# A NARRATIVE INQUIRY OF WOMEN'S SUBSTANCE USE IN PREGNANCY AND MOTHERHOOD

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## ABSTRACT

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Substance use during pregnancy and motherhood is both a public health and criminal justice concern. Negative health consequences associated with substance use impact both the mother and the developing fetus, and there are ongoing attempts to criminalize substance use during pregnancy that put pregnant substance-using women at risk of detection, arrest, and punishment. Although there has been research on the consequences of maternal substance use, little is known about why some women are motivated to desist during pregnancy and why others persist. The purpose of this dissertation was to advance the understanding of (1) women's decision-making regarding substance use and motherhood, (2) how women desist from substance use during and after pregnancy, and (3) how women navigate or overcome barriers to care. To accomplish the aims of this study, narrative identity theory was employed as a theoretical framework for understanding women's sense-making of their experiences.

Based on data from in-depth life history interviews with thirty recently-pregnant women who had used alcohol, tobacco or other drugs during their pregnancies, this study captured the experiences of substance-using mothers as they navigated health and criminal justice consequences and accessed needed resources in the community. The data reveal multiple patterns of substance use desistance behavior, from prompt desistance to persistence throughout the pregnancy. Women who desisted described themselves as exercising their agency in pursuing opportunities for desistance. Desisting women were less likely to be embedded in social networks that included other substance-using individuals. Women supported their desistance

during and after pregnancy by reinterpreting their life stories as narratives of redemption. They achieved this reinterpretation by highlighting past experiences that demonstrated that they had good core selves and had simply been overwhelmed or distracted by substance use. By reinterpreting their past suffering as redemptive, desisting women were able to narrate prosocial and generative futures in which they would tell their stories to others to show that desistance is possible. Finally, women's stories highlighted their strategies for managing their risk of detection by health or criminal justice authorities and revealed multiple barriers to treatment and healthcare, including a lack of suitable treatment options. The theoretical and policy implications of the findings are discussed, particularly the need for further development of narrative identity theory and the expansion of treatment programs and social services to meet the needs of substance-using women.

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## TABLE OF CONTENTS

## LIST OF TABLES

# CHAPTER 1

## Introduction and Literature Review

Pregnant women who misuse substances (alcohol, tobacco, prescription and illicit drugs) are positioned at the nexus of public health and criminal justice intervention. The impact of their substance use on their health and the health of their fetuses is a public health concern, as professionals in this field are dedicated to improving maternal and infant health and improving the United States' infant mortality statistics. In addition, the past three decades have seen prenatal substance use become a criminal justice issue as the fetal protectionism movement spurred the increasing use of criminal sanctions for "deviant" mothers. Substance-using pregnant women, especially women of color and women in lower socioeconomic brackets, are subject to increased surveillance and may face arrest, prosecution, conviction and/or child removal. The positioning of this topic as both a public health and criminal justice issue has resulted in two very different possible solutions: on the one hand, there is treatment, social services and needs-meeting; on the other, child removal, arrest and possible incarceration.

The purpose of this qualitative study is to explore the experiences of pregnant women and mothers who are or were misusing alcohol, tobacco, illicit drugs and medications. The following literature review will detail the health and criminal justice consequences of substance use during pregnancy and motherhood. It will then discuss past and present policies designed to address the problem of substance use during pregnancy and motherhood and the unintended consequences of these policies. Finally, a novel theoretical framework will be suggested for improving the understanding of mothers' substance use with the goal of informing effective and compassionate social policies.

## Alcohol and Tobacco Use

Figures from the most recently-published report from the National Survey of Drug Use and Health (Substance Abuse and Mental Health Services Administration, 2012) show that, of pregnant women aged 15-44, 9.4% reported current alcohol use, 2.6% reported binge drinking, and 0.4% reported heavy drinking. Of pregnant women aged 15-44, 17.6% report smoking tobacco in the last month, a figure that represents a small, nonsignificant increase from the 2009-2010 and 2008-2009 findings. The percentage of pregnant women in this age group who report smoking tobacco in the last month has not changed significantly in the last decade, while tobacco use among nonpregnant women in the same age group has decreased slowly but significantly each year. Of pregnant women aged 15-44, 5% report current illicit drug use, a proportion not significantly different than in the previous study year. The rate of illicit drug use varies widely with the woman's age. Teenaged pregnant women have the highest rates of illicit drug use (15-17, 20.9%), followed by young adult women (18-25, 8.2%) and adult women (26-44, 2.2%). The known health consequences of each type of substance are discussed below.

**Alcohol.** Alcohol is one of the most commonly-used substances among both pregnant and nonpregnant women. It is an interesting substance in relation to the topic of this study, as it is legal for adult women to consume in any quantity and its teratological properties are quite clear. Alcohol is the human teratogen that produces the most serious neurobehavioral effects on fetuses (Bennett, 1999). In fact, fetal alcohol exposure is one of the leading known and preventable causes of mental retardation and has been linked to long-term consequences like craniofacial abnormalities, motor deficits, learning disabilities, and behavioral problems (NIAAA, 2012). Fetal Alcohol Syndrome (FAS) was first described in 1973 and is now considered part of Fetal Alcohol Spectrum Disorder (FASD), the umbrella term now used to

encompass the physical symptoms once alternately referred to as fetal alcohol effects, prenatal alcohol effects, alcohol-related birth defects or alcohol-related neurodevelopmental disorder (Sokol, Delaney-Black & Nordstrom, 2003). Fetal alcohol syndrome is at the most severe end of this spectrum and is characterized by facial dysmorphology, growth restriction, and central nervous system or neurodevelopmental abnormalities. Children may show some but not all characteristics of FAS and therefore be diagnosed with FASD. FASD is the preferred term of advocates, educators and federal agencies when referring to the range of outcomes associated with prenatal alcohol exposure (Sokol, Delaney-Black & Nordstrom, 2003).

While there is substantial evidence that exposure to alcohol can be very harmful for the fetus, resulting in FASD or intrauterine death, studies have not yet determined a "safe" amount of alcohol use for pregnant women. Curiously, at least to those of us today who are aware of FASD, alcohol was used clinically to avoid premature labor in the late 1960s and during the 1970s (Albertsen, Andersen, Olden and Gronbaek, 2004), though studies find no evidence of any significant tocological effect. FASD is certainly linked to heavy drinking during pregnancy (Coles, Brown, Smith, Platzman et al., 1991; Mattson, Goodman, Caine, Delis & Riley, 1999; Roebuck, Mattson & Riley, 1999), but the relationship between light drinking and deleterious outcomes is unclear. Though some researchers define "risk-drinking" during pregnancy (enough to potentially damage the fetus) as an average of more than one drink (0.5oz) per day (less if consumed in binge-drinking episodes) (Hankin & Sokol, 1995), other research has documented FASD in children prenatally exposed to even smaller amounts of alcohol (Sood, Delaney-Black, Covington, Nordstrom-Klee et al., 2001). The timing of drinking during pregnancy has been linked to the development of certain anatomical defects or neurodevelopmental issues. For example, the characteristic facial features used to diagnose FAS are short eye openings, a smooth

philtrum (the vertical groove between the nose and upper lip), wide-set eyes and a thin upper lip. These facial features develop during the sixth to ninth week of gestation. If the mother's drinking results in high blood-alcohol contents during this time, then these features are likely to be negatively affected (May & Gossage, 2011). This is particularly important because many women may not know they are pregnant during this time, especially if they have previously had irregular menstrual cycles. Finally, frequency of maternal alcohol use is thought to be a necessary condition for FASD. It has been suggested that for FAS to occur, drinking must be frequent and heavy over the course of the pregnancy (e.g. weekly binge episodes) (Abel, 1998).

The relationship between alcohol and fetal health is further complicated by what appears to be varying susceptibility to FASD. Animal and human models have linked susceptibility to FASD to genetic and epigenetic factors in the mother or fetus (Warren & Li, 2005). Alcohol metabolism varies from one individual to the next, and pregnancy can affect alcohol metabolism in a variety of ways. Furthermore, other physical conditions interact with genetic conditions. Maternal undernutrition and low socioeconomic status (resulting in high stress and poor health) may increase the likelihood of fetal damage (Abel, 1995; Abel & Hannigan, 1995). Women who are older, have had a higher number of previous pregnancies and a higher number of previous births have been found to have children who are more severely affected by fetal alcohol exposure (Jacobson et al. 1996, 1998; May et al., 2005, 2006, 2007, 2008). The combination of these maternal risk factors suggests that it is women in the most disadvantaged populations whose children will suffer most severely from fetal alcohol exposure, further compounding existing race and class health inequities.

**Tobacco.** Tobacco cigarette use is the leading preventable cause of disease and death in the United States (CDC, 2005). Despite numerous public health campaigns to combat maternal

smoking, 17.6% of pregnant women aged 15-44 report current tobacco use (SAMHSA, 2012). Tobacco use during pregnancy is especially prevalent among women with less than 12 years of education, 20% of whom report smoking in their third trimester of pregnancy (CDC, 2007). The connection between education and maternal smoking is quite strong. In one study, only 2% of college-educated women reported smoking during pregnancy, whereas 25% of women who attended but did not complete college smoked (Martin, Hamilton, Ventura, Menacker et al., 2002).

There is unequivocal evidence that maternal smoking and exposure to second-hand smoke cause lower birth weight (Cnattingius, 2004; Dejmek, Solansky, Podrazilova & Sram, 2002; DiFranza, Aligne & Weitzeman, 2004; Misra & Nguyen, 1999; United States Department of Health & Human Services, 2004, 2006; Ward, Lewis & Coleman, 2007; Windham, Eaton & Hopkins, 1999) as a result of fetal growth restriction. The underlying mechanism is not well-understood and is likely complex, but it is thought that smoking compromises uterine blood flow and the carbon monoxide in cigarette smoke causes hypoxemia (a deficiency of oxygen in the blood). The consequence is a reduction in blood flow (and therefore oxygen) to the fetus, resulting in restricted growth. A meta-analysis of 13 studies (considering a total of 1,358,083 pregnancies) found that smoking was associated with a 90% increase in risk of placental abruption (Ananth, Smulian & Vintzileos, 1999). A dose-response relationship between maternal smoking and preterm birth (33-36 weeks gestation) and very preterm birth (<33 weeks gestation) has been repeatedly established (Burguet, Kaminski, Abraham-Lerat, Schaal et al., 2004; Cnattingius, Granath, Petersson & Harlow, 1999; Fantuzzi, Aggazzotti, Righi, Facchinetti et al., 2007; Kyrklund-Blomberg & Cnattingius, 1998; Nabet, Lelong, Ancel, Saurel-Cubizolles & Kaminski, 2007). Smoking during pregnancy is also associated with a wide array of other

adverse birth outcomes, including spontaneous abortion, prenatal death, cleft chins and deficits in learning and behavior (Bennett, 1999; Lorente, Cordier, Goujard, Aymé et al., 2000; Pastrakuljic, Derewlany & Koren, 1999). The frequency of smoking-related adverse birth outcomes has led the Surgeon General to state that eliminating maternal smoking and smoke exposure "may lead to a 10% reduction in all infant deaths and a 12% reduction in deaths from perinatal conditions" (USDHHS, 2001).

**Illicit Drugs**

**Heroin and prescription opioids.** The issue of prenatal illicit substance use garnered national attention in the 1960s and 1970s, when a confluence of discoveries regarding the "placental barrier" prompted concern about the health of fetuses. The rubella epidemic and the thalidomide and diethylstilbestrol (DES) tragedies demonstrated to the public that the placental barrier, once thought to protect the fetus, was actually quite porous (Lester, Andreozzi and Appiah, 2004). The diets and behaviors of pregnant women suddenly presented potential threats to the health of the next generation, and pregnant women's bodies became the sites of public health intervention. These discoveries coincided with the heroin epidemic of the 1960s-70s, and thus some of the first research on the impact of illicit drugs fetal development focused on heroin and methadone (e.g., Blinick, Wallach, Jerez and Ackerman, 1976; Kandall, Albin, Gartner et al., 1977; Naeye, Blank, LeBlanc and Khatamee, 1973; Perlmutter, 1974; Pelosi, Frattarola, Apuzzio, Langer et al., 1975). The 2011 National Survey of Drug Use and Health showed higher numbers of heroin users and initiates than in some prior years. News reports have linked this trend to the rapid increase in prescription opiate abuse, citing individuals who report replacing expensive prescription opiates with cheaper, more available heroin (Schwartz, 2012; Steinway, 2008). This connection appears to have found some support in scholarly and professional

literature (Inciardi, Surratt, Cicero and Beard, 2009; Lankenau, Teti, Silva, Bloom et al., 2012; Office of National Drug Control Policy, 2007; Siegal, Carlson, Kenne and Sworda, 2003).

The NSDUH includes in its measure of illicit drug use the nonmedical use of prescription drugs. Nonmedical use of prescription drugs is the third most common drug category of abuse after marijuana and tobacco. The most frequently abused prescription medications are opioid pain relievers (SAHMSA, 2012). White women are more likely to abuse prescription opioids than women of color. Alarmingly, prescription drug abuse appears to be increasingly at a rapid pace. The number of individuals receiving treatment for prescription pain reliever abuse more than doubled from 2004-2009, far exceeding treatment visits for other drugs of abuse (SAHMSA, 2010). Data from the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics indicate that abuse of opioids is driving the increase in drug overdose deaths, which increased in 2010 for the eleventh consecutive year. In 2010, nearly 60% of drug overdose deaths (22,134 of 38,329) involved pharmaceutical drugs, and three of every four of these cases involved opioid pain relievers such as oxycodone, hydrocodone and methadone (Jones, Mack & Paulozzi, 2013). Between 2000 and 2009, prenatal maternal opiate use increased from 1.19 to 5.63 per 1000 hospital births per year (Patrick, Schumacher, Benneyworth, Krans et al., 2012)

Taken as prescribed, opioids can provide powerful pain relief, as they bind with natural morphine or *mu* receptors in the human body to produce feelings of euphoria and decreased perception of pain (Trescot, Datta, Lee & Hansen, 2008). These medications have a powerful potential for physical and psychological addiction, as a common complication of opioid treatment is increasing tolerance resulting in decreasing effectiveness (Benyamin, Trescot, Datta, et al., 2008). As tolerance increases, greater dosages must be taken to achieve the same effect,

increasing the potential for overdose. Overdose can result in death through respiratory depression or aspiration of the stomach contents (American College of Obstetricians and Gynecologists, 2012).

While withdrawal from opioids is unpleasant for most users, it is especially dangerous for pregnant women, as withdrawal has been linked to spontaneous abortion. Other obstetrical complications among opioid-dependent women include intrauterine growth retardation (resulting in low birthweight), preeclampsia, placental insufficiency, chorioamonionitis (bacterial infection of the fetal membranes), premature labor, premature rupture of membranes and intrauterine death (Kaltenbach, Berghella & Finnegan, 1998). After birth, infants may exhibit symptoms of Neonatal Abstinence Syndrome (NAS), including hyperirritability and dysfunction of the nervous system, gastrointestinal tract, and respiratory system (Finnegan & Kaltenbach, 1992). Between 2000 and 2009, the incidence of NAS among hospital-born newborns increased from 1.20 to 3.30 per 1000 births per year. Total hospital charges for NAS during this time period are estimated to have increased from $190 million to $720 million, adjusted for inflation (Patrick et al, 2012). State medicaid programs are the predominant payer for opiate-using mothers (60.0%) and exposed newborns with NAS (78.1%) (Patrick et al., 2012). However, it is possible that some of the increase in NAS diagnoses could be attributed to growing recognition of NAS symptoms and increased surveillance of pregnant women.

**Cocaine**. Cocaine is perhaps the substance most strongly associated, at least in the minds of the public, with maternal drug use, fetal drug exposure and adverse fetal health outcomes. This connection was formed during the crack cocaine epidemic of the 1980s and early 1990s. The shift in cocaine consumption patterns facilitated by the development of “crack” cocaine reduced the price and availability of the drug. Previously, powdered cocaine was associated with

middle- and upper-class users. It was the "champagne of drugs," expensive, high-status and linked to Hollywood playboys and Wall Street businessmen. The introduction of "crack," a relatively cheaper, smokeable form of cocaine that offered a short, intense high, increased the availability of the drug to urban minorities (Lyons & Rittner, 1998).

The link between crack use and poor communities of color heightened public anxiety and incited more negative and punitive attitudes towards those using crack, especially pregnant women and mothers. Mothers using crack were alleged to have multiple pregnancies within short periods of time, to exhibit little interest in and to often abandon their infants, and to be sexually promiscuous (Boyd, 2004). Crack was believed to ruin a woman's "maternal instincts", leading to widespread child neglect and abuse (Gomez, 1997). Medical literature on this topic from 1985-1990 was alarmist in tone, linking cocaine exposure to physical, mental and emotional irregularities. Early studies suggested that crack-exposed infants had low birth weights, small heads and neurobehavioral deficiencies. An early study of 36 primarily urban hospitals led to an estimate that 11% of women abused chemical substances during their pregnancies (Chasnoff, 1989). This figure was then hastily extrapolated to the national population to result in an estimate of 375,000 drug-exposed infants born each year. These early estimates of the number of "crack babies" were widely publicized in news coverage and, by the time more realistic figures emerged, the impact of the ensuing public panic could not be reversed (Daniels, 1997; Gomez, 1997; Lyons & Rittner, 1998; Roberts, 1999). The narrative of the crack-using mother and her addicted baby was created, the crack epidemic's "leading characters – the pregnant addict and the crack baby, both irredeemable, both Black. The pregnant crack addict was portrayed as an irresponsible and selfish woman who put her love for crack above her love for her children" (Roberts, 1999: 156).

In the early 1990s a second wave of research was published, indicating a serious lack of scientific rigor in first-wave studies and showing that, after controlling for poverty and polydrug exposure, there were few differences in the developmental scores of two-year olds from the cocaine-exposed and control groups (Azuma & Chasnoff, 1993; Hurt, Brodsky, Betancourt, Braitman et al., 1995). These later studies identified the influence of other drugs (especially alcohol and tobacco), poverty, and poor environment as potential contributors to gaps in development originally attributed to illicit drug exposure. A 2001 meta-analysis on prenatal cocaine exposure found scant evidence of longterm effects (Frank, Augustyn, Knight, Pell & Zuckerman, 2001), leading Chavkin (2001: 1626) to conclude that "The modest and inconsistent nature of findings [of the effect of prenatal cocaine exposure] to date suggests that these harms are unlikely to be of the magnitude of those associated with in utero exposure to the legal drugs tobacco and alcohol." The differences initially observed between exposed infants and their unexposed peers were likely due to confounding factors associated with poverty (Hurt et al., 1995).

**Methamphetamine**. Relative to cocaine, heroin, alcohol and tobacco, methamphetamine use during pregnancy has received substantially less attention in the media and in academic literature. This is likely due to its more recent popularity as a drug of abuse and because methamphetamine use is not concentrated in impoverished urban areas historically associated with drug use and other social problems. Methamphetamine has existed as a synthetic substance since 1919, but it was not until the 1990s that new ways to "cook" methamphetamine appeared, resulting in a more potent substance. At this time, methamphetamine use increased in the rural Midwest, as rural locations are ideal for cooking because they are isolated and have available supplies of anhydrous ammonia, a common farm fertilizer and methamphetamine ingredient.

Since this time, methamphetamine has become the "most widely abused and most frequently produced synthetic drug in the United States" (Deutch, 2011: 1).

Methamphetamine users are disproportionately white and tend to be unemployed or working in blue collar occupations (Herz, 2000; Kyle & Hansell, 2005; SAHMSA, 2005; Rodriguez et al., 2005). Women who use methamphetamine during their pregnancies are more likely than non-using women to be of lower socioeconomic status, to receive less prenatal care and to have been diagnosed with psychiatric disorders or mental illnesses (Shah, Diaz, Arria, LaGasse et al., 2012). Though both the methamphetamine-using and non-using groups studied by Shah and colleagues (2012) included individuals who had used alcohol, tobacco and marijuana during their pregnancies, use of these other substances was more common and more frequent in the methamphetamine-using group. Exposed infants were slightly shorter and had smaller head circumferences (Shah et al., 2012), but did not exhibit other conditions previously associated with methamphetamine exposure, including drug withdrawal symptoms, tachycardia, facial dysmorphism, skeletal or cardiac defects, or respiratory problems (Plessinger, 1998). Shah and colleagues (2012) attributed the more severe health consequences found in earlier studies to poor study design, including the lack of matched comparison groups and failure to control for polydrug exposure.

**Mothering and Substance Use**

Pregnancy is not the only time period in which maternal substance use presents a challenge for maternal and child health and development. There are concerns that substance use problems interfere with a mother's ability to nurture and protect her children. Parenting problems in populations of substance-using women are often attributed to the substance use lifestyle. Research suggests that children whose parents abuse substances are more likely to experience

maltreatment (Chaffin, Kelleher & Hollenberg, 1996; Magura, Laudet, Kang & Whitney, 1999) and abuse (Walsh, MacMillan & Jamieson, 2003). A meta-analysis of 155 studies found parental substance misuse to be significantly associated with the physical abuse of children (Stith, Liu, Davies, Boykin, et al., 2009). However, in their review of literature linking parental substance abuse to child maltreatment, de Bortoli and colleagues (2012) find that many of these studies draw their samples from social services or court records and thus the sample likely represents the most serious cases of child abuse. Women of lower socio-economic status are also more likely to be overrepresented in samples drawn from social service agencies. Finally, many of the studies fail to take into account contextual factors like comorbid psychopathology, parents' experiences of abuse, and risks associated with living in poverty. The authors conclude that there is an alarming lack of studies examining the interplay between other risk factors like polydrug abuse, paternal drug use, stress, domestic violence and mental health (de Bortoli, Coles & Dolan, 2012).

Many studies have demonstrated that women are capable of using substances and adequately parenting their children, though as their substance use becomes more severe, this balance becomes more difficult to maintain (Hardesty & Black, 1999; Murphy & Rosenbaum, 1999; Scannapieco & Connell-Carrick, 2007). Much of the risk to children may come not from the parental substance use itself, but from the "chaotic and high risk lifestyle" associated with illicit drug use (Hulse, Milne, English & Holman, 1998: 1040; Hulse, English, Milne, Holman & Bower, 1997). Others argue that many of the parenting difficulties attributed to substance use are common among non-using populations of mothers facing similarly difficult life circumstances like parenting in poverty, social isolation, violent relationships or unstable housing (Banwell & Bammer, 2006), though women who use illicit drugs are often blamed for their parenting difficulties in ways that other women are not. It has been suggested that women's substance use

and parenting difficulties may have common causes like childhood trauma, violence in their families of origin, the stress of living in poverty, experience of violent intimate relationships, and mental illnesses (Hans, Bernstein & Henson, 1999). Nair and colleagues (2003) found that greater parenting stress and potential child abuse and neglect were associated with maternal drug users who had at least five of the following risks: maternal depression, domestic violence, non-domestic violence, larger family size, no co-parent in home, negative life events, psychiatric problems, homelessness, and severe drug use. Thus, it appears that the factors that increase the risk of child abuse and neglect by maternal substance users are likely to be the same factors that increase the risk of abuse from non-using parents. The authors conclude that their findings support a theory of risk accumulation, that "regardless of the specific risk, as the number of risks increase or when they reach a threshold, there is a negative impact on parenting and on children's development" (Nair, Schuler, Black, Kettinger & Harrington, 2003: 1013).

Though they may be depicted in the media as uncaring or lacking maternal instincts, women struggling with substance use have demonstrated both a desire and an ability to be 'good mothers', to provide for their children and to make decisions regarding their care (Baker & Carson, 1999; Brudenell, 2000; Hardesty & Black, 1999). Interviews with substance-using mothers have revealed a hierarchy of strategies employed by these women to protect their children, including desisting from drug use or switching to a less harmful substance, organizing childcare with family members or trusted friends, maintaining active roles in their children's lives, and even voluntarily placing the children with a family member (Boyd, 1999; Hardesty & Black, 1999; Murphy & Rosenbaum, 1999). Despite these mothers' efforts, children removed from substance-using parents are less frequently reunified with their mothers, tend to remain in out-of-home placement for longer periods of time and are more likely to experience multiple

placements than the children of non-users (Besharov, 1990; Walker, Zangrillo & Smith, 1991). This is especially the case for children from minority families (Tracy, 1994). There is evidence that loss of child custody can be a trigger for relapse for recovering women (Smith, 2009; Sun, 2007; VanDeMark, 2007), which may complicate women's attempts to reunify their families.

**Past and Present Policies**

The legacy of the "crack baby" panic has been a proliferation of deterrence-based criminal justice policies. These policies are have been criticized for contradicting the recommendations of major medical groups, for discouraging women from seeking prenatal care and substance abuse treatment, and for discriminatory outcomes for poor and minority women (Figdor & Kaeser, 1998; Paltrow, 1997; National Association of Alcoholism and Drug Abuse Counselors, 1998).

The American College of Obstetricians and Gynecologists (ACOG, 2008: 1) recommends that pregnant women abstain from alcohol completely, taking the position that "no amount of alcohol consumption can be considered safe during pregnancy." The recommendation of complete abstinence from alcohol during pregnancy has been translated into law. For example, in Wisconsin the state may take a woman into custody if she is pregnant and demonstrates "habitual lack of self-control" in the use of alcohol or controlled substances (Wis. Stat. Ann. § 48.193). South Dakota (S.D. Codified Laws § 34–20A-63) and Minnesota (Minn. Stat. Ann. § 253B.02, subd. 2) laws authorize the civil commitment of women who are pregnant and abusing alcohol or drugs. Where states lack specific laws mentioning drug or alcohol use during pregnancy, prosecutors have used laws written to target for child abuse, child neglect, contributing to the delinquency of a minor, causing the dependency of a child, child endangerment, delivery of drugs to a minor, drug possession, assault with a deadly weapon,

manslaughter, and homicide (Paltrow, 1992) despite, in some cases, explicit provisions protecting pregnant women from punishment (Flavin, 2009; Paltrow and Flavin, 2013). In their study of state actions taken against 413 women in the United States between 1973 and 2005, Paltrow and Flavin (2013) identified 15 cases in which alcohol was the only drug mentioned. While this may seem a tiny number, it is important to remember that in most of the cases identified by Paltrow and Flavin (2013), state action was taken with no evidence of actual harm to the fetus or newborn and no adverse pregnancy outcome was reported. In one particularly startling case, *State of Wyoming vs. Pfannenstiel*, a 29-year old woman went to the police to report that she had been physically abused by her husband. She had bruises on her neck, arms and back and was concerned that her fetus might have been injured. She went to the hospital emergency room for treatment, but was arrested because she was intoxicated and deemed to be abusing her unborn child (Lewin, 1990; Paltrow, 1992). The judge dismissed the case on the grounds that no harm to the fetus had been shown, but nonetheless, in this case, a battered woman seeking treatment was still deprived of her liberty for alcohol use during pregnancy.

Similar policies have been enacted to detect and punish pregnant women who use cocaine. Despite new evidence that prenatal cocaine exposure was not as harmful as initial studies suggested and that abject poverty may be to blame for poor infant health, the image of the "crack baby" and his wanton mother survived. The narrative of the monstrous crack-using mother is reflected in news media depictions of substance-using mothers. Springer (2010) found that, despite greater evidence for the teratogenic properties of alcohol and tobacco, crack cocaine-using mothers were more likely to be depicted in New York Times articles as "bad mothers" and to be scapegoated for social problems. Alcohol- and tobacco-using mothers were less likely to be portrayed using negative frames. Women in the news articles, regardless of the

drug they used, were more likely to be portrayed in a negative frame if they were low-income or race/ethnic minorities. Pregnant alcohol and crack users were also blamed for overburdening the foster and adoption systems with damaged and unadoptable children. Given what we now know about the lack of long-term effects of prenatal cocaine exposure, it is more likely that the "crack baby" epidemic manufactured in part by the media bears a greater share of responsibility for exposed infants being deemed damaged and unadoptable. Exposed children were described in the articles as "languishing," "damaged," "neglected," and "abused" (Springer, 2010: 495) while mothers were "evil" women who deserved to "get their tubes tied" or "buy a gun and shoot themselves with it" (2010: 492).

In their review of the literature, Banwell and Bammer (2006) note the epidemiological construction of a deviant risk group that stigmatizes mothers seeking treatment for substance use. The authors argue that the construction of risk categories pits the health and welfare of young children against the behaviors (and failures) of their mothers, who are considered only to the extent that they transmit harms to their children (2006: 505). Substance-using mothers and pregnant women are considered part of a higher risk-category than other women and may be placed under heightened surveillance by health and welfare professionals, increasing the likelihood that they will suffer consequences ranging from subtle discrimination to child removal and arrest (Boyd, 1999; Murphy and Rosenbaum, 1999; Paltrow, 1999). Fear of these consequences represents a significant barrier to care for mothers and pregnant women, with many mothers reporting that they delayed or avoided prenatal care altogether out of fear of punishment (Murphy and Rosenbaum, 1999; Poland, Dombrowski, Ager & Sokol, 1993; Roberts & Nuru-Jeter, 2010; Roberts and Pies, 2011). The effect of stigmatization, discrimination and fear of punishment present a barrier to wanted care. This creates a health risk, since substance-

using women who *do* receive prenatal care experience more positive birth outcomes and have greater opportunities for other health promoting interventions than women who do not receive care (Berenson, Wilkinson & Lopez, 1996; El-Mohandes et al., 2003; Green, Silverman, Suffet, Taleporos & Turkel, 1979; MacGregor, Keith, Bachicha & Chasnoff, 1989; Racine, Joyce, & Anderson, 1993; Richardson, Hamel, Goldschmidt & Day, 1999).

When pregnant women seek treatment for their substance-use, they may find that there are no suitable treatment programs available. Many programs refuse to treat pregnant women and do not allow children to stay with their mothers, necessitating some sort of long-term childcare while women are in treatment. For example, in the late 1990s hospital staff at the Medical University of South Carolina (MUSC) worked with police to secretly search pregnant patients (predominantly African American women) for evidence of drug use and facilitate in-hospital arrests. Defenders of this policy claimed that the goal was to get women into treatment, because they would not go voluntarily. At the time, not a single drug treatment program in the state provided services for pregnant and parenting women (Paltrow, 2002: x). Furthermore, in spite of the claim that drug-exposed children were severely harmed (and thus the justification for punishment of drug-using women), no program to treat or monitor the children existed (Paltrow, 2000: x).

Policies and procedures designed to detect pregnant drug users are organized in a manner that disproportionately impacts low-income women of color. For example, South Carolina's program, which requires medical professionals to report prenatal drug use, is instituted only in Charleston's low-income urban hospital and enforced only for Medicaid clients (Springer, 2010). In Pinellas County, Florida, despite urine toxicology results demonstrating equal prevalence of substance use for white women and black women, black women were reported to criminal justice

authorizes at a rate approximately *ten times greater* than the rate for white women (Chasnoff, Landress, Harvey and Barrett, 1990). Low-income women were also more likely to be reported. The cumulative effect of socioeconomic disadvantage, increased surveillance and monitoring, and discriminatory and punitive policies places poor women of color and their children at a greater risk of negative health outcomes, loss of custody, and involvement with the criminal justice system. These policies persist despite extraordinary consensus by public health and medical associations that such actions undermine attempts to improve maternal and infant health (e.g., American College of Obstetricians and Gynecologists, 2011; National Perinatal Association, 2011; American Psychiatric Association, 2001; American Nurses Association, 1991; American Academy of Pediatrics, 1990; March of Dimes, 1990; National Council on Alcoholism and Drug Dependence, 1990).

The stigmatization and poor treatment of illicit drug users stands in stark contrast to the treatment of those who use alcohol and tobacco. While pregnant women are likely to be monitored by others and have others pass comment if they choose to use alcohol or tobacco, the criminal penalties attached are not nearly so severe. This is in contradiction to the known teratogenic properties of alcohol and tobacco, which are better known than the effects of many illicit drugs. This is further evidenced by the fact that major public health and medical associations are in consensus that such policies undermine maternal, fetal and child health. Deterrence-based policies treat women's substance use as a monolithic issue of deviance divorced of socioecological influences like women's past or current victimization, lack of resources, and possible comorbid mental health challenges.

**The Need for a New Theoretical Model**

The punitive approach towards substance-using pregnant women is grounded not in medical or public health research but in criminological deterrence or rational choice theories. These theories are rooted in the classical school of criminology, which views human behavior as a function of rational choice (e.g., Beccaria, 1764/1963). Deterrence theory assumes that severe penalties imposed on offenders will prevent them from committing further crimes and will also deter others from committing similar crimes. These theories remain popular in the United States because they resonate with "common-sense" beliefs about the causes of crime, and they are reflected in the preponderance of "get tough" interventions that have dominated criminal justice policymaking over the last several decades (Cullen, Pratt, Miceli and Moon, 2002). The deterrence approach remains popular despite little evidence that it is effective. Two meta-analyses have sought to answers questions about the empirical status of deterrence theory. Pratt and Cullen (2005) examined over 200 aggregate-level studies of crime and found that many of the variables specified in macro-level tests of deterrence approaches were consistently among the weakest predictors of crime rates. At the micro-level, considering how individuals weigh or perceive the costs and benefits associated with offending, Pratt and colleagues found that the mean effect sizes of the variables specified by deterrence theory are modest to negligible, concluding that this finding "suggests that the causes of criminal conduct are multifaceted and extend far outside the limited range of deterrence theory" (Pratt, Cullen, Blevins, Daigle & Madensen, 2009: 383-4). Further evidence suggests that while imprisonment may actually increase the likelihood of recidivism for a general population of offenders, the criminogenic effect of imprisonment on drug offenders may be even more pronounced (Spohn & Holleran, 2002).

For the issue of illicit substance-using mothers, the argument seems to be that if women are sufficiently afraid of punishment, they will find a way to change. Such an argument ignores the multitude of socioecological factors influencing women's health behavior. It also assumes that women are not already concerned about the health of their fetuses and that they make no efforts to seek help. In contrast to these assumptions, many substance-using pregnant women report that their pregnancies served as catalysts for change, prompting them to decrease or cease their substance use (Copeland, 1998; Mallory & Stern, 2000; Murphy & Rosenbaum, 1999; Noble, Klein, Zahnd & Holtby, 2000; Pursley-Crotteau & Stern, 1996; Sterk, 1999). This evidence stands in stark contrast to the notion that these women do not care about their health or the health of their children. It does not appear that "rational actor" models offer a sufficient explanation or understanding of the issue of maternal substance use.

The weakness of rational choice and deterrence models as explanations of the behavior of substance-using women or to offer effective interventions suggests that we must find a new approach. This is necessary for both practical and moral reasons. Practically, deterrence models appear unlikely to achieve the purported goals of improving maternal, fetal and infant health outcomes. The threat of punishment is unevenly distributed by race and class and discourages women from seeking treatment that may improve health outcomes. Furthermore, the risk of punishment appears to be lowest for the use of alcohol and tobacco, when these substances have the strongest potential for fetal harm. A different theory of behavior motivation may better explain women's pathways in and out of substance use while pregnant or mothering and the various strategies they employ as they experience this transition. Sociopsychological theories of identity offer a promising avenue of inquiry seldom employed in criminology. Specifically, narrative identity theory offers an explanation for the construction of identity over the life course

and the power of identity to explain behavior. This theory would provide a more complex understanding of women's experiences told in their own words, situating their experiences of motherhood and substance use within the context of their lives.

# CHAPTER II

## Theoretical Framework

Narrative identity theory states that individual identities are constituted by the integration of life experiences into a "personal myth" or "life story," which provides the individual with a sense of coherence and purpose. This is a promising approach for the study of substance use during pregnancy and motherhood because it links women's experiences and the meanings they attach to these experiences to both their position in the social structure and to their behavioral motivations and intentions. By understanding how women experience pregnancy/motherhood and substance use, we may improve our understanding of their perspectives and health behavior and better inform our models of intervention and health promotion.

This chapter presents the theory of narrative identity as an alternative to the deterrence/rational choice approach to the topic of motherhood and substance use. This sociopsychological theory examines the way that individuals construct their identities through the telling of stories about their lives. In the face of "master narratives" that stigmatize or spoil certain identities, individuals craft stories that challenge these narratives and allow them to form coherent, agentic selves. The chapter begins with an overview of the theory, followed by an explanation of the development of the identity-constituting narrative over the life course. It then turns to the role of master narratives in casting certain identities as damaged or spoiled. Finally, it concludes with a discussion of resistance to master narratives through the telling of "counterstories" and how telling and hearing counterstories can help to repair damaged identities and restore moral agency.

**The Relevance of Story-Telling to Identity Development**

Studies have found that story-telling is ubiquitous (Bohanek, Marin, Fivush and Duke, 2006; Miller, 1994; Miller, Fung & Mintz, 1996; Miller, Wiley, Fung & Liang, 1997; Thorne, Korobov & Morgan, 2007; Wang & Fivush, 2005): humans tell stories. We tell them to entertain, educate, explain, and persuade. We tell them to our children to put them to sleep at night. We tell them to our friends and loved ones when we return home each day or see each other after long periods of time. Importantly, we tell stories to make sense of our lives and the lives of others, to imbue them with meaning and continuity. As McAdams (2006) explains, we cannot understand others and what their lives might mean without having some sense of their life stories, and we cannot understand ourselves and what our lives mean if we cannot see our lives as intelligible and coherent stories. In essence, "stories give us our identities" (McAdams, 2006: 76). It follows, then, that an individual's identity can only be known through the stories she tells and the stories told about her. Bruner (1990, 2002), Gergen and Gergen (1988), McAdams (1988, 1997, 2006), and Polkinghorne (1988) all contend that personal narratives, both their form and their content, *are* people's identities. The relationship between story and identity is reciprocal: identity is shaped by the life story being told while simultaneously infusing the life story with content and meaning (McAdams, Josselson & Lieblich, 2006). The identity is particularly important in the modern world, where the self has come to be seen as a reflexive project for working on, developing, improving and perfecting (McAdams, 1996, 1997, 2001). While people see the self as complex, layered, and dynamic, they also feel a strong urge for a coherent self that is unified and purposeful – they seek to lead "a life of purpose" or to "make life meaningful." This quest for self-coherence is situated within discordant cultural parameters wherein every positive model and example of how to live a meaningful life has some drawbacks and nothing close to

consensus about "meaningful life" exists. Thus, McAdams (2006: 313, n. 19) concludes that "[i]n modern life, constructing your own meaningful life story is a veritable cultural imperative."

**Human Capacity for Storytelling**

Psychologist Jerome Bruner (1986) distinguishes between two different forms of human knowing: paradigmatic knowing and narrative knowing. Paradigmatic knowing is the knowing of cause and effect through science and rational discourse. Paradigmatic knowing concerns the search for a logical and causal truth. In contrast, narrative knowing is what we learn from stories. Bruner argues that it is through stories that we explain human conduct. According to Bruner, stories are told when there is a "deviation from a culture's canonical pattern" (1990: 49-50). Something must happen to make the story worth telling – the character's intentions must be thwarted or some obstacle arise that must be overcome or resolved before the story's end. In this way, narratives are deeply embedded in a cultural canon of expectations. The structures of cultures, societies, polities and economies shape expectations of how individuals move through time and place and engage in interactions with others. Meaning is made of human behavior in the context of these structures, and deviations from structurally-informed expectations must be explained and resolved through story-telling.

Bruner cites, as support for his argument that humans are natural story-tellers, the phenomenon of episodic memory. Episodic memory is a component of human psychology that allows us to recall specific events (episodes) from our pasts. We can recall memories of important events and, in a sense, relive and reexperience them. This is in contrast to semantic memory, which is our ability to remember factual information (important dates, figures, numbers and locations). Not all that we experience is important enough to be coded as an episodic memory. We tend to create episodes of particularly emotional events. These episodes are the

"dots" connected by stories; our episodic memories allow us to connect past episodes to imagined futures and thus explain our own or others' actions over time. Episodic memory is necessary for story-telling, as McAdams (2006: 79-80) illustrates through the story of a young man who survives a motorcycle accident. In the accident, the young man suffers a brain injury, specifically an injury of his brain's medial temporal lobes and hippocampus. As a result of the injury, the young man in this story is unable to access his episodic memories – he cannot remember any important life events from the time of his birth until the present day. Unable to recall or create episodic memories, he is also unable to construct a narrative to explain his conduct or to predict his future. He is unable to explain what he plans to do later in the day or why. He can still, however, recall facts and figures from before his accident. He remembers where he was born, the names of the schools he attended, and other factual information stored in his semantic memory, but he cannot remember the events that happened at these locations. It is clear that his semantic memory is at least somewhat intact, but his episodic memory is not, and it is the loss of his episodic memory that prohibits him from connecting past events to imagined futures. This suggests that the human story-telling capacity is key for formulating behavioral intentions and making plans for the future, both important factors in understanding of how substance-using individuals employ strategies of harm reduction or make plans to quit.

**The Development of Narrative Identities**

**Early childhood.** The capacity for story-telling develops throughout childhood and adolescence. The developmental psychologists discussed below have identified several critical stages for identity development. It is important to understand this process in order to place women's life stories in context. Disruptions, traumatic experiences, or changes in the social

environment during childhood may have a lasting impact on the stories women tell as adults. Understanding this process helps to connect individual stories to theory.

McAdams (1997) traces the development of storytelling ability and narrative identity to its roots in early childhood. He begins by recognizing that most peoples' episodic memories begin around the time they were three or four years old. He connects this recognition to neuroscience research suggesting that humans do not have "extended consciousness" until around two years of age (Damasio, 2000). Extended consciousness allows children to take the role of narrator. At this age children start to develop reflexivity, the ability for the "I" to think about and act towards the "me." By the end of their second year, most children have started to personalize episodic memories and are developing an *autobiographical memory* (Howe and Courage, 1997) by organizing past events as "things that happened to me." From this point on, "the "me" expands to include autobiographical recollections, recalled as little stories about what has transpired in "my life"" (McAdams, 2006: 312, n. 14).

The development of reflexive thought is an important first step in the development of storytelling, but it is for another year or two that children start to understand human behavior as a result of motivation. Children first understand that people do things because *they want to*, and later understand that people do things because of *what they believe*. A large body of developmental psychology research demonstrates that during the preschool years, children develop a *theory of mind*: they come to understand that other people have desires and beliefs and that they act upon those desires and beliefs (e.g., Baron-Cohen, 1995; Sodian & Kristen, 2010; Bretherton & Beeghly, 1982). Parents typically encourage their children throughout this developmental period (Fivush & Kuebli, 1997), stimulating each child's memory and telling of the past by reminding the child of recent events ("Remember when we went shopping yesterday

and you rode in the cart?") and encouraging children to talk about their personal experiences ("What happened at school today?").

Life motives begin to form in the elementary school years. These motives provide energy and direction for behavior, and thus motives shape our identities by emphasizing particular themes in our life stories. McAdams (1997), drawing on the work of psychologist David Bakan (1966), suggests that there are two major motivational themes: agency and communion. Agentic themes concern power, autonomy, independence and status, while communal themes include strivings for love, intimacy, interdependence and acceptance (McAdams, 1997: 71). Individuals whose narratives feature strong agentic themes may emphasize the importance of individuality, mastery of a skill, knowledge set or the environment, and the quest for self-improvement. In contrast, individuals with strong communal motivations are more interested in feeling connected to others, fostering strong relationships and participating in something larger than themselves. These themes emerge in late childhood and begin to govern goals and behaviors. It is in the adolescent years that the narrative identity is truly created, though it is clearly built upon and structured by the images, themes and self-reflections experienced by the individual during childhood. The stories that children see, hear and love influence the kinds of images and themes they eventually incorporate into their own stories as adults.

**Adolescence.** The biological changes of puberty coincide with cognitive changes and adolescents become increasingly capable of abstract thought. The adolescent is now able to reason about *what is* versus *what might be* and to view reality as a subset of possible alternative realities. McAdams (1997) argues that these new abilities may prompt the adolescent to look back on her life and note inconsistencies, occasions when she acted in one way but could have acted in another. For example, an adolescent girl may be well-mannered and deferential at her

father's company picnic but be more rebellious when out with her friends. This inconsistency prompts her to wonder "Who am I?" – the well-mannered daughter or the independent rebel?

It is at this stage that individuals start to realize that they can be many things to many different people. The adolescent girl can play the role of the student, the daughter, the fun-loving friend, the anti-establishment rebel. Of course, with the realization that one has many selves comes the realization that the "real self" is unclear. Is the girl not her "real self" when she's at home with her family, or is she being "fake" when she is out partying with her friends? Of course, the answer is that all these "selves" are part of who she is, and the solution to her confusion is to find a way to incorporate these many selves into a coherent life narrative. The adolescent does this by "backgrounding" her many selves with an ideological setting. McAdams (1997: 84) states that this ideological background is necessary for the fashioning of narrative identities, because "each of us must also come to some implicit conclusions about the meaning of the world, so that our identities may be anchored by ideological truths." These truths are discovered through interactions with others; the ideological truths available to us are restricted by our positions in the social structure, at least initially. We consolidate the ideological settings for our narrative identities through interactions with those around us. Like motivation and behavior, fundamental beliefs and values also seem to be characterized by the tension between agency and communion. Ideologies concern what is true and what is good. Agentic ideologies emphasize autonomy and well-being of the individual and the importance of ethics that protect individual autonomy from encroachment by others. Communal ideologies, in contrast, emphasize group and interpersonal relationships more highly than individual rights and freedoms. In this sense, the "goodness" of a particular action can only be evaluated by considering its social ramifications; "What is good and what is true depend on who is involved

and what is at stake" (McAdams, 1997: 88). While it has been suggested that women are more likely to adopt communal ideologies and men to adopt agentic ideologies (Gilligan, 1982), to date, psychological research has not provided definitive support for such a gender division (Brabek, 1983; Ford & Lowery, 1986). It is clear, however, that the ideological settings established in adolescence remain relatively stable throughout the adult years (Krosnick & Alwin, 1989; Loevinger, Cohn, Bonneville, Redmore et al., 1985).

**Structural Restraints on Identity Construction**

The fledgling narratives of adolescents are often fantastical and self-aggrandizing, stories that affirm perceived uniqueness. Elkind (1981) describes the content of teenage diaries and letters as affirming the individual's perceived uniqueness ("Nobody understands me," "I am different," "Nobody has ever felt the way I do") and potential for greatness (fantasies about changing the world or achieving celebrity). These personal fables may be dismissed by adults as flights of fantasy or delusions of grandeur, but they are healthy and developmentally appropriate: these adolescents are simply flexing their imaginative muscles and considering the whole range of possibilities open to them. With time and experience, their expectations will be adjusted; these first attempts at narrative are just drafts that can be "rewritten, reworked, and made more realistic as the young person becomes more knowledgeable about the opportunities and limitations of defining the self in his or her particular society" (McAdams, 1997: 80). Sadly, or perhaps just realistically, young adults become aware that their identities are grounded in a social world that imposes restrictions and limitations on those within it. We must all come to the realization that "identities begin and must ultimately remain woven into a historical and social fabric" (McAdams, 1997: 80).

The individual's social, political and cultural environment structures the availability of resources for constructing identities. An individual's position in the social structure may determine the images and narrative fragments available to her as she creates her own narrative identity. As Foote and Frank (1999: 177) explain, "[t]he social availability of preferred stories, and the assimilation of experience to these narratives is how power works. The power of the dominant discourse is to include some stories as tellable and to exclude others as marginal and abnormal." Each individual adopts a narrative based on the archetypes "proposed, suggested and imposed on him by his culture, his society and his social group" (Foucault, 1988: 11). Thus, the types of narratives individuals concoct and the words they use to construct them reflect the dominant sociocultural and historical paradigms.

**Identity Construction through Interaction**

Of course, we are not the sole creators of our identities; despite what the motivational posters may tell us, we cannot be whoever we want to be. We live in a social world full of other storytellers casting us as characters in their own narratives; at best, "we are never more than coauthors of our life narratives" (MacIntyre, 1984: 213). If one's identity is constituted by the content of her life narrative, comprised of the features of her life and herself that she cares most about, then there is also an extent to which her identity is constituted by the content of others' narratives and the features of her life and herself that *they* care most about.

Identities require social recognition. The power of the life narrative is in the telling, and listeners can choose to affirm or contradict the stories we tell about ourselves. Our stories are limited by what Nelson (2001: 92) terms "the credibility constraint." First, the narrative must have *strong explanatory force*. The narrative must satisfactorily explain the individual's motivations and actions as part of her coherent self so that others may understand her past

experiences and perhaps predict how she may respond or act in the future – to "know" her. Credible identity-constituting narratives must also have some *correlation to action*. Not only must an individual's narrative correlate to her present behavior, it must satisfactorily explain her actions in the past and, to some extent, predict her future behavior by structuring the field of action. Finally, credible stories must have *heft*. In other words, the content of identity-constituting narratives must have considerable personal meaning – the images and experiences that we incorporate into our stories must be important to us, otherwise they would not warrant inclusion in the story.

Thus, identity is created through personal narration and through interaction with others, who must receive and confirm the stories we tell and who, in turn, tell stories about us. These stories may contain verbal instructions, guidelines or prescriptions for behavior. Some of these messages are forgotten or intentionally ignored, but others are retained and integrated into the individual's identity. The messages that are retained and integrated are known as "memorable messages" (Knapp, Stohl and Reardon, 1981). Memorable messages are thought to "transcend any one specific context" (Knapp et al., 1981: 32) to influence the message recipient's general life actions. Previous studies have found that memorable messages may guide people in sense-making processes by influencing the self-assessment of behavior (Smith & Ellis, 2001; Smith, Ellis, & Yoo, 2001; Ellis & Smith, 2004), as memorable messages are recalled when individuals self-assess their behavior as in violation of their perceived "selves" or identities. These messages function to maintain or enhance personal standards of behavior.

Messages that substance-using women receive throughout their lives about how others perceive them, cultural meanings of motherhood, their strengths and deficits as mothers, and how to care for themselves and their children may influence the course of their lives in ways that can

be detected through their narratives. Messages may be positive or negative and be linked to different outcomes. For example, women who receive many positive messages about their efficacy as mothers may experience increased self-efficacy that helps them overcome barriers to substance use treatment and desistance. Women who receive negative messages may internalize these negative perceptions and feel incapable of pursuing harm reduction strategies, or they may rebel against these negative messages and be determined to prove that the message is wrong. The concept of memorable messages and their incorporation into identities has important implications for health risk communication between health providers and substance-using women.

**Master Narratives and Spoiled Identities**

In the introductory chapter, moral panic about “crack babies” was identified as a precursor to current deterrence-focused policies about substance use during pregnancy. The stories told about “crack babies” and “crack whores” are perfect illustrations of “master narratives.” The concept of the master narrative was introduced by Boje (1991) to explain how members of organizations constructed organizational narratives to legitimate particular values and actions (and to delegitimize others). The "master" label indicates that these are the narratives propounded by those with some amount of cultural authority, and these narratives are not just seen as guidelines but are often enforced. Certain values and actions are legitimated through "master narratives," dominant cultural standards against which community members feel compelled to position their personal experience (Thorne & McLean, 2003).

Master narratives can come to be so widely accepted that other possible narratives are rarely considered. It is neither possible nor desirable to fully escape these cultural clichés – after all, these are the understandings we share in common, the cultural shorthand through which we

understand each other and convey shared meanings. It is important to recognize, however, that these narrative fragments exercise great power over our imaginations and that it takes a conscious effort to become aware of and to criticize such "culturally entrenched figurations," which are otherwise "passed on without obliging anyone to formulate, accept, or reject repugnant negative propositions about any group's standing or self-congratulatory positive propositions about one's own" (Meyers, 1994: 53). The content of master narratives is presented to us in such a way that makes no evaluative demands on us – it just is what it is. It is only when we consciously challenge the narrative that we realize there are alternative narratives to be told.

When used by a dominant group to justify the oppression of a less powerful group, these narratives distort and falsify the group's identity and the identities of its members. They are depicted as morally subnormal. In this way, master narratives assist in "cultivating and maintaining norms for the behavior of the people who belong to these groups, and weighting the ways others will or won't tend to see them" (Nelson, 2001: 106). For individuals subjected to multiple oppressions, master narratives are especially damaging:

> "If you are poor, African American, and pregnant, for example, you are likely to be buffeted by the pressive forces running through racism and sexism; dismissive forces surrounding your poverty, race, and impending motherhood; preservative forces that keep ideologies of class, race, and gender in place; and possibly expulsive forces if you fail to comply with the norms of behavior to which pregnant women are held. You'll be confronted not only by the large signs in bars admonishing all pregnant or potentially pregnant women to refrain from alcohol, but also by medical professionals and professional social workers, who are ten times more likely to report you for a positive drug screen than they would a pregnant white woman who also tests positive (Nelson and Marshall 1998, 130). To one degree or another, the forces that run through this particular nexus of multiple oppressions bring it about that you are exploited, marginalized, powerless, and a victim of cultural imperialisms." (Nelson, 2001:117)

A large body of literature on recovery from substance abuse draws on the symbolic interaction tradition and argues that the social and cultural associations between drug use and addiction, criminality, disease and lack of self-control result in the drug user's identity becoming "spoiled" or stigmatized, a condition that those in recovery work to restore (Vandermause,

Severtsen & Roll, 2012; Martin, 2011; Radcliffe & Stevens, 2008; McIntosh & McKeganey, 2001, 2000a, 2000b; Anderson, 1993). Many of these sociological studies argue that recovery depends on the "addict" building a new non-addict identity, often in the face of "powerful countervailing forces" in her social world (McIntosh & McKeganey, 2000b: 181). Many pregnant women seeking drug treatment see this transitional period of pregnancy as an opportunity to turn their lives around (Tobin, 2005; Taylor, 1993). A fear of the impact of their substance use on their children is a major motivator for women to reduce or desist from substance use (Daley, Argeriou & McCarthy, 1998; Copeland, 1998; Martin, 2011; Powis, Gossop, Bury, Payne & Griffiths, 2000; Tobin, 2005). This is because harming their children or being "selfish" is inconsistent with ideals of motherhood that condone selflessness and protectiveness.

However, becoming a mother can also complicate women's attempts to repair spoiled identities. Pregnant women and mothers are heavily stigmatized for their substance use (Radcliffe, 2009; Boyd, 1999; Murphy & Rosenbaum, 1999; Taylor, 1993; Rosenbaum, 1981; Springer, 2010; Banwell & Bammer, 2006). In their review of the literature, Banwell and Bammer (2006) note the epidemiological construction of a deviant risk group that stigmatizes mothers seeking treatment for substance use. They argue that the construction of risk categories pits the health and welfare of young children against the behaviors (and failures) of their mothers, who are considered only to the extent that they transmit harms to their children (2006: 505). This concern for the welfare of children by health and social service professionals can inadvertently harm children when mothers' needs are ignored because of the stigmatized identity of the "bad mother." This representation of the substance-using mother can serve as a master

narrative with which women self-identify, especially if they face extreme discrimination when seeking treatment.

**Resisting Master Narratives: The construction of counterstories**

To combat oppression and reclaim moral agency, individuals with damaged or spoiled identities may create a "counterstory", "a story that resists an oppressive identity and attempts to replace it with one that commands respect" (Nelson, 2001: 6). Counterstories aim to alter not only social perceptions of the oppressed group, but the oppressed individual's perception of herself. If the retelling is successful, members of the group can reclaim their moral agency and combat the disrespectful treatment they have received due to the master narrative. Narrative repair is achieved through resistance. Counterstories can be constructed by groups or by individuals, but individuals alone cannot legitimate a counterstory. Legitimation requires the recognition of a community willing to listen. Nelson (2001: 175) labels such communities "morally abnormal," a phrase that is confusing at first but simply indicates that this community does not ascribe strictly to the morality espoused by the master narrative. These communities produce advances in moral knowledge that survive the social mechanisms for disseminating and enforcing master narratives, opening a gap between what "everyone knows" about people with spoiled identities and creating room for an alternate perspective. For example, sympathetic treatment communities that emphasize substance-using women's strengths rather than their deficits could be such a community. Rather than buying into the master narrative that stigmatizes the addict identity, these communities recognize and restore the moral authority of those with the addict identity.

Frye (1983: 66) distinguishes between the "arrogant eye" and the "loving eye." Master narratives, created as they are by those with social authority and privilege, view oppressed

groups with an arrogant eye, which assumes that members of oppressed groups cannot possibly have agency or authority and must be deviant. In contrast, "morally abnormal" communities see these identities through a "loving eye," a gaze that "knows the independence of the other… It is the eye of one who knows that to know the seen, one must consult something other than one's own will and interests and fears and imagination" (Frye, 1983: 75). Of course, counterstories are still subject to the credibility criteria mentioned earlier and there are many counterstories that lack credibility. The power of a good counterstory is that it pulls apart the master narrative and replaces it with a *more* credible, less morally degrading narrative. By allowing substance-using mothers to construct and tell their counterstories, we can empower women and improve our understanding of the challenges faced by this population.

**Studies of Identity Change and Desistance from Crime**

The best-known application of the identity theory approach in criminology is likely Shadd Maruna's *Making Good* (2001). Maruna employs narratology (consistent with the biographical-historical perspective on identity) to explore the process of identity reconstruction through which repeat offenders reform and go on to lead social and productive lives. Maruna found that the offenders who successfully desisted from criminal activity had powerful personal narratives that helped them make sense of their pasts and feel in control of their futures. Maruna's work is reminiscent of Singer's (1997) *Message in a Bottle*, a study of men and substance addiction that finds that the first step to the men's recovery from addiction was the creation of a personal narrative that could successfully explain their past substance use and connect them to the rest of the world. Individuals in recovery relied on an "antithetical" narrative framework to explain how a bad past could lead to a good present. Individuals still suffering from chronic addiction were more likely to employ "compensatory" (good past leading to a bad

present; drug use as compensation for uncontrollable negative experiences) or "self-absolutory" (bad past leading to a bad present; drug use as "paying the price" for past failings) narratives (Singer, 1997: 108).

The work of Peggy Giordano and colleagues (2002; 2007) emphasizes the influence of social processes like social interactions, social experiences and socially-derived emotions in driving the motivation to change through self-improvement. Giordano and colleagues refer to catalysts for cognitive change as "hooks for change" to highlight the actor's role in "latching onto opportunities presented by the broader environment" (2002: 1000) and also to describe the components of narratives that seem essential to the communicator – the "hooks" that the communicator emphasizes when telling her story as moments or objects of significance.

More recently, criminologists Paternoster and Bushway (2008) ventured an identity theory of criminal desistance that examines one's current or "working" identity and one's "possible self." These conceptualizations certainly seem consistent with the "perceptions" and "identity standard" components of contemporary psychological identity theories (e.g. Burke and Stets 2009) or the "ideal self" of McCall and Simmons' (1978) prominence hierarchy. Paternoster and Bushway (2008) argue that motivation for change (in this case, for desistance from criminal offending) can be driven by fear of an unsatisfactory "future self." If a present-day offender looks forward and sees a "future self" who continues to offend and ends up in prison, the fear of this future self may motivate him to desist from crime if his ideal future self is a man with a stable job and a family. This approach is consistent with work from the field of addiction recovery. Denzin (1987) argued that an individual is more likely to desist from alcohol abuse when "she comes to define herself in terms of who she no longer wants to be" (Paternoster and Bushway's "feared self"). Biernacki observed a similar phenomenon among opiate addicts who

come to “see the continued use of opiates, and their involvement with other addicts and the world of addiction, only as undesirable” (1986: 72). In these examples, the addicts were motivated to change by concerns about the identities (alcoholic, opiate addict) they did *not* want to claim for themselves. It may be that these identities are in conflict with other pro-social identities the individuals wanted to claim, like “good mother” or “valuable employee.” The advances made by Maruna (2001), Giordano and colleagues (2002; 2007) and Paternoster and Bushway (2008) suggest that identity theories are highly relevant for the study of desistance.

Narrative identity theory offers a promising framework for examining the problem of substance use during pregnancy and motherhood. By examining women’s stories holistically, embedded in the context of their lives within a social structure, we have the opportunity to better understand their health behavior in a way that recognizes both their agency and their constraints. This more multifaceted and complex vision of the issue of maternal substance use offers better opportunities than deterrence/rational choice theories for crafting more effective health-promoting interventions and reducing negative consequences of substance use for maternal, fetal and infant health.

# CHAPTER III

## Method and Data

### Current Research

**Aim**. The purpose of this qualitative study is to better understand how women make sense of their experiences throughout the process of transitioning to motherhood while being actively involved in or desisting from substance misuse. The study will explore how women connect their present circumstances to their pasts and make plans for the future and how their interactions with others shape their personal narratives through messages about health risks and good motherhood.

**Research questions.** This study is designed to explore and answer three research questions. The first is, how do substance-using mothers manage their identities as mothers and substance users? The second research question is how do mothers who are desisting from substance use narrate coherent identities that explain their past substance-using identities and present non-using identities? Finally, the third question is how do fear and stigma create barriers to care and result in unmet needs for this population?

### Research Design

This study follows the traditions of narrative inquiry by employing a qualitative method. The qualitative research design allows for the capture of rich and intricate detail in participants' narratives. For the purposes of narrative inquiry, the research interview is viewed as a conversation in which both the interviewer and the research subject are participants who jointly construct narrative and meaning (Riessman, 2008). Techniques of narrative inquiry depart from traditional structured interview formats and emphasize reciprocity in the conversation. A loosely-structured interview schedule of open-ended questions helped to guide the conversation through the topics of identity, health behaviors and barriers to care. Participants were encouraged to tell

their stories using their own words and narrative styles. All interviews were audio-recorded on an electronic recorder and written notes were recorded on interview booklets for each participant. Written notes reflected the immediate thoughts of the interviewer and served as a back-up in case sections of the audio recording were unclear.

**Sampling strategy and recruitment.** The target population for this study was women who were pregnant or recently pregnant (within the last twelve months) and who had used alcohol, tobacco, illicit drugs, or misused prescription or over-the-counter medications at any time during their most recent pregnancies. The targeted sample size was 30 women.

The participants were selected through purposive sampling with the goal of sampling a wide range of women with different sociodemographic characteristics and substance use histories (Kerlinger & Lee, 2000; Patton, 2002). As interviews were completed, sections of the interviews were transcribed and analyzed for key themes, and additional participants were recruited with the purpose of further exploring these themes. This constant comparative method of jointly collecting, coding and analyzing data and sampling for the purpose of developing emerging themes is consistent with the ground theory method (Glaser and Strauss, 1967). The sampling strategy is consistent with theoretical sampling, as developed within the grounded theory method (Glaser, 1978; Strauss, 1987). As a result, the sample is not representative of any general population, but is selected for the purpose of generating "theoretical jumping off points" (Thompson, 1999).

Entry into the target population was first gained with the assistance of public health nurses employed by the county health department. The health department runs a home visitation program for at-risk mothers to help connect eligible families with needed social services, provide them with health education, and to support health childhood growth and development. Public

health nurses agreed to disseminate recruitment materials (flyers [Appendix A] and business cards) to women on their caseloads. No identifying information was shared with the investigator. Women were free to contact the investigator to hear more about the study and, if eligible and consenting, schedule an interview. The public health nurses also distributed flyers and business cards to other clinics within the health department. Of the final sample of 30 women, five were recruited from the public health nurses' caseload, and a further six were recruited through flyers posted by the public health nurses around the health department offices.

In addition to recruitment through the health department, efforts were made to recruit from public areas. Recruitment flyers were posted in the maternity wards of local hospitals and at drug treatment centers, community centers and service enrollment offices. Advertising in treatment centers has proved to be an effective way to recruit research participants for health research (Frosch, Shoptaw, Huber, Rawson & Ling, 1996; Metzger et al., 1993; Paul, Stall, & Davis, 1993; Perlis, des Jarlais, Friedman, Arasteh & Turner, 2004). Participants have successfully been recruited from substance use outpatient programs (Metzger et al., 1993; Perlis et al., 2004) and in-patient programs (Paul et al., 1993; Perlis et al., 2004). Flyers posted at local transportation hubs (e.g., the central bus station) were especially productive. Examples of other recruitment locations included bathrooms at the local library, pregnancy support clinics, obstetricians' and pediatricians' offices, and substance abuse support group meeting locations. Nine women were recruited through flyers and business cards posted in public locations.

Women who completed interviews were also invited to refer others to the study. In fact, invitation was not usually necessary; women volunteered to pass along recruitment materials to other women they knew might like to participate. A further ten women were recruited through

referrals by study participants. No one participant was responsible for more than two referred participants.

**Interview guide and procedure.** The interview schedule (Appendix B) was composed of three sections. The first section collected basic demographic data and assessed lifetime and recent substance use. Substance use was assessed through a modified section of the World Health Organization's Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). The ASSIST was designed by substance abuse researchers to detect problem or risky substance use. It was designed to be used in primary health care settings across a range of countries and cultures. The WHO conducted a test-retest reliability study in nine countries between 1997 and 1999 and found that ASSIST items were reliable. A validity study was conducted in seven countries in 2000 using a population that included known substance users. The results of this study indicated that the ASSIST had good "concurrent, construct, predictive and discriminative validity" (Humeniuk & Ali, 2006). The ASSIST instrument was modified for the purpose of this study to inquire about lifetime substance use, substance use in the three months prior to discovery of the most recent pregnancy, and substance use after discovery of the pregnancy. Participants were also asked about their current substance use.

The second section of the interview schedule is the Life Story Interview, developed by Dan McAdams and colleagues at the Foley Center for the Study of Lives. It was most recently revised in 2008. This instrument focuses the respondent's story-telling on "chapters" of interest while still satisfying Mishler's (1986) prohibition against fragmenting and interrupting story sections. Respondents may tell stories for each chapter in full without interruption. The use of this instrument assists in the focused and efficient collection of data while still empowering respondents to tell their stories in their own words. The first section of the instrument asks

respondents to tell their “life stories” in full. The second section then draws the respondents back to key “episodes” in the story to elicit more detailed information about high points, low points, turning points, positive and negative memories, dreams and goals for the future, and recognized life “themes.” Out of concern about the length of interviews and participant fatigue, the instrument was modified by removing questions about political and religious ideology. This allowed for the inclusion of the third section of the interview schedule.

The third and final section of the interview guide contained supplementary questions regarding the major themes of this study. This section included questions about women’s mothering experiences, their mother role models and ideas about “good” and “bad” mothers, their experiences with law enforcement and Child Protective Services (CPS) authorities, and their history of treatment-seeking and health behaviors. In this section, women were invited to share their experiences interacting with legal, medical and social work professionals and to identify their unmet needs.

Interviews were completed in a single session in a place where women felt comfortable. These locations included restaurants at non-peak hours, cafes, private rooms at a local library, and in a private area overlooking a neighborhood playground. Women were asked to choose an interview location where they could have a discussion with the interviewer and that would be convenient for them. In some cases, the interviewer provided transportation to and from the interview location. At the end of the interview, women received a $50 VISA giftcard.

**Analysis**

Audio-recordings of each interview were downloaded and transcribed soon after each session. The transcriptions were then imported into NVivo (QSR International, 2013) qualitative analysis software. The transcriptions were first auto-coded according to the interview schedule

topics for organization purposes, and then coded line-by-line by hand. This required multiple close readings of every interview. Existing coding schemes published by the Foley Center for the Study of Lives were used to code for themes of redemption and contamination, agency, communion and generativity. The data were also coded for themes relating to the meaning of motherhood and parenting, pathways into and out of substance use, experience of stigmatization and attempts at narrative repair of spoiled identities, substance use and risk, unmet needs and barriers to care, and memorable messages received regarding motherhood.

Categories were developed through a process of open coding. In open coding, the researcher examines the text and develops categories of information supported by the text (Creswell, 2007). As these categories are identified, the research attempts to "saturate" the categories by locating in the text all instances of the category and conducting further interviews until new information obtained provides no further insight. Open coding reduces the database to a set of themes that address the research question being explored by the study (Creswell, 2007). Once these themes have been identified through the process of open coding, they are each examined in turn and the process is repeated, returning to the database or conducting further interviews to understand the sub-themes that relate to this major theme. For example, a major theme identified in this study was women's strategies for avoiding detection of their substance use when they sought prenatal care, and each different strategy became a sub-theme. This process was repeated for all major themes and sub-themes relevant to the purpose of this study.

**Validity and Reliability**

**Validity.** There are some researchers who argue that traditional concerns about reliability and validity are not appropriate for evaluating qualitative research with a hermeneutic emphasis (Becker, 1996). This is especially true for research designed to generate detailed descriptions of

individuals' experiences and the meanings they hold for these experiences. However, even when the focus is description rather than measurement, the researcher must still establish that the accounts produced through narrative inquiry are accurate or valid representations of the interviewee's interpretation of her experiences. This is a key point: the narratives should not be accepted as valid or accurate accounts of objective history, but as accounts of how the interviewee *makes sense of* objective history. A narrative does not capture a simple record of the past, but reflects an individual's interpretations of her experiences.

For most researchers, there is a necessary trade-off between breadth and depth: should the researcher focus on in-depth interviews to produce detailed and contextualized descriptions, or should she prioritize breadth in the form of large samples in order to produce more generalizable findings? Elliott (2005) suggests a 'common-sense' approach to generalizability by which the reader is left to decide how far the evidence from a specific study may be transferred to other settings. By describing the sampling method and the resultant sample, the researcher provides the reader with the information necessary to assess the generalizability of the results.

At any rate, the generalizability of the findings of narrative inquiries concerns not the subjective meanings of individuals, but the intersubjective meanings shared between individuals – in other words, a generality of findings across many individuals within the sample. Intersubjective meanings are "constitutive of the social matrix in which individuals find themselves and act" (Taylor, 1987: 58). If individuals' life narratives are considered as interpretations of objective history according to dominant cultural themes and master narratives, then life narratives reveal "the relation between this instantiation (this particular life story) and the social world the narrator shares with others; the ways in which culture marks shapes and/or constrains this narrative; and the ways in which this narrator makes use of cultural resources and

struggles with cultural constraints" (Chase, 1995: 20). Thus, the external validity of evidence of intersubjective meanings depends on a demonstration of how widely these meanings are shared.

A common method of increasing validity in qualitative work is the triangulation of multiple data sources. Due to the highly sensitive topic of this study and the pressing need to protect women's confidentiality, triangulation with official records or other individuals was not possible. However, it has been argued that theoretical sampling is an example of triangulation (Denzin, 1989). Through theoretical sampling, the investigator searches for many different data sources (for the purposes of this study, participant interviews) that can speak to the events under analysis. This was accomplished in the current research through a constant comparative method and purposive sampling of participants to develop or contradict emergent themes.

In cases where women described experiences or thoughts that contradicted the themes present in other cases, negative (or discrepant or deviant) case analysis was conducted. This analysis approach increases rigor by examining and discussing pieces of data that differ from expectations or working theories.

**Reliability.** Interrater reliability was assessed according to the method described in Maruna's *Making Good* (2001). The data were unitized first according to the interview schedule (the primary phase of coding) and then assigned to particular subnodes during analytic coding. A random sample of these units was taken from subnodes relevant to the research questions. The subnodes sampled were desistance/persistence behavior categorizations, redemption and contamination sequences, and memorable messages. Codebooks for these themes were developed to inform independent coders how to assign units to their subcategories. These codebooks and the reliability samples were given to two independent coders (fellow graduate

students at Michigan State University with qualitative analysis experience), who were asked to code each section according to the categories identified in the codebook.

Conger's kappa (1980) was calculated to measure the agreement between all three coders. Conger's kappa is a form of Cohen's kappa modified to accommodate more than two coders (Dates, 2008). Calculation of these measures is considered preferable to simple measures of percentage agreement because they correct for agreement by chance alone. Kappa values range from -1 to 1, where values above zero reflect agreement greater than what would be expected by chance. There is no set threshold for "acceptable" kappa values, but a commonly cited rubric suggests that values under 0.40 indicate poor agreement, 0.41-0.60 indicate moderate agreement, 0.61-0.80 indicate substantial agreement, and 0.81-1.00 indicate almost perfect agreement (Landis and Koch, 1977).

**Table 1. Interrater Reliability Metrics with 5,000 Bootstrap Replicates**

| Thematic Area | Conger's Kappa Observed / Bootstrapped | Bias | SE | 95% Confidence Interval |
|---|---|---|---|---|
| Redemption Themes | .869 / .857 | -.011 | .093 | .667 – 1.00 |
| Memorable Messages | .839 / .823 | -.016 | .119 | .522 – 1.00 |
| Desistance Behaviors | .753 / .739 | -.014 | .107 | .529 – .937 |

Reliability analyses were performed in the R statistical computing environment (R Core Team, 2013). Results from the reliability analyses are presented in Table 1. All reliability sample areas generated kappa values in the "substantial" range. Due to the small number of passages used to generate point estimates, bootstrap resampling with 5,000 replicates was used to generate 95% confidence intervals and to check the sensitivity of the results. The small reliability sample results in some variation in the results across bootstrapped samples, so the bootstrapped estimates are lower than the observed point estimates. The lower bound of the confidence interval suggests that the estimates fall within the moderate to substantial levels of agreement.

# CHAPTER IV

## Patterns of Desistance and Persistence

### Description of the Sample

A comprehensive list of all women in the sample and their pseudonyms may be found in Appendix C. The sample consists of 30 women between the ages of 19 and 41 (Table 2). The mean age is 28.5 years old. Slightly more than half the women in the sample self-identified their race or ethnicity as White (n = 16, 53.3%). Eight women in the sample self-identified as Black or African-American (n = 8, 26.7%), one woman identified as Hispanic (3.3%) and one woman as Native American (3.3%). Four women in the sample self-identified as "other" (13.3%). Two of these women were of mixed race, one woman was adopted and did not know the races of her parents, and the fourth preferred not to answer. The sampling strategy was not designed to collect a representative sample, but it is worth noting that the racial composition of the sample loosely reflects the composition of the city of Lansing, which, according to the 2010 census, is 61.2% White, 23.7% African American, 6.2% "two or more races" and 0.8% Native American.

Participants in the study represent a spectrum of educational achievement. Seven women (23.3%) had dropped out of high school and had not attained a GED. Six (20.0%) had dropped out of high school before graduating but had later gone on to earn a GED. Eight (26.7%) women had successfully completed high school, five (16.7%) had completed at least some college coursework, and four (13.3%) had attained a college degree of some kind (ranging from two-year Associate degrees to a Master of Education). More than half of the participants (n = 18, 60.0%) were unemployed at the time of the interview. Two women (6.7%) were receiving disability benefits. The remaining participants were employed either part-time (n = 4, 13.3%) or full-time

(n = 6, 20.0%). Common areas of current or past employment included nursing and health care, food service, childcare, customer service and administrative work.

The criteria for participation in the study included being currently pregnant or having recently (within the past 12 months) given birth. The current pregnancy or recent birth did not have to be the participant's first child. The number of born children per participant ranged from one to eight ($\bar{x}$ = 2.8).

More than half of the women in the study were on Medicaid (n = 17, 56.7%). Five women (16.7%) had private insurance. This insurance was provided either through their employers, or because they were young enough to still be eligible for coverage through their parents' plan. Four (13.3%) women relied on a county health plan that provides some prescription coverage and affordable office visits but does not cover emergency room visits, surgeries or other types of expensive care (Rovin, Stone, Gordon, Boffi & Hunt, 2012). It is important to note that this is a "health plan" and *not* "insurance." Finally, four (13.3%) women reported having no health insurance at all at the time of the interview.

The sample was purposively selected to include women with experience using a broad array of substances. The two time periods of interest for this study are the three months prior to discovery of the most recent pregnancy, which for most women included some time before they became pregnant and some time when they were pregnant but did not know yet, and the time period between discovering the pregnancy and giving birth. In the three months prior to discovery of the most recent pregnancy, the most common substance used was tobacco (n = 26,

86.7%). Alcohol (n = 18, 60.0%), marijuana (n = 17, 56.7%) and prescription[1] medications (n = 16, 53.3%) were also very commonly used.

| **Table 2: Description of sample (n=30)** | | |
|---|---|---|
| **Item** | **Mean or Percent (n)** | **Min – Max** |
| Age | 28.5 | 19 – 41 |
| Number of children | 2.8 | 1 - 8 |
| Race/Ethnicity | | |
| White | 50.0% (15) | |
| African American | 26.7% (8) | |
| Hispanic | 6.6% (2) | |
| Native American | 3.3% (1) | |
| Mixed/Other | 13.3% (4) | |
| Health Insurance | | |
| None | 13.3% (4) | |
| Health Plan | 13.3% (4) | |
| Medicaid | 56.7% (17) | |
| Private Insurance | 16.7% (5) | |
| Education | | |
| Less than high school | 23.3% (7) | |
| GED | 20.0% (6) | |
| High school graduate | 26.7% (8) | |
| Some college | 16.7% (5) | |
| College + | 13.3% (4) | |

Of the 16 women who reported misusing prescription medications in this time period, 12 (75% of prescription medication users) reported using opioid analgesics like Vicodin, Percocet, Dilaudid, Fentanyl and Lortab. Six[2] women (37.5% of prescription medication users) reported misuse of prescription benzodiazepines. The most common benzodiazepines used by participants were Valium and Xanax. Women usually referred to the drug by its brand name or with the catch-all "benzos."

[1] For the purposes of this study, "prescription medication use" refers only to misuse of prescription medications, i.e. use of the medication in any way other than as prescribed by a medical professional or use of medications not prescribed to the participant.

[2] The sum of the number of participants using different types of prescription medications exceeds the total number of participants misusing prescription medications due to polysubstance use. Women misusing prescription medications may be misusing numerous types of medicines.

Less common were other substances including cocaine, methamphetamine, heroin and hallucinogens. These substances were far more likely to appear in women's lifetime histories of substance use than to be mentioned in the three months prior to the most recent pregnancy. For example, 14 (46.7%) women reported lifetime use of hallucinogens, but only two (6.7%) women reported using hallucinogens three months prior to discovering their recent pregnancies.

**Patterns of Substance Use Desistance**

This being a study of identity and desistance, the first task is to assess the desistance behavior of women in the sample. "Desistance" has been traditionally defined as the behavioral change from active involvement in offending to zero or near-zero involvement in crime (Bushway, Thornberry and Krohn, 2003: 149). In accordance with this definition, desistance has been conceptualized as a *discrete event* or a *state* of non-offending and has been examined through the use of static measures. Bushway and colleagues (2003) identify three weaknesses of this approach. The first is that the selection of the "cut off point," the point after which any offending makes the offender a "persister," is often arbitrarily selected not for theoretically relevant reasons but by the availability of data. The second weakness is that this approach does not recognize the heterogeneity of offenders and treats the desistance behavior of offenders with criminal careers of varying length, seriousness and frequency as equal. Furthermore, because low-frequency offenders may have long periods between offenses, any post-"cut off" observation period will likely observe more high-frequency offenders than low-frequency offenders, resulting in the "desister" group simply consisting of low-level offenders who offend at widely-spaced intervals. Finally, there is no way to determine whether desistance is permanent. This is recognized as one of the key problems in the study of desistance (Elliott, Huizinga & Menard, 1989). The conceptualization of desistance as a state of zero involvement in crime means that

any future involvement erases the previous achievement of a long period of non-offending. The conceptualization of desistance as a discrete event or state obscures important theoretical and practical concerns about why and how offenders desist from crime.

Instead of treating desistance as a discrete event or a state of being, scholars (Bushway, Thornberry and Krohn, 2003; Fagan, 1989; Laub and Sampson, 2001) have argued for a reconceptualization of desistance as a *process*. Rather than "a state of non-offending," desistance should be examined as a transition from offending to non-offending. This dynamic approach is inherently descriptive (Bushway, Thornberry and Krohn, 2003) and allows for a more in-depth examination of the process of behavioral change. This conceptualization of desistance is also better suited to studies of substance use and addiction, where desistance from substance use has long been recognized as a process that may begin with a "turning point" event (Prins, 1994; Simpson, Joe, Lehman & Sells, 1986; McIntosh and McKeganey, 2000) but often includes a cycle through periods of relapse and recovery (Anglin, Hser & Grella. 1997; Anglin, Hser, Grella, Longshore et al., 2001; Hser, Anglin, Grella, Longshore & Prendergast, 1997; White, 1996).

When examining the desistance behavior of women in the current study, it quickly became apparent that women could not be neatly divided into "desisters" and "persisters." Maruna encountered the same difficulty when he set out to study persisters and desisters in his Liverpool Desistance Study. He reflects on his initial study design as "more than a little naïve" and concludes that "most of the persisters one finds do not seem to really persist, most desisters do not seem to really desist" (2001: 3). He argues that such classifications have been made purely for the convenience of statistical analyses and conceal meaningful variation in patterns of desistance. This is the finding of the present analysis. Though some women promptly desisted

from (most) substance use and others clearly persisted at the same frequency and amount of substance use throughout their pregnancies, most women fell somewhere in between these two extremes.

When the participants' substance use in the three months prior to pregnancy discovery is compared to their use post-discovery, four behavior patterns emerge. These patterns are *prompt desistance* (cessation of use within one month of discovery), *delayed desistance* (continuing to use for a month or more after discovery, but desisting before delivery), *partial/incomplete desistance* (persisting use of the substance but in smaller amounts or are less frequent intervals), and *persistence* (no change in amount or frequency of use). In contrast to Maruna's (2001: 5) approach of selecting individuals at "two extremes of a long process of change," this analysis compares four groups between which the differences are more nuanced.

A complicating factor in assessing women's desistance behaviors was their use of nicotine. 26 women (86.7%) of women in the sample smoked tobacco in the three months prior to discovering their pregnancies. After discovering their pregnancies, only three women (11.5%) desisted, two promptly and one after a few months. This makes tobacco the most commonly-used substance both before and during pregnancy for the women in this sample. Responses to the question about substance use after discovery of pregnancy revealed that 23 women persisted smoking tobacco throughout their pregnancies, in the same frequency and amount (n = 12, 46.2%) or "cutting back" to some degree (n = 11, 42.3%). Two women in the study were included because they were primary tobacco users and did not use alcohol or other drugs. All other women in this study who used tobacco were also using alcohol or other drugs.

Cigarette smoking was widely acknowledged by women in this study as addictive and harmful, but continuation of cigarette smoking was not perceived by the women as ongoing

involvement in substance use *unless* tobacco was the primary substance of use for that woman. The focus of this study is not objectively defining a non-substance-using group, but instead exploring women's experiences of the desistance process. In consequence, women identified as "prompt desisters" for the purposes of this study may have continued with tobacco use but desisted from their primary substances of use. Smoking cessation as a requirement of inclusion in a desistance category obscured women's meaningful desistance from other substances. Thus, for the purposes of this study, only primary tobacco use was considered when deciding to which desistance category women belonged. For example, a woman who was a primary tobacco smoker who discovered her pregnancy after three months and desisted from tobacco use in the sixth month of her pregnancy would be categorized as a "delayed desister." A woman who was using heroin, alcohol and tobacco before discovering her pregnancy and immediately desisted from everything *but* tobacco use would be considered a "prompt desister."

The differences between women in each desistance category were not immediately apparent. Desistance behavior did not appear to be related to demographic variables like race or ethnicity, age, education or marital status. It was also unrelated to women's substance of choice or histories of trauma and abuse. However, women in the same desistance/persistence group revealed some common within-group themes, which provided evidence of the validity of the approach to categorizing the women. These themes will be discussed within and across desistance/persistence categories.

**Prompt desistance.** Eight women (26.7%) promptly desisted from substance use. Women who promptly desisted from substance use upon discovery of their pregnancies did not have in common the use of any one substance. The category included women using cocaine, prescription opioids and heroin, alcohol, marijuana, methamphetamine and benzodiazepines.

There was broad variation in the timing of pregnancy discovery, with some women discovering their pregnancies at only five weeks and others not discovering until their third trimesters. Thus, though the behavior pattern here is "prompt desistance," defined as desistance within a month of discovering the pregnancy, this category does include women whose fetuses were exposed to substances for much of their development. Women in this category shared themes of immediate and successful help-seeking, experience with loss of custody of older children, and a commitment to motherhood ideals of responsibility, selflessness, and protectiveness.

***Agentic selves.*** Women who promptly desisted from substance use upon discovery of their pregnancies emphasized their own agency in choosing to quit and seeking treatment. Their descriptions of this time period were dotted with statements about "I," "me" and "myself." Women who desisted expressed a sense of mastery over their substance use, even while revealing that they had been through this cycle of desistance many before.

Natalie, Shannon and Loretta all sought treatment soon after the discovery of their recent pregnancies. At the times of their interviews, these women were still desisting from substance use (other than Loretta's tobacco use). Pregnancy was a significant motivating factor for these women to seek treatment and desist from substance use:

> **Shannon**: I found out I was pregnant at the end of April, beginning of May, and that kinda kicked my ass into gear to get help, because I wanted to get help but kinda didn't know – it just kinda made me want it more. Because I've been wanting another baby and pregnancy itself is stressful and I didn't want an addiction on top of that.
>
> **Loretta**: Oh, boy. I realized I was pregnant, I guess it was like four months. I got into the clinic right between four and five months.
> **Interviewer**: So from that point you were only on methadone at the clinic?
> **Loretta**: Yeah. Because it's always worked for me, I always, you know, was able to stop everything on it. Everybody else, I don't know, I don't understand – I don't think they really want to quit, is what the problem is.

Seeking treatment required motivation, knowledge and resources. Natalie, Shannon and Loretta all returned to treatment facilities that they had used at other times in their lives. They knew how to find these resources, how to be admitted and what to expect. As will be demonstrated in the later discussion of women in the "persistence" category, the knowledge of how to access treatment and the belief that treatment is a safe option likely play a greater role in women's behavior than Loretta's assertion that "they [don't] really want to quit."

Cora was able to cut back or desist from substance use during her pregnancies but not at other times. When asked how she achieved sobriety during pregnancy, she responded:

> **Cora**: I don't know, because I have another person inside of me, and they're not saying "Yeah, I want to get high, too." They don't have a say, and I think that if I don't have that kind of self-control, what kind of person am I?

Cora's questioning "what kind of person am I?" is the crux of identity, and implied in her response is that if she had not stopped getting high once she discovered her pregnancy, she would not be the type of person she wants to be. She expresses her agency as "self-control" and employs it to avoid what Paternoster and Bushway (2008) have labeled the "feared self," what Cora fears she would be if she lacked such self-control and continued to expose her fetus to drugs. Paternoster and Bushway's "feared self" conceptualization of identity-driven desistance emphasizes deliberate self-change and recognizes that movement out of a "spoiled identity" is likely to be based not only on a sense of what one wants to become, but on what one does *not* want to become. This is consistent with the work of Denzin (1987) and Biernacki (1986) regarding alcoholism and opiate addiction, respectively. In Cora's case, Cora does not want to be the type of person who exposes her fetus to drugs, and this motivates her to move toward desistance. In this way, Cora emphasizes her own agency and deemphasizes the role of structural events that supported her desistance.

***Social network alignment.*** Identities dictate how we think about ourselves and also the types of others with which we associate. Desistance, the surrender of an offending identity, necessitates the severing of ties with offending others and a realignment of one's social network with prosocial others. These prosocial others have been identified as "structural supports" (Kiecolt, 1994) or "hooks for change" (Giordano, Cernkovich and Rudolph, 2002). For desisting offenders, these hooks for change are a social network of others more prosocial or conventional than herself. Kiecolt (1994) and Giordano et al. (2002) both argue that intentional self-change and successful desistance from crime are unlikely unless there is a social network realignment with non-offending, prosocial others.

Bushway and Paternoster (2008) argue that social realignment is not exogenous (driven by external factors) but endogenous, suggesting that an individual intentionally affiliates with more prosocial others as part of the change in identity. This makes sense, because if one is trying to "go straight," one would want to surround herself with others who will verify and support this new identity. However, social network alignment may not be such a simple task, especially for offenders deeply embedded in a criminal context. These offenders may have few or no prosocial others to support their desistance and may be surrounded by active offenders who encourage them to continue offending (Giordano et al., 2002; Paternoster and Bushway, 2008).

Women who promptly desisted were supported by networks of prosocial others. They spoke of their relationships with male partners who were not substance-involved and did not approve of substance use. Much of this information came up when women were asked about a "turning point," as they identified the beginning of this prosocial relationship as the point where their lives changed for the better.

> **Shannon**: Um, well obviously I was still using when I met him, but… I don't know, I just found myself, you know, falling in love with him and wanting to change for the

> better, so that's when I stopped the heroin, but… you know, I didn't have insurance, so I knew to get on Suboxone from the family doctor, one of those – they come in either tablets or like, films that absorb on your tongue. One of those apiece is $9.34 from RiteAid, so I just didn't know if I had any other options, so… he just kinda made me want to be a better person. He wanted the same things out of life that I did, like wanting another baby, and then when that happened I made the decision to want to get help, to go to rehab. […] So yeah, but… just, you know, I knew he was somebody that I didn't want to lose, that I wanted in my life for a long time, so I'm like, you know, something's gotta give.

Shannon expresses a desire to "change for the better" now that she is in a relationship with a supportive and non-using man. This supports the idea of prosocial relationships as support structures or hooks for change through which women bolster their own prosocial identities. Faced with the choice between keeping this man in her life or returning to heroin use and losing this highly valued relationship, Shannon concluded that "something's gotta give" and that something was her heroin use. She went to treatment and was looking forward to her new life.

Other women had cut ties with men they felt were bad influences. When asked about turning points in her life, Ebony identified her recent break-up with the father of her infant son.

> **Ebony**: When I broke up with my oldest son's dad. Because it was like… he pulled me down in ways, and he made me irresponsible a lot of the time, too, because it was stuff that I wouldn't normally spend money on or things that I wouldn't normally do, I would do it because he was doing it, or we were together so I felt like that was my obligation.
> **Interviewer**: So breaking up with him – what changed, how was this a turning point?
> **Ebony**: I got control of my life again and I was able to be myself.

In this exchange, Ebony clearly expresses that her relationship with her son's father was something that made her "not herself." "Herself" is someone who is in control of her life, who spends money on the things she wants and needs for herself and her children, who is responsible and who makes choices in her own best interest. Being herself necessitated disentangling herself from this antisocial relationship. In the same way that prosocial relationships can be "hooks for change," antisocial relationships may sink their hooks into women and try to drag them down.

This will become all the more apparent when discussing women in the "partial desistance" and "persistence" categories.

***Second chances.*** Experiencing a loss of custody of an older child was another powerful shared experience for women in this category. Natalie, Eleanor, Shannon and Ebony shared the experience of losing custody of an older child, and this experience shaped their behavior in their most recent pregnancies. Ebony had lost custody of her three older children because her oldest child's father reported her to CPS for smoking marijuana while she was pregnant with her second child, a daughter. Her daughter was born, and when she tested positive for THC, she was placed in a foster home. While working to regain custody of her two older children, Ebony gave birth to a third child, another daughter. Both Ebony and her baby tested clean, but because of the ongoing custody case, this child was also placed in foster care. After the custody case had been drawn out for three years, the court determined that Ebony did not have enough of a relationship with her children (two of whom had been in foster care since birth) and terminated her rights. At the time of the interview, she was single-parenting her fourth child, her ten-month old son.

> **Ebony**: I was just so happy to have a baby. It was hard, but it was like, everything I went through made it worth it for me to have him. So when I lost him, it was like—well, when I lost my three kids, it was like, I promised myself if I ever got pregnant again, I was not gonna let all the things that you have to go through with the state and the court system, I was not gonna let that, like, defeat me, 'cause I feel like, I was younger at the time, so I didn't know how to approach all that stuff that I was going through, so I felt like I was cheated. So I kinda promised myself, like, I'm not gonna give up, 'cause those are my kids, and they're gonna look back like "Maybe she really didn't care about us," or something like that, 'cause that's how I felt when my mom just up and left me, so. Yeah, so I don't want my kids to feel the same thing.

Ebony's mother was a crack cocaine addict and had left newborn Ebony at the hospital and disappeared. Ebony was raised by her maternal grandmother and did not want to repeat her mother's behavior, because she did not want her children to feel the same way towards her that she had towards her mother. Ebony wanted to protect herself in case she ever had to go to court

again, so she took initiative to contact the health department and enroll in the home visitation program for pregnant women and new mothers. She was determined to prove to herself, her children, and everyone else that she was not the same woman her mother was and that she could be a loving and capable parent. She was determined that her experience with the court and loss of custody of her older children would not change her core self.

Natalie expressed a similar motivation. She, too, had experienced the painful loss of her oldest child and vowed that she would never put herself through that again.

> **Natalie**: I went to inpatient treatment on my own, I was already clean a month when I went in there, they released me in 14 days and said I didn't need it. I've paid for drops and outpatient classes on my own, completed all that and am still taking drops that I got funded through a woman's program on my own. I'm in, like, all kinds of things, anything I put myself in. […] I guess it shows like, losing [my first daughter], what it did to me and then… you know, even though with the close call with losing [my second daughter], like how soon that I stopped and, 'cause if I had lost her then – and I knew it, I think that's why I quit like I did. I knew if I didn't quit and if I lost her, my life would be no more good to nobody. I wouldn't be able to live through it.

Having her role as a mother negated by the court system for a second time would devastate Natalie. She "wouldn't be able to live through it." Furthermore, the loss of such a highly valued identity would cause her self-worth to plummet, to the point that she feels her "life would be no more good to nobody."

Eleanor identified the experience of losing custody of her first daughter as a motivating force to desist from substance use when she became pregnant with her second child. When asked what effect the loss had had on her life story, she explained "I think it's just made me wanna do better and strive to… be a better mother, to try and make up for that, not being there in the beginning." She described how having another child felt like an opportunity for missing out on her first daughter's childhood.

> **Eleanor**: So I met [my boyfriend] and we started dating, and uh, like I said, I got pregnant and had a miscarriage. And then it's like… I shouldn't have been, but I really—like, because that was an accidental pregnancy, but then I was like, "I want a baby." Even

> though I shouldn't, because I didn't have my own place, you know, still at my mom's, and it's irresponsible, but I was just like, I feel like I needed to fill the gap, that I never got to really like, participate in [my first daughter's] babyhood. I was gone, I was in North Carolina, and I know that's not a good reason but I just… you know. That's what happened.

Eleanor strongly identified as a mother, repeating "I've always loved babies, I've always wanted to be a mom," throughout her interview. When she became pregnant with her second daughter, she did a lot of her own research on attachment parenting, breastfeeding, and what to expect when having a baby while on methadone. In her interview, she talked at length about how her infant daughter was so "bonded" to her, how much she loved mothering, and how much she "overcompensates" for missing out on her older daughter's childhood by spending extra time rocking her younger daughter to sleep every night. She had also surrounded herself with prosocial others, including contacting Family Outreach Services and working with a public health nurse. For Eleanor, her new baby presents the opportunity for a second chance at claiming for herself the mother identity she had always wanted.

In conclusion, women who promptly desisted emphasized their own agency in recognizing their need to desist and taking steps to make that happen. They located the source of their motivation to desist within themselves and their pregnancies. They resisted a "feared self," a self who lacked self-control and who would put her children at risk, perhaps because they had *known* their feared selves when they experienced a loss of custody of their older children. "Prompt desisters" had realigned their social networks in favor of prosocial others and away from people who "pulled them down." Finally, they cast their recent pregnancies as "second chances" at achieving a desired mother identity after experiencing past failures. These themes set 'prompt desisters" apart from women in other categories.

**Delayed desistance.** Six women (20%) were categorized as "delayed desisters." They desisted during their pregnancies, but not immediately upon discovery. Whereas prompt desisters

took action within a month of discovery and either sought treatment or desisted alone, delayed desisters took more than a month to decide what to do. Their desires for healthy pregnancies were similar to those of prompt desisters, but women in this category were more likely to feel uncertain about their pregnancies. Once the uncertainty was resolved, women in this category were motivated to desist by their desire to avoid health complications.

***Uncertainty*.** One theme that set delayed desisters apart from prompt desisters was uncertainty about their pregnancy outcomes. This uncertainty could stem from a woman's indecision about continuing with the pregnancy or uncertainty about her ability to carry a wanted pregnancy to term. For example, Rosa discovered that she was pregnant with her third child and wanted to have an abortion, but couldn't afford one. Even with partial financial assistance, Rosa would still have to come up with several hundred dollars to cover her portion of the cost. As she said, "Can't have an abortion if you can't pay your light bill." In the time period when she was aware of her pregnancy, considering abortion and trying to raise money, Rosa drank heavily to manage her stress about her situation.

> **Rosa**: [I stopped drinking a] month ago [*laughs*]. I was like… 'cause I was still debating on if I was gonna have the abortion or not, and then me stressing financially, so… I was drinking. Pregnant and all. Even when I knew I was pregnant.

Lauren, a primary tobacco user, had struggled to get pregnant for three years before resorting to fertility treatment. When she finally became pregnant, she had difficulty believing that she would successfully carry her pregnancy to term and deliver her baby.

> **Lauren**: Um, honestly I think in the beginning, I was so fearful that he wasn't going to make it that I didn't really even try to quit, in the very beginning, because I was kind of… I guess in shock, and then I started cutting down a lot and I was able to quit once I realized we made it through the difficult part.

There are interesting parallels between Rosa and Lauren's stories. Although their pregnancies occurred under very different circumstances, both expressed a lack of control over the process.

For Rosa, pregnancy was something that seemed to happen to her. She revealed she had considered abortion for her last three pregnancies because of the stress of being a single parent to multiple children and the fragility of her financial situation. She didn't appear to want or plan for more children, but spoke of pregnancy as something that just seemed to happen outside of her control. Lauren, in contrast, desperately wanted to be pregnant but could not conceive without medical intervention. Pregnancy was something she could not control, either, but in the opposite sense: when she wanted it, she couldn't make it happen, whereas pregnancy happened to Rosa when she didn't want it. Lauren describes a feeling of powerlessness over the survival of her fetus early in her pregnancy, and it was not until she was sure that the pregnancy would continue that she was motivated to stop smoking cigarettes. It was at that point that Lauren felt she had more control over the situation and could exercise her agency to desist from substance use.

Once the uncertainty about the pregnancy was resolved (e.g., Rosa passed the 24-week limit for abortions in Michigan; Lauren's fetus survived the first trimester), the women desisted from substance use to protect the health of their fetuses:

> **Lauren**: I needed to be healthy for him, we had gone through so much to get him and why would I keep trying to hurt him in any way?

These same concerns for fetal health were echoed by other women in this category:

> **Elizabeth**: I had to stop, because you know, it was already in my system, but I didn't want to harm my baby or anything like that.

> **Sarah**: I was scared! I didn't know—like I felt bad because I didn't know, and then I was scared, I was like "I hope nothing's wrong with my baby," you know, stuff like that.

These motivations correspond to women's definitions of mothers as providers and protectors of their children. The women's words emphasized being selfless and putting the fetus' needs above their own, especially because fetuses had no choice of being exposed to harmful substances. Their words echo those of the women who promptly desisted, like Cora's question "What kind of

person am I?" if she could not stop using to protect the health of her children. These statements, when compared with women's uncertainty earlier in their pregnancies, seem to indicate that women had experienced a shift in their orientation towards their fetuses from something uncertain and perhaps unwanted to "my baby." This suggests that women defined their identities in relationship to another (the fetus), only assuming the conventional identity of "mother" once they accepted that they had a "baby." Whereas women in the "prompt desistance" category immediately reacted to discovery of their pregnancies by taking steps to desist, women in the "delayed desistance" category needed more time to assume their identities as mothers.

***Social network alignment.*** Much like women who promptly desisted, women in this category achieved desistance by aligning themselves with prosocial others and distancing themselves from other substance users. Hazel had already taken steps towards desistance when she met her husband:

> **Hazel**: I was done with it anyways, but then I met their dad and I knew that he wasn't going to date nobody smoking crack so I just knew that then, I knew I wanted to be with him.

This supports Paternoster and Bushway's (2009) assertion that social network realignment is endogenous. Hazel had already taken steps towards desisting from crack cocaine use when she met her current partner, but her relationship with him is helping her maintain her desistance. Her identity as a wife and mother is now insulating her from returning to her former lifestyle:

> **Hazel**: It's stopped me from going back, it's definitely stopped me from going back. I still get attention, I have guys pull over all the time, perverts and stuff like that, and I choose not to. I choose that I'm a better person. I choose to turn my back and keep walking because I've been there, and you just never know where that could go. […] I see people nowadays that I used with before, and just be like… I would never go back there and be that person, ever again. I see them now and they keep me stronger.

In these others, Hazel sees her feared self and this strengthens her resolve to stay away from crack cocaine. Her narrative highlights her own agency in doing so, emphasizing her choice to

stay away from that lifestyle.

Women in the delayed desistance category were very similar to women who promptly desisted. They echoed prompt desisters' emphasis on individual agency in desisting from substance use and aligned themselves with prosocial others to support their changing identities. Their narratives depicted them as women who cared enough to desist from substance use to protect their children. The key difference between prompt and delayed desisters appears to be uncertainty surrounding the beginning of the pregnancy, whether it be indecision about going through with the pregnancy or uncertainty about the pregnancy outcome. Once the uncertainty was resolved, delayed desisters acted much like prompt desisters and narrated similar reasons for desisting.

**Partial/incomplete desistance.** The most common pattern of desistance behavior was partial or incomplete desistance. Twelve (40%) women described patterns of reducing their substance use but not desisting entirely, reducing or ceasing their use of some substance but not others, or substituting substances that they perceived as "less harmful" than their normal substances of choice. Women in this category expressed greater attachment to and investment in their identities as addicts, often citing their addiction or their addict identity as the reason they did not completely desist from substance use. They were also more deeply enmeshed in valued relationships with other substance users.

***Cutting back*.** Women in this category discussed a wide range of desistance behaviors that included reducing the frequency of substance use or the amount used each time, desisting from some substances but not others, and substituting substances they perceived to be less harmful to help them desist from substances like heroin, prescription pills, and cocaine. Kim, for example, was using tobacco, alcohol and marijuana when she discovered her pregnancy:

> **Kim**: I continued to use tobacco every day, the amount was cut down to half, so about five. I discontinued the marijuana use at all, and I still continued to drink some wine, but it wasn't like a daily wine bottle.

Some women were aware of the negative appraisals of others, especially once they were visibly pregnant and others could identify them as substance-using mothers. In response to perceived judgment, women would adjust their substance use so that it was less visible. Kathryn, for example, had a job as a cashier at a gas station. She felt self-conscious about going outside for her smoke breaks because, in the past, she had been scolded for smoking while pregnant:

> **Kathryn**: Even customers, like when I was working at Burger King and I'd be out on my cigarette break, they'd be like [angry voice] "You shouldn't do that, da-da-da, this and that, blah blah blah," so, um. With this one, I'll go out, try to sneak out, because at the gas station I see the same customers every day, so I'll try to sneak out, I know about the time they're coming, and I get caught once in a while [laughs], but… um, yeah, like I said, with her especially, because I didn't really think about it that much until people started making all their smirks and comments, and that's what really made me insecure about smoking in public.

In response, she "cut back" by smoking fewer cigarettes a day and tried to avoid smoking in public. Kathryn's behavior is an example of behavior adjustment in the face of (perceived) negative appraisals by others. Such adjustments are not discussed in narrative identity theory but feature heavily in psychosocial identity theories like Burke's (1991) perceptual control model. In these theories, the negative appraisals of others pose a threat to identity verification, the acceptance of our performed identities by others. In narrative identity theory, such discord may be considered a threat to narrative integrity. By concealing her smoking from her regular customers, Kathryn maintains the integrity of her motherhood narrative.

***Substitutions*.** Another pattern of partial desistance was "substituting." Some women, upon discovery of their pregnancies, desisted from one substance but initiated or increased use of another. Women made these decisions by assessing the risks of one substance over another, and these assessments included both risks to fetal health and the risk of having their substance use

detected. For example, Suzanne discovered her pregnancy at the end of a several-month long crack cocaine binge. She had previously indicated that she had used Xanax and Vicodin during her pregnancy, but when asked about her use of these substances in the three months prior to discovering her pregnancy, she admitted that she actually began using the pills as a substitute for crack cocaine:

> **Suzanne**: I didn't really start doing [Xanax and Vicodin] until I was pregnant, and actually I guess I was trying to do like, a substitute for… you know? And so, I mean, I was taking them like I was supposed to at the beginning, but I'm an addict, so before long I was eating them up like candy.

Suzanne felt that Xanax and Vicodin were safer for her fetus than crack cocaine, but her decision was also based on her own safety; she was able to get prescriptions (albeit illegal prescriptions from a "pill doctor") for these medications, so if she happen to be drug tested and came up positive for these substances, she would have some measure of protection from penalty.

Tasha also made substitutions during her pregnancy by cutting back on her prescription opioid abuse and increasing her use of Xanax instead:

> **Tasha**: I would say I used more [Xanax after discovering the pregnancy], just because I tried to stay away from the pain pills, and I figured the Xanax would kind of be better in some odd way, I guess? […] And I guess in my own head, because my mom had taken it when she was pregnant with me and my brother, I guess I thought it was okay.

In Tasha's case, she was self-medicating her opioid withdrawal by increasing her Xanax use, and she felt that this would be safer for the health of her fetus because she knew her mother had used Xanax while pregnant. This was how Tasha could rationalize her substance use, by making what health changes she could and following her own mother's example.

***Social network alignment.*** In one case, the substitution was not a case of swapping a more harmful substance for a "safer substance," but the reverse. Latoya had been injured in a car accident two years prior and was prescribed methadone for pain management. She had been

abusing her methadone prescription by taking twice the prescribed dose. When she discovered her pregnancy, she immediately quit her methadone against medical advice. She was worried about the effect the methadone would have on her fetus and chose to stop taking it, even though her prompt desistance put her at risk of withdrawal symptoms that can cause miscarriage. After quitting methadone, Latoya used heroin and cocaine "a couple of times" throughout the rest of her pregnancy:

> **Latoya**: Well, I stopped taking the methadone, and I did take heroin a couple of times, because my husband is actually a junkie. […] He just does it in front of me all the time and I'm just like "What the fuck?" and he's just like "Rrrrr!" and we just get into it and then he's like "You want some?" and I'm like, "Sure. Whatever."

Latoya's relationship with her husband interfered with her desire to protect the health of her fetus. He continued to use heroin in front of her and encouraged her to use it with him. They would argue about it but Latoya would sometimes give in and use.

Latoya's story highlights the role of significant others in women's desistance behavior. Women's lives as substance users included relationships with family, friends, and intimate partners, and many of these relationships supported, encouraged or enabled women's substance use. For women connected to these meaningful relationships with other substance users, narrating their identities away from "substance user" and towards "mother" meant the possibility of losing these attachments. For some women, this would set them intolerably adrift, disconnected from relationships they felt were important. Vicki's story exemplified this theme. Vicki had two adult daughters and was pregnant with a son at the time of her interview. Her life story showed a pattern of substance use when she was in relationships and sobriety when she was single. From a very early age, Vicki had felt disconnected from people she cared about. When she was in relationships with substance-using men, she would start using with them as a way of feeling connected and involved in their lives.

> **Vicki**: I feel like that's because I couldn't connect with--- I felt like I wasn't connecting with him and for me to connect with him then I needed to do what he was doing, yeah. […] The times that I felt like I couldn't [cut back or quit], it was because I felt like I had to fit in.
> **Interviewer**: With whom?
> **Vicki**: With… I don't know, like, with my boyfriend, or friends, or…

At the time of her interview, she was in a relationship with a man who used methamphetamine. She had started using with him so that she could feel connected to him and do something he liked to do, but now she desperately wanted to stop. She didn't enjoy using methamphetamine and she was worried about her baby and her risk of being detected, but desisting from methamphetamine use would mean losing that connection with her boyfriend. In this way, Vicki and Latoya's attachments to other substance users functioned as "hooks" that kept them at least partially involved in substance use, even when they expressed a desire to desist. Belinda had a similar experience, not with a romantic partner but with her group of friends:

> **Belinda:** I tried stopping [drinking], like, after I found out I was pregnant I had stopped, and I wanted to stop after that, too, even after I had him I didn't want to start, but I was hanging with friends again, didn't really want to drink, but I ended up starting and I'm back at it again.

Similarly, during her pregnancy Denise was embedded in a social network of other substance users:

> **Denise**: I just fell into the wrong crowd, 'cause I'm a very big people person. I'm friends with everybody up until you give me a reason not to, and… I really started falling with the wrong crowd, didn't see it, and finally started—when I was smoking my pot and stuff, people were lacing it with other things, and on top of it my friend's like "Try this," and then I'd try it, and… like, it just, it all became an overwhelming thing.

For Belinda and Denise, as with Vicki, Latoya, and other women in this category, relationships with other substance users kept them involved in that lifestyle. For Vicki and Latoya, it was highly-valued romantic partnerships. For Belinda, Denise and others, their involvement in these social groups was a product of their narrated identities as a "people person" or a member of a particular friendship group. In Belinda and Denise's cases, they achieved partial desistance by

isolating themselves from these influences, the first steps in social network realignment:

> **Denise**: So in the long run, I started distancing myself from people. I kind of keep to myself, go to and from friends' houses, to and from job interviews and stuff, I don't associate with people as much.
>
> **Belinda**: Like every once in a while they would come and visit me and stuff at home, but I really didn't hang out with them like that, 'cause I know that that's what they're around and I didn't really want to be around that stuff.

Although this distancing behavior helped women to desist from some substance use, it is important to acknowledge the negative consequences of social isolation. For women deeply embedded in a criminal context, distancing oneself from a substance-using social group may mean losing access to needed resources, like help with transportation, childcare, and job-seeking. Amelia, for example, relied heavily on her friends to provide childcare for her infant son while she went to work. Her friendship group was largely made up of other substance users. Distancing herself from these friends would mean losing this important resource, which might then result in her losing her job. Many women had very few prosocial family members or friends to support their desistance. Faced with the choice of being sober but alone and unsupported, or using but having access to instrumental and emotional support, there is little wonder why some women remained embedded in antisocial networks.

***"Pawn" selves.*** Unlike women in the "prompt desistance" and "delayed desistance" categories, women in the "partial desistance" category were more likely to claim an addict identity. From women who used only tobacco or alcohol to women using crack cocaine, heroin or prescription medications, the common refrain was "I'm an addict" or "I am addicted":

> **Kim**: [The alcohol] was more of a stress reliever, but I continued it throughout my pregnancy, just because of the addiction.
>
> **Kathryn**: I don't even—I don't like smoking cigarettes, I don't even like to smoke cigarettes. I don't like the taste, I can't freaking breathe, I don't like to smoke cigarettes, I just am addicted. I am.

> **Suzanne**: But I'm an addict, so before long I was eating [prescription pills] up like candy.

These refrains suggest a feeling of helplessness in the face of addiction, indicative of low self-efficacy and lacking a language of agency (Larson, 2000). Maruna (2001) draws on the work of de Charms (1968) and identifies the persistent offenders in his study who express a similar lack of agency as subscribing to a "Pawn" story of self. As suggested through the analogy of a chess game, pawns are considered weak, easily manipulated, and meant for sacrifice. Women who only partially desisted appeared to subscribe to this story of self, positioning themselves as helpless in the face of other powerful forces and lacking any control over the direction of their lives. Where desisters emphasized their agency in immediately deciding to desist and seeking the treatment to help them, women who only partially desisted demonstrated a weak sense of personal control over their substance use. They were more likely to claim an "addict" identity for themselves and to attribute their persistent substance use to their addictions.

**Persistence.** Women who persisted with substance use throughout their pregnancies were most likely primary users of heroin (n = 2, 50%) and/or marijuana (n = 2, 50%), in addition to other substances. The remaining persisting woman, Darla, was pregnant at the time of her interview and drinking heavily as she tried to decide if she would seek an abortion or not. She was, in her words, "80/20" about aborting her pregnancy, but was struggling with the idea that this was her last chance to "do it right." As a 41-year old woman in a rocky marriage, Darla felt that this pregnancy was her one opportunity to raise a child the way she had always wanted, with a husband to co-parent, explaining that she removed her IUD because she thought she was too old to conceive, though "I'm not lying, part of me wanted a kid by him, 'cause I love him… but, God, that was fairytale thinking." She had her two older children when she was much younger, unmarried and unemployed, and she wanted the opportunity to live her "fairytale." She remained

poised at the point of a decision. Her pregnancy seemed to offer the possibility of living the life she had wanted to lead, the possibility of being the mother she had wanted to be but had not managed to be in the past. Continuing the pregnancy offered an opportunity for the alignment of Darla's "imagined life" with her real life. As Darla herself recognizes, though, her current situation was not really as close to her "imagined life" as she hoped, and the likelihood of bringing her "real" and "ideal" into congruence seemed low. As she concluded at the end of her interview, "reality is gonna win over the fairytale, definitely."

***Good intentions.*** Kellie and Brittany both used heroin throughout their pregnancies. Kellie was actively using when she discovered her most recently pregnancy, and Brittany had just left a treatment facility and was trying to "be good" but struggling to maintain her sobriety. Both women's persistent heroin use was associated with missed opportunities for help from others. Brittany was trying to regain custody of her two young children after her stay in a residential treatment facility, but the stress of working with the court system and then becoming pregnant again resulted in her relapsing first on prescription opioids and then on heroin.

> **Brittany**: I found out that I was pregnant and then, um, I don't know, it's just… I first started maybe using like, prescription pills thinking that I could, I don't know, I could do it maybe just on the weekend, keep it on the weekend, you know, like, I'd never tried doing it that way. So I stupidly thought maybe I could figure it out, I think just 'cause I was just so hurt by everything else that happened, I didn't know how to deal with it, so I guess it just kind of, almost, looked at it like a reward in a sense.

Brittany quickly slipped back into daily use:

> **Brittany**: At first, yeah, I'd say like once a week or even once a month sometimes, like at the beginning. It didn't stay like that for the whole pregnancy. By pretty much the end, I had pretty much stopped using pills and was pretty much using heroin every day. […] Middle towards the end, and still trying to do everything with, like, CPS and the drug tests like three times a week and everything. So I'm still trying to do all this and then use, it's ridiculous in that way.

Brittany's desire to seek help was complicated by her precarious relationship with the court. She was trying to regain custody of her two sons and felt that any admission of "slipping up" or not "being good" would result in termination of her rights. Instead, she tried to get along by herself, but quickly lost control of the situation. She carried her pregnancy to term and gave birth to a third son around the same time that her one-year time period for regaining custody of her older two sons expired. Her rights to all three children were permanently terminated. Brittany's story illustrates the way that pregnant substance users find themselves between the idiomatic "rock and a hard place." Already involved with the court and burdened with the task of proving herself an adequate mother, Brittany knew that admitting that she had relapsed would put her at risk of losing her children because her one-year period to get them back would expire. Without admitting to relapsing and seeking help, she could not stop using, which was what made her an inadequate mother in the eyes of the court in the first place. She could not conceal her relapse and was identified again as an inadequate mother and lost custody of her children. In her position at that time, Brittany lacked the resources to satisfactorily perform her role as a mother to her sons. The court did not believe her story of herself as a good mother who was just overwhelmed by addiction and terminated her parental rights.

Kellie was injecting heroin multiple times a day and at "a really bad spot in [my] addiction," living out of her car and "down to, you know, nothing, exhausted everyone and everything." She and her boyfriend decided to seek treatment together. The treatment program they chose prescribed Suboxone (buprenorphine), a popular opioid receptor agonist approved for the treatment of opioid dependence. Buprenorphine has been demonstrated to be safe for use during pregnancy, with some evidence that fetal buprenorphine exposure results in milder neonatal opioid withdrawal than observed in neonates exposed to methadone (Jones, Kaltenbach,

Heil, Stine et al., 2010). When Kellie was subjected to a pregnancy test at the treatment center and the result was positive, she was quickly informed that Suboxone was not safe for pregnant women and told to seek help elsewhere. Reluctant to turn to methadone, but urged by nurses at the treatment program and her local hospital to "make sure you don't go into withdrawal because it will put a lot of distress on your baby, and it will probably most likely induce a miscarriage," Kellie continued to use heroin. She approached multiple doctors and asked if they would oversee her unmedicated detox but was turned away after being told that the risk to her fetus was too high and the hospital would not accept the liability. Finally, she tried to get help from her obstetrician:

> **Kellie**: I was doing dope and I had gone to my OBGYN for my first appointment when I was probably about ten weeks along, and I told her the truth – well, I kinda told her the truth, I didn't want to say I was doing heroin, so I just said "Look, I've been taking Vicodins for my teeth, 'cause they're really bad" – which I was, a couple of years ago, which is kinda how I got back into doing heroin. I'd tried it when I was younger and then quit for a while, and I was taking Vicodin for my teeth, which I did have a valid script for, but then I was taking more and more and more and it wasn't enough, and it was too expensive, so then I went back to doing heroin. So I told my OB that I was just taking the Vicodins and when I stopped I was having withdrawal symptoms, and I didn't want to hurt the baby, and blah blahblah, and she said "Well, just try and wean yourself down, do the best you can, blah blahblah," this went on for maybe two or three months and I just kept going in there saying "It's not working, I can't, I'm getting too sick, I'm scared something's going to happen to the baby," and she said "Where are you getting this prescription?" and I said "My mom's just been giving me her pain pills, I don't have a valid script for it, that's another thing I'm worried about." So she actually said, "Okay, I'm going to write you a script for Vicodin so you have a valid script," [laughs], "and I want you to take – I'm gonna write you for four a day and I want you to take one at a time, four times a day, and that should keep you cool and that way we'll try to taper you down, or at least when the baby comes, at four a day, it won't be as excessive as what it sounds like you're taking." So I said okay, so she wrote me out 120 for the month, and of course they were gone in, you know, how many—a week or two, whatever.

After this, the doctor became suspicious and required Kellie to submit to a drug test if she wanted another prescription. The drug test showed far more than just the prescribed medications, and the doctor told Kellie she needed to stop what she was doing. By this point, Kellie was into

her third trimester and running out of time. She tried to find treatment facilities that would accept pregnant women and could find only one, located one hundred miles from her home. She finally checked in there and was immediately offered Suboxone, the same treatment for which she had been turned down in the beginning of her pregnancy. She started treatment (opting for methadone instead) but continued using heroin as her dose was adjusted, and delivered her baby several weeks early. She has continued with her treatment and has not used heroin since delivery.

Kellie and Brittany's stories both highlight missed opportunities for intervention that might have interrupted their substance use. In Brittany's case, her fear of the court system drove her to conceal her escalating substance use. This initiated a cycle of feeling like a failure and using pills or heroin to feel better; the more Brittany tried to cooperate with the court, the more stressed she felt, and the more stressed she felt, the more she wanted to use. When she used, she felt guilty and like she was a failure, which exacerbated her negative feelings and drove her to use even more. She was caught in a paradox: using heroin

In Kellie's case, her initial motivation to get clean was not sufficient because she encountered barriers at every turn. She wanted to get clean because she was pregnant, but her very status as a pregnant woman made help-seeking all the more difficult. She was told that her first treatment choice, Suboxone, was not safe for pregnant women. Her second choice (unmedicated, medically supervised detox) was also unavailable, due to the risk of miscarriage. Her third attempt to seek help from her obstetrician was curbed by her fear of being discovered as a pregnant heroin addict, which prevented her from being honest with her doctor. Her substance use was enabled for several more months until she finally found a treatment center that would accept pregnant women, at which point she was "out of time" and her pregnancy was over. It is interesting to consider how these stories might have unfolded had women's fear not

been such a powerful factor. Fear of discovery and punishment prevented Kellie and Brittany from being honest with people in their lives who were in the position to intervene and help them. If Brittany had felt comfortable telling the court that she wasn't managing well and needed more help, and if Kellie has felt comfortable telling her doctor that she was using heroin and couldn't find the help she needed, their substance use may not have persisted for so long.

***Social network alignment.*** All four women in this category were in committed relationships with substance-using men who enabled, supported and encouraged their persistent substance use. Kellie and Brittany both used heroin with their male partners. Elsie, who used marijuana and assorted prescription pills, continued using with her boyfriend throughout her pregnancy, even when she was on bed rest at the hospital to stall premature labor:

> **Elsie**: Me and my boyfriend, the dealer would actually come meet us up at the hospital and we'd go out in the parking lot and smoke [*laughs*]. It's so horrible! Right at the hospital! Like, how horrible [*laughing*].

Elsie's boyfriend offered no resistance to her desire to keep using pills. In contrast, Brittany's boyfriend criticized her persistent opioid use even though he was also using heroin:

> **Brittany**: Rick knew I was using, I was just taking pills and he was constantly on me, like, "What if this baby's deformed or, like has problems?" You don't know what could happen.
> **Interviewer**: Was Rick using as well?
> **Brittany**: Yeah, he was.

Rick and Brittany went to separate treatment facilities after an intervention by their families, but both relapsed soon after leaving treatment. Brittany became pregnant again and went back to using heroin, and Rick convinced her to leave the state.

> **Brittany**: What happened with that was, um, we ended up just taking off, I guess, like a month before I was due. Rick was, I don't know, I never really pictured being away from him and we were just unprepared for everything and had nowhere to go, and his family was pretty much done helping us out at that point, it was obvious we weren't doing good anymore, you know? […] He just told me he was leaving, that he loved me and if I wanted to go he would take me. […] I remember just like, sobbing and telling him that I

> didn't wanna go, I didn't want him to leave me, I was pregnant, but I didn't wanna go. At that point, you know… And I guess I couldn't see any other choice, I couldn't really see any.

Brittany's attachment to her boyfriend enabled her substance use. She attributes her lack of a criminal record to the fact that it was her boyfriend who took most of the risk by going out to buy their drugs, so she was "kinda sheltered in that way." When she was using during her pregnancy, he argued with her about putting their children at risk but made no change to his own use. When Brittany and Rick were involved with the court system and trying to win back custody of their two older boys, Rick encouraged Brittany to leave the state. Brittany's ongoing association with Rick kept her involved with substance use. At the time of the interview, Brittany had lost custody of her three children. She and Rick were both enrolled at a methadone clinic and were still in a relationship.

***"Pawn" selves.*** In contrast to the narratives of women who desisted, which emphasize agency and choice, the narratives of women who persisted instead emphasize what they felt was a lack of choice. Kellie felt she encountered obstacles to desistance everywhere she turned. Brittany felt that she was out of chances, that the court was going to take her older children anyway and that her only option was to leave the state with Rick. To observers, it likely appeared that Brittany was abandoning her older children and fleeing from her responsibility to them in favor of continuing her substance use, but this was not how Brittany saw it. Instead, she narrates a story of being trapped and running out of options, and of being forced to do something that she says she didn't want to do. Kellie said she did not want to continue using heroin but describes her attempts to get help being thwarted at every turn. Brittany said she did not want to run away from her children but described it as the only choice she could see at the time. Like women who

only partially desisted, persisters narrated stories about themselves as pawns and not as agentic beings.

***Narrative resistance.*** From both the criminal justice and public health perspectives, women who persisted with substance use through their pregnancies are living out the worst-case scenario. From the public health perspective, they are placing themselves and their fetuses at the greatest risk of negative health consequences by continuing to use. From the criminal justice perspective, they are at the greatest risk of having their substance use detected (either in themselves or their neonates) and becoming involved in the criminal justice and child protection systems. Despite being the "worst cases," women in this category resisted master narratives that would depict them as bad women and bad mothers. Brittany's narrative cast her as a loving mother with good intentions who became overwhelmed by parenting stress and substance use that spiraled out of her control. Though the court had terminated her rights to her three children, she maintained that she was not the terrible person the court had made her out to be:

> **Brittany**: I met this other lady who went there, she's in treatment, too, and she had six kids that she had lost to CPS, like at all different times, and it seemed kinda like she was feeling the same way as I was, just like… a bad person, or she didn't love the kids enough, or that kind of thing, and… you know, I guess, that's the main thing I'd wanna say, is that I'm not, like – like a monster. I care.

Elsie was unapologetic about her substance use and admitted that she was still using marijuana and prescription pills regularly. She described a conversation with her mother, who disapproved of Elsie's substance use but had conceded that "at least I'm not on meth or heroin or something." Elsie also emphasized that she was a better mother than others she knew:

> **Elsie**: But I mean, for instance, these two girls I work with, this one girl is a year older than me and is on her fifth fucking kid. Her fifth kid! […] And, you know, she don't act like I do. I'm like "Oh my god, my baby, my baby!" And she's like "Yeah, get them kids away from me." I know she loves her kids, what mother does—I mean, there's mothers who don't, but you know, I know she loves her kids but she's not at all like the mother I

am.

In this excerpt, Elsie positions herself as a good mother because she only has one child and she misses her daughter when she's at work. These factors are more important than her persistent substance use. Bad mothers, by Elsie's definition, are those who have too many children and don't want to spend time with them. This definition of motherhood allows Elsie to tell a self-narrative of being a good mother even as she admits to behavior that others consider incompatible with good mothering.

**Discussion**

Rather than a clear dichotomy between substance use "persisters" and "desisters," the data revealed a spectrum of desistance behaviors stretching between these two poles. The behavior patterns fell into four broad categories: prompt desistance, delayed desistance, partial desistance, and persistence. Demographic variables like age, race and educational achievement were not related to persistence or desistance, nor was the type of substance used, age of substance use onset, or experience of trauma. Analysis of the accounts of women in each category revealed that substance use desistance before the end of pregnancy was supported by women's perceptions of themselves as having agency and not being "pawns," the realignment of their social networks with more conventional individuals who did not support their substance use, and their determination to avoid a "feared self," often motivated by prior experiences with substance use persistence in pregnancy and loss of custody. In contrast, women who partially or completely persisted spoke about themselves as "pawns" and "addicts" who were not able to desist. They were embedded in social networks that supported their substance use and thwarted their attempts to desist. Despite their continued substance use, women who persisted offered some resistance to master narratives that would depict them as "monster mothers," emphasizing

their love for their children and their capabilities as mothers and attributing their substance use to being “overwhelmed” or to failed help-seeking attempts, for which the women felt health practitioners or medical professionals shared equal blame.

This chapter has described women’s behavior during pregnancy, from the time they discovered the most recent pregnancy until the birth of their youngest children. Curiously, desistance during pregnancy did not necessarily result in desistance after pregnancy. Some women who had desisting from substance use while pregnant relapsed after pregnancy, and other women who had persisted until the birth of their children desisted soon after and had been maintaining their desistance for many months. Chapter V explores how desisting women were maintaining their desistance by restorying their lives as redemption narratives, which enabled them to continue making prosocial and health-positive changes in their lives.

# CHAPTER V

## Restorying and Restoring Identities

### Desistance and Redemptive Narratives

The previous chapter explored women's desistance behaviors during pregnancy. This chapter examines the ways that women's narrative identities sustained desistance *after* their pregnancies. Of the 30 women in the sample, seven (23.3%) were pregnant at the time of their interviews. Six of these seven were persisting with some substance use. Only one woman, Shannon, was pregnant and desisting. Of the remaining 21 women who were not pregnant at the time of their interviews, 13 (61.9% of non-pregnant sample; 43.3% of total sample) were desisting from substance use. It is important to note that these 13 non-pregnant desisters were not necessarily women who had desisted during their pregnancies. Some women had been categorized as "persistent" substance users during pregnancy but had desisted in the months following the birth of their youngest children. Similarly, women who were categorized as "desisters" during pregnancy often returned to substance use once they were no longer pregnant. Women's desistance from substance use during pregnancy was not always followed by continued desistance after birth.

How, then, do women maintain desistance from substance use? It seems clear that continued desistance is not the result of just one choice to stop using substances, but the product of many choices, multiple times a day, to maintain a prosocial identity and resist falling back into old patterns of behavior. To achieve this, women who were desisting at the time of the interview narrated a redemptive self. To support such a drastic change in behavior, from offending to non-offending, women had to recreate their narratives to show that their capability to lead a prosocial life was there all along. They drew on past experiences to depict themselves as strong, resilient, and good. Maruna writes that the purpose of such stories "maintain[s] equilibrium by connecting

negative past experiences to the present in such a way that the present good seems an almost inevitable outcome" (2001: 87). The opposite of the redemption script is the "contamination" (McAdams, 2001) or "condemnation" (Maruna, 2001: 75) script, in which positive or neutral episodes are transformed into negative episodes. In Maruna's sample, active offenders "largely saw their life scripts as having been written for them a long time ago," and the scripts were not positive. Contamination scripts feature the identification of points where everything goes wrong, a downward deflection in the narrative arc that is never corrected. This sets contamination scripts apart from redemption scripts, where negative events are reinterpreted as necessary experiences for personal growth and development.

Maruna (2001) identities five common themes in these redemptive scripts. The first is the establishment of the "true self" or "core self", the "real me" that is good and normal. The second theme is the identification of a bad "it," a force that is responsible for bad behavior and experiences. The establishment of a bad "it" external to the self helps to protect the core "good" self, as it allows the narrator to escape being overwhelmed with shame for past transgressions. For substance users, the substance or the addiction usually fills the role of the bad "it." The third theme is the acknowledgement of helpful others or a higher power that believed in the individual's potential and showed them that they have worth and value. These helpful others are often described as seeing the individual for who they "really are" (i.e., good and normal) when others could not. A fourth and very powerful theme is that of "redemptive suffering." Individuals narrating a redemptive self must find a way to connect their negative pasts with more positive futures. This is vital for achieving a coherent narrative identity. Redemption stories cast past negative experiences as necessary for the positive present and future: "If I hadn't gone through that, I wouldn't be the person I am today." Finally, redemption narratives forecast a purposeful

future. The storyteller demonstrates commitment to generativity, "the concern for and commitment to promoting the next generation […] and generating products and outcomes that aim to benefit youth and foster the development and well-being of individuals and social systems that will outlive the self" (McAdams and de St. Aubin, 1998: xx). Women who were desisting spoke at length of their desire to be better parents to their children and to teach them well so that they didn't have to learn things "the hard way," as women in this study had done. They expressed interest in writing books about their experiences or becoming motivation speakers so that they could help others, and identified areas in the criminal justice and child protective systems that needed to be changed so that other women would not struggle the way they had struggled. Women who were currently desisting from substance use expressed a greater number of these five themes than women who were currently persisting.

**Good core self.** The first theme in this set of five, and perhaps the first step on the path to identity change, is the recognition of a good core self, a true self that was there all along, even if it was buried under layers of negative circumstance. Of the fifteen women who were desisting at the time of their interview, fourteen (93.3%) expressed their belief in their good core self. Only six (40%) persisting women made similar claims.

Women who were desisting from substance use interpreted past experiences in a way that highlighted glimpses of themselves as good people, even though they had made some bad decisions or done some things that they regret now. When asked about a low point in her life, Natalie talked about losing custody of her first daughter and how this loss had sent her on a "suicide mission" to take as many drugs as possible because she felt she no longer had a reason to live. She felt she was "no better than [her] mother," who had also battled addiction. When asked what this memory says about her life, she responded

> **Natalie**: That I at least still have a heart. Because I'm the opposite of my brother, like what we went through, what both of us went through has turned him, like, unemotional and like, hard, and like, he can't show his emotions and he's like, a sociopath, swear to God. And me, I'm still a loving person, like – a lot of my therapists say it's just amazing that I still care the way I do, I still see the good in the world the way I do. […] That it hasn't-- it didn't totally ruin me as a person.

In this excerpt, Natalie demonstrates a protection of her core "good" self by explaining that her traumatic experiences haven't "ruined" her. She is and always has been "a loving person," a quality that has persisted through bad life experiences that would ruin others, like her younger brother. Kellie, who persisted with heroin and marijuana use until the birth of her son but was now desisting, explained:

> **Kellie**: Ummm, I don't know, I guess it kind of always—when I think about it, reminds me that no matter how bad I feel about myself for the things I've done, that I am a good person, and I am special, and, um, you know, yeah, despite all the crap and all the dirt and whatever, that deep down I am, you know, a good person and capable of loving and deserving of love, and I get really down on myself and I just kinda—seems like I kinda go back to just myself at my purest state, I guess, when I was a kid, and that's how I *really* am. I thought I had it all figured out [*laughs*].

Kellie refers to going back to herself at her "purest state," when she was a child, because that's how she "really" is. "Deep down" she is a good person who is capable of loving and being loved, "despite all the crap" of her years of heroin use, which included periods of homelessness, losing custody of her older son, and being disowned by her family. When she starts to feel overwhelmed by shame and guilt, she reminds herself that at her core, she is still the good person that she was as a child, before her addiction.

These excerpts stand in marked contrast to the expressions of women who were persisting. Elizabeth was using cocaine and Vicodins when she became pregnant with her son. She persisted until the end of her second trimester and then quit, but her son tested positive for some substances when he was born and was placed in foster care. Elizabeth shared that she was not allowed to see him and had not yet had a court date to find out what she needed to do. At the

time of her interview, she was trying to get into a shelter and "staying anywhere" right now. Her two older daughters were living with an aunt. When asked about her current substance use, she said,

> **Elizabeth**: I still smoke marijuana and pop Vicodins. I haven't did any cocaine lately, but if it comes around I'm pretty sure I'll join in, you know.

Elizabeth's son was born in April and she had returned to cocaine use in July. Her interview date was in late August. She talked about her feelings about persisting:

> **Elizabeth**: I feel like I'm a bad mom and a bad person, 'cause I feel like I'm putting my kids through the same thing I went through as a child, and they don't deserve that. […] I'm a bad person, a bad mother. I'm being selfish and not thinking about my kids and just thinking about me.

Six women who were persisting with substance use also expressed the theme of a good core self. These cases were examined as negative or deviant cases. Women who were persisting and claimed a good core self did not exhibit other themes of redemptive narratives, particularly the themes of redemptive suffering and narrative a generative future. It appears that claiming a good core self is necessary for redemptive narratives, but not sufficient.

**Bad "it".** Desisting women accounted for their past transgressions by assigning them to the influence of a bad "it," a force that had caused them to act badly in the past but was now controlled or eradicated. This force is internal (for example, an addiction) but is responsible for behavior the women considered unintentional or uncontrollable. Eleven (73.3%) desisting women attributed negative experiences in their past to a bad it, whereas only five (33.3%) persisting women did so.

Alyssa, for example, had struggled with her addiction to heroin and crack cocaine for decades. She had spent months living in hotel rooms, communicating with no one but her drug dealer, while her children stayed with relatives. At the time of her interview, she was receiving

methadone treatment and caring for her three-month old daughter. She spoke about how her drug use created a "not-real me" that was different from her true self:

> **Alyssa**: The not-real me was when I was using drugs. I wasn't the real me, you know, I did it to fit in, in the beginning, at the end I just did it to stay numb. And the real me cares. When I was on drugs, I didn't care about nothing. You know, I'm a caring, loving person, I'm very into my children's school activities and was *not* when I was doing drugs, so. I mean, you don't give a damn, because that wasn't me, because none of that stuff I believed in, you know. I never believed in doing—believe in some of the stuff, like sleeping with that guy for drugs, I don't believe in that shit, that wasn't me. That was me on drugs. I mean, it was me, I take responsibility, but I also know I would've never done it if I wasn't on drugs. It's something I'm not proud of, and I would never do in my right state of mind, so to me, that's what I mean "not me," so.

In this excerpt, Alyssa simultaneously confirms a good "real me" while explaining how drugs made her "not-real." She "would've never done it if I wasn't on drugs," so now that she is not on drugs, she is free to be her "real" self, which is caring, loving, and involved in her children's lives. She can attribute her past behavior to the influence of her substance use and confirm that as long as she stays clean, she can be her "real" self.

Casting substance use and addiction as the bad "it" presented an interesting tension with public narratives that encourage patients to claim an addict identity and recognize that they may be "in recovery" for life. Some women, like Diane, strongly resisted the notion that they would always be addicts:

> **Diane**: You know, a lot of people just don't understand, like you were saying, people look at people different when they use drugs. 'Cause like they say, when you're recovering—an addict is always gonna be an addict, no matter what, and it's like, I'm not no addict no more. I don't care what anybody, AA, NA, no, I'm not no addict no more. 'Cause I don't, 'cause I'm not always gonna be a addict. No possible way. I'm not no addict no more. 'Cause if I was an addict, I would've relapsed three, four times, you know, a lot of people just don't understand that.

Interestingly, Diane *had* relapsed multiple times in the past. Her substance use history was lengthy and punctuated by periods of desistance only when she was pregnant. In between pregnancies, she had always returned to crack cocaine use. However, at the time of her interview

she was maintaining her longest period of desistance since she had started using and expressed a determination to be done with her old lifestyle. Shannon, in contrast, was desisting with the help of a treatment program and the support of her church community and her new fiancé:

> **Shannon**: Let me figure out how I want to word this… Because addiction is a disease, I have this disease but it doesn't have to define me or my life, or where I'm going in life. I can still accomplish anything, plus more than a quote-unquote "normal person", a person without addiction. It just means that the disease of addiction doesn't define who I am, it's just a small part of me and… you know. […] It's a big part of my life 'cause naturally I'm always in recovery, everything, I do have to keep in mind that it's healthy and safe, but yeah.

Shannon identifies her addiction as an internal part of herself but something that "doesn't define who I am." "I'm me who's in recovery, I'm me who is a mom, I'm a fiancée, I'm a teacher," she explained. Where Diane rejects the "once an addict, always an addict" narrative to support her continued desistance, Shannon integrates her addicted self with her multiple other selves and simply downplays the primacy of this part in her core self. Both women were successfully desisting at the time of their interviews, suggesting that both strategies have merit, at least in the short-term. Both strategies include the identification of addiction as a "bad it," but present different responses. Women may reject the addict self in total, or downplay it relative to their more prosocial selves.

In contrast, Suzanne was persisting with heavy alcohol use and expected to return to cocaine and prescription pill abuse in the future. She, too, claimed her addiction as part of herself, but did not downplay the addiction or emphasize her prosocial roles. Where Shannon and Diane express some degree of control over their addictions and refuse to be defined as addicts, Suzanne embraces this definition of herself and expresses a lack of control over her addiction:

> **Suzanne**: I'm an addict, and I fall off, and I have problems, and my kids know, my family knows, I don't hide it, I don't lie about it, I don't have an issue with people

> knowing that it's – it's a sickness, it's a disease, and it's not always something that I can control.

Even though both Shannon and Suzanne describe addiction as a "disease" and recognize that they are people with addiction, they take very different approaches to this "bad it." For Suzanne, her addiction is a flaw in her core self that is beyond her control, and she expects that it will continue to negatively impact her life. Shannon depicts her addiction as something that does not have to define her or hold her back from accomplishing what "normal" people can accomplish. In her view, addiction has hurt her in the past, but she is capable of overcoming it and achieving her goal of being a good mother and fiancée.

Suzanne was one of five persisting women who expressed the theme of a "bad it" responsible for their past behavior. In Suzanne's case and two others, women identified the "bad it" but expressed the feeling that they were powerless to stop it. They lacked the "good core self" underneath or a sense of empowerment through others that could help them overcome their addictions. Suzanne recognizes her addiction as a "bad it" but expects that she will continue to "fall off." Elizabeth recognized that "drugs make you be bad," but had no expectations of overcoming her addiction to cocaine. Women who were persisting but expressed the "bad it" theme thus seemed to lack the sense of agency and mastery present in desisting women's redemptive narratives.

Finally, in two of these five cases, persisting women identified a "bad it" as one particular substance like heroin or crack cocaine, and they had desisted from that substance but were continuing with others, like marijuana, benzodiazepines and alcohol. In this way, it appears that some themes of redemptive narratives may be present when women overcome an addiction to one particular substance but are not fully desisting. Future research should examine how redemptive narratives develop throughout the desistance process, for example, which themes are

embraced first, in which order they are added to narratives, and which themes are most strongly related to total and sustained desistance.

**Empowerment.** Women who were desisting frequently mentioned being empowered by others, describing scenes in which they were "enlarged, enhanced, empowered, ennobled, built up, or made better through his or her association with something larger and more powerful than the self" (McAdams, 2001: 7). This force could be God or some other higher power, or an influential mentor, parent, treatment professional or other figure who "believes in" the woman and made her feel valued and worthy. Nine (60%) of fifteen desisting women described being empowered by a parent, an intimate partner or a higher power, versus only two (13.3%) persisting women.

Hazel met her husband shortly after leaving treatment for her crack cocaine addiction. She ran away from home when she was only fourteen years old and was introduced to crack cocaine by an older woman, who Hazel now believes might have been running a prostitution ring. Hazel was soon working as a prostitute to support her crack cocaine addiction. This continued for ten years until her mother helped her get away from that lifestyle:

> **Hazel**: I had so many—I got so many tickets from doing [prostitution], I started getting tickets and tickets and… they were misdemeanors, but three misdemeanors is a felony, so then I got tired of getting caught and they, what'd they do, they sent me to a rehab and then after that I had talked to my mom, and she had – she told me that if I came back home, she had something for me and if I did good, she would show me the way to be a real lady. […] My mom was my biggest influence, she stayed by me, she coached me, she paid for me to get my hair and nails done so I look like something else, and I had never looked like that before. She bought makeup, she bought me towels, I just… I didn't know I was worth all this. I mean, she set it up so I didn't have to go out there and look for anything or ask anybody for anything. And they say money isn't everything, but that part helped me the most so that I wasn't out there looking for anything. I didn't have no excuse. I had a house, a fully furnished house that I had picked everything in, and that was nice, I thought that helped. I had no excuse to go looking for anything. And she was trusting me with money and stuff, more money than I had ever been trusted with. It was different. This was a new feeling for me. […] My mom gave me every right to stay clean. She told me three words, "Look presentable, look like you want it," something like that –

> not look like you want it, but you have to look how you want to be, basically. If you're not that trashy person no more, you can't dress like that. Keep yourself up, and – that was one of the first things she told me, so I did it, and every morning I woke up and I prayed on it.

Hazel's mother had received some money from a medical malpractice lawsuit and this allowed her to financially support Hazel while she transitioned into her new lifestyle. Hazel describes not only the emotional support her mother provided by coaching and trusting her, but also the material resources that helped her actualize her new prosocial identity. She had a new hairstyle, a new manicure, a new house to live in and new furnishings that all supported her identity as a non-addict, and this helped Hazel to sustain the desisting behavior she had already started when she entered treatment.

Ongoing support was important to women's success and was highly valued. When asked about a high point in her life, Alyssa identified the positive appraisal of her mother-in-law and her older daughter:

> **Alyssa**: It'd been last Christmas, when my mother-in-law come to me and told me she was proud of me, and [my daughter] told me she no longer feared me leaving and not coming back. That's when I realized—I was pregnant, you know, and I realized "I am doing the right thing."

Even though Alyssa had started to desist on her own, the support of her family encouraged her to keep going. This support helped her to maintain desistance and to keep making healthy choices for herself, like staying in her methadone treatment program and seeking permanent contraception so that she didn't have any more unplanned pregnancies.

For many women in the study, assistance came in the form of a new romantic relationship with a non-using partner. The love of this partner made women feel worthy and deserving of a better life for themselves, and this feeling provided motivation to start the process of desistance

or to keep desisting. Tasha, for example, was very grateful for having met her fiancé and credits him with her desistance from prescription pill use:

> **Tasha**: From the day I started dating him, he accepted my kids, he loved my kids, and he treated me how I should've been treated from day one. He actually made me feel special and like I was loved. At that point, I realized a lot. I realized that I am worth something to somebody and I needed to get my shit together. And that's when I said enough is enough.

Hazel, too, felt empowered by a relationship with a prosocial partner. She met her husband shortly after leaving a treatment facility. She was living in the apartment her mother was providing and he knocked on her door to collect her signature for a political campaign.

> **Hazel**: So he was trying to get people to register to vote, so… I ended up seeing him and he said he was going to come back later and see me, and I told him no, don't do that, I didn't want no boyfriend. And, anyway, he did come back that night and we sat up and talked, and I ended up keeping him as a friend, and I had my place, and I got on Social Security, and I just ended up staying clean. […] I knew that he wasn't going to date nobody smoking crack so I just knew that then, I knew I wanted to be with him. He didn't even want to have sex with me when I tried, I did try, he told me no. And he told me the reason why no, and I knew he was telling the story and I still tried for like three months, and he never messed with me. And I thought that was so respectable. But he was still there every single night. And he would always talk, we would talk until we fall asleep, he wouldn't even sleep in the bed with me, he would sleep on the side of the bed and he'd stay on his knees, like he didn't even want to sit on my bed. I used to laugh, like, "Yo, you can sit on my bed, it's okay, we're talking!" [*laughs*] It's like a fairytale to me. It's like a fairytale to me, and I believe in myself. I had a man, I had a house, and I had somebody who loved me, my mom.

Hazel's resources – her house and furnishings, and the love and support of her husband and her mother – helped her "believe in" herself, or more precisely in herself as a person who could and should have such things. These resources helped her to sustain her prosocial identity because returning to crack cocaine use would be incongruent with her current lifestyle, and taking up her old lifestyle would mean losing valued resources like the trust of her mother and the love of her husband. This could be described as a feedback loop that bolsters desistance. The more Hazel "went straight," the more reinforcement she received from her mother and her husband. The more reinforcement she received, the stronger her belief that she can maintain her desistance.

The stronger her belief that this prosocial person is who she really is, the more likely she is to continue desisting and continue receiving reinforcement from her loved ones.

Children could also empower women to maintain their desistance. Women spoke about their children giving them a reason to live, "to get up in the morning," and "to keep going."

> **Ebony**: It makes me… appreciate life more, and appreciate my kids more, and it even actually makes me appreciate myself more, and it teaches me to be more independent and be responsible, and to be mature. And to never, ever, ever do anything to lose my freedom. Um, so… I don't know, that's why I said, my kids are like—they are my life, my kids are my foundation, that's what I'm trying to build myself up on, my kids, even though that might sound backwards to somebody, like "Your kids are supposed to build themselves up off you!" No, my kids are my foundation because they are my backbone. When I'm down, they make me smile. Not my friends, and I don't really have any family so I can't say my family, so I say my kids are my foundation and my backbone, 'cause they're the ones that give me their hand to pick me up, and they're the ones that make me feel good when I'm not feeling the best, so that's why I say I'm building myself up off of them because they motivate me to do everything that I'm doing now, they motivate me to work these ten days that I've worked non-stop, so. Everything I'm doing, I'm doing for my children.

Women spoke about their children as a support network of people who would love them "no matter what," people who were "here to stay" and wouldn't leave them as other loved ones had in the past, and who made them feel "needed," "important," and "here for a reason." Women described themselves as being empowered by their children to keep doing well.

Finally, women said they were empowered by their belief in a higher power who had intervened in their lives when they were at their lowest. This was common in Maruna's (2001) study, too, but women in the present study specifically identified their pregnancies as messages or gifts from God that helped them to desist.

> **Kellie**: Then, when I found out I was pregnant with J, it was kind of like…. [*makes heavenly noise*], like God had just sent down this life raft, this – what are those circle things they throw out to you when you're drowning?
> **Interviewer**: A lifesaver?
> **Kellie**: Yes, like, God was just like "Here!" Because I always, for some reason, had in my head when I was going through this drug stuff, "God, if I could just—if I just had a baby, if I had my baby or I had another baby, I would stop doing all this stuff, I know I

> would, and I would just be fine and all I would wanna do is just take care of my baby and it would fix everything and blah blahblah." And then it was like, I found out I was pregnant with him but it was just in the most horrible circumstance that I even could imagine, I was so overjoyed and happy but also so devastated because I was like, "How could God give this gift to me like this, in this situation where there's a chance for him to be taken again, and I can't get any help?" So that was kind of a big turning point, too, where I thought this is it, this is what I've always wanted and maybe needed, and I've gotta figure out a way to do this somehow.
>
> **Naomi**: I think… that… God always knows when I've hit my rock bottom and when I need help, like when I was pregnant with my first daughter, we were out doing everything stupid. Getting high, wherever, whenever, however we could, and then I got pregnant so I stopped. Then my grandpa got sick, so I stopped. Then I got pregnant again, so I stopped.

In both Kellie and Naomi's interviews they identified their pregnancies as sent by God to help them turn their lives around. They described themselves not as passive recipients of this gift; rather, they saw receiving this gift as the catalyst that empowered them to "figure out a way to do this somehow" or motivated them to seek treatment. In these stories, it is God who "believes in" the woman's ability to mother the child he is sending to her. This belief in motherhood bestowed by a higher power supports the fifth theme in redemption narratives, that of narrating a purposeful and generative future.

Only two persisting women expressed the theme of empowerment through others. These cases were examined to understand why the women were persisting with substance use despite feeling strongly about the help they had received. In Denise's case, she reported feeling very empowered by her new relationship. She felt that her new boyfriend saw her ability to succeed and believed in her, "because he don't want me to do all the stuff I was doing, he wants me to do better, he wants me to go back to school." Denise liked that her boyfriend was the first person to take care of her, but then mentioned that he was currently in prison in a fourteen-month sentence for "boosting," stealing "clothes, hats, whatever he could get his hands on" and selling it to pay rent and buy food and bus passes, "whatever we needed." He was also part of Denise's

substance-using circle of friends. It appears that the source of empowerment may be important for the support of desistance. For desisting women, empowerment from pro-social others or a higher power helped them to desist. In Denise's case, she felt empowered but by an individual still embedded in a social network of substance users and offenders. This finding supports the concept of "social network realignment" discussed in Chapter IV. Denise had not yet realigned her social network, whereas desisting women, through their empowerment by others, had taken further steps in that process.

Suzanne had also been empowered by a man who had offered her a job. At the end of a recent relapse, Suzanne had been offered a job by a friend who ran a construction company. She felt empowered by his belief in her and by the physical demands of her job. She spoke proudly about learning everything "from scratch," like how to use all of the different tools of the job, and boasted that by the end of the summer, she had learned how to put a roof on a house. Unfortunately for Suzanne, the work was only seasonal and when she got pregnant she could no longer keep up with the physically demanding work. Now that she was trying to parent her infant daughter and her older children, she wasn't sure she could return to construction work because of the very long hours. She was desisting from cocaine at the time of her interview but persisting with alcohol and prescription pills. She expected to "fall off" from sobriety in the future and her narrative lacked other redemptive themes like a "good core self" or "redemptive suffering." Though Suzanne had briefly been empowered by her friend giving her a job on his worksite, the effect of the empowerment seems only short-term and insufficient for sustaining her desistance.

**Redemptive suffering.** The fourth theme identified in the redemption narrative is that of "redemptive suffering." Desisting offenders need to make sense of their traumatic experiences in light of their new, prosocial selves. They need to find "some reason or purpose for the long

stretches of their lives for which they have "nothing to show"" (Maruna, 2001: 98). The solution is to reinterpret one's history in such a way as to allow the good to emerge from or be caused by the bad. Ten (66.7%) desisting women had reinterpreted traumatic incidents from their past as necessary for their heightened strength and wisdom today. Only three (20.0%) persisting women interpreted their suffering as redemptive.

Desisting offenders demonstrate a belief that their suffering has made them stronger and wiser, and, most importantly, *better suited* to their new purpose:

> **Naomi**: I don't think… well, I know if I wouldn't have been addicted, I would've been farther along in my life, but who's to say if I didn't have my addiction I would've known what I wanted to do in my life or, you know, what kind of things needed to be done.

Women spoke of being "behind" in life because of their addictions. As Naomi describes, if not for her addiction, she "would've been farther along" in life, as measured by prosocial milestones like graduating from high school, going to college, getting married, owning a house, and so on. If not for her addiction, though, Naomi would not have discovered her true purpose in life. She feels she had to experience her suffering in order to realize "what kind of things needed to be done." Women frequently cited their traumatic pasts as what "made" them who they are today:

> **Alice**: That I can overcome issues, things, I can make the situation better than what it was. And I'm forgiving, 'cause I still speak to [my abusive male relative]. I'm not as close to him as I was, but I am very forgiving. I didn't forget, but I forgive him. [Long pause] I feel like my childhood was horrible. Completely horrible. But that's what makes me who I am today.

Many desisting mothers expressed the belief that their experiences with substance use made them better mothers, because they would be able to explain the dangers of substance use to their children. In this way, they turned negative experiences into resources for better performing their more prosocial roles. What might once have been considered weaknesses in their identities are now narrated as strengths. Some women reinterpreted their suffering as a sign that they were destined for a greater purpose:

> **Natalie**: Yeah, I don't think I went through it – I don't think God let me go through everything I went through without a reason, and I think it has to do with me helping somebody in the future. I don't think I've done what I was supposed to do yet. And I think, I absolutely think it has to do, whatever I've gotta do is connected to what I went through. It's just gotta be.

Natalie felt that she must have been put on earth by God for the purpose of helping others avoid the suffering she had experienced. By doing so, she could interpret her life as planned or orchestrated by a higher power to deliver her to her present self. She interpreted her suffering as a necessary precursor to her purposeful and generative future.

The most interesting negative case for the theme of "redemptive suffering" is Sara. Sara had been taking prescription methadone prior to her pregnancy to help manage pain from an injury she suffered two years ago, when she was involved in a near-fatal car accident. Concerned about the effect of methadone taken during pregnancy, she quit methadone "cold turkey" against medical advice, but then used heroin approximately once a month throughout her pregnancy and cocaine "once or twice." At the time of her interview, she was back on her methadone but using twice the prescribed amount. She had used heroin and cocaine "a couple of times" in months prior to her interview.

Despite being categorized as a "persister," Sara expressed very strong redemption themes throughout her interview. When analyzed as a negative case, the explanation became clear: Sara's redemptive themes are all associated with her recovery from injuries sustained in her car accident and not with her substance use. In fact, she insisted that despite a lifetime of substance use, she was not addicted to anything. After her accident, she had overcome extreme odds to wake up from a coma and to learn to walk and talk again. She had amazed her doctors, friends and family and now felt near-invincible. "I think I'm special," she said, laughing. "I survived, like, a hardcore accident. I'm not addicted to anything." She recalled her time in the hospital:

> **Sara**: When I was in the accident and everybody was *so* surprised I made it through the accident, they started calling me a miracle and stuff, and I would go around the hospital saying "I'm a beast! I'm a beast!" Because I lived in the hospital for like, three months. But I was just like, "I'm a beast," whatever. And my grandparents would say "It's the Irish in her!" and my dad would say "It's the Indian!" And I would say "IT'S THE DRUNK!" [*laughs*] I mean, if I wasn't drunk I would've died. I was so drunk, I didn't even realize what was going on and my whole body went limp instead of tensing up. I would've died if I wasn't drunk.

Sara felt that her accident had changed the course of her life. She felt that she would not have her husband or her daughter today if she had not lived through this experience. This fits the theme of "redemptive suffering," where the past trauma (the accident) was necessary to the present good (her relationship and her daughter). The theme had nothing to do, however, with desisting from substance use. This suggests that the content of the redemption themes is important, not just the presence of the theme in the narrative. Sara's narrative was coded for the presence of the "redemptive suffering" theme, but on closer examination, the theme was not related to her desistance from substance use. Future research should explore the relationship of redemptive suffering to desistance when the "suffering" is not caused by the offending behavior itself.

**Generativity and purpose.** The preceding themes – the good core self, the bad it, empowerment by others and redemptive suffering – set the stage for the narrator's greater purpose. The "good self" was destined for this purpose all along, but waylaid by the "bad it." With the assistance of others who could see through the badness and recognize the narrator's core goodness, the narrator comes to see that the suffering caused by the "bad it" was necessary for their personal growth and development. The persons they are today is the culmination of these experiences and is uniquely positioned to fulfill a great purpose. Nine (70%) desisting women and two (13.3%) persisting women narrated generative futures for themselves that included goals such as raising their children well, writing books about their experiences,

becoming motivational speakers to serve as inspiration for others, and working to "change the system" so that others did not have the difficulty they had faced accessing needed resources.

***Motherhood as purpose.*** In the Liverpool Desistance Study, Maruna (2001: 97) observed among desisting offenders a theme of role hyperperformance, such that

> The fathers I talked to were not just fathers, but super-fathers. The volunteers were super-volunteers. The counselors were super-counselors. In the redemption narrative, making good is part of a higher mission, fulfilling a role that had been inherent in the person's true self.

The same was true of desisting women in the present study. They were not content just to be mothers, they were the best mothers. They talked at length of their philosophies on child-rearing, including appropriate discipline, boundary-setting and attachment parenting. They were effusively joyful in their descriptions of their mothering experiences and how much they loved being mothers. Jenny's children were in foster care and she was working hard to meet the court's requirements so that she could bring them home again:

> **Jenny**: I love being with my kids, I love playing with them, I love taking them places, shopping with them, going to their school events, watching them grow up, watching them fight. I love to hear them nag me. I didn't realize how much I loved it until they were gone

Kellie had struggled to find treatment for her opioid addiction while she was pregnant, but had desisted once her son was born. At the time of her interview, she was keeping up with her methadone program and enjoying raising her son:

> **Kellie**: [Being a mom] is the most important thing to me, I mean, sometimes—I always tell my girlfriends, "I'm sorry I'm not being a great friend right now, I'm never around, I'm too busy being a super-good mom," you know. That's just all that matters to me and all that's important. I've spent my last thirty years being a party girl and Miss Here, There and Everywhere, hanging out, and I don't even want any of that, I just want to sit home with my baby, that's all I want.

Women who were persisting expressed greater ambivalence about motherhood:

> **Amelia**: Sometimes I love it, other times I hate it. As I'm sure you can tell, I'm the kind of person who enjoys being able to do whatever with her time. Usually I'd like to just go

> out to the lake and trip and take my clothes off and run around bonfires and shit, but on nights when I want to do that, I have to look for a babysitter. And can I afford to pay for a babysitter? And if I can't afford a sitter, will my family babysit for me? And what do people think about me when I leave my child with them, do they think I'm a bad mom for wanting someone to babysit him so I can go out? You know, it's just constant thoughts.

Although Amelia talked about loving her son and that she enjoyed interacting with him, she expressed frustration that her responsibilities as a mother conflicted with her desire to party with her friends.

> **Amelia:** My thing is like, I spend as much time with my kid as I possibly can, but… like, people don't understand how limited my freedom really is, you know. Yeah, I have my kid with me when I'm going to my friend's house, blah blah blah, but I want to be able to go to a friend's house without having to change his diaper every few hours. I need time to myself, too, outside of work and taking care of him. I think moms that go without "mommy time" are the ones that go crazy. [*laughs*]

Amelia's description of her restricted freedom and her ambivalence about motherhood may be more realistic than the descriptions of desisting women wanting to spend every waking moment interacting with their children. It seems likely that most mothers experience moments of ambivalence or frustration about the demands their children make on their time. These frustrations were not frequently expressed in the narratives of desisting women, however, perhaps because their descriptions of motherhood were performances designed to convince both the interviewer *and* themselves that they were dedicated, capable, loving mothers. By talking about motherhood in positive terms and affirming their attachment to the role, women may have been practicing active desistance from lifestyles that were not consistent with the type of motherhood they described. In the descriptions of motherhood offered by Amelia and other persisting women, there remained a space for substance use during "mommy time" or as "stress relief" or "nerve medicine."

***Motivational speaking.*** Women who were desisting often looked outside of their own families and expressed a desire to take their message to a broader audience. Two women

reported that they were in the process of writing a book about their lives because, as Eleanor joked, “People love it when people fail and succeed!” Others wanted to become youth mentors, motivational speakers, or substance abuse counselors. As Maruna (2001: 102) recalls, “one reintegration worker told me, “I don’t know how much time you’ve spent around recovering addicts, but every addict who gives up drugs wants to become a drug counselor.”” Desisting women in this study felt especially qualified to be mentors and counselors because they had experienced substance abuse themselves:

> **Natalie:** I don’t know if really mentor is the word, maybe… I wanna help the ones that went through, that’s going through the streets and stuff like that, that are really, really lost, and I think they need more than just mentoring. Set something up, maybe… And I know that, like, for me, there was nobody that had really been through anything of any kind of nature that – the people that were stepping in to help just sat behind a desk a lot. They had no-- they mighta had life experience but they didn’t know shit about what was going on with me, and I guess that brings to mind that therapist that wanted to blame everything on the rape and not the four years I was living on the street. Are you fucking kidding me? I still don’t believe it. I still don’t. To this day I can still hear her saying “Wellllll, let’s not talk about…!”
>
> **Eleanor**: I would like to work in substance abuse, you know, with… um, people who are addicted to substances. Just in some sort of field. I want to turn my experience into something positive, so. […]I’d get involved in things like charity and, you know, like start my own, and just raise awareness on substance abuse. A big dream is if I could speak about it, at schools and just wherever, you know, and tell people my story, tell people that they can, they can get better. Like if I went to rehabs and talked to people. […] Because you feel kinda hopeless in rehab, and I think to have somebody speaking to you that has been through it and is better, it helps.

For Natalie and Eleanor, such futures were still daydreams. For Hazel, her desire to “tell my story to thousands” was off to a promising start. Hazel had been invited to speak in front of “younger girls that were like, 12 to 16 year olds” from “a youth or bad girls camp.” She had the opportunity to talk about her experience as a teenage runaway who wound up working as a prostitute to support her crack cocaine addiction. She recalled telling them to turn their lives around now, “’cause you never know where you’ll end up,” “’cause I always said that would be me and, guess what?” She reflects on this experience as a high point in her life:

> **Hazel**: I think there was like over a thousand girls in there, and they let me stand up and speak to them. I felt good that day, I did. I was like, wow! All my life I wanted to stand up and like, I'm somebody now. That felt good. I was almost about to cry. [*laughs*]

Goffman (1963: 24-5) identified the task of the "speaker" as a representative for the stigmatized:

> Another of their usual tasks is to appear as "speakers" before various audiences of normals and of the stigmatized; they present the case for the stigmatized and, when they themselves are natives of the group, provide a living model of fully-normal achievement, being heroes of adjustment who are subject to public awards for proving that an individual of this kind can be good.

For Hazel, sharing her experience with others was not only an act of generativity that showed her concern for helping young girls avoid the pain she had experienced, but also an affirmation of her "success story." She was demonstrating to an audience of stigmatized young women that they, too, could be "good" and follow her "model of fully-normal achievement," her transition from cocaine addict and prostitute to the married mother of twin girls. Telling her story to others fulfilled Hazel's need to legitimize her identity, and this identity was confirmed by the counselors who invited her to speak as a positive role-model.

Women who were desisting from substance use told life stories that featured a greater number of Maruna's (2001) themes of redemptive narratives. Though women who were persisting sometimes expressed some of these themes, like the "good core self," they lacked other important themes like redemptive suffering and narrating a generative future. In some cases when persisting women did express a high number of redemptive themes, analysis of their stories reveals that the themes were not related to desistance but to overcoming some other significant obstacle, as in Sara's recovery from a car accident. This analysis suggests that it is a combination of multiple themes and not the presence of any one theme that is supportive of desistance, and that it is important not only to look for the presence of the theme, but at the content, as demonstrated by cases like Sara, Suzanne and Denise.

An important subtheme of the "empowerment" theme was women's reflections on the

things that others have said to them and about them and how this helped them to reframe their experiences in a way that supported their desistance. Other women described messages from others that hurt them and made them feel hopeless and worthless. The next section describes the findings of the analysis of "memorable messages" women recalled in relation to their identities as mothers.

**Memorable Messages as Behavioral Guides**

Previous studies have found that memorable messages may guide people in sense-making processes by influencing the self-assessment of behavior (Smith & Ellis, 2001; Smith, Ellis, & Yoo, 2001; Ellis & Smith, 2004). Memorable messages can be recalled when individuals self-assess their behavior as exceeding or violating the behavior standards of their identities. These messages function to recalibrate, maintain, or enhance personal standards of behavior. Twenty-seven of the thirty women in this study recalled memorable messages about motherhood. This unusually high number of recalled messages may be because women were primed by the preceding interview questions about their histories, their relationships with others and their perceptions of motherhood. It is also possible that these messages were particularly memorable for women regardless of the interview context.

The twenty-seven memorable messages recalled by women in this study were evenly split between two different categories: action-oriented behavioral guides and assessment-oriented identity appraisals. Memorable messages that functioned as behavioral guides contained instructions about how to be a good mother and how to avoid being a bad mother. Memorable messages that functioned as identity appraisals told women something about their core selves, either by affirming and supporting their identities as mothers or raising questions about their abilities to mother effectively.

**Action-oriented behavioral guides.** Thirteen (48.1%) of the memorable messages women recalled functioned as behavioral guides that informed women either how to be good mothers or how to stop or avoid being bad mothers (Smith & Ellis, 2001; Smith, Ellis, & Yoo, 2001). Instructive messages about how to be a good mother came from women's mothers or aunts and emphasized calmness, patience and protectiveness. For example, Shannon's mother told her "Just take one day at a time," and Shannon linked this phrase to the similar message of her rehabilitation program. Lauren's mother told her to "Just walk away" before losing her patience with her son. Jenny's aunt emphasized Jenny's role as a protector, telling her "You always have to be there for her and watch over her." Natalie took instruction from her religious aunt, who told her "Spare the rod, spoil the child." Natalie described her interpretation of the "rod" not as a punishment device, but as a shepherd's staff, which symbolizes protectiveness and leadership.

For these women, these messages structured their mother identities by shaping their definition of a "good" mother. Good mothers, according to these messages, take one day at a time, do not lose their patience with their children, are always there to watch over them, and take the role of leader and protector. When women recalled acting in accordance with these instructive messages, they remembered feeling proud and capable. Jenny's message emphasizing the importance of "being there" for her daughter had helped her walk away from fights with other women because she knew that if she went to jail, she wouldn't be able to be with her daughter and something might happen to her. Shannon's message about taking things one day at a time helped her manage her anxiety about her son's future ("paying for college and that type of stuff") and also helped her stay in recovery and not feel overwhelmed by the process of desisting from opioid abuse. When women acted against these messages, they felt bad about their

behavior. Natalie and Lauren both mentioned their messages coming to mind when they lost their tempers and yelled at their children, and recalling the messages at those times made them feel "bad" and "frustrated with myself." Natalie, Shannon and Jenny were desisting at the time of their interviews, and Lauren was a primary tobacco user who had desisted during pregnancy but returned to tobacco use after the birth of her son.

The remaining nine messages in this category were negative in tone and told women not to behave in certain ways or to stop the way they were behaving. These messages came from family members, friends, and people women encountered when trying to seek treatment. These messages included phrases like "You'd better get your stuff together," "Look at your kids, you should be able to stop," "You have to do this for your daughter! Think about her instead of yourself!" and "Don't let drugs get your kids taken." These messages emphasize themes of good motherhood like responsibility and selflessness and condemn mothers who put their needs before the needs of their children.

Darla's friend told her "You'd better get your stuff together" because Darla would "scream and yell [at the children], and I would hit them." "I don't hold my anger real well," Darla explained. When asked when this message had come to mind and how it made her feel, Darla explained that she had pulled her life together but "still would yell and scream" and would slap her teenage son. The message had not stopped her from behaving this way, but she was able to recall the message and see that there was a discrepancy between her behavior and the ideal motherhood behavior. Tasha's mother had told Tasha "Look at your kids, you should stop, you should be able to stop." She communicated to Tasha that if she really loved her children, the sight of them should be enough to make her stop abusing prescription opioids. Tasha did eventually seek treatment, but even this did not appease her mother, who told Tasha that

methadone was "just a crutch." This message made Tasha feel bad about herself, even though she was in treatment and had been sober for many months. "It just really hurt," she explained. "I would cry all the time, I would feel so guilty." She felt confused about why she couldn't "just stop," and she was worried about what would happen to her if she stopped taking methadone. In this case, the negative tone of Tasha's memorable message from her mother was complicating her attempts to desist, because it made her feel guilty about relying on methadone and not being able to "just stop" and desist without treatment.

Other messages of this type were helping women be more responsible and achieve their motherhood or desistance goals. Eleanor's memorable message was "You have to do this for your daughter! Think about her and not yourself!" This was yelled at her by a counselor in a rehabilitation facility as Eleanor walked out the door and away from treatment. Eleanor still ended up leaving treatment at that time, but now she thinks back on that memory and appreciates how different things are today. She recalls this message every day:

> **Eleanor**: I can't think of any big events, but just my every day, the everyday way I live, how I'm choosing to put my kids first, and even like, recently, I've been saving my money. I don't have a job, but my boyfriend gives me money to spend for gas and I've been saving it. My dad gives me money sometimes, and I've been saving all of it. I used to be like the most ridiculous spender, and I have a good amount of money in the bank, not a huge amount or anything, but… […] Yeah, saving, just the fact that I'm saving, I'm proud of that. And just to have emergency money, just little things like that, like I think "Wow, I'm doing a lot different, that's good for my kids that I'm actually being responsible." Just being responsible, little things that I do.

How can such a message help her act this way now? Eleanor explains, "God, I don't want that woman to be right about me." For Eleanor, the message of that woman and the way the woman saw her in that moment is a representation of "everyone who was against me," all of the people in Eleanor's life who thought she was a selfish, bad mother for putting drugs before her daughter. "I don't want to fulfill their expectations of me." This message comes to mind when she thinks about reconnecting with old friends who are still using heroin and makes her feel bad about all

the times that she wasn't there for her first daughter. Now that she is raising a second daughter, she is determined not to be the woman she was in the past.

Alice's uncle told her "Don't be selfish with your body. Y'all deserve way more than what you have, so it's up to you to become that person you want to be."

> **Alice**: "Who you are is who you want to be." So, it's been sticking with me for years, and he said it to me a loooong time ago and it's been sticking with me, so I been trying to make the right decisions. I fall off sometimes, but… I really been trying to make the right decisions, 'cause like he said, who I am is who I wanna be, so… if I'm making the right decisions and trying to stay on the right path, then that shows me to myself that I want more than what I have and I'm capable of getting it, so, if I put forth effort.

"Who I am is who I wanna be" is an expression of the importance of identity performance. If Alice wants to be a good mother and wants others to see her as such, she has to act that way. The identity she performs, "who I am" is the identity she chooses for herself, "who I wanna be." If she keeps making the "right decisions," like staying in one place and "making it work," she shows herself that she is capable of achieving this prosocial identity. Her uncle's message continues to help her "move forward" towards her goals of stability for her family and "making everything right from it being so wrong for so many years."

In summary, just less than half of the memorable messages recalled by women in this study were action-oriented guides to behavior. These messages could be instructions for how to behave or messages that communicated that the woman's current behavior was not appropriate. When women acted in accordance with positive messages, they felt proud and capable, and when they failed to act in accordance with the messages, they felt frustrated and upset. When women recalled messages that were negative in tone at times when their behavior did not match the motherhood ideal, they felt guilty. In some cases, the message was negative at the time but women could look back on it from their current position and be proud that they were now living up to a more ideal motherhood standard. Action-oriented messages provided women with

instruction for how to behave. These messages differ from the other half of recalled messages, which featured assessments of women's mother identities.

**Assessment-oriented identity appraisal.** Fourteen (51.9%) of the twenty-seven recalled messages functioned as assessments of women's mother identities. Three of these messages were variations of "I always knew you would be a good mom." Eleven of these messages were negative, for example "You're a bad mom," "You'll never do nothing with your life," "You're a piece of shit for choosing a needle over your kids," and "You ain't gonna be nothing, you gonna be just like your momma." These messages came from women's parents, other family members, the fathers of their children, and friends.

Three women recalled messages that supported their identities as good mothers. Kim recalled her first child's father telling her "I always knew you were gonna be a good mom," and this made an impression on her because she felt he thought she was a horrible mother. This message came to mind when she went to great lengths to provide for her two daughters when she has no income, no transportation, and no social support:

> **Kim**: When I walked three miles with my baby in my arms, like we're in a foreign country with no vehicles, and I get to my destination […] I always think to myself, this walk is long, and I'm hungry and I'm tired and whatever, but I did it, we made it, we're here at the zoo or wherever it is. From my house, [the pet store] is a nice walk, and my daughter, she loves—we have some bettas, so she loves going shopping for the fish food or just looking at the other animals, so. To me, it's like, I could be sitting around crying, having a pity party for myself, sitting in the house on a beautiful day because I have no money. Instead, let me take the change that I have -- 'cause it's never money, it's just change -- let me take these bottles or this change or let me call my mom and ask for $10, and let me take my child out to a restaurant or to somewhere and just get them out of the house and get some fresh air, and it makes me feel good because we don't have transportation and we don't have anyone that's supporting us to where they'd be like "Oh hey, here's a car, let's to go to the park," or "Hey, let's go to a barbeque," we don't have any of that.

This message helped Kim keep going even though she was experiencing a very dark time in her life. She was recovering from an episode of intimate partner violence that had resulted in her

being hospitalized for some time and felt "like I couldn't protect my girls anymore." Thinking of this message helped her see "I was a good mom and I had just made bad choices, and I started to think "Well, maybe I am just a horrible mom," but now I feel like I'm an okay mom." Latoya and Hazel recalled similar messages that affirmed their mothering capabilities and reported that thinking of these messages made them feel proud. Latoya said that thinking of this message "pushes me to keep on her, you know, I've gotta make sure that she's taken care of," and Hazel shared that recalling this message told her "I didn't belong out there" on the streets and hanging around with other cocaine users.

Most of the identity appraisal messages women recalled were negative. Elsie's father told her "You're not gonna be shit, you'll never do nothing with your life," and Diane's parents told her "You'll never be nothing." Alyssa's sister-in-law called her a "piece of shit for choosing a needle over my kids." Vicki, Ebony, Belinda, Naomi, Denise and Amelia all recalled messages from their family members telling them they were "bad moms" or "not good moms." Kathryn and Elizabeth's family members told them they would be just like their own substance-using mothers.

Many women who recalled negative messages said that these messages motivated them to prove the speaker wrong. Women cited holding down jobs, keeping custody of their children, buying things for their children and spending time with their children as proof that they were good mothers and those who said they were bad mothers were wrong.

> **Vicki**: I mean, she can think whatever she wants to think, but I was actually there for my daughter, at least I was there for my daughter, you know, and gave her—and I feel like I gave her her basic needs and did stuff with her, you know, and that's being a good mom. That's being a good parent, is somebody who's actually there for their kids.
>
> **Belinda**: Like when I get my check or whatever and I buy something for him, like shoes or clothes or something, I feel like "I'm not a bad mom, I'm taking care of my child, I'm doing on my own, I'm not bad, I'm doing real good," like. It makes me not really pay attention to what anybody says that's negative.

> **Amelia**: [My mother] says I'm a bad mom, blah blah blah, she thinks I'm neglectful of my child, but how am I neglectful? I take very good care of him. I'll bend over backwards for that kid. I'll take three buses to his doctor's appointment. It's just that… and I'm sure she would agree, it's that I can't take care of him the way she can, with her money. I can't take care of him at that level, and she's ashamed of that, and she's made it pretty clear that it's shameful. You know, I bought him a brand new car seat, she said it was too ghetto, she went and got me, she got me a nice car seat and a nice stroller, but, you know, the little bit that I did have, yeah, my car seat didn't fit in my stroller right, but it was my car seat and my stroller. They weren't great, but I got them.

Women resisted the negative appraisals of others by highlighting the things they did that made them good mothers, even when they were persisting with substance use. Vicki was using pregnant and using methamphetamine, but she prioritized spending time with her older children because she felt that was something missing from her own childhood. Belinda drank too much on weekends and felt ashamed when she came home drunk, but receiving paychecks from her job and buying clothes for her son made her feel like a good mother. Amelia was smoking large amounts of marijuana, but she bought her son a car seat and stroller. Amelia's actions did not meet her wealthy mother's expectation, which annoyed Amelia because she was proud that she had purchased these items herself, even if they were lower quality than what her mother could afford. Women resisted the negative appraisals of others by emphasizing the mothering tasks they *could* achieve and downplaying the importance of the behaviors that marked them to observers as bad mothers.

Motivation to prove others wrong was not the only outcome of negative messages. For some women, negative identity appraisals infiltrated their perceptions of themselves and lowered their self-esteem and their belief in their ability to be good mothers. Naomi's mother told her she "was a bad mom because of choosing drugs over my kids." The message had come to mind when she relapsed, and it had not motivated her to desist:

> **Naomi**: [I felt] like I was a bad mom, like she was right. It made it worse, made me think "Well, she's right, I am a complete screw-up. My kids do deserve better." […] It made me—you know, a lot of people want to get clean, but they just can't. So it made me want

> to get clean, but then it made me want to get higher because I knew that I wasn't gonna get clean.

Elizabeth's extended family told her "You ain't gonna be nothing, you gonna be just like your momma, not good for nothing." "They won," she said,

> **Elizabeth**: I feel like they're right, because look how I am. […] It just makes me wanna do it more, because I don't have to think about that, I don't have to think about them, I'm just thinking about being high.

At the time of her interview, Elizabeth was persisting with cocaine use and Naomi was desisting from all substances, including tobacco. She had achieved desistance by taking Suboxone and then weaning herself from it. She did not attribute any of her success to the negative message, suggesting that it had only complicated her past attempts to desist and was not supporting her current desistance. Similarly, Elizabeth felt condemned by her family's negative appraisal and felt doomed to continue an intergenerational cycle of addiction. "Our generation, we're supposed to break the cycle, you're not supposed to do the same things, you know?" she explained, referencing her mother's cocaine addiction. "I don't feel like I broke it, because I'm doing the same things my mom did." Elizabeth wanted to break the cycle, but at the time of her interview she identified herself as a "bad mom" and expected she would continue to use cocaine in the future.

Finally, some women didn't disprove or internalize negative identity appraisals, but simply attributed them to external forces. Denise's family told her she was a bad mother for using methamphetamine and marijuana, but she felt that her substance use was their fault:

> **Denise**: They feel that I'm a bad mom because I focus more on my drugs and partying and boys, this that and the third. In reality, if they stopped and paid attention, if I felt that I had the support system that I needed, that I had family that was there for me, versus to hurt me, I probably wouldn't be where I am today.

When asked if this message came to mind when she did something she wasn't proud of, she deflected, "Mmm, not really, because I feel I'm a good mom, I just made bad choices, and who

doesn't sometimes?" In this way, Denise protected her perception of herself as a good mother and shifted the blame for her substance use to the lack of support from her family and "bad choices" that anyone could have made.

Ebony's memorable message was spoken to her by a family court judge, who told her "We're not gonna terminate your rights to your oldest son, because you have a relationship with him but you don't have a relationship with your daughters." This may seem a strange message for Ebony to recall, but she identified it as a judge telling her that she was an unfit mother. Ebony reported that the message had not come to mind when she did something she wasn't proud of, because:

> **Ebony**: I don't—I really don't try to dwell on that situation, 'cause like I said, I am to blame, but then, in ways, I'm not to blame, so it's like… I take probably like, eighty-five percent responsibility for that because, I don't know, like I said, I feel like there's a lot that I could've done and… then at the same time, I feel like I just picked the wrong person to be with, as far as my son's dad, so.

Denise and Ebony both demonstrate, through their reaction to their memorable messages, what Maruna (2001) identified as the "bad it." The circumstances they were in that would lead observers to condemn their mothering abilities were not their faults. Denise felt she would not be using methamphetamine and marijuana if her family had been more supportive of her in the past. Ebony took some blame for the circumstances that lead up to her loss of custody of her daughters but also attributed blame to the negative influence of her son's father.

The valence, content and response to the memorable messages women recalled were not related to their current desistance behavior, but this may be because women were asked about memorable messages regarding motherhood, not substance use or desistance. The messages about motherhood did women's mothering behavior and their explanations of their behavior. Women who recalled messages that instructed them how to be good mothers reported feeling proud when they behaved accordingly and guilty and frustrated when they did not. Women who

recalled messages about what *not* to do felt shame when they engaged in those behaviors, but did report being motivated to avoid those behaviors. As for messages that contained appraisals of women's mother identities, women who received positive messages were encouraged to keep moving forward in a positive direction, but this did not necessarily include desisting from substance use. Finally, women who recalled messages that contained negative appraisals of their mother identities responded in different ways. Some internalized the negative appraisals that affirmed their "addict" identities and increased their substance use, at least in the short-term. Others rebelled against the negative appraisals and highlighted the ways in which they were "proving wrong" those people who would call them bad mothers. Finally, women deflected negative appraisals, not by changing their behavior in any way but by attributing the appraisal to forces beyond their control, like lack of family support or the bad influence of another person. It appears that memorable messages were incorporated into women's identities, but in unpredictable and unexpected ways. This is an area that calls for further research.

**Discussion**

This chapter has demonstrated that the narratives of women who are desisting from substance use more frequently feature the themes of redemptive narratives as identified by Maruna (2001). It has also elaborated on the form that these themes might take in the narratives of substance-using women. For example, where Maruna's (2001) work identified the sources of empowerment as authority figures, mentors or higher powers, some women in this study were also empowered by their children. Negative case analysis revealed that when persisting women's narratives featured some redemptive themes, these themes were related to experiences other than substance use (e.g., recovering from a car accident). The chapter then turned to an analysis of motherhood-related "memorable messages" women recalled and how these messages had shaped their identities and their mothering behaviors. The analysis showed that memorable messages

instructed women on appropriate mothering behavior or assessed their identities as mothers, and these messages were incorporated into women's identities in various ways. Positive messages encouraged women to keep doing the right thing and made them feel proud and accomplished. Negative messages were either rebelled against or internalized. These findings highlight a need for further research on the role of others' appraisals in shaping narrative identities.

# CHAPTER VI

## Fear, Stigma, and Barriers to Care

The third and final research question for this study is: do stigma and fear create barriers to care and result in unmet needs for substance-using mothers and, if so, how? Women were asked if they ever feared coming into contact with criminal justice agencies or child protective services (CPS) and, if they had had such contact, how they felt about their experiences. Women reported feeling fear of being identified as substance-users by medical professionals or other authorities and discussed their strategies for avoiding detection. They described how they felt that others' perceptions of them as substance-users had influenced the type of medical care they received. Finally, women talked about their experiences of seeking treatment for their substance use, the barriers they encountered, and which types of treatment were most effective for them and why.

### Fear of Detection

Twenty-two women (73.3%) reported that during their pregnancies they had been afraid of being identified as substance-users. The scenarios of which they were most afraid were testing positive for substances at prenatal visits or after delivery, losing custody of their newborns and/or their older children, and experiencing criminal justice consequences for their substance use.

The remaining eight women (26.7%) in the sample reported that they were not afraid of detection. For most of these women, this was because they were not using illegal substances. Though they recognized the harmful effects of alcohol and tobacco, they were not worried about being tested, having positive test results, losing their children or being arrested. Women who were using illegal substances but were not afraid of being detected said that they felt they had their substance use "under control" and that they could avoid detection. Some women were simply unaware that they might be tested at prenatal visits or at the hospital and that they could

lose their children. For example, when asked if she had feared coming into contact with the police or CPS, Brittany said that it hadn't really occurred to her to be afraid until it was too late:

> **Brittany**: Honestly, no. I would have to say I think I'm kind of – me and [my boyfriend], because we were together all the time – we're kind of weird that way in that we never had any issues with getting arrested or with police or with CPS until that… one. You know? So…
> **Interviewer**: So you weren't, even like before that, you weren't worried about getting caught?
> **Brittany**: I didn't really. I mean, I knew it probably wasn't something I would walk down the street doing or advertising it, but… I mean, I don't know, I guess I wasn't like… I don't know. I guess I would say it was somewhat contained maybe more at that time, so that's… why I can say I wasn't worried too much about it.
> **Interviewer**: Did you have any concerns about CPS taking the children?
> **Brittany**: I guess I would say no, only because nothing like that had happened before. So I hadn't seen it and I never really knew anybody who it had happened to, either, so it really almost didn't even seem like a possibility, I mean. That's why there's kind of like a lot of like, that feeling, like the CPS thing 'cause like I said I never knew anyone really before that it had happened to, so there's nobody I can relate with or, you know, hear about how it went or it worked out with them or anything like that, so.

Brittany had permanently lost custody of her three boys. Her case presents an interesting example of the way that some women were protected from consequences by their relative privilege. Brittany is white, in a long-term and stable relationship with the father of her boys, and had previously enjoyed a certain amount of family support. She had managed to keep her opioid addiction a secret for many years until it spiraled out of control. She spoke about how her addiction had never resulted in contact with the police because it was her boyfriend who would take risks and go out to buy their heroin. "So I guess I was kinda sheltered in that way," she reflected, "We were a using couple, so I guess that's different than doing it yourself."

Women who were using illegal substances and did not feel afraid of being identified as substance users were the exception. Pregnancy was a time of great uncertainty for most of the women, and this was compounded by the threat of detection. This was especially true for women who did not know what to expect at prenatal appointments or delivery. Some women believed

they were drug-tested at every prenatal visit and that every baby delivered at the hospital had his or her meconium tested for drugs. Other women felt that the decision to test mothers and babies was on a case-by-case basis. Others thought that babies could not be drug-tested without the parents' permission.

> **Denise**: I didn't find out about it until after I asked my doctor, and that was because all my friends were saying "Oh, you need to stop smoking pot, you need to stop doing this, da-da-da-da-da." And I was like, wait a minute, I walked in my doctor and I asked him, "When the baby's born, are you doing to test me? Are you going to test me and the baby?" "No, we're not gonna test you unless you drop dirty at your visits." And I was like, so wait, when you make us pee in the little jar every time….
> **Interviewer**: It's a drug test every time?
> **Denise**: Yes, that's a drug test every time. And that's because it's CPS's way of knowing if you're doing drugs beforehand, they're gonna take that baby instantly from you. It's only for the hardcore drugs.
>
> **Interviewer**: And were you ever worried that you would drop dirty at the hospital when you delivered?
> **Loretta**: This [pregnancy] was the only one I was worried with. Well, Kerry, yeah. I take that back. Kerry, because they asked me to do a drug screen and I told them no, and they took it anyways. And Kerry was the only one where the law switched and they could do it. Because with Tammy and Andi, they never did that shit back then. They couldn't. It was against the law. And it still should be against the law to take part of your body, and it is part of your body, it's your bodily fluids, and now they don't need a warrant, they don't need nothing, they can do it without your permission.
>
> **Interviewer**: Do you know if they drug test every baby?
> **Sarah**: I don't know. I would imagine it's every baby. Because I don't know why they would single-handedly pick out me, maybe because my knuckles are tattooed [laughs]. Well, I mean, [my husband]'s got track marks, you know, they might have saw that and thought that maybe I was doing it, too.

Others were uncertain about the "rules," like which substances could be detected, which would trigger CPS involvement, and how far back into the pregnancy a meconium test could detect substance use.

> **Vicki**: Well, 'cause my friend Karen says now is a good time to quit cold turkey, because they do check—Sparrow does check the umbilical cord, and… her baby had—but she had different, she had an addiction, like my friend Jamie, like to heroin, but she said if there's like a certain time limit that if you stop, it won't show up in your system or whatever. It's like… see, I didn't—I don't know anything about that.

> **Eleanor:** No, I don't think they even tested her. I don't know, though. Because I wasn't doing anything, so she would've been clean then – unless they did a thing where they could see the whole, throughout the whole pregnancy. Because I think they can, now.

Some uncertainty may be attributable to variation in testing and reporting policies between different obstetric clinics and hospitals. Medical organizations have some discretion in their policy decisions, although they are of course subject to federal and state laws and administrative codes. At the federal level, hospitals must comply with the Keeping Children Safe Act of 2003, which added requirements to the Child Abuse and Treatment Act. Under the new act, states had to develop procedures requiring healthcare providers to notify CPS if they suspect a child has been subjected to drugs, or is suffering from withdrawal symptoms at birth. Michigan likely complies with this requirement by having mandatory reporting statutes within the Michigan child protection laws. In Michigan, "mandated reporters" include physicians, physicians' assistants, and nurses, among many others.

At the state level, Section 722.623 of the child protection laws lists those who are required to report suspected abuse to the Department of Human Services (DHS). This list includes healthcare professionals that a woman would come into contact with at a hospital. Section 722.623a requires reporting to the DHS when a healthcare professional has "knowledge or suspicion of alcohol, controlled substance, or metabolite of controlled substance in body of newborn infant**."** Thus, a nurse or other healthcare professional does not have to have specific knowledge to report a mother to DHS; they need only have suspicion.

Finally, clinics and hospitals must comply with Michigan's administrative codes. These are the regulations that help describe the laws and policies of the state. The specific section that deals with hospital regulations is R 325.1051 through R 325.1059. Within the regulations for hospitals is section 325.1058(2)(f), which states that unless admitted in an emergent situation,

records for admittance to the maternity ward must include a urinalysis. However, the rule does not state what must be checked for within that urinalysis, just that a urinalysis must be included within the mother's records. Individual clinics and hospitals likely have varying internal policies regarding what is to be detected through urinalysis, along with other testing and reporting procedures. It is unlikely that most women are aware of these numerous federal and state laws and policies. Inquiring about the drug testing policies at a clinic or hospital may increase staff's suspicion of one's substance use habits and is unlikely to be of much use, as most women in this study had no choice in the clinic they attended or where they delivered their babies.

**Strategies for Avoiding Detection**

To manage the risk and uncertainty of being identified as a substance-using pregnant woman, women in this study adopted various strategies. Some strategies seemed pro-social and pro-health, like being honest with medical practitioners or seeking out treatment. Other strategies seemed more damaging, like isolating oneself from friends and family who might detect the substance use, hiding or denying the pregnancy, timing prenatal appointments so that persistent substance use would not show up in drug tests, skipping some prenatal visits or avoiding prenatal care altogether.

**Honesty.** Some women adhered to the idiom that honesty is the best policy and were up-front with medical practitioners. They felt that being honest showed that they were good mothers despite their substance use and they hoped that doctors and nurses would appreciate their honesty and affirm their motherhood identities:

> **Interviewer**: Are you worried about them drug-testing you or anything like that?
> **Vicki**: [*emphatic*] Yeah. [*nervous laugh*].
> **Interviewer**: Do you still go?
> **Vicki**: Yeah. That's why I still go, because I want to show them I'm not a big time drug user — if something does happen, I'm not a big-time drug user and… I do care about myself and I do care about the baby's health, you know. I have a friend who has a baby

> due any day, or in a week or so, and she hasn't had no prenatal care through her whole pregnancy.
>
> **Kim:** I mean, I was honest, and I think that's the best thing, so I was able to tell them "Look, I did smoke marijuana and I didn't know that I was pregnant, and I'm not addicted, and is there anything you can give me to where it would be out of my system or anything you can tell me about the effects on being pregnant?" I asked for information, and I think a lot of those people respect you a little more, as to where there won't be so much concern, because if you're hiding it and they see it right in your levels, especially being pregnant, there's going to be some concern and they're going to go behind your back and call CPS. With me being so blunt, so open and wanting the help, I think it shied a lot of people away from being so concerned or disturbed.

In these excerpts from interviews with Vicki, a methamphetamine user, and Kim, who was using alcohol and marijuana, both women express their hope that being up-front with doctors would help them be perceived as good mothers who were concerned about the health of their fetuses, resisting the master narrative of substance-using mothers who are selfish and unconcerned. Vicki was pregnant at the time of her interview and was yet to see if her strategy would be successful. Kim had stopped smoking marijuana before the birth of her daughter and was only using alcohol, so she did not have any contact with CPS.

Not all women were pleased with the outcome of their strategy to be honest with their doctors. Melinda had been honest with her doctors about her opioid and benzodiazepine use but felt that this strategy had not worked for her, because she was unhappy about how long her son had to stay in the nursery before he could come home with her:

> **Melinda**: I would *never* advise somebody to have a child [at the hospital]. Now, yes, if your child has some horrible, crazy thing that needs care, alright, *then* take them where they need to go, but I would advise a home birth if you could manage it before ever taking them to a hospital. I had advised mothers to not tell them honestly about the substance abuse because otherwise they're opening up— I thought I was helping my child by being honest during my pregnancy, I thought I was helping him if I was honest with my doctors. No, I wasn't. All I did was damage that relationship and our early bonding by letting them have that "in" to keep him from us. We could've, and we would have, taken better care of him than what they did, leaving him in his bassinet with a million other babies in there and not enough people to take care of all the babies.

The risk of being honest may be lower when women are using legal or socially-accepted substances or when a woman has a trusting relationship with her medical provider. The relationship between a woman and her medical provider might be one way that socioeconomic status may grant some substance-using women privileges and health benefits. If a woman has health insurance and a private doctor with whom she has a long history, honesty may be a safe strategy that allows her to receive support and treatment specific to her risk status. If, in contrast, a woman must rely on a public health clinic that she can attend only when pregnant and where she may see a different doctor every time, she may not know the doctor or the practice's drug testing and reporting policies and will not have the opportunity to develop a trusting relationship with the practitioner. In this case, revealing one's identity as a substance-user seems a more risky strategy, because the outcome is more uncertain. These possibilities suggest an area in need of further research.

**Social isolation and denial of pregnancy.** Another set of strategies women employed was to keep to themselves, avoiding friends and family who might report them to CPS. For a small number of women, this went as far as concealing or denying their pregnancy:

> **Interviewer**: Did you do anything to try and hide it or avoid getting caught?
> **Kim**: Yes, I did, I did, um, to hide the pregnancy, I denied that I was pregnant. I drank as if I wasn't pregnant, and I denied some more, I kept denying. And I lied, a lot.

Of course, pregnancies are typically only concealable for a limited amount of time. A more common strategy for women was to socially isolate themselves from anyone who might report them to CPS:

> **Interviewer**: Did you do anything to avoid getting caught? What was your way of dealing with the fear?
> **Loretta**: Just trying to stay away from anybody that you think would call CPS or do anything to you, but, you know, it didn't matter.

> **Interview**: Did [fear of detection] stop you from doing anything you might've otherwise wanted to do, like stop you from doing something you wanted because you were worried?
> **Alice**: Yes, yes. I had stopped talking to everyone, period, because I didn't want the wrong person to go over there and say something. I didn't want them to go do that and I didn't know who to trust, so I wasn't saying anything.

The strategy of avoiding people may be based on women's past experiences with CPS. Of twenty-two women who reported having past contact with CPS, the most commonly mentioned source of contact (n = 10, 45.5%) was a report to CPS by a third party. These third parties included roommates and friends, family members, ex-partners, and neighbors. Some of these reports were made out of concern for the children, but many reports were identified by the women as acts of retaliation. For example, a mother would get into an argument with another woman and that woman would report her to CPS in retaliation. In another case, a mother broke up with her abusive boyfriend and, in retaliation, he called CPS and told them she was pregnant and smoking marijuana. Other women had family members who wanted custody of their children and would call CPS very frequently, forcing CPS to investigate every time, even though they had found time and time again that the children were happy and healthy. In light of these experiences, women may feel that isolating themselves is an effective strategy for avoiding contact with CPS and law enforcement.

**Avoiding medical care.** The most common strategy employed by women afraid of detection was avoidance of medical care (n = 12, 54.5%). This strategy included scheduling visits around their substance use so that any tests would come up negative, skipping some visits, or avoiding prenatal care altogether.

Women who used substances that are only detectable through urinalysis for several days after use were able to schedule their appointments around their substance use.

> **Interviewer**: And during this time, while you were pregnant, were you ever worried that if you went to a doctor, they would drug test you?
> **Sarah**: Kind of, yeah. Kind of. But that was only a couple of days after I did the heroin. But I would make sure that, um, I would do it on days like, 'cause you know, that stuff lasts in your system for three to four days, so I would make sure not to do it around the time of the appointment, just to be on the safe side.
>
> **Denise**: I drank a lot of water. I always made sure that I stopped certain stuff before I went in. I had it already charted out for how long it took to get out of my system, this, that and third, like, I made sure I had my stuff on lock. It's the good thing about being able to make your appointments before you go in.

Some women, like Denise and Amelia, seemed proud of their ability to avoid detection. Amelia laughed, "A lot of people think drugs are dumb or hippies are stupid, but it's some hard work, man, it's like chemistry." Women would "chart out" on a calendar the days that they used and how long it would be before they would test clean and then schedule medical appointments accordingly. By doing so, they were able to avoid positive prenatal drug tests. This method is not effective for avoiding detection at delivery, though, because meconium begins to form in the second trimester of pregnancy and a positive test can indicate substance use a month or longer prior to delivery (Farst, Valentine & Hall, 2011). This is an important consideration if meconium testing is triggered only by positive prenatal tests, as women who use substances that pass quickly through the body may successfully evade detection at prenatal appointments and also at delivery. This strategy is less effective if women deliver at a hospital that tests all mothers and/or babies or makes decisions about testing based on other factors, like late prenatal care or the mother's appearance, demeanor, or history of involvement with CPS.

Some women would skip appointments if they had used recently and others would avoid care altogether:

> **Suzanne**: I wouldn't go to the doctor's. I would skip appointments and things, and stretch them out. I always went because, again, CPS will get involved if you don't go to the doctor's, so you still have to go, but you know, you didn't—you just have to stretch it out or go late or delay it or whatever.

**Interviewer**: And did worrying about being involved with CPS or getting her taken away, did it keep you from doing anything you might otherwise do?
**Elsie**: I just didn't go.
**Interviewer**: Didn't go to the doctor?
**Elsie**: Yeah. I just wouldn't show up, I was so scared.

**Alice**: I stopped going to my doctor's appointments because I thought that they were going to test me and see it in my system and call CPS.
**Interviewer**: So you stopped going to your appointments?
**Alice**: Yes. And CPS is in the same building so I just didn't, um, wanna, didn't want them to do that, didn't want them to do that, so I stopped going. I missed a whole four or five months of prenatal care. And then when I was in Mississippi, same thing with [second-youngest child], I didn't have no prenatal care with her.
**Interviewer**: No prenatal care?
**Alice**: My third child, I had no prenatal care.
**Interviewer**: For what reason?
**Alice**: Because I was taking drugs, well, not drugs-drugs, I was down there smoking on marijuana and drinking liquor. And they told me if they see THC or something like that in my system, then protective services would get involved. So I didn't go to no care for her, none.

Research repeatedly demonstrates that substance-using women who receive prenatal care experience more positive birth outcomes and have greater opportunities for other health promoting interventions than women who do not receive care (Berenson, Wilkinson & Lopez, 1996; El-Mohandes et al., 2003; Green, Silverman, Suffet, Taleporos & Turkel, 1979; MacGregor, Keith, Bachicha & Chasnoff, 1989; Racine, Joyce, & Anderson, 1993; Richardson, Hamel, Goldschmidt & Day, 1999). Prenatal care appointments provide practitioners the opportunity to connect women to needed resources, to screen them for dangerous illnesses or injuries, to screen for intimate partner abuse victimization, and to implement many other public health interventions. By adopting policies that scare women away from treatment, clinics and health organizations lose the opportunity to intervene and promote maternal and infant health.

**Experiences with Medical Care**

Pregnancy and childbirth frequently brought women into contact with medical professionals who suspected or knew them to be substance users. Many women recalled

individual nurses who had been very kind and helpful, but they also recalled doctors, nurses or staff who treated them poorly, and women believed (in some cases, knew) that this was because of their stigmatized identities.

> **Kellie**: I was treated—there was a few nurses that were very nice and treated me like a normal person, and the doctor that I dealt with luckily treated me that way, but for the most part, all of the other staff were very rude, very… like I said, just judgmental. They watched me very closely when I was with him, like I was going to—I mean, I gave him a bath one day and one nurse literally stood behind me the entire time, watching me, and I mean, they just basically treated me like a piece of shit drug addict, like "Look at what you're doing to your baby, how could you do this."

The consequences of this stigmatization ranged from brusqueness and heightened scrutiny, as Kellie describes, to more serious outcomes. Some women described doctors misattributing their medical complaints to women's substance use and not checking for other underlying conditions. In Alyssa's case, she felt that her identity as a former addict and current methadone user resulted in mistreatment by an urgent care physician and judgmental attitudes from her labor and delivery nurses:

> **Interviewer**: How did the doctors and nurses treat you, like how did they interact with you?
> **Alyssa**: Pretty crappy back then, but it was probably because of my behavior, so, you know. Now, I can say I've seen a bunch of it, you know, and I don't like it. My daughter had thrush, the baby, and I took her into the pediatric urgent care right down the street, and the doctor proceeded to tell me that I needed to take her to the emergency room because it wasn't common, blah blah blah. Thrush is one of the most common things a baby gets, and we feel he did it because he found out I was on, you know, methadone during my pregnancy, and just didn't want to treat her, because the hospital couldn't believe it and, you know, I've had another doctor call him and really cuss him out, because it wasn't right. They told me—he tried telling me she would have to be hooked up to an antibiotic IV and everything else, told me it was so uncommon for my baby to have thrush, and it was one of the most common things. The hospital looked at me like I was crazy. And I'm like, well, Urgent Care sent me here. So I think that was over, you know, me being on methadone and then when I gave birth to her, there was two nurses that were really… judgmental, you could tell they just didn't care for me because of the situation.
> **Interviewer**: And did it come through in the way they cared for you?
> **Alyssa**: Yeah, the one—you know, she actually made it so she wouldn't have nothing to do with me and my daughter, because me and my husband stepped out to smoke and she

> proceeded to ask my mother-in-law if my other kids were born on methadone and if I believed in birth control and stuff she should've been asking me, not my company […] You know, you could just tell she did not approve of it. She was just really foul.

While this treatment may be unconscious or may be intended to shame women for their behavior, it can have the unintended consequence of pushing women back towards substance use. Just as the women who lost custody of their children felt that the court's decision to terminate their rights was a condemnation of their "mother" identities and an affirmation of their "addict" identities, women who were treated poorly by medical professionals were at risk of using substances to soothe their guilt and shame:

> **Kellie**: It just made me feel even more horrible than I already felt to begin with. I mean, of course I was already devastated and crushed, having to sit there and watch him go through this, especially knowing how he felt, you know, I've detoxed before and it's horrible, I couldn't imagine my poor two-day old baby having to go through this, I mean, it just killed me to watch him, and then to have these people who were supposed to be helping me take care of him treat me like that was horrible. To read the CPS paperwork and to see how I was actually referred to, as a "perpetrator" and my child a "victim" when I didn't do anything but follow the advice of the medical professionals themselves. […] No, it honestly at some points made me so crazy that I just wanted to go back and not feel, because it just made me feel so horrible and I think that's—that's just one thing that is common in people who have substance abuse issues, when things go crazy and you feel horrible, that's automatically somewhere where you think about turning, you know, you just don't want to feel that anymore.

Medical professionals do not see a substance-using woman's history of abuse, her chaotic life circumstances or her failed attempts to seek help. They see infants in withdrawal and medical complications stemming from maternal substance use. It is understandable that they feel negatively towards substance-using mothers. However, in their role as caregivers, it is their duty to promote not only the infant's health, but the mother's health, and actions that stigmatize (or are perceived as stigmatizing) mothers who use substances not only break down the doctor-patient relationship, but may push women away from care and treatment and towards continued substance use.

**Finnegan scoring.** In three cases, women who had used opioids mentioned their infants being "scored" or assessed using a "Finnegan" scale. A search of the literature on the treatment of drug-exposed neonates revealed that this is likely the Finnegan Neonatal Abstinence Syndrome Test (FNAST), a 31-item scale designed to quantify the severity of neonatal opioid withdrawal symptoms and to guide treatment decisions. The scale, developed by pediatrician Loretta Finnegan and her colleagues (Finnegan, Connaughton, Kron & Emich, 1975), is one of the most popular assessment tools for neonatal abstinence syndrome. In general, it has been found to be an inclusive, easy-to-use tool for neonatal care nurses, but only when paired with suitable education. However, the test has been criticized for being too subjective, allowing for inaccurate scores that lead to inappropriate treatment, increased length of hospital stay, and increased incidence of poor neurodevelopmental outcomes (D'Apolito, 2009). Studies of the use of the FNAST have found scoring inconsistencies throughout infants' charts (D'Apolito, 2009; Lucas & Knobel, 2012; O'Grady, Hopewell & White, 2009). The problems with using the FNAST include inconsistency regarding scoring intervals and the infants' sleeping and feeding schedule (e.g., nurses waking infants just to score them), inconsistencies in scoring between staff members, and difficulty defining the signs and symptoms of withdrawing, for example, differentiating between mild, moderate and severe symptoms.

A few women in this study highlighted the subjectivity of the FNAST in their stories about their experiences. Kellie felt that there were some nurses who consistently scored her son higher than others, and this kept him in hospital for longer than necessary:

> **Kellie**: And then, um, so after the first couple of days, J did start showing withdrawal symptoms, so they started him on morphine and they did it, administered him the morphine and slowly dropped down the dosage, you know, every day or two they'd drop it down 10%, so anyway—and they scored him on this scale, I can't even remember what it's called now, but they'd give him a score about how many withdrawal—what kind of withdrawal symptoms he was having. Finnegan… It's Finnegan or something like that.

> They wanted it to be in the low numbers, like 5 or below means he was doing good and not having many symptoms, and the higher numbers was, he was really having a lot of symptoms, and as long as he was staying low on his symptoms they would decrease him. So they kinda just monitored him on that, but it was kind of odd because different nurses would come in and it was kind of a matter of opinion, they would judge him on how rigid he was or how many—if he was sneezing a lot, and a lot of that is kind of up to the interpretation of the specific nurse, so I'd have certain nurses that would consistently score him high and certain nurses that would consistently score him low, which got kind of frustrating because they were basing these scores—they were taking the results of these scores and basing when his dose would go down, based on these scores, and I kind of felt like it was very subjective.

After eighteen days, Kellie was allowed to take her son home. Eleanor reported a similar experience, remembering that her daughter was scored higher whenever Eleanor was not sitting in the nursery with her and that her daughter's doctor disagreed with the nurses' scores:

> **Eleanor**: So they do a score, a Finnegan Score, where they judge them on certain withdrawal symptoms that they see. And, oh, it was hard for me, because she would do so good, and I was up there *all* the time, like, the only time I would leave, basically, is when I had to go get [my older daughter] from school… […] But I was, you know, always there, but when I would leave for a couple of hours, I would come back and her scores would be higher than when I was there. So it was like, you know, it depended on her scores whether they could lower the medication, but finally my doctor came in and said like, "They are mis-scoring her. Stop the medication and let her go home in a couple of days." So she got to come home. I think she got to come home sooner than most babies because of her doctor. He stepped in.
> **Interviewer**: What do you mean, they were mis-scoring her?
> **Eleanor**: I don't know, it was really weird. I've heard the nurses at the hospital can be really mean to women. They were—they didn't ever show it to me, I don't know if it was because I was there all the time so they saw… […] But, um, what would happen is like, she—they would score, the main things she would get scored for were like, stiffness, yawning, um, sneezing, sweating, I'm just naming some of the other things, too… Diarrhea or loose stools, and what they were saying, my doctor was saying, they would score her for loose stools, and that was a big score that would add a lot, and [the doctor] would say, "She's breastfed. Breastfed babies have loose stools." And he would look at her stools and say, "These are normal breastfed baby stools." Because there was a time when it was a little watery and I could see then, but they were scoring when it was just like normal.

This perceived mis-scoring of normal infant behavior as withdrawal symptoms was also reported by Melinda, who complained that her newborn son had behaved no differently than her older daughters, who were born before she started abusing opioids and benzodiazepines

> **Melinda**: I went to [this particular hospital] because I wanted to go to a hospital where if my child was going through withdrawal, they would handle that, but I also wanted a hospital that was not going to prevent me from taking my child home, and they kept him for a month, without him needing to be there for a month. They did not— I am not stupid. I understand the rating scales, and I understand that what they were rating my child on, they were rating my child worse than—okay, my last child, I've already had two kids. I know how babies behave. My first two children had more challenging behaviors on the things they rated him on than he did, and yet they would put him higher for those behaviors, having no physical withdrawal symptoms. They went through totally behavioral scales and rated him higher on things so that I could not take him home for over a month. I missed all of these things, moments with my baby. I missed Christmas and New Years with my baby when he should've been home with me by then, because it had already been almost a month, and there was no physical withdrawal symptoms. Everything they were rating him on were normal baby behaviors, because my girls, when I hadn't used *anything*, had worse behaviors in those areas than what he did. There was no reason for them to keep him from me.

Melinda has no medical training, so it is very likely that the nurses could detect withdrawal symptoms that she could not see. However, her excerpt suggests that there was inadequate communication between Melinda, the nurses and her doctor about which symptoms her son displayed that suggested the need for more treatment, how the scoring system worked, and how long Melinda should expect him to stay at the hospital. Melinda felt very negatively towards the hospital staff after her experience and now advises other women she meets at her methadone clinic to avoid the hospital and to avoid being honest with medical practitioners lest they suffer the same bad experience.

### Custody Loss, Identity Loss

In some cases, women's substance use was detected and they temporarily or permanently lost custody of their children. In some cases, women avoided losing legal custody by placing their children with other family members, although some of these cases resulted in legal battles when family members resisted returning the children to their mothers. Other women lost legal custody but were able to place their children with relatives. If no family members were available or capable, children entered the foster care system.

Women who had lost custody of their children spoke about this event as the darkest period of their lives. They frequently used the phrase "downward spiral" to describe their reaction to the loss.

> **Eleanor**: So they took her away, and thank God for my mom, because she took her, so she wasn't in foster care or anything. Um, but—so, I just like, went, just terrible from there. Just a downward spiral. And I just started using all the time, and it's like, I cared, but what do addicts do when they're sad or depressed? […] I remember I would just—living with Dan, I would just start crying non-stop and I would just think "I want to stop using but I don't have my daughter, and what is there to live for, what is there to stop for? Even if I stop, they're still going to do this to me, I'm not gonna have her," so. It was just that constant battle with myself that I really, you know, felt hopeless and like, "What am I gonna do?" So that, yeah.

Eleanor's feelings of hopelessness and lack of purpose were shared by other women who had lost custody. Women felt that, without their children, they had no reason to try and stop using, especially if the custody loss was permanent and there was no hope of reunification.

When Natalie's first daughter was taken from her, there was initially an opportunity for reunification. However, Natalie's negative experiences with child protection authorities when she was a child led her to believe that she would never be able to convince them to reinstate her custody. In her mind, the authorities had never been able to protect her or help her when her own mother was addicted to crack cocaine and when Natalie was a homeless teenager, so they would certainly not be able to help her now. In response, Natalie went on a "suicide mission":

> **Natalie**: So, like… here's the thing. I was, I wasn't that young, I was twenty, but I had been through the court system and stuff all my life, I'd been lied to by the court system and the foster homes, some of our homes were super, super, really, really bad, I had no trust for anybody in authority because of what I'd been through as a child. So when they released -- I had to go to CMH [Community Mental Health], like a temporary insanity thing, and they released me from the hospital and they send you out in a cab and from that moment -- I just had them drop me at the dope dealer. And from that moment I never even… like, I tried a little bit to try and get my baby back, but I didn't really believe… to me, she was gone, lost already.
> **Interviewer**: Because you didn't think they would give her back?
> **Natalie**: Right. So… that brought me to drugs so bad that… nobody could ever know. I had always said that I wasn't going to be like my mom and that I would never put my kids through, you know she put us through so much, all those years on the streets by

> ourselves, it's just… So losing [my daughter] was—it was bad. It was bad. I committed so many crimes, I would rob people, I was on a suicide mission. I was one of the worst, probably, out there. Um, and the things that I did, like… 'cause I was like, not just tricking, I wasn't just ho-in' for twenty dollars here and there, no, I was hitting like, for thousands, so I was smoking like thousands of dollars in drugs a day, not just twenty here and twenty there, twenty here and twenty there, I always had that much in my pocket. So, and I was doing the heroin and the pills and anything I could get my hands on. I could find a pill on the floor and not know what it was and take it. Self-destructing. And then the day they actually terminated my rights to my daughter, which was about a year later, I took a needle of heroin and slammed it into my chest and sliced my wrists and cut my tendons in my arm. I almost died.

In contrast with Natalie, Ebony and her partner had made an effort to comply with the court's request. Ebony came into contact with the court system when she tried to end her relationship with her emotionally and physically abusive boyfriend and father of her oldest son. When she told him that she didn't want to see him anymore, he called CPS and reported that Ebony was pregnant and smoking marijuana. Ebony's son went to live with his paternal grandmother. When Ebony delivered her daughter at the hospital, both mother and baby tested positive for THC and the baby was placed in a foster home. While cooperating with the court to regain custody of her daughter, Ebony became pregnant again and delivered another daughter who, despite testing negative for any substances, was placed in foster care due to Ebony's ongoing CPS case for her older daughter.

> **Ebony**: And [the case] was drug out for like three years. And all to end with them telling us, uh, basically, well, you guys aren't good parents and we're throwing the books at you and taking your rights. Get out of my courtroom.
> **Interviewer**: And what was this failing on your part?
> **Ebony**: They said I did—basically, I didn't complete the classes the way they wanted me to complete the classes. And… what was so crazy about it was I had certificates from where I'd graduated, all the classes they'd sent me to, [my daughters' father] had certificates from where he graduated and all the classes he went to, he even went to a father's retreat for this parenting class that he did, and he got two certificates from that, and I'm just like, "How in the hell are you guys gonna sit here and say that we didn't--?!" The instructors obviously seen a change.

Ebony insists that she has no idea why her custody case dragged on for so long and why the court wasn't satisfied with her compliance with their requests. She shared that at the end of the three years, the judge told her that she hadn't done enough and that, furthermore, she did not have enough of a relationship with her daughters, who had been in a foster home since the first days of their lives.

Ebony was confused about the outcome of her case and felt she had been treated unfairly. In her opinion, she had done everything the court had asked of her, and yet they had still terminated her parental rights to her daughters. After the court decision was final, Ebony experienced a downward spiral:

> **Ebony**: I don't feel like it's necessary for you to take someone's child. Um, not especially if you want them to do classes and they know that if they don't, they're gonna lose their child. I don't feel like it's necessary for you to take their child anyways, because I feel like if they are a real parent and they really cared, they're gonna stop doing whatever they're doing and go to those classes without their kids being taken from them. So that was one thing with [the CPS worker], and then I feel like she lied to us because they told me if I went and got my own place, and either got a job or went to school, and my son's dad went and got a job or went to school, then we could have our kids back. I had an apartment for two years, I was going to school and he was working. They terminated our rights that year, and it was just like, screw everything, I got—I lost my apartment, I just, I went on this binge of drinking alcohol, that was probably the only time where I just really didn't care.

At the end of Ebony's interview, when asked if she had anything else to say about her experiences, she offered some insight on her understanding of the relevance of her race to her custody case:

> **Ebony**: I was looking at something on the internet where it was talking about, um, like… kids being taken from their parents for using marijuana, or just any type of different drugs or whatever, and it's almost a given fact that a lot of the kids that are taken, they're African American kids. I've always—I really want to know why that is, though. I really feel like it's because of how we've been categorized as, you know, uneducated, and just belligerent, obnoxious type of people and we don't have many, you know… I guess, like real upbringing or whatever, proper upbringing, and I think that's why, like… I don't know. I don't like being part of that statistic because it's not true to everyone. Maybe you could conduct a study with just—not to be racist or anything, but just, you know, African

> American women, because I feel like that is a problem. Like I was telling you, I know people that are doing services like, a lot of them are of the Caucasian or even Hispanic race, and it seems like the African American race doesn't get that great of a chance that any other race would, and I've always wondered why. Is it just actually because of the whole color, or is it because of everything that everyone said and they've kinda built the system from their own opinions or… what?

For Ebony, losing custody of her children was not only a terrible personal loss, but a reflection on her race, making her just another "part of that statistic" of African American women who have lost custody of their children. Without having read the book, Ebony, through her lived experience, has arrived at a similar conclusion to Dorothy Roberts' *Shattered Bonds* (2003), wherein Roberts dissects the overrepresentation of African American children in the child welfare system. Roberts' (2003) review of the literature on abuse symptom misdiagnoses, substance use testing and reporting, and child removal decisions suggests that White parents are less likely to be seen as being at risk of serious abuse, while African American parents are more likely to be viewed with suspicion. Furthermore, Roberts (2003) finds that after contact with the child welfare system has occurred, African American families are less likely than White families to be offered in-home services and housing assistance, and that African American children placed with relatives receive fewer services, less financial support and less health care. It appears that Ebony's suspicion is not inaccurate and that further study of the role of race in child welfare decisions is indeed necessary.

Kellie's parents took temporary custody of her son when he was a toddler and later permanently adopted him. In talking about the downward spiral she experienced when this decision was finalized, Kellie elucidates how the failure to claim a "mother" identity can push women further towards the "addict" identity:

> **Kellie**: When it was official that my dad had adopted [my son] and there was absolutely no chance of me ever getting him back, um—because it took a few years between when he got temporary guardianship and then for the actual adoption to be final, so for those couple of years I was kinda thinking "Well, maybe, maybe I still have a chance," and

> then once it was finalized and I knew that there was absolutely no getting him back, I was just kinda like… fuck it. I've lost my child, I have—you know, I've spent most of my late teens and early 20s, the time people are setting up their foundations for the rest of their life, their credit and their schooling and their jobs and getting ready, I've been dicking off, doing drugs and doing nothing. I have no bank account, no credit, nothing, and I guess I'm just kinda—I just thought, okay, I'm destined to be a fuck-up forever, and that's it. I'm better at, obviously, getting into mischief and maintaining a drug habit and procuring drugs and finding them all day than I am getting up and going to work nine-to-five, and it seems like that's just kinda where I am and I don't really have any reason to go right.

Kellie echoes the sentiments of other women who lost their children when she describes her feeling of having "no reason to go right." She had seen her motherhood role as an opportunity to make up for her transgressions as a teenager, but the loss of her son made her feel that her worst perceptions of herself must be true: her secret fear that she was "destined to be a fuck-up forever" and that she wasn't cut out for a conventional lifestyle was affirmed. It wasn't until Kellie became pregnant again ten years later that she was able to reclaim a mother identity:

> **Kellie**: And then when I had [my second son] it was kind of like a second chance [*crying*], you know, to – sorry – to actually live my life and be a mom, which is all I've ever really wanted to be. So I've just been really thankful for that, I don't know how, why I managed to get so lucky to get this second chance, but I am grateful that God let me have it.

The stories of women who lost custody of their children demonstrate how the loss of such a valued identity as "mother" can trigger a downward spiral characterized by feelings of hopelessness, loss of purpose, and affirmation of another role, that of the addict. Women described their feelings in the wake of custody loss as "What good am I now?" "I had no reason to live," "I had no reason to get clean," and "I'm destined to be a fuck-up forever." These reactions may explain why some women appear to make no effort to regain custody, as Natalie explains that she had no belief that she would be able to achieve this goal. Women's accounts also suggest that some sort of support or counseling provided for women after custody loss may be necessary to prevent injury or death from periods of grief-induced binging behavior.

**Substance Abuse Treatment-Seeking Experiences**

Medical care for pregnancy and delivery was not the only time women had sought professional help. Twenty women (66.7%) had sought substance abuse treatment at some point in the past and had navigated barriers to finding, affording and attending different types of treatment programs. Of the ten women who had not sought treatment, most used only alcohol, tobacco, and/or marijuana. Two of these ten women used methamphetamine, one used assorted prescription pills, and a fourth used hallucinogens.

The twenty women who had experience with substance abuse treatment had explored a variety of different programs, from short-term detox and outpatient support groups to residential treatment and long-term methadone maintenance. Each program type came with its own limitations and barriers to entry.

**Detox.** Three women had sought out treatment facilities that would allow them to detox (most commonly from opioids). These programs were very short-term, usually less than a week, and offered medically-assisted or unmedicated detox. Women were in agreement that unmedicated detox was an awful experience and that they would only stay at places that would give them medication to help with their withdrawal symptoms. At some places, such medication was promised but not delivered:

> **Tasha**: When I went there, oh my God, [treatment center] was awful. I wouldn't send my dog there. I went there during the day and the lady was really nice. “Oh we'll help you, we'll give you something to ease the withdrawal and help you sleep and we'll keep you comfortable.” I'm like okay, this is what I need, this is where I need to be. And that night, they refused to give me anything to help with the withdrawals and I was freaking out and I was sick and I had just had it. Two o'clock in the morning, I ended up walking out of there. They wouldn't help, they just basically looked at me like I was some horrible drug addict.
> **Interviewer**: So you walked out of there?
> **Tasha**: Mmhmm [yes], gave up on that and went right back to using.

Even if Tasha had stayed and detoxed, such programs frequently offer little in the way of aftercare unless they are paired with residential or outpatient counseling. Women who had detoxed, with or without medical assistance, reported that the process did nothing to address the triggers for their substance use. They spent up to a week in detox but then returned to the same environment and same social setting they had been in when they were using.

A problem with detox is that it is rarely a possibility for women who are already pregnant. Though the physical withdrawal symptoms are unpleasant for adults, they can be lethal for the fetus. For substance-dependent women who wanted to continue their pregnancies, withdrawal was a dangerous choice, and few medical professionals would agree to supervise the process. Kellie found out that she was pregnant and didn't want to start taking methadone, so she tried to find a treatment center or a hospital where she could be monitored while she went through withdrawal from heroin. She couldn't find anyone who would help her:

> **Kellie**: It was just the whole, I guess liability issue of the miscarriage associated with treatment and withdrawal of the pregnancy that really scared people. And even when I went to [the local hospital] and said "Can you guys watch me while I detox?" and they said no, I mean, I even—and then they ended up sending me home, and I was like "I'm sick, can you at least send me home with some Vicodin or something?" and they were like, no, so I said "So you're going to send me home to have a miscarriage, then?" and they ended up writing me, like 10 Vicodin or something. But I had—I remember asking the nurse, like, "What kind of signs should I look for that might be happening if I start to have a miscarriage or something?" and they wouldn't even talk to me, the lady wouldn't answer any of my questions, she actually, like, just kind of ignored me and turned around and walked out of the room. They would not talk to me, they would not give me any information, they were just very—I mean, I was amazed, I was just like "Wow, really, are you serious? Because you're worried something you're going to say is—What about me, what about my baby?"

According to Kellie's understanding, the medical staff did not want to monitor her withdrawal for fear they would be liable if anything happened to her fetus. Instead, they gave her more opioids to stave off the withdrawal and then turned her away. Kellie continued to use heroin while seeking out other treatment possibilities.

**Support groups.** Five women had attended support groups of different kinds, including outpatient group counseling and Narcotics Anonymous. Women's experiences with support groups were mixed. For some, support groups were a positive experience that helped them form new pro-social friendship networks that supported their ongoing desistance:

> **Shannon**: [Quitting] was more of a process, like… I had changed in aspects, I started to change my lifestyle, but it's not just one change – there's a lot of things you have to change about yourself.
> **Interviewer**: Sure, like what?
> **Shannon**: You have to change your friends, you can't hang out with using people anymore. You have to change the places you go to and the things that you do. Um, you don't wanna continue hobbies that you used to do when you were using or that might remind you of using. Those kinda things.
> **Interviewer**: So how did you do it, how did you get through it?
> **Shannon:** With my support system, faith, and meetings, NA meetings.

Women reported that it was helpful to find other women who had shared their experiences. In contrast, some women strongly disliked support groups because they didn't want to hear "war stories" about other peoples' substance use. They had trouble relating to other people in the group:

> **Jenny**: Oh my god, it's the worst, I don't think I need it.
> **Interviewer**: So inpatient worked really well, but outpatient you're not a big fan of?
> **Jenny**: No. I go there and they're not even talking about anything, they're talking about smoking crack and heroin, no one's in there for weed like I am, so.

Others felt that support groups were of limited effectiveness because they did not address their physical dependence on a substance. Although support groups were free to attend, they could be difficult to access. Women reported taking multiple buses to get to group meetings or complained that the meeting times were inconvenient.

**Opioid replacement therapy.** Opioid replacement therapy is the practice of replacing illegal opioids with longer-acting opioids like methadone or buprenorphine administered under medical supervision. Methadone emerged as a treatment solution for heroin addiction in the

1960s. A team of researchers at Rockefeller University hypothesized that heroin addiction was a disease of the brain with behavioral manifestations, not simply a criminal behavior. Clinical observations suggested that treatment with a long-acting opioid agonist (in this case, the synthetic opioid called methadone) could help to prevent withdrawal symptoms, reduce or prevent drug cravings, and block the narcotic-like effects of any additional short-acting opiates the patient used (Kreek, 2000). Over the next 35 years, the safety and effectiveness of methadone maintenance for heroin addicts was repeatedly demonstrated, but federal regulations on the distribution of narcotics combined with the stigmatization of addiction prevented widespread adoption of the treatment protocol. Finally, in 1994, the Institute of Medicine of the National Academy of Sciences recommended changes to the federal regulations to allow the medicalization of pharmacotherapy for the treatment of addiction (Kreek, 2000). In 1998, the National Institute of Health published a report that unequivocally supported methadone maintenance therapy for heroin addiction and called for increased access to treatment program (NIH Consensus Conference, 1998). Methadone maintenance therapy spread quickly and became the gold standard for treatment of opioid dependence, "probably the most evaluated form of treatment in the field of drug abuse treatment" (Farrell, Ward, Mattick, Hall et al., 1994: 997). It is recognized as the most effective treatment for heroin addiction according to reviews by the Institute of Medicine (1995) and the National Institutes of Health (1998).

Despite such robust evidence of the benefits of methadone maintenance therapy, it remains for some a highly controversial practice. Since the beginning, methadone programs have been accused of merely substituting one drug for another (Joseph, Stancliff & Langrod, 2000). Methadone maintenance programs have been cited as an example of evidence-based medical programs that have been adversely impacted by misperceptions and biases, limiting their

implementation and reach (Gordis, 1991). As a result, patients fear that the stigma associated with being a methadone user will negatively impact their jobs, their social relationships and the medical care they receive (Joseph, 1995). Stigma and discrimination appear to be powerful forces preventing the full acceptance of methadone treatment, and likely impacts both pregnant and non-pregnant women seeking treatment.

The controversy surrounding methadone maintenance was demonstrated by women in the current study. Eleven women had, at some point in their lives, sought opioid replacement therapy with either methadone or buprenorphine, another partial opioid agonist more recently approved for opioid addiction treatment known by common product names like Suboxone and Subutex (FDA, 2013). Although most women were overwhelmingly in favor of opioid replacement therapy, many of the same women were concerned about never being able to stop taking methadone.

> **Alyssa**: I would honestly say it's the day I got on methadone, because it totally, has totally changed my life, because as an adult, you know, I really didn't lead the greatest lifestyle up until the last two years, and prior to that I don't have any good memories, so. […] I had a lot of people say "Methadone's like liquid handcuffs." You still have to get it every day. I look at it as you're not going out and getting into trouble, but some people still look at it as you have to have it, and you have to have it every day or else you're sick, so it's a… you know, now I look at it different, I'm glad it was there to change my life.

Others were slightly less effusively appreciative of methadone treatment but still felt that they could not have achieved sobriety without it:

> **Eleanor**: I needed something – no. I mean, I wish I didn't need, didn't need to get on the methadone, I wish that I would've been able to do it the other way, you know, without any medication, but no, I wouldn't say it makes me weak. I would just—you know, I didn't need some help, but when I got on it, I was able to do it. Because there are some people on methadone that still use, and continue to use, and even that doesn't… doesn't help them. So you know, with a little help I was able to pretty much beat my addiction.

> **Kellie**: I guess it is working for me, as far as controlling cravings. I haven't been using any other opiates, once I got my dose right. I feel good, you know, I go about my daily business, I'm able to function, I'm able to be a normal person, which I think is good. The only thing that worries me about it is, um, when it's time to come off it. I mean, how long do I stay on it? And then people say that once they slowly taper you off, you still have withdrawals and you're never really right, and that most people either go back to using drugs or they end up being on methadone for their whole lives, and that's something I'm worried about.

Most women shared similar experiences, but two women expressed a strong dislike for methadone maintenance. One woman called methadone "liquid handcuffs," because she felt that once someone started taking methadone, they would be on it for life. Naomi explicitly described many of the arguments made against opioid replacement. She had recently used Suboxone (buprenorphine) to recover from her dependence on opioid painkillers but had made a point to wean herself from it quickly thereafter:

> **Naomi**: I went to [a residential treatment facility] and… I forgot what they gave me, it wasn't methadone… Suboxone.
> **Interviewer**: Suboxone?
> **Naomi**: Yep. And I got Suboxone, and I've been clean since.
> **Interviewer**: So you got the Suboxone at [treatment facility]?
> **Naomi**: Yep. I was in their detox facility for three days, and then I went into their residential program.
> **Interviewer**: Are you still on the Suboxone?
> **Naomi**: Nope.
> **Interviewer**: Oh, wow. Some people stay on for years, I've heard.
> **Naomi**: Yeah, and I don't agree with that. Suboxone is like a quick detox, is more what Suboxone is. Some people stay on Suboxone maintenance, but other people don't. I didn't want to. There can be Suboxone maintenance, but a lot of people don't do it.
> **Interviewer**: So you didn't want to be on maintenance?
> **Naomi**: Nope. I think it's retarded [*laughs*]. All it is is a legal way for you to get high. Most people abuse it, they don't take it the way they're supposed to. […] You're still getting high, and you're not going through withdrawal. All it is is a state-funded way for you to get high. Now the state's paying for your way to get high, and that's the way I feel about methadone.

Women on maintenance programs were aware of these perceptions of their treatment programs and explained why "substituting" opioids was so successful:

> **Loretta:** And people are all "Well, you're substituting for another drug" and da-dada-dada, well, the reason why it works is because it's legal, so you change your whole lifestyle. Because of the fact of it being legal, you don't have to deal with the illegal aspect of taking it and dealing with all the illegal people and all the stealing and doing this to get it and doing that to get it and running around with drugs on you. You don't have to do that no more, 'cause it's legal, so you don't have to be in that whole circle no more, and you get yourself away from places, people and things, and it works.

Of course, as with other treatment options, women encountered barriers to enrolling in methadone programs. Interestingly, the barriers they encountered were the opposite of what one might expect. Women who were pregnant were able to enroll in programs immediately:

> **Interviewer**: How was your experience trying to get into [the methadone clinic]?
> **Cora**: It was really easy, because I was pregnant, so I got on the same day. But if I wasn't pregnant then it takes a couple weeks, so you have to use, and so on and so forth.

Women who sought out methadone maintenance treatment when they were pregnant had no difficulty enrolling in a clinic. Women who were not pregnant when seeking treatment were not so successful. Brittany had unsuccessfully sought methadone treatment after the birth of her second son and had not been able to overcome the barriers she encountered. She continued to use and became pregnant again, and finally lost custody of all three of her children.

> **Brittany**: I think, I think the program has changed a lot, though, honestly, because in between the time when I – after I had [my second son], like a couple of months, we really briefly tried looking into going to another one at that time… I don't know if like the requirements changed or something, but it was, it was a different point, too, though, but it was a lot more running around and we never ended up going through with it. 'Cause it was like, well, first they wanted us to go see a doctor, and they wouldn't take our insurance, because they wanted us to take a heart test first… and then it was just like, so much drama with that that we never ended up going through with it.
> **Interviewer**: So there was a lot of screwing around?
> **Brittany**: Yeah, like I said, I don't know if the requirements changed, 'cause it was a couple of years before when I started coming to this one and it was a different clinic, too, so maybe they had different requirements, but it was where it was so ridiculous in the end that we didn't go through with it, whereas with this one, if you have your money for the week, you show up that day and you're basically starting that day. Whereas the other one it was different, it was like they wanted us to wait a couple of weeks in between, you know. And you have like a fleeting moment between when you have the money in your hand and you wanna start to when you start shutting down, so...

Once enrolled in methadone programs, women were concerned about continuing to pay their bills. Women who were pregnant or who had recently given birth were eligible for Medicaid, which would cover the cost of treatment, but they worried about what would happen to them once they no longer had insurance:

> **Alyssa**: With the methadone, I do have my Medicaid that pays for it, and I do sometimes worry like, "What if that gets cut off?" Because it's expensive. But I would just have to find – I would have to find a way to pay for it. But, I mean, it's… the community has been pretty good in helping find, you know, helping me find the help that I need to get clean.

Other women were cobbling together some Medicaid allowances and assorted grants, but were facing the possibility of being rapidly tapered off methadone if they could not afford to continue paying for it:

> **Melinda**: I got a grant to go to [a treatment program], grant funding, and then I somehow got Medicaid to help with the methadone treatment, however, that may be in jeopardy, and if they're not going to pay for it, I'm gonna have to get off of it a lot faster than would be healthy, and I'm scared. […] I think I might have some Medicaid, like, a special thing maybe covering it, but I've been moved to a spend-down, which isn't really any insurance at all, unless it goes past some crazy, astronomical number, and I'm not sure they're gonna continue to cover me. I'm not sure that I don't already have some hundreds of dollars of bills just sitting there that they may be one of these days saying, okay, we're going to start dropping your dose unless you pay, and I'm just gonna be screwed, and then there's gonna be no way out unless I use heroin or something to survive. I don't know. I'm scared of that possibility.

Finally, women who did take methadone during their pregnancies felt that there was insufficient information about what they should expect at the hospital and when they brought their infants home. Methadone has been deemed safe for use during pregnancy but can still produce symptoms of withdrawal in exposed infants. Some women were surprised at the severity of their infants' withdrawal symptoms:

> **Alyssa**: But man, having my daughter, being on methadone, I know it changed my life, but shoot, I went and got my tubes tied. That's how much that methadone—I don't understand how women can have child after child on the methadone.
> **Interviewer**: Really? That bad, huh?

> **Alyssa**: Watching my daughter go through it? Yeah, that bad. It really woke me up, I want to come off methadone, I'm at that point, you know, yeah. It wasn't fair, it wasn't fair to her. I don't think my doctors were 100% honest, you know, I was already on the methadone when I got pregnant, so there was absolutely nothing I could do, but, you know, they sugar-coated it. We were in the hospital five weeks, she was on a very high dose of morphine, and she had to be on phenobarbital and just, it sucked. And now it's like she's very sensitive, her stomach – her formula's $54 for a can of formula. And still, if you get loud and go up to her, you'll startle her, and she's just now getting on a normal sleeping pattern and, yeah, it's hard thing—it's hard to watch your child go through that, knowing it's something you did, you know.

> **Loretta:** When they tell you about, you know—what they tell you is that it don't matter what kind of dose you're on, you know, that ain't what matters about the kid going through withdrawals, is not your dose, which is true. There is no record of doctor records where it don't matter, someone could be on 180, someone could be on 120, the person that's on 120, the baby will end up with more withdrawals than the person that's on 180. So it don't have nothing to do with dosage. There's been records of that. But they don't tell you, you know, what you're going to be going through, what the baby's going through, how the hospital's going to treat you, what you're going to do if you're there, they don't—it's just that type of stuff. They don't tell you, "Hey, get ready, because you're going to be seeing your baby go through shakes and tremors, when you feed her she'll go through tremors," you know. That's hard, to see a little baby go through that, it's terrifying. None of my girls went through that, and I was on Vicodin through all my kids. None of my kids went through tremors and withdrawal, you know?

Others were unprepared for how they would be treated at the hospital. In some cases, they were informed by medical personnel that CPS was called for all mothers using methadone, whether it was prescribed or not. Others reported that CPS was mistakenly called. Kellie felt trapped by hospital policies about methadone use, as she thought that enrolling in the methadone clinic would help her escape involvement with CPS:

> **Kellie**: I guess I feel kind of confused as to, they tell you [methadone treatment]'s your only option yet it's considered so questionable or harmful that they have to call CPS, it's required for your baby and stuff.

Kellie had used other opioids and marijuana throughout her pregnancy, so it is possible that CPS was called because of the presence of those substances in her son's meconium and that she misunderstood the hospital's policy. However, she was not the only woman confused about, on the one hand, methadone as a prescribed treatment and, on the other, its role in their newborns'

withdrawal symptoms and their involvement with CPS. The confusion was shared by other women in the study and by the public health nurses with the County's Family Outreach Services, who were in the process of trying to assemble articles and pamphlets about methadone use during pregnancy so that they can better prepare the women on their caseloads for their experiences with hospital delivery, watching their newborns' withdrawal symptoms, and soothing their babies when they go home.

**Residential treatment.** Fifteen women, half of all women in the study, had experience with residential or in-patient treatment programs. These ranged from general "rehabs" to special programs in prisons. Natalie said that the most effective treatment she had ever received was an inpatient program inside a women's prison. She called it "RSAT," which may be the Residential Substance Abuse Treatment program administered through the Bureau of Justice Assistance (2012).

> **Natalie**: And the last six months of my prison sentence I did a program called RSAT and it's an inpatient treatment inside the prison, so it was like 40 or 50 girls in the program and we all lived in the same unit, and you do treatment from, you know, 7, 8 in the morning to 4 in the afternoon, Monday through Friday, and classes on Saturday and Sunday, but they, um… go into a lot of the cognitive thinking, a lot of, you know, they look at the addiction as a symptom of whatever's underlying, like PTSD or mental issues or some kind of trauma, and I think that's when I really started working through, like, everything from my childhood. […] I don't think if I hadn't went through and really realized, like, all my background was what was keeping me sick, like… not dealing with it, not talking about it, not saying this is what happened and this is what happened, 'cause like, I was never one to put blame anywhere, I just would say this is what I'm gonna do, and I just gave up. But when I went through all that and I started bringing them emotions out and digging deep and talking about what I went through and stuff, I had to look at it and deal with it. And a lot of that has so much anger in me, anger towards my mom, towards the court system, towards everybody that failed me all my life, as a child. And then, you know, anger at myself with losing [custody]. Once I dealt with all of that, it really, really changed who I was inside and it made me stronger. You would think I had a lot of strength going through everything I went through, but I just buried everything under drugs.

Natalie had been in other residential programs before RSAT and had not found them effective. After leaving prison, she did return to substance use briefly before desisting for some time. At the time of her interview, she reported that she had relapsed for a few months at the beginning of the current year and became pregnant at the end of that period, and now she felt that she would be clean for good.

Hazel had been to a residential treatment program to help her overcome her addiction to crack cocaine. She found the classes offered there very helpful, both in their instruction but also for the social opportunities:

> **Hazel**: Well, the classes helped, too. They had classes in the rehab, the lifestyle changes class, different classes I could take. The, um, I say the lifestyles class is the one that helped me more, because they helped me to prepare for what the real life was really all about, and beside the drugs and all that, I was actually somebody else. And the dance class helped me, because I could try something different with girls that—it was girls there that wasn't all on drugs, or girls that claimed they wasn't on drugs but really was… [*laughs*], yeah.

Natalie and Hazel's comments both draw attention to identity change during treatment. Natalie says the RSAT program helped her deal with her traumatic memories and "it really, really changed who I was inside and it made me stronger." Hazel also found that "beside the drugs and all that, I was actually somebody else." This suggests that the programs Natalie and Hazel attended helped them to restory their lives in a way that supported desistance.

Residential treatment was not effective if it was too short or there was no outpatient support. Women who returned immediately to substance-using social networks and environments quickly returned to substance use. Alyssa recalled finishing three months in treatment and being picked up at the facility by her mother, who drove them straight to the "dope house." Elizabeth had recently spent two weeks in treatment but was not optimistic about the future:

> **Elizabeth**: Yeah, but once I left – I just recently left – once I left, I'm just back out here in the real world.
> **Interviewer**: When were you there?
> **Elizabeth**: I went on the 21st, I think.
> **Interviewer**: Oh, wow, you were just there. So after release?
> **Elizabeth**: I started back drinking. Haven't found any cocaine, or it hasn't been an urge right now. I've popped Vicodins.
> **Interviewer**: So the real world is not the same as the treatment world?
> **Elizabeth**: No. Lot of temptation. […] It's not long enough, I don't think so either. It's not, it's so not long enough. It's like a vacation from the real world.

In interviews with women who had sought residential treatment during their pregnancies, references to the same treatment facility in the same town in Michigan repeatedly arose. It became obvious that women were talking about this single treatment facility because, to their knowledge, it is the *only* residential substance abuse treatment program in Michigan that will accept pregnant women.

> **Kellie**: [The nurses at the local hospital] gave me the list of methadone clinics in the area, there's a couple, and some other rehabs in the area, rehab clinics, and I called all of them on the sheet. None of them would accept pregnant women unless I was already detoxed or on a methadone maintenance. None of them would do a withdrawal while I was pregnant, until I finally found *one* place that was in [distant town], Michigan, it's called [name of program]. And they are, as far as I know, the only place in the state that will take pregnant women who are, you know, addicted to opiates and have to go through withdrawal or be put on methadone or whatnot. But unfortunately I did not find them until I was probably about seven and a half months along…

The facility women mentioned is located 104 miles from the study site. At this location, there is an option for children to stay at the facility with their mothers. Childcare during treatment has previously been identified as a barrier to care for substance-using mothers (Blume, 1990; Center for Substance Abuse Treatment, 1994; Finklestein, 1994; Marsh, D'Aunno & Smith, 2000), but women in this study reflected that having their children there was not necessarily helpful:

> **Cora**: Yeah, I went somewhere where I could take my kids, and I ended up taking my youngest, and she ended up getting abused by other children in there that had it way worse than my kids had it. They had no training at all, they didn't have contact, they were almost feral. […] I think it's the only place in Michigan. And I don't really think it

should be a setting—I mean, it's good for some people, but you can't concentrate when you gotta go everywhere with screaming kids in recovery, you just can't.

Cora ended up sending her daughter to live with her daughter's father, but for women lacking that option, it is not clear what the solution might be. Cora's experience suggests that although allowing children to stay with their mothers at treatment facilities may reduce barriers to care for some women, it may reduce treatment effectiveness for others.

**Past failures, "readiness" and agency.** As demonstrated by the preceding discussion, women in the study had experiences with many different treatment programs. Some women had experienced success in effective programs and were desisting at the time of their interview, but most women had experienced at least one "failure" in their past attempts to desist. The way that women who were desisting at the time of their interview spoke about their past failures revealed a tendency to blame these failures on a lack of "readiness" to change. This time, they believed, they were truly "ready" and that's why it would be different. For example, Shannon had tried Suboxone in the past but relapsed after a few months. She had repeatedly tried to desist without treatment, but had not been successful. When she became pregnant, she went to a residential treatment and was now attending an outpatient support group. She talked about how things were different now because she "wanted it":

**Shannon (on Suboxone):** It was good, like it made me feel normal, but for some reason, I just think if you're really, really ready to give it up and you put in all the work and go to meetings and stuff, you know, it'll work, but my heart just wasn't in it at all.

**Shannon (on present day)**: What was different about it this time was that I really, really wanted it in my heart and I wasn't doing it for anybody else. There were other things that motivated me to do it, but at the end of the day I was doing it because I wanted it.

Other desisting women expressed similar thoughts on past versus present "readiness":

**Alyssa**: I mean, you've gotta put your kids first, you know? And if you're truly ready to stay clean, you know, if you do get a doctor, you tell your doctor you're an ex-addict. I did that.

> **Naomi**: Because I went a time before, too, and it didn't. I didn't want to get clean then. I went 'cause I had to. […] [This time] I was ready. Before, I don't think I was completely ready to give it up or stop that.
>
> **Cora**: I wasn't ready. […] You can't do that for anyone unless they're willing to do it for themselves, and that's why I said you have to be sick and tired of being sick and tired. They have to be ready to do it. If they're not ready, then there's going to be no change.

The "readiness" and "wantedness" narrative appears to protect women from the implications of past failures. It allows them to attribute past failures not to a flaw in themselves, like some sort of fundamental incapability to "go straight," but simply to not being ready at that time. This time, women would assert, things are different. It is not that they are different people today, no more or less *capable* of change, but simply that they are more prepared to *exercise* their capability to change. The capability was there all along. The readiness narrative protects women's sense of agency by making success or failure the product of their own decisions and not external factors like the grip of addiction or uncontrollable life circumstances. It appears that failure is sufficient evidence that one was "not ready" at that time but might be ready at some point in the future. In this way, narratives about readiness can be connected to narrative identity theory by supporting the concepts of the "good core self" that has been there all along, waiting for an opportunity.

**Discussion**

This chapter provides an overview of the issues substance-using mothers encounter when negotiating prenatal care, hospital delivery, and seeking substance abuse treatment. First, women discussed the strategies they employed to avoid being detected as substance-users or, in some cases, explained why they had not feared detection. Women who used alcohol and tobacco were less likely to fear being identified by medical professionals or law enforcement authorities than women who were using illicit substances. Some women who were using illicit substances were not afraid because they had no personal or vicarious experience with the consequences of

detection, particularly loss of custody. Of the women who did fear detection, some were up-front and honest with their doctors, and they felt that this would protect them from the worst consequences because their doctors and nurses would appreciate their honesty. Others hid or denied their pregnancies, isolated themselves away from others who might report them to authorities, and delayed or avoided prenatal care.

Some women perceived that they were stigmatized as substance-using mothers and that this affected the quality of the medical care they received. Women's stories about receiving medical treatment highlight a need for better communication between medical staff and their patients. For example, women's anger and frustration about what they perceived as subjectivity in the scoring of their substance-exposed babies may be reduced through clearer communication between nurses and mothers about the purpose of the test, the scoring criteria, and the baby's prognosis. Future research may delve deeper into the issue of subjectivity in the Finnegan assessment method for the purpose of improving patient care and reducing mothers' perceptions of stigmatization and unfairness.

Finally, women shared their experiences accessing substance use treatment. The benefits and drawbacks of different treatment options were discussed, as well as the barriers women encountered as they searched for and received treatment. The findings identify a need for more residential treatment facilities that will treat pregnant women, greater dissemination of information about treatment options available to women in the study area, and more financial support to allow women to stay enrolled in their treatment programs.

# CHAPTER VII

## Conclusion

The purpose of this study is to explore substance-using mothers' desistance behavior during and after pregnancy through a framework of narrative identity theory. This chapter summarizes major findings and discusses the limitations of the current study. It then turns to a discussion of the implication of the findings for theory development and policy improvement, and concludes with suggestions for future research.

### Summary of Findings

Consistent with scholars who argue for the conceptualization of desistance as a process rather than a state or discrete event (Bushway, Thornberry and Krohn, 2003; Fagan, 1989; Laub and Sampson, 2001; Maruna, 2001), women in this study could not be categorized neatly as "desisters" and "persisters" but instead demonstrated a spectrum of desistance behaviors best categorized as prompt desistance, delayed desistance, partial or incomplete desistance, and persistence. Women's membership in any of these four categories was related to their narrations of themselves as agents or "pawns" (de Charms, 1968; Maruna, 2001) and to the composition of their social networks. As Paternoster and Bushway (2009) predicted, women's social network realignment appears to be endogenous, not driven by external factors but by the women themselves as they intentionally affiliate with more prosocial others as part of their change in identity.

The analysis then turned to the content of women's narratives and their desistance behavior at the time of their interviews. Consistent with narrative identity theory (Maruna, 2001; McAdams, 1997; McAdams, Josselson & Lieblich, 2006; McIntosh & McKeganey, 2000b, 2001), women who were desisting from substance use at the time of their interview narrated life

stories rich with the themes of "redemptive narratives" (Maruna, 2001). Desisting women spoke about themselves as good people who had been led astray by drugs and alcohol, but through empowerment by others and their own agency, they overcame their addictions and had intentions to use their past suffering to help others. In contrast, persisting women's narratives did not prominently feature these themes. When their narratives did feature themes common to redemption narratives, they were aligned towards continued substance use. For example, some persisting women reported being empowered by others, but these others were part of a substance-using social network. Another woman's narrative was rich with themes of redemptive suffering, but connected to overcoming injuries from a car accident, not to overcoming her addiction.

Communication from other people proved to have a strong impact on women's claiming of prosocial identities and their appraisals of their own behavior, as demonstrated by the analysis of women's "memorable messages." Women recalled messages that were either action-oriented or assessment-oriented. Action-oriented messages contained prescriptions for appropriate mothering behavior. When women acted in accordance with these messages, they felt proud; when their behavior fell short of these standards, they felt guilty and upset. Assessment-oriented messages were others' appraisals of women's motherhood identities. When these appraisals were positive, women felt empowered to keep up their behavior. When the appraisals were negative, women either internalized the negative message and felt incapable and inadequate, or rebelled against the message and tried to prove the speaker wrong.

Women's fear of punishment and perceptions of stigmatization were explored as possible barriers to treatment. Most women who used illicit substances during their pregnancies reported that they were afraid of being identified as substance users; women who were not afraid

explained that they had not thought about the risk of detection until it was too late, or that they had employed various strategies that they thought would conceal their substance use. Women who felt afraid responded by using strategies like being honest with medical professionals, isolating themselves from people who might report them to authorities, and avoiding medical care. In the delivery ward, women's perceptions of stigmatization resulted in confusion about the treatment their neonates received. Women who had been encouraged to start methadone maintenance treatment during their pregnancies were dismayed to learn that their babies still went through opioid withdrawal after birth. Some women felt that their children received unnecessary treatment or were kept in the nursery for too long. In both of these situations, there seems to have been a breakdown in communication between women, treatment professionals, and labor and delivery medical professionals that left women feeling vulnerable and angry.

In cases where women's strategies failed and they were detected and lost custody of their children, women described experiencing a "downward spiral" that led them into increased substance use and risk-taking behavior. The loss of their valued role as mothers left them feeling hopeless and without purpose. The path out of this spiral was the acquisition of other prosocial roles, like becoming employed or, in some cases, conceiving another child.

Finally, women's treatment-seeking experiences highlighted the benefits, drawbacks, and barriers to various treatment options, including supervised detox, support groups, opioid replacement therapy and residential treatment. Women's experiences with these treatment options suggest many areas where policies might be improved. Importantly, women cast past failed attempts to desist as failures of readiness, suggesting that their present desistance would be sustained because they were truly "ready" this time.

**Limitations**

The current study was limited in sample size by practical considerations of time and cost. The target sample size of 30 women was set with some optimism that at least 30 women could be recruited to participate in this exploratory study. The recruitment efforts were highly successful, resulting in an unexpected number of responses in a short amount of time. This suggests that a much larger sample might be recruited for future studies using a similar recruitment approach. A larger sample would allow for more comparison within and between groups of women who share similar characteristics. For example, a larger sample size would allow for a better understanding of women's experiences specific to their substance of use. It would also allow for a better understanding of the role of race and class in women's experiences with help-seeking and desistance.

This study was designed with a goal of minimizing the collection of identifiable information about the study participants. Many women in the study would be considered "active offenders" by criminal justice authorities. To minimize their risk, the investigator did not collect legal names, addresses or other identifying information. No signatures were collected on consent forms or incentive receipts. The advantage of this approach was increased protection for participants, but the disadvantage is that it prohibits follow-up interviews or check-ins, because participants cannot be tracked or contacted after the interview. The analysis, therefore, offers interesting insight into the way women who are desisting support their desistance *at that time* through their redemptive narratives, but cannot speak to the way that redemptive narratives might sustain desistance over time. If the desisting women from this study were contacted six months or one year later, would they still be desisting? If they had relapsed, would their narratives have changed? The findings of this study suggest that yes, if women relapsed then

their stories would have to account for the period of desistance, the relapse, and their intention at that time to desist again or not, but this is speculation without a longitudinal research design. In light of the findings of Maruna's *Making Good* (2001) and this study, it seems time to assess narrative identity theory and desistance over time through a multiple-interview study.

Finally, the exploratory nature of this study precludes the ability to control for the influence of women's mental health. Considering the well-supported comorbidity of substance use and mental illness (e.g., Chilcoat & Menard, 2003; Grant, Stinson, Dawson, Chou et al., 2004; Kessler, Sonnega, Bromet, Hughes & Nelson, 1995; Najavits, Weiss & Shaw, 1997; Stinson, Grant, Dawson, Ruan et al., 2005), it is highly likely that substance use, mental health and narrative are interconnected. This does not mean that narrative plays no role in substance use desistance, but it seems likely that women who struggle with depression, anxiety, or more severe mental illnesses may struggle with the task of reinterpreting past negative experiences in a positive light. Many women in this study had histories of neglect and abuse; very few could say that their childhoods had formed a foundation for psychological health. The effects of unstable and unsafe childhoods are likely exacerbated by low-income women's difficulty accessing mental health care (Anderson, Robins, Greeno, Cahalane et al., 2006; Angold, Erkanli, Farmer, Fairbank et al., 2002; Edlund, Wang, Berglund, Katz et al., 2002; Olfson, Marcus, Druss, Pincus, & Weissman, 2003; Sturm & Sherbourne, 2000). Women in this study reported that their substance use was a form of self-medication for their histories of trauma and abuse, a relationship supported in other literature (Brown & Wolfe, 1994; Brown & Stewart, 2008; Jarvis, Copeland & Walton, 1998; Leeies et al., 2009). The research design for this study does not allow for the assessment of women's mental health, and this limitation should be addressed in future research. A mixed-methods research design that combines quantitative mental health scales and

the qualitative life history interview would be a promising approach that may elucidate the relationship between narrative identity construction, mental health and desistance from substance use.

Despite these limitations, this study makes an important contribution to the literature on women, motherhood, substance use and identity. The implications of the findings for theory development and policy are discussed below.

**Implications for Theory**

The findings of this research support narrative identity theory as a promising framework for the study of desistance from substance use. Importantly, this approach allows for a process-oriented understanding of desistance that is well-suited to the study of substance use and addiction. The findings contribute to the development of narrative identity theory in several key ways. First, they highlight the importance of other actors to the construction of narrative identity. Second, the findings demonstrate that it is not just the presence of redemption themes that is important, but the content of those themes. Finally, the findings draw attention to the consequences of identity damage or loss.

The findings highlight the importance of other actors to the construction of narrative identity in several ways. Social network realignment appeared as an important correlate of women's desistance during pregnancy. Women who promptly desisted or desisted after some delay were more likely than others to have realigned their social networks to include more prosocial others, including supportive parents, non-using romantic partners, and new friends who were not connected to past antisocial friendship groups. The importance of social network realignment has been mentioned in recent work on identity and desistance (e.g., Paternoster & Bushway, 2009), but does not yet seem to have been incorporated into the main body of

literature for this theory. This study contributes to this literature and supports Paternoster and Bushway's assertion that social network realignment comes *after* initial steps towards identity change have been made. In the narratives of women in this study, they reported deliberately seeking out prosocial others to support their identity change, rather than finding prosocial others first and then initiating identity change. This is important for several reasons. Prosocial others can help to connect women to needed resources that support their continued desistance, like the way that Hazel's mother supported her by buying her new clothes and paying for an apartment. They can also be sources of empowerment, an important theme in redemptive narratives. This suggests that there may be a time-order to the accumulation of redemptive themes, beginning with the "good self" and "bad it," which may prompt social network alignment that puts offenders in contact with candidates for supporting the women's "empowerment." These three themes may then support the restorying of past suffering as redemptive and the narration of a generative future. A longitudinal research design would allow for further development of this theory. For example, narratives collected at multiple intervals could be analyzed by the time of collection, desistance progress, and the number and type of themes present.

The importance of communication from others to identity construction and change is also supported by the analysis of memorable messages as behavioral guides. The findings were consistent with previous studies that suggest memorable messages guide people in sense-making processes by influencing the self-assessment of behavior (Smith & Ellis, 2001; Smith, Ellis, & Yoo, 2001; Ellis & Smith, 2004). This is closely related to other identity theory development that suggests that individuals constantly assess their behavior against an internalized identity standard and make adjustments as necessary to conform to that standard (Burke, 1991; Powers, 1973). Narrative identity theory appears to stand apart from other theories of identity, but the findings of

this study suggest that an integration of perceptual control theory and narrative identity theory might be warranted. Individuals' perceptions of deviation from an identity standard may be important triggers for behavioral change, which must then be incorporated into the narrative identity for the purpose of maintaining a coherent "whole" identity. The integration of narrative identity theory with other psychological identity theories could be a rich area for future research.

Finally, the findings of this research contribute to theory by highlighting an area in need of further development, namely the symptoms and consequences of identity damage or loss. The literature on narrative identity is largely concerned with the way narratives are adjusted to account for failure episodes post-hoc. Little is said about the immediate consequence of having one's identity damaged or stripped away. For several women in this study, the loss of custody of their children stripped them of their identities as mothers, leaving them feeling hopeless and without purpose. This triggered a "downward spiral" of increased risk-taking behavior, described as "a suicide mission" and "self-destructing." Once again, this is an underdeveloped area of narrative identity theory that may be strengthened through integration of other psychological theories of identity, specifically those that concern the importance of reflected appraisals and support for identities. For example, McCall and Simmons (1978) assert that when others fail to support an individual's role performance (e.g., the role of "mother"), the role identity has failed to be "legitimated" and individuals will experience negative emotions like shame, guilt, anger and frustration. In response, they may employ "mechanisms of legitimation" (McCall and Simmons, 1978: 92) to cope with these negative emotions. There are multiple mechanisms of legitimation, but two that are particularly relevant to the current study are *switching identities* and *withdrawal*. When faced with an ongoing lack of support for an identity, an individual may switch to an alternative identity with better chances of being legitimated. An individual can also

simply withdraw from the interaction. If the problem persists, an individual may cease trying to activate the problematic identity or restrict his interactions to only those he can be sure will legitimate the identity. Women's narratives of the "downward spiral" certainly demonstrate this response to a failure of identity legitimation and the mechanisms employed in response, suggesting that these role identity concepts should be incorporated into narrative identity theory.

Finally, the findings of narrative resistance offer support for Nelson's (2001) description of "narrative repair," suggesting yet another integration that might strengthen narrative identity theory. Nelson describes the process of narrative repair of damaged identities, writing that individuals with damaged or spoiled identities may create a "counterstory," "a story that resists an oppressive identity and attempts to replace it with one that commands respect" (2001: 6). The goal of such stories is to open a gap between what "everyone knows" about people with spoiled identities, which creates room for an alternate perspective. Women in this study offered narrative resistance to master narratives about substance-using mothers, crafting stories that demonstrated their ability to mother effectively and insisting that not all substance-using women are "the same," that they are not "monsters" but simply women who are doing their best in the face of adverse circumstances. Women resisted the narrative of substance-users as a homogeneous group and described the efforts they were taking to defy negative stereotypes. These findings lend support to Nelson's (2001) ideas and suggest that the relationship between offender's narratives about themselves and the master narratives told by others about offenders should be further examined.

**Implications for Policy**

This study was conducted with a goal of making suggestions for informing policies concerning substance-using mothers, and the findings suggest many areas for improvement.

First, the support for narrative identity theory suggests that narrative therapy may be an effective counseling approach for substance-using women. Narrative therapy builds on narrative identity theory and focuses on externalizing and objectifying problems so that the patient can better understand them (Morgan, 2000). Through the telling of life stories, patients reflect upon and connect with their intentions, values, hopes, and commitments. Once values and hopes have been located in specific life events, they help to "re-author" or "re-story" a person's experience and clearly stand as acts of resistance (Epston & White, 1990; Etchison & Kleist, 2000; Freedman & Combs, 1996). This therapeutic technique has not received widespread attention, but the findings of the present study suggest that women might benefit from some assistance in reinterpreting past events in order to restory their identities. For example, one study found that women with backgrounds that included substance abuse, domestic violence, and imprisonment who were encouraged to "tell their stories" were able to shift from focusing on their deficits to focusing on their potential for living more positive lives (Feinsilver, Murphy & Anderson, 2007). Other research shows positive results when programs help woman offenders restory their lives in a way that supports desistance (Andrew, 2011; Surratt, 2005; Swora, 2001; Weegmann & Piwowoz-Hjort, 2009). This is a promising area of theory and practice that is in need of further research and evaluation before widespread implementation.

More broadly, women are in need of more treatment options, better access to the treatment of their choice, and more support for staying in treatment. The women in this study revealed that in their searches for residential treatment centers they could locate only *one* facility that would accept pregnant women or women who needed to bring their children with them. This treatment facility is located more than a hundred miles from the study site, making transportation and visitation expensive and time-consuming. Women would benefit from an increased number

of residential care facilities. There are several methadone clinics in the study area and women who sought treatment there when pregnant were pleased to find that their status as pregnant women afford them expedited enrollment in treatment. This is an excellent policy that should be continued, as most women spoke positively about their experiences on methadone. However, when women sought methadone treatment *between* pregnancies, they faced waiting periods of days or weeks. During this delay, women continued to engage in risky substance use and, in some cases, lost their desire to enter treatment. Increased funding for methadone treatment clinics to support larger client populations would help to cut down on these waiting periods and get women into treatment when they are motivated to enroll. Additionally, increased grant funding to help women stay in treatment once they are enrolled would help to decrease women's anxiety about what will happen if they can no longer afford to pay for their methadone.

Women's experiences seeking methadone treatment also highlighted a need for more information about this treatment option, both in general and specifically for pregnant women. In general, women harbored some misconceptions about methadone and were unclear about the treatment process. They were concerned that if they start taking methadone, they would never be able to stop. Women who were pregnant and on methadone were not well-informed about what to expect when their babies were born. They did not expect to see such severe withdrawal symptoms, they did not know that CPS would be called in for hospital and home visits, and they did not understand the way doctors and nurses assessed their infants' withdrawal symptoms and administered treatments. This lack of information left women feeling confused, vulnerable and in some cases mislead or betrayed by treatment professionals. Better communication between medical staff and mothers may help to ease some of this confusion and reduce feelings of stigmatization and unfair treatment. Methadone clinics should offer information sessions and

materials to help prepare pregnant women for the experience of delivering their babies at hospitals, including what to expect in regard to pain management, infant withdrawal symptoms, CPS involvement, treatment approaches for withdrawing infants, and how to work with doctors and nurses to help the process go smoothly. These information sessions could also include advice for comforting methadone-exposed babies once they come home.

Women's descriptions of a "downward spiral" after the termination of their parental rights suggest that a support program for these parents is sorely needed. Women reported using illicit drugs and alcohol in greater amounts and with greater frequency after the termination of their parental rights. They also described practicing much less caution when using substances during this time, including using others' hypodermic needles and taking unidentified pills. These practices represent a huge increase in risk for women's health and contact with the criminal justice system. To reduce this risk, a program should be implemented to provide parents who have lost their children with counseling and support. The program could be run by a local substance abuse or mental health treatment provider and could offer free individual counseling sessions and group sessions and connect parents to resources like employment assistance, substance abuse treatment, and housing assistance. Such a program may help to decrease the likelihood or severity of "downward spirals" and promote parents' health in the wake of termination of parental rights.

**Directions for Future Research**

A major contribution of this study is that it suggests so many avenues for future research. The exploratory design allows for the identification of numerous questions that remain unanswered and provides a background from which to develop the next generation of inquiry. The first step is to address the limitations of the current research by increasing the sample size

and incorporating scales to measure mental health and other relevant conditions. As recommended above, a mixed-methods research design could be a promising approach to exploring the potential of narrative identity theory while controlling for rival explanatory factors. The relationship between mental health, substance use, and the ability to reinterpret past trauma as "redemptive suffering" is one area in particular need of further exploration, and there are doubtless many intersections in need of untangling.

Future research should also feature a larger and more diverse sample for the purpose of analyzing race and class differences. The sample for this study was recruited with the intent to include diverse voices, but the small sample size restricts the ability to explore, for example, variation in the experiences of women of different races using the same substance. In addition, the results of this study suggest that a quantitative analysis of termination of parental rights in cases of parental substance use may help to identify other factors in the decision to terminate rights. Such an analysis should focus on the race of the parents, the substance used, the requirements placed on the parents by the court, the parents' adherence to court orders, and the time to family reunification or termination of rights.

The current research presents only the perspectives of substance-using mothers. They expressed frustration and anger with the system, which included treatment professions, CPS caseworkers, judges, attorneys, social service providers and law enforcement. In some cases, women's anger and frustration with the system seemed justified, but there is a need for a better understanding of the perspectives of individuals on "the other side" of this social problem. Future research should incorporate the perspectives of medical professionals, CPS caseworkers, and members of the court system to develop a more complete picture of how the system functions and how women's frustration and anger might be reduced.

Finally, future research using a narrative identity theory framework should employ a longitudinal research design. The findings of this study, consistent with those of Maruna (2001), support the prediction that women who are desisting from substance use are supported in their desistance by redemptive narratives that cast their past negative experiences in a more positive light. This seems a fragile support structure, though, as past events may be reinterpreted at any time. A depressive episode may result in a reinterpretation of one's past experiences as overwhelmingly negative and hopeless. The support for narrative identity theory would be strengthened if it could be demonstrated that maintaining a redemptive narrative supported *ongoing* desistance and helped women desist even in the face of adversity. A recommended approach would be a prospective, mixed-methods design that allowed for data collection and multiple interviews, perhaps every three to six months for a two-year period. The difficulty of such a design would be the tedium of participants' having to re-tell their life stories at each interview point. A possible solution would be to use different interviews each time, so that the story was told anew at each meeting, but this then introduces the risk that the identity or skill of the interviewer could influence the telling of the story. Whatever the solution to this issue, the prospective, multiple-measure design would allow for analysis of the way narratives change over time and how they coincide with desistance from crime.

**Concluding Remarks**

Substance use during pregnancy and motherhood is an issue of concern in the fields of public health and criminal justice. Research and public policy have largely focused on identifying and detecting pregnant substance-users, but little is known about why and how some women desist from substance use during pregnancy or while mothering. This study explored mothers' desistance from substance use through a framework of narrative identity theory. The findings suggest that women's substance use during pregnancy is not as simple as matter of

"desisting" or "persisting," as some women desist from some substances but not others, and other women cut back on all substances but do not desist completely. The differences in desistance behavior are related to women's alignment of their social networks (in support of desistance or persistence) and their perceptions of themselves as agents or "pawns." Women who were desisting at the time of their interviews told life stories rich in themes of redemption and generativity that support their prosocial identities. Finally, women described their treatment experiences and the barriers to care they had encountered, which highlighted the need for more treatment options, greater access to treatment, and improved communication between treatment professionals and their patients. The findings suggest multiple areas for policy improvement and future research. Additionally, proposals were made for integration of other identity theories with narrative identity theory and the consideration of narratives as "counterstories" told in resistance to master narratives.

Substance use during pregnancy and motherhood is an emotionally-charged social problem in need of a compassionate and evidence-based solution. A greater effort should be made to incorporate women's voices, as they are the authorities on their experiences. This study provided an outlet for their voices and has identified promising avenues for future research and policy development. Future research should continue in this direction with the goal of improving maternal and infant health outcomes for this population.

# APPENDICES

## APPENDIX A: RECRUITMENT FLYER

### Meanings of Motherhood:
### A Study of Maternal and Infant Health

Researchers at Michigan State University want to understand how women who use substances during pregnancy experience the transition to motherhood. This research study is for women who are or have recently been pregnant and used alcohol, tobacco, or other substances during that pregnancy.

*Participation is always voluntary!*

**Would the study be a good fit for me?**

This study might be a good fit if you:

- Are currently pregnant or gave birth in the last 12 months AND
- Used any of the following substances at any point during your most recent pregnancy:
    - Alcohol
    - Tobacco
    - Medication in any way other than as directed
    - Any illegal substances

**What will happen?**

If you decide to take part in the study, you would:

- Meet with an interviewer at a convenient location
- Take part in 1 **confidential** interview (approx. 2 hours)
- Receive a Visa gift card as payment for $50

**To take part in the Meanings of Motherhood research study or for more information:**

Call or text Rebecca Stone: (910) 467-8678
Email: stonere3@msu.edu

The principal researcher for this study is Dr. Merry Morash at Michigan State University.

## APPENDIX B: INTERVIEW INSTRUMENT

**ID:**

**Age:**

**Race and/or Ethnicity:**

**Education:**

**Employment Status:**

**Marital Status:**

**Health Insurance/Plan:**

| **Children:** | **Sex** | **Age** |
|---|---|---|
| | ____ | ____ |
| | ____ | ____ |
| | ____ | ____ |
| | ____ | ____ |
| | ____ | ____ |
| | ____ | ____ |

### SECTION I
### Substance Use Assessment

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, I will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While I am interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

**In your life, have you ever used any of the following substances? (<u>Non-medical use only</u>)**

a. Over-the-counter medications (pain relief, cough syrups, decongestants)
b. Prescription medications not prescribed to you
c. Prescription medications in a manner other than prescribed
d. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
e. Alcoholic beverages (beer, wine, spirits, etc.)
f. Cannabis (marijuana, pot, hash, grass, etc.)
g. Cocaine (coke, crack, etc.)

h. Amphetamine-type stimulants (speed, diet pills, ecstasy, etc.)
i. Inhalants (nitrous, glue, petrol, paint thinner, etc.)
j. Sedatives or sleeping pills (Valium, Serepax, Rohypnol, etc.)
k. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)
l. Opioids (heroin, morphine, methadone, codeine, etc.)

**In the three months prior to discovering your current/most recent pregnancy, how often did you use the substances you mentioned?**

| | Never | Once or Twice | Monthly | Weekly | Daily or Almost Daily |
|---|---|---|---|---|---|
| a. Over-the-counter medications (pain relief, cough syrups, decongestants) | | | | | |
| b. Prescription medications not prescribed to you | | | | | |
| c. Prescription medications in a manner other than prescribed | | | | | |
| d. Tobacco products (cigarettes, chewing tobacco, cigars, etc.) | | | | | |
| e. Alcoholic beverages (beer, wine, spirits, etc.) | | | | | |
| f. Cannabis (marijuana, pot, hash, grass, etc.) | | | | | |
| g. Cocaine (coke, crack, etc.) | | | | | |
| h. Amphetamine-type stimulants (speed, diet pills, ecstasy, etc.) | | | | | |
| i. Inhalants (nitrous, glue, petrol, paint thinner, etc.) | | | | | |
| j. Sedatives or sleeping pills (Valium, Serepax, Rohypnol, etc.) | | | | | |
| k. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.) | | | | | |
| l. Opioids (heroin, morphine, methadone, codeine, etc.) | | | | | |
| m. Other – specify | | | | | |

**After discovering your pregnancy, how often have you used the substances you mentioned?**

| | Never | Once or Twice | Monthly | Weekly | Daily or Almost Daily |
|---|---|---|---|---|---|
| a. Over-the-counter medications (pain relief, cough syrups, decongestants) | | | | | |
| b. Prescription medications not prescribed to you | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| c. Prescription medications in a manner other than prescribed | | | | | |
| d. Tobacco products (cigarettes, chewing tobacco, cigars, etc.) | | | | | |
| e. Alcoholic beverages (beer, wine, spirits, etc.) | | | | | |
| f. Cannabis (marijuana, pot, hash, grass, etc.) | | | | | |
| g. Cocaine (coke, crack, etc.) | | | | | |
| h. Amphetamine-type stimulants (speed, diet pills, ecstasy, etc.) | | | | | |
| i. Inhalants (nitrous, glue, petrol, paint thinner, etc.) | | | | | |
| j. Sedatives or sleeping pills (Valium, Serepax, Rohypnol, etc.) | | | | | |
| k. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.) | | | | | |
| l. Opioids (heroin, morphine, methadone, codeine, etc.) | | | | | |
| m. Other – specify | | | | | |

**CURRENTLY?**

## SECTION II

## LIFE HISTORY INTERVIEW

This section is about the story of your life. As a social scientist, I am interested in hearing your story, including parts of the past as you remember them and the future as you imagine it. Your task is simply to tell me about some of the most important things that have happened in your life and how you imagine your life developing in the future. I will guide you through the interview so that we finish it all in about two hours or less. The interview is for research purposes only, and its main goal is simply to hear your story. Everything you say is voluntary, anonymous, and confidential. Do you have any questions?

### A. Life Chapters

Please begin by thinking about your life as if it were a book or novel. Imagine that the book has a table of contents containing the titles of the main chapters in the story. To begin here, please describe very briefly what the main chapters in the book might be. Please give each chapter a title, tell me just a little bit about what each chapter is about, and say a word or two about how we get from one chapter to the next. As a storyteller here, what you want to do is to give me an overall plot summary of your story, going chapter by chapter. You may have as many chapters as you want, but I would suggest having between about 2 and 7 of them.

### B. Key Scenes in the Life Story

Now that you have described the overall plot outline for your life, I would like you to focus in on a few key scenes that stand out in the story. A key scene would be an event or specific incident that took place at a particular time and place. Consider a key scene to be a moment in your life story that stands out for a particular reason – perhaps because it was especially good or bad, particularly vivid, important, or memorable. For each of the eight key events we will consider, I ask that you describe in detail what happened, when and where it happened, who was involved, and what you were thinking and feeling in the event. In addition, I ask that you tell me why you think this particular scene is important or significant in your life. What does the scene say about you as a person? Please be specific.

1. High point. Please describe a scene, episode, or moment in your life that stands out as an especially positive experience. This might be the high point scene of your entire life, or else an especially happy, joyous, exciting, or wonderful moment in the story. Please describe this high point scene in detail. What happened, when and where, who was involved, and what were you thinking and feeling? Also, please say a word or two about why you think this particular moment was so good and what the scene may say about who you are as a person.

2. Low point. The second scene is the opposite of the first. Thinking back over your entire life, please identify a scene that stands out as a low point, if not the low point in your life story. Even though this event is unpleasant, I would appreciate your providing as much detail as you can about it. What happened in the event, where and when, who was involved, and what were you thinking and feeling? Also, please say a word or two about why you think this particular moment was so bad and what the scene may say about you or your life. [Interviewer note: If the participants balks at doing this, tell him or her that the event does not really have to be the lowest point in the story but merely a very bad experience of some kind.]

3. Turning point. In looking back over your life, it may be possible to identify certain key moments that stand out as turning points -- episodes that marked an important change in you or your life story. Please identify a particular episode in your life story that you now see as a turning point in your life. If you cannot identify a key turning point that stands out clearly, please describe some event in your life wherein you went through an important change of some kind. Again, for this event please describe what happened, where and when, who was involved, and what you were thinking and feeling. Also, please say a word or two about what you think this event says about you as a person or about your life.

4. Positive childhood memory. The fourth scene is an early memory – from childhood or your teen-aged years – that stands out as especially positive in some way. This would be a very positive, happy memory from your early years. Please describe this good memory in detail. What happened, where and when, who was involved, and what were you thinking and feeling? Also, what does this memory say about you or about your life?

5. Negative childhood memory. The fifth scene is an early memory – from childhood or your teen-aged years – that stands out as especially negative in some way. This would be a very negative, unhappy memory from your early years, perhaps entailing sadness, fear, or some other very negative emotional experience. Please describe this bad memory in detail. What

happened, where and when, who was involved, and what were you thinking and feeling? Also, what does this memory say about you or your life?

6. Vivid adult memory. Moving ahead to your adult years, please identify one scene that you have not already described in this section (in other words, do not repeat your high point, low point, or turning point scene) that stands out as especially vivid or meaningful. This would be an especially memorable, vivid, or important scene, positive or negative, from your adult years. Please describe this scene in detail, tell what happened, when and where, who was involved, and what you were thinking and feeling. Also, what does this memory say about you or your life?

7. Wisdom event. Please describe an event in your life in which you displayed wisdom. The episode might be one in which you acted or interacted in an especially wise way or provided wise counsel or advice, made a wise decision, or otherwise behaved in a particularly wise manner. What happened, where and when, who was involved, and what were you thinking and feeling? Also, what does this memory say about you and your life?

Now, we're going to talk about the future.

**C. Future Script**

1. The next chapter. Your life story includes key chapters and scenes from your past, as you have described them, and it also includes how you see or imagine your future. Please describe what you see to be the next chapter in your life. What is going to come next in your life story?

2. Dreams, hopes, and plans for the future. Please describe your plans, dreams, or hopes for the future. What do you hope to accomplish in the future in your life story?

3. Life project. Do you have a project in life? A life project is something that you have been working on and plan to work on in the future chapters of your life story. The project might involve your family or your work life, or it might be a hobby, avocation, or pastime. Please describe any project that you are currently working on or plan to work on in the future. Tell me what the project is, how you got involved in the project or will get involved in the project, how the project might develop, and why you think this project is important for you and/or for other people.

**D. Challenges**

This next section considers the various challenges, struggles, and problems you have encountered in your life. I will begin with a general challenge, and then I will focus in on three particular areas or issues where many people experience challenges, problems, or crises.

1. Life challenge. Looking back over your entire life, please identify and describe what you now consider to be the greatest single challenge you have faced in your life. What is or was the challenge or problem? How did the challenge or problem develop? How did you address or deal with this challenge or problem? What is the significance of this challenge or problem in your own life story?

2. Health. Looking back over your entire life, please identify and describe a scene or period in your life, including the present time, wherein you or a close family member confronted a major health problem, challenge, or crisis. Please describe in detail what the health problem is or was and how it developed. If relevant, please discuss any experience you had with the health-care system regarding this crisis or problem. In addition, please talk about how you coped with the problem and what impact this health crisis, problem, or challenge has had on you and your overall life story.

3. Loss. As people get older, they invariably suffer losses of one kind or another. By loss I am referring here to the loss of important people in your life, perhaps through death or separation. These are interpersonal losses – the loss of a person. Looking back over your entire life, please identify and describe the greatest interpersonal loss you have experienced. This could be a loss you experienced at any time in your life, going back to childhood and up to the present day. Please describe this loss and the process of the loss. How have you coped with the loss? What effect has this loss had on you and your life story?

4. Failure, regret. Everybody experiences failure and regrets in life, even for the happiest and luckiest lives. Looking back over your entire life, please identify and describe the greatest failure or regret you have experienced. The failure or regret can occur in any area of your life – work, family, friendships, or any other area. Please describe the failure or regret and the way in which the failure or regret came to be. How have you coped with this failure or regret? What effect has this failure or regret had on you and your life story?

**F. Life Theme**

Looking back over your entire life story with all its chapters, scenes, and challenges, and extending back into the past and ahead into the future, do you discern a central theme, message, or idea that runs throughout the story? What is the major theme in your life story? Please explain.

## SECTION III

## SUPPLEMENT TO LIFE HISTORY INTERVIEW

Thank you for sharing your story with me. Next are some questions about being a mother and using cigarettes, alcohol, and other substances.

**Section I: Motherhood**

1. How do you feel about being a mother/mom? What has it been like for you?

2. Where did you learn how to be a mom?
    a. Was there anyone who really helped you or set an example for you that you did or didn't want to follow?
    b. What sort of messages did you receive about what it means to be a mom?

3. What do you think are the most important things mothers do? What does a "good mom" do?

*How has your substance use influenced your meeting of these criteria, for better or worse?*

4. We get a lot of messages every single day. Some of those messages become really memorable, and we remember them word for word and use them in deciding what to do in our lives. They help us to decide "I should or I shouldn't do this." Also, after you do something the message could help you to decide "I probably shouldn't have done that" or "I am really proud of myself for doing that." That is what we are going to ask you about now. Do you have any message about motherhood that has become memorable to you?
    a. What is that message word for word?
    b. Who told you that message – not the name, but the role, for example relationship to you or what kind of professional.
    c. Has the message come to mind when you to do something that you were proud of? If so, what was it that you did?
    d. Has message helped you stop from doing something that you would later regret? If so, what was it that it helped you stop from doing?
    e. Has the message come to mind when you did something that you were not proud of? If so, what was it that you did that you were not proud of?

**Section II: Substance Use**

5. Have you ever tried to cut back on your substance use or tried to quit altogether?
    a. When?
    b. What motivated you to try?
    c. Were you successful? Why/why not?

6. Have you ever sought treatment for your substance use?
    a. When? What happened?
    b. Did you encounter any difficulties trying to get treatment?
    c. Was it effective? Why or why not?

7. Have you ever been afraid that your substance use will get you into trouble with the law or Child Protective Services?
    a. When?
    b. How did it make you feel?
    c. Did this thought stop you from doing anything you might otherwise do, like asking someone for help or getting medical advice?
    d. Did you do anything to avoid coming into contact with law enforcement or social services? Did it work?
    e. Did you get prenatal care?

8. Has your substance use ever resulted in contact with the criminal justice system or with Child Protective Services/child welfare? If so, could you tell me about it?

**Section III: Health and Social Services**

9. Have you ever felt that your substance use was putting your own health at risk?
    a. How?
    b. Did you hear this information from someone?
    c. Did you take any action to try to keep yourself healthy or reduce your risk?

10. Have you ever felt that your substance use was putting your child(ren) at risk?
    a. How?
    b. Did you hear this information from someone?
    c. Did you take any action to try and protect your child(ren) from this risk?

11. What sort of help, services or information do you need to promote your health?
    a. The health of your child(ren)?
    b. Do you know where to get/find this help/service/information?
    c. Have you tried to access this help/service/information before?
        i. If you have tried before but have been unsuccessful, could you tell me what happened?
    d. How would it help?

**Section IV: Reflection**

12. Is there anything else you would like to say about your experiences, anything that you feel is important for someone to know about you that we haven't covered or didn't talk about as much as you'd like?
13. Do you have any questions for me?

## APPENDIX C: PARTICIPANTS

| Table 3: Comprehensive List of Participants (n=30) | | | | |
|---|---|---|---|---|
| Pseudonym | Age | Race or ethnicity[1] | N°. children[2] | Substance(s) of choice[3] |
| Brittany | 28 | White | 3 | Prescription opioids, heroin |
| Lauren | 29 | White | 1 | Tobacco |
| Jenny | 25 | African American | 5 | Marijuana |
| Darla | 41 | White | 2 | Alcohol |
| Natalie | 32 | White | 2 | Cocaine, heroin |
| Tasha | 26 | Hispanic | 2 | Prescription opioids |
| Elsie | 19 | White | 1 | Marijuana, assorted prescription pills |
| Eleanor | 28 | White | 2 | Heroin |
| Alice | 23 | African American | 3 | Marijuana |
| Kathryn | 26 | White | 2 | Tobacco, alcohol |
| Melinda | 32 | White | 3 | Cocaine, heroin, benzodiazepines |
| Alyssa | 31 | White | 3 | Heroin, cocaine, marijuana |
| Vicki | 39 | White | 3 | Methamphetamine, marijuana, tobacco |
| Kim | 28 | Other | 2 | Alcohol, marijuana, tobacco |
| Sarah | 27 | African American | 1 | Alcohol, marijuana, tobacco |
| Shannon | 29 | White | 1 | Prescription opioids |
| Ebony | 26 | African American | 4 | Marijuana, tobacco |
| Belinda | 20 | Other | 1 | Alcohol, marijuana |
| Rosa | 25 | African American | 3 | Alcohol, tobacco |
| Kellie | 31 | White | 2 | Heroin, prescription opioids, marijuana |
| Elizabeth | 27 | African American | 3 | Cocaine, marijuana, alcohol |
| Naomi | 29 | White | 3 | Prescription opioids, cocaine |
| Diane | 27 | Other | 4 | Alcohol, cocaine, tobacco |
| Latoya | 29 | Native American | 1 | Methadone[4], heroin, tobacco |
| Denise | 23 | African American | 2 | Methamphetamine, marijuana, alcohol |
| Hazel | 29 | African American | 2 | Cocaine, marijuana |
| Cora | 33 | White | 4 | Benzodiazepines, tobacco |
| Loretta | 34 | White | 4 | Prescription opioids, methamphetamine |
| Suzanne | 39 | White | 8 | Cocaine, alcohol |
| Amelia | 21 | Other | 1 | Alcohol, marijuana, hallucinogens |

1: Women were asked to self-identify their race or ethnicity. "Other" category includes responses of "Mixed," "Unknown," and "Prefer not to answer."
2: Number does not include current pregnancies (7 participants were pregnant at the time of the interview). Number may include children to whom the participant no longer has parental rights.
3: Most-preferred substances women self-reported using in the three months prior to the discovery of their most recent pregnancies.
4: Prescribed, but using double prescribed amount.

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