

**DRUGS AND HAVING BABIES: AN EXPLORATION OF HOW  
A SPECIALIST CLINIC MEETS THE NEEDS  
OF CHEMICALLY DEPENDENT PREGNANT WOMEN**

Submitted by

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A thesis submitted in total fulfilment of the requirements for the degree of  
Doctor of Philosophy

School of Nursing and Midwifery

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December 2009

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## **STATEMENT OF AUTHORSHIP AND SOURCES**

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma.

No parts of this thesis have been submitted towards the award of any other degree or diploma in any other tertiary institution.

No other person's work has been used without due acknowledgment in the main text of the thesis.

All research procedures reported in the thesis received the approval of the relevant Ethics/Safety Committees (where required).

.....

## DEDICATION

To my paternal grandmother, Hannah Sarah Morris, who showed me what miracles can bring when coupled with an immeasurable depth in relationship, love and support.

I said to the man who stood at the gate of the year  
'Give me a light that I may tread safely into the unknown.'  
And he replied, 'Go into the darkness and put your hand into  
the hand of God  
That shall be to you better than light and safer than a known way!'

Minnie Haskins (1908) *The Gate of the Year*

and

To my Finals Tutor at the Royal Adelaide Hospital, Sr. Mary Weston, who showed me that when strength of intellect is combined with courage and moral rectitude, the result is surprisingly soft and enduringly gentle.

May the roads rise to meet you,  
May the winds be always at your back,  
May the sun shine warm upon your face,  
The rains fall soft upon your fields,  
And until we meet again  
May God hold you in the hollow of His hand.

*An Irish blessing prayer*

## ACKNOWLEDGEMENTS

First, my grateful thanks to the twenty participants whose narratives and experiences both humbled and inspired me, and whose contributions made the study possible. I also wish to acknowledge and thank the following people:

...the principal supervisor, Associate Professor Carmel Seibold for her determined and diligent supervision.

...Professor Ruth Webber who provided me with valuable critique in her role as second supervisor.

...to Dr. Pat Bazeley who gave me support, guidance and selfless hospitality at vital times during my candidature.

...to Liz Ryan, late of the ACU Research Office for sound advice and relentless commonsense.

...to the librarians and library staff at the Raheen Library, St. Patricks' Campus

...my husband Bryan Noakes who provided me with emotional support, motivation and for his belief in the power of language.

...to my daughter Philippa for her creative talents and my son Alastair for his formatting expertise, both always helping me to keep the study in perspective.

...to those friends and work colleagues who supported, tolerated and encouraged me in numerous ways, especially when I got stressed and 'out of sorts'.

This study was a joint initiative of the Australian Catholic University and the Mercy Hospital for Women. It was funded by an Australian Research Council Strategic Partnership with an Industry Research and Training (formerly Linkage) grant.

## **ABSTRACT**

This study sought to evaluate the care provided to chemically dependent pregnant women by a specialist clinic, the Transitions Clinic of the Mercy Hospital for Women, a major Victorian metropolitan women's hospital. A critical ethnographic approach informed by critical, feminist and postmodern perspectives, namely Habermas, Foucault and feminist interpretations of Foucault, was employed. During the process of data analysis I was also drawn to the existential theorists, Frankl and Yalom. Twenty women were interviewed three times (twice prior to giving birth and once post birth). As well, interactions between clinic staff and the women were observed over a twenty-five month period, field notes were taken and medical records accessed.

This thesis addresses a gap in the literature in regard to chemically dependent women and their response to pregnancy, antenatal care and birth. It argues that most of the women, to varying degrees and despite significant problems, negotiated strategies for recovery and the development of a 'mother identity'. This was despite the fact that fifteen of the women had significant predisposing factors that had influenced development and maintenance of their chemical dependency. At the time of becoming pregnant most felt rejected by the wider society, were largely alienated from it and as a result had become immersed in the drug culture, which for some provided a sense of identity, albeit deviant. While the women's experiences of pregnancy were variable, a number used pregnancy and impending motherhood to construct a sense of self and discover what was possible for them. For this group pregnancy became a focus for change and transformation, but for

others less so. The women's relationships with the clinic staff reflected their responses to care. Initially the women believed that power was exercised in all aspects of their care without consideration of what they had to offer in terms of life experiences and skills. However as their pregnancies advanced and they explored possibilities for collaboration they came to accept that they could also exercise power and a degree of control over their lives, instead of being subjected to a paternalistic approach to care. This resulted in the negotiation of a more egalitarian relationship with the clinic staff, particularly the midwives. For the majority of the women their level of motivation towards ongoing care and recovery matched the level of collaboration achieved. Pregnancy appeared to be a turning point for thirteen women with pregnancy and the birth of a child appearing to provide them with a deeper connection to life thus helping them to overcome feelings of despair and helplessness and assisting them to employ active rather than passive approaches to managing their life choices and life chances. This thesis emphasises the importance of an individualised approach to care, the need for clinic staff to work in partnership with the women and the importance of building up trust and addressing power issues. As such it has value for health care professionals caring for this vulnerable group of women.

## **CHAPTER ONE**

### **INTRODUCTION: SETTING THE SCENE**

Having someone listen to me and care about my story was  
like sitting in the sun for a time (Maggie)

#### **INTRODUCTION**

This introductory chapter provides a frame of reference and background to an ethnographic study of twenty chemically dependent pregnant women who attended a specialist antenatal clinic in a Victorian public hospital. The ethnography is theoretically informed by critical, feminist and postmodern perspectives which help guide analysis of the women's accounts of how they coped with the challenges of substance abuse and pregnancy. Following an overview of the origins and purpose of the study, the theoretical and methodological foundations are briefly outlined in order to set the scene.

#### **BACKGROUND TO THE STUDY**

The tangible social cost of drug use in Australia has been estimated to be \$18.3 billion or approximately 5.5 per cent of gross domestic product in 1998-1999 (Collins & Lapsley, 2002). It is known that drug use and misuse contributes to illness and disease, workplace injury concerns, violence, crime and breakdown in families in Australia (Commonwealth of Australia, 2005; Hamilton, King & Ritter, 2004; Ross, 2007).

The occurrence of illicit drug use by chemically dependent pregnant women in Australia is between 8 per cent and 17 per cent (AIHW, 2005). However, these figures are likely to be conservative as many cases go unreported. Licit drug use, including tobacco and alcohol is higher still.



Births in mothers with opioid, stimulant and cannabis diagnoses were also associated with several negative neonatal outcomes. Babies born to these mothers were more likely to be born before the gestational age of 37 weeks, to be of low birthweight, and to be admitted to neonatal intensive care units or to special care nurseries (Chavkin, 1990; Forrester & Harwin, 2006).

Pregnant women who use substances are at risk of developing physical, mental and social problems (Walton-Moss & McCaul, 2006). Maternal health problems include risks of human immunodeficiency virus transmission (Shieh & Kravitz, 2006), sexually transmitted diseases, hepatitis, spontaneous abortions and malnutrition (Lutz, 2005; Volpicelli, Markman, Monterosso, Filing & O'Brien, 2000). In addition to physical health problems, women who engage in use of substances are also likely to be subjected to physical and sexual abuse and also to suffer severe depression (Pajulo, Savonlahti, Sourander, Helenius & Piha, 2001).

A number of studies have identified certain factors in the lives of women – including pregnant women – that may increase their risk of substance abuse. These include a history of childhood sexual abuse and troubled relationships in both the family of origin and current relationships, leading to depression and poor self-esteem (Finkelstein, 1996; Benedict, 1990; Brown & Finkelhor, 1986; Rohsenow, Corbitt & Devine, 1998); family history of alcohol or drug problems (Brems & Namyniuk, 2002; Daley et al., 1997; Zilberman, Tavares, Blume & el-Guebaly, 2003); having a chemically dependent partner (Anglin, Hser & Booth, 1998; Bresnahan, Zuckerman & Cabral, 1992; Swift, Copeland & Hall, 1996); chronic anxiety and depression (Finkelstein, 1996; Jarvis & Schnoll, 1995; Zilberman et al., 2003); being a victim of violence (Freeman, Collier & Parillo, 2002;

Ouimette, Kimerling, Shaw & Moos, 2000); lack of family and social support (Cohen & McKay, 1984; Gabe, 1991; Marsh & Miller, 1985); homelessness and/or transiency (Fischer, 1989; Fischer & Breakey, 1991; Galaif, Nyamathi & Stein, 1999; Milburn & Booth, 1988). In America, Eiden, Foote and Schuetze (2006) found that women who used cocaine during pregnancy had higher perinatal risks, higher childhood trauma and more psychiatric symptoms than women who did not use cocaine. The results highlighted the importance of addressing childhood trauma issues and current psychiatric symptoms in substance abuse treatment with women who engage in substance use during pregnancy.

Chemical dependency often goes hand in hand with a chaotic lifestyle and marginalisation from mainstream society. A woman who uses drugs is often considered doubly deviant within society (Broom & Stephens, 1990); she has transgressed not only the law or general social convention, but she has specifically violated the norms of being a "good woman". Her drinking and drug use opens her to suspicion of sexual promiscuity or prostitution and incompetence as a mother and wife. Addiction or alcoholism among males, by contrast, is more or less accepted as a "social fact" (Fillmore, 1984) of masculine excess. In women, such problems are viewed as profound threats to the social order. This can result in more oppressive responses to their drug use (Jones, 2006). Women also deal with the common perception of society related to their behaviour and its effect on their babies.

There is a persistent belief that the children of chemically dependent mothers will be at risk (Fischer et al., 2006; Lester, Andreozzi & Appiah, 2004; Murphy & Rosenbaum, 1999), and there is a public perception that chemically dependent pregnant women are unconcerned and uncaring about birth outcomes, but anecdotal evidence and emerging

research data suggest otherwise (Ezerd, 1998; Hall & van Teijlingen, 2006; Mitchell, Hall, Campbell & van Teijlingen, 2003).

As many chemically dependent pregnant women are polydrug users (using three or more licit and/or illicit drugs) it is difficult to competently identify the consequences for the infant of perinatal substance abuse. There is a growing body of evidence of the relationship between smoking and poor birth outcomes (AIHW, 2005; Kleinman, Pierre, Madans, Land & Schramm, 1998; NSW Dept Health, 2006; Oster, Aldea & Colditz, 1998; Shiona, Klebanoff & Rhoad, 1986), and between heavy alcohol use and disability (Barr & Streissguth, 2001; Streissguth, Barr, Sampson & Bookstein 1994, cited in Howell, Heiser & Harrington, 1999). Heroin use throughout pregnancy is associated with foetal growth restriction, miscarriage, stillbirth and premature labour (Chavkin, 1990; Jones, 2006). Early and appropriate intervention in the form of specialist care can mean far better outcomes for mother and baby (Jones, 2006). Chasnoff (1992) and Hjerkin, Lindbaek and Rosvold (2007) reported that women who used drugs during pregnancy and received antenatal care had newborns with higher birth weights than those women who used drugs and did not receive antenatal care.

Like hospitals in the U.K. (Siney, 1995; Lewis, Klee & Jackson, 1995), Victorian women's hospitals recognised the need in the 1980s to develop clinics which were specially designed to cater for the complex needs of this group of women. A Chemical Dependency Unit for pregnant women was established at the Royal Women's Hospital in Melbourne in 1985. In 1999 there was a move to decentralise the service because of the increase in the demand for it across the state and the availability of funding in relation to Maternity Enhancement Strategy. This led to a number of special services and clinics

being established in several major maternity hospitals including the Mercy Hospital for Women.

### **The Transitions Clinic**

The Transitions Clinic at the Mercy Hospital for Women in East Melbourne was established in 2000 and commenced operating on 6<sup>th</sup> May of that year. It seeks to meet the needs of chemically dependent pregnant women, pregnant Koori women and young mothers-to-be. The Clinic is a specialist outpatient unit attached to the Mercy Hospital for Women which is currently situated in Heidelberg, Victoria; it is held twice a week when women accessing its services are able to confer with obstetricians, midwives and other specialised nursing staff, social workers, dietitians, parenting and child-birth educators.

The Transitions Clinic, in meeting the needs of chemically dependent pregnant women, offers care which is “comprehensive, coordinated, family-centred and holistic” (Finkelstein, 1996). The Clinic has a multi-disciplinary team of two obstetricians (Methadone prescribers), a paediatrician, a psychiatrist and psychologist, two social workers, two midwives, one midwife/birth educator, a Koori liaison officer, a dietitian and a post-graduate research student. The Clinic provides a staged process of recovery through stabilisation on Methadone Maintenance Therapy (MMT), along with other treatment options. The women are provided with antenatal and postnatal care and monitored in a localised environment. Care includes childbirth education, social, financial and psychological support and referral to community agencies. Harm minimisation, the strategy adopted (which will be discussed in chapter 3), assumes that risk behaviour persists despite education and legislation, and so aims to minimise adverse results by working with women to improve health outcomes. A harm minimisation philosophy,

therefore, assumes that any meaningful change in the woman's life "is likely to be rather protracted where advances and setbacks are an expected part of the journey" (Marlatt, Blume & Parks, 2001, p. 17).

## **HOW THE STUDY WAS INITIATED**

This study was a joint initiative of the Mercy Hospital for Women and the Australian Catholic University (ACU) National and was funded by an Australian Research Council Strategic Partnership with an Industry Research and Training (SPIRT) (now Linkage) grant. Approval for this research project was granted by the Australian Catholic University's Human Ethics Research Committee on 2<sup>nd</sup> July, 2001 and the Human Research Ethics Committee of the Mercy Hospital for Women on 2<sup>nd</sup> August 2001 (see Appendix A for the Ethical Approval Statements). The study commenced in February 2001, but was suspended at the end of 2002 when the first doctoral candidate was unable to continue. The study recommenced in November 2003 when I joined the project.

## **PURPOSE OF THE STUDY**

The purpose of the study was to evaluate the care provided to chemically dependent pregnant women by the Transitions Clinic of the Mercy Hospital for Women, a major metropolitan women's hospital. Related aims were to:

- Provide rich descriptions of the range of problems chemically dependent pregnant women face;
- Identify the extent to which chemically dependent pregnant women believe the services offered by the Transitions Clinic at the Mercy Hospital for Women meet their own and their family's needs;

- Assess whether pregnancy is a time of transition or a turning point in the lives of some of the women.

## **GETTING IN**

As already mentioned, I joined the project after it had been initiated and spent some time considering the approach that would best work for me. As part of this reflection, I reviewed the methodology (ethnography) and tradition (qualitative research) selected for undertaking the study. Qualitative research both requires and provides great flexibility in approach (Patton, 2002; Strauss & Corbin, 1990), and a huge investment of time and this certainly proved to be the case, as appointments often had to be rescheduled three or four times in order to interview the participants because as a number of the women had a cavalier attitude to time-keeping.

I also identified the capacity of qualitative research to not only generate “new knowledge”, but also to “inform critically public policies, existent social movements and daily community life” (Fine & Weiss, 1996, pp. 264-265). This then has the potential to produce new knowledge relevant to the problems that chemically dependent pregnant women face, the way in which they are cared for within the healthcare system and the influence of pregnancy on their substance use.

With this in mind, the research was planned and undertaken within the tradition of critical ethnography. According to Thomas (2003), critical ethnography is not a theory but a perspective through which a qualitative researcher can frame questions and also promote action. Since critical ethnography has its origins in the theoretical foundations of critical theory, it is premised upon the assumption that cultural institutions can produce a false

consciousness in which power and knowledge together with oppression become taken-for-granted 'realities' or ideologies. In this way, critical ethnography goes beyond a description of the culture to action for change, by challenging the false consciousness and ideologies exposed through the research.

New insights and alternative understandings of chemically dependent pregnant women did emerge when a critical ethnographic approach was applied. Contrary to the stereotypical view of manipulative, inadequate individuals, the participants in this study are shown in many instances to be rational, active women making decisions based on the contingencies of both their substance abuse and their secular roles in society (mother, wife, partner, employee). Such an approach also allowed for the ordinariness as well as the deviant aspects of their lives to be seen, demonstrating that the women in the study exhibited many of the same concerns, fears and hopes as other women.

### **Gaining Access**

The issue for me as the researcher when faced with the need to gain access, was how was this to be achieved with the minimum inconvenience and maximum benefit? As noted by Glesne and Peshkin (1992), it needed to be done ethically, it needed to be done wisely, and it needed to be done in a way that would ensure, or at least open up the possibility of flexibility in the context of the research questions. While some groundwork had been laid, I needed to establish my credentials as a researcher.

### **Getting On**

The negotiation regarding access for this study had already been carried out successfully and I was able to capitalise upon that. However, when I commenced data collection in

October 2004, I had to make myself known to the staff at the Transitions Clinic and this involved some effort as the previous candidate had been a staff member and was familiar with the ‘workings’ of the hospital and the Clinic. There was no orientation period for me; I learned as I went and although, with hindsight, it seemed daunting and at times precarious, it was a steep but rewarding learning curve. Mistakes were made, but not usually repeated.

## **THESIS STRUCTURE**

This thesis comprises ten chapters. Chapter 2 - The Scope of the Problem and Approaches to Treatment - expands on the background to the study and articulates the scope of the problem in more detail, including the public perception of chemically dependent pregnant women, the consequences associated with substance abuse during pregnancy, including social and environmental factors, the effect of licit and illicit drugs on the foetus, the effectiveness of specialist clinics and barriers to the women seeking and accessing antenatal care.

Chapter 3 - Understanding Drug Addiction and the Implication for Treatment in Pregnancy -explains the theories and models of addiction and their relationship to chemical dependency in pregnancy, including the trans-theoretical model (TTM) which underpins the Clinic’s philosophy and the concept and practice of harm minimisation. This chapter also examines some of the contemporary discourses of addiction which helped to frame the analysis of the women’s accounts.

Chapter 4 - Theoretical Framework - explores the theories that underpinned the study. This includes the work of Foucault, especially his innovative ideas on power-knowledge



relations, which helped to emphasise the unstable ways in which power was constantly recreated in the study. Perspectives from critical theory, particularly professional client relations and communication (Habermas, 1984), as well as several key constructs from existential philosophy helped to inform and explain the various psychological coping strategies used by some participants. For the study, I used the metaphor of the “toolbox” (Grimshaw, 1993; Manias & Street, 2000; Pahl-Wostl & Ebenhoh, 2004) to guide me in developing an intertwined theoretical and methodological framework of Foucault’s work and critical theory. Tools from each approach were manipulated in ways to suit the study. I believe each approach asks different questions and offers distinctive insights that helped address the aims of the study. The toolbox involved the research process of data gathering and refining, which encompassed the notion of critical empowerment embedded within a critical ethnographic approach.

Chapter 5, the Methodology, provides details of the critical ethnographic approach and the decision trail I followed when gathering the data. In this chapter, I also provide a framework for data analysis using the theoretical and epistemological principles described in Chapter 4. Ethical considerations for interviewing a vulnerable population are also included.

Chapters 6 to 9 present the findings and results of the research project. Chapter 6 - The Women in the Study - is the first ‘analysis’ chapter and re-introduces the twenty women, addresses the risk factors that influenced the participants’ development of chemical dependency, the influence of their chemical dependency on life choices and life chances and their initial responses to pregnancy.

Chapter 7 - Pregnancy and Birth Outcomes - focuses on their experiences of pregnancy, the motivating factors and barriers to seeking antenatal care, their responses to the planned treatment regimes, birth outcomes, and their progress towards recovery and the achievement of a 'mother identity'.

Chapter 8 - Relationships Between the Clinic Staff and the Women: The Ideal versus the Real - examines the relationship between the chemically dependent pregnant women and the staff of the Transitions Clinic, the factors that influenced relationships both positively and negatively and included differing expectations, and the way in which the Clinic architecture influenced interactions and relationships between the women and the Clinic staff, the so called paradoxical private and public spaces.

Chapter 9 - Alienation and Redemption - reports how, for some of the women, birth represented hope for the future, and discusses the extent to which the women viewed pregnancy as a turning point and a chance to claim/reclaim a socially acceptable and respectable identity. In this context it also details the women's reflections related to pregnancy, their struggle with drug addiction and their efforts towards recovery.

Chapter 10, the Conclusion revisits the aims of the study in relation to the findings, lists recommendations relating to care of chemically dependent pregnant women emanating from the study findings, and reflects, from a personal perspective, on the research process.

## **CHAPTER TWO**

### **THE SCOPE OF THE PROBLEM AND APPROACHES TO TREATMENT**

“To construct a female framework for the analysis of women’s literature,  
to develop new models based on the study of female experience,  
rather than to adopt male models and theories”.

Elaine Showalter (1979 *Women Writing and Women Writing About Women*)

### **INTRODUCTION**

This chapter provides an overview of the literature relevant to chemical dependency and pregnancy. It outlines the extent of the problem in Australia, including the most common drugs, both legal and illicit, used in pregnancy, the consequences associated with substance abuse/use during pregnancy, treatment options for chemically dependent pregnant women, factors both positive and negative influencing women’s seeking antenatal care and those antenatal services found to influence better outcomes.

### **RATES OF CHEMICAL DEPENDENCY IN PREGNANCY AND COMMON DRUGS USED**

Consistent with international research, Australian maternity units have recorded steadily increasing rates of chemical dependency in pregnancy, although these figures may represent greater preparedness for self-disclosure by pregnant women rather than increased per capita use (Murphy, 2000). It was estimated in a federal government survey that 25.6 per cent of women aged 20-29 years (and thus of typical child-bearing age), had consumed some form of illicit drugs in the 12 months prior to the survey (AIHW, 2005). However, the exact number of chemically dependent pregnant women is unknown because this statistic is based on self-disclosure of substance use. To present an estimate of the scope of the problem, recent statewide surveys of maternity hospitals in 2000 and 2004 (with an over 92 per cent response rate) consistently estimated that 1.3 per cent of all women who

presented for delivery reported some form of chemical dependency or substantial exposure to illicit drugs during their pregnancy (Craig, Oei, Kent-Biggs & Lui, 2005). In another study, up to 5 per cent of high-risk new born infants who were admitted to neo-natal intensive care units in New South Wales and the Australian Capital Territory had mothers who had used some form of illicit drugs during their pregnancy (Abdel-Latif, Bajuk, Lui & Oei, 2007).

The only domestic database is that by Kennare, Heard and Chan (2005) who found that substance use was reported by 0.8 per cent of confinements in South Australia, with 12.5 per cent of these having a history of heroin use. Australian researchers (Richardson, Bolisetty & Ingall, 2001) have noted differences in the prevalence of self-identified substance use in pregnancy between rural and metropolitan women in New South Wales, with rural women reporting an incidence of 7 per 1,000 births, a figure ten times higher than previously reported metropolitan figures. As previously mentioned, as these reports are based on self-disclosure, they are likely to significantly under-estimate prevalence. By way of example, a large study (n=8527) from the United States found 66 per cent agreement between maternal reports and positive meconium toxicology levels, suggesting that over 30 per cent of pregnant women who are chemically dependent do not disclose (Johnson, Jones & Fischer, 2003).

Illegal drug use by pregnant women is problematic. Substance use and abuse among pregnant women has changed from being viewed as a small-scale problem to a major public health concern (Chasnoff, 2005; Moore, 2006; Walton-Moss & McCaul, 2006; Zuckerman, Frank & Hingson, 1989). While chemically dependent pregnant women represent a minority of pregnancies, the impact and consequences of addiction in

pregnancy can be long-lasting and devastating (Jones, 2006). Despite the known risks for the foetus associated with substance use during pregnancy, as well as the increasing prevalence of substance use among pregnant women, screening and identifying chemically dependent pregnant women is still poor (Svikis & Reid-Quinones, 2003). This, as already noted, is compounded by the fact that many chemically dependent women are poly drug users. Their drugs of choice - licit and illicit – include alcohol, nicotine, amphetamines, cannabis, cocaine and heroin.

### **Alcohol**

Alcohol consumption is common among Australian women. In 2004, about a third of adult women reported drinking at least weekly, and this was most frequently reported by women of childbearing age (AIHW, 2005). Serious health consequences for alcohol abusing pregnant women have been reported, including nutritional deficiencies, pancreatitis, alcoholic ketoacidosis, alcoholic hepatitis, cirrhosis of the liver, precipitation of labour and deficient milk ejection (Mitchel, 1993).

There is also clear research evidence that alcohol consumption at high levels during pregnancy is a risk factor for a variety of adverse outcomes in the unborn child, (Barr & Streissguth, 2001; Broom & Stephens, 1990; Smit, 1979). A high level of consumption refers to consumption that is above the recommended levels for women as set out in the National Health and Medical Research Council Guidelines (2000/2009). The recommended levels for women are no more than 2 standard drinks per day on average, and no more than 4 standard drinks on any one day, or one or more alcohol-free days per week. Adverse outcomes can range from learning and behavioural problems to foetal alcohol syndrome (FAS), a condition that includes physical abnormalities, growth

retardation and neurological dysfunction (NH&MRC, 2000/2009). While FAS appears to be extremely rare in the Australian population as a whole, it is possible that it may be an issue of concern in some indigenous communities (O’Leary, 2002, pp. 19-22).

## **Nicotine**

The risk factor responsible for the greatest disease burden in Australia is tobacco smoking, which accounts for about 12 per cent of the total burden of disease in men and 7 per cent in women (McDermott, Russell & Dobson, 2002). Tobacco smoking contributes to higher drug-related morbidity and mortality than both alcohol and illicit drug use combined (AIHW, 2005). Reproductive health is harmed by nicotine use in men and women. There is conclusive evidence that smoking causes compromised fertility, and that parental smoking potentially has long-term and serious consequences for child health (Mathers, Vos & Stevenson, 1999; NSW Dept. Health, 2006).

Cessation of smoking during pregnancy can benefit the infant, improving birth weight and reducing the risk of prematurity. A study at maternity clinics showed that infants born to mothers who were able to stop smoking were, on average, 241 grams heavier compared with infants whose mothers did not change their smoking habit during pregnancy (Li, Windsor, Perkins, Goldenberg & Lowe, 1993). Stopping smoking prior to week 16 of pregnancy ameliorates most of the ill effects of cigarettes on the foetus, while stopping in the third trimester can have a positive impact since most of the foetal growth occurs during this period (MacArthur & Knox, 1988).

Group therapy programmes and replacement therapy with nicotine patches for medium to heavy smokers are the recommended treatments for nicotine addiction in women (Day et

al., 2003). Cognitive behavioural methods are also reported to be successful (Windsor, Boyd & Orleans, 1998).

Chemically dependent pregnant women using alcohol or illicit drugs are far more likely than abstainers to use tobacco as well (King, 1997), underscoring the problem of polydrug exposure for the foetus. The obstetrical complications of smoking cigarettes during pregnancy include an increased risk of intrauterine growth retardation, ectopic pregnancy, spontaneous abortion, premature rupture of membranes, placenta previa, abruption placentae and sudden infant death syndrome (SIDS) (Feng, 1993).

## **Cannabis**

Cannabis is the most widely used illicit drug in Australia and its use since the 1980s has continued to increase. The average age for first-time use of cannabis in 2004 was 18.7 years (AIHW, 2005), but there is evidence that this age is decreasing (Degenhardt, Hall, & Lynskey, 2000). There is considerable variation in the estimate of women who use cannabis during pregnancy (Muhuri & Gfroerer, 2008). In a large investigation of 420 middle class pregnant women in America, it was found that 3% used marijuana regularly during pregnancy (Fried, 1991).

One of the problems faced in studying the effects of cannabinoids in pregnancy and in outcome measures in infants is that pregnant women who only smoke cannabis are difficult to enrol in study protocols (Jones, 2006). Several studies from the 1980s reported an association between cannabis use in pregnancy and reduced birth weight (Gibson, Baghurst & Colley, 1983; Hatch & Bracken 1986; Zuckerman et al., 1989). Also in the study by Fried (1999), referred to above, the pregnant women were matched in terms of

nicotine and alcohol use in order to assess the effect of marijuana on pregnancy variables and infant health. Marijuana use was associated with a shorter gestational period and decreased maternal weight gain (Fried, Watkinson & Gray, 1998). However, no effect on infant birth weight, length of labour or means of delivery was detected. Newborns whose mothers smoked more than five joints per week demonstrated marked tremors with startled and altered visual responsiveness at 2-4 days old. By 30 days these symptoms disappeared and no developmental alterations were observed. The children of the women who had smoked two or less joints per week during pregnancy showed no development impairment in their first year (Fried et al., 1998).

The only longer-term follow-up study (Fried, 1982) of infants exposed to antenatal marijuana showed that cognitive variables, especially memory and verbal measures, were affected in infants of heavy antenatal users. The Ottawa Project is the only study to report cognitive and neuromotor evaluation of infants exposed antenatally to marijuana (Fried, 1982); the negative association was only noted at four years of age. Based on this study, Feng (1993) speculated that the effects of marijuana on the immature nervous system may be subtle and not detected until more complex functions are required, usually in the formal education setting.

A later prospective study by Fried (1999) observed a small head circumference in the children of cannabis-using mothers in all ages, which reached statistical significance in the 9-12 year-old children. Degenhardt and colleagues (2000) and Shieh and Kravitz (2006) found children born to mothers with a history of cannabis were more likely to have cognitive deficits.



## **Amphetamines**

The results of the 2004 National Drug Strategy Household Survey indicate that amphetamines and amphetamine-type substances (“ice”, MDMA, Ecstasy) were used by more than 1.5 million Australians, aged 14 years and over, at least once in their lifetime (AIHW, 2005). The mean age of amphetamine initiation use was 20.8 years (AIHW, 2005). Amphetamine (racemic-B-phenylisopropyl-amine) has powerful central nervous system stimulant actions and causes increased wakefulness, alertness, mood elevation and euphoria in the user. Methamphetamine, commonly known as “ice”, “meth”, “crystal”, “crank” and “speed” is fast becoming the drug of choice on Australian streets (McKetin, 2005).

Reports on amphetamine use in pregnancy may have to be revised due to an increase in the numbers of young adults using the drug (Arria et al., 2006). Methamphetamine use in pregnancy causes increased maternal blood pressure and heart rate which can result in premature delivery or spontaneous abortion (Wells, 2007; Woules, La Gasse, Sheridan & Lester, 2004). The drug also constricts blood vessels in the placenta that supply nutrients to the foetus. This results in reduced blood flow and ultimately reduced oxygen and nutrient supply (Lester et al., 2004). The use of crystal methamphetamine (“ice” or “blue ice”) by gravid women has therefore been associated with reduced foetal head circumference, increased risk of abruptio placentae, intrauterine growth restriction, and foetal death in utero (Kennare, Heard & Chan, 2005; Little, Snell & Gilstrap, 1988; Oro & Dixon, 1987; Shieh & Kravitz, 2006).

Human research studies have shown that amphetamines and amphetamine-related substances used in pregnancy are also associated with cardiac abnormalities (Gilbert & Khoury, 1970; Kelly, Davis & Henschke, 2003), clefting (Thomas, 1995), impaired

placental function (Ranamoorthy, Ranamoorthy, Leibach & Ganapathy, 1995), malformation (Little, Snell & Gilstrap, 1988), and congenital abnormalities (Sherman & Wheeler-Sherman, 2000), including neural tube malformations as a result of impaired nutrition (King, 1997) in infants.

## **Cocaine**

The incidence of cocaine use in pregnancy is rising (Hulse, Milne, English & Holman, 1998; Leri, Bruneau & Stewart, 2003). Cocaine is a tropane alkaloid derived from the leaves of the erythroxylon cocoa plant from the mountain slopes of Central and South America. It affects multiple neurotransmitter systems in the central nervous system, such as dopaminergic and norepinephrine systems. During pregnancy, the norepinephrine-mediated vasoactive consequences of cocaine exposure in animals include decreased uterine blood flow and constriction of umbilical arteries (Chasnoff, Bussey, Savich & Stack, 1986). Cocaine is highly water and lipid soluble, therefore it is distributed widely in the body. Like other psychoactive substances, cocaine crosses the placenta and blood-brain barrier, yielding brain concentrations that are four times higher than peak plasma concentrations (Frank, Augustyn & Knight, 2001). It has been found in amniotic fluid (Garcia, Romero, Garcia & Ostrea, 1996), the placenta and foetal tissues (Chasnoff, 1992, Leri et al., 2003). Foetal and maternal concentrations rapidly equilibrate, exposing the foetus to high concentrations of cocaine (Askin & Diehl-Jones, 2001; Chasnoff & Lewis, 1988; Egelko, Galanter, Dermatis & DeMaio, 1998). The parent drug and its metabolites are readily detectable in many infant tissues, including nails (Ludlow, Evans & Hulse, 2004), meconium and urine (Ornoy, 2002).

The specific perinatal complications due to cocaine are hard to isolate because cocaine users are also more likely to use other drugs, such as heroin, tobacco, alcohol and cannabis (Leri et al., 2003). Cocaine-using pregnant women in the USA have also been found to have less antenatal care than non-cocaine-using women (Chasnoff, Landress & Barrett, 1990), although comparisons between Australian chemically dependent pregnant women who use cocaine and other illicit drugs has not been made (NSW Dept. Health, 2006).

In summary known maternal complications of cocaine include malignant hypertension, cardiac ischaemia, cerebral infarction and sudden death. The impact on the foetus includes risk of placenta previa (Chasnoff et al., 1986; Macgregor al., 1987), miscarriage, premature rupture of membranes leading to preterm labour and delivery, stillbirth, intrauterine growth restriction and abruption placentae (Gillogley, Evans & Hansen, 1990; Woods, Plessinger & Clark, 1990).

## **Heroin**

Heroin, the semi-synthetic drug derived from opium ingredients is the most common illicitly used opioid worldwide. Other synthetic products like morphine, codeine and fentanyl show a lower prevalence of abuse, but equal psychoactive effects (Fischer, Bitschnau, Peternell, Eder & Toptitz, 1999; Kakko, Heilig & Sarman, 2008).

The 1980s and 1990s saw a marked increase in the available literature on the effects of opiate use in pregnancy. Heroin addiction is known to be connected with problems such as miscarriage, premature rupture of membranes, impaired foetal growth, diminished birth weight, preterm delivery, maternal infections, meconium staining, stillbirths, toxemia and infant withdrawal (Bartu, Sharp, Ludlow & Doherty, 2006; Chavkin, 1990; Forrester &

Harwin, 2006; Hardiman, 2002; Hulse, Milne, English & Holman, 1998; Jones, 2006; Murphy & Rosenbaum, 1999; Wilbourn, Wallerstedt, Dorato & Curet, 2001). Maternal use of opiates during pregnancy places the infant at risk of neonatal abstinence syndrome (NAS) (Fischer, 2000). A Victorian study found that around 30 per cent of babies born to opiate-dependent women required admission to the special care nursery because of NAS (Kelly et al., 2003) while in New South Wales, Oei and Lui (2007), carrying out a study at a major Sydney teaching hospital found that many chemically dependent pregnant women presented with a dual diagnosis, with co-occurring mental health and substance abuse disorders. Methadone is prescribed and administered in Victoria under the Drugs, Poisons and Controlled Substances Regulations 2006. It acts as a narcotic blockade to relieve symptoms of withdrawal and craving from heroin. It is a long-acting drug that is administered in a single daily dose.

Opioid dependence requires particular awareness in chemically dependent women as heroin leads to females neglecting themselves medically, nutritionally and socially. Most pregnancies are detected in a progressed state and many opiate dependent pregnant women do not seek medical help, for fear of repercussions from health professionals and government agencies (Deleon & Jainchill, 1991).

In addition to the consequences of psychoactive substance abuse, serious health risks to mother and foetus have been described, mostly due to intravenous opioid use and the increased risk of infectious diseases as a result of sharing needles and equipment (Finnegan & Ehrlich, 1999; NSW Dept. Health, 2006). Abscess formation, endocarditis, hepatitis B and C, malnutrition, anaemia due to iron and folic acid deficiency, absorption abnormalities and vitamin and mineral deficiencies, sexually transmitted diseases and HIV

infection are seen with increased frequency among injecting opiate users (Hahn, Onorato, Jones & Dougherty, 1989).

HIV, hepatitis C virus (HCV) and hepatitis B virus (HBV) can all be transmitted to the infant. HIV can be transmitted to the infant via the placenta, during labour and birth, and via breast milk (Lyall, Bloat & De Rueiter, 2001; NSW Dept. Health, 2006) so too can HBV and HCV be transmitted via the placenta and during labour (NSW Dept. Health, 2006). Mothers are at higher risk of contracting HCV and therefore testing positive for HCV infection if: they or their partner have injected drugs using needles that have been used by others; they have shown abnormal liver function test results; they have received blood products before 1990; have had a previous organ transplant or haemodialysis; their partner is infected with HIV and/or they have a history of incarceration (NSW Dept. Health, 2006).

Pregnant women who resort to prostitution also increase their risk of sexually transmitted diseases (Finnegan, 1994). Furthermore, chemically dependent pregnant women are often incapable of fulfilling their responsibilities as they are either “high” or “sick”. When “high” the woman is absorbed in herself; when “sick” she suffers from opioid craving, accompanied by malaise, nausea, lacrimation, perspiration, tremors, vomiting, diarrhoea and cramps (Chasnoff, 2001; Chasnoff et al., 1990). Infection, self-neglect and poor housing situations can be responsible for low birth weight infants, early deliveries and bad nutritional status in neonates.

Once in treatment, it is the recommended standard that pregnant, opioid dependent women are maintained with synthetic opioids (Jones, 2006). In addition to maintenance

programmes, multidisciplinary collaboration has to be established in order to improve the situation for the drug dependent woman and the foetus. Methadone was first used in 1965 and is still the standard agent for the maintenance treatment of pregnant opioid dependent addicts (Fischer et al., 1999). Its use is associated with good antenatal care, since women are stabilised on a supervised dose (Jones, 2006).

However, a known consequence of methadone therapy is neonatal abstinence syndrome (NAS), which follows delivery in 60 – 80% of neonates born to methadone maintained mothers (Ebner et al., 2007). NAS is characterised by tremor, irritability, hypertonicity, high pitched cry, vomiting and diarrhoea, respiratory distress, sneezing, diaphoreses and fever, poor suckling and sometimes convulsions (Ebner et al., 2007; Finnegan & Kaltenbach, 1992).

Based on the benefits gained from methadone treatment, recent studies have investigated the safety and efficacy of other opioids in the treatment of pregnant opiate addicts. Oral slow-release morphine has been shown to be effective and well-tolerated (Fischer et al., 1999; Kashiwagi, Arlettaz, Lauper, Zimmermann & Hebisch, 2005). Newer treatments include buprenorphine, which shows different receptor affinities compared with heroin, methadone and morphine and has proven to be effective in the treatment of opiate addiction (Doran, Shanahan & Mattick, 2003; Lejeune, Simmat-Durand, Gourarier & Aubisson, 2005; Srivastava & Kahan, 2006).

Opioid maintenance therapy leads to stabilisation. However, accompanying psychosocial counselling and psychotherapeutic support including the partner (who also may be opioid dependent) improves the outcome (Fischer et al., 1999; Fraser, Barnes, Biggs & Kain,

2007). The consideration of a client's individual circumstances, behavioural responses, culture, education and job status and prospects are crucial to a successful treatment outcome. Factors contributing to successful treatment outcomes will be discussed later in this chapter.

This section has discussed the effects of licit and illicit drugs on maternal and infant morbidity and mortality. The next section addresses the social, environmental and psychological consequences of chemical dependency and pregnancy.

### **SOCIAL, ENVIRONMENTAL AND PSYCHOLOGICAL CONSEQUENCES OF CHEMICAL DEPENDENCY IN PREGNANCY**

In addition to chemical dependency during pregnancy having negative outcomes for the foetus (Fischer et al., 1999; Jones, 2006), it has also been revealed to be one of the leading 'preventable' cause of physical and mental health problems among children (Fraser et al., 2007; Heaman, 2005; O'Rourke, 2003). Identifying negative birth-related outcomes directly associated with substance use during pregnancy is difficult, because chemically dependent pregnant women's lives are often complicated by other factors that are also related to poor birth outcomes (e.g., intimate partner violence, poor nutrition, lack of support, and illegal activities) (Daley et al., 1997; Jones, 2006; Sun, 2004). However, there are consequences that have been consistently associated with maternal substance abuse during pregnancy; these can be separated into two overarching areas: social/environmental and psychological consequences.

Research suggests that infants born to substance-using mothers are at a disadvantage both socially and environmentally. The social and environmental consequences associated with

drug use often begin with poor maternal nutrition (Fischer et al., 1999; Frank et al., 2001) and a lack of adequate antenatal care (Siney, 1999; Svikis & Reid-Quinones, 2003). While some data suggest that a substantial proportion of chemically dependent pregnant women utilise antenatal care early in the pregnancy (El-Mohandes, Herman & Nabil El-Khorazaty, 2003), the majority of relevant research indicates that substance abusing women are more likely to enter antenatal care late in their pregnancies or not to receive antenatal care at all (Armstrong et al., 2003; Jones, 2006; Kelly et al., 2003).

Antenatal care is an integral component of a healthy pregnancy (Bauer et al., 2002; Hankin, McCaul & Heussner, 2000; Miles, Sugumar, Macrory, Sims & D'Souza, 2006). Substance use during pregnancy together with delayed, inadequate, or non-existent antenatal care can lead to consequences for the foetus. Adequate and appropriate antenatal care, even among infants exposed to drug-use perinatally, has been found to result in a substantial reduction in risk for premature birth, low birth weight, and lack of development for gestational age associated with the level of antenatal care (El-Mohandes et al., 2003). This study reports that infants with no or deficient antenatal care (even without substance abuse) were at higher risk for both premature birth and low birth weight when compared with infants born to women with intrauterine drug exposure (El-Mohandes et al., 2003; Oei & Lui, 2007).

Postnatal social and environmental concerns related to substance use primarily surface as poor parenting skills because addiction can often prevent the mother from responding adequately to the infant's needs (Jessup & Brindis, 2005; Fraser et al., 2007). Additionally, pregnant women who use substances perinatally may offer a less stable or more chaotic home environment (Fraser et al., 2007; Gorin, 2005; Howell et al., 1999;



Zuckerman et al., 1989), with these children being at an increased risk of abuse and/or neglect (Fischer et al., 1999; Harrington & Stubbs, 2006; Lutz, 2005). Substance use is frequently accompanied by other psychosocial stressors, such as homelessness or transiency, inadequate housing, unemployment, legal concerns and illegal activities (Crandall, Nathans, Kernic, Holt & Rivara, 2004; Daley et al., 2000). Illegal activities, which are often part of the drug-using lifestyle, are problematic for children through exposure to violence, accidents and disease (Boyd, 1999; Daley et al., 2000; Fraser et al., 2007).

Multiple stressors, some of which have been referred to above, have been identified as commonly impacting upon chemically dependent [pregnant] women. Poverty, inadequate education, insufficient job skills, social isolation, and dysfunctional interpersonal skills are but a few of the stressors that prevail among this population. Because of this group's poor coping skills, many of the women are unable to manage these stressors effectively. Their attempts to do so through drug use result in maladaptive life styles which influence all areas of their lives. Perhaps the most devastating consequence of drug addiction is the negative parenting techniques that chemically dependent women have been shown to demonstrate (Buchanan & Young, 2002; Coyer, 2001; Dawe et al., 2003; Forrester & Harwin, 2006; Walton-Moss & McCaul, 2006).

Chemical dependency is considered by some theorists to be a maladaptive response to both internal and external stressors (Boothroyd, 1980; Jellinek, 1960; Kallant & Hawkins, 1969; Petrakis, 1985; Stafford, 2001). Alexander and Marks (1982) claim that faulty upbringing, defective social support, and genetic unfitness comprise a causal relationship which results in chemically dependent women making maladaptive responses

in the areas of interpersonal roles, awareness of self needs, development of self worth, and competency in adult roles. The addiction becomes a substitute way of adapting by providing the individual with a false sense of stability and a compensation of needs.

### **Dual Diagnosis and Pregnancy**

Dual diagnosis refers to the co-occurrence of chemical dependency and mental illness which may take many forms (Lindsay & McDermott, 2000; Little, 2001). Women with a chemical dependency problem are more likely than men to be diagnosed with a psychiatric disorder, particularly depression or personality disorder (Grella, 1996). The interaction of pregnancy, mental illness and substance abuse creates complex needs that often go unrecognised by treatment providers (Grella, 2003; Williams & Ziedonis, 2004). Historically, a substantial body of literature on chemically dependent pregnant women presented the view that “women are addicts because of their dysfunctional personalities, and they are incapable of mothering because their addiction is directly related to the inadequate or pathological nature of their relationships with their own mothers” (Waldby, 1988, p. 2). Adding weight to this perception are the many studies that have found an association between parental substance abuse and child abuse (Arellano, 1996; Chaffin, Kelleher & Hollenberg, 1996; Cummings & Davies, 1994).

However, there have been some sympathetic perceptions of chemically dependent mothers that are more understanding of their individual needs and give recognition to the attempts they make to overcome their substance abuse. Murphy and Rosenbaum (1999) reported that the majority of women in their North American research project expressed normal love and concern for their children. In her ethnographic study in Scotland, Taylor (1993) argued that her pregnant participants wanted their children even though they may

experience some ambivalent resentment towards them at times. While Boyd in her (1999) Canadian study found that, although substance abusing pregnant women expressed doubt about their parenting adequacy, they were appropriately concerned about their parenting competency and were keenly aware of the expected child's needs. Despite the catalogue of potential problems and issues chemically dependent pregnant women face, they are very sensitive to the suggestion that their behaviour may harm their unborn child (Denning, Little & Glickman, 2004), as already noted. Early and appropriate intervention in the form of specialist care can mean far better outcomes for mother and baby.

The next section considers treatment options for women and discusses those factors that influence women's attendance at antenatal care and the services that have been found to be effective in contributing to better outcomes.

## **TREATMENT SERVICES FOR CHEMICALLY DEPENDENT PREGNANT WOMEN AND FACTORS INFLUENCING SUCCESSFUL TREATMENT**

Pregnancy or other childbirth-related contact provides a unique opportunity for offering substance abuse treatment services for women (Ebrahim & Gfoerer, 2003). There is evidence that chemically dependent pregnant women attend antenatal care late and/or conceal their drug use from maternity care providers (Clarke & Formby, 2000). Barriers to seeking care and to compliance were previous experiences with antenatal care attendance, child custody issues and the fear of losing social networks (Clark, Dee, Bale & Martin, 2001).

Chemically dependent pregnant women have also been found to avoid contact with necessary services, especially antenatal services (Klee, Jackson & Lewis, 2002; Lia-

Holberg, 1990; Leung, Kluckow & Lui, 2002; Loveland-Cooke, Selig, Wedge & Gohn-Baube, 1999; Siney, 1999), for fear of judgemental attitudes. A study by Murphy & Rosenbaum (1999) showed that clinic appointments were rarely positive experiences, providing evidence for women's fears. Anticipated judgmental attitudes and criticisms have been found to be deterrents to the seeking of early antenatal care (Sword, 1999; Tobin 2005). Clark and colleagues (2001) reported that 224 chemically dependent pregnant women attending a North Carolina clinic were concerned about child custody issues and feared losing existing social networks if they became drug free. Jessup, Humphreys, Brindis and Lee's (2003) qualitative study in California reported that while the majority of participants sought antenatal care, fear of health professionals, and the status of their drug dependency and partners were identified as the main barriers to attendance, and Tobin's (2005) analysis of antenatal attendance records of a major Victorian teaching hospital also revealed fear of child protection services and judgmental attitudes of health professionals as the main barriers to antenatal attendance.

While it is often difficult to convince chemically dependent pregnant women to attend antenatal care, women who do attend such specialist clinics are found to reduce their substance intake (Fraser et al., 2007; Jones, 2006; Miles et al., 2006). However, there is also the concern for health authorities, of women who attend antenatal services and whose drug use remains undetected. It is therefore critical that processes for screening and identifying women at risk in this vulnerable population are in place, and that treatment options are offered in a non-threatening and non-hostile environment in order to secure the health and well-being of the foetus (Jones, 2006) and the child-bearing women. Similar processes to these are practised by the Transitions Clinic.

Studies (Chasnoff, 1992; Chasnoff, 2005) have reported that women who used drugs during pregnancy and received prenatal care reduced the overall risks to the pregnancy and the child and had newborns with higher birth weights than those women who used drugs and did not receive prenatal care. There is no doubt that supervised care like that of the Transitions Clinic, involving close monitoring of mother and foetus and related health care, provides a better start for the foetus (Jones, 2006). However, it is important for effective treatment outcomes that health professionals' legitimate concerns for the health of the baby do not lead to inappropriate blaming of women, or the overlooking of women's own health needs (Boer, Smit, van Huis & Hogerzeil, 1994; Harding & Ritchie, 2003).

The importance of providing appropriate services to meet the needs of this group of women, with an emphasis on a non-judgmental attitude, has been acknowledged (Hepburn & Elliott, 1997; Hepburn, 2004; Mitchell et al., 2003) and merit associated with substance abuse treatment services developed specifically for women has been demonstrated (Ashley, Marsden & Brady, 2003; Grosenick & Hatmaker, 2000). A recent review of the literature suggested that women-specific treatment programs reduce barriers to treatment entry and retention, by combining treatment with other necessary services (Jones, 2006). Furthermore, treatment programs developed for women are likely to offer services to pregnant women, establish priority admissions (Grella, 1999), provide paediatric/infant services, and offer antenatal as well as postpartum services (Ashley et al., 2003). To be effective, antenatal care should be appropriate to these women's needs, be easily accessible, and the women should be involved in the planning of care (Philipps et al., 2007; Tobin, 2005). These aims endorse the philosophy of the Transitions Clinic.

It has been recognised that providing special services to attract and retain chemically dependent pregnant women into antenatal care can help to address their complex problems (Hepburn, 2004; Tobin, 2005) and that these services need to be multidisciplinary in order to address drug use at the same time as providing antenatal care (Murphy & Rosenbaum, 1999).

Studies of clinics with a multidisciplinary focus in Scotland Hepburn (2004), Mitchell and colleagues (2003), Hall and van Teijlingen (2006) and in North America, Hankin, McCaul and Heussner (2000) found them to be effective in terms of positive treatment outcomes for their own health and that of their unborn child. The emphasis in these clinics was on drug stability rather than abstinence. All clinics reported that the women, as well as having positive outcomes, were able to reduce their overall drug use. Part of the provision of stability for heroin addicted women, as has already been mentioned, is a methadone maintenance program (MMT). Such studies have found that early commencement on a MMT has contributed to increased antenatal care attendance, reduction in premature labour (Miles et al., 2006) and better health and social outcomes (Day & George, 2005). Fischer and others (2006), in a study (n=14) of Austrian women, sought to evaluate the efficacy and safety of methadone versus buprenorphine maintenance programmes with a group of pregnant opioid-dependent women. The research project measured mothers' retention in treatment, urine toxicology and drug use and examined the neonates' routine birth data and neonatal abstinence syndrome (NAS) in severity and duration, and found that there was greater retention in the buprenorphine group than there was in the methadone group.

Clinics that offer a range of support services such as child care, parenting classes (Howell et al., 1999; Volpicelli et al., 2000), vocational training (Howell, et al., 1999), drug

counselling (Harding & Ritchie, 2003), and psychiatric interventions and individual therapy sessions (Volpicelli et al., 2000), were also found to be effective in achieving positive outcomes for chemically dependent pregnant women. Howell and colleagues (1999) found that chemically dependent pregnant women in their study had a background of poverty, significant substance abuse and family violence. Retention, as measured by abstinence from illegal drug use, was facilitated by the provision of support services, such as child care, parenting classes and vocational training. Harding and Ritchie (2003) explored the education and counselling implications of (n=23) opiate-addicted pregnant women in rural New South Wales and revealed that 80 per cent reported that drug counselling gave them the confidence to successfully practise harm reduction strategies, while Volpicelli and colleagues (2000) found that by including psychosocial enhancement services (parenting classes, psychiatric interventions and individual therapy sessions) in an outpatient treatment programme in Pennsylvania, the participants significantly reduced their cocaine intake.

It is worth noting that with the emphasis on services for pregnant women focused on the birth and for several weeks post-delivery, but then responsibility for support was handed to a statutory health visitor. From the client's perspective this was unsatisfactory because there was a high level of support before birth and a close relationship had developed with staff at the clinic (Marcellus, 2002; Mitchell et al., 2003). In the Scottish study by Mitchell and colleagues, the women reported feeling vulnerable and abandoned when the clinic ceased contact with them after 28 days. This raises the question of how well do those women, who view pregnancy as a time for change or reassessment, cope after the birth of the baby?

## **Pregnancy as a Turning Point**

Pregnancy was found to be a time of reassessment for some chemically dependent women (Harmer, Sanderson & Mertin, 1999; Jessup & Brindi, 2005; Lewis, Klee & Jackson, 1995). Hall and van Teijlingen (2006) in their qualitative study of 40 Scottish women found that several participants used their pregnancy as a “lifeline” and an opportunity to reduce their drug-taking, while the British study by Lewis and colleagues (1995) reported that the 30 participants in that research project felt that pregnancy was an opportune time to “reappraise their life and come off drugs” (p. 222). Jessup and Brindis (2005) in a study of women (n=36) in a perinatal residential substance abuse treatment programme, which aimed to gather information about their life experiences prior to drug treatment, also found that pregnancy and motherhood motivated the women to enter treatment and seek antenatal care.

Family support and family participation in treatment outcomes (Walton-Moss & McCaul, 2006; Saatcioglu, Erim & Cakmak, 2006), and having other children (Walton-Moss & McCaul, 2006) were revealed as the predominant factors that led to the women seeking and then following through successfully with antenatal care and harm minimisation. Saatcioglu with colleagues (2006) in a Turkish study also found that family was an important part of the treatment “chain” for substance abuse. They held that family participation in the treatment process helped to prevent relapse.

An approach to considering how women confront their substance use in pregnancy can be explained by their reactions to critical events. Ideas from existential philosophy can provide additional information and illuminate many paradoxes that are related to negative life events (Crossley, 1998; Greening, 1971). This includes the idea that inner growth is



often preceded by suffering and despair (Frankl, 1963, 1967), and the fact that these are necessary ingredients in forging more meaning in one's life (King, Valle, & Citrenbaum, 1978). For example, within this framework it is argued that as "one becomes aware of one's own mortality, one takes on a 'vitality and immediacy'" which includes the experience of a heightened consciousness of oneself, the world and others around one" (May, 1958a, p. 48).

May (1958b, p. 17) notes that existentialism was born during a time of cultural crisis, when individuals were thrown into spiritual and emotional turmoil. Thus, as with psychotherapy, existentialism concerned itself with individuals who were in crisis and characterised human beings as always evolving and changing through these crises. In light of this, it focused on the individual's need to strive for a "heightened self-consciousness" that is an awareness of his/her existence on a "new basis" with a new and more solid conviction (Van Deurzen, 2005, p. 117).

For the purposes of this aspect of the study, I drew on several key constructs that derive from existential philosophy: existential loneliness, existential anxiety, helplessness, guilt and authenticity. Existential loneliness is defined as an ever-present feeling of aloneness experienced by human beings (Moustakis, 1961; Vanden Bergh, 1963; van Deurzen, 2005; Von Witzleben, 1958), which it is assumed one defends against for much of the time, and for which no permanent remedy can be found. Since death and existential loneliness are intertwined, to grapple with one implies confronting the other (Moustakis, 1961). Existential anxiety results from the threats imposed on us by the human condition, in particular the awareness that we are finite (Frankl, 1967, p. 276). The way in which we manage this anxiety will determine whether our lives will be fulfilled or not, for

confrontations with such threats, in particular death, have the power to provide a massive shift in the way we live our life (Frankl, 1967, p. 377). The extent to which one expresses helplessness or manages to develop feelings of control also contributes to one's level of anxiety. While guilt over past actions and the fact of one's death both pose threats, these may also have positive repercussions for, according to Frankl (1963, 1967), it is in the face of these that one is motivated to change one's life, and act in a more meaningful way. Existential theoretical realities and reactions to critical life events, in terms of the participants confronting their substance abuse were also addressed. Authenticity occurs as one becomes aware of one's potential and acts on it (Bugental, 1965, p. 45).

Frankl (1967) believed that the meaning of life is found in every moment of living and that life never ceases to have meaning, even in suffering and death. He concluded from his experience that a person's psychological reactions are not solely the result of the conditions of his/her life, but also of the freedom of choice he/she always has even in severe suffering. The inner hold a person has on his spiritual self relies on having a faith in the future, and once a person loses that faith, he is doomed.

## **SUMMARY AND CONCLUSION**

This chapter, through a review of the literature, has given an insight into the consequences associated with substance use in pregnancy, that is the physical, social, environmental and psychological consequences of chemical dependency in pregnancy, the factors that influence chemically dependent women's seeking of treatment and those treatment modalities that are most effective, as well as the motivating factors, for change. The next chapter explores the theories, models and discourses of addiction and their relationship to chemical dependency and its treatment during pregnancy.

## **CHAPTER THREE**

### **UNDERSTANDING DRUG ADDICTION AND THE IMPLICATIONS FOR TREATMENT IN PREGNANCY**

Just a gaze  
Michel Foucault (1973). *The Birth of the Clinic:  
An archaeology of medical perception.*

#### **INTRODUCTION**

This chapter explores theories and models of addiction that influence the treatment of chemically dependent pregnant women, including theories that focus on recovery and include the Trans-Theoretical Model (TTM), which underpins the Transitions Clinic's philosophy as a basis for changing addictive behaviour. The chapter also identifies and critiques discourses of addiction. While addiction is popularly conceived as a constraint on self-motivated actions, in this chapter it is argued that popular discourses influence experience, treatment and recovery and, therefore, are useful to guide analysis. I begin the argument by examining the perception of addiction.

#### **THE CONCEPT AND DEFINITION OF ADDICTION**

The concept of addiction has been criticised both within and outside the mental health disciplines on a number of grounds (Cottler, 1993): It is often used without an attempt to define it: many proposed definitions are vague or imprecise, some being so all-inclusive as to leave the term devoid of pragmatic value; it has moralistic connotations which are inappropriate to scientific inquiry; it represents a way of understanding people, behaviour and the mind that is incompatible with a scientific approach; it adds no information that is not previously conveyed by a term or concept that is accepted in the field.

Addiction has been defined as a behaviour over which an individual has impaired control with harmful consequences (Cottler, 1993; Rounsaville, Bryant, Babor, Kranzler & Kadden, 1993). Thus, “addicted” individuals who recognise that such behaviour is harming them, or harming those for whom they care, can find themselves unable to stop engaging in this destructive behaviour (Heather, 1998). This tends to be the definition favoured by health professionals. The severity of the medical, psychological and social harm that can be caused by addiction, together with the fact that it violates the individual’s freedom of choice, makes it appropriate for it to be considered a psychiatric disorder, that is a disorder of motivation (West, 2001).

The main challenges for theories or discourses of addiction are to explain in a meaningful way how this happens both at an individual and a societal level, and what mechanisms and societal changes underlie prevention and recovery.

## **THEORIES OF ADDICTION**

There are inevitable questions about what constitutes a theory in the field of addiction. The Oxford English Dictionary defines a theory as “a scheme or system of ideas or statements held as an explanation or account of a group of facts or phenomena”. Much of what is proposed as theory may be considered by some to be too specific or descriptive to warrant the epithet. Often the terms “theory” and “model” are used interchangeably. Strictly speaking, a “model” is better construed as a coherent representation of key elements of a structure or system and is thus more descriptive than explanatory, but in practice the dividing line between “model” and “theory” is fine and open to differing interpretations. This chapter adopts a fairly pragmatic approach, including models and

theories which attempt to make some kind of statement about mechanisms and processes which go beyond the immediate observation.

A search of Blackwell Synergy, Medline, Ovid and Taylor and Francis databases using the keywords “theory” or “model” together with “addiction”, “chemical dependence” and “drug” yielded many articles. Reviews of theories of addiction can also be found in Hughes (1989), Glass (1991) and Lowman, Hunt, Litten and Drummond (2000). Examining the theories uncovered by the literature search, a simple classification system involving five groups became apparent. Each one approaches addiction from a different perspective and focuses on particular aspects of the addiction process. This group of theories is described in the next section.

### **Theories that focus on conceptualisation and general processes**

Theories that focus on conceptualisation and general processes attempt to provide broad insights into the conceptualisation of addiction. Thus addiction may be construed in terms of biological, social or psychological processes, or some combination of these. Orford (1992, 2001) has proposed a general conceptualisation of addiction from a particular disciplinary perspective. Heather (1998) similarly proposes a broad theoretical framework. McCusker and Gettings (1997) and McCusker (2001) focus more specifically on cognitive mechanisms. Drummond (2001), Jones, Corbin and Fromme (2001) and Littleton (2001) provide varying perspectives on important aspects of addiction from the psychological to the biological.

### **Theories that focus on effects of addictive stimuli**

Theories that focus on the effects of addictive stimuli seek to explain why particular stimuli have a high propensity to become a focus for addiction. It has been apparent from earliest investigation that stimuli that give pleasure, relief or excitement have a propensity to become a focus of addiction. If these effects can be achieved reliably and quickly, this may enhance their addictive potential. If, in addition, they change the recipient so that the effects are enhanced or come to be relied upon, their addictive potential may be further improved. A dominant theme is the positive and negative reinforcing properties of addictive drugs (and other stimuli) for some individuals. Bozarth (1994) is perhaps one of the main proponents of this approach.

An interesting and perhaps counter-intuitive view is proposed by Robinson and Berridge (1993, 2001), who argue that the positive reinforcing effects of addictive drugs are potentiated rather than diminished by repeated exposure. Miller (1997) provides an innovative account of how drugs may become addictive through their effects on adaptive mechanisms.

### **Theories that focus on individual susceptibility**

A third group of theories focuses on why particular individuals are more susceptible to addiction than others. People who are particularly receptive to the effects of a given stimulus, whether biochemically, psychologically or socially, or in need of those effects, would be expected to be most at risk. Genetic susceptibility is clearly a dominant theme (Buck, 2001; Cheng, Swan, Carmelli, 2000; Cunningham, Niehus, Malott & Prather, 1992), however, other vulnerability factors have also been widely postulated.

### **Theories that focus on environmental factors**

A fourth set of theories explores the environmental and social conditions which make addiction more or less likely. Thus situations which lead to a need for the effects of a stimulus, or in which those effects take on a greater significance would be likely to promote addiction. The literature includes accounts in terms of stressors (Breslin, Hayward & Baum, 1995), social roles (Hajema & Knibbe, 1998), social influences and opportunities (Buck, 2001). Ferrence (2001) proposes a model based on the notion of diffusion borrowed from the physical sciences and Kenkel (2001) discusses the role of economic factors and progression of drug use.

### **Theories that focus on recovery and relapse**

Theories that focus on recovery and relapse cut across those that take a broad perspective, while other theories concentrate on the effects of withdrawal from particular stimuli such as drugs. Some theories focus on an individual's make-up while some seek to model environmental influences which can include discussion of conditioning and psychosocial factors (Annis, 1991; Bradizza, Stasiewicz & Maisto, 1994, Hughes, 1989; Hughes, 2007). A dominant model in this area in recent years is the Trans-Theoretical Model (TTM) of recovery (Prochaska, DiClemente & Norcrosse, 1992) which will be discussed later in this chapter.

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In summary, at the beginning of the twenty-first century, there can be little doubt that the conceptualisation and understanding of addiction had advanced considerably. This has almost certainly fuelled advances in prevention and treatment. Unfortunately, the environment has also been shifting and the opportunities and social forces leading to addiction have created new problems. It would be no exaggeration to consider addiction

to be as much or more a global epidemic now than it was a century ago. In fact, some of the main advances in control of addiction have merged without recourse to sophisticated theories. Looking into the future, it seems likely that major advances in the biological sciences, and in particular the mapping of the human genome, will offer new insights and new opportunities for treatment and harm reduction. It is hoped that there are also new insights to be had at a behavioural level as it is likely that societal and policy interventions will be needed to make significant inroads into this global epidemic.

Theories are useful tools for understanding addiction, for promoting prevention and establishing treatment models. In the next section a number of broad treatment models are examined.

## **MODELS OF ADDICTION: INFLUENCING TREATMENT**

Four early models described by Brickman and colleagues (1982) have been identified as tending to shape attitudes and influence treatment, namely the moral model, the medical model, the enlightenment model and the compensatory model. The social learning model, the public health model and the trans-theoretical model are more recent treatment models found in the literature (Hughes, 2007).

### **Moral Model**

With the moral model, addiction is considered to be the result of the weak will or immorality of the individual. Thus, the woman with an addiction is seen as entirely responsible for her situation, with the solution resting only with her. She needs to exercise the willpower and self-control to stop the addicted behaviour. From this viewpoint, if the



woman remains addicted despite attempts to stop, she is seen as “lazy” and is thought not to have worked hard enough to resolve her self-made problem (Hughes, 1989).

With the full responsibility for the problem and solution resting with the individual, the role for professionals is minimal. Helping from this perspective consists of reminding those with addictions that they are responsible for their addictions and that they must help themselves. An outgrowth of the moral perspective is the self-labelling or labelling done by others of “addict”. The stigma attached to these labels has been shown to have negative effects on treatment and recovery (Dean & Rud, 1984).

### **Medical Model**

Within the medical model is the disease perspective of addiction. The individual’s body chemistry is viewed as responsible for making that person susceptible to addiction. From this perspective, women with addiction[s] would be seen as not responsible for their addictions or for the solution but as ill or incapacitated and requiring medical assistance and treatment. This perspective is supported by findings of a gene-linked predisposition for alcoholism from adoption and twin studies (Schuckit & Smith, 1996). The premise that addiction is beyond one’s control allows women with addictions to accept help without being blamed for their problems. The potential disadvantage for not taking responsibility for the problem, is that some women may view themselves as victims (McDowell & Spitz, 1999).

### **Enlightenment Model**

As with the medical model, the enlightenment model does not view a woman as able to solve her drug problem. However, in contrast to the medical model, a woman with

addiction needs to accept responsibility for her problem. Problems are seen as resulting from a disease of mind and body (Hughes, 2007), in which the disease of the mind is a reflection of moral or spiritual failing. Addiction is seen as primarily experienced in the existential interior, with the individual as the only one who can fully negotiate its meaning, and break free of its bonds. A perspective of addiction consistent with the enlightenment model is the philosophy espoused by the 12-step programmes (Wilson & Smith, 1935). With this philosophy, individuals must acknowledge the true nature of their problems and accept the difficult course of action necessary to correct them. The 12-step doctrine holds that one must surrender personal control to a higher power to change one's behaviour (Saulnier, 1996).

### **Compensatory Model**

The compensatory model views addiction as the result of multidimensional factors which are held to be beyond the control of the person, but for which the person can “compensate” by taking responsibility for addressing the problem. In one such perspective, addictive behaviours are considered maladaptive coping mechanisms in response to an array of antecedents. Marlatt (1985), a proponent of this perspective of addictive behaviour, focuses on the determinants of addictive habits that encompass situational and environmental antecedents, expectations and beliefs, and the person's family history and prior learning experiences with the addictive substance. Marlatt also posits that attending to the consequences of addictive behaviours is helpful in understanding the reinforcing effects that help perpetuate the addictive behaviour. Addictive drugs are positive reinforcers (Carlson, 2001). As a habit pattern, addiction is seen as resulting from the interplay of cognitive, environmental and biophysiologic variables that are “locked in by

the collective effects of classical conditioning and operant reinforcement” (Marlatt, 1985, p.11).

### **The Public Health Model**

The public health model takes a multidimensional approach. Copeman (2003) defines addiction from a public health perspective, identifying three aetiological factors: (1) Agents – the psychoactive drugs; (2) Hosts – individuals who differ in their genetic, physiological, behavioural and socio-cultural susceptibility to various forms of chemical; and (3) Environment – the availability and accessibility of the agents (Coombs, 1997, pp. 176-177). The Transitions Clinic, in broad terms, aspired to this model – the preferred model for treatment (Coombs & Howatt, 2005).

### **The Social Learning Theory or Biopsychosocial Model**

The social learning model, as the name suggests, puts emphasis on the social environment and modelling of behaviour. For example, social reinforcement causes individuals to model the drug use behaviours of their parents, older siblings and peers. Social learning theorist Albert Bandura (1977, p. 23) indicated four stages of social learning which have relevance to this model: (1) Attention – the individual makes a conscious cognitive choice to observe the desired behaviour; (2) Memory – the individual recalls what she has learned from the modelling; (3) Imitation – the individual repeats the actions that she has observed; and (4) Motivation – the individual must have some internal motivation for wanting to carry out the modelled behaviour. This model is currently used by the World Health Organisation (Coombs & Howatt, 2005).

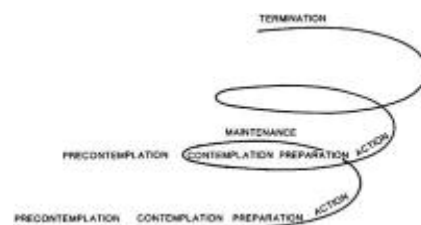
## **The Trans-Theoretical Model (TTM)**

The seventh model - the Trans-Theoretical Model (TTM) – which is widely used as a treatment model attempts to explain or predict a person's success or failure in achieving a proposed behaviour change, such as developing different habits. This model currently the most popular stage model in addictive behaviour therapy (Horwatt, 2000), has proven successful with a wide variety of simple and complex health behaviors, including smoking cessation, weight control, sunscreen use, reduction of dietary fat, exercise acquisition, quitting cocaine, mammography screening, and condom use (Prochaska & Norcross, 1994).

The TTM explains intentional behaviour change along a temporal dimension that utilises both cognitive and performance-based components. Based on more than two decades of research, the TTM has found that individuals move through a series of stages, pre-contemplation, contemplation, preparation and action in the adoption of healthy behaviours, or cessation of unhealthy ones (Prochaska & Norcrosse, 1997).

*Pre-Contemplation* is the stage in which an individual has no intent to change behaviour in the near future, but may be considering behaviour change, and is usually measured as a period of approximately six months. The *Contemplation stage* is when individuals openly state their intent to change within the next 6 months. Individuals in the next stage, the *Preparation* stage, intend to take steps to change, usually within the next month (DiClemente et al., 1991). This stage is viewed as a transition rather than a stable stage. The *Action stage* is one in which an individual has made overt, perceptible lifestyle modifications for fewer than 6 months (Prochaska & DiClemente, 1982, 1983, 1984, 1986). *Maintenance* occurs when individuals are working to prevent relapse and consolidate gains secured and is usually measured as longer than 6 months (Prochaska,

DiClemente & Norcross, 1992). Prochaska and Norcross (2001) later added a sixth stage, *Termination* where former problem behaviours are no longer perceived by the individual as desirable.



**Figure 1. A Spiral Model of the Stages of Change** (Prochaska & Norcross, 2001)

The spiral represents the advances and retreats among the stages of change. For example, injecting drug users trying to “change” on their own will usually average from three to four action attempts before they reach the maintenance stage (Prochaska et al., 1992; Prochaska & Norcross, 2001). The advantage of this model is that with accurate assessment of the stages of change demonstrated by chemically dependent pregnant women, health professionals can direct their interventions to more effectively promote positive change. This model, underlined by a philosophy of care, complements a policy of minimising harm for the drug user (in this instance, the chemically dependent pregnant woman) with the ever present goal of recovery.

## **HARM MINIMISATION**

Within Australia the most important policy development in the field of drug use was the adoption of a harm minimisation approach in 1985 (Duff, 2003; Hamilton, King & Ritter, 2004). A harm minimisation approach considers that all drugs have the potential to cause

harm, not just the illegal ones. As already noted an estimate of the economic costs to Australia of harmful drug use in 1999 was \$34.4 billion, with \$6 billion due to illegal drug use, \$7.6 billion due to alcohol use and \$21 billion due to nicotine use (Hamilton, King & Ritter, 2004). Harm minimisation therefore has potential economic as well as social benefits.

According to Rumbold and Hamilton (1998), harm minimisation attempts to “assess the actual harm associated with any particular drug and then asks how these harmful effects may be minimised within an amoral framework” (p.135). This tactic takes a number of important steps towards a sound approach to drug use, in terms of both treatment implications and the development of a greater understanding (Erickson, 1993; Mugford, 1993; Single, 1995). However, many harm-reduction strategies such as needle exchange, remain highly controversial in Australia, particularly within organisations that aspire to the role of “moral guardian” (Duff, 2003). The role played by institutions such as medicine, the government and pharmaceutical companies forms the basis of a number of important criticisms of harm minimisation (Duff, 2003; Van der Sterren, Anderson & Thorpe, 2006).

From a sociological perspective there is a number of shortcomings with harm minimisation such as its failure to engage with the dominant discursive practices within social institutions. As illustrated by the works of Michel Foucault (Foucault, 1973, 1977b; Foucault & Gordon, 1980), discourse plays a central role in society and the current framework of harm minimisation may be criticised for extending the mechanisms of social control and “medical dominance” (Willis, 2000).

In summary the theories and treatment models of addiction outlined above contribute to the various contemporary discourses of addiction, namely, addiction as the failure of the will, addiction as pathology, the helpless addict in need of expert medical care, addiction as a disease of the mind and body, and addiction as a result of multidimensional factors beyond the control of the individual, but for which they can take responsibility. At the same time, the link between the influence of a particular discourse and the adoption of a particular treatment model is not always clear, nor is the impact of discourses on individuals, both the client and the carer.

## **DISCOURSES OF ADDICTION**

Since the concept of addiction was developed a century ago – and has subsequently been incorporated into social policy – popular discourses of addiction have also developed. Addiction discourse has been analysed as a major social and cultural myth (Bailey, 2005; Hammersley & Reid, 2002). The myth of addiction suggests that the biological effects of various drugs will lead quickly and inevitably to addiction and force addicts to stoop to any level to acquire their drugs (Gibson, Acquahu & Robinson, 2004). However, this critique argues for the importance of examining these popular discourses – the way each is represented in the media, in casual speech and in popular literature (Bright, Marsh, Smith & Bishop, 2008) – in order to be aware of the linguistic resources for conceptualising addiction to which we all have access. It suggests that it is crucial to look at the interplay of different discourses of addiction in the addicts' own accounts and the way in which this interplay contributes to a sense of self.

### **Discourse and the self: Conceptualising agency in a discursive paradigm**

The relationship between discourse and identity has engrossed researchers from many fields. Feminist researchers, for example, have seen a discursive approach as a way of analysing their positioning in patriarchal mechanisms of power (Sawicki, 1991). However, it has also been suggested that it is an approach that cannot adequately account for the systematic inequalities in power relations (Hartsock, 1990). While aspects of Foucauldian theory drawn on in this study will be more fully explicated in the next chapter, in charting these difficult waters, I will introduce Foucauldian theory of discourse, and explore the concept of freedom with reference to the work of Rose (1989).

The concept of a discourse is useful in understanding how we are both de-limited and defined by what we are able to say/represent. In other words, it is a concept that has implications for how we conceptualise power and powerlessness, for how we understand the relationship between mind and body, and – importantly – for what we conceive of the self. Discourses are the sets of rules (implicit and explicit) about what can and cannot be said, and by whom, in any given situation (Potter & Wetherell, 1987); they are often left unquestioned as “commonsense” and are reified “in institutional practices” (p. 168). They are the rules of speech and of representation. They are largely implicit, but discourses may also be organised into disciplines and expressed through forms of expertise which constitute a rationale for decision-making within which those ascribed expert positions in a discourse, such as doctors, midwives and nurses, move.

Discourses are therefore not a form of social control, but offer a way of understanding how we are recruited in our own government (Barry, Osborne, & Rose, 1996). Discourse analysis is useful because it discourages a division between actions which are “free” and



actions which are not. Rather, as Rose (1989) has argued, “freedom” is not the opposite of control or regulation; “freedom” has become, in modern societies, the primary means by which we are governed. The elusive pursuit of “freedom”, whether from material dependency on the state, or from the state of addiction, delimits clear parameters to our action (p. 83). Consequently, the self is constructed through discourse; people’s sense of who they are, of what is possible for them, and of how they act does not operate in a vacuum, but rather comes from a shared understanding of these parameters (Bright et al., 2008). It is expressed through the self-forming behaviours that Foucault termed “practices of the self” (Foucault, 1991a).

Discourse theory therefore raises questions about our ability to forge new forms of self-identity, and about how we may be constrained in our behaviour by the oppositions that discourses establish, for example between the “addict” and the “non-addict”, and the institutional practices that reflect such opposition (Albertin & Iniguez, 2008). The challenge then, is to establish whether any meaningful sense of agency remains for someone who has been labelled, or has labelled themselves an “addict”, and whether they can ever move beyond that discursive construction?

### **Interrogating addiction**

The rise of this modern form of power that coincided with the rise of the figure of the addict, the notion of “addiction” and the identity of the “addict” are inextricably connected with the operation of modern power through discourse (Bailey, 2005). Addiction has been a gendered and racialised concept during much of its historical development throughout the last two centuries (Musto, 1973).

At the start of the 19th century, consumption of opium was socially acceptable; it was seen as an important drug within medicine, and respectable businessmen experimented with growing it in the UK. By contrast, by the century's end, regular opium users were labelled as sick (medical model) or deviant (moral or compensatory model) and in need of professional intervention (Berridge, 1999).

The term “addiction” first appeared in the Oxford English Dictionary as referring to drug use in 1906, and the first recorded use of “addict” as a noun is dated 1909 (Brodie and Redfield, 2002). Legislation in the area of social policy to control “dangerous drugs” in the UK was not passed until the 1916 Defence of the Realm Act, and subsequently reinforced in the 1920 Dangerous Drugs Act (Berridge, 1999). In the US, a free trade in drugs at the beginning of the 20th century was gradually replaced by what Szasz (1992) terms a “command economy” by the end of the century. As Brodie and Redfield (2002) point out:

Much can be made, then, of this sudden pathologisation and criminalisation of habit: it occurred as part of the emergence, on the one hand, of a disciplinary society in which typologies of deviance play a significant role in the operations of power; and, on the other hand, of a society of consumption in which identities and desires become attuned to the repetitive seriality of commodity production. . . addiction, like culture, belongs as a concept to the social and technical regimes of the modern era (p. 4).

Some interesting shifts have occurred in which substances or behaviours have been pathologised within the medical model by this label. Over the course of the 20th century, this new term, or category of behaviour, “addiction”, grew in magnitude and importance until, by the century's end, the concept had become so all-embracing and it was possible to apply it to almost any kind of behaviour (Bright et al., 2008).

Sedgwick (1993, p.131) argues that “addiction” is now predominantly seen as “lying” in failure of the will (as in the moral model). Whilst a person with healthy free will can choose any of those activities which now commonly fall under the umbrella of potential addiction, the addict engages in these activities under some kind of compulsion. Sedgwick sees the figure of the addict standing in opposition to the activity of choice. We are free to choose, but the figure of the addict making bad/uncontrolled choices is needed to render our own choices as good and meaningful.

Whilst in the 19th century, regular consumption of opiates was widely viewed as a “habit”, during the 20th century a disease view of addiction (medical model) came to the fore, although as Valverde (1998) notes, this shift was contested. Alongside this, however, a third strand to the discourse developed, with the extension of addiction in certain quarters to being a form of identity. In an Alcoholics Anonymous (AA) discourse, for example, being an alcoholic is seen as a form of identity, not a sickness or a form of behaviour (Warhol, 2002). The individuals attending an AA meeting are expected to introduce themselves as occupying this specific subject position – “Hi, I’m \*\*\*\*, and I’m an alcoholic”. Warhol has noted tensions between competing elements of AA philosophy.

I would argue that addiction (as a concept) remains at its very essence, a moral concept resting in a dualist conception of the mind–body relationship (Albertin & Iniguez, 2008); it is conceptualised as a failure of the self in its imperative to exercise control over bodily desires and functions. Yet, paradoxically, in contemporary discourses, consumption is used as a source – perhaps the source – of identity (Du Gay, 1996), and addiction positions itself as the logical extreme of such a consumption identity. Addiction, therefore, relates in complex relationship to issues of identity – particularly identities of consumption – the

body and the self. According to Giddens, a key element in the process of identity formulation is the capacity on the part of the individual to maintain a narrative of his or her biography (Giddens, 1991, p. 54, 1992).

The existential question of self-identity is bound up with the fragile nature of the biography which the individual supplies about herself....a person's identity is not found in behaviour....but in the capacity to keep a particular narrative going.

One could argue that an addict may also sustain a life narrative that may or may not exclude destructive behaviours. However, failure to acknowledge that identity can result in a 'spoiled identity' (Goffman, 1968). Goffman, writing of a "spoiled identity", says that stigmatising an individual "has the effect of cutting [the stigmatised person] off from society and from himself so that he stands as a discredited person facing an unaccepting world" (Goffman, 1968, p. 19). The modes of stigma enforcement by "normals", though adaptable to any number of relatively benign traits and mild prejudices are horrible. As Burris (2008) notes: "By definition, we appear to believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce one's life chances" (p. 27).

To summarise the contemporary position of the individual, the possibility of addiction, now ever-present in any activity, acts as a constant threat to the integrity of the self-willed individual, thereby requiring a similar constant attention to that self and its assertion through renewed acts of (differentiated) consumption. It is a discourse – or rather a series of discourses as will be discussed below – that both define and threaten the self. Moreover, this conceptualisation of addiction, and consequently of the individual, is in sharp contrast to the way that these matters were seen as little as a hundred years ago; that is to say, these views are historically contingent. To say this is not to deny the reality of addiction, for discourses are constitutive of reality (Potter & Wetherell, 1987). However, it suggests that

further exploration of contemporary discourses is important in order to examine the nature of that reality both for the “addicted” and the “non-addicted”, who must define themselves in opposition to this pathologised state (Albertin & Iniguez, 2008).

The multiple popular discourses now available need to be taken seriously in order to understand the sense that addicts make of their lives, and to investigate potential for change (Fitzgerald, 1996). Popular discourses can be seen as misleading by experts in the field; however, subjects draw on popular conceptions of an issue in making sense of their lives and they (discourses both potential and actual) have a role to play in people’s behaviour.

### **Contradictions and Challenges: The lure and attraction of drugs**

A contradiction can be seen in the popular discourses of addiction. It was noted above that “addiction” emerged primarily as a moral concept, thus making a negative judgment of the behaviour in which the addict is engaged. Yet, some contemporary popular discourses of addiction are challenging this moral positioning of the addict. Instead, the addicted self is constructed as the natural conclusion of a consumerised identity, and as indeed affirming that identity, with the coffee-lover happily claiming to be “addicted” to their expensive latte, and the “chocoholic” smiling as they justify their tastes. Whilst it would be easy to dismiss these accounts as offering no insight to the expert in the field of addiction, these discourses deserve exploration, as part of the field of discourses within which the addict moves. Another more cogent example is the websites aimed at young people encouraging them to experiment safely.

## **Discourse of recovery**

In terms of understanding recovery processes the work of Davies (1992) and McIntosh and McKeganey (2000a, 2000b, 2001) has particular resonance. John Booth Davies' work on addiction using the psychological theory of attribution (Heider, 1958) was significant (moral model), as was McIntosh and McKeganey's (2001) linking the recovery process (medical model) to the chronic illness literature of medical sociology. The role given to the expert in this prevailing discourse is to save addicts from their helpless situation. Yet, as Davies has suggested, this discourse may be a position of "learned helplessness" (Davies, 1992; Seligman, 1975). The TTM outlined above offers a far more contemporary and pragmatic approach to recovery, acknowledging the potential for relapse and the importance of the individual taking responsibility.

To summarise, there has been a proliferation of discourses of addiction, and these discourses (some more than others) have the potential to provide a framework for the researcher interested in understanding the sense that addicts make of their lives, as well as the labels that others, including health professionals, may apply to the chemically dependent client.

## **SUMMARY AND CONCLUSION**

This chapter has attempted to 'set the scene' with an overview of addiction theories and the models of treatment that are interwoven with several of the popular discourses of addiction. I have described the key constructs of the stages and processes of change of addictive behaviour, using the six-stage Trans-Theoretical Model (TTM) which I see as the most useful explanation of behaviour change and as a way of guiding treatment.

At the same time how people live with or intentionally change addictive behaviours is not well understood by health professionals; however I have argued that discourses of addiction are useful in reconceptualising the relationship between addiction and agency in addicts' own accounts. In this context I have drawn upon discourse theory and introduced Foucault to explore the relationship between addiction and the self. Multiple competing and intersecting discourses of addiction have been identified, and the ways in which discourses construct and position subjects have been explored. The next chapter will more fully explore Foucault's theory of power-knowledge relations, normalisation and his notion of surveillance (of bodies), Habermas' concept of communication and the role it plays in health professional/ client relationships. Perspectives of critical theory are also examined.

## CHAPTER 4

### THEORETICAL FRAMEWORK

Anthropology is a field that celebrates complexity and ambiguity in a world  
looking for simplicity and clarity.

M.H. Agar (1996) *The Professional Stranger*

### INTRODUCTION

This chapter explores the theoretical framework that underpinned the study and also guided analysis. As a researcher, development of a theoretical framework was both theory/concept driven and theory/concept generating (Grbich, 1999, p.29). I was initially drawn to the work of Foucault in terms of surveillance of bodies, constructions of normality and his innovative ideas on power-knowledge relations. At the same time perspectives from critical theory, particularly health professional/client relations and communication (Habermas, 1984), were useful as analysis proceeded, as were several key constructs from existential philosophy identified (and described in Chapter 2) which helped to inform and explain the various psychological coping strategies used by some participants.

I used the metaphor of a “toolbox” as articulated by Grimshaw (1993) to guide the development of a theoretical framework which informed methodology. In this context I did not consider the work of critical theory and Foucault to be two discrete “blocks” of theory. Instead, I set out to “question...what affinities there are between some of the questions that...[critical] theory has addressed and those that Foucault addresses, and what sort of dialectic can be created between these” (Grimshaw, 1993, p. 38. See also Manias & Street, 2000, Pahl-Wostl & Ebenhoh, 2004). The tools encompassing these approaches were therefore manipulated in ways to suit the study. However, neither approach was



privileged, since I considered “each approach asks different questions and offers distinctive insights that the other has ignored or missed” (Diamond & Quimby, 1988, p. 43).

For example, the work of critical theorists, like Giroux (1988a, 1988b, 1991, 1992, 1993, 1994) and McLaren (1988a, 1988b, 1989, 1991, 1994), provides an understanding of the forms of subordination that create inequities in the health professional/client relationship. Their work also challenges the institutional and ideological boundaries that historically mask power relations. As previously noted in Chapter 3, the work of Foucault is useful for “mapping the discourses in circulation” as well as the discursive practices associated with professional relationships in the health care setting (1994a). His innovative work on power-knowledge relations (1977a, 1980a) also allowed me to emphasise the unstable ways in which power was constantly recreated in the participants’ accounts.

Before I detail the way in which I used ‘the tools’ derived from critical theory and Foucault’s later work, I will provide an overview of modernism as a movement since modernism has formed the basis of much research on relationships within the health care sector. Contemporary philosophical approaches of critical theorists and Foucault have also challenged key concepts within modernism in their development of more innovative approaches.

## **MODERNISM AS A PHILOSOPHY**

Modernism has as its central assumption the notion that humans shape themselves as individuals. It emerged in the Renaissance when the Enlightenment values of the eighteenth century predominantly shaped Western intellectual thought. While the

definition of modernism has been the subject of intense debate (Watson, 1995), Hartsock (1989-1990), a feminist poststructuralist, defined it in the following way:

First, the “god-trick” was pervasive, and the tradition depended on the assumption that one can see everything from nowhere. Second,...[it] was marked by a faith in the neutrality of reasoned judgment, in scientific objectivity...Third, it claimed to assume human universality and homogeneity, based on the common capacity to reason... Fourth, all this had the effect of allowing for transcendence through the omnipotence of reason. Finally, ...[it] was characterised by a denial of the importance of power to knowledge and concomitantly by a denial of the centrality of systematic domination in human societies (p.84).

This worldview supported ways of knowing that entrenched, for example, the expansion of patriarchal relations. It came to value science over the church, and was increasingly concerned with control and dominance (Watson, 1995). As control was removed “from the feudal tyrannies of kings and priests” (Lather, 1991, p. 87), the self-determining, rational individual was poised to take over. However, the creation of a rational individual also required the construction of devalued others (Hartsock, 1989-1990), and so it became the means by which certain privileged groups, including the health professions (particularly within medicine), have been able to dominate patients/clients in the name of universal values and progress.

At this point I wish to detail aspects of critical theory that I appropriated for my toolbox. I drew in particular on critical theorists’ notion of critical empowerment, as it carries a political intent of change and agency.

## **CRITICAL APPROACHES**

Critical theory evolved from a response to the scientific knowledge being developed by logical positivism and its effect in creating oppression in the working class. The Institute of Social Research, founded in 1923, became known as the Frankfurt School (Giroux,

1983). There is not one critical theory but rather a school of interdisciplinary thought. The original group of scholars at the Frankfurt School included Horkheimer, Adorno, Marcuse, Pollock, Lowenthal and Benjamin. Habermas, a student of Adorno and Horkheimer, is a more recent exponent of critical theory (Agger, 1991).

While critical theory had its basis in the Frankfurt School of the 1920s, renewed interest and rediscoveries became evident in the 1960s and 1970s, through the work of Habermas. In contrast to the early critical theorists, Habermas (1989) has held slightly different views on modernism. While he agreed that modernism emphasises technological rationality and reason, he defended it as an unfinished project with emancipatory potential. In late modernism, he claimed that state and private corporations had taken over the functions of the public sphere, thus displacing rational individuals and groups as the major political forces. Habermas is, therefore, a strong advocate of the major tenets of modernism, defending what he perceived as its progressive elements, while at the same time criticising its oppressive aspects.

Critical theory typically encompasses a “*complex of theories*” (Fay, 1987, p. 31, emphasis in the original). Through these theoretical areas, critical approaches abrogate positivist methods; they explore phenomena by judging the contextual effects of power, knowledge and values, not by adopting rigorous tests that are deemed to be verifiable and replicable. These approaches seek to actively free individuals to question the prevailing norms. Their goal is, therefore, transformation from the constraints of unequal power relationships through self-reflection and free communication (Bernstein, 1978).

Habermas (1984) claimed that true knowledge, and with it the impossibility of human indoctrination and subordination, can only be achieved in the sphere of communication. Instead, Habermas (1995) argued for equality within relationships.

### **Habermas and Communication**

Although modern medicine is related to changes and non-changes in the world, these are not achieved in a technical way, i.e. by acts that are considered linear means to fixed ends. Rather, the 'rationality' embedded in medicine should be more closely related to what Habermas (1984) describes as rationality oriented toward understanding.

Habermas distinguishes between action oriented toward success and action oriented toward reaching understanding, and between action in non-social and in social situations. According to these distinctions, there are three types of action: instrumental, strategic, and communicative action; action oriented toward understanding is not possible in non-social situations, since understanding always means understanding between two or more individuals (1985, 1995). For example, when two or more people are communicating, truth can only emerge if they have the same opportunity to speak, and they have equal opportunities to contradict each other (Habermas, 1985). These are important concepts to consider when examining the manner in which the childbearing woman and the health professional interact.

Firstly, it means that the foundation of medical and nursing care lies within the communicative attitude. The idea of such care should not be to exercise power over the childbearing woman, or to control and manipulate them to behave in a specific way, but rather to try to understand them as both a person and as an individual, to also collaborate

with her to understand her existing health situation (if possible) and to provide support by incorporating the client, that is in this instance, the childbearing woman's resources and requirements in the planned treatment regime (Habermas, 1985, 1995). Secondly, the childbearing woman is an equal in the treatment process, and is not an 'object' of strategic influence. The process of health and well-being, or of maintaining a balance between health and ill-health always starts with the childbearing woman: her resources, requirements, wishes and goals are the starting point. Thirdly, the view of modern medicine as communicative interaction emphasises the role of understanding. This means that the childbearing woman's mind, her interpretation and experience play an active part in the process. The chemically dependent pregnant woman, in her interaction with the Transitions Clinic staff as the consumer can gain new insights and knowledge. These experiences of the childbearing woman may influence her choices with regard to change. In conclusion, it could be said that the possible changes in her health and well-being are not 'produced' in a technical, one-way process by the health professional's action. Instead, they are the results of the childbearing woman's own activity, of her experiences in the interaction with the caregivers.

Habermas' theoretical approach explores phenomena by judging the contextual effects of power, knowledge and values and this approach seeks to actively free individuals to question the prevailing norms. Their goal is, therefore, transformation from the constraints of unequal power relationships through self-reflection and free communication (Bernstein, 1978; Szreter & Woolcock, 2004).

A midwifery model of care reflects similar principles to those identified by Habermas in his concept of ideal communication, that is that the client is the centre of care and there is,

within the relationship, a striving for equality. The Changing Child Birth Report (1993) called for women-centred services that meet the needs of women and their families and called for the “three C’s”, namely, continuity of care, choice and control. Choice and control are synonymous with the principles espoused by Habermas (1984). The principles of continuity of care, choice and control were also confirmed as the ideal by child-bearing women surveyed in Victoria (Having a baby in Victoria, 2001) and in an evaluation of an Australian Midwifery Group Practice (Fereday, Collins, Turball, Pincombe & Oster, 2009).

### **Enlightenment, Empowerment and Emancipation**

Enlightenment, empowerment and emancipation are the processes that create the practical intent of critical theory (Fay, 1987; Gore, 1992). Enlightenment, or raising the consciousness of the oppressed, is used by critical theorists to explain why people are dissatisfied with their lives. Using this process, critical theorists provide individuals with alternative ways to understand themselves. Enlightenment by itself is not enough for individuals to become liberated from a social order. Critical theory must provide a motivating resource for individuals, therefore empowering them. Empowerment encourages people to undertake liberatory activities by which they stand up to their oppressors; this is not to say that the Transitions Clinic staff set out to be deliberately oppressive in the interaction with the chemically dependent pregnant women. One aspect of the analysis study was to identify forms of knowledge and practices which constitute a therapeutic alliance between the staff of the Transitions Clinic and the chemically dependent pregnant women, and to consider the ways in which an environment was provided that empowered, or disempowered, the women participants, as well as to reflect on just what is meant by empowerment.

Processes related to empowerment have been subject to major criticism, especially in poststructuralist and postmodernist literature (Ellsworth, 1989; Gore, 1992, 1993). As described by Harding (1987), empowerment becomes something performed by a central agent for individuals who are yet-to-be empowered.

This central agent assumes the position of “empowerer”. Most critical theory assumes an egalitarian view of power, in which the liberatory culture is a safe place for individuals to freely articulate their voices. However, some critical theorists believe that it is important to determine the hidden power relations inherent in an empowering process that positions individuals as either the empowerer or the oppressed. Aronowitz and Giroux (1991) examined the notion of voice in oppressed individuals by referring to silence:

Voices forged in opposition and struggle provide the crucial conditions by which subordinate individuals and groups reclaim their own memories, stories, and histories as part of an ongoing attempt to challenge those power structures that attempt to silence them (p.127).

What seems entrenched in this view of voice is the construction of a less-privileged group as “other”. In health care relationships, this view of the empowerer or the oppressed concerns interactions between health care professionals and clients/patients in this study - between the health professionals of the Transitions Clinic and the chemically dependent pregnant women. Members of the Clinic health care team could be said to occupy a privileged position. Despite their best intentions, it would be difficult for anyone situated in a privileged position to fully understand individuals of a less-privileged group. Imposing exclusive boundaries around terms like “oppressor”, “empowerer” and “oppressed” and conceptualising individuals as rational, unified beings, who are fully

aware of their intentions, means that empowerers are unprepared to deal with the oppressive moments of their own activities (Orner, 1992).

Ellsworth (1989) was highly critical of empowerment when she wrote of her experiences as a university professor. Her premise centred around the invisible power relations inherent in a forum where the empowerer “helps” the empowered in developing and expressing knowledge. Gore (1993) explored this issue further, debating that the empowerer is necessary for either giving voice or silencing the empowered. She explained the danger of this approach as “cannot[ing] not only a refusal to compromise but also a certainty about the ‘proper’ approach that leaves little space for tentativeness or openness” (p. 102).

Both McLaren (1988a) and Giroux (1988a) vehemently attacked Ellsworth’s arguments as simplifications and misreadings of empowerment. On the other hand, Lather (1991) presented a different reading of Ellsworth’s intention as: “Instead of dead or failed practice, I read her [Ellsworth] as positioning herself always in the position of beginning again” (p. 47).

Lather regarded Ellsworth’s arguments as an attempt to create space to articulate her own position of self-critique. Integral to this focus is removing the “empowerer” as the *source* of what the oppressed can achieve. This move means that “empowerers” must examine their own experiences and appropriate different voices depending on the power relations and cultural tensions that mediate their experiences (Szreter & Woolcock, 2004). Also important in developing a reflexive stance is the possibility of challenging contextual issues of subjugated histories and experiences (Ellsworth, 1989). This process involves



determining how particular interventions used by empowerers lead to the creation of passive individuals and involves listening “to those who have been asking others to speak” (Orner, 1992, p. 88). I further discuss this concept in the next chapter when exploring the methodology. I will now turn to aspects of Foucault’s work that I appropriated for my toolbox.

## **FOUCAULDIAN PERSPECTIVE**

Foucault’s critique of modernism provides an interesting comparison to the views of critical theorists. Like Horkheimer and Adorno (1972), Foucault’s early writings demonstrated that he regarded modernism as a coercive force. However, while Horkheimer and Adorno concentrated on the colonisation of individuals and individuals’ subsequent repression, Foucault focused on the effects of social institutions, discourses and practices on individuals.

Foucault’s work is essential to my toolbox approach because of the way he theorised power-knowledge, body surveillance and self-identity. His work is commonly organised according to specific phases (Dreyfus & Rabinow, 1982; Gutting, 2005). Foucault called the first phase “archaeology”; it concentrated on the formation of discourses or disciplines of knowledge. The premise of the archaeological method is that systems of thought and knowledge (epistemes or discursive formations, in Foucault's terminology) are governed by rules, beyond those of grammar and logic, that operate beneath the consciousness of individual subjects and define a system of conceptual possibilities that determines the boundaries of thought in a given domain and period (Carrette, 2000). The second phase, which he called “genealogy”, focused on power-knowledge relations and the control of populations through disciplinary practices. Foucault intended the term “genealogy” to

evoke Nietzsche's genealogy of morals, particularly with its suggestion of complex, mundane, inglorious origins — in no way part of any grand scheme of progressive history (Marsden, 2009). The point of a genealogical analysis is to show that a given system of thought (itself uncovered in its essential structures by archaeology, which therefore remains part of Foucault's historiography) was the result of contingent turns of history, not the outcome of rationally inevitable trends.

The third phase dealt with a “theory of the self” in which individuals created their own identities (Gutting, 2005). Foucault provides a highly illuminating account of how the ancient Greeks and Romans cared for and constituted themselves in terms of their diet and health, sexuality and vitality, abstinences and self-constraints, as well as their general critical attitude towards the self that anticipates its continuous improvement.

In the following discussion, I refer also to the works of theorists who further articulated Foucault's theories. These include Bordo (1993), Danaher, Schirato and Webb (2000), Dreyfus and Rabinow (1982), Gore (1993), Gutting (2005), Hekman (1996), Sawicki (1991) and Weedon (1987/1992, 1999).

### **Discourse and Discursive Practices**

Foucault's conception of discourse altered during various phases of his work. In his early interpretations of discourse, Foucault (1994b) analysed specific bodies of knowledge by asking questions such as, “What can be said?” and “What can be thought?” (McHoul & Grace, 1993, p.36). Foucault's early interpretations of discourse were problematic as they were unable to explain why certain types of knowledge are established and survive (Dreyfus & Rabinow, 1982; Gutting, 2005). For these reasons, I focus on Foucault's later interpretations of discourse, which initially viewed discourses as a form of social dialogue

that differs according to the positions of individuals who speak or who listen (Macdonell, 1986).

Foucault moved beyond this consideration of dialogue or language to include effects of power relations, whereby “discourses are tactical elements or blocks operating in the field of force relations” (Foucault, 1990, pp. 101-102). According to this latter view, discourses are not merely effects or end products of power; rather power relations are seen to be immersed in discourses (Danaher et al., 2000; McHoul & Grace, 1993) and individuals appropriate and apply discourse by using their conscious and unconscious mind (Danaher et al., 2000; McHoul & Grace, 1993; Weedon, 1999).

In this study, the chemically dependent pregnant women are seen to participate in social and institutional practices produced and maintained by discourses. An analysis of the knowledge constituted in discourse can help these participants to discover what constrains and enables their ways of thinking and speaking (McHoul & Grace, 1993). There exists then, an unstable relationship between the material practices and forms of knowledge that make up discourses. I now wish to focus on how these discourses are formed through discursive practices.

Discourses are made up of discursive practices which “*refer to the rules by which discourses are formed, rules that govern what can be said and what must remain unsaid, and who can speak with authority and who must listen*” (McLaren, 1994, p.188, emphasis in the original). These discursive practices maintain discourses that subsequently constitute power relations and knowledge. For example, the Transitions Clinic is regulated by discursive practices such as institutional policies and procedures.

Foucault did not view discourses as having dominant and marginal forms but rather “as a series of discontinuous segments whose tactical function is neither uniform nor stable” (Foucault, 1990, p. 100). Dominant discourses, which are those produced as part of powerful cultures, are themselves under constant challenge. Some discourses do not have the power and authority associated with a secure institutional location (Weedon, 1999). Resistance can occur as a result of the processes through which discourses become the instruments and effects of power. Thus, discourse

transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it. In like manner, silence and secrecy are a shelter for power, anchoring its prohibitions; but they also loosen its holds and provide for relatively obscure areas of tolerance (Foucault, 1990, p. 101).

For the health professionals and the chemically dependent pregnant women to increase the visibility of marginal discourses, they need to ask certain questions: “Whose voice is being heard in this analysis? Whose voice is being left out? Do people feel constraints against speaking? Are all voices equally informed?” (Powers, 1996, p. 212).

From this perspective, dominant discourses may be considered as regimes of truth that determine what counts as important, relevant and ‘true’ knowledge. “Truth is a thing of this world: it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power” (Foucault, 1980b, p. 131).

Hence, regimes of truth cannot be understood in absolute terms that exist outside the knowledge and power relations of discourses, but rather they must be understood in relational terms. Therefore, a particular view of truth depends on the history, cultural context and power relations that operate in society or a given institution (McLaren, 1994).

Such a view has implications for the Transitions Clinic environment where dominant discourses of technology, skill, power, knowledge and competency operate. The health care professionals who adopt these discourses may understand them as a truth about their environment, whilst individuals may reject these discourses as the truth about their practice (McDonald, 2005).

Critics who asserted that Foucault's view precludes political action and change, positioned their case on his interpretation of truth. One representative of this line of criticism is Taylor (1984), who stated that Foucault's notion of truth was relativistic because it precludes the possibility of judging one form of "truth" to be better than another. He also objected to Foucault's association of "truth" with power. For Taylor, truth is a liberatory concept, which frees individuals from power.

These criticisms can be seen as attempts to fit Foucault into traditional categories of political theory. According to Taylor (1984), important conceptions of political theory involve a subject who could make decisions, a corresponding notion of "truth" that transcends specific regimes of power and emancipation as an ultimate goal. As Foucault fails to fit into these categories, Taylor described Foucault's position as nihilistic; his position precludes the possibility of judging one regime of "truth" to be more important than another. The weakness in these criticisms lies in their failure to see that Foucault's intent was to unravel these traditional conceptions of political theory. Furthermore, as mentioned earlier, Foucault's later writing has forced a rethinking of charges that he was nihilistic. I will now explore Foucault's perspective on power and knowledge.

## **Power-Knowledge**

As Foucault progressed with his writings, he shifted his focus from an analysis of discourses to an analysis of power and knowledge emerging from discourses (Grbich, 1999). Traditionally, power has been considered in terms of a “juridico-discursive” model of power. This model is based on three assumptions: power is possessed, it flows from a centralised source from top to bottom and it is primarily oppressive in its exercise (Moore, 1994; O’Farrell, 2005; Sawicki. 1991). While Foucault did not deny the existence of the juridico-discursive model, he criticised it as representing only one form of power. According to Foucault (1980a, p. 92), power is defined as:

the multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organisation; as the process which, through ceaseless struggles and confrontations, transforms, strengthens, or reverses them; as the support which these force relations find in one another, thus forming a chain or system.

Foucault’s own account of power is not intended as a theory as this would imply a context-free, ahistorical, objective description. Rather, he constructed power in the form of an analytic in which social relations determine the focus of power. Foucault’s reformulation of power suggests that the juridico-discursive model carries “the force of a prohibition”, emphasising “a wholly negative, narrow, skeletal concept of power” (Foucault, 1980b). Instead, in Foucault’s view, power is implicated in the production and reproduction of social practices (Crotty, 1998).

Foucault has explored the ways in which the juridico-discursive model has been so readily accepted in society. First, he referred to the “speaker’s benefit” (1990). The speaker appeals to a better future by proclaiming to find a liberating truth and speaks for humanity. This promise for a better future allows the speaker to adopt a privileged and highly valued

position, which others are ready to accept. Second, Foucault argued that the speaker for humanity is located outside of power and within the truth.

When this speaker reveals the truth, the negative and repressive aspects of this form of power are challenged. The connection that Foucault made between power and truth is, therefore, masked by society's acceptance that power is "a pure limit set on freedom" (Foucault, 1990, p. 82). Foucault did not deny that the juridico-discursive model of power described one form of power, but he also argued that this form does not fully represent the power relations operating at the micro-level of society.

Foucault's interpretation of power can be seen to differ from the traditional model in various ways. First, power is exercised and not possessed (Foucault, 1990). Focusing on power as a possession had led to a preoccupation with questions such as, "Who then has power and what has he [sic] in mind? What is the aim of someone who possesses power?" (Foucault, 1980c, p. 35). By focusing on the power relations themselves, Foucault concentrated on how individuals are affected by power relations, whereby power becomes non-egalitarian and mobile. Power and knowledge are therefore "less like a marriage, more like two sides of the same coin" (Richer, 1992, p. 111).

Second, unlike the juridico-discursive model, power does not flow from a centralised source (Foucault, 1990). Foucault further posited that power is not restricted to political institutions or to a centralised source. Instead, power is multi-directional, operating from not only the "top down" but also from the "bottom up". He did not deny the existence of a state of centralised power, but argued that a mixed ensemble of power relations operates at the micro-level of society. This "bottom up" analysis avoids the potential problem of

using global terms, such as repression, patriarchy and passive-aggressive violence, to explain the practices and forms of knowledge that may constitute relationships between health professionals and the chemically dependent pregnant women.

Third, Foucault claimed power is not primarily repressive but also productive (Foucault, 1977a). In society, cultural and institutional practices have used effective mechanisms of power to produce individuals who act and conform in particular ways, and the “objects” with which they interact. Foucault’s concept of power relations challenges the positivist notion of a scientific, continuous, unified knowledge, to a perception in which discourses consist of local, fractured, discontinuous forms of knowledge.

In Foucault’s (1977a) analysis of power, power and knowledge are intimately connected and expressed as one: power-knowledge. He argued that: “power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations...”(p. 92)

For Foucault, knowledge is an important technique of power. Knowledge reinforces and supports existing regimes of truth. In addition, power generates and shifts with changes in knowledge (Coleman, 2008; Grosz, 1994; O’Farrell, 2005). While the literature has often conveyed this relationship by an oblique slash (/) as power/knowledge, Keenan (1987) interpreted and justified Foucault’s use of the dash (-). He argued the dash holds the two words together and apart, indicating their independence with, and their difference from, each other.



It is of interest to compare Foucault's interpretation of power with critical theory's constructions of empowerment and emancipation. His notion of power as something that "circulates", "functions in the form of a chain" and is "exercised through a net-like organisation" (Foucault, 1980c, p. 98) refutes the idea that power can be 'given' to someone to empower that person.

Despite Foucault's sympathy for those individuals who are subjugated, some critics have indicated that he wrote from the perspective of the dominator who exercised power as a repressive force on individuals (Hartsock, 1990; McNay, 1992; Oksala, 2005; Street, 1992b).

### **Disciplinary Technologies of Power**

To enable power to operate productively and efficiently, a complex network of disciplinary technologies is required. According to Foucault, disciplinary technologies are the techniques by which the body can be divided up, manipulated and reconstituted (Dreyfus & Rabinow, 1982). The spread of these technologies into everyday operation creates mobile and asymmetric power relations. Foucault (1977a) called these techniques of power, disciplines, where the body becomes an object to be separated into its constituent parts, analysed and manipulated. Disciplines allow for meticulous control of the body; they create docility. The aim of disciplinary technology is to create a "docile [body] that may be subjected, used, transformed and improved" (Foucault, 1977a, p. 136).

The main function of disciplinary power is to train individuals, for example, to instruct the chemically dependent pregnant women to attend ante-natal care, practise harm minimisation and deliver a healthy baby.

Knowledge acquired through disciplinary power is formulated according to norms of practice. Specific procedures or instruments operate on individuals and train them to produce desirable forms of knowledge (Foucault, 1977a). The goal of the first instrument, hierarchical observation, is to make surveillance an integral element of control. Hierarchical observation promotes and upholds the general visibility of the individual and, therefore, supports the institution's power structure. The perfect observational apparatus makes it possible for a single observation to encompass everything in all directions.

The second disciplinary instrument described by Foucault is normalised judgment. Normalised judgment involves the maintenance of specific, acceptable standards and the reinforcement of conformity (Foucault, 1977a). If a person fails to conform to expected norms, 'little punishments' are inflicted to highlight the failures. Foucault characterised this judgment as a kind of "micro-penalty" that makes an example of individuals who fail to maintain particular, specified standards, for example those participants who attended irregularly for antenatal care and chose not to divulge their drug habits.

The third disciplinary instrument described by Foucault is the examination, which in this study is predominantly "natal-panopticonism" (Terry, 1989 (see Chapter 7)). The examination amalgamates the techniques of hierarchical observation and normalising judgment (Foucault, 1977a). It imposes a compulsory visibility over individuals, allowing for differentiation and judgment. Foucault (1976) argues that once individuals internalise the notion that they might be observed at any time and – in the case of the chemically dependent pregnant women – that their bodies become "public property" and are continuously subject to the gaze of "natal panopticonism" (Terry, 1989). Individuals often

become their own observers and enforcers, thereby turning themselves into “docile subjects”. Docile subjects comply with the demands of the establishment willingly, and thus power structures remain invisible until they are overtly challenged (Foucault, 1982). The examination also manifests its power through its invisibility. The importance of the examination is based on a subtle form of power reversal. In the traditional juridico-discursive form, power itself is rendered visible. Disciplinary power through the examination reverses these power relations. In this context, “it is power itself which seeks invisibility and the objects of power – those on whom it operates – are made the most visible” (Dreyfus & Rabinow, 1982, p. 103).

Through comprehensive documentation, the examination segregates each individual into a known case. Documentation allows for individuals to be described, judged and measured against others, therefore permitting further correction, classification and normalisation (Foucault, 1977a). This is considered useful when examining the ways in which the clients in health care are judged against normative standards and expectations.

## **Resistance**

As indicated by Foucault (1990), an intimate relationship exists between power and resistance. Foucault explained: “Where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power” (p. 95). Foucault insisted that “points of resistance are present everywhere in the power network” (p. 96); therefore he did not view power in terms of overcoming resistance.

Despite Foucault's assertion that power relations are diffuse and productive, McNay (1992) proposed that his analysis of power was one-sided and not presented from the point of view of those individuals 'subjected' to power. However, McNay's view of power lies within the juridico-discursive model, which Foucault regarded as only one form of power. Foucault's (1980a) defence would have also relied on the idea that resistances allow for the exercise of power to be modified. In this way, everyone is implicated in power relations. Through resistance, all individuals have the opportunity to undermine the structures on which power relations depend. As indicated by Sawicki (1991):

resistance involves using history to give voice to the marginal and submerged voices which lie "a little beneath history" – the voices of the mad, the delinquent, the abnormal, the disempowered. It locates many discontinuous and regional struggles against power both in the past and present. These voices are the sources of resistance, the creative subjects of history (p. 28).

The struggles of resistance do not rest with those who authorise power; in fact, such a view is contrary to Foucault's concept of power as a force relation (Root & Browner, 2001). Instead, resistance is an issue for all individuals. Although Foucault has no particular utopian vision, his notion of resistance creates a voice for the "injustices....[of] the present" (Sawicki, 1991, p. 29).

## **Subjectivity**

Foucault (1980a) refuted the concept of the active subject because he considered it to be an effect of power-knowledge. As articulated in the previous chapter, subjectivity is therefore constituted through those (multiple) discourses in which the person is being positioned at any one time. According to Curtis and Harrison (2001) and Weedon (1987/1992), while individuals are unable to control their overall direction, they are still able to choose among the practices available to them. They may consider the implications of various choices as these are taken up and established into a hierarchical network of power relations. For this

reason Weedon's (1999) definition of subjectivity as "the conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world" seemed appropriate (p. 32).

This view of language is in stark contrast to the humanist view, which casts language as "merely reflecting and describing (pre-existing) subjectivity and human experience of the world" (Gavey, 1989, p. 463). Within humanism, the language of both the health professionals and the chemically dependent pregnant women is seen to transparently reflect their experiences. These experiences are often regarded as universal and ahistorical, and are applied to all. When both groups speak from their experiences, this creates an unquestionable authority in much of the available literature. For example, the pregnant women who have a chemical dependency are marginalised because of the power exerted on them by a dominant discourse, the addict in need of expert medical care. The contradictory nature of subjectivity means that these women may align themselves with this discourse at the beginning of their pregnancy. However their experiences throughout this [pregnant] journey and the subsequent birth outcomes may change their subjectivity to position themselves among other discourses, namely the addict in recovery and the "mother identity".

## **THE POSSIBILITIES OF A TOOLBOX APPROACH: USING CRITICAL EMPOWERMENT AND THE WORK OF FOUCAULT**

I believe that the contemporary philosophical approaches of Foucault and critical theorists share a number of commonalities as well as divergences. Both approaches seek a transformation of traditional views of society, modernity and reason, leading to self-understandings that produce social implications. Poststructuralists, in particular reject the

position of the disengaged, autonomous, rational subject of humanism, and recognise knowledge as a social product embedded in practical contexts. Both critical theorists and poststructuralists perceive that speech and action occur within taken-for-granted contexts, which are historically and culturally contingent (McCarthy, 1992; Vaughan, 2002).

These approaches differ in a number of ways. While critical theoretical approaches aim to restructure humanism's notions of subjectivity and autonomy, a Foucauldian approach situates subjectivity as an effect of power relations. Critical theoretical approaches seek to combine a particular context with universal truth, allowing for accounts of origins, structures and tendencies of existing social orders. On the other hand, a Foucauldian approach discounts compatibility between local context and universal truths (McCarthy, 1992).

In summary, I employed a reformulated notion of critical empowerment that sustained a political intent of agency, identity and change. This notion of critical empowerment was used to reconstruct the practices and forms of knowledge, previously mapped and unmasked by a Foucauldian approach and underpinned by Habermas' concept of ideal communication, to bring about improved relationships between the staff of the Transitions Clinic and the chemically dependent pregnant women. Although the work of critical theorists - including Habermas - and Foucault encompasses different philosophical approaches, they along with existential theories provided me with an appropriate framework for analysis.

## **SUMMARY AND CONCLUSION**

In this chapter, I have examined the strengths of two approaches to create a complementary theoretical and methodological toolbox. My goal in sustaining the metaphor of the toolbox was not to view Foucault's work, Habermas' communicative action and critical theory as discrete entities. Instead, I questioned the value of each approach in constructing a theoretically informed and practically relevant focus for this study. In my critique of Foucault's work, I believe that he was not greatly concerned with notions of agency, change and empowerment. The toolbox incorporated three components, each complementing the other. The first component comprised my theoretical conceptualisation for the study, which involved Foucault's work. The second component involved the methodological process of data gathering and refining, which encompassed the notion of critical empowerment embedded within a critical ethnographic approach. The third component of the study involved research analysis. A Foucauldian approach enabled me to map out the practices and forms of knowledge informing the differing relationships that the chemically dependent pregnant women experienced as consumers of the Transitions Clinic. Critical empowerment and existential philosophy were used to assist the participants to evaluate their lives, challenge previously unquestioned assumptions and behaviour and move forward with their lives with improved power and knowledge.

In the next chapter, I detail the methodological framework of critical ethnography and describe the methods I used in the data collection and analysis.

## **CHAPTER FIVE**

### **METHODOLOGY**

Methodology embraces the entire scientific quest and  
not merely some selected portion or aspect of that quest.

H. Blumer (1969) *Symbolic interactionism: Perspective and method*

#### **INTRODUCTION**

This chapter describes the methodology of the study. Harding (1987) defined methodology as “a theory and analysis of how research does or should proceed” (p. 3). The methodology guides how methods are used according to Harding’s schema and the methods are “a technique for (or way of proceeding in) gathering evidence” (p. 2). The chapter is divided into three sections: the first explores ethnography as a method, specifically critical ethnography, the methodological framework for the study; the second describes the methods and techniques; while the third explains the details of the data analysis and the writing up of the study.

#### **EXPLORING ETHNOGRAPHY AS A METHOD**

The rationale for using traditional ethnographic approaches is based on two types of hypotheses about human behaviour (Grills, 1998). First, the naturalistic-ecological hypothesis that claims that human behaviour should be studied in an individual’s natural environment rather than a contrived setting (Atkinson, 2002; Roper & Shapiro, 2000) and second, the qualitative-phenomenological hypothesis that values the researcher’s understanding of the meanings that individuals place on their actions. Fieldwork is, therefore, a central component of an ethnographic study in which the researcher collects data in a cultural setting (Hammersley & Atkinson, 1996).



Sociological ethnography, a form of ethnography to which this study belongs, is usually assumed to have originated in the 1920s with the Chicago School (Silverman, 2001). As Silverman (p. 50) notes: “A crude (and sometimes inaccurate) way to distinguish sociology from anthropology is to say that, unlike anthropology, sociology’s ‘tribe’ is the people around them.” Early sociological ethnographies were within urban settings. Nursing and medical ethnographies have tended to focus on the enclosed space of hospital wards or outpatient clinics (Sandelowski & Barosso, 2007). This ethnographic study is situated in the Transitions Clinic of the Mercy Hospital for Women.

Grill’s (1998) text *Doing Ethnographic Research* describes ethnography as “a qualitative research method based on observing, participating in, and recording a people’s way of life, or social experiences” (p. 94) and the ethnographic interview as a “variant of unstructured interviews that is particularly sensitive to the social context of the respondents’ lives” (p. 86), or in this instance the respondents’ experiences in a particular context.

From the 1960s onwards there has been an overt rejection of traditional ethnography, allowing for a radical thinking, and development of innovative approaches to ethnography. I believe the use of a traditional ethnographic approach was inadequate to determine the mundane, intuitive and emotional realities of the lives of the chemically dependent pregnant women and their interactions with health professionals at the Transitions Clinic. I needed to confront the issues of power, reflexivity and critical intent within my methodological framework. Since critical ethnography embraces these issues, it was seen to stand against the policing structures of the sovereign discourses of traditional ethnography (McLaren, 1992).

Critical ethnography adopts the same methods as applied in any ethnographic study, although the purpose is different since it has an emancipatory interest. This means that the research is not only descriptive or interpretative, but the aim of the research is to actively expose personal, cultural and political aspects of social action (Carspecken, 1996). Kincheloe and McLaren (1998, p. 266) comment that “critical ethnography continues to redefine itself through its alliances with recent theoretical currents”. Giddens (1984, p. 284) writes that “all social research has a necessary cultural ethnographic or “anthropological” aspect to it”, since meaning in the field is already constituted. The condition of entry for the researcher to this ‘constituted’ field is that they become familiar with what agents already know *and have to know*, to go on in daily life. Kusher and Morrow (2003, p. 41) support this concept of critical ethnography as an “every day experience”, necessary to illustrate how social life is organised. As with any ethnography, a critical ethnographer requires prolonged periods of time in the context of the ‘field’, focusing on meaning where socio-cultural phenomena are observed with the aim of making the hidden unhidden (Carspecken, 1996), and for that reason, “ethnographic research must be deliberately and consciously political” (Quantz, 1992, p. 448).

The participants in critical ethnography are purposely selected because of what the researcher may think they know, with the aim of gaining rich and meaningful data (Carspecken, 1996). The notion of empowerment expressed by critical theorists and its critics enabled me to rethink the premise of empowerment for this study. The hierarchical foundations of hospital [and clinic] structures are seen to impede health professionals and consumers from establishing equal, emancipated and democratic relationships. I believed that a more feasible way of appropriating empowerment was to read the participants’ interviews in terms of a sustained encounter with the Clinic staff, and examine how their

subject positions may lead to oppressive moments impeding effective collaboration and communication, or conversely, the development of subversive techniques. Within these encounters, the research participants and the Clinic staff were seen as continually acknowledging and renegotiating their own subject positions. These encounters also allowed me to examine how power legitimates and perpetuates particular practices and forms of knowledge. Such an encounter also permits an examination of the way in which the Clinic staff moved beyond the space of being “master of truth and justice” (Foucault, 1980b, p. 126) and recognise the complexities, contradictions and complicities that affect efforts to alter practices of collaboration. For this study, the term “power relations” refers to the staff (the doctors, midwives, social workers, dietitians) of the Transitions Clinic and their exercise of power as perceived by the chemically dependent pregnant women utilising the Clinic’s services.

Critical ethnography also identifies “the complexity of social relations and the researcher’s own socially determined position within the reality that one is attempting to describe” (McLaren, 1992, p. 217) and the “critical ethnographer seeks to explore how those who lack autonomy and coherence of cultural construction of disempowerment (for example, chemically dependent pregnant women) respond to their positioning or that they recognise their response as anything other than individual choice, or even agree that they are disempowered” (de Laine, 1997, p. 23).

Simon and Dippo (1986, p. 197) identify three conditions that must be met to consider critical ethnography as “critical” and that coincide with Kincheloe and McLaren’s (1998, p. 263) assumptions of critical theory. First, critical ethnography must define data and analytic procedures consistent with the project, addressing the social practices operating in

groups that determine meaning and consequence. Second, the research must have an emancipatory aspect in helping participants understand their behaviour within an historical and social context and still be willing to challenge the conditions of oppressive and inequitable social practices. While the nature of this research meant that it did not have an overtly emancipatory aspect, it could be deemed emancipatory in that it acknowledged that all power relations are social and historically constituted, that inequalities between certain groups in society can be revealed, and new understandings can be gained and reported. Thus critical research, regardless of approach, has the potential of being emancipatory and shares the “danger of being disruptive” (Freire, 1970, p. 55), since it is about giving opportunity for silent voices to be heard and involves the interplay of power-knowledge relations in local and specific settings (Fay, 1987; Goode, 2005; Habermas, 1984).

Simon and Dippo’s (1986) third requirement is that the critical ethnographer concede that her/his personal worldview may also be constituted and regulated through relations of power and authority. This requires that the researcher shows self-awareness, through reflective practice, of the influences that shape their beliefs, thoughts and practices (Hammersley & Atkinson, 1996). Language, according to Kincheloe and McLaren (1998) is central to the formation of subjectivity, that is conscious and unconscious awareness; therefore “language is a form of power” (Thomas, 1993, p. 45). Dialogue is an important tool in gaining an understanding of subjectivity, accepting that the affiliation between concept and object, and between signifier and signified is never stable or fixed (Giddens, 1984). Critical ethnography, then, according to Grundy (1987, p. 19) places the researcher within “the natural context to examine asymmetrical power relations”, and so the method has a political orientation towards addressing imbalances.

The research could be deemed feminist, as a feminist interpretation of Foucault's theory helped inform the theoretical framework and it was research on women, by a woman researcher (Harding, 1987). In keeping with a feminist approach the aim was to develop a trusting, confidential, comfortable and non-judgmental environment which promoted open reciprocal interactions between the researcher and the participants (Goode, 2005), where the perspectives of the women were afforded primacy (Harding, 1987).

## **METHOD AND TECHNIQUES**

As outlined in Chapter 1, the purpose of the study was to evaluate the care provided to chemically dependent pregnant women by the Transitions Clinic of the Mercy Hospital for Women, a major metropolitan women's hospital. The research aims are: providing rich descriptions of the range of problems chemically dependent pregnant women face; identifying the extent to which chemically dependent pregnant women believe the services offered by the Transitions Clinic at the Mercy Hospital for Women meet their own and their family's needs, and assessing whether pregnancy is a time of transition or a turning point in the lives of some of the women.

The non-inclusion of the staff of the Transitions Clinic in the study might be seen as a limitation, however, as the previous paragraph attests, the project was focused on the chemically dependent pregnant women as participants and this was the study funded by the ARC Grant. Efforts were made at a later date to recruit staff (obstetricians, midwives and a social worker), however they declined to participate. As detailed under Data Collection on p. 92, frequent observations of the interactions between the health professionals and the chemically dependent pregnant women were recorded in my reflective journal.

## **Participant Recruitment**

A convenience sample of twenty (20) chemically dependent pregnant women who attended the Transitions Clinic at the Mercy Hospital for Women was recruited for the research project. The selection criteria specified that they must be non-Koori, English-speaking, aged between 18 and 35, and not be too compromised by the effects of substance abuse. The reasons that Koori were excluded was because the Koori representative approached within the Koori community in order to gain consent for Koori women to be included, expressed “strong pejorative views that any academic non-Koori researcher needs to have considerable experience within the Koori community” in order to carry out research with Koori women (Tuttle & Seibold, 2003, p. 32).

I approached the twenty women who had been referred to the Clinic and enquired if they were interested in participating in a research project that sought to evaluate the Clinic’s care and services. All agreed to participate. The participants were at varying stages of their life (see Appendix B for a brief biographic profile of each participant): three were married, eleven were in relationships, while six did not have a partner. Nine participants had other children, all gave birth during the research period and two participants became pregnant again before the study was completed. The mean age of the respondents was 24.8 years, and the range was from eighteen to thirty-five years. The mean length of time that the women had been using drugs was 8.9 years, varying between three to fifteen years. Seventeen participants were born in Australia, two found during the study period that they shared an Indigenous heritage, two were born in Asia (Thailand and Hong Kong) and one came from Lebanon. Table 1 (see p. 91) introduces the women’s demographic details and Hep C status.

Informed consent (see Appendix C for the Plain Language Statement and Consent Form) was obtained according to the National Health and Medical Research Council (2001, 2005) guidelines. In addition the women's attention was drawn to the conditions of the consent in terms of the researcher's requirement under law to report any information received regarding children at risk. They were also asked for their permission to publish verbatim quotes in conference presentations and journal articles, while also being assured that to preserve confidentiality any uniquely identifying and sensitive passages would be omitted (Morse, 1998, p.78). This explanation was repeated at subsequent interviews.

## **DATA COLLECTION**

The course of ethnography cannot be predetermined (Hammersley & Atkinson, 1996), but this does not imply that the researcher's behaviour will be haphazard, and as ethnographers study holistically, multi-methods are used to gain a broad perspective (Silverman, 2001). The methods employed in this study are consistent with this approach, that is, interviews, observation and field notes, chart audits and a reflective journal as well as "hanging about", "sussing out" and "listening and thinking" (Hunt, 2004, p.53). From the perspective of a feminist researcher, I considered I was required to be visible, known and embodied as a "real, historical individual with concrete specific ideas and interests" (Cole, 1995, p.195).

**Table 1 The Women in the Study**

<b>Pseudonym</b>	<b>Age</b>	<b>Parity</b>	<b>Education</b>	<b>Marital Status</b>	<b>Employed</b>	<b>Ethnicity</b>	<b>Hep C Positive</b>	<b>Polydrug Use</b>	<b>Drug Of Choice</b>
Jasmine	19	G2P2	Year 10	P	No	Anglo/Celtic	Yes	Yes	Heroin
Lisa	20	G1P1	Year 11	P	No	Indigenous	No	Yes	Marijuana
Alice	26	G2P2	TAFE	S	No	Asian	Yes	Yes	Heroin
Monique	28	G1P1	TAFE	M	No	Anglo/Celtic	No	Yes	Cocaine
Sharon	23	G3P3	Year 9	P	No	Anglo/Celtic	Yes	Yes	Heroin
Kate	31	G1P1	PostGraduate	P	Yes	Anglo/Celtic	No	No	Cocaine
Erica	22	G3P1	Year 8	S	No	Anglo/Celtic	No	Yes	Marijuana
Cathy	24	G3P3	Year 8	P	No	Anglo/Celtic	Yes	Yes	Heroin
Naomi	26	G3P3	Year 10	S	No	Lebanese	Yes	Yes	Heroin
Peta	29	G1P1	VCE	S	No	Anglo/Celtic	Yes	Yes	Cocaine
Leanne	32	G3P1	TAFE	P	No	Anglo/Celtic	No	Yes	Methamphetamine
Amanda	23	G2P2	Year 10	P	No	Anglo/Celtic	Yes	No	Heroin
Nicole	18	G3P1	Year 10	S	Yes	Anglo/Celtic	Yes	Yes	Heroin
Jo	22	G2P1	UnderGraduate	M	Yes	Anglo/Celtic	No	Yes	Cocaine
Rosa	24	G2P2	VCE	S	No	Anglo/Celtic	No	Yes	Marijuana
Maryanne	18	G1P1	Year 10	P	No	Anglo/Celtic	Yes	Yes	Heroin
Sara	20	G2P1	Year 8	S	No	Asian	Yes	Yes	Heroin
Maggie	27	G1P1	TAFE	M	No	Indigenous	Yes	Yes	Heroin
Dee	31	G3P3	TAFE	P	No	Anglo/Celtic	Yes	No	Cocaine
Debbie	35	G3P3	UnderGraduate	P	No	Anglo/Celtic	Yes	Yes	Heroin



## **Interviewing the Women**

Interviews are an important method of data collection in ethnography (Rogers & Bouey (1996), and may range from spontaneous, informal conversations to being formally arranged (Hammersley & Atkinson, 1996). The emancipatory potential for this ethnography was critically related to the position I established with the chemically dependent pregnant women. Inherent within this perspective were other feminist ethical researcher practices: trust, presence and safety to speak and non-hierarchical relationships (Harding, 1987). In interviewing, I invited the women “to recall, reveal, and construct aspects of subjective experiences and to make that discussion coherent and meaningful” (Minichiello, Sullivan, Greenwood & Axford, 2004, p.37). In this way, I did not construct specific questions to elicit predetermined answers or information corresponding to pre-coded response categories; however I did use an interview schedule to ensure that I covered the research aims. I also asked the participants at each interview to indicate their recovery progress using the Trans-Theoretical or Stages of Change Model (TTM) tool used by staff of the Transitions Clinic and described in Chapter 3. I spent 204 hours over 25 months at the Transitions Clinic recruiting and interviewing participants.

It was apparent that the depth of participant disclosure was dependent upon the level of trust established between the chemically dependent pregnant women and myself, as the researcher. There were a number of personal ways of being: sensitive, ethical, communicative and enabling, which aimed to establish and maintain trust and to provide support to the participants if the situation became stressful (Goode, 2005). Lemert’s (1997, p. 13) words were a pertinent reminder of the importance of maintaining trust, in that “when trust is broken, the truth is beyond even scientific rigour to restore”.

I promised the participants that I would personally transcribe the digitally taped interviews as I believed this afforded the women greater privacy, and in turn resulted in the depth and breadth of the participants' disclosures and their frank and forthright responses. The transcripts did not contain any identifying names or locations.

Following each interview, as the researcher I made notes which included objective descriptions of what I heard and observed, such as non-verbal behaviour and expressions. I also maintained a reflective journal in which I examined my own beliefs, biases, values and interests. I did this to ensure that I engaged critically with my own experiences in relation to the women's narratives (Gordon, 2009). This increased awareness is well documented as a hermeneutic principle that lessens the possibility of projecting a researcher's pre-understanding onto the process of investigation (Braud, 1998; Jones, 2002).

## **Observation**

Observation sets out to capture the social setting, (in this instance the Transitions Clinic) in which people functioned (Mulhall, 2003) and were recorded in my journal. Observations were undertaken at the Transitions Clinic, the sites where the informants were also interviewed, as well as on the ward following delivery. Observations recorded the interactions between the women and the Clinic staff and between the women and their partners and families.

I attended the Clinic on Tuesday afternoons and Thursday mornings over the twenty-five month period of data collection. The East Melbourne site was always a flurry of activity with the coming and going of clients and staff, and its central location and proximity to the

city made it a perfect ‘dropping off’ point for partners, friends and families of the women. The participants appeared relaxed and comfortable in this environment, animated and talkative, and responding to the questions and comments made by the Clinic staff. This changed when the Clinic moved to the Heidelberg site as all interactions appeared to be in the consulting rooms. The waiting areas appeared sterile and lifeless and everyone, including staff and clients, seemed ‘dwarfed’ by the bright lighting and the gleaming tiled floors.

### **Field notes**

Field notes are a vital data source for the ethnographer. What they do or ought to contain is open to debate, but they could be thought to include raw data or material such as diagrams, maps, notes jotted in the field and detailed notes written away from the field and reflexive journals (Mulhall, 2003). Prepared by a researcher, they are, therefore, dependent upon the writer’s style and personality.

From the beginning, my journal was both a reflective document and a document detailing my observations, opinions, theories and the women’s anecdotes. The act of formulating these thoughts helped me to make sense of what I had observed. I recorded details of telephone conversations, intimate confidences, the dreams and desires of impending motherhood, drug habits and behaviours, fabricated stories for government and community agencies, and, of course, additional details of the interviews I conducted, most of which were audiotaped. The development of analysis can be traced through my journal, as well as the highs and lows of fieldwork.

## **Chart Audit**

One method of retrieving valuable information is the chart audit which is the process of systematically identifying and collecting clinical data that have been recorded as part of a formal documentation system (Herman, 1996). Doing a chart audit helped make the choice of the methodology sound (Borkan, 2004) and provided additional confirmation or validation of the information obtained from the women. Gaining access to the medical records was problematic in that no-one seemed to want to make this decision. All in all it took nearly ten months and representations to various senior nursing staff and administrative personnel. Finally, a directive was issued from the Human Research Ethics office that “smoothed the way”; however, there was still some overt resentment at my having access to the medical records. Confidentiality and privacy were the reasons given to me when access was “blocked”, and I then realised how little understanding the health professionals and allied health staff had of the research study, despite the fact that permission had been given by the hospital’s Ethics Committee. I accessed the medical records to confirm appointments kept or cancelled, test results where applicable, drug histories, and birth details and health status of the newborn. The chart audit took place over a twelve month period and revealed both expected and surprising findings. The details obtained from the medical records provided strong evidence to suggest that attendance at the first Clinic appointment before twenty weeks greatly increased the likelihood of ongoing antenatal care. These findings support the current emphasis in the literature on early intervention for people with substance use issues (Wetherington & Roman, 2001) and confirm that early intervention greatly improves the likelihood of longer term retention within a service.

### **Journalling, self-reflection and reflexivity**

Glass (2000) highlighted the benefit for the feminist researcher of the use of reflective journalling, as a form for both personal and interpersonal reflexivity. Street (1995, p. 145) asserted that journaling enabled the writer to “identify and clarify the taken for granted assumptions”. Journalling was intended as an audit tool that captured decisions and reflections along the way and identified factors that constrained and enabled me throughout the research journey. However, finding the time to write regular personal reflections, as well as field notes, was sometimes difficult to achieve. Hammersley and Atkinson (2007) also identified this problem. An approach I used to overcome the problem was to capture my thoughts and feelings on audiotapes immediately following an interview and these were later transcribed into my journal.

Pellatt (2003, p. 29) claims that “to increase the plausibility or rigour of ethnographic research it is suggested that researchers include a reflexive account in their report”. Self-reflection was part of the journalling process that assisted in maintaining critical theory principles. The purpose was to expose my personal constructions, that is, my values, beliefs, strengths and weaknesses that moulded the research journey and the choices made (Mulhall, Le-May & Alexander, 1999). Atkinson (2002) explains that reflexivity is a term widely used as a research tactic yet poorly defined. Generally, reflexivity is an acknowledgement of the role and influence the researcher may have during the research process (Rice & Ezzy, 1999). Therefore, reflexivity becomes a conscious and deliberate act whereby the researcher, in addition to the research, is examined and accepted as part of the research design. Giddens, (1984, xxiii) defines reflexivity slightly differently, recognising that every person is inherently reflexive, yet “operates only partly at a

discursive level”. For the purposes of this study, I actively engaged in reflexivity at both a practical and discursive level, recognising that not all could be known or spoken about.

Within critical ethnography, reflexivity involves the researcher intimately interacting with the data in order to make some sense of their meaning. A reflexive researcher is aware of the ways in which self affects both research processes and outcomes, and rigorously conveys to readers of research accounts how this happens. Reflexivity then plays an important role in all stages of the research process, including how the researcher practises ethnography in the research setting, how the researcher constructs data, and participants’ interpretations of the data (Wiles, Crow, Charles & Heath, 2007). The reflexive process also extends to the production of ethnographic accounts. Here, the researcher is concerned about the extent to which an ethnographic text represents the “reality” of participants’ experiences (Atkinson, Coffey, Delamont, Lofland & Lofland, 2007). An important concern of reflexive ethnographic texts is to show how, in textual constructions of the culture, there is also a construction of the researcher’s self (Sandelowski & Barasso, 2007).

Keeping a reflective journal kept me deliberately aware of “self”, as in my responses and internal state in relation to specific situations, while at the same time attempting to understand the research participants and how they made sense of their world (Creswell, 2003). It also allowed me to identify biases and their potential influence on the data and the interpretation of the data (Coffey, 1999; Roper & Shapira, 2000).

In this context, I regularly wrote personal memos which reflected my own thoughts, feelings and perspectives about the experience of carrying out this research, as well as my emerging thoughts with respect to analysis. These were formally included as raw data, and

were processed, coded and used in the analysis. During regular meetings with my supervisors, who were experienced in the use of qualitative research methods, I was encouraged to question and justify my developing explanations and interpretations. The drafting of an account of the research started before analysis was complete, and repeated redrafting proved a useful means of testing and challenging new ideas. Concurrent readings from the social science disciplines, including sociology, philosophy, psychology and midwifery helped to inform my ideas as did presentations at conferences and seminars (see Appendix D for a complete list for conference and poster presentations..

## **DATA ANALYSIS**

### **Preparing for Data Analysis**

“The analysis of qualitative data is usually seen as arduous” (Basit, 2005, p.145) and this study was no exception. I considered several data management methods used by other critical feminist researchers and feminist postmodern ethnographers (Cheek, 2000; Davis, 1998; de Laine, 1997; Lather, 1991), postmodern narrative researchers (Boje, 2001) and qualitative studies in general (Richards, 2005). I felt that none of these methods, in their entirety, were suitable to help me adequately address the research aims of this study. I needed to create a different and unique way for me to analyse the data. I had taken the decision to manually code, categorise and theme my data as I felt a computer-based programme would create unnecessary restrictions, inhibit the development of research skills and impose time-consuming learning curves (Glaser, 1998). It has to be said that I’m also a recovering technophobe, so I was well satisfied with butcher’s paper and a whiteboard to draw box diagrams that represented the interrelation of emerging concepts and perspectives. I also used Word to combine and analyse sets of ideas and themes.

## **Doing the data**

Data analysis occurred during all stages of the study. Fox (1993) articulated a comprehensive framework of three types of questions that I found useful in helping me to make sense of my reflective journal and field notes.

First, what is the politics of the truth-claims about what is happening in this setting? Whom do they benefit? How do these beneficiaries try to ensure that they are not subverted by other truth-claims? Second, what kinds of subjectivity are constituted in...[myself] by the discursive practices...[of my interactions]? What is inscribed upon...[my body]? Third, and importantly, what are the conditions of possibility of resistance to these...[discursive practices and participants]? What investments would be entailed in such resistance? (Fox, 1993, p.40)

During this period of data analysis, I re-read Foucault and some feminists' interpretations of his work to help me to place the data in the context of the theoretical framework. I devised the following guide to help me analyse the data. I sought to determine:

- Who is speaking: Is the individual speaking for someone else or about something else? When and why does this occur and under what circumstances? What contradictory and conflicting positions do individuals take up when they are speaking? Is silence a form of control or resistance? How and why is silence a form of control? How is power exercised in the spoken situation? By whom is power exercised in the spoken situation? What is true for the speaker? Is the individual speaking the truth?
- The effects of space and surveillance: Who is positioned where and how? Who is under surveillance? When and how are individuals under surveillance? Is self-surveillance present?



- The power-knowledge relations of power and dominance: Which discursive practices are more apparent than others? How and why are they more apparent? Who and what is included and who and what is excluded from these discursive practices? Under what circumstances are decisions made?
- The desire for collaboration: Did the participants want better communication and equality and parity with Clinic staff? Was this a valid expectation? How would this desire affect the influence of the dominant discourses in circulation?

My examination of the data began with frequent readings of the transcripts so that I developed an increased familiarity with them. At the same time I would also refer to my field notes and reflective journal to assist in contextualising the transcripts (Richards, 2005). As I read, I constantly interrogated the data using Fox's (1993) guide. I noted my interpretations on the blank, left hand page of my transcripts. Multiple codes initially identified were condensed into key categories. The text was coded to create arbitrary demarcations.

Eventually I reached a stage in which my interpretation of the issues became cumbersome, so I then moved to something approximating situational maps as described by Clarke (2005) and used these to create connectedness. For this process, I developed flow charts comprising the several "satellite circles" branching off from a central hub or issue. From these satellite circles, smaller satellite circles evolved. Linkages were created between central issues and the various levels of satellite circles to indicate the complexity and interconnectedness of data (Basit, 2005; Carpsecken, 1996; Roth & Roychoudhury, 1994). The step-by-step approach I used to authenticate the ethnographic data is presented below:

1. I reviewed the four research aims and typed these onto a Word document. Into this Word document I inserted the participants' transcribed data for each interview, my field notes and reflective journal. I formatted the transcribed data into a one-column table which split the sentences into rows.
2. I then created a second Word document as a four-column table to accommodate the next steps to address the pseudonyms and demographics of the participants, the factors that may have influenced their chemical dependency (for example, life choices and life chances) and their perceived barrier(s) or motivators to antenatal care. This information was later transposed to form the introductory tables and matrices of the study.
3. I realised that I couldn't work efficiently with a set of Word documents so I moved to abstract situational maps (Clarke, 2005) because I was comfortable with this form of analysis – it was visual – and I could look at the charts when doing basic household tasks. In situational mapping the goal is first to describe the “most important human and nonhuman elements in the situation of concern” and then move to “who and what is in the situation? Who and what matters in this situation? What elements make a difference in this situation?” (Clarke, 2005, pp. 86-87). Figure 2 is an example of a “messy working map” (Clarke, 2005) that was used to trace the predisposing factors that led to the women's chemical dependency.
4. As previously discussed, I developed a toolbox approach as a focus for analysis of the data. My approach focused on the women's lived experiences (current and previous), their sense of identity and agency, how they made sense of their pregnancy and impending motherhood, their relationships with the staff of the Transitions Clinic and the impact of circulating discourses.
5. At all times I attempted to view the participants' data through a feminist lens. I assumed the positively expressed experiences (abstaining from drugs and regular antenatal

attendance) as empowering and the negatively expressed experiences (the belief that their voices weren't heard and they were being judged) as oppressive or disempowering. Emergent from this analytic phase was the first frame of insights.

6. By reviewing the positive and negative 'lived' experiences of the women and the way in which they presented, three groups were initially identified, whereas others were situated along a continuum. The women in Group One were viewed as being responsible for their day-to-day existence and having a strong sense of identity and agency; the women in Group Two appeared to happily immerse themselves in the drug lifestyle and culture; while the women in Group Three presented as vulnerable and marginalised, that is, trapped within their existence.

7. I then reviewed my understanding of Foucault's (1980c) notions of disciplinary technologies of power, power-knowledge, resistance and subjectivity as these potentially influenced the participants' lived experiences, and thus their emergent states of being.

8. From a Foucauldian (1980b) perspective I viewed the social, historical and cultural context of the women's experiences as an enmeshed always-present competing web of power-knowledge relationships. Dominant discourses at this time were: the helpless addict in need of expert medical care, addiction as a result of multiple factors beyond the control of the individual, the chemically dependent pregnant woman in search of identity and agency and the addict in search of recovery.

9. For the latter discourse I drew on Prochaska and colleagues' (1994, 2001) Trans-Theoretical or Stages of Change Model (TTM) to determine which stages each participant had reached. Emergent themes were motivators and barriers to antenatal care, the desire to be treated as 'normal' and a need for a collaborative approach to communication and decision-making. This information helped to shape the second and third analysis chapters.

10. I also applied Habermas' (1984) theory of communicative action to establish which women felt that they were experiencing positive/negative relationships with the Clinic staff and the effect this had on pregnancy and birth outcomes, social outcomes of pregnancy and the stages of the women's behavioural change status. This phase of analysis was a difficult and time-consuming process as I needed to ensure that I was authentic to the participants' data. The women's narratives had made a deep impression on me and at times I felt overwhelmed by the content and substance of the interviews.

11. Interrogating the data further I was able to identify whether pregnancy was a time of transition or a turning point for the women and I was directed to existential theory as a way of understanding the women's insights and motivations for change. This information supported the third research aim.

**Figure 2: Abstract Situational Map: Messy Working Version for Predisposing**

**Factors for the Participants' Chemical Dependency**



### **The writing up of the study**

In writing up, I initially manually coded and then used Word for advanced coding. Matrices and abstract situational maps were also useful, for example, in the second analysis chapter *Pregnancy and Birth Outcomes*: these methods were used to trace the women's progress in terms of the management of their chemical dependency, their attitudes to pregnancy and their responses to motherhood; the chapter was divided into the following sections as determined by the abstract situational maps which identified the major categories and their sub categories: revisiting the functions and philosophy of care of the Transitions Clinic, the geography of the Clinic sites, factors influencing Clinic attendance, birth outcomes and acquiring a "mother identity" while struggling with a chemical dependency. I now turn to the validation considerations of the study.

### **VALIDATION CONSIDERATIONS**

The traditional approach to promoting and ascertaining a text's validity involves pleas for authority, certainty and legitimisation (Denzin & Lincoln, 2000a). In understanding validity in this way, the researcher seeks out a set of rules, which if properly followed, will establish the validity of the data. Such moves are seen to guarantee that a culture is captured truthfully and accurately by the researcher's methods. In detailing the validation process, Denzin and Lincoln (1997) explained, "Without validity (authority) there is no truth, and without truth there can be no trust in a text's claims to validity (legitimation). With validity (legitimation) comes power" (p. 47). In this way, traditional modes of validity act as the researcher's "mask" of authority by presenting a particular regime of truth to the reader (Denzin & Lincoln, 2000a). Researchers hide behind, put on and take off these masks as they present a particular view in their writing.

The positivist position further argues that there are no differences between the validation process in quantitative and qualitative research and hence that the same criteria can be applied for each approach. These criteria include internal validity, external validity, and objectivity (Denzin, 1997). The positivist assumption assumes that knowledge can be generalised to a variety of contexts, which exists independent of the characteristics of researchers who produce it (Stanley & Wise, 1993). Compared to other positions, the positivist position gives less attention to participants who maintain marginal status in society. Clearly, this validation process is inappropriate for evaluating critical ethnographic texts. The second position of postpositivism suggests that criteria specific to qualitative approaches can be used. Lather (1986) in earlier writings proposed a set of criteria located in the postpositivist position. She recommended the use of triangulation, construct validity, face validity and catalytic validity as criteria for data credibility. Triangulation, according to Lather, involves the use of multiple sources of data, methods and theoretical schemes in seeking to establish “counterpatterns” and “convergences” of the data (Lather, 1986, p. 23). For Lather, construct validity is determined by means of reflexivity (Lather, 1986). I consider construct validity was supported by the use of triangulation and served to strengthen the rigour, breadth, richness, confidence, validity and credibility of my ethnographic data collection and analysis. Use of multiple methods also supported an audit trail, built empowering links throughout the research process and supported research credibility (Murphy & Dingwall, 2003).

For Lather, construct validity is determined by means of reflexivity (Lather, 1986). I have addressed reflexivity earlier in this chapter, detailing the way in which I maintained a journal that documented the decisions made at each step of the research process. In this

journal I also examined my values, assumptions and motivations, and interpreted how these may affect the study (Hall & Stevens, 1991). Catalytic validity refers to the degree to which the research succeeds in producing change (Lather, 1986). Lather argued that catalytic validity is not only focused on transforming action, but also on participants gaining self-understanding.

Later, Lather (1993) rejected her earlier stance of validation located in the postpositivist tradition, by arguing that it promoted a particular regime of truth with dominant normalised discourses. In seeking to disrupt her earlier position, Lather suggested four frames of validity: ironic, paralogical, rhizomatic and voluptuous (Lather, 1993). Rather than suggesting a new set of strategies to follow, Lather clearly offered these frames as a means of raising questions about validity.

The rhizomatic frame was useful in my examination of the data and challenged my position in appropriating Lather's (1986) earlier forms of validity. Rhizomatic validity uses the metaphor of the rhizome to represent multiple, complex openings, with underground stems and aerial roots, in contrast to a linear root and trunk system (Lather, 1993). For Lather, rhizomes work as a metaphor "against the constraints of authority, regularity, and commonsense, and open thought up to creative constructions. She notes: "[It is the] creativity which marks the ability to transform, to break down present practices in favour of future ones" (Lather, 1993, p. 680).

In this study I struggled with moving beyond a linear system of inquiry to articulate "rhizomal" tracks and to construct alternative ways of thinking about issues. In my data analysis, I attempted to adopt a non-linear approach of using abstract situational maps



(Clarke, 2005) to draw out the issues and their complex interconnections on large pieces of butcher's paper. I sought to constantly question the data, searching for lateral mappings rather than linear, central 'truths'. However I also found myself experiencing difficulties in making arbitrary decisions about where to position the information in the data analysis chapters, without destroying the integrity of these lateral mappings. I was, therefore, drawn towards more linear constructions as I struggled to challenge my own subject positions within normalised discourses of validity. I now discuss some of the ethical issues and challenges emanating from this study.

## **ETHICAL ISSUES**

Ethical approval was sought and given by the Human Research Ethics Committee of the Australian Catholic University National on 2<sup>nd</sup> July, 2001 and by the Mercy Hospital for Women Human Research Ethics Committee on 2<sup>nd</sup> August, 2001, and encompassed adherence to the principles discussed below in relation to this group of participants. The first of these, informed consent, pertains to interviewing vulnerable groups.

### **Interviewing Vulnerable Research Participants**

Certain populations are deemed "vulnerable", a status that generates a duty for researchers, review committees, and regulators to provide special protections for them (NHMRC, 2001/2005). Until recently the concept of vulnerability has been relatively unexamined. The most prevalent questions raised about vulnerability have been whether to add a particular group to the vulnerable category (Kottow, 2003), and to a lesser degree, what form the special protections should take. The issue of informed consent in relation to vulnerable groups was addressed by the first doctoral candidate I referred to in the

introduction and who was unable to complete the project (see Tuttle & Seibold, 2003). I encountered similar issues.

Informed consent means that the research subjects have the right to know that they are being researched, the right to be informed about the nature of the research and the right to withdraw at any time. The researcher also has a responsibility to ensure that consent remains valid for each interview. Because of the sensitive nature of this research, before each interview I reinforced the participant's choice of continuing with the interview and with the research project in particular. Although all twenty women in the study signed the written consent, two made it clear that they would rather have given oral consent or used a pseudonym on the consent form. I later found out that they were facing criminal charges and possible incarceration.

Collecting data from this cohort of vulnerable women was fraught with other ethical dilemmas. What of the ethics of interviewing these participants when they are under the influence of hard drugs? How does the researcher handle the issue of informed consent, when it appears anything but? Where does the researcher "stand" when a participant admits to lying to a government agency? And when the participant keeps an interview appointment, but is nursing a broken wrist that she is attempting to hide, do you proffer assistance or, mindful of her dignity, proceed with the interview? I have also found the role of researcher/friend can become blurred. I have, while attempting to separate the role of researcher, from time-to-time acted in the role of confidant, counsellor, social worker, and nurse.

Although qualitative research methods often make it difficult to predict how data will be collected through interviews and observation (Streubert & Carpenter, 1999), researchers have the obligation to anticipate the possible outcomes of an interview and to weigh both benefits and potential harm. For example, when I conducted an interview with a research participant – at her request – just after she had received treatment following an assault by her then partner and was in a highly distressed and emotional state, I was confronted by an ethical dilemma; whether to complete the interview and gain more insight about this woman's life or excuse myself and make arrangements to continue at another time. I always made it quite clear to the participants that I would stop the interview(s) if they became distressed or upset and they wished me to do so.

Fine (1993) wrote about the potential therapeutic benefits of participants reviving unpleasant memories and also the importance of seeking ongoing consent. Hutchinson, Wilson and Wilson (1994) identified the benefits of qualitative interviews as catharsis, self-acknowledgement, sense of purpose, self-awareness, empowerment, healing, and providing a voice for the disenfranchised, and this proved true for the women in this study

The second standard ethical issue is confidentiality. However, not all of the chemically dependent pregnant women were concerned about confidentiality. In fact, some offered me their photographs. One participant recommended the brand of digital recorder that I might purchase that came with a camera, indicating her willingness to be filmed.

At the start of my involvement with the project it was helpful to outline how the research data would be managed, stored and used. Of course, such guidelines would not be sufficient when a participant disclosed legally sensitive information, as previously noted.

All participants were given a letter warning about mandatory reporting. But the question as to whether or not a researcher should again caution a participant during data collection, thus possibly limiting the research study, remains a difficult one. However, it is within the spirit of co-operative inquiry that such issues were openly addressed – where possible – from the outset in order to inform all participants.

Non-maleficence is the most important of the ethical principles and stipulates that the researcher is obliged to do no harm. Research participants may experience anxiety, stress, guilt and damage to self-esteem during data collection (Murphy & Dingwall, 2003). This study was underpinned by a feminist approach stressing giving “voice” and empowerment (Lather, 1993), and feedback I received from the women would suggest this occurred. None of the women withdrew from the study or requested counselling during or after the research process. In fact, twelve of the original twenty have formed a support group and meet regularly and they include me in their correspondence. I also still occasionally hear from the remaining eight women. Always apparent though, was the researcher-participant divide and the need to manage withdrawal; this can be challenging.

Beneficence mandates that research on human subjects should produce some positive and identifiable benefit rather than simply being carried out for its own sake (Beauchamp, Faden & Wallace, 1982). Most of the women told me they found the research experience cathartic and felt it pertinent to lend their voices to the topic. For some, the opportunity to be heard was significant and added to their sense of self-worth. One participant (Jo) likened it to “being in the sun for a time; before the shadows come again”.

The principle of justice refers to equality, transparency, honesty and democracy (Beauchamp, Faden & Wallace, 1982). One of the crucial and distinctive features of this

principle is avoiding exploitation and abuse of participants (Orb, Eisenhauer & Wynaden, 2001). My understanding and application of this principle lay in recognising the vulnerability of the participants and their courage in participating in the study. It was, therefore, important for me to create a non-hierarchical and non-judgmental environment for the women. Judging by the comments and the frankness of the interviews revealed in the data analysis, this was certainly achieved and links to the next principle, trust.

Trust is seen as the magical key to building good field relations (Fine, 1993) and is essential for a productive relationship between the researcher and participants. Trust also applies to a researcher's responsibility not to "spoil" the field for others, in the sense that potential research subjects become reluctant to be involved in research (Marks & Yardley, 2004). Again feedback from the women and their desire to maintain contact with me would suggest I achieved this; however at all times, then and now, the vulnerability of the participants was foremost in my mind. Fine & Weiss, In conclusion, the difficulties inherent in qualitative research can be alleviated by the researcher's awareness and use of well-established ethical principles as outlined above.

Experiences in the field taught me that that informed consent is a negotiation of trust, and it requires continuous renegotiation (Field & Morse, 1992; Fine & Weiss, 1996; Kvale, 1996; Mulhall, 2003) and as a researcher desirous of promoting meaningful involvement with the participants, I was faced with the need to demonstrate a safe and supportive approach whilst avoiding overly paternalistic measures which may have led to exclusion.

Arguably also, there are risks to all participants engaged in research which focuses on individual experiences; however, these were somewhat compounded by the real or

assumed vulnerability of participants with a history of mental health problems. As Mulhall (2003) asserted, such research can invade both the space and the psyche of participants, whilst Cole (1995) proposed that this class of interviews can be emotionally exhausting for everyone involved. My responsibility was to assess and manage risk during the course of the research project in order to maximise the benefits and minimise the harm to participants. While it is incumbent on ethics committees to make a judgment of the risk:benefit ratio prior to the start of a study, this may be extremely difficult in ethnographic research due to the lack of predictability of the direction a study will take.

## **SUMMARY AND CONCLUSION**

I consider that critical ethnography provided me with a methodology that enabled me to achieve the research aims and also to raise other questions. As part of my toolbox approach, I used a theoretical framework to guide data gathering and analysis and this had the effect of providing a framework for analysis. Addressing my own reflexivity was an important part of the research process and allowed me to critically examine the tensions in my own practices, and my struggles with documenting and analysing ethnographic accounts.

The next chapter reports the findings relating to factors which influenced the women's development of chemical dependency, their responses to pregnancy and the discourses that cemented them in that lifestyle.

## **CHAPTER SIX**

### **THE WOMEN IN THE STUDY**

Just a perfect day. You made me forget myself.

I thought I was someone else. Someone good.

Lou Reed (1972) *Perfect Day* (from the album “Transformer”)

### **INTRODUCTION**

This chapter re-introduces the twenty women and considers the factors that contributed to the development of their chemical dependency and the multiplicity of discourses (implicit and explicit) that cemented them in that lifestyle. It also examines how, through these discourses, the women made sense of their lives, including the degree of agency they perceived they had, and their sense of self or identity. I will be drawing upon several interweaving contemporary discourses of addiction that I have outlined in Chapter 3, namely, addiction as the failure of the will (moral model), addiction as a disease of the mind and body (medical, public health or disease model), the control and desire of addiction (the social learning model) and addiction as a result of multiple factors beyond the control of the individual, but for which they accept responsibility (the enlightenment model). By listening to the women’s narratives and appreciating their sense of self and agency together with some of their responses to being pregnant, we begin to understand how some participants may use pregnancy as a means of empowerment, with the potential for change.

### **FACTORS INFLUENCING DEVELOPMENT OF CHEMICAL DEPENDENCY**

This study revealed a complex set of issues associated with the participants’ chemical dependency. These included family instability and a lack of family and social support, a family history of drug or alcohol abuse, a history of childhood sexual abuse, having a chemically dependent partner, being a victim of intimidation or violence, and having a

diagnosis of current depression (see Table 2), while homelessness or transiency were both a cause and effect of chemical dependency.

**Table 2 Factors Influencing Chemical Dependency**

<b>Pseudonym</b>	<b>Family Instability and Lack of Family Support</b>	<b>Family History of Drug/Alcohol Abuse</b>	<b>History of Childhood Sexual Abuse</b>	<b>Having a Chemically Dependent Partner</b>	<b>A Victim of Violence</b>	<b>Dual Diagnosis</b>
<b>Group 1</b>						
Alice	No	Yes	No	No	No	No
Kate	Yes	Yes	No	No	No	No
Nicole	Yes	Yes	Yes	No	No	No
Jasmine	No	Yes	No	No	No	No
<b>Group 2</b>						
Rosa	No	Yes	Yes	No	No	No
Lisa	No	Yes	Yes	Yes	Yes	Yes
Monique	Yes	Yes	Yes	No	No	Yes
Sharon	No	Yes	No	Yes	Yes	Yes
Naomi	No	Yes	Yes	No	Yes	Yes
Leanne	No	Yes	Yes	No	Yes	Yes
Maggie	No	Yes	Yes	Yes	No	No
<b>Group 3</b>						
Erica	No	Yes	Yes	No	No	No
Cathy	No	Yes	No	Yes	Yes	No
Peta	Yes	Yes	No	No	Yes	No
Amanda	Yes	Yes	No	No	No	No
Jo	No	Yes	No	Yes	No	Yes
Maryanne	No	Yes	No	Yes	Yes	Yes
Sara	No	Yes	Yes	No	No	No
Dee	Yes	Yes	No	Yes	Yes	No
Debbie	Yes	Yes	No	No	Yes	Yes



Each of these influences is examined in detail in the following section. However, it is worth noting that at the time of conducting the interviews, the women appeared to fall into three discrete groups as indicated in Table 2. Although there were some overlaps, there was a lot of commonality between the participants in particular groups. The women designated as Group One (Alice, Kate, Nicole and Jasmine) I have identified as taking responsibility for their lives and problems and having a relatively strong sense of identity and agency, with all speaking of plans for the future. Group Two (Rosa, Lisa, Monique, Sharon, Naomi, Leanne and Maggie) embraced the lifestyle; drugs were their “career”, they appeared to see little need for change and for the most part were quite resilient in surviving within a drug context. In contrast, Group Three (Erica, Cathy, Peta, Amanda, Jo, Maryanne, Sara, Dee and Debbie) presented as extremely vulnerable. They appeared to be trapped in their lifestyle, saw little hope of change, and accepted with resignation the violence and intimidation from their partners.

I will return to these groups at the end of this chapter and in subsequent chapters as a means of understanding the women’s responses to pregnancy and to the care offered by the Transitions Clinic.

The role of family of origin and childhood trauma is widely recognised in the genesis of drug addiction. Parental death and/or desertion, divorce, marital disharmony, poor parental role modelling, parental substance abuse, high rates of physical and sexual abuse, as well as intimidation and violence by partners and/or male family members have been identified as characteristics of family histories of drug addicts (Velezet al., 2006).

### **Family instability and lack of family support**

Lack of stability and support within the family of origin was shown to be a factor for most of the women. Fifteen of the study participants grew up in disorganised and disrupted households that had minimal family support. These families were spread across the social spectrum. Of the fifteen women, six came from households that could be described as middle class, nine came from working class backgrounds, and of these five were from families with an entrenched history of welfare support. Single parent families were common and adult supervision was scarce. Five participants (Monique, Peta, Nicole, Dee and Debbie) began their chemical dependency (with marijuana) aged between 11 and 13 and came from families impaired by divorce, desertion, or death. The father or father-figure was often away for long periods of time or the parental relationship was weak or severely dysfunctional.

Several women became distressed when they recalled painful memories. Peta started to cry when she recounted some of the difficulties of being around drugs in early childhood and growing up in a family that lacked stability and any semblance of routine or attention to the children's needs:

Mum and dad would have their friends over, they'd smoke a few bongos, us kids would be watching the TV, there'd be no food, nothing to eat 'cept potato crisps... the adults'd be off in lala land....playing card games like 'Strip Jack Naked' or whatever...Christ...I was 9...oh! What the hell...now I'm gonna bawl. I can remember it like it was yesterday.

Those families who experienced disruption were also often marked by frequent moves that added to the sense of chaos and instability. This was true of Debbie's family, although the substance abuse was hidden. Debbie described an episode from her early childhood:

We were always on the move. Dad was a.....minister and there were four or five times the church moved us on...once it was in the dead of night...too much of the 'white lady' [methyated spirits] and little

boys.... didn't start my substance abuse until I was 23...but I was well taught...Mum was a cupboard drinker....I think just to put up with it all. In the end the church had to let him go, and we left him and went to live with an aunt....she was our only support.

Dysfunctional or chaotic families are often a result of parental alcoholism and/or substance abuse (Coyer, 2001) and all study participants had either, or both, of these factors present in their family of origin.

### **Family History of Drug and Alcohol Abuse**

Regardless of the degree of instability of the family, all research participants told of a family history of drug and/or alcohol abuse to a greater or lesser extent. Seven women (Nicole, Kate, Leanne, Alice, Dee, Sara and Maggie) were exposed to drug use at a very young age. They witnessed family members, friends and neighbours using drugs and by early adolescence many had begun to experiment with drugs themselves. Leanne remembers her mother saying “there’s a little pill for every occasion” and believed that she was given “something” to keep her quiet when “people came around”:

My parents and their friends smoked their bongs and then took their Valiums in between times. Looking back, it was like it was like one big party. I don't how they coped or worked. It was just...well pop a pill and wait for the problem to disappear. God knows how they held their lives together. But it was learned behaviour. I never touched any of it [drugs] until I found myself in a couple of scrapes in my early twenties. Then I got in deep shit and ended up doing time.

Alice has similar memories to Leanne regarding parental drug use:

I grew up believing that most people used marijuana to relax. I remember mum and dad and the neighbours would spend whole weekends smoking it. I can even remember one of the women baking cannabis cookies. I didn't use it until I was 20 or 21, but it quickly became a habit.

It was evident in this study that parental drug use and family dysfunction resulted, for some, in the taking on of adult responsibility while still children. Several women

(Monique, Lisa, Leanne, Kate, Sharon and Rosa) assumed adult roles before they reached adolescence. They regularly performed household tasks such as caring for younger children, cooking and cleaning, as well as undertaking a role reversal so that the child actually cared for the parent. Both Kate's parents were alcoholics and she recalled this incident as the most painful day of her young life. It occurred during the Christmas period when she was eight: "When dad left....mum took to her bed and the bottle. She never cooked a meal for me again. Most Christmas/New Year periods were spent at a hospital dealing with a crisis when she had overdosed on valium."

Family dysfunction was therefore linked to a lack of parental supervision and control. Nine participants attributed their tendency to go wild during their teenage years to the early assumption of family responsibilities which left them little time for fun and recreation as children. Sharon recounted: "Mum spent most of her time at the local pub and would sometimes bring a bloke or people she'd met home. I knew better than to leave a mess." Sharon went on to say that this role was then transferred to younger members of the family, saying "I joined her at the pub when I was fourteen; it was [then] my little sister's turn to be Miss -Fetch -It."

Sharon thus modelled her behaviour and early use of alcohol on her mother's habit. Another participant, Maggie, also attributed her use of drugs at an early age to the influence of older siblings and parents. She told of being introduced to marijuana by her older brother at age fifteen and of having a confirmed addiction by sixteen. Maggie said she had obtained money to feed her addiction by letting the boys at her high school "feel her up", but only through her clothing. At seventeen, she became addicted to heroin to "hide the pain of the sexual abuse going on at home". Thus, a family history of drug abuse

often went hand in hand with sexual abuse, either through lack of parental supervision or as a result of abuse by older family members.

### **History of Childhood Sexual Abuse**

Childhood sexual abuse can be defined as: “the involvement of dependent, developmentally immature children and adolescents in sexual activities which they do not fully comprehend, are unable to give informed consent to and that violate social taboos of family roles” (Kempe & Kempe, 1978, p. 60). The importance of the definition lies in the acknowledgement of the inability of the children to give truly informed consent. The Australian Institute of Health and Welfare provides a useful and similar definition of child sexual abuse: “Sexual abuse is any act which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards” (Angus & Woodward, 1995, p. 46).

Nine participants (see Table 2) reported a history of sexual abuse as a child, which ranged from fondling to penetration. Two more women (Jo and Maryanne) believed that they may have suffered childhood sexual abuse but found it too distressing to recall and discuss. Four women (Naomi, Alice, Sara and Maggie) acknowledged incestuous incidents of abuse and it is worth noting that these women started using drugs at an earlier age (12 years) than did the remaining 11 women. All perpetrators were known to the victim and some of the women reported having been encouraged or forced to use drugs while being sexually assaulted in their homes. Lisa related what usually happened to her on Sunday nights:

As soon as I heard the music that meant the movie of the week was nearly starting, I'd take a tablet, usually a valium, from my mother's room and lay there, waiting for my fourteen-year-old brother. I used

to leave my underpants on because it [the assault] didn't hurt as much then. I was ten at the time.

Twelve research participants in all reported some form of victimisation, usually at the hands of male relatives or family friends. Women described going to bed fully clothed to impede fathers, brothers and 'uncles' access to their bodies. Emotional, physical and sexual abuse was an integral part of some childhoods. Nicole recalled her experience:

Mum brought so many men home, often had three or four on the go at the one time....and I was supposed to call them all uncle!!!! One in particular knew I liked horses. So Mum would send me over there when she had to work and he would supply me with money and cigarettes so he could have a feel.

Nicole's story is particularly poignant. Her mother was a street prostitute in St. Kilda. She gave birth to Nicole when she was fifteen. Nicole never knew who her father was, and if her mother knew, "never passed the information on": that space on her birth certificate is blank. Her mother introduced her to heroin just before her twelfth birthday and she was addicted by the time she was fourteen and turned to street prostitution at fifteen to support her drug habit. At the time she became involved in the study, she had had two abortions; one when she was fifteen and another a year later. She was eighteen when referred to the Transitions Clinic at twenty four weeks pregnant; her heroin addiction had masked the symptoms.

Comments made in my field notes make mention of the quiet dignity and stoic determination that I encountered each time I interviewed Nicole. Although on paper her life sounds sordid and distasteful, she had a firm belief that she would "move on" and become a success. Nicole did achieve success and this will be discussed in Chapter 9.

Brown and Finkelhor (1986) in their review of the literature examining child sexual abuse found that the initial effects of sexual abuse often include anger, depression, fearfulness and sexually inappropriate behaviour, whereas the long-term effects may include not only continuation of most initial effects, but also self-destructiveness, feelings of isolation and stigma, low self-esteem, substance abuse, sexual maladjustment and a tendency towards victimisation. The women in this study reported similar feelings, affecting their sense of identity and their ability to influence events. Sara expressed her sense of futility and inability to resist or report what was happening:

Why bother I reckon. My uncle was our regular babysitter. He was only 14 but he was cunning, really cunning. He's in prison now for rape. But I felt so alone. I began cutting myself...it helped me cope at the time.

Rosa was also abused by her father and male family members. She recalled that smoking marijuana from age twelve helped her cope with the frequent assaults. She thinks her younger brother was also sexually assaulted but hasn't been able to raise it with him as it is too sensitive a topic:

It's only a very funny feeling that I have. What if he wasn't. It's so personal, that trespass to your body. I have no contact with my parents. I'm sure they wonder why, but it was their job to protect us.

Rosa contacted me after the data collection was completed. She told me that her parents had recently separated and that her father was a step-father to two young girls. She was worried that her father might molest or rape these girls and so went to the police to report her own sexual assaults. He was found guilty of rape and incest and sentenced to four years imprisonment. As a consequence of the convictions, her mother and siblings no longer have contact with her.

Five participants (Rosa, Naomi, Alice, Debbie and Maggie, women from Groups Two and Three) related their early drug use to unwanted or uninitiated sexual activity and often linked this to seeking a partner who was “into the drug scene” or seeking out another drug user as a sexual partner. Debbie described this as “it’s a ‘spoken’ – no whys, no hows ...just an is”. Several studies reported similar findings in relation to linking substance abuse and sexual partnering (Al-Kandari, Yacoub & Omu, 2004; Gelder, Gath & Mayou, 1994; Rossow & Lauritzen, 1999).

### **Having a chemically dependent partner**

As well as actively seeking a partner who is a drug user, the circles in which the women moved meant that partnering with a drug user was highly likely. Female substance users are more likely to be introduced to “hard” drugs such as heroin, cocaine and methamphetamine by male partners than are male substance abusers (Eaves, 2004; Henderson & Boyd, 1997; Taylor, 1993; Uziel-Miller & Dresner, 2002). This held true for nine participants (Lisa, Sharon, Cathy, Amanda, Jo, Maryanne, Maggie, Sara, Dee, again women from Groups Two and Three). In any case, the partners of chemically dependent women are themselves likely to be using drugs, and are often the suppliers of the women’s drugs (Neale, Sheard & Tompkins, 2007). Conversely though, it was sometimes the women who provided themselves and their partners with the drugs they used (Higgins, Clough & Wallerstedt, 1995). Jo, Dee and Maggie (Groups Two and Three) spoke of supplying drugs in order to feel “needed” and equated this with being loved, such was the damage to their self-esteem and self confidence. Jo’s eyes filled with tears when she said: “It might mean that he actually speaks to you instead of the usual grunt”.



Of the twenty women, thirteen had a husband or partner with a substance abuse problem. They recounted the difficulties experienced trying to “get clean” with a partner who was still “using”. Seven participants had entered a treatment programme within the last three years, but reported having left before completing the treatment regime. Lisa recalled: “I mean...what’s the bloody use... you’d try to get clean...and then you’d come home for a weekend and he’s shooting up in the kitchen. Fat lot of good going into rehab was.”

Both Maryanne and Dee (Group Three) had partners who, while they continued to use drugs themselves, tried to persuade them to give up their habit while pregnant. Both expressed their frustration with this one-sided approach. Maryanne expressed her disappointment: “It’s one thing to tell me to give up the stuff, but he’s in the f....shed shooting up with his mates like there’s no tomorrow.” Dee also expressed her annoyance at what she perceived to be a double standard: “Mostly though, I’d just wish he’d put his money where his mouth was...it’s easier to talk but hard to do.”

In addition, Maryanne struggled with her partner’s lifestyle of drug trafficking and dishonesty. She later ended the relationship when he re-offended and was sent to prison for theft (“he just couldn’t leave those bad cheques alone”). She now has a new partner who gave up his drug habit several years ago and this makes her feel much more supported. Maryanne recalls: “We actually live a normal life and do normal things. I’m happy with my methadone level and just smoke some weed in the evenings but [partner] is after me to give that up as well.” Both Amanda’s partner and Maggie’s husband also led by example and gave up their drug habits when both women were in the third trimester of their pregnancy.

The effects of the choices - positive and negative - made by partners on the women's drug status are supported in Pettiway (1987) and Schroeder's (2007) studies. Both studies found that male partners have a profound influence on the drug use and criminal involvement of female drug users and this study supported these findings.

Three participants (Sharon, Leanne and Debbie – Groups Two and Three) reported how partners used violence and intimidation to force them into petty crime to support their substance abuse. This included theft, fraud and working as a prostitute in unlicensed brothels. Working as a street prostitute meant that the women were often assaulted or bashed. This victimisation was in addition to the treatment meted out to them by a violent or intimidating partner or family member.

### **Family and Intimate Partner Violence**

Research and clinical experience suggests that women who are chemically dependent are often involved with violence and abuse that may be related to their [and their partner's] current drug use (Anglin, Hser & Booth, 1998; Bresnahan, Zuckerman & Cabral, 1992; Browne, 1993; Swift, Copeland & Hall, 1996; Walsh, 2004; Weiner, Sussman, Sun & Dent, 2005). This involvement may take several forms such as physical and sexual assault, psychological, emotional, economic and verbal abuse as well as social isolation. Current family or domestic violence may also influence their ongoing chemical dependency (Collins & Messerschmidt, 1993; Miller, Downs & Testa, 1993). Several studies reported that repeated female battering that was linked to substance abuse could lead to serious mental health problems (Browne, 1993; Browne & Williams, 1993; Gunn et al., 2006; Carrington & Phillips, 2006; Taft, 2002) or attempted suicide (Gomberg, 1989; Phillips et al., 2007). This held true for four participants (Leanne, Sharon, Naomi

and Debbie) who talked about suicide as a means of escaping violence and abuse. Leanne spoke of how she contemplated suicide:

I would think that it would be such a release...just peace and silence...then I'd think that he'd probably kill the dog just to get even...so I put up with slaps and punches...I actually miscarried when he laid into me once.

In addition to Leanne, eight women (Lisa, Sharon, Naomi (Group Two), Cathy, Amanda, Maryanne, Dee and Debbie (Group Three)) in this study suffered violence at the hands of their husbands or partners. Two participants (Dee and Debbie), reported that the abuse was sometimes carried out in front of young children. However, it was mostly covert and happened suddenly and often seemingly without provocation, as Dee recalled: "You'd be eating your tea and whack, the meal was cold, too hot or something."

I observed the following episode while I was waiting to interview a participant at the East Melbourne site. A client of the Transitions Clinic (not a participant in this study) was waiting with her partner and baby to see the obstetrician for her routine postnatal appointment. I was concentrating on reading a journal article (and also unobtrusively observing the reactions and interactions around me) and raised my head when I sensed a male starting to 'pin' the woman down by pressing both his hands on her shoulders and speaking to her in a low but threatening tone. She started to cry very softly and asked him to "please let me go, we will sort this later". His response was to punch her hard in the abdomen and then suddenly let go. She fell off the chair and onto the floor. Clinic staff then attended to her and took her into a room. The partner told her to "not make a drama of it" and wheeled the pram and baby outside.

I did see evidence of the women participants' unease in the company of partners. Often partners would leave the participants at the Clinic while they attended to other business such as going to the hardware store, getting a car serviced or going to the pub for a drink; their business never seemed to include shopping for food or other domestic commodities. However, the women would visibly relax when their partners left. Leanne, who did report suffering physical and emotional abuse from her partner, summed it up thus: "I can actually breathe when he's not here. It's OK if I can keep him focused. But when he's coming down [from the drugs]....I leave him well alone then."

Family members were also guilty of intimidation and control. Alice reported that, prior to becoming pregnant, she had thought about reducing her methadone dose, but her brother (who lived with her) insisted she keep on a high dose: "I think he thinks it's better when I'm off my face, but I'm not. He really doesn't understand what M [methadone] is. And I keep him in the dark. He's easier to manage that way."

Lisa – who also reported intimate partner violence - felt that her partner's unpredictable behaviour, including violence, financial and verbal abuse, always ended with him falling into a deep depression emanating from daily substance use. She also reported experiencing depression and spoke of the difficulty of living with depression herself, as well as having to contend with a depressive partner: "Sometimes I prefer the slaps to the silence. I know all about depression because my GP has got me taking these pills that are supposed to help."

In addition to a chemical dependency, some participants had accompanying mental illnesses and/or psychological disorders.

## **DUAL DIAGNOSIS: CHEMICAL DEPENDENCY AND MENTAL ILLNESS**

There is some confusion as to whether depression is a cause or an effect of drug use (Ross-Durrow & Boyd, 2000). Although prevalence rates for co-existing substance abuse and depression are not known, depression is still believed to be a risk factor for substance abuse. Depression may be an effect of chemical dependency, because of, or as a result of, social and/or pharmacological effects (Crome & Myton, 2004; Little et al., 1988). Although depression appears to be the most frequently cited psychological diagnosis among substance abusers, other diagnoses such as schizophrenia, obsessive-compulsive disorder and borderline personality disorder are also identified (Vadja & Steinbeck, 2001).

Eight women (Lisa, Monique, Sharon, Naomi, Leanne (Group Two), Jo, Maryanne and Debbie (Group Three)) reported a dual diagnosis of chemical dependency and a psychological condition. This diagnosis was confirmed in their medical histories. Dual diagnosis or co-morbidity is when substance abuse or dependency is diagnosed alongside a mental illness (Flick et al., 2006; Najavits, 2005). Debbie considered the link between mental illness and drug use: "It's a bit like the chicken and the egg...as to what one came first...maybe the heroin, then the blues...most days it's hard to get out of bed."

Leanne also hinted at the link between depression and drug use and described her attempts at self medication: "When I feel down...I take another shot of what's going round...moggies, val, temazie...I call them Leanne's little helpers."

I was given evidence of 'Leanne's little helpers' used by other participants during field work at the Transitions Clinic. Valium appeared to be the drug of choice and it was

handed around like sweets between the waiting women. It was a 'given' that it was to be taken after the women had seen the doctor and midwife, but before they left the building. So, sometimes they were "spaced out" and "glassy-eyed" when they arrived for the interview. They were quite open about this with me. Although I had some reservations about conducting the interviews, I did continue with them with some qualification. Firstly, I ensured that I could understand what the participants were saying and secondly, that the content of the interviews made sense in the light of previous conversations that I'd had with the women. I took this decision because some participants had a cavalier attitude to appointment-keeping and it usually took several attempts to secure a successful interview. However, I was hesitant in proceeding with interviews if or when the women exhibited cognitive deficits which affected their concentration, comprehension or expression.

All participants admitted to suffering from depression of varying severity at times but only Monique, Lisa, Jo and Naomi were diagnosed with clinical depression while attending the Clinic. The remaining four women (Leanne, Sharon (Group Two), Maryanne and Debbie (Group Three)) had been diagnosed as suffering from schizophrenia or personality disorders and having experienced a psychotic episode. These included bi-polar and borderline personality deficits. Occasionally, it wasn't possible to use extracts from formal interviews because of the participant's lack of a reality check (occasionally a level of paranoia would enter the interviews). Those women who were not diagnosed with depression, nevertheless felt that depression was a feature of drug withdrawal, but saw it as an occasional and inevitable hazard. The manifest forms of depression often include immobility, insensitivity and unavailability (Hepburn, 2004). These were symptoms the women exhibited and which, when present, provided a degree of frustration and provocation (for example, not keeping predetermined appointments and arriving clearly

under the influence of some substance) to the participant and the researcher. Much of the afore-mentioned paints a poignant picture of young lives filled with abuse and exploitation at a very early age, often compounded in adulthood by their choice of partner. This, in turn, led to the inevitable slide into chemical dependency with limited life chances.

## **IMPACT OF CHEMICAL DEPENDENCY ON LIFE CHOICES AND LIFE CHANCES**

The women's life choices often included a close association with law enforcement agencies, the criminal justice system and bouts of homelessness and transiency. These, in turn, impacted their lifestyles and how they utilised these choices and opportunities.

### **Involvement in the criminal justice system.**

Nine women (Jasmine, Peta, Dee, Debbie, Naomi, Leanne, Sharon, Alice and Cathy) reported past or current involvement with the law and had criminal records that ranged from theft to aggravated burglary and assault, with two women serving custodial sentences of nine months and six months for passing 'dud' cheques, and all had experienced credit bail. Victoria's Court Referral and Evaluation for Drug Intervention and Treatment is a treatment programme for defendants who have an identified drug dependency. Two of the women (Peta and Jasmine) expected to be incarcerated while giving birth. Peta stated she had: "Got caught passing dud cheques [trying to purchase drugs]. But they said I could keep the kid in with me. Don't know for how long though."

Jasmine had a history of theft and false pretences and had been given a juvenile justice custodial sentence when she was seventeen. She broke out and "hooked" up with a male drug user and became pregnant. Her son was born when she returned to serve the

remainder of her sentence, but he “was put into foster care immediately”. She met up with her current partner when she created her own needle exchange programme in Collingwood. He is not a drug user and was impressed with her initiative. However, she was worried about his habit of breaking into warehouses, stealing cigarettes, and getting caught. Jasmine stated: “I have the feeling that K’s got more warrants than he’s letting on...him going inside would really stuff up the hope of getting C [other child] back.”

Despite the fact that her partner is not a drug user, Jasmine remains caught up in a criminal lifestyle and is at risk of guilt by association. Having a close connection with police, courts and prison and being chemically dependent – often with little social/family support – can result in itinerancy, homelessness and living “rough”.

### **Homelessness/Transiency**

The four women who reported periods of homelessness had left their family of origin because of violence and sexual assault. Nicole’s mother, a prostitute, was bringing men home and introducing them to her daughter. Nicole decided to leave home and “If I have to do that [prostitution] at least I can keep the money instead of handing it over to her.”

Homelessness and drug use have been linked in several studies (Bessant, 2003; Fischer, 1989; Fischer & Breakey, 1991; Galaif et al., 1999). How homelessness is defined will affect its prevalence as will the characteristics of the population under review. Being homeless or in a transient living situation frequently follows loss of family support. Although only four women (Monique, Cathy, Naomi and Nicole) reported experiencing “formal” homelessness or transiency, all participants recalled leaving home for short periods over arguments about their drug use. Eventually, relatives reacted to the theft and



loss of trust in them by removing that person from their homes and lives. This was similar to the findings in the study by Faragher and Hayes (2007). Cathy recalled an incident that occurred when she was thirteen years old: “Jeezus....I mean the olds kicked me out...said I was thieving from them....I told ‘em I had nowhere to go, but no, they want me out, away from their precious friends and the old nosey parker next door”.

Homelessness, or being forced into homelessness, also meant involvement with the refuge system which placed some participants in contact with other addicts. Several refuges for the homeless and drug addicted have a policy against accepting drug-affected women, and yet many survivors of the streets use drugs as a way of coping (Murphy & Rosenbaum, 1999). Naomi remembered an incident that had happened five years previously:

I went to a refuge when he (partner) kicked me and the kids out one night. He made us strip to our underwear and then pushed us out the door. It was freezing and raining hard. He’d brought a blonde in a mini-skirt home. To help cope, I smoked a joint, but the bag in charge of the place called the cops and we had to spend the night in a cell at the local copshop.

A chaotic early life that was often the result of a dysfunctional family of origin and that included substance abuse, as well as partnerships with violent and criminal men, and for some homelessness, meant that the women became increasingly involved in and attracted to, the illicit drug culture.

## **THE LURE AND ATTRACTION OF DRUGS**

Many factors are thought to contribute to the development of drug addiction. These include characteristics of the individual, the environment, and the drug itself, and interactions among all of these elements. I have presented some of the environmental factors that may have contributed to the development of chemical dependency of the

women in this study, including early exposure to illicit drug use. Epidemiological evidence suggests that there is an inverse correlation between the age of first exposure to a drug of abuse and the likelihood of developing dependency (Andrade et al., 1999). Specifically, initial intake before the age of 15 years is a strong predictor of drug dependency liability (Brandon, Herzog, Irwin & Gwaltney, 2004; Meyer & Neale, 1992). There is debate, however, as to whether intake at a young age causes dependency (a “vulnerable brain” hypothesis), whether those who experiment with addictive substances at an early age are already predisposed to dependency by environmental or genetic factors (a “common predisposition” hypothesis) (McGue et al., 2001), or whether a combination of the two possibilities is at work. Consistent with the vulnerable brain hypothesis, for some drugs of abuse the progression from experimentation to addiction is more rapid in adolescents than in adults (McDonald, 1994). However, the comorbidity of other psychiatric diagnoses (true for eight women in this study) with addiction lends support to the common predisposition hypothesis.

Reasons given by participants in previous studies for the use and abuse of drugs included the availability of the substance, the personal characteristics of the user, properties of the drug and social pressure (Bergeschmidt, 2004; Gelder et al., 1994; Sun, 2004). The participants in this study reported that they began to use drugs in order to satisfy curiosity, self-medicate or to relieve boredom. Thirteen study participants admitted to using drugs continually because they wanted a pleasurable change in their state of mind. This pleasurable change ranged from a mild “lift” to a “high” which became euphoric. The search for pleasure was a constant theme in the talk of several women and prime among these pleasures had been the use of drugs. By their own accounts, they loved drugs. Peta argued that she had always liked the “sort of mind expanding aspects . . . liked being able

to go into myself". Dee recalled having suffered from childhood asthma when she had been 'potted up on drugs' and stated "now I really love drugs", and Monique, even at school, had always been interested in "what they, drugs, did to you and stuff and it sounded quite nice". In keeping with this, five young women described drug using careers pursued with a blithe indifference to any adverse consequences, speaking of a progression so inevitable in the light of their personal traits as to be unremarkable: it "just" happened, it was "blah de blah". Amanda was fifteen when she "got into tripping and um smoking heroin and mushrooms and blah de blah." Injecting began with just some guy . . . "he just said "oh we'll cook this up" so we cooked it up and we had it and then it just got every day and then we just started using every day . . . any drugs I try I get quite into you know, I use it and abuse it as you'd say" (Maggie).

The drug that held the greatest attraction for the participants was heroin. Seventeen women had tried it with eleven listing it as their "drug of choice". Nine participants were currently on or had been on methadone maintenance therapy (MMT) (see Table 1 in Chapter 5). As with other opiates, heroin is used both as an analgesic and a recreational drug. Frequent administration quickly leads to tolerance and dependency as it has a very high potential for addiction (Andrade et al., 1999). If sustained use of heroin for as little as three days is stopped abruptly, withdrawal symptoms can appear (Eaves, 2004). In spite of this several participants spoke of their 'love' of the drug. Maggie said:

When I've had a hit, I believe I can do anything. I feel like I'm on top of the world...I love it, I really do. My husband shoots it too, but we never use at the same time. We look out for each other.

Sharon told of "shooting up" with her partner, or when supply was scarce, sharing with their house-mates via a vaporiser ("chasing the dragon"): "We talk, like really talk...we

can talk for hours. Yep, just talk for hours...we try to do this once a week, every Wednesday night. Turn off the TV and talk.”

It is stated in the literature that heroin often promotes physical and psychological coping skills, self-expression and productivity (Frenken & Sifaneck, 1999), however I gained no first hand impressions of this whilst doing field work. I believe that for many participants it was the excitement, the unpredictability and sense of adventure that held the “buzz” for them. Leanne, Jasmine, Naomi and Jo reinforced these impressions when they said that they started experimenting with drugs as an expression of rebellion, or because it made them feel better, but also for the thrill.

Lisa, Monique, Sharon, Naomi, Leanne (Group Two), Jo, Maryanne, Dee and Debbie (Group Three) turned to drugs to escape depression or other personal problems, including difficulties with their studies, jobs or families. Thus, chemical dependency becomes the means to what researchers (Solomon, 2004; Winship & Unwin, 1997) have termed a type of psychic retreat from reality. Alice explained it thus:

My habit started with smoking a bong if I felt there was going to be a stressful part to the day. It just grew from then on till I was selling furniture and some of my grand-mother’s jewellery to feed the heroin habit it grew into. I was already trying to give it up when I found I was pregnant. And because I got really stressed about it all, I slipped back into my eight hundred dollar a day habit, I went back to pinching stuff and selling it. I even took a picture off a wall of a pub and ‘fenced’ that. I could never ever go back there...and you know that publican had been really really good to me.

Dee, aged 31, had the longest history of chemical dependency among the participants. She had started smoking marijuana when she was 12, progressed to heroin at sixteen and had a daily cocaine habit at 19. Dee recalled her early experiences:

It was everywhere, everywhere I went, worked, shopped and socialised. I don't think I was a vulnerable person when my habit started...but it wasn't long before I became dependent upon it. It wasn't peer pressure, just that nearly, no not nearly, that is everyone in my crowd experimented. Some could stop but not many, and I became one of those that became an addict. And I got ugly with it. Most people went out of their way to avoid me.

As Dee's narrative suggests, some participants - once they became addicted to "using" - often became isolated from affective relationships outside their drug-taking and it became a foundation for a style of living, contributing to their sense of identity, however fractured that might have been. The drug subculture membership offered the women a strong sense of self worth which will be explored later in this chapter. These findings have been reported in recent similar studies in Canada (Fischer, Haydon, Kim, Rehm & el-Guebaly, 2007) and in the United Kingdom (Radcliffe & Stevens, 2008).

## **CONCEPTUALISING A SENSE OF IDENTITY**

Establishing a sense of identity is a central task in human development (Erikson, 1950/1980). The person we are, how we see ourselves, how others see us, and how we connect or align with others are all aspects of identity and these factors were endorsed continually in the women's discourses. Erikson (1959/1980, 1968), the primary theorist of identity development, defined identity as a process of defining oneself relative to shared characteristics with others. It is through language and discourse that one's sense of identity is produced. In other words, subjectivity or identity is discursively constructed (Weedon, 1999). Identity then, is a bimodal phenomenon, linking internal self-perceptions with the perception of self as part of a social environment (Josselson, 1987). Erikson (1959/1980) looked at identity as a developmental task along a continuum of tasks over the life course.

Each of Erikson's Eight-Stage Human Developmental Model (1968) is characterised by a developmental issue that must be resolved in a healthy, fully functioning manner in order to progress to the next stage. Failure to resolve the crisis successfully during a stage results in maladaptive responses in later life. Erikson's stages are chronologically linked, with specific tasks salient at particular ages. The eight stages are: trust versus mistrust, autonomy versus shame and doubt, initiative versus guilt, industry versus inferiority, identity versus identity diffusion, intimacy versus isolation, generativity versus stagnation, and integrity versus despair (Widick, Parker & Knefelkamp, 1978).

Identity versus identity diffusion, the fifth stage in Erikson's model, is a task of the adolescent years. It is during this time that young people form a sense of what kind of person they will be and what kind of life they will lead. Some do this by adopting the values and beliefs of their parents as their own, some reject their parents' beliefs and forge their own way, some explore multiple selves and have difficulty choosing one self-definition, and some do not resolve this task and stay in a state of identity diffusion, drifting among different paths without ever solidifying an identity (Josselson, 1987). For many participants this stage was most likely to have been interrupted because of experiences in adolescence identified earlier in this chapter.

Although identity is conceptualised as an adolescent task, the process of forming an identity is not static, but relies on the capacity of the individual to maintain his/her own biography (Giddens, 1991), as illustrated by the participants' narratives. As new challenges or situations arise, belief systems are re-examined to cope with the new information. This is done through a process of assimilation or accommodation. Assimilation occurs when new information is interpreted in a manner that fits with the

individual's current knowledge and beliefs; accommodation occurs when the individual makes changes in the self to account for new experiences (Bailey, 2005; Whitbourne, 1986). Ego identity as conceptualised by Erikson (1959/1980) is largely formed in the adolescent years and refers to the internal psychosocial processes associated with Erikson's theory.

In order to understand how the women participants conceptualised a sense of identity in adulthood and in relation to becoming a mother, it is necessary to consider the extent to which ongoing drug use contributed to a sense of identity and/or inhibited their sense of identity and/or their ongoing development of a sense of self.

Of the twenty women participants, eight (Lisa, Monique, Kate, Erica, Peta, Leanne, Jo and Rosa) identified as being dependent upon drugs (heroin, alcohol and marijuana) while twelve (Jasmine, Alice, Sharon, Cathy, Naomi, Amanda, Nicole, Maryanne, Sara, Maggie, Dee and Debbie) admitted that at various points in their chemical dependence to having an "uncontrollable addiction" (eleven were heroin users, these details were verified by chart audits). Dependency is considered to be when the body has grown used to, or adapted to, the amount of the drug being taken, while addiction is comprised of tolerance to the drug and/or psychological dependence on the drug in question (Orford, 2001). With tolerance, a person must over time take more and more of the particular drug to get the same desired effects and psychological dependence means that a person will take the desired drug no matter what the consequences. One or both of these must be present to constitute a possible addiction (Hughes, 2007; Orford, 1992; Orford, Morison & Somers, 1996).

Despite the women's identified status as dependent as opposed to addicted, there were specific patterns in the reasons the women gave for their drug use. They presented as motivated by a need which at best was only partially within their conscious control. A strong sense of agency was often missing from their narratives, that is, they often felt helpless in the face of their addiction. For example, nine women felt powerless to make changes in spite of being adversely affected by the pain of their lifestyles. They expressed this pain in various ways. Leanne overdosed regularly on a cocktail of whatever was at hand and practised self-harm by cutting herself, noting "it seemed to relieve the pain." Rosa's parents had separated and her mother then had serial partners and as Rosa recalled "there was no privacy, they'd be f.....g on the couch when I'd come in from school." After a traumatic experience of coming close to being sexually assaulted, she recalled having "lost it" and being admitted to a psychiatric hospital, but in retrospect said, "God I wasn't the mad one." She did not go home after this but went to live with friends and immersed herself into a drug career. In these accounts, chemical dependency was linked to a release from personal pain, whether consciously recognised or not. As Jo revealed: "Bad experiences and suppressed emotions.... they make you want to hide from the pain and shit of everyday life."

Similar arguments were used by participants who could not identify any specific reason or cause of the psychological or existential pain they reported as a reason for drug use. Maryanne, who couldn't recall any specific trauma, said she didn't know why she hated herself so much, adding, "I don't know, don't know, just don't know." Amanda, who admitted to a reasonably happy and secure childhood and family life, said that "life's a bit of a bugger and pretty boring at times and you need to get away from it", and escaped by



entering into a drug induced state. So, as these participants described it, they were compelled by a psychological imperative beyond their understanding.

The women also felt they were at the mercy of their ‘addictive personalities’. Naomi reflected the experiences of the majority when she said, “I’ve got such an addictive personality” felt that she was always driven to extremes, while Nicole took everything that was “on offer”, noting “you just got to be in it”. In their narratives, the women spoke of the need to suppress the pain of everyday living, and this seemed to make continued chemical dependency inevitable. The seventeen women with a history of polydrug use had started with marijuana or alcohol and then progressed to heroin, methamphetamine or cocaine. Very occasionally, they reported, they might try speed or pseudoephedrine.

The major discourses weaving through the women’s narratives can be identified as addiction as the failure of the will, and addiction as pathology, with the women identifying with the drugs as agents, and their weakness and vulnerability in resisting the illicit chemicals. Also implicit in their narratives are the influences of the environment (the public health model). Linked to the environmental influences was addiction as a result of social reinforcement (the social learning or biopsychosocial model) wherein the women learned to model their chemical dependency on the drug-taking behaviours of their parents and close family members. Although not explicit, their life stories demonstrated how environmental influences had predisposed them to addiction.

### **Rejecting the “junkie” identity**

While participants readily admitted to using drugs and being at the mercy of their addiction, they resented being branded as “junkies”. “Junkies” was an epithet reserved for

a chosen few (Radcliffe & Stevens, 2008). For female “injecting drug-users, the historically embedded discursive identity of “junkie” is a particularly powerful and negative one” (Malins, Fitzgerald & Threadgold, 2006, p. 519). As Goffman (1968) demonstrated, for the discreditable person whose source of shame can be concealed and hidden, there is the possibility of “passing” as normal. However, the information about the source of shame must then be managed and the management of identity would seem to involve a balancing act between the individual's own sense of her particular self and her perceived relationships to both a moral community (Bailey, 2005), of which she forms a part, and communities of “others” of which she does not. However, in an attempt to resist association with what Rhodes and others (2007) have termed a “junkie identity”, all the women reported “using”, in what they called “private spaces”.

The physical environment chosen for the drug-taking was therefore very important to them. It needed to be clean, “not dirty or smelly” and not in “public toilets or disused buildings”. These were thought to be unsafe, too public and lacking in privacy. So, drug-taking took place in ‘safe’ private homes (“no need to hide there”), churches (“it was real quiet and peaceful, like”), popular parks (“just go behind a tree, or Captain Cook’s cottage”) and, very occasionally, on public transport (termed “the red-eye run”).

Each participant spoke of developing a sense of identity with fellow drug users [especially those who were pregnant], not only via reciprocal activities but also through discussions related to their chemical dependency and lifestyle. The illegal nature of that lifestyle meant that much of their activities had to remain hidden from the larger mainstream community. But with each other they could share the successful aspects of their life and downplay the failures. However, there are contradictions between their described behaviours and self-identity. While contradictions between self-identity and described

behaviour may not be a conceptual problem, in that an expected characteristic of discourse is the presence of contradiction (Potter & Wetherell 1987, 1998), it is a problem if narratives of identity are taken to provide transparent accounts of coherent motivations.

It seemed that when some participants rejected self-identification as a “junkie” they were using a strategic discursive technique known as a “disclaimer” (Edwards & Potter, 1992), by which speaker play down their interests in presenting a particular version of events. This is done in an attempt to make them seem more credible or “respectable”. In other words, it is as Cathy phrased it: “the wider world thinks we are junkies, but we are not, we have our own rules that we go by.” Of course, this avoidance strategy may not always work (Cathy could end up getting arrested) but, if successful, then she achieves the double benefit of keeping up appearances and maintaining a reasonable sense of self.

In this section we have heard how the women admit to their chemical dependency, and indeed, their sense of self as an addict but never a “junkie”; that in their world there is a set of rules as to where and how to use; each woman has her “story” of how she came to her addiction. At one end of the spectrum, pregnant women who use drugs are viewed as self-centred individuals who can and should carry full responsibility for their actions; at the other end, they are defined as victims of substance abuse and social circumstance who have no agency and, therefore, no responsibility for their actions. Both positions assume that chemically dependent pregnant women are either unable (at best) or unwilling (at worst) to take steps to reduce the risk of harm to self or the foetus. This, however, was not the situation for all the women, despite the various experiences recounted.

Revisiting the participants' group classifications from Table 2, it is worth noting that while the women from Group One appear as having experienced some of the various influences culminating in and attributed to their chemical dependency, Groups Two and Three were well represented in this respect. For example, while two women from Group One had suffered sexual abuse as a child, none had a chemically dependent partner, nor had they been a victim of violence, or been diagnosed with a psychological illness and while three were injecting drug users (IDUs), two were employed, and two were in stable and long-term relationships. Although the women in Group One had varying backgrounds they shared a common sense of purpose in admitting their problems and taking responsibility for them. They appeared to have a relatively strong sense of self.

The seven women in Group Two were unemployed and this featured in their attitude to life. Some appeared to be "drifting" while others talked about goals that never seemed to materialise (they were 'gunna's). Lisa, a 20-year old Indigenous Australian was the only participant who registered "yes" for all six factors that influenced chemical dependency and yet she did not appear "weighed down" by this. Naomi, a woman of Lebanese background and mother of three had also experienced a three-month period of homelessness and frequent "run-ins" with the police and the court system. Two participants had a criminal history and one had been "sofa-surfing" for twenty months; "sofa-surfing" in this context means a cheap form of lodging where one stays on an acquaintance's couch rather than a hotel or a residence of their own.

In contrast to the women in Group One, of the seven women in Group Two, five had a medically diagnosed mental illness (borderline personality disorder, schizophrenia, bipolar disorder and/or obsessive compulsive disorder), five had been sexually abused as children,

four had a history of family instability (all were from single parent families), four had experienced violence within their family of origin and three had a chemically dependent partner. Three participants in this group were IDUs, and all had a polydrug habit (alcohol and marijuana). As well, two participants had a criminal history, all were unemployed and this featured in their attitude to life.

There were nine very vulnerable women in Group Three. They appeared vague, hesitant, and had great difficulty in expressing opinions and original thoughts. They struggled to make eye contact when their partners were in attendance. Yet when they were alone, their demeanour changed. They were still cautious and diffident but spoke frankly and candidly about their lifestyle. Of these nine women, one was employed, seven were partnered, and five had a partner with a drug habit. Five respondents were IDUs (heroin), three snorted cocaine, while one had a marijuana habit. Five women were assessed as having a dual diagnosis, four had family support, four had experienced violence and two had episodes of childhood sexual abuse. While four participants had been arrested (and one incarcerated) only one admitted to a period of homelessness. I now turn to examine the chemically dependent women's responses to pregnancy.

## **THE WOMEN'S RESPONSES TO PREGNANCY**

The participants' responses to pregnancy varied and some women took time to come to terms with their pregnancy. Eight pregnancies were planned (Monique, Maggie, Erica, Amanda, Maryanne, Jo, Dee and Debbie) while twelve were accidental or unplanned. It is worth noting that the women whose pregnancies were planned belonged to Groups Two and Three. In light of this, six of the eight women had stopped taking contraception while the remaining two were only taking it irregularly.

Several participants didn't know that they were pregnant until they were well into their second trimester as amenorrhoea and/or an inadequate diet helped to mask their condition.

Lisa, whose pregnancy was unplanned, described her reaction:

It never occurred to me that I was in the family way. It was just another problem to deal with. My boyfriend wasn't too happy about it. And we fought and carried on. In the end it was better to go. He could get pretty violent. And even if I wasn't going to keep the kid I knew I had to get out and change my living arrangements. So I lived on the streets for a time until the Salvos found me a place.

Kate's pregnancy was also unintentional and she recalled that it was an unwelcome surprise: "I was shattered, shattered. It was unexpected, I was having relationship issues and was experiencing trouble at work. It's not that I didn't want to be a mother....but the timing wasn't right."

The absence of menstruation was not therefore taken as an indication of possible pregnancy; and other signs of pregnancy had to be present before a woman would begin to suspect she had conceived (Murphy & Rosenbaum, 1999). Leanne argued this point:

It was only when I got morning sickness...only it wasn't just in the morning, but all through the day and night...I thought I had a virus...and when I found I was pregnant, it was too late to do anything about it. I was twenty-four weeks gone before I saw a doctor.

Peta was unsure about being pregnant and felt that she wouldn't be able to cope (or didn't want to cope) with the responsibility that motherhood would bring. Peta explained her reasons: "I didn't want to put a baby in care like I was.....My life is such a mess, I'm a drifter and I'm not the maternal type."

These feelings, common to many participants, were compounded by the fear that drug use would pose additional problems for the foetus and for them. For this reason, four women

had previously terminated their unwanted pregnancies. Alice, pregnant with her second child, exposed her ambivalence stating: “I’d already got a four-year-old. It’s not easy trying to cope with a drug habit and a baby.” These women, however, had not taken these decisions lightly or for selfish reasons. Rather, they felt that they could not give a child the attention it would need and said that they reacted out of consideration for the child, and at considerable psychological cost to themselves. For some participants, the knowledge that they were pregnant came too late for them to have an abortion.

Again like other mothers, those who decided to continue with their pregnancies – once they got used to the idea – began to look forward to the event, not least because many saw it as an opportunity to begin a new life away from drugs. Leanne noted: “I think that knowing I was pregnant...well, it was like here I was having a baby, someone to love and be responsible for.”

There is much literature on the deleterious effects of drugs on the foetus (see Chapter 2). The exact mechanism of each of these complications is unclear (Chasnoff, Neumann, Thornton & Callaghan, 2001), and it has been argued that other conditions such as inadequate antenatal care, poverty and poor nutrition accompanied by psychological or physical health problems, can all be contributory factors. Nevertheless, it is continued drug use which is usually regarded as the activity most dangerous to the foetus, both in the literature and by the women themselves (Chasnoff et al., 2005). Most participants were aware of the risks associated with continued drug use, and as will be reported in the next chapter, almost all the participants attempted to reduce their [illicit] drug-taking out of fear of the harm they might do to their child, and out of fear that the child, when born, could be removed from their care (Victorian Dept. of Human Services, 2000).

The fears expressed by the women about the harm to the baby have also been endorsed by participants in other studies (Finnegan & Ehrlich, 1999; Jones, 2006). While some women expressed concern for their child's survival, a minority (Nicole, Naomi, Cathy and Peta) voiced their reluctance to provide for the child. This unwilling attitude is replicated in Mondarno's (1989) study which found that little preparation was made by pregnant drug users for their forthcoming child and the difficulty they have in experiencing the reality of the child until it is born.

The knowledge that she is pregnant may also present the chemically dependent woman with another serious repercussion of her lifestyle. She may contract Hepatitis C and fear that her baby may be born infected. Catt (2000) has shown that the risk of passing infection to an unborn child is the most upsetting aspect of testing positive. Out of concern that this might happen, most women who were unsure of their Hep C status were anxious to be tested. Alice explained: "If I had tested positive, I wouldn't have gone ahead with the pregnancy. And I'm against abortion but I would have had one." Fifteen participants were positive when tested for Hepatitis C. The transmission (vertical transmission) rate in Australia from mother to baby is very low - approximately five per cent (Novick & Kreek, 2008). Babies, however, cannot be screened for Hepatitis C until after they are eighteen months old.

Like chemically dependent pregnant women in other studies (Boyd, 1999; Klee, Jackson & Lewis, 2002; Murphy & Rosenbaum, 1999; Taylor, 1993), the participants in this study often had ambivalent feelings about their impending motherhood. While some participants were specifically grounded in the drug lifestyle, they were still anxious to have a healthy



baby, but guilt-ridden if they felt that they were risking this by continued drug use. Some viewed their pregnancy and the impending birth as a chance to move out of the drug culture, whilst still fearful that this may not be possible (Gillmore, Gilchrist, Lee & Oxford, 2006). Above all they wanted to be “good” mothers and were fearful they would fall short of the ideal or that they would not be given the chance to prove their capabilities.

All participants spoke of their intention to achieve abstinence from illicit drugs and alcohol while pregnant but the attraction to the lifestyle of dependency was always a constant feature and this will be further examined in the next chapter.

## **SUMMARY AND CONCLUSION**

This chapter has re-introduced the participants and revealed, through their narratives, the risk factors that influenced their chemical dependency, life choices and life chances. It has been demonstrated that, rejected by wider society and largely alienated from it and without the basic human acceptance to produce a sense of belonging, the women became immersed in the drug culture. Immersion in that culture was also seen to provide a sense of self-identity, which at times was at variance with reality, for example “you’re not a “junkie” if you’re not perceived to be one”. Being chemically dependent and pregnant further marginalised the majority of these women from mainstream society. Greater familiarity with the social precursors of chemical dependency among pregnant women and their current lifestyle will assist health professionals working with this client population to better understand the major social issues many bring to pregnancy and antenatal care.

The next chapter will examine the interface between the women and the Transitions Clinic, as well as the motivating factors and barriers to seeking antenatal care.

## **CHAPTER SEVEN**

### **PREGNANCY AND BIRTH OUTCOMES**

Every woman has something important to say about the  
disjuncture in her own life and the means necessary for change.  
P.A. Lather (1991) *Getting smart: Feminist research and pedagogy with/in  
the postmodern*

#### **INTRODUCTION**

The previous chapter addressed the risk factors that influenced the participants' chemical dependency, life choices and life chances and also discussed their initial responses to pregnancy. This chapter examines how, through these discourses, the women made sense of their lives, including the degree of agency they perceived they had, and their sense of self or identity. I argue that underpinning the women's responses was their sense of self, their degree of agency and the often interweaving and competing contemporary discourses that influenced their reactions to pregnancy, antenatal care and motherhood. These discourses included the addict in need of expert medical help and the addict in recovery. In addition to considering the influences of discourses, Foucault's notions of discipline, power, surveillance and forms of resistance also guided analysis. As articulated in the methodology, I interviewed the participants on three occasions – twice before giving birth and once post birth and it was through these staged interviews that I was able to trace the women's progress in terms of the management of their chemical dependency and pregnancy and their responses to motherhood.

#### **REVISITING THE FUNCTIONS AND PHILOSOPHY OF CARE OF THE TRANSITIONS CLINIC**

In order to set the scene, I will briefly revisit the function and philosophy of the Transitions Clinic that were outlined in Chapter 1. The Clinic was established in 2000 to

meet the needs of marginalised populations including chemically dependent pregnant women by offering care (founded on a midwifery model of care) that is comprehensive, co-ordinated, family-centred and holistic. The treatment advocated includes a staged process of recovery for heroin-addicted participants to be stabilised on methadone or buprenorphine, where appropriate (see Table 1 in Chapter 5). The chemically dependent pregnant women attending the Clinic are monitored in a localised environment where they have access to antenatal and postnatal care up to six weeks post delivery. Childbirth education and parenting skills along with social, financial and psychological support are also available. The Clinic also refers the childbearing women – where appropriate - to community and government agencies for housing assistance and counselling. The midwives purported to care for these women using a women-centred approach (see p. 62), however this at times proved to be problematic.

A behavioural change model is employed which encourages the women to view their behaviours as occurring along a continuum of risk. These behaviours range from those which present no risk or a minimal risk to self (or foetus), to those which pose an extreme risk. For example, not using cannabis is less of a risk than using cannabis, using small amounts of cannabis is less of a risk than using large amounts. The Trans-Theoretical (Stages of Change) Model (TTM) which underpins the philosophy of the Clinic encourages a view of behavioural change as an incremental process with complete abstinence (termination) from harmful behaviours being the final stage. Such an approach acknowledges that a woman who engages in one form of harmful behaviour (chemical dependency) is not precluded from engaging in other healthier and responsible behaviours.

## **The Trans-Theoretical Stages of Change Model**

Several treatment models for individuals with substance abuse were outlined in Chapter Three including Prochaska and DiClemente's (1984) Trans-Theoretical Model (TTM). This model assumes change is achieved over time, and requires progression through six sequential stages: pre-contemplation, contemplation, preparation, action, maintenance and termination. In the final section of the previous chapter, I focused on the women's responses to pregnancy and only referred in passing to their state of mind regarding chemical dependency and how it might impact upon pregnancy and motherhood. In order to trace changes occurring in the women during and post pregnancy, I will now consider where the women were placed at first interview in terms of the TTM when they were between eleven and twenty weeks pregnant.

At first interview, there were no women who could be considered to be at the pre-contemplation stage. Pre-contemplators are often characterised as resistant or unmotivated and tend to avoid information, discussion, or thought with regard to recovery. This period is measured as six months from the time an individual first exhibits "change talk". However, six participants (Leanne, Lisa, Naomi, Rosa, Maggie and Sharon) whom I describe as attracted to the drug subculture and lifestyle were at the contemplation stage and openly stated their intent to change within the next six months. At the same time some of the women exhibited the typical ambivalence of individuals at this stage in the process and had doubts about their ability to effect lasting change. Leanne reflected the attitudes of some of the women in this group when she stated her concerns about the need to change as well as the prospects for long term recovery:

I know that I should do it. But I'm cutting back [from using 'ice'] while I'm pregnant, but I'm pretty sure I'll get back on it after it [the pregnancy] is over...So what's the use of giving up if I'll use again.

This group - contemplators - were aware that a problem existed and usually knew the benefits of change but were still attracted to drugs, the drug subculture and the associated lifestyle. Four other women (Nicole, Erica, Amanda, and Monique) appeared to be at the preparation phase. This is the stage where there is an intention to take steps to change, usually within the next month. Preparation is viewed as a transition rather than a stable stage. Nicole described how she entered this phase after finding out she was pregnant:

I knew what I had to do in order to beat the heroin. I had no intention of going on methadone. I knew it was much worse than H and I wasn't going to be constantly watched by doctors and the like.

The recommended treatment regime in pregnancy is methadone or buprenorphine, however Nicole was successful in giving up heroin and remained drug free throughout her pregnancy. Two women (Jo and Maryanne) were entering the action phase which encourages successful behavioural change. When Maryanne found a new partner as discussed in the previous chapter, she resolved to rethink her illicit drug habit: "I'm on methadone but I've given up smoking the weed. G [partner] kept nagging at me. I still miss me old mates."

Eight participants (Kate, Dee, Jasmine, Alice, Debbie, Sara, Cathy and Peta) were at the maintenance level and were working to prevent relapse and to consolidate gains made at the action level. Kate identified this pregnancy as an impetus for change:

It was knowing I was pregnant and that I really wanted my child to have a good start....so I knew that I had to throw away my crutch (cocaine). I spoke to S [partner] and together we went to Narcotics Anonymous.

Maintainers report the highest levels of self-efficacy and are less frequently tempted to relapse and this was true for most of these women. There were no women at the termination level where former problem behaviours are no longer perceived as desirable. Inherent in the Trans-Theoretical Model (TTM), as with most stage theories, is the means by which motivation to change is identified, enhanced and capitalised upon (not

necessarily in this order) and this held true for all participants at this point in their pregnancy. With TTM an individual's motivation for change is encapsulated in the term "state of readiness" which Davidson (2002) has equated with the idea of reaching a turning point in life. For some of these women pregnancy may have provided the "turning point", and it is at this stage, that chemically dependent pregnant woman are in greatest need of expert health care and must be encouraged to access treatment. However, resistance to treatment in the form of antenatal care via the Transitions Clinic was a reality for all participants at some point. The recommended schedule was four weekly visits for the first 30 weeks of pregnancy and weekly thereafter. Before I examine the women's responses to the treatment offered by the Clinic, I will describe the geographical nature of the East Melbourne and Heidelberg sites as this impacted upon the women's perceptions of the Clinic.

## **THE GEOGRAPHY OF THE CLINIC SITES**

### **The old site at East Melbourne**

At the time when the study commenced the Transitions Clinic was situated within the Mercy Hospital for Women located in East Melbourne. Twelve of the twenty participants were recruited from this site. The site was opposite parklands and gardens that the women enjoyed and utilised during the warmer weather. The hospital enjoyed a central location and travel to the hospital was accessible for most women. Almost all the participants used public transport as private cars are a scarce commodity among this group of women. The hospital building, built in the 1970s, was well-worn and showed signs of age and overcrowding: however it provided a warm and often welcoming ambience for its clientele, as evidenced by the participants' references to the Hospital and Clinic in interviews. The Hospital site was ideal in other ways as the women often combined their antenatal appointments with shopping in the city or Richmond and lunch and/or afternoon tea in the

Treasury and Fitzroy Gardens. This was a particularly popular spot for participants with younger children as there is a fairy tree and children's playground in the Fitzroy Gardens. From its inception in 1971 until the closure of the East Melbourne site in May 2005, the Mercy Hospital for Women touched the lives of thousands of Victorian women (Brown, Darcy & Bruinsma, 2002). Nine women reported having been born there. For many of the women the old site had provided a sense of place. This attachment was described in ways that suggested a long physical, emotional, intimate and even spiritual relationship with that specific location. After 34 years of operation, the MHW was transferred to a new "state of the art" home in Heidelberg. Immediately after the move, I walked over the old site and saw first hand the abandonment and decay and yet the beginnings of a reincarnation. I felt the ghosts of patients and visitors past, and as I took my leave, I picked up a loose tile (for no particular reason or purpose) and took it with me. That item for me, captured the legacy of the people, places and objects that had sculpted the East Melbourne site over three decades. In later interviews conducted at the new site, various participants recalled a sense of attachment and belonging to such an emotionally charged site. Leanne recalled: "The old place had personality and all the druggies [would] sit together. Now you could be sitting next to anyone". In remarking that "you could be sitting next to anyone", Leanne was referring to the fact that the old site had its own waiting area, whereas at the new site outpatient areas were shared with clients attending other clinics.

### **The new site at Heidelberg**

The new hospital is "housed" on three levels and architecturally resembles a department store with its stark minimalism of white painted walls and red-carpeted floor. The infrastructure is purpose-built and for some women it lacked the reassuring and slightly shabby comforting spaces of the old hospital building. Notes from my reflective journal state that the out-patient clinics appear to be more "tightly" held to a fixed schedule, with

the waiting areas rotated for the differing client populations. This had the effect of what appeared to be a far more regulated and impersonal attitude. Jo reflected a view of the women when she explains how the new environment affected her:

It was cold and unfriendly. I felt that it was all about the building and not the patients. With all that bright light, it seemed that we were pushed further into the shadows, not to be seen, not to be heard either.

It is worth noting Jo's reference to being "pushed further into the shadows", suggesting that the women felt secondary to the environment. Maggie observed that when the Clinic was at the East Melbourne site, patients had just one door to go through, but at the new site, there were two and sometimes three doors to pass through until they met with their obstetrician. This made the women feel institutionalised, isolated and that they were to be "hidden from view". However, six participants (Kate, Nicole, Cathy, Amanda, Lisa and Naomi) felt that the new building epitomised a new beginning for them and I believe this attitude assisted the women as they prepared to think about their recovery process as they made the transition to motherhood. I now turn to the factors that influenced the women's Clinic attendance.

## **FACTORS AFFECTING CLINIC ATTENDANCE**

Regardless of the site, several participants (Jasmine, Monique, Naomi, Amanda, Sara and Jo) felt that attendance at the Clinic was always intimidating and even threatening. The genesis for these psychological and personal feelings was not necessarily the Clinic or Clinic staff but rather was an amalgamation of emotions of guilt and fear that were endemic amongst the women. They felt remorse and shame for being pregnant and chemically dependent and were often fearful of being reported to the Child Protection Services (DHS) if they did not conform to the Clinic regime and expectations. Many women reported that they found it difficult for a number of reasons to remain motivated and to continue to access the Clinic for health care and support; their reasons included a



fear of being judged. Previous research has shown that entering into an antenatal programme constitutes a considerable loss of power for the chemically dependent pregnant woman, especially when personal information about their drug use and habits is sourced from them (Homer, Davis & Brodie, 2000; Little et al., 1988; Lutz, 2005; Powis, Gossop, Bury, Payne & Griffiths, 2000; Raine, 2001; Taylor, 1993).

Foucault's notions of a person's subjectivity, or sense of identity and its relationship with discipline, power, surveillance and discourse are useful for understanding the women's reluctance to attend the Clinic. The women's perception was that they were often defined as the helpless addict in need of expert medical care, rather than someone who could take charge of their life and make decisions regarding accessing antenatal care (Brady, Visscher, Feder & Burns, 2003). Naomi explained her reasons for feeling ambivalent about Clinic attendance:

I felt I didn't need to go there [Clinic]. I have a doctor who I trust and who knows my history. He delivered my other two kids with no problems. He knows about the heroin, so he puts me on the MMT and keeps a check on my depression. Also he's Lebanese, same as me and that helps heaps. So I don't go [to the Clinic] if I can help it. It makes more sense for me to go to the doctor I know. But I know that I have to turn up sometimes.

For Naomi, Clinic attendance was considered neither necessary, nor appropriate for her needs as she participated in a shared care option where Clinic attendance was minimal. One of the principal self-managing resistive strategies when in disempowering situations is for individuals to withdraw and move to empowering situations (Devereaux, 1996). For some participants, resistance to engaging in Clinic attendance was an empowering self-managing strategy enabling them to distance themselves, and thus avoid exposure to disempowering situations. Jasmine and Nicole described experiences they considered to be disempowering. Both reported that they felt that their voices were not being heard and

that they were not being treated with respect when they did attend the Clinic for antenatal care and for pathology testing. Jasmine recalled an incident:

I met a friend there [an off-duty policeman] and the staff must have thought that I was under arrest because they ignored me and addressed all questions to me through him. He explained that he was there to support me, but the staff ignored me. It was really awful. I felt so upset and angry.

In addition to psychological barriers related to a sense of disempowerment, there were other barriers to Clinic attendance (see Table 3).

The participants reported the following barriers to regular clinical attendance: ambivalence about being pregnant (9 women), transport problems (17 women), illicit drug use and methadone maintenance treatment (MMT) (11 women), ongoing health issues and those associated with pregnancy (11 women), Child Protection and legal services (8 women), lack of child care (7 women), lack of partner support (6 women), housing/transiency (6 women) and financial difficulties (3 women). In addition, the women found that the often anticipated attitudes of Clinic staff (10 women) had a strong effect on their appointment-keeping. The relationship between the women and the Clinic staff and its influence will be discussed in detail in the next chapter.

**Table 3****Barriers to Ante-Natal Care Attendance**

<b>Pseudonym</b>	<b>Pregnancy Ambivalence</b>	<b>Transport</b>	<b>Drug Use</b>	<b>Health</b>	<b>Legal Issues</b>	<b>Lack of Child Care</b>	<b>Partner Problems</b>	<b>Housing/ Transiency</b>	<b>Financial Difficulties</b>
Jasmine	Yes	Yes	No	No	Yes	No	Yes	Yes	No
Lisa	No	Yes	Yes	Yes	No	No	Yes	No	No
Alice	No	Yes	Yes	No	Yes	No	No	No	No
Monique	Yes	Yes	Yes	Yes	No	No	No	Yes	No
Sharon	No	Yes	No	Yes	Yes	Yes	Yes	No	No
Kate	Yes	No	No	No	No	No	No	No	Yes
Erica	No	Yes	No	No	No	No	No	No	No
Cathy	No	Yes	Yes	No	No	Yes	Yes	Yes	No
Naomi	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No
Peta	No	Yes	Yes	No	Yes	No	No	No	No
Leanne	No	Yes	Yes	Yes	Yes	No	No	No	No
Amanda	No	Yes	No	Yes	Yes	Yes	No	No	No
Nicole	Yes	Yes	Yes	No	No	No	No	Yes	Yes
Jo	Yes	Yes	No	Yes	No	No	Yes	No	Yes
Rosa	No	Yes	Yes	No	No	Yes	No	No	No
Maryanne	No	Yes	No	Yes	No	No	No	No	No
Sara	No	Yes	No	Yes	No	No	No	No	No
Maggie	No	Yes	Yes	Yes	No	No	No	Yes	No
Dee	Yes	No	No	No	Yes	Yes	No	No	No
Debbie	Yes	No	Yes	Yes	No	Yes	Yes	No	No

### **Ambivalence About Pregnancy**

Twelve women reported that not knowing about the pregnancy until the advanced stages created a barrier with regard to seeking antenatal care. However, the eight women who said their pregnancies were planned were happy and didn't consider termination felt that had they had an early confirmation of their condition, or undertaken appropriate family planning practices, it would have assisted in minimising the level of ambivalence they occasionally felt and the late attendance for antenatal care. Dee expressed the feelings of several participants when she described her own feelings: "It is such a roller-coaster ride. One minute you are happy that you're pregnant, the next you're cursing yourself for letting yourself get this way".

### **Transport Problems**

Transport problems have been identified as a major obstacle for Clinic attendance for marginalised groups and vulnerable populations (Murray & Pearson, 2006). Likewise, seventeen participants in this study cited transport problems for not attending the Clinic regularly, and this was especially apparent when the hospital moved to the Heidelberg site. All participants reported that the relocation of the hospital to Heidelberg meant more complex travel arrangements and often longer travelling times. Although the hospital is situated next to a railway station, all but three women reported having to catch various forms of public transport over long distances, as few had access to private transport. Monique explained her travel difficulties:

I had to catch two trams and a train just to get there [Heidelberg]. My kid was in breech and I was in real pain. It was pretty hard on me. I was always exhausted by the time I got to the hospital.

Those participants who were able to access private transport reported that parking was an issue, as were the carpark charges, which if left unpaid, resulted in expensive fines. Peta

describes her exasperation with this situation: “God, the cost of the parking fines, also the signs aren’t all that clear and sometimes you haven’t got the readies”.

Even when some participants had access to private transport, this could prove problematic if they had to rely on other people as it often shortened the time they could spend at the Clinic and the opportunities for socialising. For example, many of the women enjoyed the opportunity to have “girl time” to gossip with each other about their pregnancies and discuss their plans for motherhood over a coffee or cup of tea. Popular topics included possible baby names and the merits of towel versus disposable nappies. Opportunities for these “get-togethers” weren’t possible if partners accompanied them to the Clinic, or if they were required to keep to a tight schedule.

### **Illicit Drug Use and Methadone Maintenance Treatment (MMT)**

Eleven participants (Lisa, Alice, Monique, Cathy, Naomi, Peta, Leanne, Nicole, Rosa, Maryanne, Maggie, and Debbie) indicated that a preoccupation with accessing a variety of drugs also posed a barrier to their attendance at the Transitions Clinic. Monique, Cathy, Leanne and Debbie noted that their frequent drug and alcohol use created a degree of unpredictability with regard to both their attitude to antenatal care and remembering to keep appointments. Sometimes they were so affected by drugs that they were unable to think clearly and make rational decisions. Sharon commented: “If it’s a choice of going [to the Clinic] or scoring....then scoring it’s gonna be”. Monique recalled how weekend drug use has influenced her Clinic attendance:

One weekend a group of us went on a bit of a binge with grog and choof. We started out to celebrate someone’s birthday, got carried away and came to on the Tuesday night...Missed me appointment set for Tuesday arvo. Doesn’t happen often, though...I’m dead scared of what goes into my case notes.

It is interesting to note that Monique, who is at the preparation phase of the TTM, is aware of possible consequences and is exerting a degree of discipline in stating “doesn’t happen often though”. Rosa, who like Sharon was also at the contemplation stage practised what she called “harm minimisation” (which it wasn’t) by reducing her illicit drug intake and self-medicating with valium, temazepam and panadeine forte, which caused her to have almost constant constipation. She reported that: “I try not to take anything on the day I’m supposed to go (Clinic), but sometimes I get the shakes and if it’s too bad I don’t go”. Again this is an example of the women making decisions so as not to put themselves in situations where they might be judged, or suffer consequences. The unfortunate result, however, is missing a Clinic visit, which might have consequences of its own.

The requirement to travel distances and to plan their day around collecting their daily Methadone dose was also perceived by the women as a barrier to Clinic attendance. Three women (Cathy, Naomi and Sara) said that the methadone maintenance treatment (MMT) programme often meant that they were unable to attend the Clinic when required. They reported that their methadone prescribers worked in suburbs that were quite distant from where they lived and since they were reliant on public transport, this often meant the travelling took nearly all day. Methadone maintenance treatment (MMT) is a vital part of preparation for motherhood as the following studies report: Methadone maintenance during pregnancy produces superior outcomes compared with not being in treatment (Ward, Mattick & Hall, 1998); opioid dependent women who receive methadone maintenance therapy during their pregnancy are more stable both physically and psychologically, and receive more antenatal care than women who are not in treatment (Fischer et al, 2000), and the incidence of problems in pregnant heroin users maintained on

methadone is lower than that in those who continue to use heroin during pregnancy (Kaltenbach, Berghella & Finnegan, 1998).

### **Health Problems**

While some participants found it difficult to talk about their health problems, those who did (Lisa, Monique, Sharon, Naomi, Leanne, Amanda, Jo, Maryanne, Sara, Maggie and Debbie) cited physical or mental health issues as having an impact on their attendance for antenatal care. The eight women (see Table 2 in Chapter 5) who were assessed as having a dual diagnosis (substance abuse and mental health illness) also suffered from clinical depression and personality disorders (see Chapter 6) with a minority (Monique, Naomi and Leanne) having had a psychotic episode. The aftermath of such an attack is drowsiness and physical discomfort. For women who did acknowledge health issues, tiredness (not necessarily drug-related) was the most commonly cited effect, with anxiety, stress and depression (non clinical) coming a close second. Whilst the topic of depression was not the most commonly cited, the poignancy of the experience is evident in Sharon's (who had a dual diagnosis) account of her illness:

There were days I would go without washing. I would just lie in bed and watch television, but not really watching it if you know what I mean....not even bothering to eat or drink. When I was really down...I never really considered the baby at all....and I knew I would get into strife when I went back to the Clinic.

In addition, five participants (Lisa, Monique, Amanda, Sara and Maggie) commented on how physical illness (liver and renal disease, migraine headaches and rheumatic heart disease) has impacted upon their ability to attend the Clinic regularly. The nature of these illnesses with their accompanying side effects often made it difficult for them to live independent lives. Amanda attributed her reasons for wanting to avoid all medical care, including attendance at the Clinic, to past experiences and reported that:

I was close to liver and renal failure about three years ago [after being involved in a motor vehicle collision], even now most quacks can't get a 'drip' in my arm...Had to have a cutdown when I was in last time...It bloody well hurt.

These women were medically assessed as having illnesses that qualified them for disability support. However, only two (Amanda and Maggie) were on government benefits as the others did not want to be viewed as a "statistic".

### **Child Protection and Legal Issues**

Fear of child protection services is an ongoing problem for chemically dependent pregnant women, particularly those with past experience with this agency. Ten participants (Jasmine, Monique, Sharon, Cathy, Naomi, Amanda, Rosa, Maryanne, Dee and Debbie) held fears about Child Protection Services (DHS) and reported this as a significant obstacle to attending antenatal care. However, only three women (Sharon, Cath and Dee) discussed this topic in terms of actual experience. Tobin (2005) in her study suggests that for many substance-using women, the fear of this agency is a foreboding presence, but in real terms, this fear may not translate into tangible practice. For those participants who have such a history, for example Dee, the fear is real. She recalled the following incident:

I've told them the odd lie, and so I'm forever looking over my shoulder. I've never told them where I really live and much about my drug habit. But about six months ago, the neighbours rang them [I was sleeping over with the kids] about being off my face with drugs. I reckon I was, but I'm not up for losing my kids. ....F.[partner] would kill me if they took his kids away. ....I'm worried too..about what is written in my casenotes.

Dee commented that going to the Clinic made her feel like she is "open to inspection", and presumably subject at any time to punishment (such as being reported to Child Protection Services). She said:

People [at the Clinic] thought me a liar before I opened my mouth. If I had a red, runny nose, it must be from cocaine, never a cold. I was



terrified that if I didn't keep the appointments, keep off the coke and speed...then it was just a matter of time before DHS were after me.

Several participants (Jasmine, Alice, Sharon, Cathy, Naomi, Peta, Leanne and Dee) who wished to avoid involvement with the above agency also had connection with the criminal justice system and this could sometimes impact upon their ability to attend for antenatal care. Six women were on credit bail (Jasmine, Sharon, Cathy, Naomi, Leanne and Dee) and a further two (Alice and Peta) were incarcerated for short periods during the data collection.

### **Lack of child care and partner support**

There were seven women (Sharon, Naomi, Amanda, Rosa, Dee, Debbie and Cathy – from Groups Two and Three) with two or more children (Jasmine's son was in foster care and Alice's daughter was in prison with her) and all cited lack of suitable child care as a major reason for missing antenatal appointments. Participants were often called to the Transitions Clinic at short notice (for tests and procedures) which meant appropriate child care was not available and if the child[ren] were of school age, the unscheduled clinic visit often coincided with the times when children were being dismissed from school. Late afternoon antenatal appointments also produced problems. Amanda explains her frustration:

It takes a three-hour round trip [from home] to get there [Heidelberg]. I've got no back-up... so who's going to collect [son] from kinder...and there's no after-care. G [partner] is never any help, he reckons child care is women's business.

Six (Jasmine, Lisa, Cathy, Jo, Sharon and Debbie) of the eleven women who were in relationships did report that their partner or significant other made it difficult for them to keep Clinic appointments on at least one occasion. There was such a high level of control in some relationships that the participants felt uncomfortable exercising their initiative in

minor decision-making. Sharon tells of her partner's control: "Even tells me what days I should be seeing the doctor...tough luck when it doesn't suit him".

Three women (Cathy, Jo and Debbie) felt that their partners made it difficult for them to exercise independence or freedom by attending the Clinic. Debbie said that her partner would phone the Clinic ahead of her appointment to verify that she would be attending.

### **Housing/Transiency problems**

None of the participants reported being "homeless" even though the data contradicted this as, according to current definitions of homelessness, four women qualified as having experienced homelessness: the remainder rented, boarded or lived in their own homes. This is consistent with current research which suggests that many people classified as homeless by welfare agencies do not share this perception (Bessant, 2003).

Six participants (Jasmine, Monique, Cathy, Naomi, Nicole and Maggie) reported a lack of suitable housing and/or being transient as an issue that prevented them from regularly attending the Clinic for antenatal care. Three women (Jasmine, Naomi and Nicole) admitted to "sofa surfing" in various houses and a fourth (Maggie) was living, for a short time, in a refuge in the outer suburbs. Their transiency made appointment-keeping difficult. This group also appeared to lack the organisation needed to manage their everyday lives in order to regularly attend antenatal care. The five participants (Rosa, Monique, Cathy, Amanda and Dee) who were living in transitional housing and the four women (Alice, Lisa, Sara and Maryanne) who were living with a grandparent or extended family member cited the living conditions as causing minor difficulties for antenatal attendance.

### **Economic/Financial difficulties**

Three participants (Kate, Nicole and Jo) cited periods of economic or financial hardship as a reason for not regularly attending the Clinic when appointments were made. As these three participants were employed, I found it difficult to understand how financial difficulties would interfere with antenatal attendance. However, notes from my journal confirm that it was because they were employed that difficulties arose. Jo and Nicole were self-employed (as a community worker and prostitute respectively) and Kate, as a senior manager, found it difficult to leave work. The remaining seventeen women (who were unemployed) overcame this barrier by accessing welfare or community support.

In summary, the major barriers to care were the women's initial ambivalence regarding their pregnancy, transport issues, the fear of being judged by Clinic staff, poor physical and psychological health, fear of being reported to child protection agencies and problems caused by the women's involvement with the drug subculture and lifestyle. These findings support those of the following studies: Clark and others (2001), Harding and Ritchie (2003), Jessup and colleagues (2003), Mallouh (1996), Tobin (2005) and Waldby (1988).

It is important to note that despite there being some negative perceptions of the Clinic staff and of the care they provided most participants made a determined effort to follow guidelines regarding diet and exercise, that is, to eat well and regularly and to participate in physical exercise. They were told that insufficient weight gain has been linked to low infant birth weight and perinatal mortality (Comfort & Kaltenbach, 2000), while excessive weight gain is associated with high infant birth weight and mortality, and gestational diabetes. Their efforts to achieve these goals, such as optimum weight throughout their pregnancy, however, were impeded by their drug use, emotional problems, limited

finances and fear of stigma. While many participants continued to use illicit drugs, they did attempt to reduce or modify their drug use whilst also paying attention to lifestyle recommendations. I now explore the women's perceptions of the care they received at the Transitions Clinic.

## **THE WOMEN'S PERCEPTIONS OF CARE**

The participants' opinions of the care received were varied. Some women (Kate, Jasmine, Lisa, Jo and Dee) were happy with the treatment regimes and care provided by the Clinic. These women closely followed the advice given and felt that it provided direction that was in keeping with the stage they had reached, while the remainder felt quite strongly that they were being judged. Indeed, there is a common theme of being under constant surveillance in all the women's narratives relating to their perceptions of care offered by the Transitions Clinic.

This took many forms: the physical surveillance via consultation with obstetricians, midwives and social workers, technological surveillance via ultrasounds, cardiotocographs and amniocentesis, chemical surveillance via pathology tests which were related to the tests necessary during pregnancy and those tests that monitored HIV and Hepatitis B and C status, and written surveillance between staff via case notes and charts. Within the Transitions Clinic, doctors, midwives and allied health professionals are expected to report on the status of clients, using consultations, pathology and interviews to assess the health of the mother and the foetus. Clinic staff realise that they have a responsibility to inform others of any observed changes and record these in case notes and on charts, or through technological means, such as computers. These reports are then subject to internal audit.

Doctors rely on Clinic staff to provide accurate assessments of the client's health status and, if necessary, to implement appropriate interventions.

Such medical surveillance of pregnant women has been called "natal panopticonism" (Deveaux, 1994; Fahy, 2002; Terry, 1989). The women felt their bodies were continuously scrutinised and that they were just a "baby incubator". At the same time, this sense that the women have of being classified and categorised (the helpless addict in need of expert medical care), and of being constantly monitored and judged against a set of normative standards can have these consequences (Root & Browner, 2001): The women respond to the "constraints of power" as Foucault (1977a, p.250) suggests by either "complying and obeying" or by employing self-managing resistive strategies when in disempowering situations by withdrawing and moving to an empowering one.

An example of a sense of being judged against a set standard is Nicole's experience: Nicole had a role in a "porn flick" early in her pregnancy which required her to wear "fake tats" and "fake piercings". This altered her appearance considerably. After she finished filming one morning she arrived at the Clinic for her afternoon appointment. Although aware of her appearance (which was out of character as Nicole usually dresses conservatively and expensively), she offered no explanation. She was handed a slip of paper as she was leaving the Clinic after her consultation: it was a referral to see a psychiatrist. Nicole took up the story:

I know I looked a sight....no-one commented and to be handed a piece to see a shrink.....oh please. It made me cross and I'm not a person who loses it easily, but I did lose it after I left the building. Looking back it seems like a conspiracy, knowing looks, smirks and nods. Didn't they [Clinic staff] need a meeting to decide this? Did I go? Yes I did, but only the one time.

For some participants, as previously articulated, resistance to engaging in Clinic attendance was an empowering self-managing strategy that enabled them to distance themselves from, and therefore avoid being exposed to what they perceived as disempowering circumstances. For example, Maryanne, Nicole, Jasmine Jo and Debbie felt that some Clinic staff did not listen to them nor treat them with respect.

Surveillance then, according to Foucault, is a mechanism of disciplinary power. Power is productive of knowledge, subjects and practices. Any discourse about knowledge brings with it the potential for social practices, for acting in one way rather than another, and for marginalising alternative ways of acting (Burr, 1995), as was the case with the Clinic staff and their reaction to Nicole's mode of dress.

I now revisit the women at the time of the second interview, which was shortly before the birth of their babies to evaluate their progress in terms of the TTM and to reflect on the original impressions and groupings.

## **APPROACHING BIRTH**

As the time for giving birth approached the participants focused their attention on their impending motherhood and how this role would alter their lives. Like most expectant mothers, they wished for a healthy baby and a trouble free confinement. They felt that motherhood would give them a second chance in life and provide them with a status and sense of self-worth that had been largely lacking in their lives to date. This held true for both planned and unplanned pregnancies, as some of the women viewed pregnancy as a means of assisting them to curb or control their drug use and to make positive changes in

their lives. Recent research supports these findings: Ashley and colleagues (2003), Burgdorf, Dowell, Chen, Roberts and Herrell (2004) and Mitchell and others (2003).

Again, as would be expected, there were no participants in the pre-contemplation stage. Those women whom I identified as having a strong sense of self and belief in their ability to deal with life's challenges and were placed in Group One were now all at the termination stage. This is the final stage and occurs when there is zero temptation to revert back to the old behaviour. Of the women whom I identified as attracted to the drug lifestyle and subculture and placed in Group Two, Sharon, Leanne and Lisa remained at the contemplation level, receiving methadone maintenance treatment (MMT) and very occasionally "using" heroin, but continuing to exhibit "change talk". Naomi, Rosa, Monique and Maggie were at the preparation stage. Rosa was still smoking cannabis and self-medicating with various licit drugs and Maggie was persevering with a MMT programme. Group Three – the participants whom I initially thought to be vulnerable – had proved to be more determined and stronger than that first impression. Jo and Maryanne remained at the action stage, still trying to implement behaviour changes that would work for them. Jo had reduced her cocaine intake but was ingesting cannabis via a vaporiser and Maryanne was on a MMT programme and taking "herbal remedies" for stress, while Amanda, Dee, Erica, Debbie, Sara, Cathy and Peta were at the maintenance stage. There were now seven women from Groups Two and Three (Amanda, Dee, Debbie, Sara, Cathy and Peta) who were at the maintenance stage and all – with the exception of Erica, Dee and Amanda – had relapsed, but with family, social and psychological support were still trying to overcome their chemical dependency. The motivational forces to succeed in the recovery process need to be strong (Miller &

Rollnick, 1991) to withstand the challenges presented by a new baby. I now detail the birth outcomes and the social aspects of motherhood.

## **BIRTH OUTCOMES**

Birth outcomes were variable: one woman had a stillborn delivery, cause unknown; fourteen of the nineteen surviving children were born at term, with an average birthweight of 3.7 kg and a mean birthweight of 3.03 kg (range 2.04 – 4.1 kg). Four were born between 30 and 36 weeks' gestation, with a mean birthweight of 2.02 kg (range 1.29 – 2.78 kg). One child was born at 29 weeks with a birthweight of 1.47 kg. Low birthweight babies are usually defined as having a weight of less than 2500gm. Leggate (2008) identifies that babies born to mothers in socially disadvantaged situations are more likely to be small, have health problems and require significant health care resources. In addition, drug use in pregnancy influenced birthweight and this is addressed below (see Table 4).



Table 4

## Pregnancy, Labour and Birth Outcomes

Pseudonym	Parity	Weeks gestation	Problems experienced	Type of birth	Neonatal outcomes	Birth weight kg	Infant feeding
<b>Group One</b>							
*Alice	G2P2	37.6		Caesarian	NAD	3.85	Breastfed
Kate	G1P1	36.4		Vaginal	NAD	2.72	Breastfed
*Nicole	G3P0	N/A	Pre-eclampsia Placental abruption	Induced	Stillbirth	N/A	N/A
*Jasmine	G2P2	38.6	Foetal respiratory distress	Vaginal	Hyperbili-rubinaemia	3.26	Bottlefed
<b>Group Two</b>							
Rosa	G2P2	37.4	Hypertension	Vaginal	NAD	3.14	Breastfed
Lisa	G1P1	29.1		Caesarian	Small gestational age	1.47**	Breastfed
Monique	G1P1	38.5	Hypertension	Vaginal	Hyperbili-rubinaemia	2.78	Breastfed
*Sharon	G3P3	31.3	Hypertension	Induced Instrument	Small gestational age NAS	2.04**	Breastfed
*Naomi	G3P3	38.4		Vaginal	Hyperbili-rubinaemia	3.22	Bottlefed
Leanne	G3P1	36.6	Malignant hypertension	Vaginal	Foetal hypoxia	2.84	Breastfed
*Maggie	G1P1	37.2	Excess amniotic fluid	Caesarian	NAD	2.57	Bottlefed
<b>Group Three</b>							
Erica	G3P1	38.3		Vaginal	NAD	2.63	Breastfed
*Cathy	G3P3	38.5		Caesarian	Hyperbili-rubinaemia	3.28	Bottlefed
Peta	G1P1	36.2		Vaginal	NAD	2.78	Bottlefed
*Amanda	G2P2	37.1		Caesarian	NAD	2.44	Bottlefed
Jo	G2P1	38.3		Vaginal	IGR	3.88	Breastfed
*Maryanne	G1P1	33.2	Hypertension	Induced Instrument	Hyperbili-rubinaemia Small gestational age	1.84**	Breastfed
*Sara	G2P1	32.5		Vaginal	NAD	2.63**	Bottlefed
Dee	G3P3	39.1	Excess amniotic fluid	Caesarian	Hyperbili-Rubinaemia/ IGR	4.10	Breastfed
Debbie	G3P3	33.6	Hypertension Insulin dependent diabetes	Induced vaginal	Small gestational age NAS	2.16**	Breastfed

Eleven women (\*) cited heroin as their main illicit drug of choice (see Table 1) and were all prescribed methadone. As previously indicated, there is a risk of the methadone exposed baby developing neonatal abstinence, however, the risks are outweighed by the benefits that methadone stability brings (Berghella et al., 2003). Two babies developed symptoms of neonatal abstinence syndrome (NAS) and one required treatment with oral morphine. Five babies of the heroin using women who had live births (including the baby with symptoms of NAS) were admitted to the special care nursery for a variety of reasons including prematurity. These findings support the Victorian study by Kelly and others (2003) that found that 30 percent of babies born to heroin-dependent women required admittance to a special care nursery. While there were just twenty women in the study, of whom eleven were prescribed methadone, making statistical comparisons meaningless, it is worth noting that the literature estimates 60 – 80 percent of neonates born to methadone maintained mothers will develop NAS (Ebner et al., 2007).

Sharon, Maryanne, Sara and Debbie listed heroin as their primary drug of choice, while Lisa used marijuana and heroin. Sharon, Maryanne, Sara and Debbie, although prescribed methadone, continued to use heroin periodically throughout their pregnancies. Their babies were small for gestational age, and were premature births, both of which are problems connected with heroin use in pregnancy. These findings support those of previous research: Bartu and others (2006), Chasnoff and colleagues (1991), Chasnoff (2001), Chavkin (1999), Forrester and Harwin (2006), Hulse and others (1998), Jarvis and Schnoll (1995), Johnson, Gerada and Greenough (2003), Jones (2006), Kakko and colleagues (2008), Murphy and Rosenbaum (1999), NSW Department of Health (2006) and Wilbourn and others (2001).

Lisa and Sara, who also used cocaine, both had babies who experienced intrauterine growth restriction, a finding similar to that of the studies of Chasnoff, Burns and Schnoll (1994) and Elk, Mangus, LaSoya and Rhoades' (1997). Nicole, a cocaine and heroin user, had a placental abruption and a stillbirth which again supports the findings of other studies in relation to the risk of heroin use: Elk and colleagues (1997), Gillogley and others (1990) and Woods, Plessinger and Clark (1987). Leanne, who used methamphetamine ("ice"), was diagnosed and hospitalised with malignant hypertension and tachycardia (increased heart rate) during her pregnancy. Her son suffered foetal hypoxia at birth. This finding is similar to that of the study by Wells (2007) which stated that methamphetamine use in pregnancy can cause increased maternal blood pressure and heart rate and reduced maternal and foetal oxygen supply (Lester et al., 2004).

Breastfeeding was encouraged for all participants and at the time of discharge from the Transitions Clinic (six weeks post birth), the ten women who kept their babies were breastfeeding. Sharon and Debbie who had babies with NAS felt that being able to breastfeed while treating their babies' withdrawal symptoms themselves was both motivating and empowering as they progressed with their recovery.

### **Social Outcomes Post Birth**

Post birth ten of the nineteen women with live births kept their children, six had their children cared for by family members (including an estranged partner), two women placed their children into permanent foster care and one child was adopted. Table 5 reports these details together with a self assessment of the participants' recovery status according to the TTM and the reasons they gave if they had experienced a relapse.

**Table 5.****Social Outcomes of Pregnancy and Behavioural Change Stage**

<b>Pseudonym</b>	<b>Parity</b>	<b>Child's Carers</b>	<b>Trans-theoretical Stages of Change Model Status</b>	<b>Reason for Relapse if Applicable</b>
<b>Group One</b>				
Alice	2	Birth Mother	Termination	N/A
Kate	1	Birth Mother	Termination	N/A
Nicole	1	Stillborn	Termination	N/A
Jasmine	2	Adoptive Parents	Termination	N/A
<b>Group Two</b>				
Rosa	2	Great-grandmother	Preparation	Lack of confidence
Lisa	1	Sister	Contemplation	Depression
Monique	1	Birth Mother	Preparation	Lack of confidence
Sharon	3	Partner	Contemplation	Depression
Naomi	3	Permanent foster care	Preparation	Depression
Leanne	1	Partner	Contemplation	Depression/Guilt
Maggie	1	Birth Mother	Preparation	N/A
<b>Group Three</b>				
Erica	1	Birth Mother	Maintenance	N/A
Cathy	3	Partner	Maintenance	Lifestyle
Peta	1	Grandmother	Maintenance	Lack of confidence
Amanda	2	Birth Mother	Maintenance	N/A
Jo	1	Birth Mother	Action	Depression
Maryanne	1	Birth Mother	Action	N/A
Sara	1	Permanent foster care	Maintenance	Financial hardship
Dee	3	Birth Mother	Maintenance	N/A
Debbie	3	Birth Mother	Maintenance	Partner's depression

N = 20

N/A = Not Applicable

Table 5 is arranged in terms of the groups already identified in the preceding chapter and previously referred to in this chapter. The four women in Group One were identified as having a responsible and self-confident attitude to life which was underpinned with a strong sense of self and agency. Of these four women Alice and Kate kept their babies and continued to abstain from illicit drugs, with professional support from a drug and alcohol counsellor and psychologist, respectively. Alice reconciled with her family of origin and with her two children went to live in church-affiliated supported accommodation. She

planned to move to private rental accommodation when she got a job and found appropriate child care. Alice was proud of her Chinese heritage and re-establishing family contacts helped to reinforce her sense of identity and highlight the progress she had made. Kate, who had an executive position and was well-supported by her organisation employed a nanny and returned to work part-time. She continued to abstain from alcohol and cocaine and entered into therapy to improve her sense of self-esteem. Kate planned to marry her long-term partner on their daughter's first birthday. Nicole reported that having a stillborn child (a son), although tragic, gave her a sense of relief as she had intended to have the baby adopted. She had continually said throughout her pregnancy that she did not want children. Nicole left the hospital immediately after giving birth and within four days had relocated to another capital city to start a new life. Despite working as a street prostitute and a short stint in pornographic films Nicole had gathered around her quite a large support network. She is currently undertaking university studies. Jasmine chose to have her child adopted as although successfully abstaining from heroin and alcohol, she felt that her son would fare better if he was raised by someone else. So, together with her older son, who was aged nineteen months, she put her baby up for adoption. She stipulated that both children must remain together and fit into an existing stable family environment. It was Jasmine's intention to have ongoing, but limited contact with her children, if the adopting family agreed. She said:

I'm just getting my life together and I can't risk messing up theirs. My mother was never there for me...and that made me angry. At this point I don't know what my future holds so it's a bloody hard decision, but a necessary one.

I was with Jasmine when she made this decision and I felt that this was when she started to really move on with her life. She was concerned that her partner was expecting to face additional criminal charges for theft and she didn't want her children put at risk if her partner received a custodial sentence and she was unable to adequately provide for them.

Although this decision could be perceived as selfish and self-interested, I believe that it demonstrated a considered and mature approach in keeping with her evolving sense of self. Jasmine had a secure support base in the form of her step-father and a young policeman who has taken an ongoing interest in her welfare from her days in the juvenile justice system

All four women in Group One were at the termination stage of the TTM and all had regularly attended the Clinic for antenatal care from early in their pregnancy. I believe the major factors that set these four women apart from the other participants was their level of education and/or social standing, which gave them a degree of self confidence, and all with the exception of Jasmine were in paid work (she did voluntary work). Kate held a postgraduate qualification from a prestigious North American university, Alice had completed a TAFE course in accounting and business studies while Jasmine and Nicole had had a private school education; all experienced reasonably stable social support networks. Family and social support has been found in other studies to encourage commitment to early antenatal attendance which, in turn, reduces birth risks and deficits and increases the likelihood of recovery from chemical dependency (El-Mohandes et al., 2003).

In contrast the seven women in Group Two were unemployed and continued to be attracted to the drug lifestyle and subculture. Of these, Rosa, Lisa, Sharon and Naomi continued to take heroin throughout their pregnancy and, not surprisingly, they relinquished their babies. Naomi, the real “drifter” of the group, was diagnosed with schizophrenia three weeks post birth which was in addition to the chronic depression that she suffered periodically. She put her third child into permanent foster care. Rosa, her

baby and an older child went to live with her maternal grandmother, who became the registered carer for both children. However, after finding Rosa in an unconscious state, her grandmother at 68 years old applied for and was granted custody of Rosa's children, leaving Rosa with limited access to them: Rosa stated: "It looks like she's going to be their legal guardian...and with my track record there's not much I can do about it...I think it will be a permanent arrangement." Rosa at the final interview continued to talk about "doing something one day" about her problem.

Lisa and Sharon, along with Leanne, were diagnosed with postnatal depression and this affected their sense of identity and agency and their perceived ability to care for their children. They couldn't remember a time when they weren't "labelled". In saying this they appeared to be assuming a "victim mentality", an example of learned helplessness. Given the progress other women had made with similar support and opportunities, it appeared that these three women were at this time choosing not to progress or move on.

Lisa's older sister took responsibility for her child and agreed to raise it with her own children, with Lisa helping in the decision-making. Sharon, whose three children were each cared for by a different father, took little interest in their upbringing and was mostly "an absent mother". Taking responsibility and mothering were not on her agenda. Sharon said: "The fathers do a better job than I could...I don't really have the time." Leanne's partner eased the situation for her when he became the child's carer for eight months. During this time he made it a condition that if Leanne was to have ongoing contact with her children, she was to enter a rehabilitation programme with a goal of relinquishing her "ice" addiction. At the final interview she was responding well to this ultimatum. She

gained further confidence when she found that others in the programme were successfully abstaining from their drug of choice.

Of these seven women, only Maggie and Monique kept their babies. Maggie bonded well, but was disappointed that she could not breastfeed her daughter. She received help and assistance from an indigenous support worker who was adamant that she continue to seek alcohol and drug counselling. It helped that she had a drug-free husband who came from the same tribal background and was proud of their indigenous heritage. Monique was slower to bond with her baby, but with the support of her mother-in-law gained confidence and joined Narcotics Anonymous to overcome her cocaine addiction. She reported that it helped her to acknowledge that she was a “recovering drug addict”. She felt that it showed that she was moving on with her life.

All the women in this group had a cavalier attitude to antenatal attendance and appointment-keeping in general (this included presenting for interviews during the data collection process), and all seven women were assessed as being at the preparation and contemplation phases of the TTM. These women did not appear to have seen pregnancy as a chance to move on with their lives and appeared to still live “in the moment”. Even though two mothers kept their babies, their sense of identity appeared to be still tied to a drug lifestyle to a greater or lesser extent. All seven women led complex lives which included for five (Sharon, Cathy, Naomi, Peta and Leanne) involvement with the criminal justice system. Three women had experienced periods of homelessness and appeared to have poor coping skills, evidenced by an inability to manage their lives including basic self-care, shopping, cooking and handling money. They all appeared to have a tendency to “use” the people who offered support, rather than to have moved to a position of



recognising that relationships require a degree of mutuality and obligation. This is in keeping with the TTM stage at which they were assessed.

However, it is worth noting that five women from this group had a dual diagnosis and that four of the five reported having been a victim of violence. Prior studies by Arellano (1996), Chaffin and others (1996), Cummings and Davies (1994) and, more recently Williams and Ziedonis (2004) found that pregnancy, substance abuse and mental illness create complex needs that often go unrecognised by treatment providers; that is treatment is not necessarily tailored to their needs.

Studies Buchanan and Young (2002), Crandall and others (2004), Coyer (2001), Daley and colleagues (2000), Dawe and colleagues (2003), Forrester and Harwin (2006), Jones (2006), Koniak-Griffin, Logsdon, Hines-Martin and Turner (2006), Sun (2004) and Walton-Moss and McCaul (2006) have found, similarly to this study, that chemically dependent pregnant women who lead complicated lives and experience intimate partner violence, have poor nutrition, are involved in illegal activities, and have periods of homelessness are likely to have poor pregnancy outcomes and exhibit negative parenting techniques). Other studies by Fraser and others (2007), Gorin (2005), Howell and colleagues (1999) and Zuckerman (1995) reported that - similar to the results of this study - chemically dependent mothers can lead chaotic and unstable lives which affect the home environment. Poor parenting techniques have also been linked to continued chemical dependency by Jessup and Brindis (2005) and Fraser and colleagues (2007).

Of the nine women in Group Three who presented as vulnerable and seemingly trapped in a marginalized lifestyle, six kept their children. These six women seemed to have acquired

a sense of place and identity largely related to motherhood. Although there are constraints and limitations to their lives, these six women (Amanda, Erica, Jo, Maryanne, Dee and Debbie) appear to manage well within these set parameters. Erica copes by living with her mother's sister and choosing to be socially isolated, stating:

I won't take him to playgroup or parks. I might meet people and have to join in...but when you have a drug habit, you can't mix with people who are different to you. And he might miss out because of that.

Erica and her aunt appear to provide much love and support to each other and the child. Erica at the final interview was abstaining from marijuana but continued to experiment with prescription drugs (benzodiazepams, valium and xanax). When her aunt took long service leave the family unit travelled around the country for three months and Erica's confidence and self-esteem grew. As she said, she was now a "mother on a holiday", not a "choof head".

Dee also kept her baby and pursued recovery despite multiple relapses, saying: "I'm a professional recovering addict." however she justified use of cocaine by stating she used it as an energiser:

This is my third kid...I'm feeling tired and I think.... I feel like a snort. So I do. It gives me a high and it's like I can do it all...kids, partner, household chores you name it...I'm in there giving it my best shot.

Debbie reveals how temptation is a constant battle, especially when caring for a newborn noting: "This baby is different from the other two. Colicky and demanding,...very hard to settle. I can feel my stress levels [rising] ...but no, I'm trying to play a straight fiddle [abstaining from drugs] this time." "Playing a straight fiddle" instilled confidence and a sense of purpose in Debbie which also improved the state of her marriage and pleased her parents and siblings. She said: "They feel I'm getting responsible at last and have invited us all for Christmas [this was the first invitation in four years]."

Maryanne, the youngest participant in the study, was excited and thrilled to have a daughter whom she named after the midwife who delivered her. She was so relieved that she hadn't suffered from post-natal depression after giving birth (as had her mother) that at the final interview she was planning a short holiday with her partner and child. Maryanne said: "I'm so happy and content and not really afraid of the future." She went on to add that "maybe I'll train as a drug counsellor one day, who knows." Amanda, her partner and their two children successfully entered a residential drug treatment programme as a family unit and now live quietly in a regional centre where her partner owns a business. They share the parenting and household responsibilities.

Of the remaining four women, only one woman's child went into permanent foster care. Sara got into financial difficulties (with credit card debt) and was arrested for stealing food from a supermarket. She put her son into permanent foster care with a view to adoption at a later date, "when I sort of make up my mind." The other three women had their children cared for by family members. Cathy's partner took parental leave and became their son's registered carer. He shares in the care of Cathy's other two children with their maternal grandmother. Cathy acknowledged that she misses the drug lifestyle and "all the wheeling and dealing, and the fun bits, you know....some of it was fun."

Peta's mother moved in with her to provide practical and emotional support. Peta explains her feelings of inadequacy and guilt thus:

I love my child more than anything...and I know that should be enough. But it's not. There's something missing. It's hard to explain. I'm supposed to have the one thing I want, but I'm far from happy...I hate feeling like this.

Peta and her grandmother frequently argue about Peta's continued "lazy lifestyle of unemployment, sleeping around and unsafe sex", with Peta noting "she's pretty worried that I'll get banged up again." Peta says that she's worried that her grandmother might lay a legal claim to her daughter, adding "but then it would be one less worry, right." Although Jo kept her child, she was admitted to a psychiatric hospital in order to treat her depression and obsessive-compulsive disorder, and was able to have her baby with her. Again she noted she had a new label (a "mother identity") which made her happy and content; however she continued to feel some guilt about a previous abortion that she had chosen to have. For the women in this group who kept their children, motherhood appeared to provide a sense of identity and agency. There was now something for them to "do", a reason, as Amanda said: "to get up in the morning and start the day in a positive way." All the women in this group were at the maintenance and action stage of TTM.

Overall, the women from this group had attended for more antenatal care treatment than the women from Group Two. They reported that the information and support provided by Clinic staff from all disciplines gave them with a degree of confidence about their parenting abilities and increased their level of competence. They considered that the Clinic staff had supported their attempts to reduce their chemical dependency and that the Clinic had provided comprehensive care which was aimed at assisting them towards recovery, while also acknowledging that for some it might be a more gradual process.

The importance of a multidisciplinary clinic with the emphasis on drug reduction to these women's progress endorses the findings of other studies Forbes and Lyon (2006), Fraser and others (2007), Hepburn (2004), Hall and van Teijlingen (2006), Hankin and colleagues (2006), Howell and others (1999), Jones (2006), Miles and colleagues (2006)

and Volpicelli and others (2000) which found that specialist clinics with a multi-disciplinary focus are effective in terms of positive evidence-based treatment outcomes where the emphasis was on drug reduction rather than stability.

Having established the women's stages of recovery and the social outcomes post birth, that is whether or not they kept their children, how the Clinic care and their stages of recovery have influenced their decision and their initial responses to motherhood, I turn to their continuing struggle to acquire a mother identity, while struggling with chemical dependency.

### **ACQUIRING A “MOTHER IDENTITY” AND STRUGGLING WITH CHEMICAL DEPENDENCY**

Acquiring a “mother identity”, particularly for first time mothers, encompassed many challenges faced by all new mothers. Motherhood is deemed by many theorists to be socially constructed (Chodorow, 1989; Rich, 1980; Ruddock, 1980), and implicit in this is the notion that mothering is transmitted by the experience of being mothered. All but two of these women (Alice and Naomi) described a history of inadequate mothering. This would inevitably have impacted on the participants' ability to mother well. Whilst there was support provided to the women to aid them in their transition to motherhood (parenting education classes and small group work), not all availed themselves of these opportunities.

Not surprisingly, therefore, the ten women who kept their babies and were the primary caregivers to their children struggled with the challenges to motherhood. Some participants expected to find the task of parenting enjoyable and fulfilling and yet were upset and

disappointed when this failed to happen. In many instances their expectations, as for many new mothers, were unrealistic and not all had the ability to recognise and overcome the difficulties associated with new motherhood through seeking appropriate help or using the support available. For example, Jo, Maryanne and Maggie didn't appear to be aware of what their local maternal and child nurses could offer. Similar findings with regard to the incongruity between expectations and reality of motherhood are reported in Boyd and Marcellus (2007), Layne (2006), Murphy and Rosenbaum (1999) and Taylor (1993).

What appeared again to make a difference (as for any new mother) was the availability of family and social support. For example, Alice (Group One) was probably managing best of all as she had considerable help and support from her family and the family's resources. The women who were managing reasonably well had varying levels of social and family support.

However, despite their best efforts, the remaining nine women had little confidence in their parenting skills. All saw motherhood as an important function, and when they sensed their efforts to care for their children were being hindered by their use of drugs, they tried to ensure that they were well cared for by significant others for short periods of time. Nor was the apparent abdication from responsibility embarked upon with any feeling of relief. Rather, the women adhered to the tradition or prevailing discourse that parenting should be their first responsibility and, therefore, totally fulfilling. When they realized that it was not so, it was the cause of much guilt and anxiety for a number and was often accompanied by further integration into the drug lifestyle. For some of the women who surrendered their children, they still held onto a sense of being a mother. The loss of their children was devastating for those participants who gave up their children or passed the responsibility to

other family members. Sara described it as the “worst thing that has happened to me”. Despite these challenges to their “mother” identities, many participants stated that they hoped to repair the relationships with their children and have them returned to them. Central to this ambition was success in the recovery process.

For female addicts, recovery means more than “getting clean”; it is about creating a new life (Pursley-Crotteau & Stern, 1996). For two participants, Alice and Amanda, it was about recreating their lives as mothers. For Rosa especially, recovery involved reclaiming the role of mother. For those women (Sharon, Monique and Lisa) who had given up their children the hope of one day reclaiming them was the primary motive for recovery, regardless of whether they had given up their children voluntarily or had them removed by Child Protection Services.

For the recovering addict to reclaim her motherhood, however, she must confront her guilt, repair the damage inflicted on those closest to her and renegotiate her “mother” identity. This was a huge task fraught with guilt and anxiety. Amanda explains:

I used to lock myself in the bathroom to use, but my older son [aged 6] seemed to know what was going on. He’s got a very negative attitude to me...like he won’t talk to me, won’t look at me when I speak to him.

Some women (Alice, Amanda, Maggie, Dee and Debbie) did not measure their success in recovery by counting the number of meetings attended or hours spent in therapy. They measured their success relationally: they watched for, kept track of and felt joy and happiness in their children’s affectionate responses to them. Connecting (and reconnecting for some participants) to their children was essential to their recovery.

For some women the demands of motherhood meant that, in order to cope effectively, there was a return to or an escalation of their drug use, mainly marijuana, which assumed a different function in their lives at this point. Sharon, Leanne and Cathy reported that the drugs helped them to manage with the mental and physical demands of being around their children (these women's partners were the children's primary caregivers). The drugs also helped them handle the guilt brought about by the gap between their expectations of what having a baby would be like, the reality of the experience and passing the responsibility to someone else. These findings support those of studies of Lester and Twomey (2008) and Goldstein, McAvay, Nune & Weissmann (2000) which found that while many women reduced or abstained from chemical dependency while pregnant, there was a steady return to use after their child was born.

## **SUMMARY AND CONCLUSION**

This chapter has focused on the participants' experiences of pregnancy. Eight pregnancies were planned while twelve were accidental or unplanned. The women's reactions to pregnancy were varied and some took time to come to terms with their pregnancy. Several participants reported that they weren't aware of being pregnant until their condition was well-advanced and this created a barrier to them seeking antenatal care. The factors that influenced antenatal care and attendance were similar to other studies and included: participants' ambivalent attitude towards the pregnancy, transport difficulties, fear of being judged, reduced physical and psychological health, concern about child protection and legal services as well as lifestyle problems. The women's perceptions of care were diverse with some reporting that a sense of being under continual surveillance with the major focus on foetal health made them less ready to engage, while others used the opportunity to connect and collaborate with the Clinic staff.



Birth outcomes again reflected the findings of previous studies in terms of the relationship of outcomes to drug use and antenatal care. The fourteen babies born at term were to participants who, for the greater part, had attended for antenatal care regularly and with a committed attitude, while six were to women on methadone maintenance programmes. There is a risk of the methadone exposed baby developing neonatal abstinence (NAS) (Berghella et al., 2003) and while two babies developed symptoms of NAS, only one was to a mother undergoing MMT. However, five babies born to women with a history of heroin use (while receiving MMT) were admitted to the special care nursery for reasons that included small for gestational age, prematurity and hyperbilirubinaemia. Two participants with a cocaine dependency had babies diagnosed with intrauterine growth restriction who did not require specialist care.

More than half of the participants used the experience of pregnancy and impending motherhood to work towards recovery, construct a sense of self and discover what was possible for them. For some women, the 'mother identity' proved elusive and disappointing and yet for others, it became the focus for change and transformation which will be further delineated in the final analysis chapter. It would appear that for some participants the discourse of the helpless addict in need of expert medical care slowly receded as they took responsibility for their chemical dependency and used pregnancy and motherhood to engage in the recovery process. But for others "mothering" was a challenge and highlights the need for consideration being given to extending the period for outreach postpartum visits by a midwife to at least six months post birth.

In the next chapter I explore the relationship between the women and the staff of the Transitions Clinic.

## **CHAPTER EIGHT**

### **RELATIONSHIPS BETWEEN CLINIC STAFF AND THE WOMEN: THE IDEAL VERSUS THE REAL**

Doctors [and allied health professionals] can safely assume that,  
whatever else they want, patients want to be understood.  
Kurt Vonnegut (1992) *Mother Night*

#### **INTRODUCTION**

This chapter examines the relationship between the chemically dependent pregnant women and the staff of the Transitions Clinic. I argue that the relationship formed by the Clinic staff and the women was a factor contributing to the women's desire to attend regularly for antenatal care, their responses to the treatment regimes and, ultimately, the progress in managing their chemical dependency and pregnancy. In examining the relationships between the women and the Clinic staff, I drew on Habermas' theory of communication including the concepts of distorted versus ideal communication and Foucault's notions of power-knowledge and surveillance and how these were exercised.

According to Habermas the process of colonisation of the lifeworld by health professionals is aided by distorted power where 'specialised knowledge' is used to restrict and control patient behaviour. In contrast, ideal communication has at its heart emancipatory knowledge which allows people through reflection to assert themselves and adopt some form of control. As discussed in Chapter 4, Habermas' theory of ideal communication has three components, that is, that there should be unlimited or non-coerced discussion between free and equal agents, that the relationships should be non-hierarchical and egalitarian with the release of controlled information and that the results should be centred around justice and best practice. Habermas' (1984, 1995) belief was that communicative action is a form of interaction and is not oriented towards success, but rather towards

reaching a mutual understanding by expanding each other's viewpoints. In essence this means that no power or manipulation is exercised, that collaboration is fostered and that the decision making is shared (Koerber, Arnett & Cumbie, 2008).

With regard to Foucault's (1973) concept of power and knowledge; Foucault (1973) saw healthcare settings as institutions where patients can be reduced to material and psychological insignificance by the regime. For Foucault, power is conceptualised as primarily productive and embodied in the everyday practices of health professionals within the institution (McHoul & Grace, 1993; Root & Browner, 2001)). There is another key aspect of Foucault's work on power, namely the role of disciplinary power in producing "truths". Within this analysis, he highlights the role that disciplinary power plays in regulating social life. Within disciplinary power, truths and falsehoods are constituted historically and they then appear to be self-evident, as in medicine. The features of medicalisation which all point to the nature of the disciplinary power of obstetrics are: the regulation of bodies; confinement and the spatialisation of "patients"; normalising judgments; minute control of timetabled activity; repetitive exercises; and a focus on principles, calculations and procedures rather than individuals (Foucault 1994a, 1994b).

Utilising the theoretical concepts outlined above, this chapter further examines the relationship between the Clinic staff and the women with regard to the differences between both parties' expectations, delivery of care and the Clinic staff's allegiance to best practice, with an arguably necessary emphasis on the unborn child. This primary emphasis on the unborn child is discussed in the broader context of surveillance and the notion of natal panopticonism articulated in Chapter 4 in terms of medical surveillance of pregnant women (Fahy, 2002; Terry, 1989).

An alternative way of analysing and understanding relationships, which embraces and complements the theoretical and methodological approaches of this study, is through paradoxical spaces, that is the paradoxical spaces of the relationship between the Clinic staff and the chemically dependent pregnant women. This concept draws on Rose's (1993) notion of paradoxical spaces which acknowledges the difference of others. Rose explains how women experience confinement in space – a recurring image in women's day-to-day lives in ways that serve to marginalise them. This chapter also reports on the participants' desire for collaboration within the communication and decision-making processes. I now turn to the differences between the expectations of the Clinic staff and the participants.

## **INCONGRUITY BETWEEN THE STAFF AND THE WOMEN'S EXPECTATIONS**

There was considerable variation between the participants' and the staff's expectations with regard to attending for antenatal care and conforming to a set regime. Variations along a recovery continuum depended to an extent on the stages of change (according to the TTM) the women had reached. As outlined in the previous chapter, all the participants in the various groups were at various stages at first presentation and demonstrated ongoing improvement throughout pregnancy and post birth, with all in Group One being at the termination stage at the final interview. In Group Two three women, by the third interview, still remained at the contemplation stage while four were at the preparation phase and in Group Three, two participants were at the action stage and the remaining seven were at the maintenance level.

The four women in Group One (Alice, Kate, Jasmine and Nicole) have been identified as predominantly having a mature and conscientious approach to their pregnancy, with Alice, Kate and Jasmine largely compliant in meeting the staff's expectations, However, Nicole who subsequently had a still birth, was not so acquiescent in following the Clinic "line". In Group Two, Monique and Maggie, who kept their babies, were largely amenable to meeting the requirements of the treatment regime, however, Rosa, Lisa, Sharon, Naomi and Leanne were more cavalier in their attitude to advice given by the Clinic staff. In Group Three, Erica, Amanda, Jo, Maryanne, Dee and Debbie (who also kept their babies), despite being identified as the most vulnerable of the participants, for the most part persevered with the antenatal advice given and were confident enough to realise their goal of motherhood. The remaining women in Group Three, Cathy, Peta and Sara, demonstrated little interest in establishing a successful antenatal treatment regime, and ultimately relinquished their children.

The staff of the Transitions Clinic ideally expected their chemically dependent clients, regardless of their stage of recovery, to attend regularly for antenatal care, to take responsibility for their and their unborn child's health care and to make appropriate informed decisions to support that care. The latter included the practice of harm minimisation, that is, the reduction of illicit drug use and its associated self-medicating practices. However, the dominant desire of all the chemically dependent pregnant women was to be treated as normal expectant mothers and not always as people who needed to be regularly assessed and warned about the dangers that could, and perhaps would, occur to the foetus. These differing expectations put several women (Nicole, Rosa, Naomi, Cathy and Sara), irrespective of their stage of recovery, on an initial "collision course" with Clinic staff, as they considered that rather than being trusted and treated like other

pregnant women, they were being judged. These women usually presented as intransigent. At the same time they craved acceptance, wished to be treated in a non-judgmental way and to receive understanding and support from the health professionals they encountered. Sara recalls her expectations:

I just wanted to be looked after nicely. I wanted someone to care for me, and for the baby too. I guess what I wanted was someone who would mother me. Well, I certainly didn't get that. What I did get was rudeness, criticism and disapproval.

The first contact the women had with Transitions Clinic staff appeared crucial in establishing a workable relationship and this was regardless of the stages of recovery they had reached. Some participants (Dee, Debbie and Rosa) recalled experiencing a critical and disapproving attitude and responded by being hostile and defensive. For example, Rosa recalls early attendance at the Clinic with her grandmother and the labelling by staff, stating, "I would bring my grandmother with me for most antenatal visits and the reception staff would act like she was a brothel madam instead of a retired primary school principal." It was difficult to understand why the women responded in a hostile manner, but I believe their resistance to any form of authority started in adolescence and could be sourced to a dysfunctional childhood.

The expectations that the Transitions Clinic staff held were that as health professionals they would engage with their clients and, as already noted, encourage antenatal and postnatal attendance, recognise and treat mental health issues and persuade the women practise harm minimisation by reducing their illicit drug use and unsafe self-medicating practices. The women, however, had different expectations and were not always "in step" with the Clinic staff's expectations. Kate, despite progressing steadily toward recovery as identified by the TTM recalled her earlier experiences:

Looking back [post birth] I realise that the Clinic staff had their job to do of course, and I could never be considered to be really responsible and perhaps even truthful, but I felt that we were always at [the] crossroads. Never quite on the same page if you get my meaning.

This was despite the fact that Kate was highly educated, but nonetheless, was cast as “the pregnant drug addict in need of expert medical care”, one whose voice was silenced by the obstetrician. She recalls her first contact with this doctor :

My personal information, which the doctor had in front of her, included my educational details [Master of Science degree] and employment history, yet that didn’t appear to come into it. I could have talked with her on her own level but in her eyes I was just another pregnant woman with a problem.

Despite a conscious effort to do the right thing within the constraints of her situation Kate never felt in equal partnership with the Clinic staff. “Ideal communication” as identified by Habermas’ (1984, 1995) where the goal is to reach a mutual understanding and where there is a non hierarchical or equal relationship appeared from Kate’s perspective to be inhibited by her status as a chemically dependent woman or, “just another pregnant woman with a problem.”

Several participants (Rosa, Nicole, Leanne, Naomi and Sara) acknowledged that their desire to be treated normally was “doomed to fail” from the start. Naomi reflected the sentiments of the others when she described the Clinic staff’s attitude thus:

You just knew that you were not going to be treated equally and like other pregnant women and accepted for who you were. I mean after all I was at the Clinic because of drug problems, and that was never forgotten [by the Clinic staff].

At the same time, several participants including Leanne and Cathy were recalcitrant and continued with their drug use until they came to the attention of law enforcement agencies. This in turn had the potential, from their perspective, to make them even more deviant in

the eyes of the Clinic staff. Chemically dependent pregnant women have traditionally been considered a difficult population for health professionals to care for and health care providers in a variety of health settings have perceived them to be challenging to work with, and in some cases, morally suspect or dangerous, with consequent distorted power relations. Some participants (Jasmine, Kate, Erica, Peta and Debbie) were aware of this and described the power imbalance and the perceived level of control exerted by the Clinic staff. Erica recalls the resentment this caused:

Because most of us didn't like being ordered about, that built up a lot of resentment between the staff and us. Sometimes it felt like we [the Clinic staff and the women] had different goals, different outcomes and that really emphasised the differences between us.

When participants (Alice, Kate, Jasmine, Monique, Lisa, Maggie, Erica, Jo, Maryanne, Dee and Debbie) encountered sympathetic treatment it was much appreciated and it was often a motivator (albeit only short-term for some of the women) for bringing about change. This change was manifest in the women's reduced substance abuse and in more regular antenatal attendance. For example, Jasmine remembers that when she and other women experienced a warm and helpful attitude from Clinic staff, it had a positive effect. She said: "Maggie, Alice and I were surprised that they appeared to be pretty well laid back and less judgmental than we reckoned. Most of the time they were pretty cool."

Despite the initial perceived incongruity between the women's expectations and those of the Clinic staff, most of the participants (Alice, Kate, Jasmine, Amanda, Leanne, Jo, Dee, Debbie, Cathy, Naomi, Monique and Sara), by the second interview spoke of having a relationship with the Clinic staff that was supportive of their needs. This connection appeared to deepen as the women's pregnancies advanced. The relationships were increasingly identified by some women as open and engendering trust. The fact that



assistance and support was almost always available helped to cement the growing sense of trust. The persistence, patience and motivation of the Clinic staff certainly had a strong positive effect on some women that created a willingness to work in partnership with them. As Alice explains, “They [Clinic staff] seemed resolute and unwavering in their attempts to try to help us but not everyone responded well to their determination, but those of us that did, certainly benefited.” However, some Clinic staff had a commitment to what they called “best practice” and this occasionally ‘clouded’ their judgment in terms of not always fully appreciating the various stages of recovery with which the women presented and the unique needs of this complex clientele.

### **Clinic Staff’s allegiance to best practice**

As previously noted, the staff had certain expectations of the women attending the Clinic and their ultimate aim was to ensure the birth of a healthy baby, through assisting the women to achieve this outcome. In order to achieve this there was an emphasis on a medical discourse with the instructions to the women by the Clinic staff focused on achieving a good outcome. Viewed through a Habermas lens, the health professionals set out to help the women understand why harm minimisation - which was essential to the wellbeing of the foetus - should be a goal. While endeavouring to understand the women’s desire for impartiality and equality, this often took second place to ensuring the well being of the unborn baby. Viewed through a Foucauldian lens, the participants’ pregnant bodies and the matter of their chemical dependency became central to the power relations between the Clinic staff and the women.

Foucault (1973) discusses the body as an object of the medical gaze, devoid of social and emotional values, excluding embarrassment and subjective information, thus allowing de-

sexualisation of the patient. The roles of client and health professional are defined within the cultural setting in which the encounter occurs. For the women participants there were no choices as to where they were located in the antenatal Clinic environment, and this environment was often perceived as cold and clinical with the health professionals exercising ultimate control. Cathy recalls being overwhelmed during her first antenatal visit at the then new Heidelberg site:

It was all so shiny and new. I felt strange and had this feeling that there must be cameras hidden everywhere...even in the space where you change your clothes. At times I wondered why we bothered to wear the gown....the poking and prodding of my body, the never-ending questioning and demand for blood and urine.

Cathy clearly articulates the sense of depersonalisation she experienced and her sense of being subject to a clinical gaze during the examination process. Revisiting the concept of the natal-panopticonism outlined in Chapter 4 illustrates how medical surveillance, or the “medical gaze”, is central to the operation of power. Foucault coined the term “medical gaze” to denote the dehumanising way in which the medical profession has come to separate the body from the person. That is, health professionals can exercise great power over their patients through their ability to look inside, beneath the surface, beyond symptoms and signs: from without to within. This becomes particularly pertinent when much of the “looking” is focused on ensuring foetal wellbeing. Terry (1989) situates natal panopticonism against the regulatory antenatal technologies, including amniocentesis, sonograms and electronic foetal monitoring.

While most participants “toed the Clinic line”, and saw value in protecting their unborn child and prioritising their pregnancy, Jasmine, Nicole, Rosa, Cathy, Amanda, Naomi and Debbie resented being viewed as “a baby incubator” and resorted to resistant and deviant

behaviour by refusing to acknowledge that- at this time - their unborn children should take priority over their own needs and desires. Debbie explains:

There comes a time when you get tired of everything being about the baby, the baby and the baby yet again. Some of us had other kids, some had jobs, some had a drug habit they were trying to crack... it fair got you down some of the time. So a group of us decided not to talk about 'B' [the baby] or our drug taking. It was what we didn't tell, and sometimes it wasn't our pee in the jar.

The women, in resisting medical surveillance, effectively undermined the authority of the health professionals, rejected the notion of the docile body, and employed a degree of agency in decision making. This in turn may have impacted positively on their sense of identity, however it had the potential to have an adverse effect on the unborn child.

The various responses of the women challenged the notion that chemically dependent pregnant women are largely passive individuals fixed to certain norms of reality. The forms of knowledge and practices influencing the relationships between the staff of the Transitions Clinic and the women involved an intricate network of power-knowledge relations. These relationships were complex, contradictory, and inherently unstable with possible sites of resistance as evidenced above. Furthermore, the women could not be regarded as "victims" of patriarchal, medical discourses that dominate professional relationships in health care. Rather, power relations were structured around ambiguities and contradictions with the chemically dependent pregnant women both complying with and resisting dominant forms of knowledge and practices in the Clinic setting. For a number of women, part of their resistance stemmed from a sense of not being heard, and/or their past experience and knowledge being discounted.

### **Subjugation and acknowledgement of the women's knowledge**

Certain forms of the women's knowledge relating to their past drug related experiences and background tended to be discounted in decision-making. This brought to mind Foucault's (1980c) notion of "subjugated knowledges" in terms of "a whole set of knowledge that has been disqualified" (p. 82), and include those of the ill or psychiatric patient. According to Foucault disqualified popular knowledge sets up the climate for hostile encounters between health professionals and clients, which can result in ongoing problems in relationships. This was true for a number of women (Nicole, Jasmine, Rosa, Amanda, Jo, Dee and Debbie). The obstetricians and allied health staff in their turn appeared to be influenced by their past experiences related to caring for chemically dependent pregnant women. It appeared to a number of the participants (Erica, Cathy, Nicole, Leanne, Jo, Rosa, Dee and Debbie) that the Clinic staff operated from the belief "once an addict, always an addict", that there was no or little chance of recovery and that they needed to be closely monitored and managed. The members of staff who were perceived in this way often encountered resistance from the participants whose understanding was partly informed by their drug culture lifestyle and streetwise "smarts", but also through their experience as mothers and daughters. Those women (Nicole, Rosa, Amanda, Jo, Sharon, Maggie, Dee and Debbie) who felt this knowledge and experience was not valued by the obstetricians and allied health staff expressed their frustrations in various ways. For example, Dee said: "I'm more than just a coke head with a 12-year-drug habit. I've got a child-care diploma, two kids, two dogs, a partner and a home I'm pretty proud of."

Other acknowledged and valued forms of the participants' knowledge included the management of drug [and polydrug] use upon their lives, existing and surviving while

marginalised, often quite successfully coping with a dual diagnosis (drug addiction and a mental health problem) while holding down a series of jobs, raising children, keeping house and caring for a husband or partner.

Politics of subjugation occurred when the Clinic staff considered their specialised knowledge to be of primary importance, for example, in decision-making and this left no room for contributions by the women. This process distanced the women from the forms of knowledge informing the obstetricians' and allied health professionals' care and led to sporadic resistance and challenges. Debbie voiced her frustration at not having her past experiences and efforts accepted and appreciated:

I've been an addict for nearly thirteen years...this is my third pregnancy, none of my kids have had Neo-natal Abstinence Syndrome...I do volunteer work and look after my partner and his mother who lives with us...and who is an alcoholic by the way. I've never had government assistance.

Maryanne expressed similar feelings:

I left school to look after my parents who weren't coping. I'm a pretty good housekeeper, even B [partner] reckons you can eat off the floor. We live with my folks...but they're pretty well brain-dead - too much of the weed. My clothes are always clean and pressed and I save a bit of scent for the days I come here. But here I'm just another naughty girl....on drugs... and having a baby. Not one person here [at the Clinic] ever asks me how I am.

Claims for legitimacy associated with these alternative forms of knowledge were powerful because of the dominant discursive practices in which they were located. The dominant discourses of health care affirm that its professionals possess expert, scientific knowledge pertaining to health and illness. Traditionally, senior health professionals are viewed, therefore, as the disseminators of this knowledge to their clients and patients.

While the participants frequently considered that their knowledge relating to past experiences and background was subjugated or discounted, an alternative discursive practice for them involved adherence to the unwritten rules and loyalties of their “half-hidden, half-lived lifestyles”. At the same time, the women believed they had the potential to provide valuable (even acceptable) input into decisions regarding their pregnancy and parenting skills by reading the recommended literature and attending parenting or antenatal classes: a number of women with children (Alice, Jasmine, Kate, Peta, Amanda and Debbie) saw information and expertise of this nature being dispensed, rather than discussed in a collaborative way which allowed for their knowledge and expertise. In so doing they illustrated the “dynamic tension between [the dominant and the subjugated], and a multidimensional geography structured by the simultaneous contradictory of social relations” (Foucault, 1980c, p.78).

An alternative way of examining relationships, which embraces and complements the theoretical and methodological approaches of this study, is through paradoxical spaces. This concept draws on Rose’s (1993) notion of paradoxical spaces which include public and private spaces, and their influence on communication and decision making.

## **PARADOXICAL SPACES OF RELATIONSHIP AND IMPACT ON COMMUNICATION PROCESSES**

Aside from Fox (1997), Karlin and Zeiss (2006) and Spain (1992), research literature has placed little emphasis on the effects of space on communication processes. Yet, observation of the interactions between the women and the Clinic staff did demonstrate that space was seen to influence the staff-patient relationships in different ways, for example communication and decision making.

When analysing relationships between the participants and the Clinic staff and the influence of the geography of the Clinic on these relationships, I was reminded of Rose's (1993) conceptualisation of paradoxical spaces and Spain's (1992) theory of gendered spaces. Rose (1993) theorises that the way in which a space is constructed, or its geography, has the potential to marginalise certain groups, for example women, who often occupy hidden spaces whilst men occupy more visible and important spaces, the so-called paradoxical spaces. Spain's (1992) theory of gendered spaces is similar but she has concentrated on the workplace and its contemporary construction. Whilst Spain (1993) was examining the workplace, for example office design, some parallels could be drawn in relation to the geography of the Clinic, specifically the Heidelberg site already described in the previous chapter. That is, the design of the Clinic was such that the women occupied a specific space, as did the Clinic staff. The women could only enter spaces, other than their designated space, with permission and this had the effect, in their eyes, of maintaining power and privilege with the Clinic staff (Spain, 1992). I argue that public and private spaces or paradoxical spaces as defined by Rose (1993), and identified by the women, could be described as gendered spaces, and consequently influenced communication and decision-making.

### **Moving Between Public and Private Spaces**

The Clinic staff generally carried out their work in particular spaces within the hospital outpatient area. As described by Spain, two spatial aspects operated to reduce the women's status in communicating with the Clinic staff. The first group, the participants' space had a specifically allocated space in the waiting area. It was a public space where the chemically dependent pregnant women waited and which required them to be highly

visible and to face repeated interruptions. The second group, the health professionals, occupied the private spaces of the treatment and consulting area which were behind “closed door[s]” (Spain, 1992, p. 206).

The Clinic staff moved between these two spaces, which I have designated public and private, as they communicated with each other and with the participants. The midwives and social workers tended to conduct their work within both spaces, that is, the public spaces of the Clinic, the birthing unit and the bedside, where their communication was constructed to function with constant interruptions. In contrast, the obstetricians and senior midwives always conducted their work in the private spaces of the consulting and treatment rooms. In seeking out alternative places and mechanisms to address the participants’ progress and make decisions, the obstetricians often chose to remove themselves from the public spaces, and this environmental influence was reflected in their formal communication styles with the women. The women reacted to this formality with subdued speech and little or no spontaneity. Jasmine recalls: “It was all question and answer. The doctors would ask the questions and we’d answer. No chitchat, no ‘how was your week?’ They were polite. But definitely no laughing, no joking.”

As another example of private space, the Clinic staff meeting was usually held in a private space at the end of the Tuesday outpatient session, and most of the medical and allied health decisions taken that day were discussed briefly. In their interviews several of the participants (Jasmine, Nicole, Rosa, Dee and Debbie) told of wondering what the staff discussed about them “behind their backs”. They felt that such meetings and the instructions contained therein were part of the “power-knowledge pull” in which they had “no say”. The women also felt that extreme or incorrect views about their addiction(s) and



their response to some medical problems would be inaccurate, or biased. Nicole comments: “It was the same old, same old, the same old story of the “good addict” versus the “bad addict””. The women’s perception was that if you gave up drugs you would be termed the “good addict” while if you continued to use drugs you would be deemed the “bad addict.” To them [the Clinic staff] the “good addict” gave up non prescribed drugs while the “bad addict” kept to their [drug] habit.

Behind closed doors, it was the Clinic staff who regulated the entry and departure of the women. Only the Clinic staff appeared to have the freedom to speak, to initiate conversation and greetings, and to regulate the periods when the women could speak. In the meantime, the women often remained silent as they struggled to create a space to speak. As a way of overcoming the asymmetrical relationship, one participant (Debbie) recommended that the Clinic staff allocate a quiet space for reflection and discussion between staff and patients with tea and/or coffee-making facilities.

The women accepted the communication processes (which included the power-knowledge emphasis of the Clinic staff), arising from the use of space, particularly the hidden spaces at the Heidelberg site, as taken-for-granted activities. Alice recalls how the staff “always seemed so busy”. She went on to say, reflecting the influence of different architectural spaces on communication: “At the old Mercy, you could actually talk to them and watch what they were doing. But now, you can’t bloody well find ‘em”. This suggested difference related to space was a major impediment to communication.

I wish now to focus on examples of communication styles influenced by public spaces, specifically the waiting area. The Clinic staff would approach the participants while they

were sitting in the waiting area and would remain standing while the women were seated. As the woman was positioned lower, it was difficult to make effective eye contact with each other and this often hindered the communication exchange. The conversation became desultory and the Clinic staff would start to talk among themselves. This would take the form of non-verbal gestures such as discerning looks and selective dialogue between each other. This made the participants feel rejected and left out. They felt that their conversational contributions and exchanges were undervalued and unimportant. Kate observed: “They [Clinic staff] are just so busy. You start having a few words [with them] but then you realise you’re talking to thin air. I’m sure it’s not meant personally, but sometimes it’s hard not to be rebuffed”. The sense of being irrelevant contributed to their sense of powerlessness. Important in this analysis of power is the characteristic of intentionality, in which power relations involve a high degree of decision-making, planning and co-ordination of activity.

The divisions that I have created for these spaces are arbitrary because they impacted on each other in complex ways. For me, a major consideration in examining paradoxical spaces was the historical and socially specific contexts of these relationships. It was through an explanation of these contexts that the paradoxical spaces became apparent. Paradoxical spaces of power-knowledge relations infiltrated communication processes between the Clinic staff and the participants in several different ways as indicated. As I mapped the paradoxical spaces of practices, it became apparent that communication involved more than a transmission of information about antenatal health care and harm minimisation: it also involved how the women saw themselves reflected in the Clinic staff’s eyes and their degree of influence in the relationship. I now turn to Habermas’

interpretation of ideal communication and contrast it against actual communication whilst also including the women's readiness to collaborate.

## **IDEAL COMMUNICATION AND THE WOMEN'S DESIRE FOR COLLABORATION**

It is generally known from clinical practice and supported by various studies that ideal communication (Habermas, 1984, 1995) and collaboration between health professionals and clients will have a favourable effect on client compliance and treatment outcomes. Part of this success lies in the importance of empowering clients to participate more equally in the treatment process. At the same time empowerment as a concept is also questioned. For it may be, as Taylor (2009) articulated, that lip-service is paid to empowerment with a traditional paternalistic attitude and practice. Debbie described an incident where she felt disempowered and her experience discounted:

This was my third pregnancy and yeh, I've got a bit of a drug problem, but I'm like having drug counselling every week and trying real hard to stick with just the methadone. But you go through the third degree with [social worker]. ..with 'how to have a healthy baby'.....It's like they just don't hear you and like... I've never had a kid before. One staff person started reading the riot act to me without even bothering to find out that I already had two kids.

Empowerment, as already noted, is an elusive concept and realising it depends very much on the readiness of the client. For example, Leanne had little confidence and preferred to be told what to do:

I reckoned that they're the experts and so I'm happy to go along with whatever they say...well with them making sense and me being able to understand it [the process]. The bottom line is about having a good delivery and a healthy baby.

For some women (Jasmine, Kate, Alice, Nicole, Maggie, Jo and Debbie), empowerment came via behaviour change and with a degree of compliance, rather than by improving health professional/client interaction. Jasmine recalls:

I got the gist early in the piece. That if I was a ‘good addict’ the word would get around and I would be treated OK. I was polite and pleasant to them all and told the truth about giving up the ‘smack’ and sticking to the methadone. I made it work by doing the right thing by them and me.

The women felt that staff would advocate on their behalf if they “obeyed the Clinic line”, whereas the participants who projected “an ambivalent and a laissez faire attitude got short shrift”. Some (Nicole, Sharon, Cathy, Leanne, Naomi, Sara, Peta and Dee) felt that various staff manipulated them and that the “good addicts” got rewarded while “bad addicts” were made to feel further marginalised. Leanne remembers:

If you’re lucky and one of their faves, you get a pat on the head, a touch on the chin or arm and a big smile. You can see I never got that and nah, wouldn’t want it neither...so there you have it.

All participants, regardless of the recovery stages they had reached, felt that the staff maintained an unnecessary authoritarian, interactional style when dealing with them, regardless of their success rate with attempting to give up or control their chemical dependency. Without exception, the women felt that the health professional/client relationship should be more equal, equitable and reciprocal. Kate said:

We are here because we want to do the right thing. That is...the right thing by ourselves and the right thing by our babies. It’s like a business partnership, a two-way street. You each want the best outcome for the child.

Several women (Sharon, Naomi, Leanne, Cathy, Peta, Maryanne, Sara, Dee and Debbie) expressed their sense of oppression engendered by the authoritarian attitudes of the Clinic staff. Dee believed that these unhelpful attitudes were designed to “keep us in our place

and stop us from rocking the boat”. This had the effect of the women not feeling able to raise sensitive topics. Sharon, Cathy, Leanne, Kate and Jasmine felt that some Clinic staff actively avoided raising sensitive topics and/or adopting positive attitudes and instead focused on issues such as their drug habits and living conditions that reinforced negative stereotypes and reduced any possibility of empowerment. Kate takes up the story:

I think that some staff treat the addiction, not the woman. It doesn't matter what else you might do in life that's positive and fulfilling and legal, of course. It always seems to come back to the fact, that here you are, pregnant with a drug habit...fullstop.

Lisa agreed, stating:

I was trying to keep off the weed, cold turkey like...and holding down two jobs to pay the rent and keep [partner's] car payments up while he's inside getting a roof over his head and three square meals a day...and the Clinic staff just yak, yak about what you should be doing. Never a hint of praise for coping the best you can. No-one ever asked me a really personal question that might have a happy answer.

Nicole recalls trying to change the topic (from pregnancy and drug issues) and talk about her future plans, which included having her baby adopted. “I couldn't get to ... adoption issue [on the agenda with the midwives] ...I was told to talk to the social worker. I gave up trying then.” It is worth noting that for a number of women it was the relationship with a known midwife that created the climate for confidences and discussion; a referral to the social worker, with whom they may have had little or no contact, was not what most women wanted.

The structure and the organisation of the Clinic and its architecture served to exert power over the participants and their compliant, “docile” bodies. The construction of this power relationship between health professionals and clients can dissolve a participant's claim to “authenticity”, as the professional interaction is often reduced to an interrogation. Kate

explains her feelings: “For the most part I felt there was little or no consideration of what I really thought...they [the staff] just wanted to hear the “right” answer. It seemed that the clinical priority was reporting my behaviour.”

Nonetheless, all participants said that they responded well to the women-only [client] environment. It could mean time away from violent and intimidating partners, time to talk with other women and sometimes a catch-up with a family member or friend who met and sat with them while they waited for their appointments. Amanda reflected the sentiments of several women when she said:

It’s wonderful to get away from the emotional and verbal abuse, the intimidation and the humiliation...where women are there for other women. You just know you should make the effort even when you’re not feeling a hundred per cent.

For some women, the Clinic staff served as role models and this in turn influenced appointment-keeping and continuation with treatment, as did the development of one on one relationships and a sense of trust, particularly with the midwives.

In mapping the paradoxical relations of power-knowledge encompassing health professionals-patient relationships, I contested the view that all parties “occupy separate, different and equally valuable places...where experience is defined...in terms of an individual as representative of a cultural group” (Mohanty, 1994, p.154), that is, all parties are valid and equal (Root & Browner, 2001).

## **SUMMARY AND CONCLUSION**

Despite considerable variation between the participants’ and the Clinic staff’s expectations with regard to attending for antenatal care and conforming to a set regime, collaborative

relationships evolved as both parties began to understand and challenge their experiences within asymmetric power relations. Strategies for collaboration involved a “terrain of struggle” (Mohanty, 1994, p.155) for the participants as they sought to make sense of the contradictions inherent in their lifestyle of chemical dependency and that of expectant mother. Aspects of that struggle included the women’s belief that their ‘lived experiences’, that is, their conviction that they were the expert in their life, went largely unacknowledged and this, in turn led to episodes of resistance, although for the majority this was usually short-lived.

From a number of women’s perspective the dominant discourse influencing the Clinic staff’s relationship with them was that of the “hopeless addict in need of expert medical and nursing care” and as a subset of this, the “good addict” versus the “bad addict”. Rather than the Clinic staff and the participants striving through “ideal communication” to achieve true collaboration from the very beginning, I contend that there were two discrete groups, which despite the best of intentions, left the majority of the participants feeling judged and marginalised.

Initially, participants believed that power was solely exercised by the Clinic staff. However, as they explored possibilities for collaboration, as well as resistance, through the development of strategies, they came to accept that they too could exercise power and work towards a more equal relationship with the Clinic staff. The quality of relationships that developed over time, if not always truly collaborative, was situated at various points along a continuum, with varying levels of success in terms of outcomes. It was often the attitude of the Clinic staff members, particularly midwives, that was the key to the way in which the women responded to care. For example, if the midwife showed genuine interest

in the participant and chose to talk about personal interests as well as health matters, the women often showed renewed vigour and interest in their pregnancy and the challenges that lay ahead. As relationships developed, and for most women this occurred as the birth approached, the participants acknowledged the professionalism, commitment and availability of the Clinic staff and the way in which they were supportive of their needs.

It is worth noting that is difficult for any health service to provide an optimal service if clients are not willing to co-operate. Lack of co-operation often means many health professionals will settle for compliance, which is a poor substitute for active co-operation which influences attitudinal change, essential for long-term recovery. Engaging women as early as possible in pregnancy and providing continuity of care – particularly midwife care – assists in developing a collaborative approach. The importance of a holistic, multi-disciplinary team cannot be under estimated however, it would appear that what is lacking is specialised care in the form of drug and alcohol counsellors and family therapists, that is specially trained staff able to deal with drug and alcohol and mental health issues.

The next chapter explores the extent to which the women perceived pregnancy as a turning point in their lives and the way in which, from an existential perspective, they responded to pregnancy and impending motherhood.



## CHAPTER NINE

### ALIENATION VERSUS REDEMPTION

The consequences of sin are threefold:  
Debt which requires forgiveness,  
Bondage which requires redemption,  
And alienation, which requires reconciliation.

Brooke Foss Westcott (1965) *The Epistle to the Hebrews*

### INTRODUCTION

This chapter focuses on the way in which the women formulated “in a dialogue their own conceptions of their lived world” (Kvale, 1996, p. 11) and the extent, to which pregnancy was viewed as a “turning point”. The women’s reflections relate to the impact of pregnancy, their struggle with chemical dependency and their efforts towards recovery. Table 6 reports the women’s stages of recovery at each of the three interviews as represented by the TTM.

**Table 6**

#### Stages of Recovery as Represented by TTM at Interview

Pseudonym	First Interview	Second Interview	Third Interview
Group 1			
Alice	Precontemplation	Action	Termination
Kate	Preparation	Maintenance	Termination
Nicole	Contemplation	Action	Termination
Jasmine	Contemplation	Maintenance	Termination
Group 2			
Rosa	Precontemplation	Contemplation	Preparation
Lisa	Precontemplation	Contemplation	Contemplation
Monique	Precontemplation	Contemplation	Preparation
Sharon	Precontemplation	Contemplation	Contemplation
Naomi	Contemplation	Contemplation	Preparation
Leanne	Precontemplation	Contemplation	Contemplation
Maggie	Contemplation	Contemplation	Preparation
Group 3			
Erica	Precontemplation	Action	Maintenance
Cathy	Contemplation	Action	Maintenance
Peta	Precontemplation	Action	Maintenance
Amanda	Precontemplation	Action	Maintenance
Jo	Contemplation	Preparation	Action
Maryanne	Precontemplation	Preparation	Action
Sara	Precontemplation	Action	Maintenance
Dee	Preparation	Action	Maintenance
Debbie	Contemplation	Action	Maintenance

The women's narratives, at various stages in their pregnancy and post birth, revealed challenges to the existential realities of life and death, especially when they were deciding whether to use the pregnancy as a turning point or merely as an interlude in their substance abuse.

The women's struggles for meaning brought to mind existential theories, such as those of Viktor Frankl (1963, 1967). As outlined in Chapter 2, Frankl theorised that inner growth is often preceded by suffering and despair and as noted by King and others (1978) experiences of suffering and despair are often the necessary ingredients in forging more meaning in one's life. Frankl's (1963) existential view is optimistic in that it regards an individual as self-determining, with the capacity to rise above unpredictable biological, psychological and sociological conditions, and to transcend them. In this context, life can become meaningful through a sense of responsibility and through "actualising values" (p.43). This was true to a greater or lesser extent for more than half of the participants.

The themes identified in the women's narratives were: loneliness, anxiety, and isolation; choice, responsibility and guilt; vulnerability, helplessness and gaining control; and authenticity and meaning.

### **Existential Loneliness, Anxiety and Isolation**

Chemical dependency or addiction, which faces one with the possibility of early death, would seem likely to arouse an inordinate amount of death anxiety and existential loneliness, as it challenges a person's world in a fundamental way. All the women made reference to at some point being confronted by their mortality, of being aware that life is finite and of being isolated. Their lives appeared to be shaped by an unpredictable and

uncertain lifestyle with little actual freedom. Personal meaning for some came from a sense of being situated in the world within these specific contexts and then, reflectively and proactively being committed to “living the best way we can” (Leanne). Participants spoke of their struggles with the isolation that their lifestyles caused. Rosa noted that her sense of loneliness was so extreme that: “Sometimes you just want to grab a kind looking woman in the street and ask for a cuddle or a hug”. Dee in speaking about a relationship that was unsatisfactory and unfulfilling felt it was better than the alternative, stating: “I knew that I could never leave him, I was as lonely as hell in the relationship, but I figured it was better than having nothing or no-one”.

It has been said that existential anxiety is triggered by boundary situations (Jaspers, 1970), the most powerful of which is death – our own, or that of others close to us. Boundary situations have been described as experiences that confront one with “frightening threats of being” (Ottens & Hanna, 1998) that may “wedge open” one’s defences causing issues such as existential isolation (often experienced as existential loneliness) to emerge (Ottens & Hanna, 1998; Yalom, 1980). Dee described how a friend’s death eighteen months previously from “a cocktail of drugs and booze” forced her to confront her drug dependency and her own mortality. She recalled how her terror in relation to this induced a psychotic episode with delusions that “she was dead.” She described how these fears were acted out on her young children: “I wasn’t all together, I’m telling you. I wouldn’t let the kids go out of the house. I wouldn’t let them put on the lights. I don’t know what I was experiencing.” Dee was hospitalised for a short time following this incident.

Following her discharge from hospital after the birth of her older son, Dee recalled continuing to struggle with her dread about dying:

I was just home with the new baby. My partner was out dealing and I felt that I was near death. I kept thinking...what's going to happen to the kids, what's going to happen to me, who's going to take care of them, that was my worst fear...just being in the house and waiting for something to happen.

However, Dee managed to overcome those early fears and has re-united with her family of origin, which has improved her relationship with her partner and older children. At the time her second (and latest) pregnancy was confirmed, Jasmine had also experienced the death of someone close to her, with two friends dying from heroin overdoses. She said that she initially “felt like putting a gun to my head”. Nicole, who was at the TTM termination stage post birth, spoke about how her previous spiralling drug abuse prior to the latest pregnancy was precipitated by vain attempts to medicate chronic feelings of “terrible loneliness”, which had become heightened by the rejecting response of other drug users because of her obvious pregnancy.

Alice was one of a number of women (Nicole, Jasmine, Alice, Rosa, Lisa, Sharon, Naomi, Leanne, Cathy, Peta and Sara) who when they initially found they were pregnant were “terrified”, as they didn't want to accept responsibility for another human being. Jasmine, who had progressed from contemplation at the first interview and was at the TTM termination stage, post birth, described the utter panic and psychological disorganisation the news of her pregnancy induced in her: “I was crying and in shock because I was the person on drugs and was sleeping around. I didn't deserve it...I was outraged, I was mad, I was scared too.” For her this was heightened by the fact that her previous child, a son was born with foetal alcohol syndrome. She said:

I already had a baby with health problems that I had caused. I really thought he was going to die...and well, now I'm pregnant again. What with the grog and the drugs, I kept thinking I was gonna die, I was outraged, I was mad, I was scared too.

While some women reacted with anxiety and even fear when they found they were pregnant, those women who were determined to overcome their drug dependency, minimised their experience of death anxiety, and focused on the positive effects of the pregnancy from the very beginning, valuing the opportunity it offered them for a “second chance in life”. Maggie, at the contemplation stage at first interview, described how she had previously confronted her mortality and this had provided her with an opportunity to forge a more meaningful life, which diminished her anxiety. She said that learning she was pregnant “was just like the icing on the cake” for it helped her to “keep on the straight and narrow”, and even go back to school. She said:

I think that knowing I was pregnant...well, it was like here I was having a baby, someone to love and be responsible for. I had to get a job and a flat. I had a future. I was no longer facing death and despair.

One explanation for the ability of many former substance abusers to respond with diminished anxiety and a focus on the “positives” may be that their chemical dependency had in the past, served to defend them against feelings of vulnerability in relation to death and loneliness. This defence is described in the literature as the “rescuer defence”, which is an attempt to shield oneself from dread of isolation, or from assuming responsibility for one’s life (Ottens & Hanna, 1998). However, Ottens and Hanna (1998) suggest that a boundary situation can also serve to loosen one’s defences, and force an individual to reassess their life and priorities. This process seemed to have occurred for a number of the participants on finding they were pregnant, encouraging them to begin a journey of growth and a search for authenticity that ameliorated feelings of death, anxiety and loneliness.

Children, or the expectation of children, also served as a crucial protective factor in helping the mothers to contain their own death anxiety, and to minimise their feelings of existential isolation. While chemical dependency can be stigmatising and therefore

predispose to isolation, a child's presence often forced the women to maintain contact with the outside world in order to adequately tend to the child's needs. Andrews, Williams and Neil (1993, p. 217) note the life-affirming nature of children, and that a child's energy and enthusiasm as well as his/her needs for care and attention provide mothers with a "built-in source of engagement with the world". When the outside world failed many of the women, and feelings of rejection became too painful, focusing on children could provide a source of what Yalom (1980, p. 355) terms "interpersonal affiliation", minimising feelings of existential isolation, and giving meaning to the loneliness experience, thereby ameliorating it. Debbie, who had progressed from the contemplation stage to the TTM maintenance stage at the final interview, noted that having children and the possibility of a new baby served as protection against loneliness, stating, "[I]... stay alone so I won't get hurt. I got used to it. Because all my life I was alone...and [now] I'm not really alone....I got kids, and a partner, that all keeps me pretty busy."

A child's need for care and attention, frequently augmented by their additional medical needs, engendered heightened feelings of intimacy on the part of the mother in relation to her child. Amanda, who had made considerable progress towards recovery, moving from the pre-contemplation stage at first interview to the TTM maintenance stage at the final interview, described how she took comfort in the thought that she and her four-year-old son – who were both HepC positive – could deal with their shared illness experience together. She said:

I tell him that he has a blood disorder, and not only does he have that, but so does his mummy. That makes him feel better. It makes me feel better, so he won't feel like he has to take something that I don't want to take and why do I have something if mummy, you don't. So that's what I do, me and my baby... every day when we have our breakfast, we take our meds.

This practice is referred to in the psychoanalytic literature as a twinship experience (Kohut, 1984) and several women appeared to share this experience, to a greater or lesser degree. Kohut emphasised two aspects of the twinship self-object experience: (1) the feeling of alikeness and (2) the role of twinship in the acquisition of talents and skills (Kohut, 1971, 1984). Alikeness, he proposed, could be the foundation of a healthy sense of belonging. With regard to the latter aspect, Kohut (1984) felt that an adequate twinship self-object experience occurs in the context of shared human experience and is the basis for a full actualisation of the self through the development of talents and skills; in this instance, mothering.

The protective quality of the attachment of mothers to their children, at least while the child was young, was summed up by Alice. She observed that the only thing that could make her “feel bad emotionally”, was her daughter becoming ill. She, like many of the participants, seemed to channel worries about her own drug use and possible demise into a healthy concern for her child’s future caretaking needs. Alice, who had progressed from pre-contemplation at the first interview to termination at the final interview, said:

...when I think of death now [because of my drug addiction],... I’m thinking of ways to secure my baby’s future which is nearly always....so I think about death a lot [but more in terms of its consequences for her children].

Even when children were in the care of others, they provided some women (Rosa, Lisa, Leanne, Cathy and Peta) with a reason to struggle on. Jasmine, at the TTM termination stage at the final interview, had occasionally wondered if [her] death would free her young children:

.....sometimes all of this [life] gets too much and I just want to go to sleep, or be at peace...it’s hard to explain but I’m frightened about being lonely...not alone, but lonely. I suppose that’s why I stay with J. It’s not that he’s violent, because he’s not...but he is moody, and

that can be as bad. Not knowing what to expect. So yeah, I think about death quite a bit.

However, the knowledge that she had children prevented her acting on her thoughts of death.

While some mothers (Alice, Kate, Jasmine, Monique, Maggie, Erica, Jo, Dee and Debbie) embraced pregnancy, others (Nicole, Naomi, Cathy and Sara) employed defences such as denial and suppression. These served as psychological coping mechanisms for managing anxiety once they had processed their feelings of shock at being pregnant. Janoff-Bulman (1992) noted that denial allows the sufferer to incorporate their experiences into their internal world, regain equilibrium and confront the trauma in “smaller, manageable doses”. Sharon, at the TTM pre-contemplation stage when she first became pregnant, described effectively suppressing her anxieties by considering the realities of her situation only periodically, such as when she attended the Transitions Clinic. Even when getting positive feedback from Clinic staff on managing reasonably well by being able to reduce her methadone intake post birth, she erected defences, preferring to revert to thoughts about her life that she perceived as “making her happy”. She said:

I really don't like talking about it. It continues the brain thinking, are you going to be here today, are you going to be gone tomorrow? I really don't want to think about anything bad that might happen. I only want to think about good things...you know, happy memories and fun times.

The women, as well as confronting anxiety and dealing with loneliness and isolation, also had concerns around making the right choices. Making responsible choices often meant confronting guilt.



## **Choice, Responsibility and Guilt**

In relation to choice, responsibility and guilt, existential psychology propounds the idea that although one's situation at any one time limits one's options, one still has the freedom and therefore the responsibility to make certain choices. Taking action by making a choice is more important than the consequences of any one choice, for it enables one to feel more control over one's life and enjoy improved [psychological] health (King et al., 1978). While dealing with chemical dependency often narrowed the range of choices in the lives of the participants, chemical dependency allied with pregnancy meant making choices about such things as which treatment regime was the most suitable for themselves and their unborn child and whether to disclose their addiction to others.

A number of women (Alice, Jasmine, Sharon, Cathy, Naomi, Rosa, Sara and Debbie) had doubts concerning the long-term and side effects of the prescribed medications: methadone being an obvious case in point. Naomi, at the TTM contemplation stage at first interview, expressed doubts about methadone as well as the problems associated with being tied to the regime of collecting her daily dose, saying:

I mean...methadone is a lot worse than heroin..so why all the fuss..I know, I know, it's supposed to be better in the long run, but it [the methadone] gives me the irrits...plus I've got to go to a special chemist to get the stuff. It takes a couple of hours. I have to go by bus and tram. It's like a weight around my neck, it's like part of something that you just get tired of doing it. I keep thinking something bad will happen [to the baby] if I don't do it.

Methadone, as noted in Chapter 2, has a slow metabolism and very high fat solubility, making it longer lasting than morphine-based drugs. Methadone has a typical elimination half-life of 15 to 60 hours with a mean of around 22 and is far more difficult to cease than heroin and the women knew this, however they were also made aware that it was the best option for the unborn baby. At the TTM action stage at second interview, Debbie's

response to methadone was less about its physical effects and more about the guilt she experienced if she didn't present for her methadone dose:

I have such a bad guilt trip if I don't make the effort. Most days I just want to stay in bed. But then I think what could be happening to the baby inside me [if using illicit drugs]...and I lie there and sometimes I can't even breathe..I feel so guilty about everything...you know, the methadone, the drugs, and everything, like how did I get in this mess?

As well as contending with the inconvenience of having to attend a chemist daily to pick up their methadone, there were also the issues surrounding disclosure and this was true for those women on the methadone programme, as much as their other drug use. The choice concerning disclosure of their drug dependency or addiction, both within the family and outside it, has been found to have ramifications for women in other studies (Siegel & Scrimshaw, 2000). The women in this study were no different. Several of the women pointed out that they felt their chemical dependency was viewed differently from other health problems, such as cancer, because people were more fearful of violence from drug addicts, and therefore were more rejecting. In light of this, conflicts around disclosure were frequently determined by the shame and stigma associated with their dependency and the impact, as a consequence, that sharing the information with family members or with others outside the home would have on the women. Semple, Patterson, Temeshok, McCutchan, Straits-Troster, Chandler and Grant (1993) similarly found that disclosure to a close relative may be the most stressful type of disclosure for this group of women.

Rosa, having progressed from pre-contemplation at the first interview to the TTM preparation stage at the final interview, found confiding in her grandmother extremely difficult stating:

I thought she must have known....I mean we grow the stuff [cannabis], harvest it and smoke it...just for our use. But no, when I told her I was

going to have another baby, and that I had to attend a special clinic [the Transitions Clinic] so the baby could be monitored for a safe delivery. Well, you should have seen the look on her face. But no, she wasn't aware of my little habit...and I felt that I had really let her down. Maybe I should have kept quiet.

As well as the decision to disclose to adult family members, there was also the issue of how much should be disclosed to children, both about current treatment and past lifestyle. It has been noted that some of the dilemmas in relation to disclosure to a child that can generate stress include: whether the child would disapprove of, or feel stigmatised by the mother's previous lifestyle (e.g., prostitution), and even reject her; whether the child might resent the parent in response to this information, or even revive a parent's childhood experiences of feeling unloved or unwanted; whether the child would be circumspect, or divulge this information outside the family and whether there might be psychological repercussions for the child, for example, depression, hopelessness, anxiety (Armistead & Forehand, 1995; Forehand, Steele, Armistead, Simon, Morse & Clark, 1998). All the participants, to a greater or lesser extent, raised all these concerns, particularly in relation to the impact on the child. Monique, at the TTM pre-contemplation stage at the first interview and taking just small steps to recovery, expressed her reticence thus:

I would just hate to have to tell my daughter – if I ever have one – what my early life was like....prostitution and drugs. Not much of a happy family story. But I've never been able to confide with non druggie friends some of the more raw episodes of my life

Allied with the ramifications associated with disclosure was the guilt associated with chemical dependency. A sense of guilt was expressed by half the women (Alice, Kate, Jasmine, Monique, Maggie, Erica, Amanda, Jo, Dee and Debbie) for having a drug dependency or addiction. One important psychological process which seemed to influence how much guilt a woman experienced in processing her diagnosis was what Janoff-Bulman (1992) describes as their perception of its origin as either "characterological" or

“behavioural”. Janoff-Bulman notes in relation to the former that if one sees one’s past behaviour as ‘misguided’ and blames one’s behaviour, rather than one’s character, as the cause of one’s present predicament, then one believes future events can be controlled, feelings of helplessness can be transformed to control, and guilt overcome. Kate’s response (at the TTM preparation stage at the first interview), might suggest that she viewed herself as “characterologically flawed” for allowing herself to become chemically dependent and therefore putting her unborn child at risk. This appeared to keep her trapped in her feelings of helplessness and guilt, despite considerable strides towards recovery by the post birth interview. She identified God as a punishing figure saying, “Once I found out I was pregnant, I said I must be a bad person....God is punishing me because I must’ve done something bad to someone and now this is my just desserts.”

Nicole in contrast appeared to view herself as “behaviourally” flawed in terms of her drug use, a view which enabled her to overcome her guilt and to take pride in the fact that she no longer abused drugs. She viewed her current behaviour of abstaining from drugs, as “good” and took comfort in the thought that she had “God’s protection” now that she had reformed herself. In a related vein, Jasmine described how her partner helped her see her past drug use as a behaviour she had overcome when he stated, “Why not you, you’ve just as real as the next person and everyone makes mistakes.”

While some women took responsibility for their actions, others tended to find excuses for all negative events, including an unexpected pregnancy, and often blamed others for their predicament. For example, in order to assuage her guilt, Jo, at the TTM contemplation stage at the first interview, employed the defence of projection by blaming the health care system for what she viewed as its negligence in allowing her to get pregnant. She was

angry that she had not received any information on the unreliability of the birth control medication she had been taking, and felt this had prevented her from making an informed choice about whether to become pregnant or not, saying:

No-one told me that I could still get pregnant while 'using'. I thought that the birth-control pills and the other stuff would keep me safe. We all thought that you couldn't get pregnant if you didn't have a period. So, it's the fault of the Clinic that I got pregnant so soon after I had an abortion...yep that's right...like they should've told us ...right.

As well as a sense of guilt, several women (Alice, Kate, Jasmine, Monique, Maggie, Erica, Amanda, Jo, Dee and Debbie) spoke of feelings of sadness and regret at being chemically dependent and the possible long term implications. Maryanne, at the TTM action stage at the final interview, spoke of her fear of not being there in the future for her child:

I mean there's no future for me and the kid if I don't kick the habit [completely]. But you know, it's hard, bloody hard and I've just got to give it my best shot. I mean the medicos don't know, don't care, it's all too hard.

Jo had similar feelings which were compounded by the fact she was HepC positive. In relation to her Hep C status, she expressed regret that she might not be alive to see her child reach adulthood, stating:

He's such a lovely little baby, but sometimes I don't think he'll know his mum. I feel so bad about that. But that's life, though isn't it. I just wish I could turn the clock back....hey, don't we all, though.

Despite the women's fluctuating emotions and feelings of guilt, most recognised the need for them to take control of their lives in the face of ongoing feelings of helplessness and vulnerability.

### **Vulnerability, Helplessness and Gaining Control**

Janoff-Bulman (1992) notes that feelings of helplessness arise when trauma shatters the illusion of invulnerability that one takes for granted most of the time. However,

paradoxically, a central claim of existentialists is that no matter how great the forces that victimise human beings, they have the capacity to influence in some way how they will relate to their fate.

A number of participants (Rosa, Lisa, Amanda, Monique, Sara, Leanne, Maryanne and Erica) vacillated between hope for a future and hopelessness. Erica, at the TTM maintenance stage at the final interview, and who as previously noted had frequent thoughts of death and had struggled to regain control of her feelings of despair that she might die, found pregnancy a “wake-up call”, stating:

I used to say to myself...get off the smack and the prescription pills and get a life...and then I get frightened again....and take a few more. Then, then I got the biggest wake up call of all [finding out she was pregnant]. And here I am, clean.

In the process of attempting to regain control of their lives, the women employed various psychological coping strategies that have been described by several authors (Bornstein, 2004; Corey, 2000; Janoff-Bulman, 1992; Jones, 2006; Suchman, Blomberg, Orr & Trigg, 2006; Taylor, 1989).

### **Psychological Coping Strategies**

The first psychological strategy included reinterpreting the event as an important or necessary part of life, thereby assigning it a meaning. This process is a basic principle in existential therapy: that people construct personal meanings and these meanings profoundly influence their lives. For example, Cathy, who had progressed from contemplation to the TTM maintenance phase, was introduced to the drug lifestyle and culture through her partner and had stayed in the emotionally and physically abusive relationship for seven years, felt herself “lucky” to have carried a pregnancy to full term,

saying: “I wanted this baby almost more than life itself. I knew that if I could stick to the methadone programme and keep healthy...then having the baby might make me strong enough to leave....”

At the same time for some women (Maggie, Nicole, Kate, Alice, Jasmine and Dee) reinterpreting past events was necessary to allow them to move on. Maggie who, having advanced to the preparation stage at the third interview, had a long history of substance abuse and drug addiction, eloquently described how making an attempt to come to terms with and overcome her chemical dependency had served as a crucial ingredient in achieving certain goals in her life. Maggie echoed the sentiments of other participants, stating:

I feel it's [pregnancy] been a gift. I'm living the life I wanted when I was a young girl. I'm retraining for a career and my partner is helping me give up the stuff...you know, not judging me for my past, but helping me look to the future.

Nicole also explained how being pregnant after many terminations had given her a sense of purpose and direction when she said: “I never thought I would be a mother. I felt I had gambled with fate too many times by having so many abortions. I didn't find out that I was expecting until way into the second trimester.” She also talked of the regret and shame at having been previously so self-absorbed and self-indulgent when she said: “I feel disgusted with myself for failing to do much about the drug addiction before now, but the pregnancy has given me another ‘go’ at life. I feel as though a door has opened for me.” Unfortunately, Nicole had a stillbirth and by the third interview had decided that this outcome was for the best. Although outwardly she appears to have moved on with her plans for the future, she says that ‘inside’ she feels that she has been punished for her

former lifestyle. Nicole was a success story, as with the help of a former client, she gave up prostitution, moved interstate and is now studying for a double degree at university.

The second psychological strategy employed by some women (Nicole, Alice and Jasmine) to gain control was through downward comparison, which defined the way in which they coped as more admirable and positive than that of some of the other participants. This process appeared to enhance their self-esteem. For example, Kate who was at the maintenance stage at the third interview stated: "I see my life like this. I know I'm an addict, but I'm still alive and I have plans for a future. I see and hear a lot of other women doing nothing much with their lives." Kate considered that as she was dealing with her life, she was doing better than others. Her self esteem was bolstered by the fact she was setting goals for herself, her partner and her unborn child. She was also proud of the fact that she was working to overcome her cocaine and alcohol dependency, even when she "failed herself" by experiencing an occasional relapse. Kate reflected what Frankl (1967) describes as finding meaning in the dignity with which one carries one's being. At the post birth interview Kate had returned to her employment as a company executive and was planning to marry her long term partner.

The third psychological coping strategy for gaining control some women (Nicole, Kate, Alice, Jasmine, Dee and Leanne and Jo) used was to reframe their situation as one in which they received special protection, despite the despair that had befallen them. Taylor (1989) notes that it is the belief that one holds about reality, rather than reality itself, that promotes a feeling of mastery. As an example, Alice spoke of the setbacks she had experienced in overcoming her chemical dependency, but had reassured herself that perhaps she had different qualities that had assisted her in finally achieving her goal. She



said: “It’s been a long battle and I’ve gone back a few times but now I feel that I’ve got the maturity to cope better with the recovery process”.

The fourth psychological coping strategy employed by the women (Nicole, Dee, Debbie, Jo, Sara and Cathy) was to universalise their situation, by placing it in the context of other possible illnesses and life’s struggles in general. Nicole demonstrated this process by saying “A lot of things are happening in the world ...things that happen on the news, people getting abused, shooting each other. I could’ve died of an overdose, but I didn’t”. Nicole’s belief that life was difficult for everyone lent a degree of normalcy to her situation and minimised the possible overwhelming ramifications of her chemical dependency.

It seems that the culture of violence in which many of the women were raised served as an additional factor in their ability to process their experience in a positive light. Several authors note that one’s experience of events as traumatic in adulthood is determined both by the culture one identifies with, or originates in, and one’s management of previous traumas (Orford et al., 1996; Janoff-Bulman, 1992). Not only did many of the women measure their struggles against those of others, but all recounted previous traumas in their lives which they had surmounted; in the context of their turbulent lives chemical dependency was seen as another challenge they felt they could overcome.

Sharing and discussing their narratives with me helped several women (Alice, Jasmine, Kate, Rosa, Naomi, Cathy, Maryanne, Leanne, Dee and Debbie) to cope better psychologically. They expressed sentiments suggesting that having their voices heard enabled them to turn feelings of helplessness into control. Wolfenstein (1957) described a

similar process that takes place amongst victims of trauma, where, as they become the “effective storyteller”, they force the audience to undergo their experience and achieve healing as a consequence. For these women, the act of recounting their story became similarly reparative, as well as empowering, as it provided them with the opportunity to work through their experience in a manner that was consistent with their identities and capabilities (Bailey, 2005; Jones, 2006). Their role as an ‘authority figure’ on the world of drugs also appeared to provide an enormous boost to their self-esteem. In addition to disclosing their experiences to the researcher, several women (Nicole, Kate, Jasmine, Alice, Monique, Amanda, Maggie, Maryanne, Dee and Debbie) emphasised that acknowledging their chemical dependency engendered more of a sense of control and enhanced their sense of self.

Finding reasons to be hopeful was the fifth psychological coping strategy employed by several participants (Nicole, Kate, Jasmine, Alice, Monique, Amanda, Maggie, Erica, Amanda, Jo, Maryanne, Dee and Debbie) and was related to the birth of their baby. For some women (Kate, Alice, Monique, Amanda, Maggie, Erica, Amanda, Jo, Maryanne, Dee and Debbie) seeing their baby provided them with a sense of symbolic protection. Being optimistic gave the women a sense of control over their situation which caused them to seek ongoing support and treatment for their chemical dependency, renew contact with family and friends and plan for the future.

The final strategy which might be viewed by some as psychological and which enhanced coping, was developing a heightened sense of spirituality. This was expressed by several of the participants (Erica, Kate, Alice, Naomi and Dee), with Erica, explaining how her religious beliefs provided her with strength and comfort and enabled her to ‘hold’ the

existential uncertainty that her situation had so starkly confronted her with. She said in relation to her path to recovery: “I guess my spirituality helped a lot because I really made amends with God....I actually found some kind of relief and He showed me the way”.

Most participants found ways of using the various psychological coping strategies to manage and organise their lives, which in turn reinforced their goal of achieving a meaningful and authentic existence.

### **Authenticity and Meaning**

From an existential perspective, pregnancy while grappling with chemical dependency can serve as a “turning point” in one’s life and an impetus to forge a more meaningful and authentic existence (Bornstein, 2004; McIntosh & McKeganey, 2001; O’Leary & Ickovics, 1995). An authentic existence includes three main characteristics: Being fully aware of the present moment, choosing how to live one’s life in the moment, and taking responsibility for that choice (Corey, 2002). The realisation that time may be short and therefore precious may shift the focus to the here and now, and to maximise the time in the present (Schneider, 2008).

Kate illuminated the way in which her pregnancy and her battle with alcohol and cocaine dependency served to shift her priorities to the present, enabling her to focus on those aspects of her life today that lent more meaning to her existence:

Being pregnancy has made me a more responsible person. I cherish the things today [the here and now] that I didn’t in the past... for me it’s a purpose here, I’ve got my family and soon I’ll have a baby...someone to love, someone that will mean a whole lot to me and that’s what keeps me going.

She added:

I don't take my life for granted anymore....sometimes I want instant gratification, but you have to have patience....once I wouldn't have understood that, but now I do. I may not have what I want but I have what I need.

Kate further reflects on how her drug use had been an attempt to artificially inflate her self-esteem. In contrast, she now describes how she will try to take care of her family:

I will do the best job I can...and I'm lucky that he [partner] still wants me around. I still get the urge to have a drink and a snort but with [drug] counselling and my partner's support I should be OK. A drug makes you feel like somebody not a nobody...always wanting to fit in, to be accepted by somebody else.

As it became clearer what was important to her, she had become to feel a "somebody" without the aid of drugs, and no longer needed drugs to enhance her feelings of self-worth. This insight indicated a growing sense of authenticity.

At the final interview, Dee, at the maintenance stage, highlighted the special meaning that caring for her baby gave her, as if by being responsible for addressing her chemical dependency, she was making reparation for the neglect that she felt she displayed towards her partner, family and close friends during her drug-taking years. She described the jolt that discovering she was pregnant had given her. This pregnancy had resulted in her trying hard to overcome her chemical dependency, and offered her the opportunity to reunite with her partner and hopefully make up for the losses of the past. She said: "I can't remember much about the early days when we met. I feel I have missed out so much when I hear him talk about those days to other people".

Reuniting with relations and significant others also reinforced the importance of family in giving meaning to the women's lives. For a number of women (Kate, Alice, Jasmine Rosa, Lisa and Peta), acknowledging their chemical dependency and beginning the recovery process was the impetus for reconnecting with extended family and supportive friends. This gave new meaning to their lives and helped them cope.

For those women (Alice, Kate, Nicole, Erica, Cathy, Monique, Peta, Amanda, Dee and Debbie) who were able to overcome their drug abuse and gain some self-respect, the reward was earning the respect of friends and extended family. At the final interview, Monique described how enriched her life had become with a renewed relationship with her husband, extended family and friends, in contrast to earlier life where her focus was "just the next drug". As she reflected on that earlier life, she summed up the feelings expressed by many of the women when she said: "[It]....it makes me realise that that wasn't the way, and my new life means a lot to me...even though at times I might have a relapse, it's all part of life".

Individuals cope with stressors through a variety of identified and preferred coping strategies and so it was for the twenty women in this study. However, what seemed to separate the three groups in terms of coping and their progress towards recovery (see Table 6) was their differing support networks and, possibly, individual resilience. For example the women in Group 1 were more likely to have a non-drug using supportive network of family and friends, to also use various non-pharmacological approaches (for example, drug and alcohol counselling) which appeared to enable them to better cope with stressful situations, thus providing help to stay away from illicit drug use. The women in Group 2, on the other hand, appeared to rely more heavily on occasional illicit drug use to help deal

with stressful and unpredictable situations. For example, pregnancy and motherhood increased the women's responsibilities and several women (Rosa, Lisa, Naomi, Sharon and Leanne) "buckled" under the added responsibility of caring for their newborn, and so handed the this task to others (see Table 5), usually on the advice of their medical practitioner or case worker. Apart from helping them cope with the physical and mental stresses of motherhood, a return to drug use was also a way of helping them cope with guilt brought about by a gap between their expectations of having a baby and the reality of the experience. An added factor was that the women in this group appeared to have had few social supports apart from immediate family members. The nine women in Group 3, who earlier were deemed to be the most vulnerable and "at risk" group, were surprising in terms of their ability to cope with a new baby and all the demands associated with motherhood. For the most part they appeared able to draw on personal resources to achieve and maintain stable recovery, acknowledging that having a chemical dependency put caring for their children in jeopardy. However, despite bursts of resilience in the face of significant odds, the women admitted to feelings of vulnerability and inadequacy.

These findings relating to the women's recovery status are consistent with previous studies (Chiamulera 2009; Gould, 2003; Murphy & Rosenbaum, 1999; Ryan, 2008; Taylor, 1993; Trulsson & Hedin, 2001) with regard to pregnancy, birth and related relapse and recovery. Negative emotional states (anxiety and depression) and lack of coping skills have been found to be risk factors for relapse, while self-efficacy and adequate social and family support have been found to be positive factors in maintaining stable recovery.

In summary, of the twenty participants, pregnancy was a turning point for thirteen women. This figure included the ten women (Alice, Kate, Monique, Maggie, Erica, Amanda, Jo, Maryanne, Dee and Debbie) who kept their babies. With regard to the other three women

(Cathy, Jasmine and Nicole), Cathy used this pregnancy to reappraise her life, enter into drug and alcohol counselling and reconnect with the father of her three children, who had legal custody of them. While Cathy continued to live apart from them she saw the children almost every day. Jasmine and Nicole also used the experience to reflect on their lives and make plans for the future; in Jasmine's case, a difficult and heart-breaking decision to have her children (including her new baby) adopted. Nicole, as previously noted, had had a stillbirth and had used the pregnancy to re-evaluate her life. At the time of the final interview she had moved to another state to pursue educational opportunities.

While eleven of these thirteen women were relatively well along the way to recovery and varied between the action and termination phases of the TTM, Monique and Maggie were the only ones assessed as at the TTM preparation stage at the final interview, having progressed from pre-contemplation at first interview. However, in spite of being early on in the recovery phase both spoke of how pregnancy and giving birth had made them reappraise their lifestyle and how continued drug use could affect their ability to be "good mothers". For Monique this meant going "cold turkey" post birth to enable her to realise her wish of being able to breast feed her infant daughter. Maggie, on the other hand, was committed to continuing with the methadone maintenance therapy as the best option in the short term, but aspired to a goal of being totally drug free.

Of the remaining seven women (Naomi, Sara, Rosa, Lisa, Sharon, Leanne and Peta) all relinquished their role as the child's primary caregiver. Pregnancy is widely regarded as an opportunity for chemically dependent women to give up drugs and become rehabilitated back into society, and this proved to be the case for a number of the women. However, the motivational forces need to be strong to withstand the challenges presented by a new baby.

I have already described in earlier chapters how many of the participants came from dysfunctional and chaotic backgrounds in which they were subjected to neglect, abuse and a variety of other stressors that left them with low self-esteem and prone to anxiety and depression. As their chemical dependency increased they had become detached from the usual support systems of family and stable relationships. This lack of secure support networks made the women more vulnerable to external stressors and precipitated mental health problems as well as emotional and physical collapse. It became apparent during this study that these seven women felt at times that they were under siege on many fronts and when this occurred it often resulted in their being unable to care for themselves, let alone for a baby. Whilst conducting the sequence of interviews and observing the interactions between the participants and their friends and families, I found evidence of impaired intellectual functioning, conduct disorders, anxiety, and low self-esteem. The nature of the women's physical and social environment was an additional factor in making parenting difficult, if not impossible. For example, Sara had no family support as she had been afraid to tell her step-father about her pregnancy and chemical dependency; she also had no financial resources. She chose to put her child into permanent foster care. Naomi, suffering from diagnosed clinical depression, felt unable to cope. She arranged for her son to enter into permanent foster care, as she had done with her two older children, and retreated into the fringes of the drug lifestyle and culture. It is however, worth noting that although these women have a significant other taking care of their child[ren], most remain involved in decision-making with regard to their children's lives.

## **SUMMARY AND CONCLUSION**

The struggles and challenges experienced by this group of chemically dependent pregnant women as they attempted to deal with life and death issues are poignantly highlighted



when examined from an existential-philosophical perspective. I found that the majority of the women (13) were able to improve their psychological functioning and confront their chemical dependency in the face of impending or actual motherhood. This was despite facing the additional burden of an addiction or dependency, which carries significant stigma and often the handicap of living in socio-economically and emotionally impoverished situations. Pregnancy did appear to be a “turning point” for a second chance at life.

As part of the recovery process many participants chose to reframe their experiences of suffering and distress as necessary for meeting this new challenge, thereby generating positive feelings. Being pregnant also provided the women with deeper connections to the meaning of life, which in turn served to ameliorate individual feelings of death, anxiety and existential loneliness. Their pregnancies also presented some participants with the motivation to overcome their feelings of helplessness and vulnerability and develop a more positive outlook and approach to their lives. An appreciation of the extraordinary difficulties this group of women face provides the context for care and follow-up. This could include, as previously noted, that consideration be given to extending the period for outreach midwifery postpartum visits to six months post birth.

## CHAPTER TEN

### CONCLUSION

...to grasp the native's point of view, [he]r relation to life,  
to realise [her] vision of [her] world.

Bronislaw Malinowski (1922) *Argonauts of the Western Pacific*

The overall aim of this critical ethnography was to evaluate the care provided to chemically dependent pregnant women by the Transitions Clinic of the Mercy Hospital for Women. Chemically dependent pregnant women are a group which has largely been neglected in terms of research, particularly in an Australian context. A critical ethnographic approach informed by critical and post-structural perspectives, namely Habermas and Foucault, with feminist interpretations of Foucault being employed, was chosen as the most appropriate means of investigating the interactions between the women and the Clinic staff, as well as the women's perceptions of their life experiences and challenges, prior to pregnancy, during pregnancy and following the birth of their babies.

I began by reviewing the literature in relation to the common drugs of addiction, the implications for pregnancy of substance abuse, the factors that influence chemically dependent pregnant women seeking and complying with antenatal treatment, and the motivating factors for change.

I then explored the theories, models and discourses of addiction and their relationship to chemical dependency and its treatment during pregnancy. One of the models reviewed, namely the six-stage Trans-Theoretical Model (TTM), was the model for assessing processes of change in addictive behaviour and the women's recovery status used by the

Transitions Clinic staff. It proved useful in tracking the women's progress at each interview and was referred to extensively in analysis. Various competing and intersecting discourses of addiction also proved useful in conceptualising the relationship between addiction and agency in addicts' own accounts, as well as their perception of the influence of discourse on antenatal care.

The data from this study challenged assumptions that chemically dependent women are unconcerned and uncaring about birth outcomes, possess little or no parenting skills, and are ill-equipped to care for their babies. However, like the general population, they were a diverse and varied group of women.

The first related research aim was to provide rich descriptions of the range of problems chemically dependent pregnant women face. Similar to previous studies, this study revealed a complex set of factors that influenced development of chemical dependency among this group of women. These included family instability, a lack of family and social support, a family history of drug and/or alcohol abuse, a history of childhood sexual abuse, having a chemically dependent partner and being a victim of intimidation or violence. For several participants, having a current diagnosis of mental illness and homelessness and/or transiency was seen as both a cause and effect of chemical dependency. Additional reasons given by the some women for their substance use included the availability of the substance, social pressure, curiosity, the desire to self-medicate or to relieve boredom. Regardless of the range of predisposing factors, the women's accounts told of a journey into drug addiction which left them feeling rejected by and alienated from society. However, at the same time, immersion in the drug culture and lifestyle provided them with a sense of identity and belonging, albeit a deviant one. Being chemically dependent and

pregnant further marginalised many of the women from mainstream society. Their responses to pregnancy varied, from ready acceptance to anxiety and stress, which set the scene for their willingness and ability to seek and comply with antenatal care.

The second research aim was to identify the extent to which chemically dependent pregnant women believed the services offered by the Transitions Clinic at the Mercy Hospital for Women met their and their family's needs. For the most part the women believed that the Clinic and the Clinic staff did meet their needs through demonstrating high levels of professionalism and commitment as well as being readily available and supportive. However, there were varying levels of commitment to the antenatal care, education and parenting services that the Clinic offered. The level of commitment tended to be reflected in birth outcomes. In the beginning, most of the participants believed that power was solely exercised by the Clinic staff. However, as relationships developed and the women explored possibilities for collaboration, the majority understood that they could also exercise power and work towards a more equal relationship with the Clinic staff. For the women who engaged well with the Clinic staff (the majority), birth and motherhood were largely positive experiences, and this helped in their recovery process.

The third research aim was to assess whether pregnancy was a time of transition or a turning point in the lives of some of the women. This held true for thirteen of the twenty participants. Impending or actual motherhood appeared to give these women a deeper connection to life and a reason for living, which helped to ameliorate feelings of death, anxiety and existential loneliness. Recovery status as identified by the TTM found that these women were able to improve their psychological functioning and confront their chemical dependency. This was despite the additional burden of addiction or chemical

dependency, which carried significant stigma, and with the often accompanying handicap of living socio-economically and/or emotionally impoverished lives. Many participants chose, as part of the recovery process, to reframe their experiences of suffering and distress as a means of strengthening themselves to meet current challenges.

The strength of the study has been its longitudinal nature, allowing me to trace the ongoing experiences of the women, particularly in relation to their stages of recovery. A study which employed a cross sectional approach with one interview and no observation would not have been able to capture the essence of the women's ongoing lives and experiences of the care provided by the Clinic. This study has "filled a gap" in the research by examining how this group of Australian chemically dependent pregnant women were able to confront their drug abuse, and despite extremely difficult life circumstances, in many instances assume a sense of control over their lives, and in some cases forge a more meaningful and authentic existence through the transition to motherhood.

I believe the study is significant for midwives and allied health professionals caring for chemically dependent pregnant women for several reasons. Firstly it has enabled the voices of Victorian chemically dependent pregnant women to be heard. Lather (1991) stated that the goal of feminist research is to correct the invisibility and distortion of the female experience in ways that serve to end women's unequal social positions, and thereby improve their societal and political existence by revealing socially constructed distortion, thus empowering or enabling positive change. In addition to "de-silencing" and reclaiming the voice of the experiences of these women (Murphy & Rosenbaum, 1999, p. 71), this study has also identified some of the ways in which dominant discourses around chemical dependency and pregnancy reinscribe women into subordinate positions.

Secondly, identifying the range of experiences, both positive and negative, that chemically dependent pregnant women bring to pregnancy, as well as the level of ambivalence, antagonism, fear and anxiety that may accompany their initial antenatal encounter highlights the need for individualised care. Thirdly, the value of specialist clinics such as the Transitional Clinic is reinforced by recognising the key role played by supportive, non-judgmental staff and early engagement with antenatal attendance.

With the preceding in mind, the following recommendations emanating from this study are put forward:

1. The importance of in-depth and unbiased history-taking that identifies the social precursors of chemical dependency, as well as the ongoing lifestyle and social issues that clients bring to pregnancy and antenatal care should be emphasised.
2. The key components of women-centred care - choice, control and continuity of care – are reinforced through ongoing relationships with the women, particularly by midwives and assisted by early establishment of a climate of trust through which ongoing engagement with the Transitions Clinic is encouraged.
3. That the period of outreach postpartum care be extended to at least 6 months for those women who are able to parent their children.
4. That the multidisciplinary team be expanded to include appropriately trained drug and alcohol counsellors and family therapists experienced in working with vulnerable client populations.

In conclusion I would like to reflect on some of the highs and lows I experienced while undertaking this study. I knew from the outset, that as an outsider I could not ever fully comprehend the culture I was investigating, but as a naturally curious person I resolved to make every effort to understand and appreciate the experiences of these twenty chemically dependent pregnant women. However, my lack of familiarity with the drug culture and the language did have its lighter side, especially when I commented on a participant partner's choice of after-shave and was met with: "Jeez, Michelle, that's not Old Spice, that's the weed".

I was constantly challenged by this population, for at times nothing appeared as it seemed. For example, when I saw a participant (Jasmine) walking with a uniformed policeman, I assumed that she was in some sort of trouble. But I found the policeman to be one of Jasmine's staunchest supporters. He would often "time" a shift break with her antenatal appointments. They would walk in the gardens opposite (the East Melbourne site) or he would buy her afternoon tea in the hospital's coffee shop. She later identified him as her chief confidant and the first person she turns to in an impending crisis.

When learning the ropes I became aware of when to smile and acknowledge the women and when to avert my eyes. Trust was essential to the collection of meaningful data. Perhaps the trust issues raised throughout the project can meaningfully be considered in terms of the balance of power. It is widely acknowledged within social science research that the relationship between researcher and researched is not necessarily an equal one, and that a number of factors may mediate researcher-researched interaction, one of which is the amount of power (perceived or actual) that the researcher may have over the participants. Indeed, it has traditionally been accepted that the researcher-researched

relationship is "powerful researcher" and "powerless-researched". Given that this study involved the participation of a vulnerable and marginalised group, who were acutely aware of their stigmatisation as drug users and as chemically dependent pregnant women, such issues could have been amplified. For example, I may well have been perceived to have power over the women: however the participants were often seen by me as having a power of their own, that is, the power to withhold information and experiences.

Trust was finely balanced with the requirement to appreciate and understand the participants' desire for autonomy, particularly in situations where I might have felt the need to interfere. For example, when a participant had been badly beaten by her husband and was in need of medical care but still chose to go to work (as a prostitute). I assessed the situation and, given the woman's obvious desire for me not to intervene, I chose not to interfere. There were also other times when I could not be there for the women in the ways they would have wished, that is, in a more personal manner. For example I was invited to family gatherings, birthday parties and a wedding and "summoned" by them to court appearances and prison visits for interviews. I compromised in terms of the level of involvement and went to one wedding (but not the reception) and visited a participant who was incarcerated to conduct an interview.

Leaving the research site can be a "bittersweet time" (Glesne and Peshkin, 1992, p. 60), when feelings of relief at finishing the exhausting process, and sadness at leaving the people and the action behind, are juxtaposed. This was certainly true for me. I was however, conscious of both practical and emotional concerns. In practical terms, once I had enough data, the next part of the research process, the writing up of the findings awaited me, leaving little time for ongoing engagement. At the same time I needed to



balance my personal regard and rapport with some participants with the need for both parties to move on. As well, several women found it difficult to understand that the boundary between participant and researcher had to remain in place even after the study was completed. Some wanted an ongoing friendship. I believe that I have been able to withdraw from the relationships gracefully. However, although it has been nearly three years since the data collection stopped and ongoing engagement ceased, I still hear from 17 former participants once or twice a year, usually around the Christmas-New Year period.

Finally, while the findings of this study may have value for similar settings, they are necessarily limited to chemically dependent pregnant women who attended the Transitions Clinic at the Mercy Hospital for Women in Victoria at a particular period. While most of the women were highly articulate and frank in conveying the subtleties of their subjective experiences and feelings, there is still the problem of knowing whether or not their verbal accounts do actually provide a valid window into their experiences. The analysis presented therefore is not intended as a definitive account, rather it is the researcher's interpretation, and the reader is invited to consider the findings from their own perspective. The understandings derived from the data should not be seen as fixed, but rather as complex, dynamic and evolving. I leave the last words to Jasmine:

I hope this study makes people listen and not judge us by our drug problems but as the people we are. There's not a very big difference between us and other women who get pregnant, have babies and try to sort out problems.

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## **APPENDICES**

**APPENDIX A**

**AUSTRALIAN CATHOLIC UNIVERSITY ETHICS APPROVAL**

**AND**

**MERCY HOSPITAL FOR WOMEN ETHICS APPROVAL**





## **APPENDIX B**

### **PARTICIPANT PROFILES**

## **Group One**

### **Alice**

Alice was 26 when first interviewed. She is a Hong Kong Chinese and is tall with an exotic appearance and a reserved demeanour (she doesn't like to look people in the eye). Alice was a highly trained child care worker but hasn't worked in that field for some time as she stated that she would not pass the current police and legislative checks to gain work in this area. While Alice has two children to the same man she points out that she is "single". Although Alice was incarcerated for two short periods (six and four weeks respectively for drug trafficking) during the data collection she was not unhappy to be there, for she could have her other young child with her as she spent most of her time in the prison hospital.

### **Kate**

Kate was 31, tall and slim with titian hair and employed as a senior manager with an international science consortium. She was very quiet and introverted and states that she needs a few drinks to "get going". She has had a drinking problem since she was 17 and took up cocaine 7 years later when she was studying at a prestigious North American university. Kate met her partner while she was overseas; he wants to marry her but Kate is wary of marital commitment as her mother has been married and divorced four times. Kate is estranged from both parents and has no plans to reconcile with them. She is an only child and was placed in boarding school when she was eight. Kate's employers were extremely supportive and she continued to work throughout her pregnancy.

### **Nicole**

Nicole was 18 and working as a street prostitute (self-employed was how she described her employment status) when she agreed to participate in the study. She is of average height, had brown hair and a tiny build. Nicole is intelligent and opinionated with a loud spontaneous laugh that hides the residual sadness which never really leaves her. Her mother was a prostitute and stripper and gave birth to Nicole when she was 15. Nicole was a polydrug user; her habit included heroin and speed, but she started taking marijuana when she was eleven. She left school at 15 and had two abortions prior to this pregnancy. A client introduced her to adult films. She appeared in two but was soon directing them. Nicole has a penchant for accounting and administration so her employer suggested she apply to university. She is now completing a double degree at an interstate university.

### **Jasmine**

Jasmine was tall and blonde with an athletic build and a heroin habit. She appeared to be a quiet and withdrawn young woman and her customary smile seldom reached her eyes. Jasmine was 19 at the start of the study and had been in juvenile justice twice. She escaped each time and got pregnant while on the run. Both children have different fathers and Jasmine's current partner is not either boy's biological father. Jasmine was introduced to drugs by her mother who left her and her younger sister to fend for themselves when she went to live with a new partner in another state. Jasmine's main support comes from her step-father (who is a cross-dresser) and a young police constable who arrested her when she escaped from juvenile justice the second time.

## **Group Two**

### **Rosa**

Rosa was 24 and already the mother of a young daughter when she agreed to participate in the study. That child was cared for by Rosa's paternal grandmother. Rosa is tall and slender and is a second generation Australian of Spanish heritage. She stated that she has four older brothers who are married with children and stick "to the old ways". Rosa was the much desired daughter and was over- indulged as a young child. When she was nine she was sexually assaulted by a friend of the family and she stated that her family blamed this on her behavior. She then went to live with an older brother and his family but turned to marijuana at 14 and speed at 15. She completed her VCE and chose not to proceed with any further education despite having an ENTER score in the 90s. Rosa's main support comes from her grandmother and the father of her children (a married man).

### **Lisa**

Lisa was 20 when she joined the study and had been a marijuana user for seven years and alcohol dependent for 4 years, although she stated that she never mixed them. During her pregnancy Lisa discovered her Aboriginal heritage, which she said gave her a "sense of place" and filled in many of the gaps in her life. She has been with the same partner for three years. He was also a frequent marijuana user and could be violent when drunk. Lisa had a relatively stable family background (her parents were happily married and both working) but she had been raped by a "white boy" when she was six and had been told by the police that it was her fault. Lisa also had a confirmed diagnosis of clinical depression.

### **Monique**

Monique was 28, married and pregnant for the first time when I spoke to her about the study. Monique was pretty with dark brown hair but was extremely overweight. She had a long history of sexual abuse and incest perpetrated by her older brothers and her mother's live-in boyfriends (who she had to call "uncle"). Monique is a trained chef but stated she cannot work because of a lack of confidence and self-belief. She also has a confirmed diagnosis of clinical depression. Her husband, a non-drug user, was her only support and he tried to teach her independence and encourages her to commit to drug and alcohol counselling. However, this had mostly been unsuccessful because Monique has been addicted to cannabis for 16 years, alcohol for 14 years and cocaine dependent since she turned 22.

### **Sharon**

Sharon was 23 and pregnant for the third time when she joined the study. She was short, overweight with light brown hair, and had an unkempt appearance. She had several criminal convictions for drug use and dealing. Heroin and marijuana were her drugs of choice. Sharon's partner was the father to all her children and was their legal custodian even though he had a history of violence and criminal convictions for drug trafficking. Sharon stated that she came from a stable family background and attended a private school but left during year 9 after a family argument. She has had no further contact with her family of origin nor does she intend to change this. Sharon has a confirmed diagnosis of bipolar disorder.

### **Naomi**

Naomi was Lebanese, 26 and expecting her third child when she agreed to partake in the study. Her other children have been placed in permanent foster care as Naomi feels unable to care for them due to her depression and heroin addiction. Naomi left school during year 10 when she became pregnant for the first time. She comes from a strict Muslim background and describes herself as “one wild child”. She no longer has contact with her family of origin and states that this is “a mutual decision” for all concerned. Her children are fathered by different men who have no ongoing contact with her or with their children. Naomi has few stable supports in her life; in her words she is a “drifter”.

### **Leanne**

Leanne was 32 and pregnant for the third time when she joined the study. She is blonde, blue eyed, slim and tall. She had been living with her partner for 12 years and it was a joint decision that her previous pregnancies be terminated. Leanne finished secondary school and trained as a hairdresser but has seldom worked in that capacity (although her own hair always looks clean and very stylish). Leanne stated that she is addicted to methamphetamine and this is verified by deep scratches along her forearms caused when she has experienced the feelings of “something crawling under my skin”. Her main social support comes from her partner who exhibits a high level of control over her by threats and withdrawal of affection. Leanne has also been diagnosed with having borderline personality disorder traits.

### **Maggie**

Maggie was 27 when she joined the project. She is blonde, buxom and of average height. She married at 19 and this is her first pregnancy. She is a trained child care worker and is excited to be pregnant. Recent blood profiles revealed that she is an Indigenous Australian and she is happy about this because “it gives me a sense of community”. She further stated that her husband is also pleased because of the government support to which she now has access. Maggie and her husband are long-term heroin users and this has caused them to live an itinerant existence from time-to-time. Maggie’s family origin introduced her to alcohol and marijuana when she was 15 as a way of “coping with life”. Maggie was sexually assaulted when she was 13.

## **Group Three**

### **Erica**

Erica was 22 at first interview (on the same day she agreed to join the study). Erica has red hair, green eyes, hundreds of freckles and is tall and slender. She is an extrovert with a ready laugh. Erica is British and longs to return to see her relatives. She is close to her parents who live near her. Erica left school at 15 after she was raped and fell pregnant. She is single, addicted to marijuana and sometimes takes speed if she feels “down”. Erica has had two miscarriages and is keen to do “everything the Clinic tells me to do” so she can give birth to a healthy baby. Her family of origin (especially an aunt) and a large circle of friends provide support and advice.



### **Cathy**

Cathy was 24 and pregnant with her third child when she became a participant. She is tall, thin, blonde and very vague in conversation. Cathy left school in year 8 when she was 14. She had been a “chronic refuser” and a “bit of a trouble-maker”. Cathy’s partner who has care of their children describes her as a “pathological liar who is always on the make”. Despite such a comment he is her mainstay and although they live separately he checks on her several times a day, does her laundry and cooks and delivers her meals. He has regular work and takes responsibility for reducing their dependency on marijuana. He also protects Cathy from her violent step-father.

### **Peta**

Peta, 29, brunette, short and thin, agreed to take part in the project because she thought her story might help others. Peta is single and was enjoying her first pregnancy. She left school after completing her VCE with an ENTER score in the low 80s. Peta has tried several jobs, usually in office administration, and has lived in each state and territory. She grew up in a “chaotic household where there were no rules and not much affection”. Peta’s maternal grandmother lives near her and checks on her each day. Peta stated that she started taking marijuana when she was 12 and later cocaine because she felt people would not find her attractive unless she had something interesting to say. She felt that cocaine made her feel more confident.

### **Amanda**

Amanda was 23 and pregnant with her second child when she joined the study. Amanda is tall, thin and handsome rather than attractive. She has lived with her partner for four years and they have a 20-month old daughter. Amanda and her partner are happy and live a stable life in the house that they are buying in a large country town. Her partner owns a well known and successful small business. He has never used drugs and is very supportive of Amanda’s attempt to reduce her heroin intake. Post birth, he moved with Amanda into a residential treatment programme to provide support. Amanda’s father is a convicted paedophile and this caused the rest of the family to continually move around Victoria and New South Wales to avoid persecution. In the end, she chose to leave school in year 10 when she was 16 because “it just became too hard to live like that”. Amanda had turned to drugs at 15 to hide her pain and embarrassment.

### **Jo**

Jo was 22, married, pregnant for the second time and preparing sit her final university exams when she agreed to participate in the study. She miscarried her previous pregnancy when she was involved in a car accident. Jo is short and buxom with long black hair (she loves to wear flowers in her hair). Jo has a confirmed diagnosis of obsessive-compulsive disorder with borderline personality traits. She also suffers from occasional bouts of depression. Jo stated that she started using cocaine to “give me more feelings, like make me feel happy and sad rather than just nothing”. Jo planned to find work after the birth of her child and to seek a second medical opinion with regard to her mental health.

### **Maryanne**

Maryanne was 18 with a five-year old heroin addiction. She had started using marijuana when she was 11 to “stop the voices”. Maryanne is very thin with long lank brown hair and huge brown eyes. She has a confirmed diagnosis of schizophrenic traits with periodic paranoid delusions. Maryanne presented as a loving and gentle woman who was overwhelmed by her mental illnesses. She always smelled of Crabtree and Evelyn’s Rosewater perfume which her partner seemed to buy her non-stop. Sometimes you would smell Maryanne before she came into view. In order to support Maryanne with her pregnancy and heroin recovery, her partner attempted to reduce his marijuana intake.

### **Sara**

Sara was 20 and is Vietnamese with long black hair. She was very beautiful and seemed to glide everywhere. Sara came to Australia with her step-father and two older brothers when she was six. Her mother stayed in Vietnam to look after her sick mother with the intention of joining her family later. However, Sara’s mother was killed in a car accident before she could re-unite with her family. Her step-father bought a brothel in inner Melbourne and made her leave school and work as a prostitute from 14 “to pay for her keep”. Sara developed a heroin habit to help her cope with this life. Her first pregnancy was to a client. Her step-father made her keep working as “men are all mother-fuckers”. Sara put her first child in permanent foster care but stays in touch with the family that will raise him.

### **Dee**

Dee was 31, loud and voluptuous when I first met her. Dee stated that she stated taking marijuana when she was 13 and was addicted by 14. She was pregnant with her third child when she joined the study, and was hoping for a daughter as she already had two sons. Dee had trained in administration (at TAFE) and until recently had worked as an office manager. She had been asked to leave (with a reference) because she had been caught “sniffing cocaine”. She felt embarrassed by this and had resolved to give up drugs before discovering that she was pregnant. She stated, however, that her partner had other ideas. He was a dealer and it was in his interest to keep her using. He was also a large man with an intimidating manner. Dee loved him and he appeared to return that affection. Both appeared proud and loving towards their children.

### **Debbie**

Debbie was 35 and pregnant for the third time when she joined the project. Debbie was a large woman with a huge and generous personality. She loved pink; she had pink and white hair, pink makeup, pink nail and toe polish and usually wore pink. Once I was tempted to ask if she liked the singer “Pink” but thought better of it. This was Debbie’s third referral to the Clinic. She had a marijuana problem during her first pregnancy (she stated that she was a marijuana user from age 13), then it was marijuana and alcohol during the second and now, marijuana, alcohol and heroin. Debbie has been diagnosed with schizophrenia and is on medication for this condition. She used a mixture of licit and illicit drugs to cope with this illness. She loved her young family and was very proud of her home and house-keeping skills. Debbie early family life had been chaotic and dysfunctional. Debbie’s partner also suffers from depression.

## **APPENDIX C**

### **AUSTRALIAN CATHOLIC UNIVERSITY PLAIN LANGUAGE**

#### **STATEMENT AND CONSENT FORM**















## **APPENDIX D**

### **LIST OF CONFERENCE PRESENTATIONS**

1. 'A pregnant pause: Drugs and having babies.' *The Australian Drug Foundation Fifth International Conference on Drug and Young People*, 24-26 May 2006, Sydney.
2. 'Drugs and having babies: Interviewing vulnerable research participants.' *Seventh International Inter-disciplinary Conference: Advances in Qualitative Methods*, 13-16 July 2006, Surfers Paradise.
3. 'Drugs and having babies: Methodology.' *Second Collaborative Deans of Nursing and Midwifery Conference*, 18-19 September 2006, Melbourne.
4. 'Research participants as consumers: What chemically dependent pregnant women want from a specialist clinic.' *Australasian Professional Society on Alcohol and Other Drugs Conference*, 5-8 November 2006, Cairns.
5. 'Walking a tightrope: The delicate relationship between researcher and vulnerable participants. *Australian Psychological Society Interest Group on Psychology of Relationships*, 11-12 November, 2006, Melbourne.
6. 'Drugs and having babies: Alienation and redemption.' *Professionally Speaking: Qualitative Research and the Professions Conference*, 13-14 November, 2007, Melbourne.
7. 'Researching Vulnerable Populations' *International Addiction Summit*, 10-17 July, 2008. Melbourne.
8. Chemically dependent pregnant women – drug ethnography. VAADA Conference: *Direction in a Time of Change*, 19-21 February, 2009 Melbourne.