk about my feelings, but now ya I guess in a way now I do want to

> know, cause I got to go down to the root of it, I got to know what my kids were going through, and how much I hurt them, cause [sic] if I don't then who knows what it's going to do to them, and it's already affecting them already, cause [sic] they are already choosing drugs and alcohol. (Chloe, interview 3, lines 177-183)

In this excerpt, Chloe challenged the "don't talk, don't trust, don't feel" rules that permeated her childhood and adult years. When presented with her children's 'actual' well-being, her "knee-jerk" response is to metaphorically cover her eyes and ears; 'if I don't know, it's not real.' However, within the text she challenges her emotionally driven response, and begins to incorporate the insight she has gained about her childhood experiences as a parenting guide post. Lying within this ability to accept the "truth", the women were empowered to take responsibility for their own mind, which "liberated the women from their past, and freed her to nurture and respond to the needs of her children" (Akerjordet & Severinsson, 2010, p. 410).

The women began to think about how they could support, and provide "solution" for their children. For Chloe, and many of the women, their increased awareness of how they had been impacted within their families of origin, motivated them to re-engage with their children in order to interrupt the "cycle." This became extremely salient for Betty after receiving a letter from her son, in which he expresses his fears, his need to "get stuff out my head", and a prayer for himself and his mother.

> Hi mom; I'm doing really good, but for 20 days I couldn't get stuff out of my head, it feels weird but I'll be okay, but I love you, I wish you well, I pray every night for me cause I just started not too long ago, I lost some eye sight but I'm kind of scared, I never felt this way in my head before, it's just lots of stuff in my head, I just need someone to talk to, but you probably feel the same, I just wish to get all this stuff out of my head, you probably feel the same, that one day I felt so scared I cried, I still feel the same way, but I thought it out and here is my prayer, dear Jesus I'm praying to you right now so you could watch over me and my mom, [his caregivers], I want you to give us another amazing day, I'm glad what my mom is doing and I'm so proud that [his caregivers] are my second parents, and [his caregivers' child] is my good little brother, amen. I love you and I miss you. (Betty, interview 2, lines 300-309)

Prior to receiving the letter, Betty had struggled to fully embrace how her son had been impacted by her addiction. Betty had spent much time in treatment working on issues related to her family of origin and extensive history of sexual trauma. She had expressed a sense of closure and belief in God that would allow her to move toward becoming the woman and mother she wanted to be; however prior to receiving the letter she continued to skim the surface of her relationship with her son. Her son's words seemed to break through the denial she was

hanging on too. A truth that once would have been unbearable to stand face to face with, had become containable. With an increased sense of forgiveness, self-reflection and ability to regulate emotion, she did not decompensate; she did not become overwhelmed by the debilitating shame that had once consumed her being. She was okay enough, for her son not to be okay. She was able to "feel" her son's hurt, and she wanted to respond.

> I hear him saying that he's crying out for help, and he doesn't know how to talk, he's scared, he needs somebody to talk to… I know he took a lot in his life from what he's seen, he's seen a lot too, and I know that I could probably sit down and talk to him, and try to get some stuff out so he could feel better, but I hurt him, he's hurting, he's twelve years old, I just want to help him, I just don't want him to fall into my shoes, get into drugs and drinking and that, cause once you have a lot of stuff inside you and your scared and you don't know where to go, that's the only answer you'll lead too, drinking and smoking, and I don't want that for him, so I'm going to try everything to get him into counseling, and tell him he doesn't have to be scared to go sit in there, this is my first letter from him, and it's all about his hurt. (Betty, interview 2, lines 317-325)

What do I Need? (Supporting Developing Maternal Identity)

Within the women's desire to break the cycle for their children, they began to look outward for resources to assist them in their mother-role. Faith, like the other women, began to consider the challenge that her children have, and may continue to experience, expressing their feelings. Like Betty, Faith was concerned her daughter may not talk about how she really feels, and identified that she and her daughter need support to move forward in their relationship.

> I'm not sure, I think it's a safety thing for her maybe, she might not feel like appropriate to say that, maybe she thinks she might get in trouble if she says it, like I'm not sure what it is exactly, but that's the stuff I need to learn how to figure out with her, that's the stuff I want to help her deal with when I get out of here, like what she's going to need to be able to get that stuff out, because I know for myself I never had that opportunity and look what happened to me right [*small laugh*], so if I kind of learn some techniques or get some more tools and resources to help her maybe I can kind of cut that negative stuff before it gets too large and she goes and starts rebelling and stuff right, cause she's getting to that age, cause I know for me it started eleven, twelve-ish [sic]. (Faith, interview 2, lines 315-322)

This reach outward reflects our understanding that "knowing" or understanding our children's behavior is not enough to cultivate and/or sustain a

sense of maternal competence, unless a mother is given context concerning how this information may be used, it will likely reignite feelings of failure and/or incompetence in the role (Flagler, Curry, Humenick & Kirgis, 1988). Faith captures this, expressing that even though she has gained insight into her and her daughter, and their relationship, she is unsure what the next steps are.

> It's that thing where I'm getting all this awareness of what's not working, and we talk about what's supposed to happen, but what does that actually look like in my life, face to face with [her daughter], how does that unfold? Nice in treatment, but ya,, so what I walk out the door and I get on the bus and I go back to Calgary, I get off the bus and what [*laughs*], I walk back into crazy world, then I walk up to my daughter and give her a hug, then what, like I have these thoughts, what am I supposed to feel, some kind of differentness, or difference. You know what I mean? I just don't think so; it's going to take time, but I don't even know where to start, and that's where I'm stuck right now, I have all these great thoughts and positive feelings where there used to be darkness I have light, but I don't know how to put it into a physical form myself to benefit her, like how do I do that? (Faith, interview 2, lines 127-135)

Skills, Social Support & Information (Practical Resources)

Maternal identity is further established as the mother seeks information and is able to develop skills that will promote the child's health (Flagler, et al., 1988; Mercer & Ferketich, 1994). This is observed as the women consider and identify what resources they need to support their children and fulfill their roles as mothers, both during and after treatment.

> I'd like to get some more feedback and support around [parenting] before I leave here; I have awareness that's the first thing right, I'm just not sure how to get there, I don't know, like I'm just blank right now, I'm a blank page when it comes to that, like I need more resources, like I don't even know where to begin, like I know within myself, freeing myself of negatives and things like that, that is all fine and dandy but I'm not sure of the actions, cause [sic] I'm a very, think analyze process [sic], but now I need to turn those into behaviors and actions and I'm not sure exactly how to start that process; like what does that even look like? I'm not sure, I don't really have any example to go by. (Faith, interview 2, lines 110-121)

> Here I am in recovery now, and so I'm clean of all the drugs and alcohol, all that is great, but I still don't know what it looks like to be a mom, like I've never been able to identify that, just because having my mom and not having a

role model, and [counselor] was like 'for sure you wouldn't know how to do that', basically I need tools, I need resources, I need. (Faith, interview 3, line 9-13)

It was pointed out that my world is very small right now … I do have other people I just don't have connection with them; that was a huge thing for me, so looking at that, even how that affects my daughter (Faith, interview 3, line 200-205)

I really want some parenting stuff, [psychologist] seems to be a good support in that, so I hope it works because I really want help with it cause [sic] I want the best for him and the best for me. (Karen, interview 1, lines 230-233)

I was feeling some stress yesterday about it [getting her son back], and then I talked about it, plus I mentioned it to you, and I talked to a few other people about it and I talked about it in the meeting last night. I think talking about it those few times made it like I'm going to be able to do this because at least I'm talking about it, so that means I'm going to be able to phone somebody up and tell them this is

> happening, give me some advice [*small laugh*], cause there are a lot of things I don't know. (Karen, interview 3, lines 261-265)

> I know I feel really lost, it's the only area in my whole life, I think it's cause [sic] it means so much to me, so I feel so stuck, not stuck, kind of like a kid, somebody show me how to do this and I will do it, but I don't know how (Karen, interview 3, lines 261-265)

> [Interviewer: Do you have support to help you during the next steps with your son?] Not really, no, I'm just letting it come as it is, like I think it would have been very beneficial for him to come here and do counseling… but they just never seen it in that way, and it's sad for me. (Betty, interview 2, lines 332-336)

I Need to Feel Good about Myself (Emotional Resources)

The women also identified psychological resources such as, self-confidence, self-esteem, and sense of mastery. In line with Mercer and Ferketich's (1994) research that suggests a woman's acceptance of her overall self-image and her perceived control over life events are central to taking on the maternal role, the women in this study felt that their self-concept greatly influenced their perceived ability to parent, and believed they needed to access resources that would help them continue to grow in this area.

> I also want to start taking classes on self-esteem, and confidence, self-care, cause [sic] I don't want to stop just right here… I still have to figure out my self-esteem and self-confidence on the inside, start learning that it is my life and I can take control of it.
> (Chloe, interview 3, lines 70-76)

> I think setting my boundaries with my family, and just being open and honest about, I'm doing this for me, if I'm not better, I can't be better for [her son], I can't be a teacher, I can't do all those things, it's based all on my solid foundation, and that if I don't take the time to actually build that properly, I won't have any of those things, I think reminding myself of that and making it clear with my family. (Trish, interview 4, lines 252-256)

Chloe explained,

> It's because if you don't feel good about yourself, and you don't feel you are a good parent, you don't feel like you are a good mother, your kids are going to feel that too, so they aren't going to feel that way about you if you don't feel that way about yourself, if you don't show you are strong, and you are capable of doing it then they aren't going to show that either. (Chloe, interview 3, lines 458-461)

Balancing & Protecting

As the women came closer to completing their program there was an increased sense that the women were considering how they would maintain balance between recovery and their roles as mothers. Brudenell (1997) found that substance dependent women describe balance as the "keystone in the arch" that connects the foundations of substance abuse recovery and the transition to parenthood. In line with her findings, the women began considering how they would balance and protect their recovery while fulfilling the mother-roles. Litzke (2004) suggests society has attached idealized characteristics to the concept of motherhood which can result in women having unrealistic expectations of themselves. This is especially pertinent in light of the significant emotional and physical resources required for both recovery and mothering activities. There was a sense that the mothers were negotiating how they would, make up for lost time, take care of themselves and fulfill their newly conceptualized notions of a "good" mother. In the following excerpts Faith is negotiating what her priorities will be following treatment. Initially her daughter precedes recovery, while in the next text, recovery precedes her daughter.

> Number one is me, number one and a half is [her daughter], then still abstaining from drugs and alcohol, then cutting the ties to the relationship, and allowing myself to grieve, get some grief counseling, CODA, then my regular 12 step, addiction counseling… positive self-care. (Faith, interview 3, lines 190-193)

> Personal promises you hope to keep in recovery. One is me, recovery is always first, keep moving forward no matter what. [Her daughter] always second. Three, maintain boundaries follow through with consequences. Four, ask for help when I'm struggling. Five, express myself openly and honestly at all time. Six, do not pick up. (Faith, interview 3, lines 195-198)

This continual and dynamic negotiation is a reflection of the daily decisions these women were preparing to engage in following treatment. Unlike the women in Brudenell's (1997) study, who became pregnant for the first time while in recovery, these women were acutely aware of the high demands inherent in active parenting, and were concerned if they moved back into the role too quickly it would jeopardize their recovery.

> Learning how to do all that [parenting] again, manage the stress, and doing a job possibly, and meetings, and all that and fitting it all in and not getting overwhelmed. (Amaya, interview 1, lines 294-296)

This became especially salient when the women felt pressured by others who were involved, such as their children's grandparents or caregivers. For many of the women, the "push" to have contact with their children, and/or start "being a mom" re-ignited feeling of guilt and panic.

> My dad when he was here visiting on Sunday, brought up some anxiety, he was kind of pushing for 'you need to call

your kid, you need to call your kid' and I haven't spoke [sic] to my son, … so I was like I was feeling anxious, well I'm not ready to pick up the phone and dive into it, so I had a lot of anxiety, so I talked to [her counselor], and we said a good starting point for this week is not to jump right in to the phone call, but to first, even if I don't send it to them, is to write … a letter, just to know where my head is, and to go over it with [her counselor] and see where my feeling and thoughts are, and how I'm going to be approaching it and really examine it before I go and make that step... so that it's not like I just dive into it then catastrophe and I'm like *aahh* [emphasized] I wish I was outside so I can have a drink [*laughs*]. (Trish, interview 2, lines 88-97)

I'm like I might get out…he's [her father] like, 'the kids are going to be in Regina', he's like '*we can go pick them up* [emphasized] they can stay at our place', he doesn't get that I can't just jump right into it, he's like 'they are so happy when you are here' like when I was there this last time, cause they sleep over there every other weekend, he's like 'they never act this happy, they need you ' and stuff like that, [he] tell[s] me how much they need me and make me feel guilty. (Amaya, interview 1, lines 341-346)

The hopes and expectations of others were experienced as additional sources of stress. Karen described the pressure to "figure it out" this time because her parents have had to take on the burden of raising her son, and that her mom "wants to be a grandma, she doesn't want to do this anymore" (Karen, interview 2, line 180). Similarly, Faith felt responsible to both her child and her child's father who is the primary caregiver.

> He's trying to leave his girlfriend right now who's not good for him, she's real selfish, she's got four kids and [her daughter] is always the last on the list, so he needs a better environment for [her daughter], so he's really counting on me right now to be there for her. (Faith, interview 1, lines 503-506)

Managing fear, demands and commitments to self and others, is inherent in the mother-role (Akerjordet & Severinsson, 2010); however, because of the ideological boundaries that surround motherhood, women will often sacrifice self to fulfill the image. Mothers in early recovery are at significant risk for relapse if this occurs. The women seemed acutely aware of this, and were actively seeking ways to manage these expectations. Except for Faith, who had contact with her daughter throughout treatment, all of the women who contacted their children during treatment only did so just prior to leaving. This was notably tied to protecting their recovery; most indicated they "didn't feel ready" to talk with their children early on in treatment. Protecting was further expressed in the women's desire to have the ability to pace the process of re-engaging with their children

after treatment. The women were explicit in decidedly "taking it slow", for their own and their children's well-being.

> He'll still look after them and all, when I do decide to get my place, until I'm stable enough to take them back … I just don't want to have to take them and move and get myself stressed out, and go back to my addiction while I still have them, plus this is the only home that they've known, and I wouldn't want to uproot them. (Chloe, interview 3, lines 29-34)

> For me I really have to concentrate on being okay where I am in the program, and not rushing it, and not letting other people make me feel like I should be rushing it, because I know what's going to be best for my health, and in the long run, what's best for my health, and me being able to take care of myself is going to be what's best for me being a mom to [her son], so I kind of just stay focused on that way of thinking, cause if I stray off of it, and I'm like oh no [her son], and I start putting other people first or anything like that, it's going to, I know for me, cause I'm a people pleaser, it's going to be detrimental to my recovery. (Trish, interview 4, lines 123-131)

> So it's going to be a transition to spending more time with [her son] but it's a transition that I'm doing so I'm there for the long run, whereas if I rush into too much at once, that again might be a relapse trigger for me, stress and not managing it properly, and not putting enough time into the program , and then all of a sudden, boom I relapse, then I'm back at square one, whereas if I actually just take the time in the beginning, do it that way, more chance of success for the long run, that's just the way I feel about it. (Trish, interview 4, lines 91-96)

Meta-theme: Sense of Closure

The final meta-theme focuses on the experience of a *sense of closure*. Within this dimension, three sub-themes emerged that highlight the participants' lived experience. These themes are depicted in Table 5.

Table 5. Sense of Closure Meta-theme and its subthemes represented in participants' lived-experience.

Themes **Participants**						
	Chloe	*Betty*	*Faith*	*Karen*	*Trish*	*Amaya*
Meta-Theme **Sense of Closure**	x	x	x	x	x	
Sub-Themes						
Saying it Out Loud	x	x	x	x	x	
Higher Power		x	x	x	x	
Me, My Mother, My Child	x		x	x	x	

Table 5.

Note: Themes that were represented within the participants' lived-experience are indicated with an x.

Saying it Out Loud

Most of the women experienced a sense of relief from "saying it out loud." Through the process of talking honestly about their histories and expressing their feeling they began "let go" of the complicated, and predominantly negative, feelings and beliefs they held about themselves. A sense of self-acceptance and self-compassion evolved out this process, in which they were able to further make sense of inner conflict they experienced as mothers. For many, the process appeared to be a slow and deliberate dis-assembling of the shame and trauma they had been so consumed by. Rather than being shattered in one fell swoop, it was as though, the shame needed to be taken apart, piece by piece, in order for it to be inspected and understood. The women needed to find reason for its being in order to weigh its validity against the truths they found in other mothers' experiences and were beginning to find in their own.

> It seems like a lifetime when you are here, you have to start releasing, being able to accept, accept it and release it and let it go … I have so much more of an understanding of myself and my feelings, everything in my surroundings, that's when you truly can have peace with yourself and let everything go, and then you can move forward… [talking in the interview] feels good, I've cried over that story how many times, it's like oh my god, am I ever going to get over it, but every time I talk about it, it releases a little bit more, that wall comes down. (Chloe, interview 1, lines 586-

600)

When I first came in here it was overwhelming, knowing that all those feelings I had pushed down were actually starting to come up and I had to deal with them, and being able to deal with them in a sober way, and not hide, and start to tell the truth instead of lying, cause [sic] my whole life was lies…I asked my counselor how is dealing with my past and my emotions is supposed to help me heal in my recovery today by telling a bunch of strangers my secrets, but now it's starting to become clearer to me, knowing that I have to start being open and trust myself to be able to trust people out there, trust people around me, be able to say what I can to a point, well I haven't been hiding anything like since I've come here it's all been truth, and it feels good, it feels good to finally be truthful to myself and to everybody instead of hiding and lying (Chloe, interview 2, lines 16-35)

I'm starting to learn how to let go of that regret, the regret of what I did to them back in the past, not being there for them and wishing I could change it, I'm actually letting go of that and not letting it hold me back to be the mother that

they need me to be… I got to let go of all the hurt, regret, the grudges, self-pity on myself, got to let it go in order for me to be me, cause I always felt like I phony, like I wasn't real, cause I didn't know how to be real, it's letting a lot go, it's starting to feel good to be able to not hold on to anything anymore, and the more I talk about it the more I release it, [*sighs*] the weight has just lifted off my shoulders. (Chloe, interview 2, lines 144-157)

I think I've been better able to work through that guilt and not feel as much shame because I'm seeing other people are accepting of me, why can't I accept myself…I've been able to talk to them, and in our primary group, the more you share the more people you realize have been in this situation, I'm a little easier on myself, and I can feel I'm starting to self-forgive a little about some of those things. (Trish, interview 2, lines 27-32)

[Working through trauma is] also contributing to how I'm feeling a little more, it's helping me work with the self-forgiveness, like a stepping stone, I'm getting it out there, looking at the differences and watching other people doing there trauma and angel eggs…looking at my trauma egg I

think I'm looking at it saying life's fucked up, people are fucked up [laughs], that's the big thing that I put there is fucked up, therefore I should die; that's the way I feel when I look at that trauma egg, but then when I look at the angel side of it and right at the top is my [son] and when I look at the angel side of it life's great, people are good, it's almost like two polar opposites, by doing both of them I'm trying to find balance between, and it's been helping me work through the trauma by thinking about the good and having it there. (Trish, interview 2, lines 143-152)

I found doing these interviews helped with my process, because the group stuff is really good and I have my one on one with [her counselor], but this was a really good way to sit and tell my story, I think that was helpful with my process. (Trish, interview 4, lines
267-269)

I have resentment toward my own child, I know that sounds sick but that's the brutally honest truth, that's the stuff I got to say, and that's the stuff that it's okay, you know, cause that's the past, that's the stuff I need to self-

forgiveness, and you know let go of some of that shame and guilt. (Faith, interview 3, lines 60-62)

I loved it [doing the interviews] it was great, I really appreciate you and feel really connected to you, I'm glad I did this, like I'm just blessed to have you in my life, it's hard for me to say this stuff to women. (Faith, interview 4, lines 213-214)

[Talking about her trauma] was the biggest part of my recovery; I think, cause [sic] I feel that that was the heaviest thing I was carrying, cause [sic] I just told my whole life story in that one little egg, (Betty, interview 1, lines 316-317)

When I first came it was hard, cause [sic] I felt alone, I felt like I was far away from home, and all my friends said just think you are not far away from home, just to try to get my spirit back, but it took me a week to adjust, and then to get socialized with other people, other clients, once I got through step one it was good, I feel like I got a lot of tools from here, cause [sic] I gave them a lot of my information

> [shared her story] that I don't have to carry no more. (Betty, interview 2, lines 245-249)

> I attend seeking safety [PTSD intervention]…it's been one of the most beneficial classes for me…it makes me more aware of what's going on inside of me that I need to be aware of so I don't start isolating, breaking my commitment, the red flags or whatever, I don't mind it, I go to it and it's a smaller group so I feel like we express more in it (Karen, interview 2, lines 90-91)

Higher Power

All the women acknowledged they had caused their children a great deal of pain, and had caused emotional scars that required healing. As the women began the process of healing their pain, the influence of their religious and spiritual beliefs became more pronounced. The need to connect with their "higher power," which many of the women called God or Spirit, became more apparent as the healing progressed. As they shared their sense of spirituality, they drew on past experiences that represented the unconditional love, guidance and protection they needed today. The women talked about how God had been there for them when they feared for their children's health and safety during their active addiction. Betty spoke about reaching to God in the face of all the guilt and fear she experienced when her son was born

> When I … went to see him for the first time, he was hooked up with wires all over, all I could think was why did I

> smoke, why did I use while I was pregnant, this is my fault, everything was going through my head, all I wanted to do was take all those wires off of him for him to be better, to make it through, I was praying to the Lord make him better, and then he finally got better. (Betty, interview 1, lines 11-15)

For many of the women, the fact that they were still alive, meant there was purpose for their life. In moments when they could not find a reason to live, their higher power provided reason and strength.

> But then I was thinking the day I just started cutting myself and didn't get very far into the cut, and I stopped and I got out of the bathtub, and I went and called dad, I said dad I need help, and you know I've been in that situation how many times in the last almost two years, where I was cutting myself, that's how I was releasing the pain and I've never stopped, what was it that day that made me stop, that was my unmanageability, but my higher power I think gave me the strength and courage. (Trish, interview 2, lines 184-189)

> It's weird how god has come in and out of my life at different times, now I look back and I know he's always been there even though for years I had great resentment

towards him, like huge, like when my mom died, but now I look back he's always been there when I let him, right, or when I'm listening, cause I'm sure he's always been there, I just wasn't letting him in or not hearing him or feeling that presence, cause I didn't want to or whatever it was or I was too sick, I'm sure he's always been there obviously cause I would have been dead so many times [*laughs*], I should have been, there's no logical reason I should be alive right now, in my eyes, none whatsoever [*laughs*] especially that stuff that happened with my trauma and how sick I was. (Faith, interview 2, lines 346-354)

I look down full of shame, the pain so intense now, ripping through my body like a thousand knives; the blades won't come out, the deep wounds are all internal making me bleed, so I suffer, can't cope, can't call out for help, I'm left helpless, barely breathing, visions dance before me. Can I grasp them? I reach, I fall fast and hard on to my knees, so I suddenly hear a voice, is it in me or coming from above? I'm not sure. It's my higher power so I ask, why didn't you protect me when my body was abused? Why didn't you stop me when I picked up and used? While my child it made you who you are and it made you become wise and

> strong which led you back to me. (Karen, interview 2, lines 271-277; excerpt from a poem she wrote)

Believing there was purpose for their life, they could challenge their feelings of worthlessness against the inherent value of their existence through the love of a higher power; this weighed into their considerations of self-forgiveness. To consider forgiving one's self for felt enormity of their transgression was impossible without the grace of God to look beyond what they had done. Trish explains,

> I know I've fucked up, god I've fucked up [*broken sad laugh*], but I think especially since I've been praying more, I'm starting to get to a point where I just feel, I don't forgive myself yet, but at the same time I feel ready to start working on that. (Trish, interview 3, lines 614-616)

The women who drew toward a higher power found strength for their recovery and an increased acceptance of self. They felt they were more able to become the mother's they wanted to be through their relationship with God. For many of them, a sense of humility and compassion for themselves arose, in which they could let go of their pain, forgive themselves and were not required to have all the answers. They began to put their fears onto God, and trust with his love, support and guidance they would be able to find sobriety and parent differently.

Trish captures this experience, describing it as, "Hopeful. Hopeful has been a word I've been using a lot. And I do feel that, I'm hopeful and I'm feeling spirituality again [*laughing*]" (Trish, interview 2, lines 412-413).

I'm good, I'm just thinking it's not easy being a mom [l*augh*s]; there's no guide book or anything, it's like you can't even prepare, it's just unreal, one day you're just walking along and you're just your own person, next thing you know you have this little thing you have to take care of, a little baby, that totally just needs you *all the time* [emphasized] [*small laugh, silence*], ya crazy, I think that's what I'll pray for next time when I go to the sweat on

Saturday, I'll pray for mothers, maybe I can get some wisdom.

(Faith, interview 2, lines 393-397)

I've been praying, and I prayed in that sweat for mother wisdom, remember I was telling you I was going to do that? And here it is, answers are coming, I'm getting blown away again, it's that whole higher power thing, like holy crap this is actually working, but it feels amazing, I just want more, cool things are happening, things are changing already, I'm not even out of here yet, just think what it's going to be when I get out there and give her a hug and to feel how it's going to be different this time. (Faith, interview 3, lines

66-70)

I feel like a lot of strength, strength out of weakness, and love and compassion, compassion for myself, and nurturing and I don't know, just filled up with spirit, like I've had some pretty powerful stuff happen to me here through the church and through the native sweats, and things like that, and I'm not fighting. (Faith, interview 4, lines 98-100)

I went to church on Sunday it was really good and I went up and had the prayer done for me and I was anointed and they prayed for me to take my pain and addiction and the emptiness away and I swear to god something really amazing happened; I felt very different, a different aspect, it did something and I can't put my finger on it; I don't want to sound like a quack but something did happen and a lot of that hole doesn't feel sick, I don't feel that hole anymore, which is awesome and amazing; my prayers are going really well lately, I'm feeling really connected. (Karen, interview 2, lines 159-164)

> I was searching for who I was, and now that I know, I can continue on with my journey, I'm not scared, I'm not afraid, I'm just ready to walk that spiritual path, I know that all my family that went before me are with me every time I'm going wherever, I believe that, like I have faith. (Betty, interview 2, lines 272-274)

> Last night I actually had my first talk with God in I don't know how long, probably three years, and it felt good and I prayed for my son, and for my family, I prayed for myself and my sobriety, it felt good. (Trish, interview 1, lines 508-510)

> The more I pray and the more I'm connected with [spirituality], I've been going to church every Sunday again, it feels great, and I love singing [*laughs*]. Ya the more I get into that, I feel comfortable with letting my Higher Power guide me again. (Trish, interview 2. Lines 180-182)

Me, My Mother, My Child

Throughout their time in treatment the women explored their own mother-daughter relationship. There was an increased sense that the relationship with their mother intricately shaped who they were, who they were becoming, and the relationship with their children. All of the women had been deeply wounded by

their mother's acts of abuse, neglect and/or abandonment during childhood, and in many ways, they were now wounded children trying to "mother" wounded children. Faith described this experience as,

> it's like I'm my mom and I'm still that kid and then I have a kid who is like me, but really in some ways I'm still at the same emotional level as her, so that's where that childish behavior that I have, even when she's around me and like you know get away from me or whatever, that way is like perfectly normal to me, but it's not healthy, I need to be more mature. (Faith, interview 2, lines 261-265)

As the women began to recognize that their childhood wounds needed to heal, in order to be "healthy" for their children, some of the women began to explore the idea of nurturing and "mothering" their hurt "little girl." Chloe said,

> I got to talk to [her inner-child] more, make her realize that she can't keep me down there, we need to grow up, cause if I don't grow up, then I don't grow up, I'll always have to have that somebody there to look after me, and that's what stopped me from pretty much taking care of full responsibility of my boys, cause I was always scared I couldn't do it… I'm kind of scared for when I get out I'm just going to back to the same way, I can't give up, I can't just let it in like that, and that's where that little girl comes in, well nothing is going to change out there why do you

> have to bother changing [*cruel, immature, impatient*]; I got to keep talking to her and let her know it's time to grow up (Chloe, interview 3, lines 237-248)

As they explored their own parenting behaviors and engaged in negotiations to self-forgive, they simultaneously began to compare, relate and reflect on their mother's actions. Within this light, a fluid reciprocity of forgiveness began to flow between the women and their mothers. For these women, a sense of peace emerged that permitted them to give and receive what their mothers were unable. Faith explained,

> it's so much different than the love I thought of always, cause I always went around whining and complaining that my mom never loved me, but I can still feel love, even though it's not the same, it is the same, it is, there's mothers here, other mothers here, I love them and they love me, and mother's love is mother's love right, and I mean it's not that she didn't love me she was just sick. (Faith, interview 4, lines 80-83)

The women appeared to be re-constructing their internal working model of self and others; she was becoming lovable and able to love, and by extension, forgivable and able to forgive. Many of the women shared how "looking" at the relationship with their mother helped her to forgive herself and gave her a new sense of hope about the relationship with her children.

It's [the relationship with her mother] making me really look at myself, and looking at the relationship with my children is now a lot clearer than before; before I just didn't have the time or didn't want to take the time to listen to hear what my boys were going through, but now it's giving me this new found freedom of knowing that I can go out there and talk to them and let them know I'm honestly 100% there for them no matter what, that's it's okay to tell me what's wrong; as long as I show them the real me then I know they'll show me the real them; as for my mother, it's starting to open up that wall, that flood gate, the wall I took so long to build towards her, its giving me a sense of peace knowing that she did what she did because it was the only way she knew and it wasn't my fault, I'm starting to come to terms with that, and I didn't deserve it, it was just her way the only way she knew how to deal with me. (Chloe, interview 2, lines 50-58)

This week was a very good visit with my mom, because she came in and said 'yep I agree with [taking it slow with her son] and I see that and you need to work on *you*' [emphasized], maybe that's because she can relate with the addiction, right, because she has her own issues,

painkillers, so maybe she can relate with that and you know having to take care of yourself before you can take care of your kids kind of thing, so maybe she had that relation to it and maybe that's why she felt you know [sic]. (Trish, interview 2, lines 302-309)

My mom is trying to protect my [son] and me from being hurt again, she's seen what's been done to us since the breakup…all she wants is her daughter back…I talked to my mom on the phone and said I'm going to take this time and not go back to work right away, I'm going to be working on being a mom to [her son], getting on a solid foundation…she's like 'yep that's what you should do'; so I think things could be okay, I think she's starting to be a bit more willing to allow different things, like maybe a while ago she didn't feel comfortable with, but I think she knows now I need to go to church, I need to go to meetings, I need to do a lot of things she wouldn't do for herself cause [sic] we are two different people (Karen, interview 4, lines 627-657)

Now I can forgive [her mother], cause I understand how sick she was, so I can deal with it, even though I still

struggle with all the shit I went through growing up, like logically and as far as that goes, and even some feelings and emotions, I can be like wow, it really wasn't her fault, and then I hear my daughter say 'it's not your fault' *already* [emphasized], and she hasn't even experienced a lot of it, like she just knows I'm not there, which is even huge too, well it's huge, right, cause it's an abandonment…all I know is I don't want that cycle to continue. (Faith, interview 2, lines 245-251)

I don't have any excuses left, oh poor me my mom wasn't whatever, everybody is dead…I really put those things to rest, I feel really peaceful about things, I don't really feel like I really have a lot more hurt that I could shed, because I feel like it's been lifted, everything I've turned over and its gone, not to say I might not come back here and there, but I mean I'm human, things will come and go, but I don't know, the foundation of it has been torn apart, the walls and the shame and guilt, the very core of how I used to think, all the negative stuff has been shattered, I might have pieces of it left, but it's broken down to a level where its manageable and I can see the light through the darkness today, and that's huge, and I don't have to be forever

> chained to incidences and circumstances and situations and bullshit because I don't want to [*laughs*] it doesn't do anything good for me, and I'm all about what is good for me, and that's a place I've never been before…I really feel I deserve this, like give me a break I deserve it. (Faith, interview 4, lines 84-94)

Chapter IV

Discussion

In many ways, the women's lived -experience affirm what we *know* about mothers who are substance dependent. All of the women in this study have lives characterized by stark disadvantage with extensive trauma histories, co-occurring mental health issues, few social supports, and complex and difficult mothering histories that include the loss of their children in addition to their substance dependence. While there is no doubt that substance abuse imposed many challenges onto their mother-child relationships, like most substance dependent women who enter into treatment, all of the women love their children and want to parent differently, but have felt trapped within a vicious cycle of shame and addiction. As Trish explained, "It's so hard to not have them but it's so hard to see them." Chapter IV brings together the intricacies of these mothers' experience and provides a unified, overall account of what it is to 'be a mom' in a residential substance abuse treatment program through phenomenological description, extant theory, discussion of research and clinical implications, and explication of limitations in the current study.

Phenomenological Description

The women's stories suggest they were deeply affected by their children and their perceptions of themselves as mothers, and were desperate to find a way to manage and merge their past experiences with who they wanted to be. The women's authentic felt sense of *self-forgiveness* became not only an expression of their lived experience but served as the conduit through which they experienced *looking back* and *looking forward,* and ultimately, for some, a *sense of closure*.

The lived-experience of *self-forgiveness* was both experienced and moved forward through a reworking of the women's past selves, while simultaneously it gave shape to their newly emerging representations of self and their children. During the women's *internal negotiations* to self-forgive they began to give themselves permission to consider self-forgiveness because others had. Other mothers' language of self-forgiveness offered the women a way through the guilt and shame, and gave rise to their first experience of self-compassion around their mother role. As they listened to other substance dependent women who shared honestly about their parenting experience they were able to challenge their negative views of self and consider the possibility of self-forgiveness. It was under this shelter that the women began to *say it out loud*, which was pivotal to the experience of *looking back*. Initially, even the briefest glimpse into the past seemed to activate an emotional response that required the quelling of an *avoidant defense* designed to alter, or at least soften, the truth. However, within the intricate weaving of self-compassion that arose within and through the acceptance of another and a *Higher Power*, each glimpse back seemed to effect movement within the experience of *self-forgiveness*, which in turn allowed the

women to extend their gaze. Lying within this symbiosis of *self-forgiveness* and *looking back* an increasing desire, and ability, to *look forward* emerged, in which the women began to construct an image of the mother *they wanted to be*. While exploring past and current relational patterns with their children and their own childhood caregivers, they began to enter into their children's feelings with maternal inquisitiveness and concern, and, moreover, without being overcome by shame. In this act the women were able to gain a *sense of closure* and hope; their pasts were no longer indicators of a flawed self, nor an unchangeable future. Within the transformation of being lovable and able to love, forgivable and able to forgive, they were able to consider, explore, and try on who they wanted to be, which cultivated a sense of empowerment, a belief, albeit fragile, in her ability to alter the life course of her and her children.

Although the women in this study were in a sense, destined for difficult parent-child relationships, their increased awareness and acceptance of self, facilitated a merging of past experiences with the mother she wanted to be. The mother-identity, along with its responsibilities, being created and tried-on by the women were, as Akerjordet & Severinsson (2010) aptly put, "reflections on the border between self-knowledge and mental health that establish a continuity of self with the past, present and emerging future" (p. 409). Who they were and who they were becoming, incorporated the past, but did not define it.

Theoretical Discussion

Attachment theory suggests internal working models are cultivated in early childhood within a biologically based system oriented toward seeking protection and maintaining proximity to an attachment figure in response to real

or perceived threat (Fonagy, et al., 2002). When a caregiver consistently, warmly and effectively responds to a child's distress, the child develops a sense of security that gives rise to templates, or internal working models, rooted in the experience and belief that others are trustworthy, self is valuable, and the self is effective when interacting with others. Within this "give and take", the primary caregiver acts as an external affect regulating system to facilitate the child's own regulation of arousal and emotion, and gives rise to the meanings of affective states and how they relate to a sense of self within the child. Co-regulation promotes learning to understand feelings, somatic experiences, and mental states and how they influence behavior and socio-emotional interaction (Allen, et al., 2008; Fonagy, et al., 2002). However, even if the attachment figure provides suboptimal caregiving, such as reflected in the women's childhood experiences, the developing child will do what is necessary to maintain proximity to the attachment figure and gradually develop stable patterns of defense and affect regulation that "adapt" to the caregivers pattern of responding (Muller, 2010; Fonagy, et al., 2002). Childhood experiences characterized by trauma and/or the psychological unavailability of a primary caregiver, leave the child unable to achieve self-integration or develop the internal working models necessary to feel safe around others, which leads to disruptions in the attachment system. Within this context, "non-mentalizing begets non-mentalizing" (Allen, et al. 2008, p.240), and the mental states of self and others become a source of terror and confusion. The child will develop a system of beliefs, expectations, and attitudes about the self and others that reflect an unsafe, and unresponsive world. This

gives rise to insecure attachment patterns, in which the individual becomes either excessively dependent on others or fiercely independent; "relationships become dangerous and terrifying rather than a source of pleasure or comfort making them complicated and exhausting rather than soothing" (Sanderson, 2013, p57). If unchallenged, this cognitive framework carries through adulthood and serves as an individual's internal working model for understanding the world, self and others, and greatly determines the way an individual will cope with stressful events (Fonagy, et al., 2002; Sanderson, 2013).

Bowlby posits an individual's mental representations guide feelings of security, suggesting that:

> Every situation we meet in life is constructed in terms of representational models we have of the world about us and of ourselves. Information reaching us through our sense organs is selected and interpreted in terms of those models, it's significance for us and for those we care for is evaluated in terms of them, and plans of action are conceived and executed with those models in mind (Bowlby, 1980, p. 229; as cited in Burnette, Taylor, Worthington, & Forsyth, 2007).

The development of "self-as-mother" is rooted in and guided by those *models*; a woman's experience as a young girl provides the template for future relationships, including those with her children. The perceptions that stem from a mother's subjective experience of her relationships, her childhood experiences

with primary caregivers as well as her experiences with her child and other significant people in her present social environment shape her maternal identity (Flagler, et al., 1988; Rubin, 1984; Walker, et al., 1986). Within the context of addiction, this is greatly disrupted, as the mother holds predominantly negative perceptions of her experiences in the role, and children will often act-out, or conversely, withdraw to manage the hurt, confusion and fear evoked by their mother's presence; moreover in many cases, the mother has developed a system of beliefs, expectations, and attitudes about the self and others that reflect an unsafe, and unresponsive world. Underpinning, and moreover fuelling, this disruption is the mother's inability to recognize her own mental states and their influence on behavior, which extends to difficulty in recognizing the child's mental states and their influence on behavior. When this is impaired, the distinction between the mothers' and child's mental experiences is not possible, and often results in the morphing of present relational patterns into *reenactments* of early traumatic relationships (Allen, et al., 2008; Fonagy, et al., 2002; Suchman, et al., 2010),. This understanding has been the basis for which attachment-based parenting interventions for substance dependent mothers have been developed. These interventions work to facilitate attachment between mother and child by fostering the mother's maternal sensitivity and responsiveness through improving her ability to mentally represent herself and the child, and by helping her identify the meaning behind the child's behavior and respond to her child at that level. This in turn will lead to improved representational images of the child and herself as the caregiver (Bick, Bernard,

& Dozier, 2013; Slade, 2007; Suchman, et al., 2013). These interventions have grown out of a deepening understanding of maternal empathy in connection with a mother's capacity for insight into her child's mental state, her relational experiences and mental state as a caregiver (Fonagy, et al., 2002; Shin, Park, Ryu, & Seomun, 2008; Suchman et al. 2004).

From the standpoint of mental representations, Oliver (1993) suggests, "the single most important modifying factor of intergenerational transmission of child abuse is the capacity of the child victim to grow up with the ability to face the reality of past and present personal relationships (p. 1315). Frailberg, Adelson, and Shapiro, (1975) support this view, suggesting:

> There are many parents who have themselves lived tormented childhoods who do not inflict their pain upon their children. These are the parents who say explicitly, or in effect, "I remember what it was like…I remember how afraid I was when my father exploded…I remember how I cried when they took me and my sister away to live in that home…I would never let my child go through what I went through." For these parents, the pain and suffering have not undergone total repression. In remembering, they are saved from the blind repetition of that morbid past. (p. 420, ellipses in original).

The truth for the women in the current study is that they had in fact determined not to parent their children like they had, but many found themselves repeating

similar patterns with their own children. Our understanding of *re-enactment* in relation to attachment trauma suggest that resolving and reworking trauma experiences and developing emotional regulation skills are critical to creating a subjective experience conducive to emotionally and cognitively exploring self and others. However, the intense shame that attachment trauma generates, compounded by the shame and feelings of failure in the mother role, perpetuate the "destruction of self" (Fonagy, et al., 2002, p. 13) and become a likely "trigger for violence against the self or others" (p.12); this made it virtually impossible for the women in the current study to step out of the *cycle*. It is in this light, that the lived-experience of these women is most profound; *self-forgiveness* became a way for them to explore, and take their initial step out of, the cycle. For many substance dependent women feelings of guilt, grief, and shame engulf their mothering experience (Coyer, 2001; Ehrmin, 2001). It has been suggested that unless women are encouraged to explore the negative and/or challenging aspects of their mothering experience they will likely be ill-prepared to resume the mother role (Maluccio & Ainsworth, 2003; Tracy & Martin, 2007; Wells & Guo, 2006), notwithstanding, unresolved guilt and shame, particularly with respect to their perceptions of failure in the mother-role, will greatly influence their recovery efforts and make it especially difficult to explore the mother-child relationship.

However, much like the body's response to a physical wound, the women's draw toward *self-forgiveness* seemed to reflect an innate, astonishing, and persistent capacity to seek healing. As they experienced an increased self-

acceptance and self-compassion through *self-forgiveness,* the women both desired, and began, to reflect on their mothering experience and the child's mental experience. This act not only guided the women toward identifying ways to parent differently, but answered Frailberg, et al.'s decades old question, "*Why doesn't this mother hear her baby's cry*?" (Frailberg, et al., 1975, p.394, emphasis in original). Like swaddling cloths wrapped too tight, the shame, trauma, pain, and addiction had restricted "the Limbs any Liberty, to act and exert themselves in the free easy Manner they ought" (Cadogen, 1748, p.10; as cited in "Swaddling" n.d.). The inherent responsibility attached to "knowing" how her child was, was unbearable without the ability to provide a solution. Self-forgiveness provided a refuge in which the women could begin to safely remove the cloths. With each unwrap, they began to believe in the possibility *to act*; within that possibility, she could finally hear her child's cry. It was in this desire, and emerging ability, to mentalize herself and her child, the women began to identify meaning behind their children's behavior and consider how to respond. This signaled a reworking of the women's internal working model of self and others that allowed them to explore and accept their relational patterns with their children and enter into their children's feelings without avoidant defenses and being overcome by shame; an indicator of positive transformation in the representational images of the child and herself as the caregiver.

Research & Clinical Implications

A critical component within attachment-based parenting interventions is the mother-clinician therapeutic alliance through which the mother feels safe

enough to examine denied or distorted mental representations of herself and of the child. This *safe alliance* was also a cornerstone in the women's lived experience of *self-forgiveness*, *looking back*, *looking forward*, and a *sense of closure*. The women repeatedly echoed the importance of how the other mothers who shared honestly about their mothering experiences provided them a model and an avenue to learn how to self-forgive that gave them permission to begin exploring their pasts and their own self-forgiveness. Although the study was designed to explore the *experience of being a mom in traditional residential treatment program*, I am acutely aware my very presence altered the women's treatment experience. Not only did the interviews create a time and space for the women to talk about their mothering experience, but my willingness to share openly about my own experiences with addiction and parenting seemed, at times, to allow the women to speak the unspeakable. Although there were a number of occasions I was humbled by, and fully aware, *these words had not been spoken before*, an especially powerful moment was when Amaya shared that she had quit using substances and smoking during her pregnancy; I responded, "you did better than me", to which she shared "well I smoked, secretly though." I wondered, if I could say the truth, and be *forgiven*, did she believe she could as well. Was it under this possibility, this protection, that she was not only able to *look back*, but *say it out loud*? This begs the question, what role does self-forgiveness play within the treatment of substance dependent mothers?

Although research in the area of self-forgiveness is relatively young, and the mechanisms by which self-forgiveness operates in recovery from substance

dependence are unclear, preliminary evidence suggests that increasing one's purpose in life by addressing the shame and guilt may play and an important role (Scherer, et al., 2004, Wei-Fen, Mack, Enright, & Baskin, 2004, McGaffin, Lyons, & Deane, 2013). A recent study by Scherer et al., (2004) found that individuals engaged in standard alcohol treatment who were exposed to a three 90- minute self-forgiveness intervention over three consecutive weeks reported more positive gains on measures of self-forgiveness and drinking refusal efficacy, as well as decreased amounts guilt and shame over alcohol-related offenses than the treatment-as-usual group. Similarly, McGaffin, et al. (2013) found that if individuals in residential treatment for substance abuse were able to "sit with (accept)", rather than "avoid unpleasant emotions towards the self in shame, and past transgressions in guilt" (p. 402), they may increase their propensity to self-forgive. Moreover, they reported that higher measures of dispositional shame were negatively associated with self-forgiveness, suggesting that shame-proneness may increase personal distress and inhibit self-acceptance, potentially keeping the individual focused on their discomfort, increase the likelihood of relapse, and decrease the likelihood to self-forgive.

Although I have been unable to find any research exploring how self-forgiveness interventions may augment traditional treatment approaches and/or specialized interventions, such as attachment-based parenting, for substance dependent mothers, a recent study published by Hernandez & Mendoza (2011) reported that women who were in treatment for substance abuse who participated in a 10-week psycho-educational curriculum based on Brown's Shame Resilience

Theory (2006) reported higher levels of general health and well-being, reduced levels of depressive symptoms, reduced levels of internalized shame, increased self-esteem, reduced levels of shame self-talk, and reduced levels of blame self-talk. Brown (2006) suggests that addressing the topic of shame in the context of substance abuse treatment might be a viable way to assist women in acquiring knowledge and skills that lead to shame resilience, because the "main concerns related to shame are the feelings of being trapped, powerless, and isolated" (p. 45) and that the "intricate weaving" of these concepts makes shame powerful, complex, and often difficult to manage (p. 46). There is also some evidence to support that shame is a "gender-responsive" phenomenon. Tangney and Dearing (2002) discovered that regardless of age, females "consistently report greater levels of shame than their male counterparts" (p. 154; as cited in Hernandez & Mendoza, 2011), underscoring the importance of further understanding shame and its impact on women. Moreover, for substance dependent women shame is often compounded because of the stigma society casts on women who violate social or cultural expectations of what a woman is and is not, and what she should do and should not do; this is especially true for substance dependent mothers. Alongside the lived-experience of the women in the current study, this research outlines the potential of further exploring the relationship between shame and self- forgiveness, and its role in the lives and healing of substance dependent mothers, and by extension, their children.

In closing, together with the literature reviewed in this thesis, the women's *lived-experience* provide the reader a rich description and understanding of the

experience of being a substance dependent mother in treatment, and underscores the value for any clinical setting working with substance dependent mothers to offer staff training in attachment-based assessment and interventions, while maintaining a nurturing environment that provides comprehensive support for mothers through such measures as creating time and space to talk about issues related specifically to motherhood, facilitating access to practical parenting resources and family counseling, and providing authentic, non-judgemental support to explore self-forgiveness, trauma, early-childhood experiences and shame, with an explicit understanding that women develop and experience their sense of self through *connecting* in the context of important relationships and often judge themselves by their ability to care about people around them (Gilligan, 1982; Jordan, et al., 1991; Surrey, 1985). Moreover, service providers should play an important role in supporting and advocating for multi-level health strategies that facilitate the continued growth and healing in the lives of mothers and their children beyond the treatment setting. It is well understood that individual behavior is shaped by a complex set of factors both embedded in, and perpetuated by social-environment (Wilkinson & Marmot, 1998; PHAC, 2004). All of the women in this study have numerous recognized barriers to health, such as homelessness, poverty, broken social networks, unsafe-often violent environments, and low-levels of education (PHAC, 2004); as such it is critical that service providers support these women beyond the inter and intra-personal processes that inhere within the mother-child relationship, and work toward

developing a continuum of services that address the conditions which more often than not, determine behavior in the first place.

Limitations

Although member checks were a part of the study design, the most significant limitation of the study was that no participant provided feedback about the final analysis or manuscript. All participants were invited to remain engaged in the study after they had left treatment, and were provided the researcher's contact information in order to receive a copy of the final draft and give feedback if they chose; no one did. To this end a peer reviewer was recruited to ensure trustworthiness and to debrief the experience and bring a fresh perspective to the analysis and challenge assumptions held by the researcher.

Although typical sample sizes for phenomenological studies range from 1 to 10 persons (Starks, et al., 2007), the lived experience of the six participants may not necessarily represent the experiences of all substance dependent mothers. Moreover, two women left treatment unexpectedly; limiting the researcher's ability to gather data that reflected the whole treatment experience. However, because the occurrence of drop-out is relatively common among women in substance abuse treatment, this was accounted for in the design. Decisions regarding the use of data if a participant should leave treatment early was made during their initial meeting; all the participants agreed to their data remaining in the study if they were to leave treatment early.

Lastly, the study intended to gather 'artistic expressions' of the mothers' lived-experience. It was hoped that they would be a valuable source for

experiential material because the products of art give shape to lived experience; moreover they would serve as an additional data source to the interviews. However, none were provided. The 'artistic expression' was not mandatory; the women were simply told, if they would like to do this, they could. All of the women indicated they were interested, but as the study progressed it became evident that the women were often overwhelmed with therapeutic assignments and busy with the day-to-day scheduling of the program. In the future, it would be recommended that a time and space be created for the participants to engage in 'artistic expression'.

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Appendices

Appendix A
Interview Guide

Interview Guide

Phenomenological Question

'Being a Mom' in Treatment

- Please describe what 'being a mom' means to you
- Please describe how 'being a mom' fits into treatment and/or your recovery
- Please describe what 'being a mom' in treatment is like for you
- Describe how you "be a mom" in treatment
- Describe how 'being a mom' affects your treatment
- Describe how treatment affects you, and/or your role, as a mother

Contextual Questions

Personal History

- Please tell me about yourself

Drug and Alcohol History

- Please tell me about your history with drugs and/or alcohol

Treatment History

- Please tell me about your treatment history
- Please tell me about why you decided to enter into treatment now
- Please describe how you are feeling about being in treatment

Parenting History/ Child(ren)

- Please tell me about your child(ren)
- Please describe your child(ren)'s living arrangement prior to you entering treatment
- Please describe your child(ren)'s living situation while you are in treatment
- Please describe what being a mom has been like for you
- Tell me about what you would like to see or hope to happen with you and your children and/or your relationship with them

Appendix B
Letter of Introduction

Serena Campbell-Barnes
2936-67 Ave
Lloydminster, Alberta, T9V3H8
Phone: (780) 874-9931

Date, October 25, 2011

Dr. Lisa M. Luciano
Director of Clinical Services
Thorpe Recovery Centre
4204 - 54 Avenue
Lloydminster, Alberta T9V 2R6

Dear Dr. Lisa M. Luciano
The purpose of this letter is to introduce myself and ask you to consider allowing me to conduct research within your agency. I am presently working toward a Master's Degree in Health Promotion at the University of Alberta. Please find attached my resume showing my education and professional background.
I am conducting a study exploring the treatment experiences of substance-dependent mothers. I am recruiting women who are enrolled in mixed-gender substance abuse treatment program, who have at least one child aged 16 years or younger, to participate in three or more in-depth interviews. The interviews will explore what it's like for these women to experience, define, and express "self as a mother' within a traditional residential substance abuse treatment program. During an approximately a three month period I hope to recruit three to five women to participate in the study. All individuals involved in this study will remain anonymous, and all information collected will be managed with a professional standard of confidentiality. The identification of your agency within the research findings will be managed at your discretion.
With your permission I would like to present my research proposal to you and subsequently to appropriate program staff to request their assistance in the recruitment of study participants. All interviews would occur within the center and would be scheduled as to not conflict with client programming. A full description of the treatment program will be included in the final manuscript following a review of relevant documents including procedural and program manuals and policy documents, and informal interviews with program staff. The information collected in the study will be shared with my dissertation committee, peer reviewers and other

appropriate members of the University of Alberta. The results of this research will be made fully available to you via the final manuscript and a presentation to your program staff. They may also be published and/or presented by the researcher to other human service professionals in meetings, workshops, or conferences.
I have enclosed a working draft of the research proposal and related documents for your review. Please feel free to contact me if you have any further questions. I look forward to discussing this project with you in person and/or by telephone. Thank-you for your time and consideration.

Sincerely,
Serena Campbell-Barnes

Appendix C
Study Flyer

Are you a Mother in Treatment?

"Being a Mom" in a Mixed-Gendered Residential Substance Abuse Treatment Program

If you are a woman, aged *18* years or older, who is currently in treatment for a substance abuse disorder, and have at least one child aged 16 years or younger, You are invited to participate in a research project exploring what it's like to be a mother in treatment. The researcher will be interviewing women while they are enrolled in the Thorpe Recovery Center. You will be asked to participate in approximately three interviews.

If you would like to learn more about the study, please contact the researcher directly at the phone number provided below, or speak to your Addictions Counselor to schedule a meeting. You will receive a small thank-you gift for your participation in this study. Confidentiality will be respected.

Contact Information of Researcher

Serena Campbell-Barnes, BA

Phone Number: (780) 874-9931

Lloydminster, Alberta

Appendix D
Information Letter

Title: 'Being a Mom" in a Mixed-Gendered Residential Substance Abuse Treatment Program

Investigator: Serena Campbell-Barnes, BA Psyc.

Centre for Health Promotion

University of Alberta

Edmonton, Alberta, Canada

serena.barnes@shaw.ca

(780) 874-9931

Supervisor: Dr. Cameron Wild

Addiction and Mental Health Research Laboratory

University of Alberta

Edmonton, Alberta

cam.wild@ulaberta.ca

(780) 492-6752

Please ask the researcher to explain any words or information that you do not clearly understand. You make take an unsigned copy of this consent form to think about and/or discuss with your counselor, family or friends before making a decision.

Purpose of the Study

You are being invited to participate in a research study exploring the experiences of mothers in a mixed-gender residential substance abuse treatment program. I am interested in learning what it is like for you being a mother in treatment. This

study will be used in support of my Master's Degree in Health Promotion at the University of Alberta.

The results of this research will be presented to the treatment program you are in. Program staff will receive a final written report and a presentation of the study results. The study results may also be published in a peer reviewed journal and/or presented by the researcher to other organizations and/or individuals who are interested in the experiences of substance dependent women. I hope that the results of this study will help individuals and organizations interested in the experiences of substance dependent women better understand what it's like to be a mother in treatment and how to best support mothers while they are in treatment

Study Procedure

If you decide to participate you will be 1 of up to 5 women participating in the study. You will be asked to take part in three or more interviews. You will be asked to meet with the interviewer approximately every other week during your stay in the treatment program. The interviews will last about 90 minutes. The interviews will be more like discussions than question and answer. You will be asked to talk about your experiences with substance use, parenting, substance abuse treatment, and what it's like being a mom in treatment. You will also be asked to describe what it's like for you being a mom in treatment through an art form such as poetry, drawing or collages. You will be asked to create this artwork on your own time during the week spending as much or as little time on it as you want. Any materials you need will be accessed through the program and/or provided by the researcher. With your permission all interviews will be audio-recorded and I will keep a copy of any art you create.

If you decide to participate you will be invited to stay involved in the study after you have left treatment in order for me to find out what you think about the study results and/or to receive a copy of the final report. If you are interested in providing feedback to the researcher, engaging in future presentations of study

and/or receiving a copy of the final research report, please supply your contact information. You will also receive the researcher's contact information.

Benefits

Although you may not benefit directly from this study, you may benefit from being able to tell your story and to shed light on the experiences of motherhood in a mixed-gender addiction treatment program, which will help organizations and individuals who work with substance dependent women better understand what it's like to be mother in treatment and how to support mothers in treatment.

Risks

You may feel uncomfortable because of the types of interview questions. I will ask you questions about your substance use, substance abuse treatment, being a mom, and 'being a mom' in treatment.

Payment for Participation

You will receive a small thank-you gift for your participation in this study following your last interview. You will receive a gift even if you choose to leave the study early.

Voluntary Participation

You do not have to participate in this study. Participation is completely your choice. Your decision will not affect your relationship with program staff and/or access to the program. If you choose to participate, you do not have to answer any questions or take part in any artistic expression you are not comfortable with. You can quit the study at any time. In the case that you leave treatment early you will decide whether you want your information removed from the study, or if you would like your information to be used in the study.

Confidentiality & Anonymity

Every effort will be made to ensure that your identity and the information you provide is protected and cannot be traced back to you. The signed consent form may be inspected and copied by the University of Alberta University Research Ethics Board. Because of the potential need to release this information to this third party, I cannot promise absolute confidentiality. However, only a false name that you choose and the date of the interview will identify you on the audio recording and the written version of the interview. All audio recordings will be transferred onto my personal computer and an external hard-drive located in my home office.

All research related documents will be kept in a locked filing cabinet in my home office. I am the only person with access to this filing cabinet. Copies and/or photos of your art will be stored in my home office. Original art work will remain with you. All digitally compatible data will be transferred onto my personal computer. All study materials will be destroyed after a minimum of five years after I complete my Master's Thesis.

The results of this study will be presented to the University of Alberta at a thesis defense and in a thesis manuscript. The results will also be presented to the substance abuse treatment program you are in and possibly to other organizations that work with substance dependent women. Your identity will not be shared in any presentations. Only the false name you choose will be used.

Further Information

The plan for this study has been reviewed for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta. If you have any more questions about this study, please contact the researcher, Serena Campbell-Barnes, at (780) 874-9931 or serena.barnes@shaw.ca. If you have any concerns about the study that you are not comfortable, or choose not to discuss with the researcher, or if you have questions regarding your rights and ethical conduct of

research, contact the University of Alberta's Research Ethics Office at (780) 492-2615.

Participant's Signature Date

Investigator's Signature Date

A copy of this participant information sheet has been given to you to keep for your records and reference.

Appendix E
Consent Form

Project title: 'Being a Mom" in a Mixed-Gendered Residential Substance Abuse Treatment Program

Researcher: Serena Campbell-Barnes, BA Psyc., Centre for Health Promotion, University of Alberta, Edmonton, Alberta, Canada. Email: serena.barnes@shaw.ca; Phone: (780) 874-9931; Cameron Wild, PhD., Supervisor, Email: cam.wild@ualberta.ca, Phone: (780) 492-6752

- I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me. I understand and agree to take part. _____

- I understand the purpose of the research project and my involvement in it. _____

- I understand the benefits and risks to participation. _____

- I understand that I may withdraw from the research project at any stage and that this will not affect my status in the treatment program now or in the future. _____

- I understand that I am consenting to participate in an interview; I understand that I will be audiotaped during the interview and written notes will be taken by the researcher. _____

- Has the issue of confidentiality been explained to you? ( ) Yes ( ) No

- Do you understand who will have access to the information you provide? ( ) Yes ( ) No

- I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential. _____

- Would you like an opportunity to provide feedback to the researcher about her interpretation and understanding of your experience prior to the final report?
  ( ) Yes ( ) No.

- Would you like to receive a copy of the final manuscript? ( ) Yes ( ) No.

- Would you be interested in being involved in future presentations of the study results?
  ( ) Yes ( ) No.

- If you withdraw, can the researcher use the data that you contributed to the point at which you withdraw? ( ) Yes ( ) No. Conversely, if you withdraw, would you like to have all of your data destroyed? ( ) Yes ( ) No.

Name of participant_____

Signed_____ **Date**_____

I have provided information about the research to the research participant and believe that he/she understands what is involved.

Researcher's signature and date_____

The plan for this study has been reviewed for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta. If you have any concerns about the study that you are not comfortable, or choose not to discuss with the researcher,

or if you have questions regarding your rights and ethical conduct of research, contact the University of Alberta's Research Ethics Office at (780) 492-2615.

Appendix F
Peer Reviewer

I have a Bachelor of Social Work Degree (1996) from the University of Regina, Saskatchewan. In 2004 I completed my Master of Social Work Degree with a specialization in Clinical Practice from the University of Calgary. During my Master's Degree I further specialized in the treatment of Post-Traumatic Stress Disorder. Since graduation I continued to attend conferences on trauma and did research on trauma treatment in order to stay current with Best Practices for trauma therapy.

My work experience includes working in the field of Child Protection, Young Offenders, Elder Abuse and Medical Social work. However, I secured a position as a Family Therapist for Catholic Social Services and from there went into a career of a Mental Health Therapist. The concurrent treatment of Mental Health and Addiction treatment was recognized as Best Practice for people suffering with both these disorders. Therefore I attended conferences and did research on concurrent treatment for Mental Health and Addictions. Currently I am not working due to a disability but I do volunteer work at Thorpe Recovery Centre in Lloydminster, AB. I co- facilitate a Seeking Safety group which provides psychoeducation regarding trauma and addiction. I also provide trauma therapy to some individual clients who are suffering from severe, chronic Post Traumatic Stress Disorder.

My personal life journey lead me into the field of trauma treatment. In my family of origin my father was physically, emotionally and sexually abusive to

both my mother and myself. On several occasions he threatened our lives with knives and guns. My father did not suffer from addictions but was mentally ill. Many times he threatened suicide and homicide. My mother was emotionally disconnected and there was no mother- daughter bonding between us. My mother was oblivious to the abuse I endured and therefore failed to protect. At the age of 15 years I became pregnant and married the father of my son. The cycle of abuse continued with me lacking "good enough" parenting skills and been emotionally unstable and unavailable to my son. My son's father was an alcoholic, emotionally abusive and lacked attachment to our son.

After four years of marriage both my husband and I began a healing journey. We developed a personal relationship with God and became actively involved in a community of Christian believers. As well, I received therapy for Post-Traumatic Stress Disorder. I needed to heal from the abuse I received as a child and the abuse I inflicted on my sons.

The research Serena did resonates deeply with me both on a personal level and as professional trauma therapist. The themes of shame, self-forgiveness and forgiveness to my abusers were major areas of healing that I also desperately needed. As the research paper so clearly articulated self-esteem and learning how to be an emotionally healthy woman/ mother were crucial to my wellbeing. The life stories of these women that participated in the research was inspiring, their willingness to honestly share their pain, shame and journey to self-forgiveness

was a testimony to the courage and determination of these remarkable women.

Marilyn Kerr B.S.W., M.S.W., R.S.W.