

**School of Nursing and Midwifery**

**Limiting loss: A grounded theory of mothers who use illicit  
drugs**

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## DECLARATION

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made. This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

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## ABSTRACT

Illicit drug use is a major public health problem with women who use illicit drugs being one of the most marginalised minority groups in our society. In Australia, the most commonly used illicit drug is marijuana/cannabis, followed by ecstasy, meth/amphetamines, opioids (heroin, non-maintenance methadone, and other opiates), and cocaine, with polydrug use being common practice.

This research focuses on Western Australian women who use illicit drugs whilst pregnant and mothering. There is a paucity of literature related to the multifaceted psychosocial phenomenon of mothers who use illicit drugs. As a result, the extent of problems faced by these women and their families has been poorly understood. Grounded theory was the method of choice to investigate the phenomenon as it allowed an exploration of participants' experiences from within their social context. The method provided strategies to discover the shared basic psychosocial problem, the processes employed to cope with the identified problem, and the conditions influencing the problem and the process.

Women who were experiencing the phenomenon, were knowledgeable about the topic and were able to articulate detailed experiential information were invited to participate. This thesis presents the findings from 14 mothers who were using illicit drugs and is supported by interviews with relevant health professionals. The 14 mothers had 60 pregnancies with 35 live births, 2 women were pregnant at the time of interview, and the mothers had collectively experienced 31 loss experiences. Twenty eight children were in the custody of their mother at the time of interview. Data were collected from individual in-depth interviews, informal interviews, field observations, review of case records, and a brief quantitative questionnaire to elicit demographic information. Data were managed using QSR NUD\*IST software and analysed using the constant comparative method consistent with grounded theory methodology.

The central problem, relevant to all study participants, was *the threat of loss*. *The threat of loss* emanated from (a) *judgment and disapproval by self and others*; (b) *being abused, manipulated, overwhelmed, and dependent*; (c) *damaging myself and damaging my baby*; (d) *losing my baby or having my baby taken off me*; (e) *having a sense of not belonging*; and (f) *not trusting others and not being trusted*. These

problems resulted in loss of respect; loss of freedom; loss of health; loss of child; loss of identity; and loss of trust. In an attempt to overcome *the threat of loss*, the basic psychosocial process employed by mothers who use illicit drugs was: *limiting loss through a process of safeguarding*. The mothers engaged in this core process through three sub-processes: *safeguarding during pregnancy*; *safeguarding as mother*; and *safeguarding to preserve integrity*. Depending on the perceived nature of the threat and the influencing conditions, the safeguarding processes employed by the mothers oscillated between reactive responses of *struggling* and proactive strategies of *taking back control*. Whilst struggling during pregnancy the mothers *struggled to make decisions* and *struggled to find a way*. When struggling as mother they engaged in *trial and error nurturing*; and when safeguarding to preserve integrity they *struggled to preserve their integrity*. However, when they were stronger, had more resources, and were more knowledgeable they were able to take back control and *promote health during pregnancy*. This was achieved by *changing their priorities* and by actively *taking care of self*. When taking back control as mother they were able to *strive to be 'good mother'* through *nurturing* and by *increasing their capacity*. When taking back control when safeguarding to preserve integrity the mothers engaged in *redefining to preserve integrity* where they actively *created a better environment*; *controlled events*; *accessed support systems*; and *remodelled self*. Conditions that influenced the mothers' *threat of loss* and *limiting loss through a process of safeguarding* included: *the self*; *the nature of support from significant others*; *negative influences of others*; *attitudes and practice of health professionals*; *fear of being 'bad mother'*; and *maturation of children*.

This substantive theory of *limiting loss through a process of safeguarding* provides a better understanding of the subjective experience of mothers who use illicit drugs. Whilst it has previously been reported that these mothers fear losing their baby to social services, this study has identified that it is multiple forms of loss that is problematic for these mothers. Additionally, this theory presents new understandings of mothers who use illicit drugs and demonstrates not only the struggle they endure but attributes of strength, resilience, motivation, capacity and 'good mothering'. The development of this theoretical framework has provided a foundation on which to inform health care provision, future research, education and policy development for this vulnerable but resilient group of women.

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## LIST OF CONVENTIONS

Throughout this thesis there are direct quotations from the study participants as it is their voice that brings clarity to this substantive theory. For the sake of clarity, at times, it was necessary for the author to insert a word(s) into the quotation, at other times, for the sake of brevity, words or sometimes sentences were removed. Conventions used in the quotations to denote those modifications are outlined below:

...	A word or a few words omitted from the quotation
....	A sentence or a few sentences omitted from the quotation
[ ]	The author has inserted a word(s) to clarify the discourse
'...'	Indicates a direct quotation of less than 40 words
"..."	Indicates a quotation by someone else within a direct quotation
	Direct quotes greater than 40 words are indented in a free standing block

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The privilege afforded me by the participants of this study has been overwhelming. I am humbled that they allowed me into their lives and entrusted me with their stories, many of which were painful to recall. I believe this work accurately reflects the experiences of the participants and I hope that the results from this study will provide health professionals with a better understanding of young women who use illicit drugs during their pregnancies and into their parenting experience. By bringing that understanding to the attention of health professionals it is hoped that it will provide an impetus to improve services available to using mothers and their children.

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This thesis is dedicated to the intelligent, articulate, and resilient mothers who participated in this study. I feel privileged to have had the opportunity to hear their stories and it is my mandate to give them a voice.



## ABBREVIATIONS

ACDC	Antenatal Chemical Dependency Clinic
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and Other Drugs
CMS	Clinical Midwife Specialist
C-POP	Community Program for Opioid Pharmacotherapy
CP	Cerebral Palsy
CTG	Cardiotocography
DCD	Department of Community Development
Done	Methadone
ELUSCS	Elective Lower Uterine Segment Caesarean Section
EPDS	Edinburgh Postnatal Depression Scale
FOB	Father of the baby
FN	Field note
HITS	Home Visiting Intervention Trial/Study
HP	Health Professional
IPV	Intimate Partner Violence
IV	Intravenous
IDRS	Illicit Drug Reporting System
KEMH	King Edward Memorial Hospital
KEMH/PMH	King Edward Memorial Hospital & Princess Margaret Hospital
MCDS	Ministerial Council on Drug Strategy
MDMA	Methylenedioxymethamphetamine – ecstasy
MMT	Methadone Maintenance Treatment
MR	Medical Record
NA	Narcotics Anonymous
NAS	Neonatal Abstinence Syndrome
NELUSCS	Non-elective lower uterine segment caesarean section
NDSHS	National Drug Strategy Household Survey
NGO	Non-Government Organisation
NHMRC	National Health and Medical Research Council
NICU	Neonatal Intensive Care Unit (a.k.a. Special Care Nursery)
NPV	Net Present Value
NSW	New South Wales
P	Participant

PEPISU	Pregnancy Early Parenting and Illicit-Substance-Use
PND	Postnatal Depression
PPH	Postpartum Haemorrhage
QSR NUD*IST (NUD*IST)	<u>Q</u> ualitative <u>S</u> olutions and <u>R</u> esearch for the management of <u>N</u> on-numerical, <u>U</u> nstructured <u>D</u> ata by supporting the process of <u>I</u> ndexing, <u>S</u> earching, and <u>T</u> heorising
Sab	Spontaneous abortion (Miscarriage)
SIDS	Sudden Infant Death Syndrome
SVD	Spontaneous Vaginal Delivery
TAFE	Technical and Further Education
TOP	Termination of pregnancy
UK	United Kingdom (Britain)
Uni	University
US	United States of America
VMS	Visiting Midwifery Service
WA	Western Australia
WHO	World Health Organisation

## **Section 1**

**Introduction and background**

**Methodology**

**Profile of participants: Mothers' stories**

# Chapter one

## Introduction and background

### 1.1 Introduction

The substantive area of interest for this study was Western Australian mothers who use illicit drugs whilst pregnant and parenting. Illicit drugs are defined as drugs whose production, sale or possession is prohibited (Ministerial Council on Drug Strategy [MCDS], 2004) and attracts legal sanctions when used without appropriate authorisation. Illicit drugs such as marijuana, opiates (heroin), ecstasy, amphetamines, methamphetamines, and cocaine, and the non-medical use of prescription drugs are considered illicit for the purpose of this thesis.

The question of which drugs are legal or illegal is historical, cultural, and political. The division separating licit and illicit drugs is a socially constructed phenomenon and there is no universal consensus on which drugs should be given legal status. The status of drugs varies through time within countries and between countries. For example, alcohol was an illegal drug in the United States during Prohibition, and is still prohibited in Muslim countries. In Australia, the use of cannabis in some states such as Western Australia is illegal, while in South Australia and the Australian Capital Territory it has been decriminalised. The distinctions between licit and illicit drugs are blurred as their legal status, in the case of alcohol, is determined by the age of the user. For some drugs, such as benzodiazapines (tranquillisers), codeine, steroids and others it is determined by how they were obtained. For example, a person may be using alcohol and be prescribed tranquillisers and be considered a licit drug user. Alternatively, they may be obtaining tranquillisers under false pretences from a number of medical prescribers, and though the drug has been prescribed, the practice of procuring it is not condoned and attracts legal sanctions if detected.

Methadone when obtained with a legal prescription is a licit drug. With the exception of a few patients with chronic pain, all people on methadone maintenance treatment (MMT) are being treated for illicit heroin use. It is known that there is a very high level of polydrug use among the chemically dependent population (Fetherston & Lenton, 2006), and almost without exception people on methadone continue to use heroin and other illicit drugs, albeit in a much reduced manner. Polydrug use is so prevalent that routine urinalysis for narcotics is no longer done at

the Western Australian Drug and Alcohol Service, at the surgeries of general practitioners who are methadone prescribers, or at the tertiary referral obstetric hospital. With regard to mothers on MMT, data from a randomised controlled trial on mothers who use illicit drugs indicates that many continue to use heroin (Bartu, Sharp, Ludlow, & Doherty, 2006).

This introductory chapter initially provides an overview of the governance of illicit-drug-use in Australia. A discussion on the epidemiology of drug use in Australia ensues, culminating with illicit-drug-use and childbearing. The deleterious effects of illicit drugs during pregnancy and adverse outcomes for the fetus and neonate are reviewed. Discourse is also provided on the lives and circumstances of mothers who use illicit drugs. The chapter concludes with justification for and purpose and objectives of the study, and an overview of the organisation of the thesis.

## **1.2 Governance of illicit-drug-use in Australia**

### **1.2.1 Laws and regulations**

Drug use is a significant political issue in Australia as it is at a political level that decisions are made about the use, misuse and consequences of drug use. Laws and their accompanying regulations are made through the legislative process at a State and Federal level which impact on the governance of drug use. Of major significance to illicit-drug-use are the State Acts of Parliament: the Poisons Act (1964) and the accompanying Poisons Regulations; and the Misuse of Drugs Act (1981). These two Acts and the Regulation, among other purposes, serve to criminalise the use of certain substances by unauthorised individuals. They also govern or prohibit the possession, sale and use of those substances thought to be harmful or addictive to humans, when used in an unregulated and indiscriminate manner. However, the same Acts and Regulation protect the medicinal use of the same substances. The implementation of these Acts and Regulation, in essence, make certain drugs illicit in an effort to control their use and manage the social consequences of psychoactive drug use.

The Acts and Regulation are the cornerstones of the governance and the consequences of their enactment impacts on contemporary illicit-drug-use. Some debate that ensues on the topic would suggest that by criminalising drug use it has, in fact, exacerbated drug use problems by marginalising and demonising users, as well as increasing crime by creating a lucrative black market in the sale, supply and production of street drugs (Lang, 1998; Laslett & Rumbold, 1998; Zinberg, 1984).

These factors, in turn, result in forcing up the cost of drugs to the user and participation in illegal activities to support the high cost of drug procurement, such as “drug dealing, property crime and prostitution” (Commonwealth Department of Health and Aged Care, 2001, p.26). However, the issues are much more complex than a simplistic blame game and require an integrated approach to the governance of the expanding public health and social problems associated with the possession, sale, production, and consumption of psychoactive drugs and substances. In developing drug policy Australia recognised that the determinants of illicit-drug-use are multifaceted, complex, interactive and multiple, and therefore policies and strategies to reduce the harm associated with their use also needed to be broad in their complexity (Commonwealth Department of Health and Aged Care, 2001).

### **1.2.2 National Drug Strategy**

Australia’s official approach to the management of illicit drugs in society is one of harm minimisation where the mission is “to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society” (MCDS, 2004, p.1).

This supportive concept of harm minimisation is a broad public health approach to the management of illicit-drug-use that aims at reducing the risk of harm to users and the associated outcomes for families and other members of society. The principle national ministerial policy guiding this model of harm minimisation is currently known as the National Drug Strategy. The current phase of the National Drug Strategy incorporates the time frame from 2004-2009 with the objective of further “reducing drug use and supply, and preventing and minimising harm caused by licit and illicit drugs and other substances” (MCDS, 2004, p.5).

The public health approach recognises that a combination of strategies is necessary with intervention at various points in the drug use cycle to reduce harm to individuals, families and society. Thus the policy focuses on demand-reduction; supply-reduction, and harm-reduction (MCDS, 2004; Rumbold & Hamilton, 1998). The burden of illicit-drug-use includes mortalities; morbidity; accidents; crime; social and family disruption; violence; neglect; economic impact from unemployment, social security, foster care, incarceration, and judicial costs (Amato et al., 2005; MCDS, 2004). Additionally, there are economic and social costs associated with acquiring and using illicit drugs. The emotional cost for users, families and society is unable to be quantified but is enormous. Similarly, the use of illicit drugs whilst

pregnant and parenting impacts significantly on the fetus, pregnant woman, neonate, other children, and significant others.

The National Drug Strategy goal to minimise the harm related to illicit-drug-use employs a diverse range of intervention programs. As the mothers in this study entered the health care system as established drug users the National Drug Strategy priority for them was to reduce drug use and related harm and improved access to quality treatment. Programs pertinent to this study include pharmacotherapy for the treatment and management of opioid dependence; management of patients with psychostimulant use problems; access to appropriate treatment programs for the management of drugs in pregnancy and improved infant outcomes; strategies to prevent the spread of blood borne viruses; support and counselling programs for users and their families; community outreach programs; and education and health promotion initiatives.

### **1.2.3 Pharmacotherapy**

The National Pharmacotherapy Policy for people dependent on opioids (Intergovernmental Committee on Drugs, 2004) provides a framework for State policies and guidelines that address clinical and legislative requirements. The aim of pharmacotherapy for opioid dependence is to reduce the demand for illegal opioids, minimise the associated harms, stabilise the lives of users, and reduce criminal activities associated with use (Intergovernmental Committee on Drugs, 2004; Ritter & Lintzeris, 1998). Currently there are three pharmacotherapies available in Western Australia for the treatment of opioid dependence: methadone, buprenorphine and naltexone. Each of the drugs varies in its pharmacodynamic properties thus allowing selection to best suit the needs of the patient, whether they plan to substitute their opioid use in a controlled program or opt for detoxification and rehabilitation. The variation in the action of the three drugs is that methadone is an agonist and produces opiate like effects (Ward, Hall, & Mattick, 1999); buprenorphine has agonist and antagonist properties and is described as a partial opioid agonist (Fischer et al., 1999); and naltexone is an antagonist thus blocking the effects of opioids at the receptors (Tedeschi, 2002). The drug treatments are prescribed and administered under strict supervision from doctors and pharmacists.

#### **1.2.3.1 Methadone**

Methadone has been used in Australia for the treatment of opioid dependence since 1969 but not endorsed for that specific purpose until 1985 (AIHW, 2005). Although

there are now other alternatives, methadone remains the most commonly used pharmacotherapy for opioid dependence (Intergovernmental Committee on Drugs, 2004). A licit, long acting synthetic opioid (15-40 hours), methadone is substituted for the short acting illicit opioids and results in a stabilisation of the plasma methadone concentrate (Cairns, 2001). Methadone maintenance treatment (MMT) results in a reduction in opiate withdrawal symptoms without significant intoxication and reduces the effects of illicit opioids if used concurrently. For the pregnant opiate-dependent woman, methadone is the treatment of choice in Australia to reduce the effects of cycling from intoxication to withdrawal when using illicit opioids (Fischer et al., 2000), which has negative consequences for the mother and her fetus. Multiple advantages of MMT during pregnancy include: stabilisation of drug use and lifestyle; potential reduction of illicit-drug-use; stabilisation of in-utero environment; avoidance of exposure to contaminants; no increased risk of congenital anomalies; and reduced risk of spontaneous abortion, intra-uterine growth retardation, and preterm birth (Drugs and Poisons Unit, 2000; Ward, Mattick, & Hall, 1998). However, a consequence of MMT during pregnancy is neonatal abstinence syndrome (NAS) in the infant which often requires pharmacotherapy to manage the clinical signs of withdrawal (NSW Department of Health, 2006a, 2006b).

In Western Australia, methadone and buprenorphine are prescribed and dispensed under the control of the Community Program for Opioid Pharmacotherapy (C-POP). Prescribers of methadone or buprenorphine must be authorised by the Commissioner of Health following a specific training program. Patients commencing a methadone or buprenorphine program must be registered with the Department of Health.

#### **1.2.3.2 Buprenorphine (Subutex) and Buprenorphine-naloxone (Suboxone)**

Although buprenorphine (Subutex) has been available internationally for the treatment of opioid dependence since the 1980s, it was not included on the Australian register for Therapeutic Goods until October 2000. In 2010 it is still not recommended for use in pregnancy in Australia despite it being used with promising outcomes in European studies (Fischer et al., 2000; R. E. Johnson, Jones, & Fischer, 2003), with potentially less risk of NAS, following abrupt cessation at birth, than for infants of methadone treated mothers. During the course of this research there was a shift in preference by women to use buprenorphine over methadone. Despite that, buprenorphine is still not recommended for use in pregnancy in this jurisdiction.



A partial mu-receptor opiate agonist, buprenorphine has agonist and antagonist properties and is used for both maintenance and detoxification treatment (Ritter, 2001). Dispensed as a high-dose sublingual tablet, this long acting opioid lasts up to 48 hours and like methadone, buprenorphine prevents or relieves opioid withdrawal symptoms, reduces cravings, and blocks the effects of illicit opioids if used concurrently (Ritter, 2001). Once stabilisation is achieved, buprenorphine is administered on alternate days under supervised conditions, thus making the product more convenient for users (O'Brien, 2004). Dispensation of buprenorphine occurs on a dose by dose model through public clinics or community pharmacists.

Buprenorphine-naloxone (Suboxone), like Subutex is administered in sublingual tablets, but contains buprenorphine and the mu-receptor opiate antagonist naloxone (US Food and Drug Administration, 2002b). Buprenorphine is a partial mu-receptor opiate agonist, and a kappa-receptor opiate antagonist (Department of Human Services Victoria, 2005). Suboxone is intended for maintenance treatment of opiate addiction following induction with buprenorphine (Subutex). The addition of naloxone is to deter intravenous abuse of buprenorphine by those dependent on opiates (US Food and Drug Administration, 2002a). In Australia this product was not registered by the Therapeutic Goods Administration until 2005 (National Drug and Alcohol Research Centre, 2005). Suboxone is not recommended for use during pregnancy or breastfeeding.

### **1.2.3.3 Naltrexone**

Oral naltrexone is a long acting opioid antagonist, and has been registered for use with the Australian Therapeutic Goods Administration since 1999 (Tucker & Ritter, 2000). It is used for abstinence-orientated treatment for opiate dependence and other disorders. Although some proponents are enthusiastic about the outcomes from naltrexone, some patients struggle with pre-naltrexone detoxification and the discontinuation rate is high (Intergovernmental Committee on Drugs, 2004). Although used for maintenance treatment and rapid detoxification, naltrexone is not approved for the latter in Australia.

An alternative method of naltrexone administration is through sustained-release implantable preparations. These long-acting, slow release implants can remain effective for as long as six months (Hulse, O'Neil, & Arnold-Reed, 2004; Stapleford Centre, n.d.). Naltrexone binds to opioid receptors and blocks the action of opioid

agonists, making it necessary for patients to be completely detoxified prior to commencing naltrexone or risk severe withdrawal symptoms and overdose (Tedeschi, 2002; Tucker & Ritter, 2000). Neither oral or sustained release naltrexone is recommended for use in pregnancy and lactation, although there is some experience with naltrexone and pregnancy in Western Australia (Hulse, Arnold-Reed, O'Neil, & Hansson, 2003).

#### **1.2.3.4 Management of psychostimulant use**

Psychostimulants are drugs that stimulate the activity of the central nervous system. Licit psychostimulants include caffeine and nicotine, whereas, illicit psychostimulants include methylenedioxymethamphetamine (MDMA, 'ecstasy'), cocaine, amphetmamine (speed), and methamphetamine (crystal meth, ice). Amphetamines are a synthetic psychostimulant first produced in the 1880s and it was not until 1970s that legal regulations over its production, distribution and use were introduced (Petroulias, 2002). Producing feelings of confidence, euphoria, alertness and increased energy (Wright & Klee, 2000), amphetamines are usually taken intranasally (snorted), smoked or injected. Psychostimulant use is associated with a high level of dependence, development of tolerance, and the risk of toxicity. Toxicity may result in extreme agitation, irrationality, impulsiveness, paranoia, and psychosis, often exhibited in aggressive antisocial behaviour (Jenner, Baker, Whyte, & Carr, 2004). Additionally, as with all injecting drug users, injecting psychostimulant users have an increased risk of contracting blood borne viruses and sexually transmissible diseases (Lee, 2004).

Many psychostimulant users do not seek treatment but manage their dependence and use as best they can, despite a range of interventions being available. These interventions range from harm reduction strategies of information, education, and supportive care, through to psychological and pharmacological management of withdrawal and issues of safety in relation to psychiatric illness and the risk of suicide (A. Baker, Lee, & Jenner, 2004).

### **1.3 Review of the literature**

#### **1.3.1 Epidemiology**

Epidemics of illicit-drug-use have been reported throughout history (Brazelton, 1991). Illicit-drug-use with its associated morbidity and mortality is a major worldwide public health problem of increasing magnitude (Daley, Argeriou, & McCarty, 1998; Gowing, Farrell, Ali, & White, 2001; MCDS, 2004) with Australia

being no exception. Collins and Lapsley (2008) report that in 2004–05 in Australia the total social costs of illicit drug use in Australia were estimated to be \$A8.2 billion with an additional \$A1.1 billion for alcohol and illicit drugs acting together. Since then those costs will have escalated considerably on net present value (NPV).

In 1998, in Australia, illicit-drug-use peaked when 22% of the population 14 years and over reported using within the previous 12 months (Australian Institute of Health and Welfare [AIHW], 2007). Since that time there has been a steady decrease in use of illicit drugs with the overall use reported in the 2001 census as 16.9%; in 2004 at 15.3%, and at 13.4% in 2006 (AIHW, 2007). This current level is lower than in 1993 when it was reported to be 14% (AIHW, 2007). The type/s of drugs used in Australia fluctuates depending on availability with a reported and continuing lowered supply of heroin (Fetherston & Lenton, 2005). Consistently the most commonly used illicit drug in Australia has been marijuana/cannabis although use has declined since 1998 to levels below those reported in 1993 (AIHW, 2007). Following cannabis in popularity is ecstasy, analgesics used for non-medical purposes, meth/amphetamines, cocaine, and opioids (heroin, non-maintenance methadone, and other opiates) (AIHW, 2007). Of statistical significance is the increase in cocaine use in Australia with 2007 levels the highest ever reported. Heroin use peaked in 1998 with 0.8% of the population using and that dropped to 0.2% in 2001 and has remained consistent (AIHW, 2007). Additionally, there is a high prevalence of polydrug use among illicit-drug-users (Fetherston & Lenton, 2006). Polydrug use is of major concern as this increases the risk of overdose; may complicate withdrawal (Petroulias, 2002); can contribute to low birthweight in infants (Ludlow, Evans, & Hulse, 2004); and can confound signs attributed to abrupt cessation in the supply of drugs to neonates following birth (R. E. Johnson et al., 2003).

Similar to Australian trends, the use of cannabis in Western Australia (WA) is widespread. Fetherston and Lenton (2006) stated that 80% of the injecting drug-using sample, used for the *WA Drug Trends 2006 Technical Report*, reported recent use of cannabis, with 29% consuming it on a daily basis. Other findings from Fetherston and Lenton's report included heroin remaining the most commonly nominated drug of choice (46%) with other opiates preferred by 18% of the sample. Methamphetamine was the second most commonly nominated drug of choice (23%). However, meth/amphetamine was the most commonly injected class of drug due to heroin not being readily available and substitute drugs such as homebake heroin and pharmaceutical preparations such as morphine and buprenorphine being

used in its stead. The illicit use of methadone and buprenorphine also appeared common amongst the injecting drug-using population in Western Australia (Fetherston & Lenton, 2006).

Approximately 90% of women who use illicit drugs are of childbearing age (K. Clarke & Formby, 2000; Linares, 1998; Llewelyn, 2000; NCADA, 1993). Although opioid use can cause menstrual irregularities such as amenorrhoea, oligomenorrhoea, and suppression of ovulation, pregnancy is not uncommon in women using opioids (Hankins, 2008; Hulse, Milne, English, & Holman, 1998; Rosenbaum, 1979) and other illicit drugs. However, menstrual irregularities results in many unplanned pregnancies (McMurtrie, Roberts, Rosenburg, & Graham, 1998), late realisation of their pregnancy, and thus, late presentation for antenatal care (Klee, Jackson, & Lewis, 2002; Murphy & Rosenbaum, 1999).

In studies conducted in the US, as many as 15% of women presenting for their first antenatal visit have exposed their fetus to some form of licit or illicit psychoactive drugs (Chasnoff, Landress, & Barrett, 1990) and the incidence is likely to be seriously under-reported (Hoegerman, Wilson, Thurmond, & Schnoll, 1990). The high potential for illicit-drug-use to be undetected or unreported during pregnancy and the postnatal period, harming the mother, fetus, and neonate is a problem of tremendous scope with complex social and medical implications (Kelly, Davis, & Henschke, 2000). In pregnant women, as in the general population of drug-users, there is a high prevalence of polydrug use (Fetherston & Lenton, 2006; Fischer et al., 2000; Hankins, 2008). Despite the fact that polydrug use is common, the majority of studies have concentrated on the effects of a single drug. In two Australian studies 75% and 68% of mothers on methadone at delivery reported using heroin and other drugs throughout their pregnancy (Batey & Weissel, 1993; Kelly et al., 2000). Subsequently, it is not known if the effects of polydrug use are additive, multiplicative or synergistic and what effect these cocktails have on the mother, fetus, and neonate.

### **1.3.2 Adverse outcomes in pregnancy and for the fetus and neonate**

In 2004 the Australian National Drug Strategy Household Survey (NDSHS) (2005) found that 6% of Australian women used illicit drugs whilst pregnant and or breastfeeding. Illicit drug use in pregnancy has the potential to result in adverse pregnancy outcomes and adverse outcomes in the fetus and neonate. For the mother, lifestyle factors such as poor socioeconomic status, coupled with illicit-drug-

use, contribute to poor nutritional status, anaemia, poor dental health, and skin disorders, which impact on maternal and infant morbidity (Ludlow et al., 2004). Other adverse outcomes associated with illicit-drug-use which impact on maternal and infant morbidity include the contraction of blood borne viruses such as hepatitis B, C, and HIV; and sexually transmitted infections (Lee, 2004). In Australia, the prevalence of hepatitis C (HCV) in the general population of injecting drug-users has been estimated at 60% (Loxley, Phillips, Carruthers, & Bevan, 1997), with enormous psychological, social, medical and financial implications (Farrell, 1999). In Western Australia HCV carriage was estimated at 57% (Loxley et al., 1997) in one study. In a Western Australian cohort of mothers who were using illicit drugs, HCV was reported at 46% (Bartu et al., 2006). Sexual and materno-fetal transmissions of HCV are relatively uncommon but do pose a real threat for infected mothers (Farrell, 1999). The pregnancies of women who use illicit drugs can also be marred by increased numbers of spontaneous abortions; hypertension; antenatal and postpartum haemorrhage; abruptio placentae; meconium stained liquor; and precipitous and preterm births (Campinha-Bacote & Bragg, 1993; Hoegerman et al., 1990; Hulse et al., 1998).

In the developing fetus of women who use illicit drugs, DNA and RNA replication is affected reducing the head circumference, linear growth, birth weight and ponderal index (Brazelton, 1991). For the neonate, adverse outcomes include pre-term births, low birth weight, low Apgar scores at five minutes, still-births, neonatal abstinence syndrome, and delayed developmental outcomes (Barnard & McKeganey, 2004; Behnke & Eyler, 1993; Brazelton, 1991; Butz, Lears, O'Neil, & Lukk, 1998; Ludlow et al., 2004).

Neonatal abstinence syndrome (NAS) is a condition resulting from exposure to psychotropic drugs in utero and it has been reported that between 55% and 94% of opiate exposed infants show signs of NAS (NSW Department of Health, 2006a). Due to the abrupt cessation of transplacental drugs following birth, infants experience physiological manifestations of withdrawal and in some cases, remnant toxic effects of the drugs (D'Apolito & Hepworth, 2002; Finnegan & Kandall, 1997). NAS from the withdrawal of opioids such as heroin, morphine or methadone is most commonly recognised and has been most extensively researched (Finnegan & Kandall, 1997; Ostrea, 1999; Rivers, 1999). The severity and course of NAS is extremely varied, with onset of symptoms ranging from birth to the end of the second week and beyond, with acute and subacute phases lasting for as long a six

to twelve months (D'Apolito & Hepworth, 2002; Kandall, 1999; Sharp, Bartu, Hewitt, & Hall, 2007a). NAS from opioid withdrawal is characterised by central nervous system, respiratory system, autonomic nervous system, and gastro-intestinal system clinical signs (D'Apolito & Hepworth, 2002). Exposure to and withdrawal from psychostimulants such as amphetamines and cocaine, and other psychoactive drugs such as barbiturates also have the potential to precipitate NAS (Sharp et al., 2007a). Babies experiencing NAS are difficult to manage, often crying excessively, are hypersensitive, experience increased weight loss in the neonatal period and have poor suck responses making breastfeeding and mother-infant bonding difficult to establish (Campinha-Bacote & Bragg, 1993; Hoegerman et al., 1990). Additionally, there is an increased incidence of sudden infant death syndrome (SIDS) in these infants (Kelly et al., 2000; Wang, 1999).

### **1.3.3 Lives and circumstances of mothers who use illicit drugs**

Whilst there is limited literature on the lives and circumstances of mothers who use illicit drugs there are some excellent studies providing insight into their world. Much of the work conducted internationally has been on populations of socially and economically disadvantaged mothers in the United States of America (US) and the United Kingdom (UK) (see for example: Hardesty & Black, 1999; Kearney, Murphy, Irwin, & Rosenbaum, 1995; Kearney, Murphy, & Rosenbaum, 1994; Klee, 1998; Klee et al., 2002; Murphy & Rosenbaum, 1999; Pursley-Crotteau & Stern, 1996; Rosenbaum, 1979). In Australia, Richter and Bammer (2000) and Banwell and Bammer (2006) have provided insight into the Australian experience.

Common themes throughout this literature is the centrality of motherhood to the identities of mothers who use illicit drugs and their firmly held values of mothering (Hardesty & Black, 1999; Kearney et al., 1994; Pursley-Crotteau & Stern, 1996); feelings of extreme guilt regarding issues of addiction and parenting (Creamer & McMurtrie, 1998; Daley et al., 1998; Klee et al., 2002; Rosenbaum, 1979), and the fear of losing custody of their baby/children because of their drug use (Hardesty & Black, 1999; Kearney et al., 1995; Kearney et al., 1994; Klee, 1998; Klee et al., 2002; Pursley-Crotteau & Stern, 1996; Richter & Bammer, 2000; Rosenbaum, 1979).

Women who use illicit drugs are highly stigmatized and marginalised (Hankins, 2008; Sherman, Kamarulzaman, & Spittal, 2008) and those who continue to use and are pregnant or parenting are judged harshly. Indeed, they have been defined as

the “antithesis of responsible behavior (sic) and good health” (Murphy & Rosenbaum, 1999, p.1). Murphy and Rosenbaum (1999) and Sherman and colleagues (2008) assert that mothers who use illicit drugs are subject to stigmatization not only because of their drug use but also because they are women and are often single parents (Dawe, Harnett, Staiger, & Dadds, 2000); they are often unemployed; and live in conditions of extreme poverty (Sherman et al., 2008). Many women who use illicit-drugs also have complex health issues including mental health problems and Hepatitis C (Corrigan, 2005; Lee, 2004; Loxley et al., 1997), which are both highly stigmatized conditions. Additionally, these women are often in dysfunctional relationships resulting in domestic violence (Velez et al., 2006), again attracting stereotyping, judgment, and stigmatization. Illicit-drug-use attracts multiple labels including “junkie” and “addict” which again serve to discriminate and identify users as unacceptable, dangerous, and bad (Roper & Anderson, 1994).

Attitudes towards the labelled and stigmatized are often embedded and deeply entrenched in community or society's belief system and are continually reinforced and perpetuated (Major & O'Brien, 2005). For example, Bronwyn Bishop, a Federal politician, was reported in The Western Australian newspaper on October 22, 2005, to say “Drug parents should lose kids” (Ghandour, 2005) (see Appendix 2). Opinions of the social and political elite have a strong bearing on how illicit-drug-use and users are defined in our society. This adds to the stereotyping and stigmatization, as well as fuelling moral judgment and further marginalising users.

Many women who use illicit drugs also exhibit behaviours consistent with low self-esteem, powerlessness and depression (Allen & Sandler, 1993; Klee et al., 2002; Murphy & Rosenbaum, 1999) and they often lead chaotic, high-risk lifestyles which expose them to further biopsychosocial problems (Hawley, Halle, & Drasin, 1995). Additionally, there is a high degree of criminal activity associated with illicit-drug-use (Hargreaves & Lenton, 2000) and with it the potential for surveillance, prosecution and incarceration. Considerable evidence indicates that many women who use illicit drugs have been victims of traumatic life experiences such as sexual, physical and emotional abuse (Davis, 1997; Jarvis, Copeland, & Walton, 1998; Murphy & Rosenbaum, 1999) during developmental stages of their lives. Children who experience abuse are at high risk of detrimental outcomes in adulthood such as illicit-drug-use, antisocial behaviour and low self-esteem (Spooner & Hetherington, 2004), and often chose partners who perpetuate the abuse (Roleff, 2000). As a

result of their life experiences, these women tend to lack trust, are emotionally vulnerable and are judged as being extremely manipulative (Linares, 1998).

Pregnancy is a time when women who are using illicit drugs have real fears for the developmental outcomes of their babies (Allen & Sandler, 1993) and motherhood often acts as a catalyst for them to improve their lives (Hardesty & Black, 1999; Pursley-Crotteau & Stern, 1996; Rosenbaum, 1979). Like most mothers, these women have good intentions to love, nurture and provide for their babies (Banwell & Bammer, 2006; Noring, 1999). However, the overwhelming responsibility of the day-to-day caregiving of the baby and other children, their dependence on illicit substances, co-morbid conditions such as mental health issues, their scarcity of resources and social support, and conditions in which they live can compromise their ability to provide a stable and nurturing environment (Daley et al., 1998; Noring, 1999; Wood, 2000). Despite these difficulties mothers who use illicit drugs employ a range of protective behaviours to lessen the impact of their drug use and lifestyle on their children. Kearney et al. (1994) identified processes of *defensive compensation* used by mothers using crack cocaine to protect their children and their identity as mother from their drug use, and of *salvaging self* (Kearney et al., 1995) for the sake of their unborn child's wellbeing. Richter and Bammer (2000) identified a hierarchy of strategies used by mothers using heroin, ranging from ceasing drug use to placing children with a reliable caregiver, either voluntarily or involuntarily, when they were incapable of providing adequate care to their children.

In addition to the challenges associated with illicit-drug-use, mothers who use illicit drugs are subjected to the same stressors of pregnancy and motherhood experienced by non-drug-using women (Daley et al., 1998). Banwell and Bammer (2006) compared mothers who use illicit drugs to mobile and low income mothers who did not use illicit drugs and to middle class mothers who also do not use illicit drugs. Their findings demonstrated that whilst all mothers, at times, found mothering difficult, mothers who use illicit drugs were often blamed for their difficulties where other mothers were not. Additionally, mothers who use illicit drugs received less social support than their non-drug-using counterparts.

Providing appropriate services for pregnant and childbearing women who use illicit drugs, and for their infants, presents challenges for health care providers. Illicit-drug-use influences the biological, psychological and social comorbidity (Powis, Gossop, Bury, Payne, & Griffiths, 2000), which increases the complexity of care



(Batey & Weissel, 1993) across the childbirth continuum (Allen & Sandler, 1993). Health care providers are often ill prepared for the complex phenomenon that the mother/infant dyad that has been exposed to illicit drugs presents (Campinha-Bacote & Bragg, 1993; Klee, 1998; Linares, 1998). Moreover, Klee et al. (2002) asserts that there appears to be a professional reluctance to engage with the issues of illicit-drug-use, keeping these women and children peripheral to mainstream health.

#### **1.4 Justification**

This study was conducted to make an original contribution to the theoretical body of knowledge on the subjective experience of Western Australian mothers who use illicit drugs. The majority of research on illicit-drug-use is conducted on men. Many of the services and treatment modalities for drug-users are also designed for and tested on men (Coles, Russell, & Schuetze, 1997; Powis et al., 2000) and do not take into consideration the gender differences that influence access to services or response to treatment by women (Hankins, 2008). Research on illicit-drug-use in women usually does not differentiate between pregnant and non-pregnant users (Coles et al., 1997). Moreover, it has been identified that treatment and services for illicit-drug-users frequently discriminate against pregnant women and women with children with services being inaccessible or inappropriate to their specific needs (Noring, 1999; Simpson & McNulty, 2008; Wright, 2002). The majority of research that does focus on illicit-drug-use in pregnancy has been conducted in the United States of America (US) and the United Kingdom (UK) where the social context, ethnic groupings, and the health, welfare and justice systems differ greatly from the Australian experience. Much of the US research is conducted amongst very low income families (Hardesty & Black, 1999; Kearney et al., 1994; Pursley-Crotteau & Stern, 1996; Roberts, 1999), whilst in Australia drug-users remain more integrated in society and provide a broader socioeconomic cross-section for investigation (Richter & Bammer, 2000).

In the fields of obstetric and midwifery, studies often exclude mothers who use illicit drugs from mainstream research because it is perceived their inclusion could negatively influence outcomes and complicate the research process (Batey & Weissel, 1993). Mothers who use illicit drugs are a discrete, socially disadvantaged, and stigmatized group (Klee, 1998; Linares, 1998; McKeganey, 1999; Mills, 1995; Murphy & Rosenbaum, 1999; Simpson & McNulty, 2008) with complex social, psychological, medical, and obstetric needs (Sharp, Bartu, Hewitt, & Hall, 2007b).

Research that does focus on mothers who use illicit drugs often centres on the pregnancy; adverse pregnancy and neonatal outcomes; and neonatal abstinence syndrome (see for example: Finnegan & Kaltenbach, 1992; Marcellus, 2002; Zuckerman, Frank, & Brown, 1995). Additionally, the research that is conducted is predominantly quantitative.

Limited inductive work, derived from in-depth interviews has been conducted. There is little description of how these mothers feel, behave, interact, function or engage in the social process. This knowledge is crucial to understanding the phenomenon of the subjective experience of mothers who use illicit drugs. The number of women presenting for care, who use illicit drugs across the childbirth continuum, is increasing and there is a need for strategies to address their associated biological, psychological and social issues. It therefore becomes relevant to conduct more humanistic research to contribute to the body of knowledge in this substantive area. In so doing, the issues experienced by this group and the strategies for dealing with their complex lives will be more clearly understood. Whilst reference is made to mothers who use illicit drugs as a group it is recognised that groups are made up of individuals and individual perspectives and it is those perspectives, on the experience of mothers who use illicit drugs, that this study set out to capture.

Until a better understanding of the subjective experience of mothers who use illicit drugs and have significant responsibility for the care of children can be achieved, the provision of appropriate and adequate health care will potentially be compromised. Through the development of a theoretical framework this work seeks to advance knowledge and lay the foundation on which to inform health care provision, future research, education, and policy development.

### **1.5 Purpose of the study**

The purpose of this study was to gain insight into and understanding of abstract problems shared by mothers who use illicit drugs and identify the processes they employ to manage those psychosocial challenges. Through examining the subjective experience in context the influence of drug-use and lifestyle on the mothering experience could be explicated.

### **1.6 Study objectives**

The objectives of this study were to systematically examine and interpret the data to:

1. Identify the basic psychosocial or central problem shared by mothers who use illicit drugs;
2. Interpret the psychosocial processes employed to manage the identified central problem;
3. Ascertain conditions influencing the central problem and psychosocial process; and
4. Develop a theory explaining how the central problem was managed and situate that theory within existing social and scientific knowledge.

## 1.7 Organisation of the thesis

The thesis has been divided into four sections. Section one has three chapters providing the background, justification, methodology, and a profile of the participants. Chapter one introduces the topic and provides an overview of the governance of illicit-drug-use in Australia, followed by an overview of the literature pertinent to the substantive area, and concludes with the purpose and objectives of the study. Chapter two provides the epistemological origins of the grounded theory method and differing interpretations of the application of grounded theory that have emerged. The major focus of the chapter is a description of the method as it was utilised in this study. Chapter three presents a demographic profile of the participants, supported by tables, and illustrated with genograms.

Section two has two chapters providing a description of the basic psychosocial problem shared by study participants and the basic psychosocial process employed to manage the identified problem. Chapter four presents the central problem experienced by mothers who use illicit drugs. The central problem was *the threat of loss* which emanated from (a) *judgment and disapproval by self and others*; (b) *being abused, controlled, overwhelmed, and dependent*; (c) *damaging myself and damaging my baby*; (d) *losing my baby or having my baby taken off me*; (e) *having a sense of not belonging*; and (f) *not trusting others and not being trusted*. The consequence of these threats was loss of respect; loss of freedom; loss of health; loss of child; loss of identity; and loss of trust. Chapter five provides the theory of *limiting loss through a process of safeguarding*. The mothers engaged in this core process through three sub-processes: *safeguarding during pregnancy*; *safeguarding as mother*; and *safeguarding to preserve integrity*. Depending on the perceived severity of the threat and the influencing conditions, the safeguarding processes employed by the mothers oscillated between reactive responses of *struggling* and proactive strategies of *taking back control*.

Section three includes two chapters and discusses the conditions influencing the basic psychosocial problem and basic psychosocial process and the implications and concluding statements. Chapter six presents the influencing conditions of: *the self*; *the nature of support from significant others*; *attitudes and practice of health professionals*; *negative influences of others*; *fear of being 'bad mother'*; and *maturation of children*. Chapter seven positions the study within related theories, discusses limitations of this work, and reviews significant concepts that emerged. The chapter examines implications of this new understanding of the lives of mothers who use illicit drugs; and provides suggestions for further research; policy development; education, and best practice. The final section provides the reference list and appendices.

## **Chapter two**

### **Methodology**

#### **2.1 Introduction**

This chapter describes the grounded theory method as it was utilised to study the experience of Western Australian mothers who use illicit drugs. Participants included mothers who had birthed their babies at the only women's tertiary referral hospital in Western Australia, supplemented by data from health professionals who provided care for mothers who use illicit drugs. The method's epistemological foundations are presented along with consideration of the differing schools of thought on the application of the method. Description of the research process; sampling strategies; data collection and management; analytical strategies; methodological rigor; and ethical considerations are provided to explain how the study was conducted.

#### **2.2 Qualitative research**

Quantitative research has had a long tradition of being the preferred method of quantifying human experiences through measuring, objectifying and statistically analysing (Field & Morse, 1985). That method is valuable, necessary and expedient in the search for understanding and explaining measurable phenomena. Furthermore, that method of scientific inquiry can be replicated on other study populations and is generalizable. However, many human phenomena defy measurement and to understand social phenomena one needs to interpret the meanings humans assign to events and situations in their lives (Hitchcock & Hughes, 1989). Known as qualitative research this approach to knowledge discovery (Streubert & Carpenter, 1999) is grounded in the social sciences and aims to explore phenomena from the emic or insider's perspective. Additionally, qualitative research allows the researcher to explore the participant's life experiences from within their social context and interpret, conceptualise, and develop theory on human behaviour, values, culture, and relationships, which is unable to be interpreted using quantitative methods (Streubert & Carpenter, 1999). By examining the richness and complexities of human behaviour using this inductive approach a better understanding of people's experiences is possible. By having that knowledge, explanations can be developed and used to inform further research, develop best practice, guide health care provision, provide education, and guide policy development. Morse and Field (1995, p.4) explained theory as "a systematic

explanation of an event in which constructs and concepts are identified and relationships are proposed and predictions made”.

Central to all qualitative methodologies is the notion that reality is dynamic and dependant on one's perception, and reality is socially constructed and context specific (Denzin & Lincoln, 2000; Munhall & Boyd, 1993). There are numerous qualitative research approaches that emanate from different disciplinary roots. The different methodologies have unique philosophic underpinnings and different central characteristics, central questions, data collection methods, and analytical approaches. This diversity allows the researcher to select the most appropriate method to explore the phenomenon of interest.

The experience of Western Australian mothers who use illicit drugs is the area of interest for this study. Grounded theory was chosen as the most appropriate method to interpret the experiences of these mothers. The desire to seek meaning and develop theory that identify the problems faced by these mothers, explain their patterns of behaviour, and clarify the processes used to manage those problems supported the choice of grounded theory.

### **2.3 Grounded theory method**

Grounded theory is a qualitative research method for the systematic discovery of concepts and generation of theory from data (Glaser, 1998; Glaser & Strauss, 1967). This method was 'discovered' (Glaser, 1998) by two American sociologists in the 1960s: Anselm Strauss (1916-1996) from the Chicago school of qualitative research and Barney Glaser from Columbia University. Glaser was trained in quantitative research by Lazarsfeld and colleagues and influenced by lessons on theory construction from role theory and social structural theory (Glaser, 1998). Strauss brought the influence of symbolic interactionism to the collaborative partnership between Glaser and Strauss (Stern, 2009).

The symbolic interactionist viewpoint was shaped by George Herbert Mead (1863-1931) and later Herbert Blumer (1900-1987) and others who had their traditions in social psychology and sociology (Eaves, 2001; Glaser & Strauss, 1967; Hitchcock & Hughes, 1989). In his interpretation of Mead's thoughts and work Blumer (1969) posited three tenets of symbolic interactionism (Robrecht, 1995), which can be simplified into: *meaning*, *language*, and *thought*. The first tenet of *meaning* states that humans act toward people and things on the basis of the meanings that the

things have for them. The *meaning* of human behaviour is central to the theory of symbolic interactionism. The second tenet is *language* and states that the meaning of such things is derived from the social interaction (*language*) that one has with others. By assigning names and thus meaning to all things, tangible and intangible, objective and subjective, *language* provides a means for social interaction. The final tenet is *thought* and states that these meanings are handled in, and modified through, an interpretative process (*thought*) used by the person to deal with the things she/he encounters. One's thought or personal conversation is based on language or symbols and is influenced by previous actions and interactions, contexts, and one's concept of self. Symbolic interactionism is thus a theory about human group life and behaviour and focuses on how human beings use and interpret symbols (*language*), suggesting a conscious creation or construction of their social reality by the generation of meanings (*meaning*) and interpretations (*thought*) within contexts (Hitchcock & Hughes, 1989). Symbolic interactionism is concerned with how people interpret events and the symbols they use to convey those meanings (C. Baker, Wuest, & Stern, 1992). The experiential aspects of human behaviour (Eaves, 2001) are subjectively defined and one's behaviour is shaped accordingly by their beliefs. This implies that people are in a continual process of interpretation and definition in each and every interaction they encounter. Social action is essentially viewed as a fluid and changing affair, open to negotiation and renegotiation (Hitchcock & Hughes, 1989). Additionally, the assumptions underlying the theory of symbolic interactionism, as posited by Denzin (1989), are that: social reality as it is sensed, known, and understood is a social production. Humans are assumed to be capable of engaging in 'minded', self-reflexive behaviour; and in the course of taking their own standpoint and fitting that standpoint to the behaviours of others, humans interact with one another (Eaves, 2001).

An example of interpretation variance is, ironically, the divergence in grounded theory method that has evolved since grounded theory was first developed and articulated. Glaser and Strauss published *'The discovery of grounded theory: Strategies for qualitative research'* in 1967. That work resulted from Glaser and Strauss' earlier work on the 'Awareness of dying', and the initial text described the research processes for generating grounded theory. In 1967 the method and the resultant text was considered avant-garde. However, today the method is well respected and used extensively in the health sciences, education, and business to generate theory on complex human experiences.

## 2.4 Divergence of grounded theory method

Grounded theory method has not been static since it was first developed in the 1960s. There has been ongoing debate and factions have emerged as to the validity of more recent interpretations of grounded theory. Strauss, with one of his students, Juliet Corbin, developed a more prescriptive methodological procedure and articulated a step-by-step process for coding and interpreting data. Their interpretation and the publication of the controversial text: '*Basics of qualitative research: Grounded theory procedures and techniques*' (Strauss & Corbin, 1990) caused a difference of opinion between Glaser and Strauss. Glaser's major objection was that he felt that the prescriptive process fostered users of the method to *look for data* rather than *look at data*, thus forcing the data and theory rather than allowing emergence (Glaser, 1992).

Given that the development of knowledge is a cumulative experience with input from various sources, influences, experience and exposure it is not surprising that the grounded theory method that scholars are applying now differs somewhat from Glaser and Strauss's original method. Could it be a natural evolution, refinement and improvement? Today, the major authors on grounded theory have different opinions on certain aspects of the method, which can confuse neophyte grounded theorists. The issue is not who is right about grounded theory and whether you agree with Glaser and Strauss (1967), Glaser (1978; 1992), Strauss and Corbin (1990) or others (see for example: B. Bowers & Schatzman, 2009; Charmaz, 2006; A. E. Clarke, 2005). The issue is what each researcher takes from those scholars before them and what they do with it, and how they argue for, advocate, and defend their own position. Glaser (1998) argues that the worth of grounded theory is not in the discussion and rhetoric but in the outcome of research conducted using the method. If the theory 'works' to clearly explain the behaviour of participants in the substantive area and has 'relevance' for them, that it 'fits' their experience and the theory is 'modifiable' in the light of new data, then this legitimises the method (Glaser, 1998). Similarly, Corbin stated that "Grounded theory is a *way of thinking*...as long as you have theoretical sampling, constant comparison, ask some sort of questions – how you actually do it is individual. We [second generation grounded theorists] all do it differently" (Morse et al., 2009, p.236-237).

The discourse one has with others and with 'self' requires thought and interpretation to extricate the meaning of issues, which in turn leads to greater understanding, refinement and improvement. The debate around the application of grounded



theory will continue as social researchers and scholars explore, re-examine, and search for clarity in the original and subsequent texts and scholarly papers, and in theories developed using the method.

## **2.5 Theory development**

Applied grounded theory method has the capacity to develop formal or substantive mid-range theory, and it is that factor that distinguishes it from other research methods. Building theory using this method is an effective way of interpreting and developing explanatory theory of what it is that others experience (Glaser, 1978). In exploring other's reality two types of mid-range theory can be developed. Grounded formal theory refers to theory developed on related concepts from diverse samples (Glaser, 1978, 2007; Glaser & Strauss, 1967). Examples of formal grounded theories are: the exploration of wellness-illness; pain; or grief experienced under different situations (Kearney, 1998; Strauss & Corbin, 1990). Using higher level data sources, such as substantive theories, one can expand their applicability and systematically develop a more abstract and generalizable understanding of human responses to the selected concept (Kearney, 1998).

For this study, the aim was to develop a grounded substantive theory on a situation-specific social process. A substantive theory explains the participant's subjective experience of a defined phenomenon, set within, and taking consideration of, their social context (Glaser, 1978; Glaser & Strauss, 1967). The goal is to generate a theory that interprets the central problem of the study domain that is experienced by the participants; to translate the processes participants use to manage the problem; identify interrelationships between and within concepts; and discover conditions influencing the phenomenon (Glaser, 1978; Glaser & Strauss, 1967). Although less generalizable than grand theories such as Blumer's *Symbolic Interactionism* (1969) or Kubler-Ross' theory *On Death and Dying* (1991), which are complex and cannot be tested empirically, this calibre of theory is valuable where little is known about a phenomenon and it is useful in providing new understandings, informing practice and guiding further research.

Primarily, grounded theory is an inductive method. However, in developing theory from others' reality, grounded theory uses both inductive and deductive strategies (Glaser, 1978) to develop an integrated set of conceptual hypotheses, and test those hypotheses, through a process of constant comparative analysis and theoretical sampling (Glaser, 1998). Constant comparative analysis is central to

grounded theory method and is a process of recursive steps where one moves backwards and forwards comparing every datum with every other datum (Glaser & Strauss, 1967) until the hypotheses 'fit' the behaviour seen in the substantive area (Glaser, 1998). The constant comparative method of data analysis described by Glaser and Strauss (1967) has four stages: *comparison of incidents; integration of categories and their properties; delimiting; and writing the theory.*

Data collection, coding, analysis, diagramming and memo writing takes place concurrently. Analysis begins with open coding to fracture the data into codes or key points. Codes with similar content are then clustered or grouped to create concepts, categories and properties of those categories. At that stage the *comparison of incidents* applicable to each of the emerging concepts, categories, and properties takes place. As the similarities and differences are recognised in and between the categories and their properties they are *integrated* and reduced to form theoretical codes as the theory develops. By further comparison and integration, links are identified between categories and their properties, until the unifying core category, to which all other categories relate, and which accounts for most of the variation in the patterns of behaviour, are identified (Glaser, 1978, 1998). Integrating the theory around one core category *delimits* or defines the theory as only variables relating to the core category are then used.

When the core category is identified sampling moves from purposive to theoretical to focus data collection around the emerging concepts, categories and their properties and to "round out thin areas" (Glaser, 1992, p.101) and develop the theory. Coding at this stage also moves from 'running the codes open' to selective coding where only codes related to the core category are used. This is followed by theoretical coding which lifts the analysis to a conceptual level as concepts and categories are identified, compared, and refined, and their properties and interrelationships are interpreted (Glaser, 1978). These processes continue until the core category stabilizes and around which all the other categories revolve (Glaser, 1992).

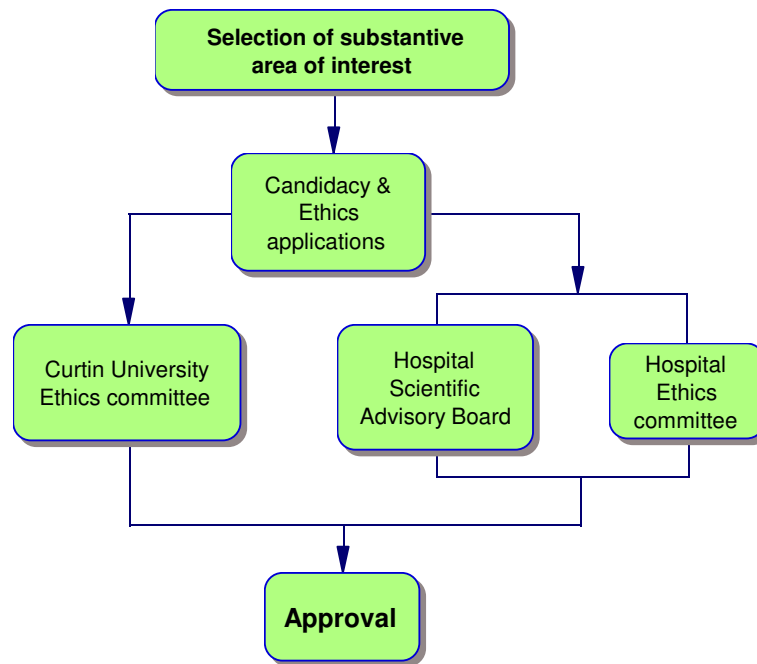
Concurrent with the coding and analysis, memos are written and schemas drawn to depict the relationships between concepts, categories and their properties to assist the conceptualisation of the developing theory. The memos, schemas, and systematically derived substantive theory are collated and integrated into the *written theory* which is supplemented with excerpts of the participants' actual words to

demonstrate 'fit' and illustrate the participant's meaning (Glaser, 1998). Finally, theoretically sampled literature is compared to and woven into the theory, placing the substantive theory within the context of contemporary social and scientific knowledge (Glaser, 1992; Wuest, Ford-Gilboe, Merritt-Gray, & Berman, 2003). The constant comparative analytical process accounts for much of the rigor of the method as it is a built-in verification system of comparison and modification until the theory 'works' and the researcher knows exactly what is going on (Glaser, 1998).

## **2.6 Getting started**

The motivation to explore the substantive area occurred as a result of the researcher's experience whilst involved in quantitative research on postpartum women. In two substantial studies in which the researcher was involved (Hagan, Evans, & Pope, 2004; Priest, Henderson, Evans, & Hagan, 2003), mothers who used illicit drugs were excluded as it was felt that issues pertinent to those mothers would skew the results and that those women were not reliable. Bias against those mothers motivated a quantitative longitudinal home visiting intervention specifically for postnatal mothers who use illicit drugs (Bartu et al., 2006). Feedback from the mothers was extremely positive with retention of 93%. However, little was known about the women and the context of their lives. The majority of available literature on the topic was from North America where the social context, ethnic grouping, health, welfare and justice systems differed to that experienced in Western Australia. It was not known what issues were pertinent to these mothers or how they perceived and managed those issues on a day-to-day basis. There was a clear deficit in the knowledge surrounding this substantive area of interest.

Having selected an area with a life cycle interest (Glaser, 1992) the process of gaining candidacy began. Prior to commencing this study, it was necessary to prepare and submit a research proposal for candidacy to the Doctoral Program. Despite the directive within the grounded theory literature not to do a literature review prior to commencing the study, a literature review and overview of the methodology was a requirement of the Graduate Studies and two Ethics Committees. However, it is felt that this did not influence the researcher's preconception of the substantive area as there were no similar studies that had been conducted in Australia. Figure 2.1 depicts the process of gaining approval to conduct the study.



**Figure 2.1: Flowchart of approval process**

Following approval from the appropriate committees to conduct the research; collaboration with significant personnel within the health industry occurred prior to commencing data collection. A précis of the study was provided for interested health care providers. As the researcher had been involved in studies within the tertiary referral hospital over an extended period she was treated as an insider and welcomed into the field. Similarly, she was known within the drug and alcohol field by health professionals and clients and was welcomed.

### **2.6.1 Researcher awareness and assumptions**

As the researcher was experienced with research on mothers who use illicit drugs it was imperative to be aware of preconceptions and possible biases prior to commencing the study. To demonstrate the researcher's ideological stance and epistemological presuppositions (Kincheloe & McLaren, 2000), a reflexive review was undertaken to bring to awareness her personal values, beliefs and preconceptions, which were recorded. The basic assumption was that mothers who use illicit drugs share psychosocial problems related to their experience. The researcher anticipated that most of the mothers, in addition to illicit drugs, would be regularly using psychoactive substances that would come into the licit category in Western Australia. Those licit psychoactive substances would include alcohol, caffeine, tobacco, and prescription drugs such as benzodiazapines, sedatives and

opioid based analgesics. In addition it was believed that some of the mothers would be on methadone or buprenorphine and might still be using other licit and illicit drugs concurrently.

The researcher thought that illicit-drug-use was the underlying psychosocial problem experienced by all mothers who are using drugs. It was held that it was entirely the choice of the mothers to perpetuate, modify or cease their drug use. Additionally, it was assumed that the mothers were likely to be poorly educated and from lower socioeconomic backgrounds with the influence of poverty and limited knowledge playing a major role in defining their behaviour. Moreover, it was felt that the ability of mothers who were using illicit drugs to adequately parent would be compromised by their dependence on illicit substances and their poor socioeconomic status. Finally, the presupposition that health professionals hold the 'best interest' of their patient as a major consideration in the provision of care was held.

## **2.7 Research process**

The primary data source for this study was in-depth interviews with informed and consenting participants. Secondary data sources included field observations in the mothers' homes or in clinical settings where the environment, mother-baby interactions, and interactions with health professionals and family members were observed. Other sources of data included a demographic questionnaire (Appendix 3); obstetric questionnaire (Appendix 4); informal conversations; medical records; documents such as the Western Australian Child Welfare Act ("Child Welfare Act," 1947) and newspaper articles; scientific and social literature; and researcher memos and reflective journals.

Although the research process may appear linear or chronological, data collection, coding and constant comparative analysis occurred simultaneously throughout this study. Figure 2.2 provides a comprehensive conceptualisation of the recursive procedural process demonstrating the progress from selection of participants to development of the theory and production of the report. The flowchart demonstrates the interrelatedness, flow, direction, connectivity, and interplays between steps and is elucidated in the following discourse.

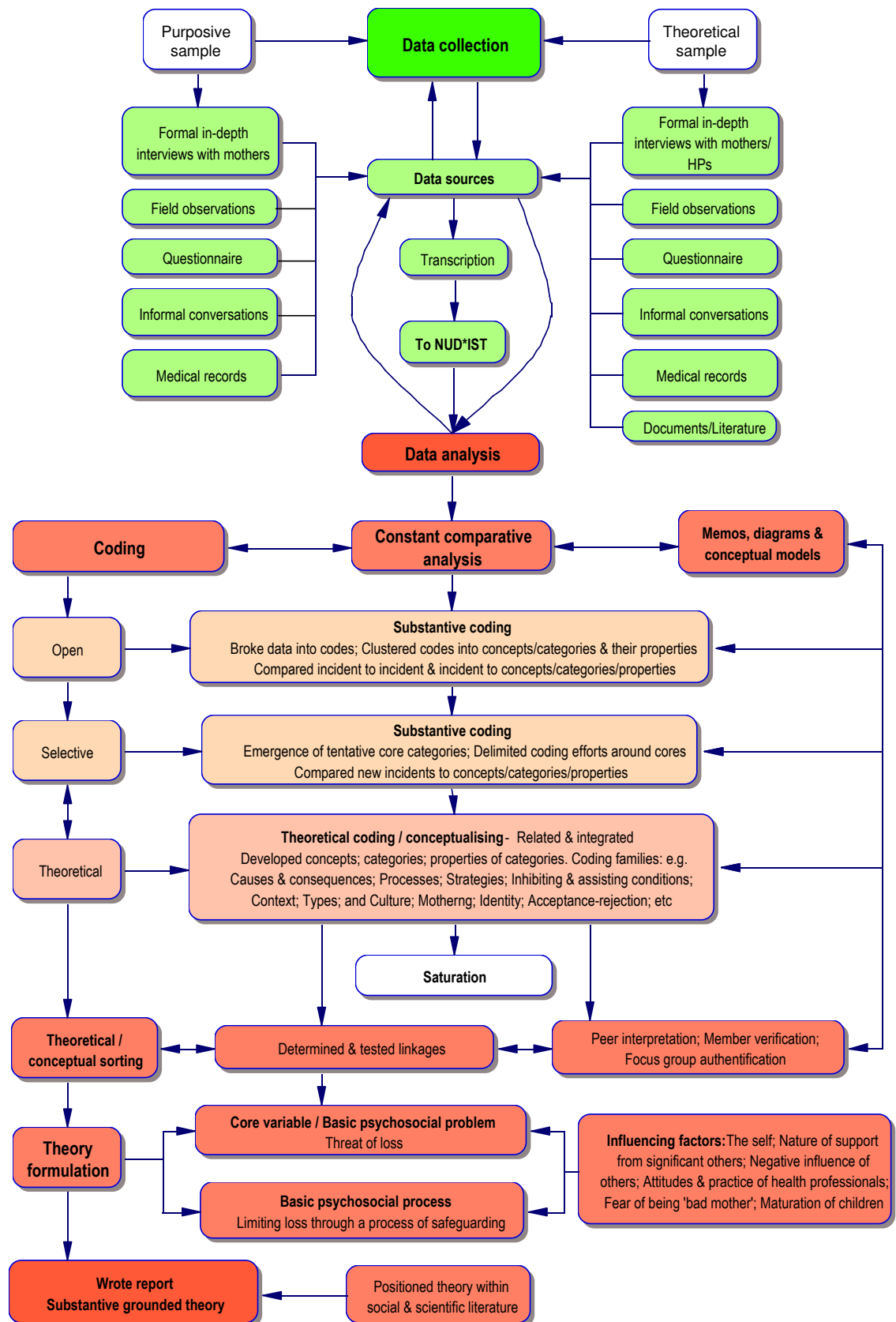


Figure 2.2: Research process

### **2.7.1 Purposive sampling**

Initially a purposive sample was selected. For inclusion into the study mothers needed to: have a history of illicit-drug-use during pregnancy; have no mental and physical conditions that would affect their ability to understand the researcher or to express their subjective perceptions of the phenomenon; be English speaking; be at least 18 years of age; and have attended the tertiary referral hospital for the birth of their youngest child.

Additional to a history of illicit-drug-use, mothers who had been in a drug treatment program during their pregnancy were also eligible. It was felt that the inclusion of mothers on methadone, buprenorphine, or naltexone was imperative as they were chemically dependent and many continued to use illicit drugs in conjunction with their prescribed treatment. Polydrug use is a common practice within this population and it would have been a grave omission if mothers on treatment programs were not included.

The tertiary referral hospital for women has a dedicated antenatal clinic for pregnant women who use illicit drugs. Referred to as the Antenatal Chemical Dependency Clinic (ACDC), this multidisciplinary public clinic features a team of midwives, an obstetrician, social worker, drug counsellor, and other allied health professionals. The women are either referred to the ACDC by their General Practitioner, the Specialist Drug and Alcohol Service, or the woman self identifies and books through the clinic for her antenatal care. The majority of women who use illicit drugs who birth at the hospital were registered with the ACDC, thus it was through the clinic that potential participants were identified.

ACDC staff was integral in assisting with identifying potential participants. As the recruitment process was not continuous, they waited for the researcher to contact them when she needed to select the next mother for interview. In the initial period, five mothers were identified by clinic midwives as typical of ACDC's patients. They were also identified as able to articulate their perceptions of the phenomenon under study. At recruitment, these mothers were involved in a home visiting intervention and were thus still engaged with the hospital. Following contact by telephone, the researcher explained the purpose and nature of the study, the mothers' potential involvement, the confidential management of data, and invited them to be part of the study. None of the purposive sample declined the invitation. Informed consent was obtained prior to commencing data collection.

### **2.7.1.1 Interviews**

Interviews for the purposive sample were conducted in the mothers' homes and the researcher assumed the status of invited guest. With the purpose of the interview being to obtain rich experiential data pertaining to the substantive area it was necessary to develop a mutual understanding and trust between the mother and researcher. Thus, the researcher spent time prior to commencing the interview with mothers to 'get to know them' and vice versa. For example, prior to commencing one interview the researcher helped bring in the washing, folded nappies, and chatted about fashion; with others she held the baby or played with other children whilst the mother attended to other things. These activities not only acted as ice-breakers but were ideal opportunities for field observations.

The researcher was experienced in providing therapeutic interviews so was comfortable in developing an engaging, relaxed, professional communication style. It was imperative to create a feeling of safety and trust which would allow the mother to share painful and intimate experiences. The style used is best demonstrated in a comment from one mother.

I did heave a big sigh when you walked in here. I thought, phew, here we go again. Maybe, it could have been very traumatic... If I'm with somebody like you who is giving me a lot of time, listening, very gentle approach, you have very gentle eye contact, very interested. You have a very nice aura about you, a very loving feel to you, a motherly type feel... That makes me feel good. It makes me feel good to be around people like that.

At the completion of another interview the mother had obviously felt comfortable as indicated in the following excerpt from field notes recorded immediately after the interview.

As I packed up my things Beth put the sleeping children into the car. We walked out to the car together and as we said goodbye she embraced me. It felt like a natural thing to do. We gave each other a hug and she hopped into the car and drove off to collect her partner from work.

Although every effort was taken to select an interview environment that was comfortable, private, quiet, well lit and ventilated, some interruptions did occur. As the participants were mothers it was expected that the baby and other children may be present, or in the home, during the interview, which was indeed the case.



Interactions between mothers and their baby, or other children, during the interview also contributed to field observations.

Interviews with the purposive sample were unstructured and commenced with the open-ended statement: 'I would like you tell me about your experience of being a mother'. This allowed the mothers the freedom to discuss any issue or experience they felt was pertinent. Mothers' recollections of events during pregnancy, labour, in the postnatal period, and whilst parenting was clear. Memories of upsetting or traumatic incidents remained vivid, often with accompanying latent emotion still palpable. The researcher guided the interview by picking up on comments and probing for greater clarification as necessary. For example, the researcher would probe with comments such as: Can you tell me a bit more about that? How did that make you feel? You mentioned feeling guilty – can you explain that to me? What did you do? Interviews with the purposive sample ranged from 60 minutes to 150 minutes, with an average interview time of 93 minutes.

#### **2.7.1.2 Field observations**

Field observations were included in the data collection process as to accurately describe the social process of the phenomenon at a high level of conceptualisation it is necessary to compare formal interview data with actual behaviour (Dreher, 1994; Wilson & Hutchinson, 1991). Unobtrusive field observations were conducted whilst with the mother, during interviews, and at points when the mother needed to attend to her baby, other children, and significant others. The observations were audio-recorded immediately after the researcher left the mother's home, whilst the observations were fresh in her mind.

Description of the environment and non-verbal aspects of interviews as well as observations of body language, emotion and impressions were recorded and transcribed for analysis. Excerpts from the resultant field notes were added to the interview transcripts in parentheses, thus adding to the true account of interviews (Poland, 1995). During the analytical process the field observations were used to compare formal interview data with actual behaviour in context as recommended by Glaser and Strauss (1967). The following excerpt is an example of the researcher's observations and impression of the environment.

When I arrived, the house was in turmoil with boxes and furniture everywhere, however, the interview was very relaxed. Kaye did display signs that she was anxious and smoked a number of cigarettes during the

interview. As she was trying to recall issues of parenting that her drug use impacted on she was twisting her clothing, rolling her cigarette lighter up in her skirt and poking holes through her skirt. (Field note)

Recorded in the same field notes were comments in relation to the researcher's feelings.

Being the first interview I felt anxious about entering the mother's home. I hope I can do justice to the stories that the mothers will relate to me. I feel privileged that these mothers feel comfortable enough to share their experience with me. (Field note)

These observations added contextual content to the study and were important when compiling the written report as they triggered latent memory of the actual events and provided the opportunity to reassess the moment, with the advantage of advanced understanding of the substantive area.

### ***2.7.1.3 Recording and transcribing***

Despite the directive of 'DO NOT TAPE INTERVIEWS' (Glaser, 1998, p.107) it was felt that as a novice grounded theorist it was necessary to tape the interviews as, in the beginning, the researcher was not familiar with what was important and what was dross. It was believed that it was better to err on the side of caution and keep everything. After gaining informed consent each interview was recorded. Recording the interview allowed the researcher to concentrate on interacting with, and observation of, the mothers instead of focussing on taking notes. The process also enhanced the flow of conversation without interruptions.

The entirety of each recording was transcribed verbatim by the researcher. Due to the sensitive nature of the data and issues of confidentiality it was believed that only the researcher should be privy to the content of the raw interviews. Transcription also provided an opportunity to increase the researcher's sensitivity to the data by hearing the 'voices of the mothers' on numerous occasions during the process. The subtleties of voice inflection, tone, pitch, speed, pauses, sighs, and laughter are not identified in the written word and these nuances contribute substantially to the meaning of dialogue, and were added to the transcript. It was also important to the researcher to maintain control over the data and avoid the possibility of transcription error as the substitution of even one word can alter the meaning of a passage

(Easton, McComish, & Greenberg, 2000). All transcripts were faithful to the interviews.

#### **2.7.1.4 Data management**

Data were managed using QSR NUD\*IST software. QSR NUD\*IST represents: Qualitative Solutions and Research [QSR] for the management of Non-numerical, Unstructured Data by supporting the process of Indexing, Searching, and Theorising [NUD\*IST] (Richards, 1998, 2002; Richards & Richards, 1997).

In light of the copious non-numerical, unstructured data that required storage, coding, constant comparison, and sorting as the theory emerged; the use of an indexing system to manage that data and the processes of analysis was appreciated. However, none of the interpretation and reflection on the data is done by the software (Richards & Richards, 1997). The intellectual work of reflecting on the data, coding, identifying threads, themes and concepts, building categories, conceptualising the meaning, and developing and testing the theory remains the exclusive domain of the researcher.

QSR NUD\*IST 6 (2002) was the software employed to store and manage the data and the researcher's reflections and interpretations about them. Transcribed data from multiple sources were imported into NUD\*IST from Microsoft Word to create 'projects'. Within NUD\*IST projects one had the flexibility to store, explore, code, record ideas, make annotations and memos and attach them at relevant points in the data (Richards, 1998). The ability to append memos, ideas and hunches to the appropriate point made accessing them at a later date more efficient and avoided losing vital ideas (Buston, 1997). Additionally, the efficient index system allowed the researcher to find and compare all data with all other data with the search and retrieve capacity, which in turn allowed the researcher to build a conceptual understanding of the meanings within the data.

#### **2.7.2 Open coding**

Transcription was conducted as soon as possible after interviews. Following transcription of interviews and field notes the researcher used the open coding technique to conduct a line by line, sentence by sentence review of the data from the purposive sample. Raw data is interwoven and stories are made up of incidents with those incidents often having a problem and process component or an issue and what they did about it. Using pencil and paper, the data were broken down into

minutiae and each component closely examined, interpreted and labelled. The codes were written in the text margins next to the incidents that gave rise to the code labels. Incidents, phrases, or sentences were often coded with multiple codes.

The in-vivo or substantive codes given to the data fragments reflected what was happening in the data. Following the manual coding process the text document was exported to QSR NUD\*IST 6 where the open coding was repeated using the electronic format. The second pass or run through the data as the coding was entered in NUD\*IST provided a more advanced interpretation of the meaning within the data and data with common meaning were conceptually grouped together. The first and second interviews elicited 232 and 245 concepts respectively, which were stored in nodes. These nodes were either 'free' standing (stand alone) or grouped together into a 'tree' structure. Below is an excerpt of a tree node for the concept '*Concealment*'.

#### **(9) Concealment**

+++ ON-LINE DOCUMENT: Part 1 ++ Text units 63-65:

63 none of my family, no-one except Peter, my husband,

64 knew that he was on the Phenobarb and all my side of the family,

65 none of them except my sisters know, my parents didn't know

+++ ON-LINE DOCUMENT: Part 2 ++ Text units 316; 328; 336:

316 No one knows about [my being on methadone] of course.

++ Text units 328:

328 Generally there is no real need to tell anybody.

++ Text units 336:

336 just something I choose not to tell people

Using the constant comparative process of analysis, data at all 'free' nodes from the first three interviews were amalgamated into a 'tree-structure' (Qualitative Solutions and Research, 1997) with 38 categories (nodes) and 502 subcategories. This was done by comparing the data at each node to data at all other nodes, and similar events and incidents clustered to construct concepts and categories. Slowly the specific properties of the categories started to emerge (Glaser, 1998; Webb, 1999) and were grouped. The following excerpt demonstrates the tree-structure including '*Concealment*' within the higher order categories of '*Coping strategies*' and '*Protecting self*'.

PROJECT: Mothers who use illicit drugs 10:48 am, Mar 15.

REPORT ON NODES FROM (6) '/Coping strategies'

- (6) /Coping strategies
- (6 5) /Coping strategies/Protecting self
- (6 5 1) /Coping strategies/Protecting self/Concealment**
- (6 5 1 1) /Coping strategies/Protecting self/**Concealment**/Inclusion
- (6 5 1 2) /Coping strategies/Protecting self/**Concealment**/Exclusion
- (6 5 1 3) /Coping strategies/Protecting self/**Concealment**/Prolonged
- (6 5 1 4) /Coping strategies/Protecting self/**Concealment**/Deception
- (6 5 1 5) /Coping strategies/Protecting self/**Concealment**/Lies
- (6 5 1 6) /Coping strategies/Protecting self/**Concealment**/Isolating self

Consistent with Glaser's directive, the data were constantly questioned in order to determine the truth and to bring out the categories, their properties and their linkages. Bearing in mind, what was important was the mother's behaviour and the motivational forces behind that behaviour, questions such as: What category or property of a category does this incident indicate? (Glaser, 1992, p.39); Where does this fit within my tentative interpretation?; What is this mother telling me?; What is happening here?; What is the issue and what did she do about it?, were asked.

Codes were run open until after the fifth interview when the central problem of 'loss' and 'fear or threat' and a provisional core category of 'protecting' had emerged. At that stage the data set consisted of 26 categories with 273 subcategories or properties.

### **2.7.3 Theoretical sampling**

With the collection of data, coding, analysis, memo writing and the development of diagrams and conceptual models occurring concurrently, concepts and patterns of behaviour began to emerge from the early data. As theoretically relevant categories emerged sample selection become more focused with the direction of the sampling and interviews being driven by the emerging theory (Glaser, 1978, 1998). Termed theoretical sampling, this involved the selection of participants with specific experience about the emerging categories which would bring depth, variation and density to the data (Glaser, 1978, 1998). Thus, mothers who had experienced loss through apprehension, abduction, death, and/or abortion; mothers in abusive relationships; long-term established users; inexperienced users; and mothers whose babies had been ill as a result of their drug use were selected.

From the mother interviews issues of being treated badly or not being believed by some health professionals; of focussing on the baby but not on the mother; of potentially losing the baby if health professionals believed they were unfit; and of being blamed for health issues related to the baby emerged. Conversely, mothers also discussed being supported and encouraged by other health professionals. Thus, health professionals who regularly provided care for mothers who use illicit drugs were included in the theoretical sample.

### ***2.7.3.1 Difficulties accessing the theoretical sample***

The theoretical sample was more difficult to contact and engage as the home visiting intervention had been completed and potential participants had disengaged from the hospital and its staff following the birth of their baby. Additionally, less was known of the mothers' whereabouts in the postpartum period as this group of mothers are often very transient. To identify potential participants, the researcher again made contact with the ACDC midwives who provided the booking register for the previous twelve months. The researcher reviewed all entries in the booking journal and selected mothers who have delivered in the previous year and who met the theoretical thrust of the study.

The researcher attempted to contact the mothers only to find that many were no longer at the addresses last recorded on the hospital system. The easiest people to contact were those who had mobile telephone numbers as they usually retained that number when they moved. It was prudent to verify the address of those contacted by mobile telephone as many had moved house. Ten potential participants had either moved, had their telephones disconnected or numbers changed and were not contactable. Ultimately appointments were made with four mothers. Prior to the appointment it was the researcher's routine to telephone and confirm the time, place and willingness of the mother to be involved in the study. However, at pre-interview confirmation mother 1 agreed to proceed but indicated a new residential address. Mother 2 appeared excited to be involved when first contacted; however, on the appointment day was not contactable on her mobile telephone. The researcher kept the appointment and went to her house but there was no-one home. Contact was attempted on a number of occasions over the following weeks. The researcher was mindful to avoid issues of harassment so attempts to make contact were discontinued. Mother 3 kept the arranged appointment and the interview proceeded. Although agreeing to an interview, mother 4 postponed the appointment on three occasions and ultimately withdrew her willingness to participate.

Morse (2000) discussed what to do when the strategies you are using are not working. She suggested looking for other sources and 'following your nose'. To this end the researcher pursued three avenues: multiparous mothers who were in-patients, having birthed a subsequent child; postnatal mothers who were currently engaged in a community outreach project (PEPISU), and finally health professionals who provided care for mothers who use illicit drugs.

### ***2.7.3.2 Inpatients, community outreach mothers, and health professionals***

The social worker attached to the ACDC informed the researcher when potential participants had birthed and were inpatients. Review of the medical records of those mothers was undertaken to select theoretically appropriate mothers for interview. On entering clinical areas the researcher informed the Clinical Midwife Specialist (CMS) of her presence on the unit prior to approaching any mothers. Following introductions, the purpose of the research was explained to potential participants, an information sheet provided, and the mother invited to participate. All mothers approached in this manner accepted the invitation.

Access to PEPISU was gained through the program coordinator. An overview of the research was presented to staff after which they were comfortable for the researcher to be present at the drop-in-centre. Brief histories of the mothers were provided by the program coordinator to enable theoretical sampling. Selected mothers were invited to participate and three were recruited through that project. The opportunity was also taken to engage in informal conversations about the substantive area with a range of mothers and staff and to conduct field observations.

Interviews with the theoretically sampled mothers also commenced with the same open-ended statement: 'I would like you to tell me about your experience of being a mother', and the progress was guided by the mother's experiential journey. As with the purposive sample, theoretical probes were used to expand on concepts raised. Examples of probes used included: 'You said that you had four abortions; can you explain why you made those decisions?'; 'After your baby was taken off you, what did you do and how did you feel?'; 'Please tell me more about that'; 'You said that you are in an abusive relationship; what do you mean by abusive and how did it influence your mothering?'; and 'Can you tell what it was like for you when your baby was withdrawing'. Theoretical sampling and probing helped define the properties of the emerging categories as well as explain the contexts and conditions

in which they occurred as well as revealing variations between experiences (Glaser, 1978, 1998; Glaser & Strauss, 1967).

Interviews were conducted in the mothers' homes; at the hospital; or at the PEPISU drop-in-centre. Observations of the mother interacting with her baby, with family members, and with health professionals were also conducted. When conducting interviews and observations in clinical settings, the researcher took every precaution not to interrupt usual care provision. Interviews for the theoretical sample of mothers ranged from 45 minutes to 128 minutes, with an average interview time of 80 minutes.

Health professionals were asked to tell about their experience of providing care for mothers who use illicit drugs. Theoretical probes were used to explore concepts that were raised, for example, 'You said that you think these mothers are shamed, would you expand on that concept please'; or 'Mothers claim that they are not treated well by some health professionals; what are your thoughts on that?'; or 'You mentioned that some mothers are afraid of DCD and believe they might lose the baby; can you tell me how these mothers deal with these issues in the clinic or hospital setting'; or 'So what would your recommendation be, to deal with that?'

Health professionals, through repeated exposure to behaviours and experiences of mothers who use illicit drugs, were able to integrate their understanding of event and formulate '*threat of loss*' stories and '*limiting loss*' stories. This is similar to what Glaser and Strauss (1967, p.109) described when health professionals 'would tell what amounted to a story about [their patients]'. The stories amounted to vignettes with rich conceptual data supporting, explaining, and clarifying the accounts of events described by the mothers. Health professionals' interviews ranged from 45 minutes to 100 minutes with an average interview length of 76 minutes.

#### **2.7.4 Selective coding**

As the core category was tentatively established prior to theoretical sampling, open coding ceased and coding of variables that related to the core category began. Termed selective coding, this delimited the data as coding of incidents within the subsequent interviews was compared to the established concepts, categories and properties relating to the core category. Questioning of the data continued as in the open coding phase. Any new relevant data was compared to existing data and incorporated by modifying the tentative theory as necessary.



### 2.7.5 Theoretical coding

Theoretical coding is the process of conceptualising, relating and integrating the theory by identifying the core category, systematically relating the core category to other categories, validating these relationships and filling in categories that need further refinement and development (Glaser, 1978). In this study relationships were identified and connections between categories made to bring density to the theory. Refinement, testing of hypotheses, and further conceptualisation continued right up until the final report was completed. Theoretically coding or conceptualising in this way identified how the categories related to each other and commenced the process of weaving the story back together (Glaser, 1978).

Glaser refers to coding families to assist in the theoretical coding process. Many theoretical codes were implicit to the researcher's knowledge base and included such codes as causes and consequences; processes; strategies; degrees; dimensions or ranges; types; description; interactions; identity-self; culture; social boundaries; models; and more conceptually based codes such as child rearing; mothering; self-image, and identity. Dichotomies such as inclusion-exclusion; good-bad; acceptance-rejection; happy-sad; and so forth were also considered. However, what was important in choosing codes to 'fit' the data was that the researcher had sufficient knowledge to see and interpret what the data was saying. Using the coding families to process the data it was possible to lift and integrate substantive codes into theoretical codes, thus shaping the theory.

As new data became available from subsequent interviews and other data sources, the simultaneous process of recursive moves between selective and theoretical coding continued. Comparisons of incidents from new data were made to the established concepts, categories and properties and subsumed to create integrated, dense, and saturated categories. As higher level conceptualisation occurred, data in NUD\*IST were renamed, sorted, merged, and integrated. By continuing constant comparisons between incidents within new data and to established concepts/categories, relationships were tested and linkages made as analysis progressed towards stabilisation of the central problem and the core category.

Through these comparative processes the *threat of loss* stabilised as the central or basic psychosocial problem experienced by all participating mothers. The core category or basic psychosocial process stabilised as *limiting loss through a process of safeguarding*. The indicators pointing to the core category as *limiting loss through*

*a process of safeguarding* appeared frequently throughout the data, were demonstrated in a wide variety of properties, and readily related to all other categories. The substantive theory rests on the core category which explains how the central problem of *the threat of loss* was managed, and accounted for most of the variation in the mothers' patterns of behaviour. In addition, the emergent substantive theory has potential implications for a more general or formal theory on *managing the threat of loss* amongst other minority, stigmatized and marginalised groups within society.

#### **2.7.6 Analysing health professional's data**

Analysing health professional's data used the same procedures as that used for the mothers' data. Initially, open coding to fracture the data into codes was undertaken. Codes were clustered into concepts, categories and properties of those categories and stored and managed in NUD\*IST. These data were stored in a separate NUD\*IST project so as not to confuse the source of the emerging categories and their properties. Keeping in mind that the experience of mothers who use illicit drugs was the mandate of the study, questions were asked of the data. For example: 'What category or property of a category does this incident indicate?' (Glaser, 1992, p.39); 'What was the consequence for the mother of the health professional's behaviour?'; 'How did the mother respond?'; 'What did the mother do?'; 'How was the mother treated?' After the first health professional interview and open coding of that data, the analysis moved into selective and theoretical coding where new incidents were related to concepts, categories and their properties. Using constant comparison to compare incidents applicable to each category the codes were progressively amalgamated into higher level codes by integrating and delimiting categories and their properties. This analysis ceased at the point of categorisation, after which the concepts, categories and their properties were compared and contrasted to the mothers' data. Relevant data was then woven into the theory that emerged from the experience of mothers who use illicit drugs.

#### **2.7.7 Saturation**

Theoretical sampling, with the concurrent collection, coding and constant comparative analysis with selective and theoretical coding continued until the researcher achieved theoretical saturation and a sense of closure (Chenitz & Swanson, 1986; Glaser & Strauss, 1967; Hutchinson, 1986). The point of saturation became apparent when the major modifications to the theory became fewer and fewer and the 'fit' was evident. Also, instead of adding new properties, during

clarification of hypotheses, further reduction and integration of categories and their properties was achieved until well established and complete categories were attained (Glaser & Strauss, 1967). The final sample size of 14 mothers who use illicit drugs and six health professionals who provide care to these mothers was determined when no new data were obtained, categories and their properties were established and relationships between the categories were clear (Glaser, 1998).

### **2.7.8 Memos and diagrams**

Memos are an integral component of the constant comparative methods of grounded theory analysis (Glaser, 1978, 1998; Glaser & Strauss, 1967). Throughout this study, writing code, theoretical, and operational memos pertinent to the research process and analysis, and drawing diagrams and schemas to illustrate and crystallise the developing theory was utilised. Memos tracked the thought processes of the researcher and elevated the description of empirical events to the conceptualisation of the basic psychosocial process and the generation of the substantive theory. By persistently asking questions of the data and documenting the thought process, memos captured the initially elusive and shifting connections between data, aided the conceptualisation of ideas (Hutchinson, 1986) and gave density to concepts. Memos also formed the basis for the composition of the thesis and contributed to methodological rigor.

#### **2.7.8.1 Code memos**

NUD\*IST provided the facility to write memos attached to coded sections of data. This capacity allowed easy storage and retrieval of the many code memos. During memo construction the ability to automatically insert date and time assured a chronological record of memos was kept. Additionally, codes were tagged to identify an attached memo, thus preventing unnecessary loss of time in searching for that elusive memo. Examples of code memos include:

9:32 pm, 2 Jun 2005. P1 L383-387: Baffled as to why parents will not discuss the issue of her drug use. She is absolutely sure they know but the topic is "out of bounds". Are they in denial; can they not cope with the situation, are they afraid of becoming involved? Their denial or refusal to acknowledge the situation has made Kaye determined to change the pattern of parenting with her own children.

3:45 pm, 28 Oct 2005. P13 L 379-381: Carlene refers to acting or playing a scripted role to meet others expectations. It appears that she sees life as an act. I have written on the transcript: "It's all an act - I have a part to play - I will follow the script. Society is the director".

These memos were a vehicle where ideas were saved and allowed to grow. They acted as the memory bank for the project. They were not structured; they were immediate so as not to lose the ideas. They were used to persistently ask questions of the data, to remind the researcher of issues for later scrutiny, to capture thoughts about the data, to link data and emerging categories, and finally some were used in the write-up.

#### **2.7.8.2 Theoretical memos**

Theoretical memos resulted from thoughts about the data. Some thoughts were more questions to pursue, others were interpretations, and some were revelations. However, all were necessary to encourage both concrete and abstract thought about the data and by writing those ideas it crystallised and recorded them for later use. Even the early musings proved useful and were the building blocks of the theory as it was emerging. Some examples follow:

19<sup>th</sup> April 2005: Lots of stuff on lying and deception. Why did she feel compelled to lie or deceive people? It appears to be a way to cope by trying to protect self. Shifting focus from truth as that is unacceptable to society. The truth would attract judgment or ridicule. Wanting to "fit in" and be accepted.

30<sup>th</sup> March 2005: Stereotype – a "tool" used by mainstream society to categorise those who are "different" and of whom they are afraid because they do not fully understand them. Mind you, they choose not to understand or even try to comprehend. Easier to label as "different" and "not acceptable" thus "keeping them in their place" and on the fringes of society but also "protecting themselves".

#### **2.7.8.3 Operational memos**

Within the operational aspect of the study, memos were recorded on all aspects of data collection and management such as recruitment, formal and informal interviews, other data sources, transcription, coding, and NUD\*IST. Memos reflecting on the supervision process were included as were reflections on the

researcher's personal safety, emotions and delays in progress. Also, memos on content, issues experienced during the research process, and networking in the health care system were recorded. Some examples include:

Second interview scheduled for today. Met Judith in the clinic and waited all morning. The management of the clinic was very poor today. Judith waited from 0900 until almost 1200 (midday) before being seen. She was extremely distressed by the time she was seen. Had her one year old baby with her who was very tired and distressed. I cancelled our appointment as she would not have been able to tolerate another hour of interview. Have rescheduled for next week.

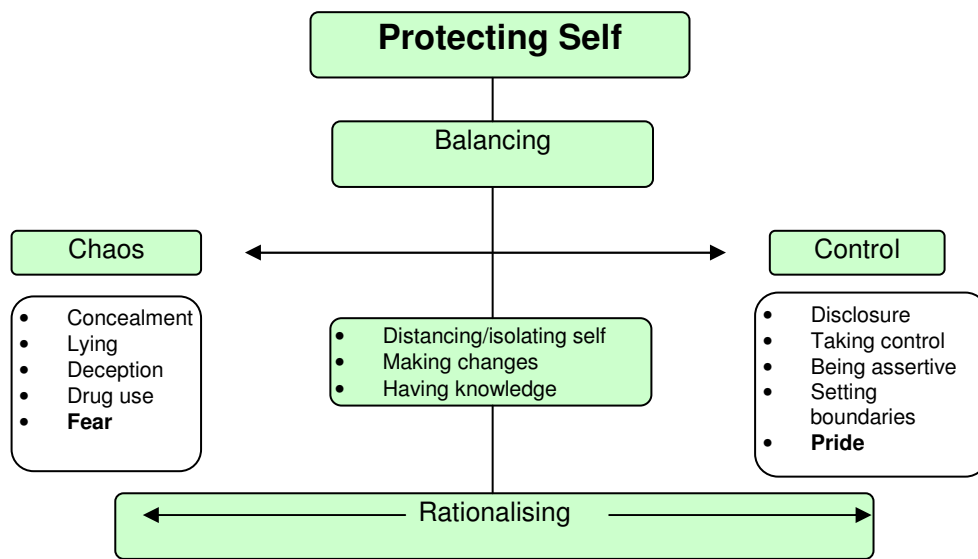
Following the interview with Cath I was very distressed as I drove home. I was weeping due to the emotion of the interview. When I left the house I had felt as if I wanted to give her a big hug. She is so vulnerable. I was also aware that I had stayed for a long time and had not informed [husband] of where I was or how he could contact me. I have to do something about that.

Initially the researcher recorded her theoretical and operational memos in a handwritten journal. This had some advantages as they remained together and were in chronological order. However, they were impossible to sort and hard to retrieve. Thus, when the memos needed sorting for integration into the theory the handwritten memos were entered into Microsoft Word. The text and diagrams were sorted and a table of contents prepared to facilitate access to the information. This yielded 80 pages of theoretical memos; 30 pages of operational memos; and 25 conceptual models.

#### **2.7.8.4 Conceptual models**

The drawing of conceptual models in grounded theory is used to visualise the relationships between categories (Glaser, 1978; Hutchinson, 1986) which can be themes, concepts, behaviours, or processes, and further progress the theoretical analysis of the data (Glaser, 1978). These diagrammatic representations of components of the data identified relationships, depicted flow, and facilitated writing as one described the cells and the interrelationships between them. Figure 2.3 depicts the tentative hypothesis of *'protecting self'*. This simple early model formed the basis for the more comprehensive models of the basic psychosocial process of:

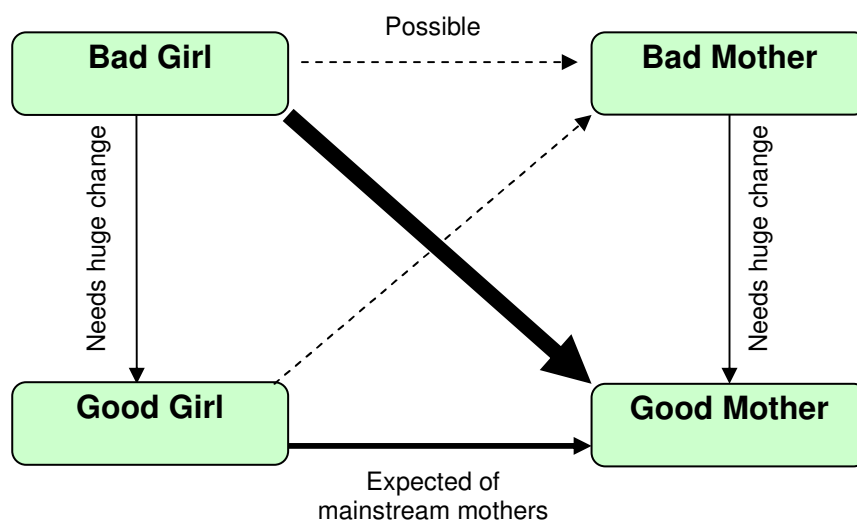
Variations in safeguarding (Figure 5.2), and, Incorporation of influencing conditions into the theory structure (Figure 6.1).



**Figure 2.3: Protecting self**

In the final model *chaos* translated to reactive responses of *struggling*. *Control* translated to proactive strategies of *taking back control*. *Concealment, lying, deception, and drug use* were all properties of *altering perceptions*, whilst *being assertive and setting boundaries* were properties of *redefining to preserve integrity*.

Another example of a progressive conceptual model is Figure 2.4: Pathways to good mother status.



**Figure 2.4: Pathways to good mother status**

This model was prefaced by the following memo.

They are pursuing 'good mother' status. 'Good mother' is a construct with various interpretations with everything judged against societal norms. Their previous status within the parameters of societal norms is 'bad girl'. So, in comparison to their previous status of 'bad girl' they are working towards 'good mother', which is challenging. At the same time there are many constraints and variables maintaining them in 'bad girl' state.

Ultimately, *striving to be 'good mother'* was the proactive strategy within the sub-process of *safeguarding as mother*. The influence of judgment against societal norms and against one's interpretation of a normative self was carried forward into the interpretation of self as discussed in the influencing conditions. Also, the *fear of being 'bad mother'* was an influencing condition affecting the basic psychosocial process and formed a motivational force in *limiting loss through a process of safeguarding*. These higher level and more abstract categories are discussed in Chapter 5.

### **2.7.9 Other data sources**

Other sources of data such as a demographic questionnaire, medical records, documents, and literature were used to contribute to the fullness of the understanding of context and concepts (Cutcliffe, 2000) and to contribute to the density and scope of the theory.

#### **2.7.9.1 Questionnaire**

Using a questionnaire, demographic data were collected on 14 mothers who were using illicit drugs. Information on age, education, marital status, and total family income before tax was elicited. Data on the mother's usual pattern of drug use during the pregnancy, for thirteen psychoactive drugs, was collected. Furthermore, three questions on whether their pattern of drug use had changed during the pregnancy were asked. The first question in this series identified if their drug use pattern had changed; the second identified if the pattern of use had increased, remained the same or decreased for the same thirteen psychoactive drugs; and the last question related to the reason ascribed to any change in use. Finally, the baby's date of birth and if the pregnancy was planned were asked. (See Appendix 3.)

### **2.7.9.2 Medical records**

Medical records were reviewed to assist selection of participants for theoretical sampling. Once recruited, data were collated from a review of the medical record to obtain socio-demographic data; obstetric, medical, and psychological history; labour and delivery details; and infant data such as whether the baby had NAS and was cared for in the neonatal intensive care unit (NICU). A form was prepared for this data collation (see Appendix 4).

### **2.7.9.3 Literature**

A literature review of the substantive area was conducted as part of the formal requirements of the Graduate Studies Committee and the Ethics Committee for candidacy to the Doctoral Program. Following that requirement, to avoid researcher contamination, being influenced by the literature, and having preconceptions imposed by others' interpretations (Glaser, 1998), no other review of literature was conducted during the initial data collection and early analysis. This is in keeping with the grounded theory dicta. It was imperative that the researcher identified the emerging categories directly from the data and recognised the relationships between categories and their properties rather than testing theories found in other literature (Glaser, 1998). Until the theory began to emerge, through the process of constant comparative analysis, it was not known what literature was pertinent to the substantive area (Glaser, 1998). Therefore, it was not until the basic psychosocial problem and process were identified and stabilised in the emerging theoretical framework (Glaser, 1978) that comparison to the theoretical and social literature was conducted.

### **2.7.10 Theoretical or conceptual sorting**

Theoretical sorting is the final step in the research process and results in the conceptual design or blueprint of the theory, which is used to guide the final write-up. This decision making process requires conceptual sorting of theoretical codes, memos, and ideas and the pieces of the theory are fitted together into an integrated complex whole showing connections between categories and their properties and eliciting the best fit or placement within the theory (Glaser, 1978).

Sorting began around the core variable of *limiting loss through a process of safeguarding* and progressed by relating the other categories and properties to that core by constantly asking, "Where does [this] fit in?" (Glaser, 1978, p.123). Sorting around the core category helped delimit the theory as those concepts that did not



relate to the core were left out (Glaser, 1978). The constant questioning of where each idea belonged in the theory and the comparison of each idea to the emerging outline was a back and forth process between theoretical codes, memos, and ideas and the emerging outline.

Theoretical sorting began in NUD\*IST and whilst the central problem, the influencing conditions, and the rudiments of the basic psychosocial process were achieved, it was felt that NUD\*IST was not flexible enough to cope with the abundance of ideas, and their relationships to each other, that emerged in relation to the basic psychosocial process. Moving theoretical sorting to a manual process allowed the researcher more freedom to move concepts around and to resort, refine, reorder, and reintegrate concepts until all relevant concepts fitted and the best fit and integration was achieved. Best fit was achieved when the greatest range of behaviours used to resolve the main concern was explained with the fewest number of concepts (Glaser, 1978). The process of theoretical sorting created more memos and assisted in condensing the theory into a parsimonious set of integrated concepts explaining the connections and integration of the theory. The final blueprint of the basic psychosocial process is at Appendix 6.

#### **2.7.11 The write-up**

Using the sorted theoretical codes, memos, and ideas as a guide, writing of the thesis began. After the initial draft was completed, recasting, editing, and refining of the manuscript took place. The result is an integrated set of conceptual hypotheses (Glaser, 1998, p.3) about how mothers who use illicit drugs *limit loss through a process of safeguarding*. The mothers viewed the central problem as the *threat of loss*, so, categories and subcategories relating to *threat of loss* were defined and described and those concepts supported by direct quotations from the mothers. The concepts were then compared and contrasted to relevant literature, which was woven into the theory. Having reported on the central problem, the substantive theory, which rests on the core category, was then presented. The core category of *limiting loss through a process of safeguarding* related the behaviours and strategies employed by the mothers to resolve or manage the central problem. Again, focusing on what emerged from the data, the concepts and categories were defined and described and their relationship to the core category discussed. Relationships between concepts and categories, subcategories and properties were provided to demonstrate the integration of the theory. These conceptual hypotheses were

supplemented with the mothers' words to illustrate concepts. Finally, comparisons were made to pertinent theoretical and substantive literature to legitimate ideas.

In addition, conditions that influenced the central problem and the basic psychosocial process were defined and linkages to the core category presented. Direct quotations from the mothers were used to illustrate the concepts and pertinent literature used for comparison. In the final chapter, limitations of the research and suggestions for future research were presented, and the theory was compared to related theories. However, the thrust of the final chapter is the implications of the theory for health care provision in the substantive area.

## **2.8 Methodological rigor**

A rigorous grounded theory inquiry must accurately represent the phenomenon under review and the experience of the study participants. Glaser (1998) identified that grounded theory is a self regulating method as the process of constant comparative analysis and modification is not complete until the theory 'works' to explain the behaviour of participants, there are no gaps, the theory has relevance for the participants and mirrors their experience. Glaser's criteria for assessing the rigor of grounded theory are 'fit'; 'work'; 'relevance'; 'modifiability'; 'parsimony', and 'scope'. To assess these criteria one must ask: Do the concepts/categories and their properties of the theory 'fit' the realities of the substantive area in the eyes of the participants, practitioners, and researchers in the area?; Does the integrated theory 'work' to explain the major variations in behaviour with respect to processing the central problem?; Is the theory 'relevant' to the participants and do the concepts/categories and their properties relate to their true issues?; In the light of new data, can the theory be modified, by constant comparison, to 'fit' and 'work' and demonstrate 'relevance' to the participants? (Glaser, 1998). The criteria of parsimony and scope are met by accounting for as much variation in the behaviour of participants, around the central problem, with as few concepts as possible (Glaser, 1998). According to Glaser (1998, p.13), grounded theory 'leaves nothing to chance' as the analytical process of constant comparative analysis demands that data are reviewed over and over again until what is actually going on is understood. In other research methodologies reproducibility or replication are often criteria for judging rigor, Glaser (1992, p.116-117) maintains that in grounded theory it is a waste of time as "theory is too fluid and changeable in time and space" to even attempt such a pursuit.

As described in the previous sections in this chapter, this research followed the rigorous process of constant comparative analysis consistent with grounded theory. As a result, the data were reviewed over and over again until the unifying core category, which accounted for most of the variation in the mothers' patterns of behaviour, emerged and readily related to all other categories (Glaser, 1978, 1998).

Other strategies for verifying the 'integrated set of conceptual hypotheses' (Glaser, 1998, p.3) included member verification, focus group authentication, and peer interpretation. During theoretical sampling, components of the emerging theory were presented to participants to comment upon, expand, clarify and validate. Using constant comparison, new data arising from that feedback were also tested against the existing data. This not only produced greater depth to the emerging theory but verified the credibility of data and expanded properties of those concepts/categories. Therefore, concepts in the developing theory were identified from or grounded in the data and tested in the substantive area. Additionally, the theory was presented to a focus group of identified English speaking mothers who also used illicit drugs, but were not selected for interview because saturation of the data had been achieved. The focus group members were able to recognise, relate to, and make sense of the substantive theory and the processes used by the study mothers to deal with the problem, thus demonstrating 'fit', 'work' and 'relevance' for others within the substantive area.

During the process of analysis the researcher also utilised a grounded theory research group to independently interpret and code sections of data (Guba & Lincoln, 1981; Le Compte & Goetz, 1982; Sandelowski, 1986). The coded sections were then verified against the researcher's analysis. These monthly seminars also provided guidance from an expert grounded theorist and support from PhD peers. Additionally, as the theory developed work was presented to peers for critique with the opportunity to defend. As the theory was emerging theory components were presented to health professionals, who worked with mothers who use illicit drugs, in the form of informal discussion. Finally, to verify the findings the substantive theory was presented to a group of health professionals who had experience working with mothers who use illicit drugs. Many stated that they were pleased to see that what they had known through working in this substantive area had been confirmed through a formal research process. However, it also expanded their understanding of certain aspects.

## **2.9 Ethical considerations**

The development and conduct of this research was guided by the National Health and Medical Research Council's (1999), *National statement on ethical conduct in research involving humans* in accordance with the NHMRC Act, 1992 [Commonwealth]; and the Privacy Act, 1998 [Commonwealth]. Central to the broad principles guiding research are the maintenance of high ethical standards, the protection of participants, and validity and accuracy in the collection and reporting of data (NHMRC, 1999). Maintaining those principles has protected the rigor and ethical nature of this research.

### **2.9.1 Protection of participants**

Approval to conduct this research was obtained from the Human Research Ethics Committee, Curtin University of Technology, and from the Institutional Ethics Committee and the Scientific Advisory Board of King Edward Memorial Hospital and Princess Margaret Hospital. One purpose of ethics committees is to ensure that the researcher 'adhere[s] to ethical principles of justice and veracity, and of respect for people and their privacy and avoidance of harm to them' (NHMRC, 1999).

#### **2.9.1.1 Participant safety**

Mothers and health professionals who met the eligibility criteria for inclusion in the study were individually approached and invited to participate. The purpose of the study, the nature and duration of involvement were explained and any questions posed were answered. Time was allowed for potential participants to read the information sheet and the researcher answered any questions and clarified issues. The information sheet contained an explanation of the study and the contact numbers of the researcher, her supervisor and the Human Research Ethics Committee secretary. A copy of the information was retained by the participant for future reference. Written informed consent was obtained prior to commencing any interview or observation. Potential participants were advised that refusal to participate would in no way prejudice their routine care. The participant's right to decline to answer any questions and the right to withdraw from the study at any time was conveyed and emphasised. Participants were advised that if they withdrew, their data would not be used and they could request that their data were destroyed or returned to them. Copies of the participant consent form and information sheets are attached at Appendix 5.

In the study design, provision was made for support and intervention in the event that the interviews should cause distress. If distress was induced the interview was to pause until the participant was sufficiently composed to continue or cease if the participant did not wish to proceed. Comfort was to be offered at the time of distress and debriefing, in which the researcher was well versed, facilitated if necessary. If distress was intense the researcher could refer participants to psychological services at the tertiary referral hospital during the study period.

#### ***2.9.1.2 Protecting identity***

All data and information on participants has been treated with strict confidentiality. Names, consent forms and contact details of participants are stored in a locked cabinet in a locked office at the School of Nursing and Midwifery at Curtin University of Technology. This information is physically separate from other data such as transcripts and was only used to enable consenting participants to be contacted for follow-up. Names have been replaced on all transcripts and data sets with pseudonyms. No name-identified data has been entered into a computer. Non-identified data including audio-tapes, digital recordings, transcripts and field notes is being stored in a locked cabinet at the researcher's home and was only accessed by the researcher for the purpose of analysis and the writing of the thesis. Care has been taken to ensure that the identity of participants can not be determined from the citing of direct quotes used in the thesis. Any names appearing in text are pseudonyms. The theory is based on group data and no actual names have been included in the thesis or any other publication. All data, including recorded interviews, will be stored in a locked cabinet for a period of not less than five years from the time of submission of the thesis, after which time they will be destroyed.

#### **2.10 Summary**

Beginning with an overview of qualitative research this chapter has described the epistemological origins of the grounded theory method. This method was first discovered by Glaser and Strauss in the 1960s and later implemented by others with differing interpretations. The divergence from the original interpretation has created considerable debate. However, if the theory 'works' to clearly explain the behaviour of participants in the substantive area and has 'relevance' for them, that it 'fits' their experience and the theory is 'modifiable' in the light of new data, then the researcher's interpretation and implementation of the method is legitimised.

The major focus of the chapter has been to provide description of the research process from inception to the written report. Selection criteria, sampling strategies, data sources, data collection, data management, and the application of constant comparative analysis, which is central to the grounded theory method, have been discussed. Finally, an account of the consideration applied to the integrity of the research; respect for participants' privacy; beneficence to the participants; and justice in the balance of benefits and burdens of the research process have been articulated.

## **Chapter three**

### **Profile of participants: Mothers' stories**

#### **3.1 Introduction**

Chapter three provides a profile of the participating mothers including their demographic, drug use and obstetric history, and their interrelationship with significant others. The quality of relationships with others was a significant aspect in the development of self, how they interpreted and responded to interactions and to challenges they faced. Presented in this chapter are individual stories accompanied by genograms to provide an introduction to the mothers and situate them within the context of their family. These visual précis' map the family structures and demonstrate family issues through time. They also capture the developmental and more recent adversities that they experienced and which influenced the trajectory of their lives. This introduction provides a contextual framework in which to place the mothers.

#### **3.2 Demographic profile**

Fourteen mothers who were using illicit drugs were recruited into this study. The average age of the sample was 29 years and ranged from 20 to 37 years. The level of education ranged from one completing only the first year of secondary school and continuing with home schooling, to 2 (14%) holding university degrees. Seven (50%) mothers had no additional education after leaving secondary school, whilst 7 (50%) gained further education either in the Technical and Further Education (TAFE) system of vocational training or at university. Two (14%) mothers were married and living with their husbands at the time of interview, 8 (57%) were in defacto (common law) relationships, and 4 (29%) classified themselves as single. One mother was in a relationship but was living alone as her partner was incarcerated. Most had experienced multiple partners and numerous casual intimate relationships. Only 1 (7%) was with a partner that did not have a history of illicit-drug-use and 13 (93%) of the fathers of the index child were users or had a history of drug use. Four of the mothers were no longer with the father of their most recent baby. Only 5 (36%) of the partners were employed or earning a legal wage. Two (14%) of the fathers were incarcerated at the time of the interview. Three (21%) partners were on MMT programs. The majority of mothers' total family income before tax was reported as being less than \$A20,000 with only one reporting an income in excess of \$A40,000. The mean Gross Household Income for all

Western Australians in 2005-06 was \$A67,548 per annum (Australian Bureau of Statistics, 2006), thus placing all of the mothers in this study in the lowest income bracket. However, the reported income and the actual income, in some cases, were at variance as there were other sources of income derived from illegal activities such as theft, prostitution and dealing. Table 3.2 provides a summary of the demographic data.

Eight (57%) mothers reported their main problem drug as heroin and 6 (43%) identified amphetamines as their problem drug. Many were polydrug-users which included the use of at least one other illicit drug, or the non-medical use of prescription drugs, in addition to their main problem drug. The drugs reported were heroin, other opiates such as morphine and buprenorphine, cannabis, amphetamines, cocaine, benzodiazepines and barbiturates. In several cases mothers used a combination of many illicit drugs. Five (36%) mothers were on a treatment program with methadone and 3 (21%) on buprenorphine at the time of interview, whilst six were not on any treatment for their addiction. The history of treatment programs amongst the mothers fluctuated with one being on methadone for as long as 12 years whilst others commenced and ceased various programs. One mother had had nine attempts at oral naltrexone detoxification, had tried naltrexone implants with her first pregnancy and ultimately settled on MMT. Others had been on MMT but changed to buprenorphine when it became available in Australia in 2001 in the hope that buprenorphine would better suit their needs. Being on a treatment program did not guarantee that they ceased using illicit drugs.

All mothers modified their drug use due to possible adverse effects to the baby (see Table 3.1). The reduction in use due to pregnancy greatly reduced the weekly cost of drugs for some mothers. For example, one mother who was not on a treatment program reported her pre-pregnant use costing in excess of \$A1750 per week but at the time of delivery her weekly use was as little as \$A30 per week. In the majority of cases there was a marked decrease in use of illicit substances, however many decreased only those substances the mother believed would cause the most harm to the fetus, but increased substances such as cannabis and tobacco.

Consistent with routine management during pregnancy, those on methadone had their dose increased towards the end of pregnancy (Fischer, 2000). The majority of mothers reported that their pregnancies were unplanned with only 3 (21%) having planned the most recent pregnancy.



Participant Pseudonym	Heroin	Other opiates	Alcohol	Cannabis	Amphets	Benzos	Tobacco	Methadone	Buprenorphine
Kaye	D						D	I	
Judith	D	D		D	D	D	D	I	
Lisa	D			D	D	D	D	NC	
Cath	D	D	NC		D	D	D		
Beth	D		D	I	I		NC		D
Laura			NC		D				
Anne									D
Carol					D		I		
Vicki				D	D				
Ruby								I	
Kerry				I	D				
Candice			D	NC	D		I		
Carlene	D	NC	D	I		D	D		NC
Susie			D					I	

**Legend: D = Decreased; I = Increased; NC = No change**

**Table 3.1: Changes in drug use and treatment programs as a result of pregnancy**

### 3.2.1 Obstetric history

The number of pregnancies (gravidity) ranged from 1 to 9 and the number of live born children (parity) from 1 to 7 with many mothers reporting terminations of unwanted pregnancies (TOP). One mother reported four terminations whilst others had birthed their infants but had lost custody of the children. Collectively the 14 mothers had 60 pregnancies with 35 live births and two were pregnant at the time of interview. One mother lost a child, who had cerebral palsy, at 4 years of age. There was one fetal death in utero at 37 weeks gestation. The remaining pregnancies ended in spontaneous abortions ( $n=9$ ) or terminations of pregnancy ( $n=13$ ). The largest family unit was a grandmultiparous mother with nine pregnancies, two TOPs and six children in her care. Antenatally, the most common pre-existing medical conditions were hepatitis C ( $n=7$ , 50%) and depression ( $n=13$ , 93%). Table 3.3 presents the obstetric history of the participating mothers.

### 3.2.2 Mode of delivery

Of the 14 mothers only 5 (36%) had spontaneous vaginal births and 9 (64%) had caesarean sections. One of the vaginal births was complicated by an intrapartum haemorrhage, one by fetal distress, and two were precipitate. Of the women who experienced a caesarean section 6 (67%) were planned and conducted before the onset of labour (elective) and 3 (33%) were emergency procedures conducted during labour (non-elective). The emergency caesarean sections were due to fetal distress and poor fetal presentation; one being brow presentation and the other a transverse lie with cord presentation. All but 3 (21%) had epidural analgesia for pain

relief during their labour and birth. The 2 (14%) who had precipitate births received no analgesia and 1 (7%) received only intramuscular narcotics. One mother required a general anaesthetic in addition to her epidural for an elective caesarean section. The most significant postnatal complication included 7 (50%) with postpartum haemorrhage (PPH). (See Table 3.3.)

### **3.2.3 Neonate**

The gender of the index babies was 10 (71%) boys and 4 (28%) girls. Problems experienced by the babies in the neonatal period included NAS 10 (71%); neonatal jaundice 2 (14%); hypoglycaemia 2 (14%); cleft palate 1 (7%); hypothermia 1 (7%); wet lung 1 (7%); umbilical hernia 1 (7%); patent ductus 1 (7%); and 1 (7%) was febrile. One (7%) of the babies was preterm and delivered at 35 weeks gestation, was transferred to the NICU where she received tube feeds and was hospitalised for 19 days. The length of hospital stay for the babies ranged from 3 to 21 days. These data are presented in Table 3.3.

Participant Pseudonym	Age at interview	Edu Years	Further edu	Marital status	Income <20000 – >40000	Main problem drug	Other drugs	Rx program	Decrease illicit use due preg	Reason for change	Planned pregnancy
Kaye	32	12	Uni	Married	20-40	Heroin	Tobacco	Methadone	Yes	Baby	No
Judith	20	12	None	Single	20-40	Heroin	Polydrugs	Methadone	Yes	Baby	No
Lisa	22	10	None	Defacto	< 20000	Heroin	Polydrugs	Methadone	Yes	Baby	No
Cath	37	10	None	Single	< 20000	Heroin	Polydrugs	None	Yes	Baby	No
Beth	30	11	None	Defacto	< 20000	Amphetamines	Polydrugs	None	Yes	Baby	No
Laura	24	8 + home schooled	TAFE	Defacto	< 20000	Amphetamines	Polydrugs	Buprenorphine	Yes	Baby	No
Anne	27	11	TAFE	Defacto	< 20000	Heroin	None	Buprenorphine	Yes	Baby	No
Carol	28	9	Other	Single	< 20000	Amphetamines	None	None	Yes	Baby	No
Vicki	36	10	None	Defacto	< 20000	Amphetamines	Cannabis	None	Yes	Baby	No
Ruby	29	12	Trade	Defacto	< 20000	Heroin	None	Methadone	Yes	Baby	No
Kerry	25	10	None	Married	< 20000	Amphetamines	Cannabis	None	Yes	Baby	Yes
Candice	36	9	TAFE	Single	< 20000	Amphetamines	Cannabis Alcohol ++ Tobacco	None	Yes	Baby	No
Carlene	34	12	Uni	Defacto	< 20000	Heroin	Polydrugs	Buprenorphine	Yes	Baby	Yes
Susie	28	10	TAFE	Defacto	> 40000	Heroin	None	Methadone	Yes	Baby	Yes

**Table 3.2: Demographic profile of participants at time of interview**

Pseudonym	Gravidity/ Parity	Antenatal Hx	Rx	Birth	Birth Analgesia	Postnatal Analgesia	Comps	Feeding	Sex	Neonatal problems	Rx	Hosp days
Kaye	G5 P3	Hep C Anaemia Depression	Ante- depressants Methadone	SVD Precipitate	Nil	IMI narcotics	PPH	Breast	Boy	NAS Jaundice Febrile	Phenobarb Antibiotics	18
Judith	G2 P1	Hep C Anaemia Depression	Methadone	Induction Brow pres NELUSCS	Epidural	Epidural pethidine	PPH	Breast	Boy	NAS Hypoglycaemia	Phenobarb	8
Lisa	G1 P1	Depression Genital Herpes	Methadone	Breech ELUSCS	Epidural	Morphine	Nil	Breast	Girl	NAS	Phenobarb	8
Cath	G2 P1	Hep C Depression APH Hashimotos	Carbimazole	Induction SVD IPH	IM narcotics	Nil	PPH	Breast Formula	Boy	Cleft palate Pierre Robin Syndrome NAS	Phenobarb	21
Beth	G2 P2	Depression	Nil	SVD Precipitate	Nil	Nil	Nil	Breast	Boy	Hypothermia	Nil	3
Laura	G2 P2	Hep C Depression Genital warts Hyperemesis	Ante- depressants Buprenorphine	SVD Fetal distress	Epidural	Nil	Nil	Breast	Boy	NAS	Morphine	21
Anne	G3 P2	Psoriasis UTIs	Hx Methadone Buprenorphine	ELUSCS	Epidural	Epidural IM narcotics	Wound infection	Formula	Boy	NAS	Morphine	?
Carol	G5 P1	Pre eclampsia Gest diabetes Depression	Numerous hospitalisations	ELUSCS	Epidural	Epidural IM narcotics	Incont- inence Mastitis	Breast Formula	Girl	Preterm 35/40 Tube feeds	NICU	19
Vicki	G5 P3	1 <sup>st</sup> trimester nausea Depression	Nil	Augmented Fetal distress NELUSCS	Epidural	Epidural	PPH	Breast	Boy	NAS	Nil	In-patient
Ruby	G7 P2 <sup>+</sup>	Hep C Anaemia Depression Anxiety ++++	Methadone Valium Numerous hospitalisations	Induction Fetal distress Transverse Cord pres NELUSCS	Epidural	Epidural	PPH	Formula	Boy	NAS Jaundice Wet lung	Morphine	In-patient
Kerry	G7 P5	Depression Nausea +++	Maxalon Cannabis	SVD	Epidural	NSAIDS	Nil	Breast	Girl	Nil	Nil	No record
Candice	G9 P7	Genital herpes Depression	Ante- depressants (non-compliant)	ELUSCS	Epidural	Epidural IV & IM narcotics	PPH	Breast	Boy	Nil	Nil	In-patient
Carlene	G7 P2	Hep C Depression Nausea +++	Buprenorphine Arapax Valium Maxalon	ELUSCS	Epidural GA	IM narcotics; NSAIDS Buprenorphine Cannabis		Breast Formula	Boy	NAS Umbilical hernia Patent ductus	Morphine	12
Susie	G3 P3	Depression UTIs	Methadone Antibiotics	ELUSCS	Epidural	IM narcotics Tramadol	PPH	Breast	Girl	NAS; hypo- glycaemia	Nil	In-patient

**Table 3.3: Obstetric history**

### **3.3 Developmental adversity**

In the formative years of these women's lives they experienced a range of incidents which could adversely influence normal development. Many of the incidents demonstrated dysfunctional relationships in their family of origin and have had long term consequences to their psychosocial wellbeing. Only 4 (29%) of the women came from families where the biological parents were still together, however, not all of those units were functional. Of the remaining 10 (71%) women 8 (57%) were raised in families where her mother had a partner who was not her biological father, and in many cases her mother had multiple partners over an extended period of time, with numerous children from different fathers. For example Lisa commented, 'My oldest sister raised us... My Mum's gone through many stages, like, being single, being with men who weren't right'. Carol remarked, '[My parents] broke up when I was six months old... [Dad] hasn't really had anything to do with us. Me and my younger sister have the same Dad but all the rest have got different Dads'.

Health professionals who are working with mothers who use illicit drugs recognise that the mothers' backgrounds are chequered, 'some of the terrible situations they had been in, and that really, nobody sort of got into the drug scene for a bit of a lark. There are usually a lot of problems that caused these women to be more at risk of getting into the drug scene'.

#### **3.3.1 They abused me**

Three (21%) women reported sexual abuse from male family members whom they should have been able to trust. Ruby was sexually abused by her stepfather from the age of 11 until she was 13 and blamed for the abuse by her mother. Cath was sexually abused by her adoptive father over a three year period commencing at 14 years of age. Cath firmly believed her mother was fully aware of the wrongdoing but chose not to intervene. Beth was sexually abused by two maternal uncles. Even though these incidents happened a considerable time ago, they remained significant in the victims' minds and affected how they managed their lives and their children. The impact of sexual and physical abuse on children is well documented and can lead to long term behavioural and psychological problems including illicit-drug-use (Jarvis et al., 1998; Martinez-Raga et al., 2002). Beth explained how a pattern of abuse in her family affected her and her siblings. She said, 'my auntie was abused, I was abused, my two brothers and my sister were abused, which I found out as an older person, so it's a cycle. So, I don't want my children to be subjected to that. Beth recalled:

I suffered sexual abuse from two of my uncles on my mother's side. I was seven when it started...and about 14 when it stopped. So, yeah, I've been through a lot, it has taken me years to, you know, get to that stage of really getting to know who I was.

Physical abuse was raised in the interviews by 4 (29%) mothers and one experienced both physical and sexual abuse. Carol recalled her experience of physical abuse and adversity. She said, 'We [self and siblings] were in and out of foster care and wards of the State and [mother] belted us and just wasn't there for us. She left us and didn't do the right thing by us'.

### **3.3.2 They abandoned me**

Issues of abandonment also played a major role in the development of 11 (79%) of these women. The impact of abandonment was perceived differently and ranged from acceptance through ambivalence to deep hurt and feelings of rejection. Abandonment by one's father, for these women, appears to be less traumatic than abandonment by one's mother. Accepting the inevitability of a biological father's abandonment is explained by Judith, 'He [father] remarried and lives in Canada.... He hasn't ever really been around... That's just the way it is'. Kerry referred to her father as, 'the sperm donor [who] is in NSW somewhere.... My stepdad has been in our lives since I was 2 years old'.

Carol demonstrated ambivalence and confusion towards her mother who had abandoned her. She said:

My Mum and I don't really have the best relationship. She did the wrong thing by me, as a mother, all my life.... Probably better [her] not being there, easier, I'm happier... It hurts sometimes, so, what do you do, deal with it.

Cath felt hurt, rejected and confused by her abandonment and her adoption and by what she perceived as inequity.

I've had to separate what were gender issues in my family; growing up with the differences of how my brother was treated and how I was treated and just being adopted and how I feel being treated differently in my family.

The experience of abandonment had implications for how Cath perceived her role as mother and protector. She said, 'I promised Andrew [baby]...when he was in my

tummy that I would never abandon him.... Like, abandonment is huge. I've got to be careful I'm not over[protective], too good a mother'. Often the abandonment was not a physical removal of person but an emotional withdrawal of support that left the women feeling abandoned in their time of need. Beth remembered:

They've known [of the sexual abuse] for...about nine or ten years.... I think it was very hard for them to...deal with, they can't deal with it.... That's what the problem was... They were telling me, no you can't deal with it but it was really them that couldn't deal with it.

Carlene's abandonment in her time of need was also painful and she related her experience.

[News of my drug use] hit mother hard...so she distanced herself from me and pretended that I didn't exist. I was banned from the family...she wouldn't speak to me. [I felt] very alone, very isolated and she even told me my sisters didn't want to talk to me.... She never actually saw it as somebody who really was just extremely weak and needed a bit of propping for a while, like would get herself together, would grow up eventually and get herself together, and rid the demons, and eventually, you know, just get on with life.

### **3.3.3 They expected too much of me**

Because of ambivalence and dysfunction within some of the families, as children some of these women took on responsibilities that were far beyond their capabilities and experience. Beth and Ruby both reported that they had to parent their siblings, and Lisa reported that her oldest sister raised her and her siblings because her mother was not available. These children took the responsibility with limited support and within environments that were often hostile. As a child, not only was Ruby caring for her siblings, but she was also being physically and sexually abused by her stepfather.

I basically brought [my siblings] up from when they were babies... [Mum] wasn't there for us. I had to look after all the kids because I was the oldest. And I was the one that brought them up. My brother was three weeks old when I started looking after him...I was eight. And he thought I was his mum. He ended up calling me Mum and I ended up getting into trouble for that but I never encouraged him to call me Mum. All I wanted to do was go and play, for God's sake. I didn't want to have to look after a little baby.

Beth related how she took responsibility within her family unit and acted as a surrogate parent but at the same time taking the brunt of her mother's anger and being blamed for 'giving [mother] a nervous breakdown'. Beth said:

I've had a difficult upbringing and being the oldest of four children and my father leaving when I was 6 [years old] and stuff like that, and being like the second role model or father figure...in the family, and stuff and...having to care for my brothers and sister.... I have had responsibility all my life and I think, for a while there, with the drug taking; it was relieving me of the responsibility.

Carlene, on-the-other-hand described a privileged childhood in which she was 'over scheduled' (Rosenfeld & Wise, 2001) and in which her parents expected a constant high level of achievement from her. She was performing within the arts from the age of five and, 'being a very, very high achiever, being a scholarship student in a prestigious private girl's school...and a straight A student and getting all the awards...'. Yet, '[mother] didn't show any particular pride in me then... [and] I had tried and succeeded in many ways but I feel like I let my dad down'.

The antecedents described above had a significant influence on how these women interpreted events, how they perceived self, and how they responded to challenges. Indeed, past events do influence interactions with others as well as physical and emotional conditions such as stress and judgment (Spooner & Hetherington, 2004).

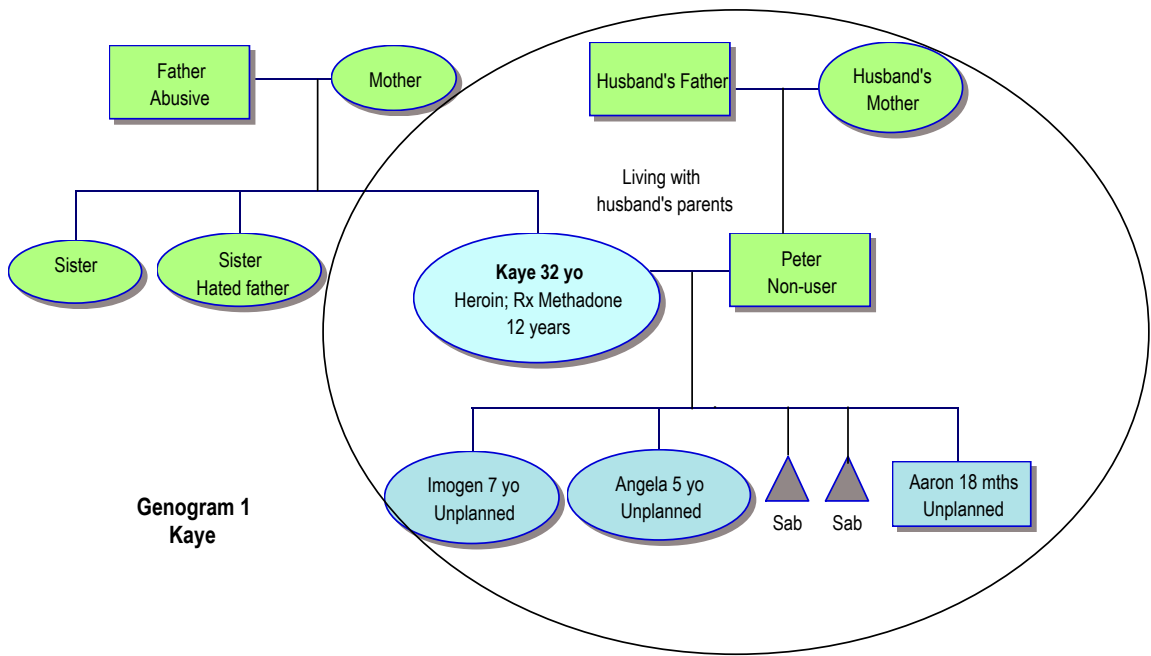


### 3.4 Meet the Mums

The lives and relationships of the mothers were complex and the author has chosen to represent those data in genograms with précis' to provide description and a visual display depicting the shifting relationships within their families of origin and with their significant others (K. G. Lewis, 1989). Many relationships were dysfunctional and the support available was limited. These issues added to the burden experienced by the mothers and contributed to the basic psychosocial problem and the processes they employed to manage their challenges.

#### Kaye

Kaye was a 32 year old with a history of heroin use. Married to Peter, a non-user, they have three children and Kaye has had two first trimester spontaneous abortions. Kaye's history of heroin use is protracted and she has been on methadone for 12 years, however, has continued to use concurrently with her methadone. The family was living with Peter's parents but Kaye was not happy with that arrangement. Kaye's parents "have their head in the sand" and did not acknowledge her addiction. She has two sisters and as a child her father was abusive to them all.

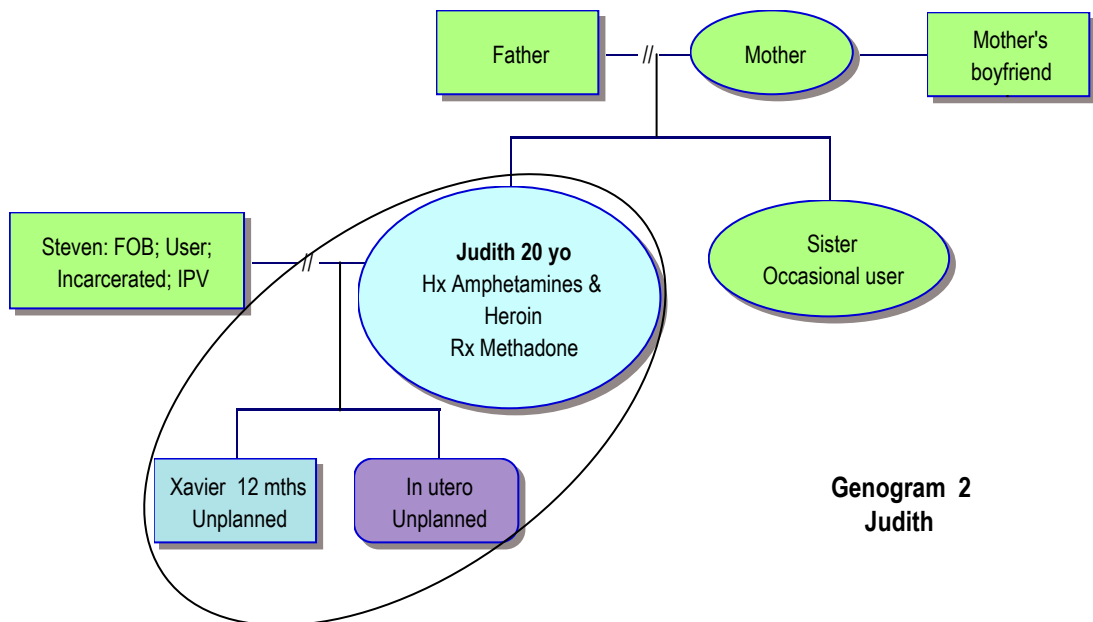


#### Genogram legend

- |                         |                                 |                                |
|-------------------------|---------------------------------|--------------------------------|
| Participant             | In utero                        | TOP = Termination of pregnancy |
| Female                  | Deceased                        | Sab = Spontaneous abortion     |
| Male                    | Divorced or estranged           | Working girl = Prostitute      |
| Sex unknown             | IPV = Intimate partner violence | No ANC = No antenatal care     |
| Children of participant | FOB = Father of baby            | yo = Years old                 |

## Judith

Judith, a 20 year old, with a history of amphetamine and heroin use, is on a methadone program. She is estranged from Steven, the father of her children. Judith and Steven met in rehabilitation and on completion of their program started using heroin together. They have one child, Xavier, and Judith was pregnant with their second child. She lived in rented accommodation with Xavier, her 12 month old son. When they were together, Steven was physically and emotionally abusive, and he has a history of periods of incarceration. Judith's father abandoned the family when she was very young and he has remarried and lives overseas. She has no contact with her father. Judith's mother lived nearby but was involved with a male friend and was unavailable to Judith and her children.



## Lisa

Lisa, at 22 years of age, is the youngest child in a family of seven children. She has a history of heroin and polydrug use and is on MMT. She is in a common law relationship with Rodney. They met in rehabilitation and continued to use heroin after completion of the program. When Lisa found she was pregnant they both commenced MMT. They have a seven month old daughter, Evelyn.

### Genogram legend

Participant

Female

Male

Sex unknown

Children of participant

In utero

Deceased

Divorced or estranged

IPV = Intimate partner violence

FOB = Father of baby

TOP = Termination of pregnancy

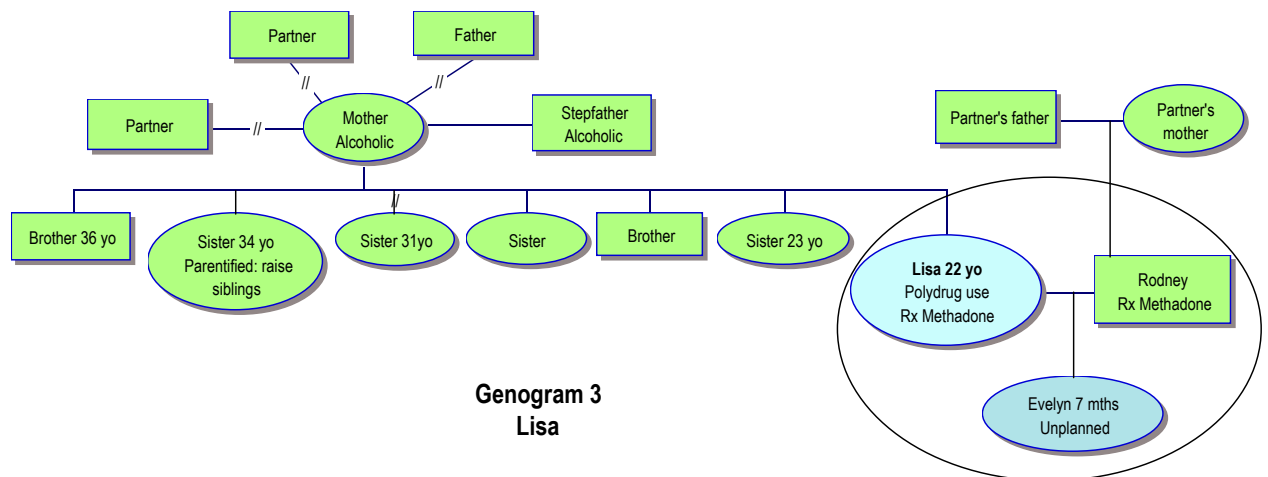
Sab = Spontaneous abortion

Working girl = Prostitute

No ANC = No antenatal care

yo = Years old

Lisa described her mother as a reformed alcoholic and her stepfather as an alcoholic. Her mother has a history of multiple partners and her siblings are from different fathers. Her oldest sister played a big part in raising Lisa and her siblings as their mother was not available to them. Lisa has a strong and supportive relationship with all but one of her siblings.



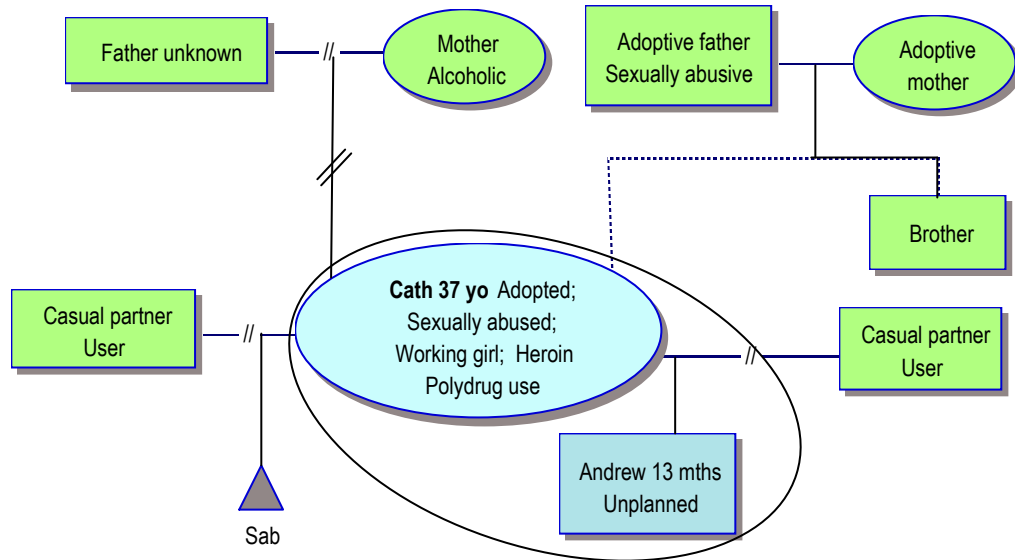
### Cath

Cath was 37 years old with a long history of polydrug use, including amphetamines, cocaine, cannabis, and heroin. At interview her main problem drug was heroin. She classified herself as single and lived with her 13 month old son, Andrew. The father of the baby was a casual encounter and she maintains no contact with him. She has a history of one previous first trimester spontaneous abortion from a casual liaison. Cath worked as a prostitute over many years. She was adopted as a baby and did not make contact with her birth mother until she was an adult. Cath remains estranged from her biological mother and does not know her biological father. Cath's adoptive father sexually abused her between the ages of 14 to 16. She believed her mother was aware of the abuse but did not intervene. Cath has one

#### Genogram legend

- |                         |                                 |                                |
|-------------------------|---------------------------------|--------------------------------|
| Participant             | In utero                        | TOP = Termination of pregnancy |
| Female                  | Deceased                        | Sab = Spontaneous abortion     |
| Male                    | Divorced or estranged           | Working girl = Prostitute      |
| Sex unknown             | IPV = Intimate partner violence | No ANC = No antenatal care     |
| Children of participant | FOB = Father of baby            | yo = Years old                 |

brother who is the birth child of her adoptive parents. She has a good relationship with him and his family.



**Genogram 4  
Cath**

### Beth

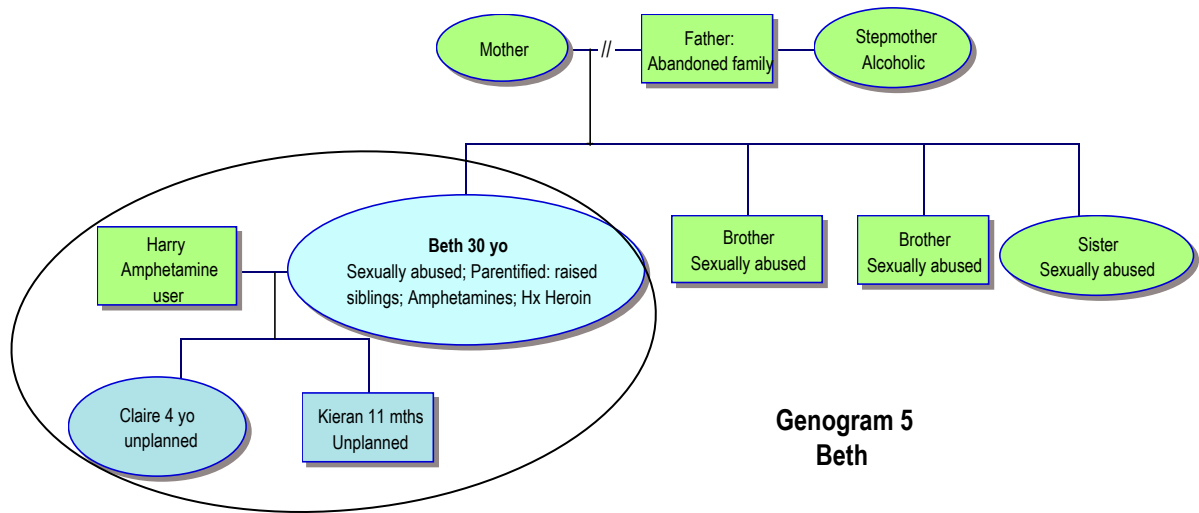
At the time of interview Beth was a 30 year old who intermittently used amphetamines and had a history of heroin use for which she had been on MMT. Her partner, the father of her two children, was an amphetamine user. Claire, aged 4 and Kieran, aged 11 months were both unplanned. Beth's parents separated when she was 6 years old and she described a role of her helping bring up her siblings. Her mother was bitter about the separation and suffered mental illness, for which she blamed Beth. As a child she experienced sexual abuse from two maternal uncles and she is still attempting to come to terms with that abuse. Her three siblings were also victims of sexual abuse.

#### Genogram legend

- Participant
- Female
- Male
- Sex unknown
- ○ Children of participant

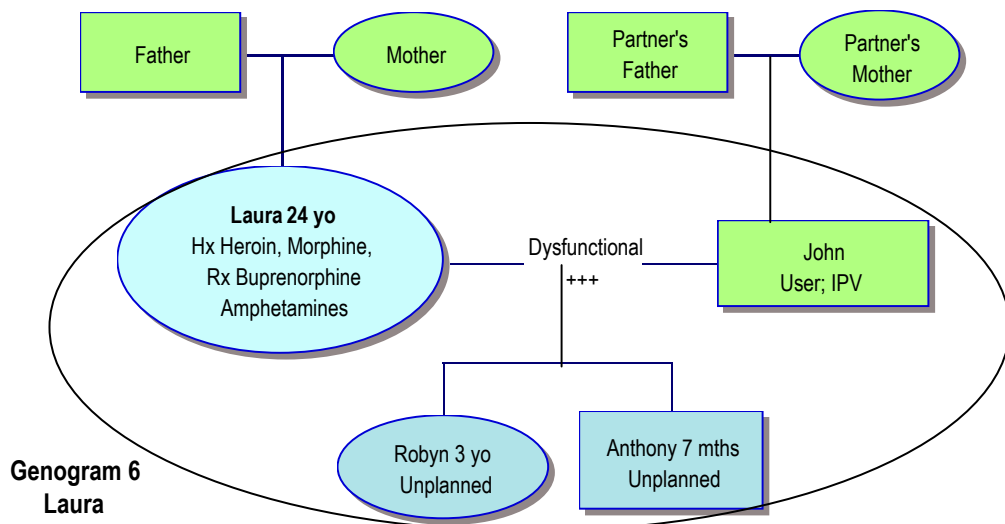
- In utero
- Deceased
- // Divorced or estranged
- IPV = Intimate partner violence
- FOB = Father of baby

- ▲ TOP = Termination of pregnancy
- ▲ Sab = Spontaneous abortion
- Working girl = Prostitute
- No ANC = No antenatal care
- yo = Years old



### Laura

Laura was 24 years old with a history of polydrug use. She described using opiates and that she was on buprenorphine treatment. Additionally, she used amphetamines to help her cope with her parenting role. She was in a dysfunctional relationship with John who was also a polydrug user. He was violent and emotionally abusive and provided no support for Laura and economically subordinated her. Their two children, Robyn and Anthony were 3 years and 7 months respectively. Her parents were supportive but both still worked so were not readily available.



### Genogram legend

Participant

Female

Male

Sex unknown

Children of participant

In utero

Deceased

Divorced or estranged

IPV = Intimate partner violence

FOB = Father of baby

TOP = Termination of pregnancy

Sab = Spontaneous abortion

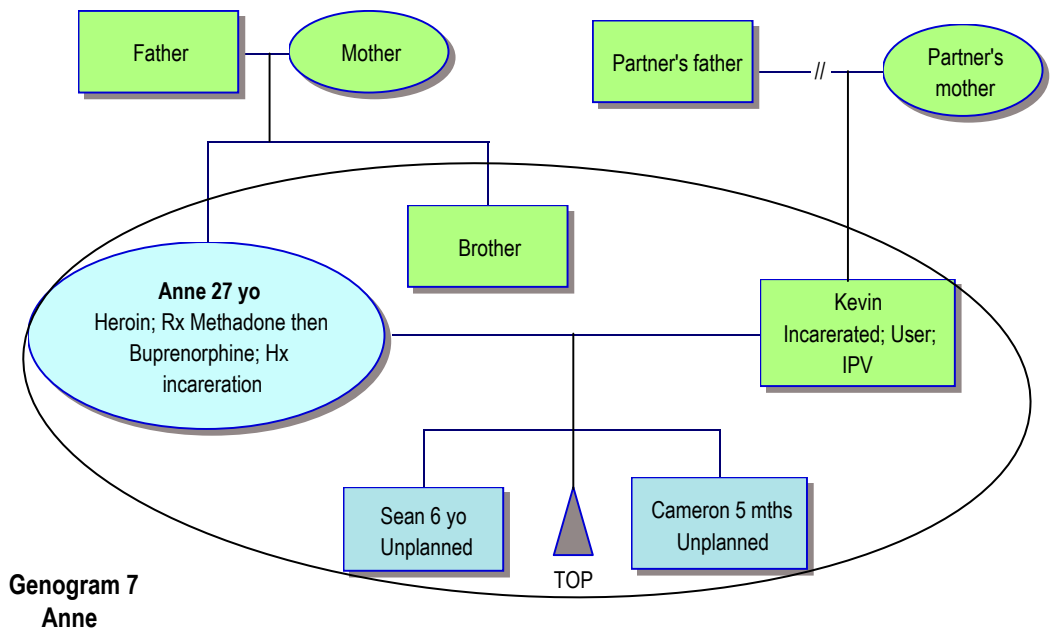
Working girl = Prostitute

No ANC = No antenatal care

yo = Years old

## Anne

Anne was 27 years old with a history of heroin use. She was maintained on buprenorphine but had previously been on MMT for four and half years. Her partner, Kevin, had been a user and was incarcerated at the time of the interview. He had previously physically abused Anne but had not done so for 4 years. They have two sons, Sean and Cameron, and Anne had had one termination of pregnancy. Whilst Kevin was in jail Anne's brother lived with her to provide assistance with her children. She had a good supportive relationship with her parents who lived nearby.



## Carol

Carol was a 28 year old mother with a history of being a Ward of the State and had been in and out of foster care during her childhood. She had had multiple partners and was an amphetamine user. She had recently separated from the father of her 8 month old daughter, Jemima. Her estranged partner shared custody of the child with her; however, that was an informal arrangement. He had a history of using, dealing, and of physically and emotionally abusing Carol. He was Carol's dealer

### Genogram legend

Participant

Female

Male

Sex unknown

Children of participant

In utero

Deceased

Divorced or estranged

IPV = Intimate partner violence

FOB = Father of baby

TOP = Termination of pregnancy

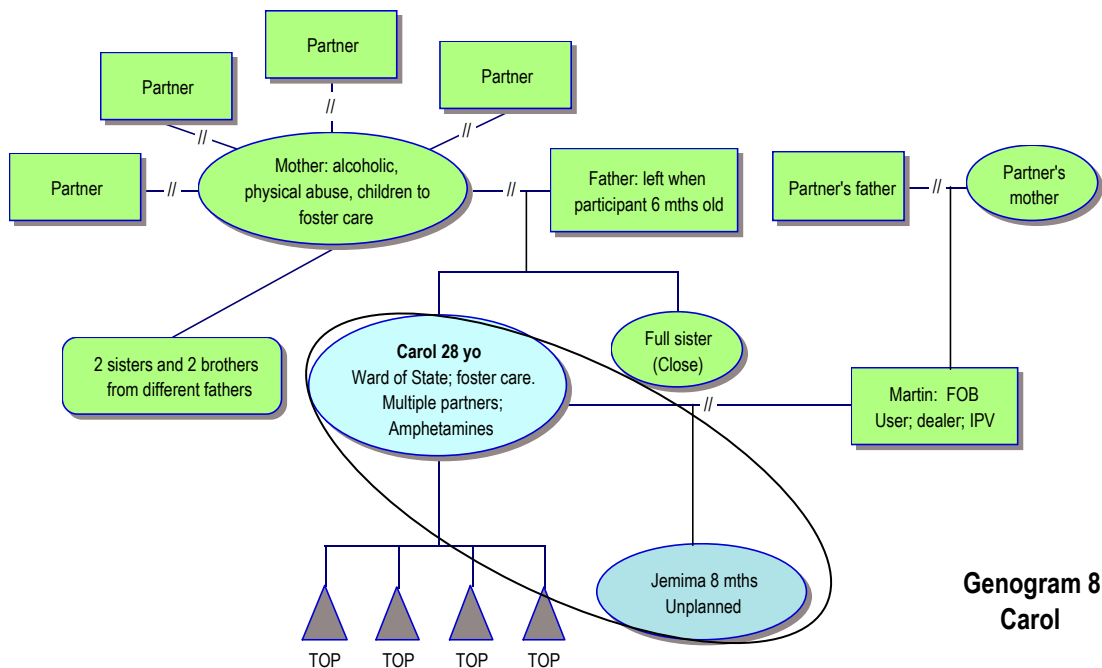
Sab = Spontaneous abortion

Working girl = Prostitute

No ANC = No antenatal care

yo = Years old

and controlled her drug use. She had previously had four terminations of pregnancy. Carol was one of six children and described her mother as an alcoholic who physically abused and neglected her children. She said her mother had multiple partners and her siblings were from different fathers. She had one full-sister and maintained some contact with her. She had no contact with her biological father.



**Genogram 8**  
**Carol**

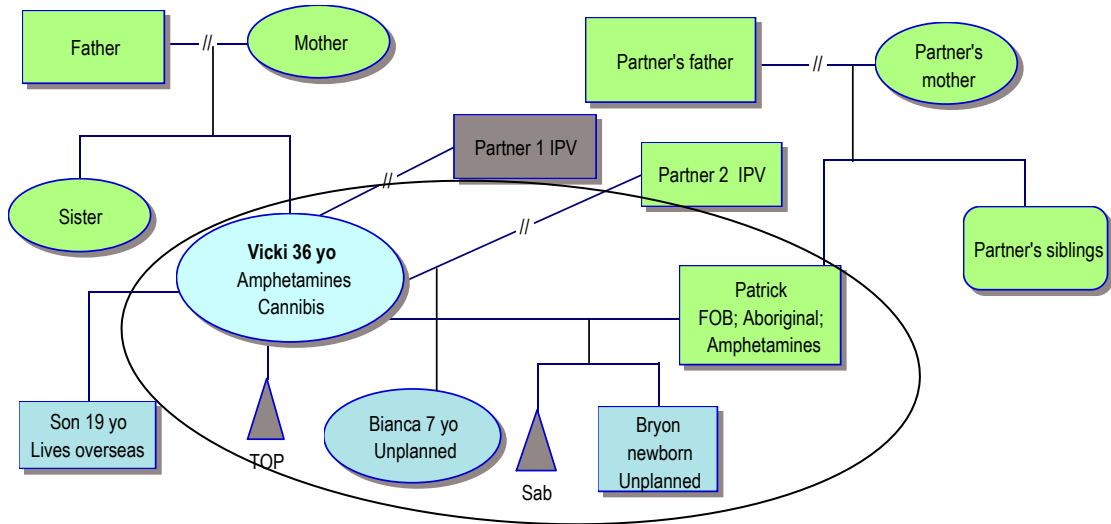
### Vicki

Vicki was 36 years old. Her main problem drug was amphetamines which she injected and she regularly used cannabis. Vicki had had five pregnancies with one termination and one first trimester spontaneous abortion. She has three living children; a son (19); Bianca (8) and a newborn. The father of her newborn is an amphetamine user. Vicki had previously been in two violent relationships that she felt she 'couldn't get out of'. The first ending when her partner died from a terminal illness. The second violent partner is the father of her 8 year

#### Genogram legend

- |                         |                                 |                                |
|-------------------------|---------------------------------|--------------------------------|
| Participant             | In utero                        | TOP = Termination of pregnancy |
| Female                  | Deceased                        | Sab = Spontaneous abortion     |
| Male                    | Divorced or estranged           | Working girl = Prostitute      |
| Sex unknown             | IPV = Intimate partner violence | No ANC = No antenatal care     |
| Children of participant | FOB = Father of baby            | yo = Years old                 |

old daughter. She escaped that relationship with the help of her father and the police. Vicki's mother and sister lived nearby and have a good relationship with her.



Genogram 9  
Vicki

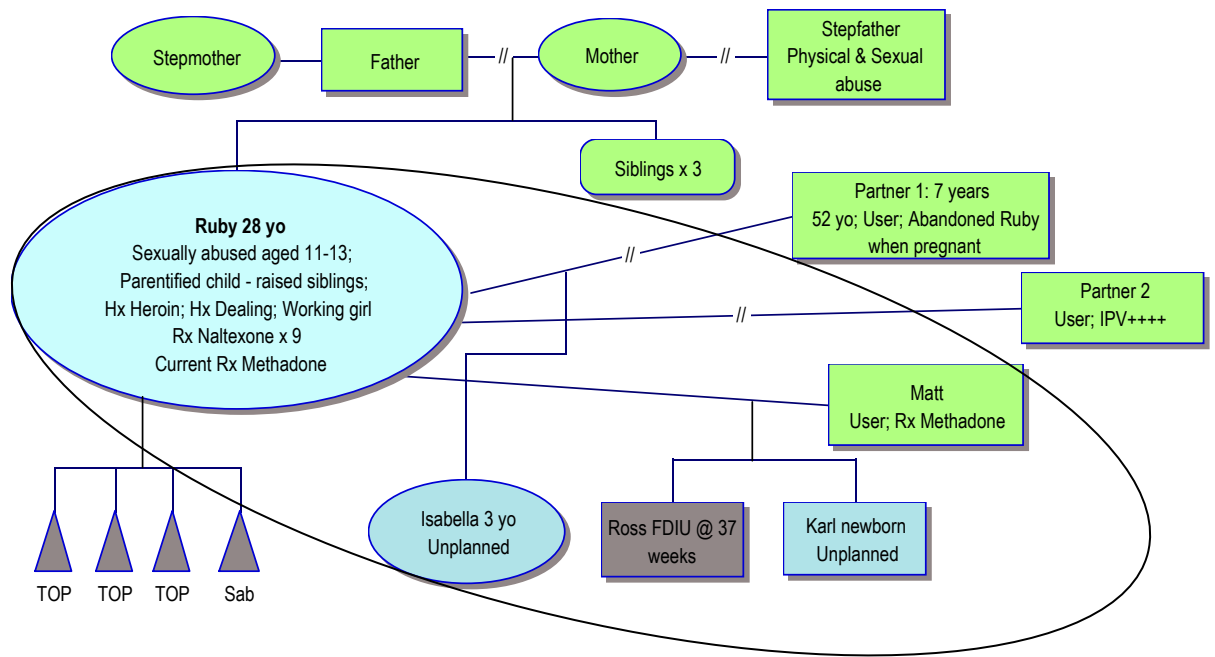
## Ruby

Ruby was a 28 year old with a history of heroin use, dealing, and prostitution. She has had multiple attempts to detoxify and was on MMT when interviewed. As an eight year old, Ruby was parentified and took care of her three siblings as her mother was ambivalent and unavailable. Her parents were divorced and she had a stepfather who sexually and physically abused her from the age of 11 to 13. Ruby had had seven pregnancies which resulted in three terminations, one spontaneous abortion; she had a four year old daughter, a fetal death in utero at 37 weeks gestation, and a newborn son. The father of her three year old was a drug-user who abandoned her when she became pregnant. She was then in an extremely violent relationship that she escaped when the baby was three months old. The father of her stillborn child and the newborn is on MMT. Ruby and Matt have a loving relationship.

### Genogram legend

Participant	In utero	TOP = Termination of pregnancy
Female	Deceased	Sab = Spontaneous abortion
Male	Divorced or estranged	Working girl = Prostitute
Sex unknown	IPV = Intimate partner violence	No ANC = No antenatal care
Children of participant	FOB = Father of baby	yo = Years old





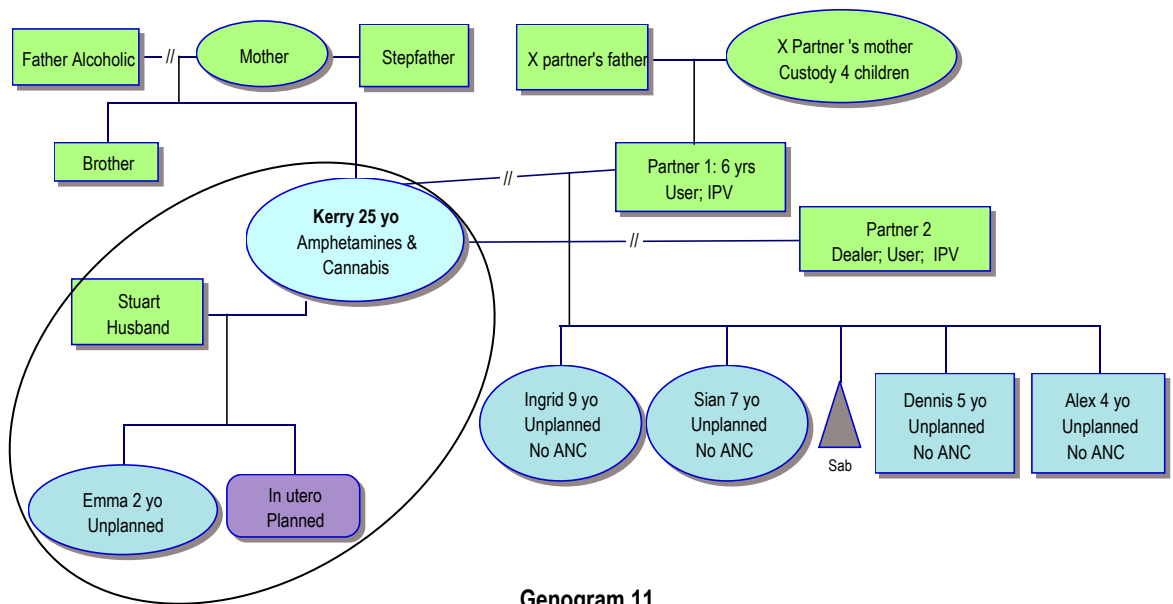
Genogram 10  
Ruby

### Kerry

Kerry was a 25 year old with a history of amphetamine and cannabis use. She has had seven pregnancies, has five living children, had one spontaneous abortion and was pregnant at the time of interview. Kerry was 16 years old when her first child was born. She has had three partners who have had an influence on her parenting experience. Partner 1 is the father of four children with whom she spent six years. He was a user and was physically and emotionally violent. His parents have legal custody of her four children to him and she is allowed supervised visits. She does not trust the grandmother and has no contact with the children's father. On the loss of her children she became homeless, increased her drug use and took up with a dealer and user who was physically violent. On breaking free from that man she met her husband, Stuart, through the Salvation Army, where she was receiving counselling and doing volunteer work. Kerry and Stuart have 2 year old Emma and Kerry was in the latter stages of pregnancy. Kerry's family of origin live interstate and she has little contact with them.

#### Genogram legend

- |                         |                                 |                                |
|-------------------------|---------------------------------|--------------------------------|
| Participant             | In utero                        | TOP = Termination of pregnancy |
| Female                  | Deceased                        | Sab = Spontaneous abortion     |
| Male                    | Divorced or estranged           | Working girl = Prostitute      |
| Sex unknown             | IPV = Intimate partner violence | No ANC = No antenatal care     |
| Children of participant | FOB = Father of baby            | yo = Years old                 |



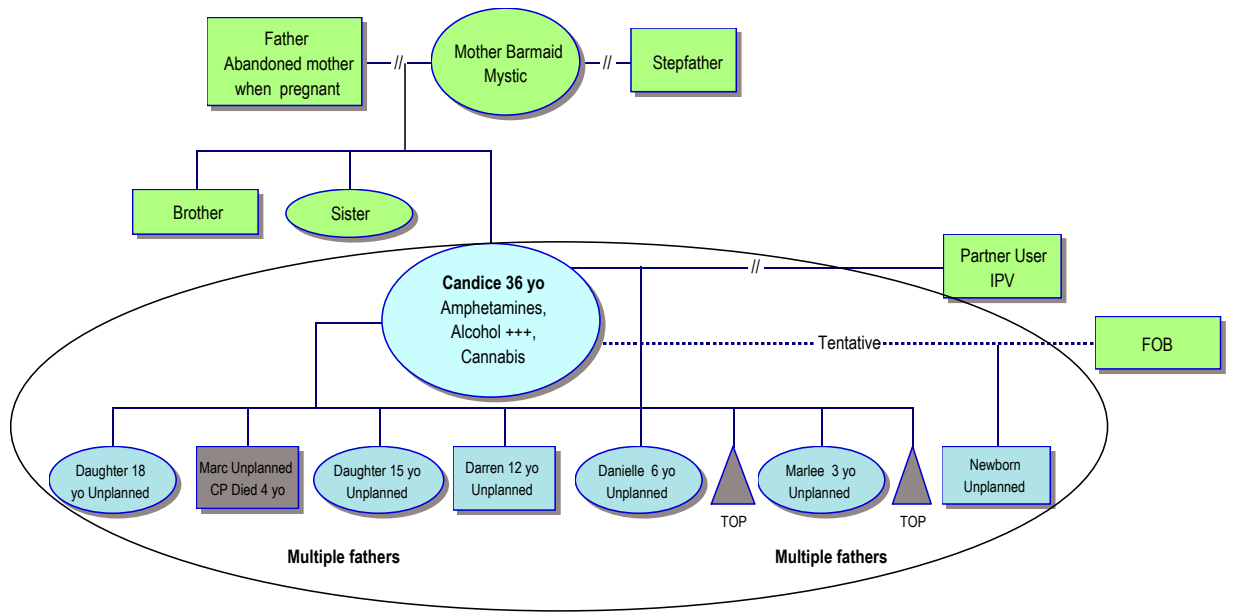
Genogram 11  
Kerry

### Candice

Candice was a 36 year old who regularly uses amphetamines, cannabis, and copious amounts of alcohol. She has chronic depressive illness. Candice has six living children ranging from 0 to 18 and has had two terminations of pregnancy. The children all have different fathers. Her relationship with the new baby's father is tentative. Her amphetamine use commenced when she was caring for her second child who had cerebral palsy and who died at 4 years of age. By that time she also had a new baby and her first born. She is still grieving the loss of her first son. The father of her 6 year old daughter was physically and emotionally abusive and abducted the child at one stage. Candice regained custody through the court system. Candice's has a brother and one sister but has little contact with them. Her biological father abandoned the family when her mother was pregnant with Candice. Her mother is a mystic, travels regularly and is unavailable to provide regular support.

#### Genogram legend

- |                         |                                 |                                |
|-------------------------|---------------------------------|--------------------------------|
| Participant             | In utero                        | TOP = Termination of pregnancy |
| Female                  | Deceased                        | Sab = Spontaneous abortion     |
| Male                    | Divorced or estranged           | Working girl = Prostitute      |
| Sex unknown             | IPV = Intimate partner violence | No ANC = No antenatal care     |
| Children of participant | FOB = Father of baby            | yo = Years old                 |



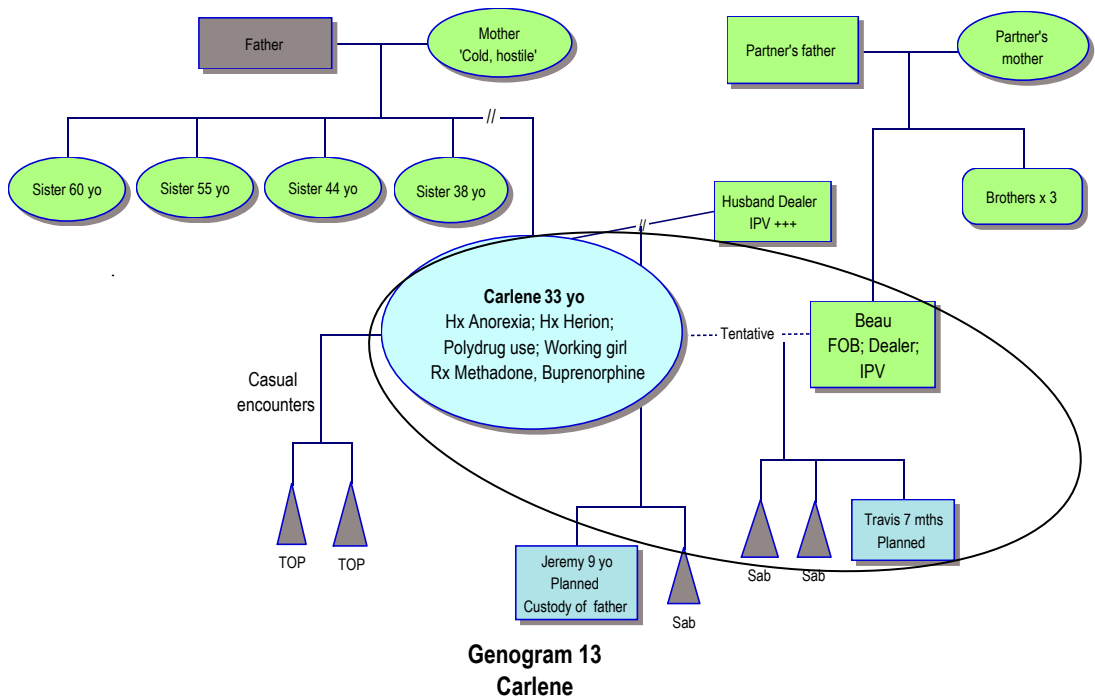
Genogram 12  
Candice

### Carlene

This 33 year old mother has a history of polydrug use with heroin being her main problem drug. She has been on MMT and at the time of interview was on buprenorphine treatment. She has a history of prostitution and has a history of chronic depressive illness. Carlene has had seven pregnancies with two terminations, three spontaneous abortions, and two live births. Her ex-husband has custody of their 9 year old. He was a dealer and was physically and emotionally abusive. Her current partner, Beau, is the father of her 7 month old son, was a dealer and was occasionally violent. Carlene's father is deceased and she described her mother as 'cold and hostile'. She is the youngest of five children and has no contact with her siblings.

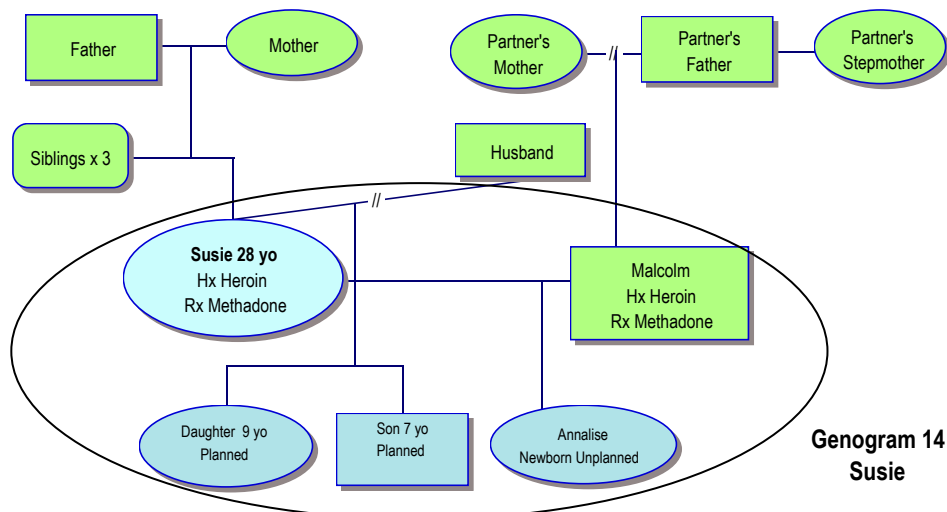
### Genogram legend

- |                         |                                 |                                |
|-------------------------|---------------------------------|--------------------------------|
| Participant             | In utero                        | TOP = Termination of pregnancy |
| Female                  | Deceased                        | Sab = Spontaneous abortion     |
| Male                    | Divorced or estranged           | Working girl = Prostitute      |
| Sex unknown             | IPV = Intimate partner violence | No ANC = No antenatal care     |
| Children of participant | FOB = Father of baby            | yo = Years old                 |



### Susie

Susie was a 28 year old whose involvement into illicit drugs was relatively recent. Her main drug was heroin and she was on MMT. She has two children from a previous marriage and was not using when they were born. She has an amicable relationship with the father of her two eldest children. Susie has been with Malcolm, the father of the baby, for five years. He was also on MMT. Susie has three siblings, her parents are still together but do not live locally.



#### Genogram legend

Participant

Female

Male

Sex unknown

Children of participant

In utero

Deceased

Divorced or estranged

IPV = Intimate partner violence

FOB = Father of baby

TOP = Termination of pregnancy

Sab = Spontaneous abortion

Working girl = Prostitute

No ANC = No antenatal care

yo = Years old

### **3.5 Summary**

One health professional who works exclusively with mothers who use illicit drugs articulated an integrated overview of the profile of these mothers.

There are a lot of challenges and difficulties in their lives, one of which might be substance misuse. That describes our clients. So they have issues around economics, you know, financial issues are huge, issues around their housing, employment problems, social problems, transportation problems, maybe mental health, maybe legal problems, you know, all of those areas that are there. Some of them might be connected to their substance use but some of them aren't.... Most of the women that we see are disadvantaged, socially and economically, they are on benefits and stuff, and they are quite poor. So, they have tough lives anyway.

This chapter has presented an overview of and introduction to the mothers who were participants in this study. The chapter included demographic profiles, and drug use and obstetric histories of the mothers. A series of genograms depicting the mothers within a three generational family structure provides a gestalt of interrelationships, family histories, behaviour, and conflicts. These family précis' offer a systematic perspective (K. G. Lewis, 1989) of developmental adversities within families of origin.

As can be seen from the presented data, complex health statuses, family disunity, intimate partner violence, criminal activity, incarceration, and estrangement from significant others contribute to their complex lives. The following chapter presents the basic psychosocial problem, or central problem shared by the mothers.

## **Section 2**

**The basic psychosocial problem: *The threat of loss***

**The basic psychosocial process: *Limiting loss through a process of safeguarding***

## Chapter four

### The basic psychosocial problem: *The threat of loss*

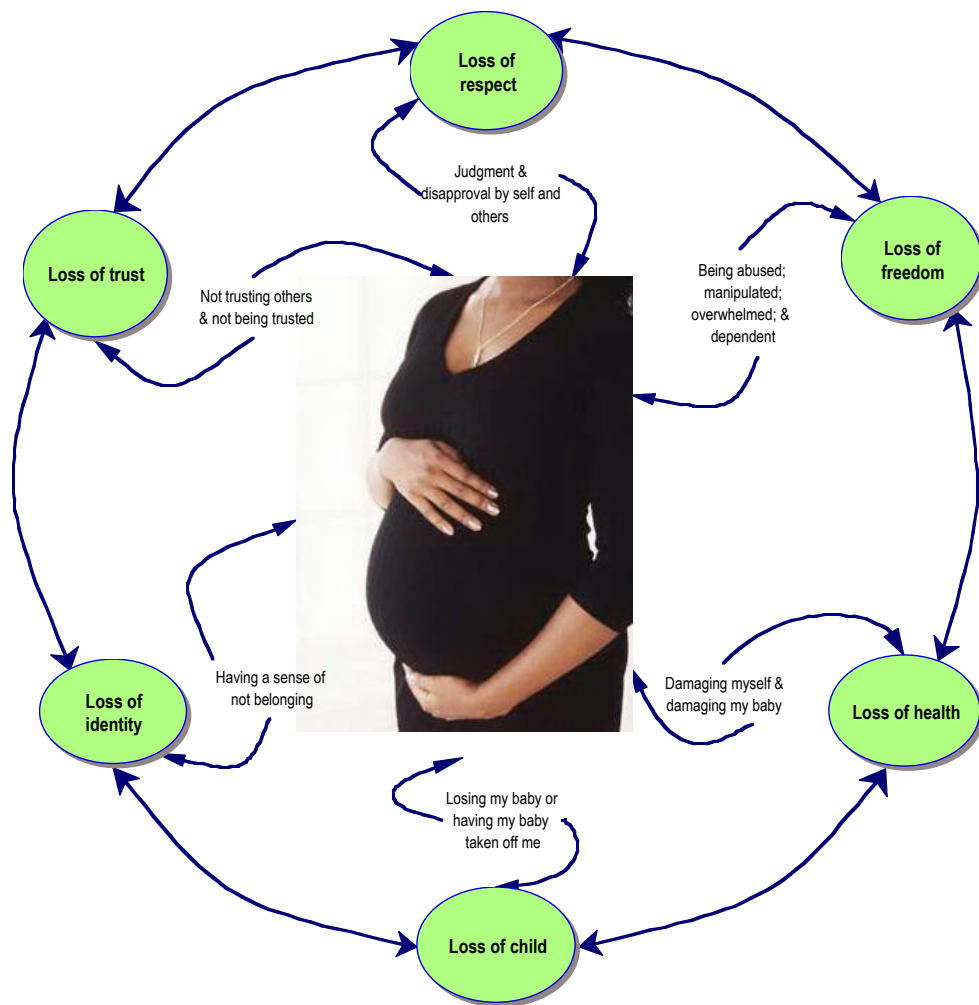
#### 4.1 Introduction

Using the constant comparative method of analysis consistent with grounded theory (Glaser & Strauss, 1967), the data from this study revealed that the basic psychosocial problem shared by mothers who use illicit drugs was *the threat of loss*. *The threat of loss* is interpreted from the data as fear inducing awareness of potential risk or harms to self and/or 'all that is mine', which results in loss of elements central to one's wellbeing. The data indicated that *the threat of loss* is common and pervasive, is variable in intensity, frequency and duration, is unpredictable and enduring, and is influenced by prior experiences. *The threat of loss* emanates from (a) *judgment and disapproval by self and others*; (b) *being abused, manipulated, overwhelmed, and dependent*; (c) *damaging myself and damaging my baby*; (d) *losing my baby or having my baby taken off me*; (e) *having a sense of not belonging*; and (f) *not trusting others and not being trusted*. These problems result in loss of respect; loss of freedom; loss of health; loss of child; loss of identity; and loss of trust. The threat of loss is depicted in the simple diagram (Figure 4.1) with the mother central to the phenomenon and the contributing symbolic interactions resulting in loss experiences which are linked and flow-on from one to another.

Each loss experience has distinct characteristics but each is interconnected to other loss experiences where a loss in one area influences or has a cascade effect to other loss experiences. For example, if a mother loses her baby it affects her identity as mother, her health, her respect for self, her trust in others, and could influence her dependence in relationships with existing or subsequent children, and her dependence on drugs. Similarly, if one is a victim of IPV it negatively influences one's freedom, one's health, one's identity, one's trust, one's respect for self, and it is the ultimate expression of a loss of respect by the perpetrator.

The mothers in this study lived their lives and raised their children in environments where the *threat of loss* was a reality. The nature of *the threat of loss* is discussed in the following discourse with direct quotes from the mothers' transcripts used to allow their 'voices' to be heard. The theoretical concepts derived from the constant

comparative analytical process are compared to relevant literature to position them within existing knowledge.



**Figure 4.1: Threat of loss**

## 4.2 Judgment and disapproval

Judgment and disapproval posed an impediment to the accordance of respect from others and the maintenance of self-respect. Respect is admiration or special regard felt or shown by a person for another. To respect is to hold in esteem or honour or to treat with consideration and refrain from interfering with other persons and to show civility toward them. Throughout this study it was evident that the mothers felt that they were the object of moral judgment and disapproval by all who were aware of their illicit-drug-using status. Despite the problematic moral and socio-political issues of illicit-drug-use in pregnancy, these mothers were conscious of their moral rights and hurt by any erosion of those rights and by others' judgment and disapproval. The mothers related feeling that they were being judged by esteemed



public figures, significant others, friends, and health professionals. They believed others felt they were unworthy of being mothers, which was endorsed by public comment and by attitudes of those with whom they interacted and those close to them. At a public meeting attended by one mother a presenter announced, 'mothers who use drugs don't deserve to have children...they shouldn't be allowed to have children'. Others reported comments made to them such as, 'You're a drug-user and you don't deserve to be a parent'. In relation to the impact of negative comments Kaye related, 'I say it doesn't [bother me] but I think it does, deep down, of course.... I say I don't give a shit what anyone else thinks, but you do, and you get hurt if someone says something nasty'.

#### **4.2.1 Being judged and judging self**

Mothers spoke of their expectation that they would be judged and thought less of if others knew of their drug use. They were deeply ashamed and guilty about what they were doing and were fearful of being 'caught'.

[I have] a lot of guilt associated with [using], like personal guilt and secrets.... And if people know then you've got nothing to live up to, sort of as well, like, that gives you a poor self-image and you think that everyone else thinks really lowly of you. (Susie)

Often the most bitter pills to swallow was judgment, criticism, and rejection by significant others. Some were already estranged from their family of origin and had experienced the pain of maternal rejection, isolation, and psychological distress. For those who maintained contact, some were familiar with their mother's ongoing critical evaluation. Yet, the fear of losing their mother's respect threatened their self-esteem, their sense of belonging and identity, as well as their confidence. Beth commented, 'My mother was probably the most negative and unsupportive in knowing that I was a drug-user.... It was very hard when she felt that way... She decided that I was abusing [my daughter]....and rang Social Services'. These findings are consistent with the literature that report that criticism, hostility, and rejection by a mother has the potential to elicit feelings of rejection which can contribute to lowered self-esteem; isolation and loneliness; depression; and other psychosocial impairments resulting in, for example, exacerbated drug use (Lefkowitz & Tesiny, 1984; Pineda, Cole, & Bruce, 2007; Younge, Oetting, & Deffenbacher, 1996).

Mothers also discussed being judged, disapproved of and rejected by other family members. They felt that they were 'looked down upon' and endured criticism for their drug use, their parenting, their housekeeping, and even for being part of the family, especially from their partner's mother. This critical evaluation undermined their self-esteem, made them angry, and encouraged withdrawal from the perpetrators. They felt that their sense of belonging was challenged and this affected their psychological wellbeing.

Rejection by an intimate partner and father of one's children also demonstrated disapproval. Rejection, even if the relationship was dysfunctional, eroded one's identity, sense of belonging, and self-worth. For some, the rejection was so overwhelming that they attempted suicide. These mothers reported being rejected at their most vulnerable periods. Ruby had been in a relationship for seven years and was rejected by her partner when she announced her pregnancy. Kerry's partner, 'moved out with his girlfriend, and I was so glad he did because he did bring his new girlfriend home when we were still together, and that is when I tried to 'do myself in'. Betrayal induced negative emotions and included grief at the multiple losses, fears for the future, intense anger, despair, and even questioned their identity; 'If I'm no longer his partner, who are I?' Laura experienced a temporary abandonment during both of her pregnancies.

When I was pregnant [my partner] would just disappear for, like three months...without a word, and then all off of sudden, he'd just turn up out of the blue. He wasn't there when I gave birth to Robyn, and then two weeks later he shows up.... He does it when I'm pregnant.

The mothers also knew that what they were doing was unacceptable in contemporary society. Each mother judged self and experienced feelings of guilt and shame for her actions which contributed to a loss of self-respect. Carlene said:

Most of the time I am my own worst judge, I am my own lawyer and my own judge.... But I do feel like I am being judged because, (1) I'm a mother and I use drugs (2) I didn't have the stable marriage then a child. I have two children to two different fathers.... So anybody who knows that automatically sees instability.

For some, the intensity of self judgment and loss of self-respect was fierce, as Ruby's comment affirms.

I always, no matter what, no matter how long it's been since my last shot, no matter how long it's been since I 'worked' [prostitution], I think that everybody looks at me and sees a dirty, heroin addict, no, smack-head, hooker. That's what I think they see when they look at me.

Not only did they judge themselves but they were also afraid of their own children judging them. When mothers realized their children were aware or made comments that indicated knowledge of their drug use it frightened them as they did not want their children to lose respect for them. Kaye recalled her daughter's inquiry about her methadone and spoke of the fear of her children ultimately becoming aware of her use. She said, 'Imogen...saw me drink my [methadone]...and said "what's that Mummy?" That was the first time she had asked...' And although her children were not yet fully aware of the implications of what she was doing, they were putting 'two and two together'.

Others were alarmed when their children commented on their use. Anne recalled, 'Oh, it spooked me because Sean remembers everything. He did see everything. You think, he was a baby and we didn't think he would remember anything, he wouldn't see it, but he did'. She later commented:

Sean is learning about drugs at school...and he told me that they had a guy come in and show them syringes and stuff and what to watch out for. And he...came [home] and goes, "that's what you and Daddy used to have". And it's like, phew!! They don't miss anything.

Mothers knew that older children were probably aware of their use however, it was rarely discussed. When direct comments were made it was very confronting. Vicki's seven-year-old daughter 'knows what marijuana is' but she was shocked when her daughter said:

"[My friend] asked me if you guys smoke out of a bottle? [She said her] Mum and Dad do". I don't go too deep with her but she knows it's not good. Bianca knows...cos the [advertisements] are coming on TV now, and she goes, "You and Patrick are naughty, ah, Mum".

The expectation and potential of being judged and disrespected by one's mother, other family members, one's partner, and one's children placed these women in a vulnerable position. They were subject to hurt, humiliation, and a sense of not belonging or of being worthy of respect. Most already had low self-esteem whilst

others were depressed and struggled with their day-to-day challenges. Their negative self appraisal contributed to their overall negative sense of self. As they entered and interacted in the health care environment they were again placed in a position of vulnerability where there was potential for judgment and loss of respect.

#### **4.2.2 Being judged in the health care setting**

A respectful relationship between health professionals and their patients is integral to the provision of quality care. However, when these mothers entered the health care setting they were fearful of judgement and disapproval. Being judged by health professionals and the subsequent loss of respect had a significant impact on patient-provider interactions. Mothers believed they were often unfairly judged and that was traumatic. They felt that respect for them had been violated, and their safety, and that of their baby, diminished. Judith vividly remembered one encounter and similar events were reported by other mothers. Judith said:

I think that once they know you are on methadone, they start freaking out... "Oh, my God, that baby's hanging out, look he's crying".... I felt blamed and...didn't feel good with the way they dealt with it... I was upset about [the baby withdrawing] and...one of them said, "Well what do you expect when you use drugs when you are pregnant?".... In my eyes I wasn't using, I was on methadone for the last seven months of my pregnancy, I wasn't using anything.

Through their attitude, health professionals often implied a moral deficit and thus demonstrated a lack of respect for these mothers. Beth remembered, with distress, one clash with staff, when she was birthing her first baby.

There was a problem with the staff believing me...[in relation to drug use].... They are very judgmental and they were expecting the baby to have all these [problems]. On top of that they kept asking me, "have you used?", because of the problem with...the meconium on his head and...he was a bit cold. So, they were asking if there were any other things that they had to worry about. I kept insisting there weren't and they didn't really truly believe me, so I felt a bit violated.

In other circumstances a lack of respect was demonstrated not by words or actions but by omission and neglect. Many mothers spoke of having to wait long periods when they had rung the call bell; of staff being less than helpful; of being ignored; of negative body language; and of insinuations regarding their trustworthiness. Anne

recalled an incident when she needing help from a health professional, 'I kept buzzing [the midwife] and it took her, like, twenty minutes for her to get to me, and then she didn't even help me...'

For these mothers, both verbal and non-verbal interaction could indicate disapproval. Ruby's experience with judgmental staff was distressing for her when she was unwell and experiencing severe pain. She was not seeking medication, as was implied by staff, but for someone to provide interim care to her newborn baby. She described the scenario:

I rang the bell...and the [midwife] came in and looked at me, like, "What are you doing? Your kid's screaming". And I said to her, "I really, really, really need for him to be taken down to the nursery for a couple of hours because I've got cramps in my stomach.... And she goes, "Well, so what is it that you want me to do? And all I can give you, before you ask, is Panadol".... And she kept going on about medications and, "OK, well when was your pethidine taken from you, when was the last time you had your morphine?" .... And she just kept going on and on and on about drugs. "I can only give you Panadol". And it was just stupid. She made me feel really bad... It was like she was thinking that either I just couldn't be bothered dealing with my child...or she thought all I wanted was some kind of Schedule 8 drug.

In others instances it was body language and actions that were interpreted as being evidence of a loss of respect for them. Candice related an incident where an attending doctor, on becoming aware of her drug use, recoiled. She said, 'you could feel it, he got cold straight away, you could feel a wall go up'. Others felt similar rejection. The power of body language was eloquently articulated by Carlene when she commented on being aware of being judged. She said:

I can pick up on body language very easily...and facial expressions, things that I just notice a lot...it doesn't have to be words, it can be a simple look, a simple stance, a simple jaw set or anything, the way someone smiles, or the way they say hello or the way they say "Oh" when you say something.

At times the mothers' knowledge, opinions, and fears were dismissed by health professionals, thus undermining their integrity and placing them at risk. Carlene commented on how she felt angry with how staff undermined her and said:

I had a lot of my own abilities taken out of my hands, a lot of my own knowledge discredited... They...turned out to be very unfriendly towards mothers like me and...babies that were going through withdrawals. They were very judgmental and assumed, well, “What would I know?”

Properties of judgment and disapproval by health professionals were endorsed by the health professionals who regularly provide care for mothers who use illicit drugs. They were aware of, had witnessed other health professionals treating these mothers badly, and had been told by the mothers, of judgment and a lack of respect. One health professional commented:

These are general complaints [by the mothers], once their drug use is known, that takes precedence over anything else that happens. So, everything is then seen through the lens of, “You are an illicit-drug-user”. And so that can lead some of them to try and conceal that information, because then they feel that nothing can be judged. Cos some of our women have chronic pain conditions as well as the pain after the birth, “As soon as they find I have an illicit drug use problem, nobody cares about my pain”. It’s more like, “Well suffer”. So, they feel like they are not treated as well. Now, that’s an on-going thing; or it takes up too much of the conversation; or it’s involved in conversations where it has no place. It isn’t what is happening right then and there. [Health professionals] aren’t treating them well.

When comparing these hypotheses with the literature on mothers who use illicit drugs, Klee and colleagues (2002) found that some health professionals were disrespectful to women who were using illicit drugs. Similarly, Rosenbaum (1979, p.435) also identified that:

...childbirth can entail psychological battering by hospital staff. Many women complained that even though they were “clean” at the time of birth, the nurses treated them with intense disrespect.... When pregnant women addicts see a physician prior to delivery, they are often treated with disdain because they are addicts.

Respect is an unconditional moral obligation and human right that is owed to all persons irrespective of their moral performance (Dillon, 2003). Kant (1724-1804) put respect for persons, including self, at the core of moral theory and argued that human beings are all worthy of respect and have an absolute dignity that must be

respected (Dillon, 1997). Respect for persons is one of the basic principles which are founded on the ideal of equal dignity of all persons (Dillon, 2003). Principles of biomedical ethics, including nursing and midwifery, decree that respect for persons and their autonomy is fundamental to the provision of care (Browne, 1993, 1997; Dillon, 2003) and is demonstrated in the way one person treats another during direct interactions. Exercising respect for persons is consistent with the tenets of symbolic interactionism of meaning, language and thought (Blumer, 1969) and occurs at every human interaction, is displayed in attitude, language and deed, and is interpreted through thought and personal conversation.

As conscious rational autonomous agents with the capacity for self determination the mothers in this study were acutely aware of people's attitudes, language and actions towards them. They, like all human beings, by engaging in thoughtful interpretation of the meaning of interactions, were able to recognize respectful, supportive, threatening, and disrespectful interactions, be conscious and responsive to them, and have and express values with regard to them.

### **4.3 Being abused, manipulated, overwhelmed, and dependent**

Adult human beings expect to have a sovereign control over their lives with the ability to make decisions, have input into what they do or do not do, and to have those decisions respected and supported. For the mothers in this study, the state of being abused, manipulated, overwhelmed, and dependent resulted in the loss of their freedom.

#### **4.3.1 Being abused**

The prevalence of domestic violence in this study was high with 9 (64.5%) mothers reporting severe violence from an intimate partner causing physical, psychological and property harm. Domestic violence is a complex pattern of behaviours encompassing, physical, sexual, and emotional abuse which results in the perpetrator controlling the life of the abused. As well as being the ultimate demonstration of loss of respect, domestic violence, and emotional abuse impacts significantly on one's freedom. For the mothers in this study aggressive behaviours by male partners varied from severe physical aggression resulting in physical injury, to coercion, threats, and intimidation which served the purpose of maintaining dominance and control.

The quality of relationships combined with drug use and its cycles of intoxication and withdrawal placed these mothers at high risk of physical and emotional violence. Some mothers spoke of being physically beaten causing bruising, broken teeth, fear and compliance. Others spoke of strangling, suffocation, and false imprisonment. Vicki related:

I was smoking marijuana when I met Bianca's father, he knew I smoked, but made me give it up. So I pretty much gave it up for those four years, but used to have a sneaky one with my girlfriends, and...he came home and caught me and punched my teeth out.

Carlene recalled not only the physical violence used to exert power and control over her but other complex pattern of behaviours which were unrelenting. She explained:

I couldn't handle any more violence or any more abuse; I had just had the gamut of it.... Non-stop physical abuse on both of us [mother and baby], like, I was cornered, I was isolated, I was trapped, imprisoned in the house. I had all my money taken away from me. I was being physically abused on a very regular basis... [and] had very little health left.

Ruby's story exemplifies the terrorising nature of intimate partner violence (IPV). Prior to her leaving her partner he had destroyed, by fire, everything that she and her daughter owned.

I really needed to escape that man... Through my whole pregnancy he would hold me down by my throat and cover my nose and my mouth so that I couldn't breathe and tell me he was going to kill my baby.... He would beat the shit right out of me and lock me in the house during the day.... He always said, "I'm going to kill the baby when it's born. If I don't kill it in your stomach, I'll kill it when it's out here".

Health professionals also reported that 'domestic violence is a huge issue', that many women attending the ACDC exhibit signs of physical abuse, and that the mothers report physical abuse to them. One health professional related a vicious attack, 'One lass kept turning up [at the ACDC] from domestic violence (DV) assaults. She became homeless at one point... The latest assault was with a baseball bat'. Another reported:

She couldn't stay with the violence, cos the violence was life threatening. We are talking about them feeling their lives are at risk. They tell you about the choking stories. I mean, you don't talk to the police. The



number of choking stories I have heard, where they feel they are going to be strangled to death.

Similarly, other authors have reported a high level of violence in this population. In a study in the US on 120 mothers who use illicit drugs 43 (36%) reported being abused during their pregnancy. Accounts of the violence were similar to that found in this study with battered faces, broken jaws, threats to kill both the mother and baby, and accounts of battering resulting in death of the fetus (Murphy & Rosenbaum, 1999).

Mothers also spoke of intimate partners stalking, bullying, and blaming to gain control over them, induce fear, and subordinate them. Candice reported intense and intrusive stalking over several months which induced extreme fear and threatened the safety of her children. Carlene explained that her partner 'has a side to him that is a bully. And the bully comes out whenever he doesn't want to...take responsibility'. Laura was the scapegoat for her partner as, 'he blames the lifestyle I was leading on him starting [drugs]... He blames it on *me* that we lost the house'. Economic subordination by her partner was another tactic to maintain control over her. She explained, 'he's supposed to be giving me \$200 a week but he comes home with all these excuses why he won't do it and can't do it'.

Abuse was not confined to intimate partners but was also evident in the health care setting where these mothers were vulnerable and there was an imbalance of power. Reports of abuse were not widespread but victims were profoundly affected. Cath remembered when her baby was in NICU, how she was repeatedly interrogated by one nurse. Cath believed that those encounters were far, 'too intrusive, to the point of unprofessionalism.... [The nurse] was out of her depth because she wasn't aware of the damage she was doing'. Cath likened the experience to abuse.

One nurse was doing this full-on asking me these questions. It got to the point, it was obvious I was very uncomfortable talking to her, and getting asked, and I was crying, I was upset, I couldn't hold it back and, she was making me feel guilty, and she was saying, "sorry, I didn't mean to upset you". But she kept asking me the questions, more questions.... I felt abused...I actually felt...abused by that, because it wasn't her place.... [There] was a week of it...I was a mess actually, because, then when I went to sleep I was just full of guilt, I was full of, "Oh, my God", you know, um, just, just left with stuff...I couldn't process.

When comparing the mothers in this study to the domestic violence literature, the patterns of behaviour and incidence reported (64.5%) were similar. Fals-Stewart (2005) Johnson (1995) and Velez et al. (2006) reported that couples who misuse alcohol and illicit drugs are at greater risk of domestic violence than their non-drug-using counterparts. In US studies on pregnant women who use illicit drugs and are in treatment programs, rates of life-time abuse are high with 73% experiencing physical abuse, 71% emotional abuse, and 44.5% sexual abuse (Velez et al., 2006). However, as those studies only focussed on pregnant women engaged in treatment programs, the findings cannot be generalised to those who have not sought treatment.

#### **4.3.2 Being manipulated**

Manipulation was used by a range of persons to control the mothers in this study and included coercion, threat, deception, and lies and played on fear and their desire to be regarded with respect. Manipulation is a behaviour that is difficult to measure as it is subject to interpretation and evaluation by the manipulated. Within this study the mothers reported being manipulated and controlled in a variety of situations and the behaviour was prominent in bonded relationships.

The mothers and health professionals spoke of the power and control the mother's partners had over them and how it compromised their freedom. Candice let herself, 'be pushed around... [Partner] just made it so that I was dependant on him. If I wanted to go out...he'd do something to [the car] so I couldn't start it, or he'd take the keys'. Carol said, 'Matt just took control, so much of me and my life, just bossed me around'. Even in situations of domestic violence when their physical and emotional safety was at risk, manipulation was used as a control mechanism. One health professional commented:

What happens, in many situations, is the power play that the man exercises... "You stay with me or you lose the children". So, why do they keep going back to this man? You know, he plays that one with them and they believe it very firmly. He has such an authority over them that, I think, they put into him powers that he doesn't actually have, because he has such control over them. So, when he says, "I'll take the kids off you", they believe him. So, they stay because they don't want that to happen.

Even their drug use was controlled by others. With one of her intimate partners Candice 'wasn't allowed to say no to drugs. If he wanted a shot, then I had to have a shot'. She was afraid to defy her partner's demands because of retribution. Judith related how her partner manipulated her through their emotional connection. He would say, "If you love me you'd use".

In relation to drug use, manipulative experiences were not isolated cases but were endured by many of the mothers. If one was being coerced to use drugs at times and places that were not planned or coordinated to minimise harm, there was potential for a flow-on effect to other aspects of one's life, including to one's children. Being affected by drugs influenced how one cared for self, how one interacted with others, and how available these mothers were for their children. Carol explained:

I can go all day without even thinking about [drugs] and [partner] can walk in the door and straight away, just seeing him, I think about it. He was my supplier...and he...had the last say. So, it wasn't a choice for me, it was for him, whether he said, and if he wanted it we would have it and if he didn't, we wouldn't.

Disruption and emotional trauma were also caused through manipulation and had considerable financial, legal and psychological consequences for some of the mothers. Manipulation by a long term friend was intrusive and threatened Ruby's family stability. Ruby explained:

[My friend] is a very, very, very manipulative person...and sneaky, and he's extremely jealous...of my partner and me and extremely jealous of the fact that we have a little family.... He...put girl's underwear in my boyfriend's bag and things like that... [And] he'd say to my partner, "Oh, while you were at work Ruby came and had a shot at my house", and I never did.

For Kerry, living in an environment with the children's paternal grandparents she felt constantly under siege. Because of physical threats from her partner she had no alternative but to remain with the family if she wanted contact with her children.

I wasn't allowed to have no say in raising the other kids. When my first one was six weeks old I got pinned up against the wall by my ex and his mother walked out of the house with my little one... From then on I basically didn't get a say in where my kids were for the night...and I wasn't allowed to say nothing.

Kerry's situation was untenable and after four children and six years of torment, the paternal grandparents gained custody. However, the manipulation continued with unfounded accusations, threats, and efforts to undermine Kerry's credibility. She related:

He [father of her children] was willing to sign the kids over to his parents. His parents said I was the one who bashed them...and it put doubt in the judge's mind so they removed them from my care as well as his.... [Since then] I have been accused of assault, poisoning their rainwater tank, and of lighting a fire in their back yard... [but] I ended up winning all that in court.... They want to discredit me as much as possible.

Manipulation was not confined to intimate partners or significant others. Some mothers also felt manipulated by health professionals and spoke of interactions that left them feeling manipulated, confused, and angry. Carol felt enormous pressure to breastfeed her baby even when she was having difficulty and wished to cease.

I didn't like being pressured... I had to sign this piece of paper that said I would breastfeed. I thought that was a legal document... They really pressured me with that and I found it a really hard thing to do and it stressed me out.... Then about two weeks later I was in tears, and "I can't do it, I can't do it, I don't want to do it, I hate it".... And they said, "You don't have to". But I said, "Yeah I do, I signed this thing". Yeah, that was just manipulation.

Some health professionals seized the opportunity to use the threat of apprehension of the baby to elicit compliance. One health professional related such a story that could be viewed as manipulative despite the fact that it achieved an intact family unit. She explained:

The doctor was alarmed, and I was able to say to [the mother], "Look, you know, they are going to carry on, they are going to want you to be reported". And I said, "You need to do what people are asking you to do". [The mother] could see the looks, she actually knew that things would happen and she...knew she had to say yes to everything just to keep her child.

Incidents of manipulation described by the mothers in this study are comparable to patterns of behaviour others use to achieve a desired goal. Bowers (2003, p.325), in his work with personality disordered clients, described manipulation as: "actions

taken to achieve a desired goal (perverse or normal, symbolic or real) using deception, coercion and trickery, without regard for the interests or need of those used in this purpose". Whilst Bowers (2003) maintained that moral human beings do not violate implicit boundaries, based on moral obligation and respect for persons, without some feeling of remorse, there is no way of knowing, in this study, if the perpetrators were aware of their affront. However, the mothers were patently aware of their loss of freedom as a result of being manipulated.

### **4.3.3 Being overwhelmed**

The overwhelming nature of mothering was described by Carlene as a 'very long walk up hill'. For the mothers in this study, to be overwhelmed was to feel beaten, worn out, or swamped by what appeared to be an excessive and unrelenting amount of work in relation to the care of their children. The mothering role contributed to their *loss of freedom* due to the incessant responsibility. Being overwhelmed also resulted in inertia, distress, agitation, anger, and despair.

#### **4.3.3.1 Pure non-stop responsibility**

The demands of babies and other children and frustrations experienced by the mothers in this study were not unique. However, what was different was that these mothers entered the mothering role from a position of social and emotional disadvantage, they often lacked support; were constantly being judged; were being manipulated and abused; were battling illicit-drug-use and dependence; and their babies had been exposed to illicit drugs in utero. Despite these circumstances they accepted the mothering role and the responsibility of parenting, however, in reality the role often became overwhelming. Mothers felt trapped with limited respite. Susie said, 'mothering is non-stop. There is no knock off at 5 o'clock... When it's hard it's hard and you've got to keep going until it gets good again'. Cath's reflection was that, 'it's ongoing and it's hard and it's changing all the time'.

These mothers tended to take total responsibility for their babies which was partly due to either having no option, or through choice as a result of antecedents, where they did not trust others to provide adequate care for their children. Candice managed her six children on her own but at times felt overwhelmed. She said, 'I get no help. Yep, I'm all on my own. I do pretty much everything. I'm the disciplinarian, I'm the provider, I'm the mother, I'm the friend, I'm everything kind of thing'.

Being in a relationship or having an extended family did not guarantee support and time out from the responsibilities of mothering. Within relationships where the partner was supportive, caring, and participatory, the bulk of the nurturing still fell on the mother. Kerry explained, 'I would say 90% of Emma being raised has been left up to me'. Beth commented, 'I do the whole parenting role. I still take the whole responsibility... I get no actual extra support in taking care or looking after them or anything, or giving me a break even'.

Mothers with limited or no support or with partners who were obstructive found mothering very difficult. Judith had no support.

I just don't get anything done when Xavier's at home with me, it's impossible, I'll clean something, just as I'm cleaning it he's messing it up and I think "Oh, why do I bother". Yesterday I'd just been cleaning up one mess...then I turned around and he'd just knocked my drink all over the floor.

Others were expected to manage the house and care for the children in an environment where the obstructive behaviours from their partner created an even greater load. Laura explained:

I don't really get much help... My boyfriend goes through stages where...he helps a little bit...and then he won't do anything. Like, even if I want to go out I've got to arrange a babysitter, and he won't look after them for me to go up the shops and do food shopping.

Even when one had lost custody of a child to the father, the responsibility did not cease and with limited access it is even more difficult. Carlene lamented:

We expect ourselves to achieve...and parenting is another achievement and it is a constant level of achievement, it's very inconsistent, you cannot be the perfect parent at all times.... And I still can't, to this day, rely on [father of child] to secure our child's future. It's up to me. It's up to me to open those bank accounts and put that money in. It's up to me to open up those educational opportunities and the extra curricula activities. It's up to me to teach them everything they need to know.... So, I sometimes do feel the weight of the world on my shoulders.... I'm the one who treats the illnesses in the family, I treat the lice, I get the haircuts, I'm the one that looks after that side of it usually. Even now I am.

Stress from mothering was common. Beth and others complained, 'I would just like that day where you could just get the housework done without kids screaming or a kid crying all the time'. Anne also bemoaned her workload:

I think that the hardest part about being a Mum is finding time to do everything.... I'm always rushed off my feet.... Even when I put Cameron down for a sleep, he may be sleeping but I'll be cleaning... I'm always doing something and that's the hard part about being a Mum of two when you've got a baby.

At time, some mothers reported feeling uncertain about their ability to continue to provide care for their infant. With her first child, and in a relationship where physical and emotional abuse was frequent, Carlene struggled. She said, 'I didn't know from one day to the next whether I would even be able to...get out of bed, even though I knew I had to, I had to look after a child'. Now, with a second child, Carlene described the dread of the baby waking up in the morning, wondering how she would cope and what 'drug' she could 'take to make it better'.

I say to Jeremy, please don't wake up now, please don't wake up now...  
And I go through a period of worrying...I sort of sit there paralysed for about 15-20 minutes, worrying how I am going to get the energy.

Not only did these mothers have to deal with the routine challenges of a baby such as crying, feeding, and sleeping issues, but their babies had been exposed to illicit drugs in utero and were often irritable; had feeding difficulties; required medication; and they were required to take their infants for regular medical assessment, making the mothering experience far more complex. Kaye had a history of long term MMT and her babies had NAS. They were irritable and unsettled and were difficult to manage. She claimed, 'It's such a full on thing to have a baby that cries all the time and because mine always have, they have always cried for at least the first six months, all the time'. Many mothers also reported their babies having high pitched irritable cries and of excessive crying which was frustrating for mothers who found it difficult to console their babies.

Some babies experienced feeding issues as a result of NAS, intoxication, or neonatal exposure to psychoactive substances. Mothers reported their babies being excessively hungry; constantly sucking; or having difficulty sucking; and vomiting and regurgitation. These issues made feeding difficult, frustrating, and incessant. Laura commented on her son's withdrawal from buprenorphine:

I was on the Subutex every second day and I was only on...6 mg... The first day after the birth he was fine, but...towards the end of [the second day]...I couldn't get him off the breast, like, he was just crying to go on all the time and he was just sucking and sucking all the time. He was on the breast for, like, 2 hours.

Some mothers found it difficult to establish breastfeeding because their baby was unable to suck properly, and some babies needed to be tube fed initially. Lisa remarked, 'I was always breastfeeding her...cos that was the only other thing that would calm her down'. However, feeding problems were not only as a result of exposure to psychoactive substances. Cath's baby was found to have Pierre Robin Syndrome with a cleft soft palate. This anomaly was not detected for a number of days post-delivery and she experienced extreme feeding difficulties. Cath spoke of her distress.

But the breastfeeding side of it, I felt I had a hell of a lot of grief there, not being able to breastfeed. It was stressing me out and he's just screaming, so that's a whole new experience that a baby screams, they cry... I didn't know that he wasn't getting [anything], you know, we were still trying to put him on the boob and I was expressing.

Lisa spoke of her inability to get enough sleep because she needed to wake the baby due to it being on phenobarbitone for NAS. She recalled how she, 'had to get up during the night a lot...because Evelyn was on phenobarb.... I actually had to wake her up every three hours...to feed her; otherwise she...would just sleep straight through'. Others also commented on the sedating effects of the treatment for NAS and the need to wake the baby for feeding.

Mothers also experienced issues with their baby's sleeping patterns. Some were so tired from their baby's lack of sleep that they had difficulty coping with the baby, other children, and their other responsibilities. Laura reported:

Once Anthony came off the morphine he was a lot more alert. He wasn't really colicky or anything, he was just awake until 6 o'clock in the morning... I would not get any sleep, not even little naps; it just wasn't even worth me going to sleep.... I was just like a walking zombie.

Traditionally, a mother is seen as the primary nurturer (Bartell, 2004), the person who tends to the physical, emotional and material needs of a child (Brown, Small, &



Lumley, 1997). When parenting in environments where relationships are dysfunctional; where physical and emotional support is limited; where one is isolated and alone; where one is misusing psychoactive substances and/or is suffering from mental illness; and one's baby has been exposed to psychoactive substances in utero, the potential for being overwhelmed by the responsibility of parenting is increased. The signs exhibited by the babies and reported by the mothers in this study are consistent with that reported in the literature for NAS. NAS is characterised by central nervous system hyperirritability, gastrointestinal dysfunction, respiratory distress, and vague autonomic symptoms (American Academy of Pediatrics, 1998; Finnegan & Kaltenbach, 1992). These signs and symptoms usually commence within the first few days of life and can persist for as long as six to 12 months with acute and sub-acute episodes (D'Apollito & Hepworth, 2002; Kandall, 1999; Sharp et al., 2007b), making the task of mothering these children very stressful.

#### **4.3.4 Being dependent**

The mothers in this study were dependent or had a physical and psychological need for psychoactive substances and that need did not abate when they became mothers. Despite a rational desire and numerous attempts to cease using, all of the mothers in this study lacked the ability to stay 'clean' or maintain abstinence from drugs for extended periods. Kaye spoke of her lack of willpower and her inability to stop. She pleaded, 'It's not like I want to be like this. You feel guilty enough that you didn't have the willpower to kick yourself in the bum and get your act together. I'm...always... bashing myself verbally about how pathetic I am because I can't stop'. Judith commented, 'I couldn't get it together, I couldn't stop using'. This inability to 'get their act together' caused irritation and self directed anger yet not the ability to cease using. Others also spoke of their inability to cease, how hard it was to stop and how they wished they were not in that position.

Carlene spoke of being entrapped and explained that, 'It's a mind entrapment more than anything. It can be a bit of a body entrapment as well'. She rationalized her compulsion to use as a 'powerful force', and said, 'The only way for me to not use is to not want to use, to not feel the need to use and to feel free from that, to fill that void with something else'. Even Susie, whose drug-using experience was limited, found it impossible to resist. She explained, 'I wanted to try it, just out of interest...then, before I knew it, it just become a habit, a full blown habit and I didn't really understand how much of a hold it takes on your life'.

These mothers feared harming their baby but were unable to change their drug-using behaviour and experienced internal conflict. This internal conflict, identified by Griffiths (2005) as intrapsychic conflict was distressing. For these mothers, persistence to use caused distress and anxiety; yet, not using caused similar distress. Candice attempted to reduce her amphetamine use during her most recent pregnancy and related the outcomes:

I got to the stage where I got very angry with everyone, with myself mainly, because I was angry that I wanted to use but I didn't want to use. I wanted to use because of the housework, because it made me feel better, cos it stopped me from thinking, for all the reasons. But I didn't want to use because I wanted to try and help the pregnancy, kind of help him.... So, in the end I decided, OK.... I had to for my own mental state I suppose, so I allowed myself rather than trying to ride myself with, "No, you can't, No, you can't, No, you can't", I just let myself.

Even after long periods of abstinence the overwhelming desire to use resulted in relapse. This cycle of relapses and recovery is not unique to this group of women and has been reported by other authors, for example, Barnard and McKeganey (2004). Beth regretted her serial relapses and said, 'I'll go months without using and I'll think, "I'm going to get to that year of not using", and I don't.... I don't get there having interruptions'. Ruby was also a serial 'detoxer' who made multiple attempts to cease drug use but was unable to maintain a state of abstinence. She said, 'I've done many, many, many detoxes and many rehabs... It was the ninth time that I had done the naltrexone....and when I found I was pregnant I made sure I got the [naltrexone] implant'. At the time of interview Ruby was maintained on methadone.

Not only was Ruby's freedom compromised with her need to use drugs, it was also compromised with her attempts to detoxify as rehabilitation required residential care and rapid detoxification could not be done alone and required a support person to provide care. Ruby explained how her mother assisted and the 'hell' she endured to achieve her goal. 'Mum used to...take care of me after the detox.... She would...look after me for the couple of weeks.... [But] I did the work...I had put my body through hell'.

If the mothers did attempt to cease using or reduce their drug use they experienced a constellation of distressing physiological and psychological symptoms. Mothers

reported many occasions when they were withdrawing and spoke of the distress it caused. Vicki said when she is withdrawing from amphetamines, 'I get frustrated... [and] very angry and that is the way it makes you feel. Oh, you need...some more... It was the only thing that would make you feel better'. Similarly, Candice explained:

Coming down off amphetamines I used to go through the usual down, the typical down that everyone goes through....but to avoid coming down you just use again. And, that was a way for me to combat the downs so I didn't get angry with the kids, so I didn't get moody'.

When comparison was made between the experiences reported by the mothers in this study to dependence as defined by the World Health Organisation, these mothers were dependent. Dependence is characterised by clinically significant impairment or distress and includes elements such as: compulsion to use; inability to cease; distress and health risk from withdrawal symptoms; a preoccupation to use; neglect of personal responsibilities; and persistence to use the substance despite knowledge of the harms it can cause (World Health Organisation [WHO], 2007). Each of those elements impinged on the mothers' freedom as time and energy was dedicated to satisfying the need.

Some mothers were on maintenance treatment of methadone or buprenorphine. However, these treatment regimes also contributed to their loss of freedom as the restrictions on access to the medication is closely regulated and monitored (MCDS, 2004). Additionally, one's dependence on opiates is maintained not treated. Despite enormous benefits from maintenance treatment, mothers raised issues in relation to restrictions to their lives. The most significant challenges included the need to travel to a central clinic or community pharmacy to access their dose; difficulty attending the clinic to get their dose; exposing their children to drug issues; prolonged use and being entrapped; being debilitated; experiencing withdrawals, and having one's freedom of movement restricted.

Those on treatment generally felt that life, as a mother, revolved around getting their daily dose, not around their mothering work, with mothers on methadone being the worst affected. Intrusion on freedom from buprenorphine was less restrictive than the daily regime with methadone as buprenorphine was usually prescribed for alternate days. Kaye was on methadone and commented:

Well it's like an automatic thing now. I know that I'll have to get up, get dressed and go. It's my daily pattern.... Sometimes I just wish I could just

kick around in my [pyjamas] until midday with the kids and watch TV instead of having to get dressed and go. We have to go all the way into the city and I've got to have drinks and stuff for the kids.... On the school holidays they've got to come with me, and I have to drag them down there every day and back again.

A home visiting midwife commented on the inordinate amount of time accessing methadone took out of the mothers' day.

One mother I see...goes into XXXX or somewhere to pick up her methadone and by the time she drops her older children off at school, she'll get the train in and that, it does take nearly the whole day almost by the time... It's probably almost time to pick the kids up again at the other end. There is not really much time to do other things.

Mothers also felt trapped by the necessity to go out to access their daily dose and by the effect on their behaviour caused by the peaks and troughs in their methadone plasma level. Ruby said:

I mean, Isabella is 3 [years old] and she wants to sit there and watch cartoons. It's not her fault that she's taking no notice of what Mum is ranting and raving about.... I've got to do a million different things before I leave the house and feeling 'shit-house' at the same time. I don't like having to go and get this drink every day to make myself feel better.... I go to the chemist and it's quite a way from my house... I want to get off it because it stops us [family] from being able to go anywhere.... All I want to do is hurry up and go and get that and come home and be who I usually am.

Susie described it as annoying that they had to present to the chemist to get their dose and feared the possibility of being detected by others who knew them. Even for those who were permitted to have takeaways, the burden of accessing their dose impacted on their freedom, especially those without transport. Lisa explained:

I don't drive.... We're allowed three takeaways now...and we have those...on Rodney's work days.... Basically we just go in Thursday, Friday, Saturday and Sunday and then on Sunday we'll get three takeaways.... Rodney will just drive us up there... [But before that]...he did have to take us everyday.

Needing to attend a central clinic to receive a daily dose of methadone was very restrictive but this was further exacerbated if one was reliant on public transport. This often resulted in an inability to attend and therefore not receiving the regular prescribed dose which would lead to fluctuations in plasma levels, the risk of withdrawal symptoms, and the potential to use illicit opiates to relieve one's discomfort. Anne explained how it used to be:

We didn't have a car...so we had to catch buses. It was hard...having to catch a bus, especially on Sundays when transport is [limited].... It was hard with the baby as well, having to get that pram on and off the bus. Sometimes I could only go every second day.

The effort of going out with a baby, small child, and/or older children for any mother is arduous, time consuming, and stressful. For these mothers, when they are feeling unwell, often lacked transport, and expected to repeat the exercise daily and for extended periods, it was a source of frustration which severely impacted on their freedom. Being on maintenance treatment was generally not a short term solution. In fact, prolonged use and a feeling of being trapped in the cycle of use was the norm and contributed to a loss of freedom as their lives revolved around their maintenance treatment. Susie commented, 'I'm finding the methadone really hard to get off. But, I think it would be a lot harder if I wasn't a mother. That sort of makes you function even when you feel like you don't want to'. Kaye said, 'I've been on methadone for so long [12 years]...you are just so used to doing that, and it's just a continuous part of my day. But I still look forward to the day I'll get off methadone, but I'm terrified'. She also commented on feeling embalmed in methadone and again articulated her fear of ceasing. 'It's an oil and my body is saturated in it because of so many years of using it, so it's going to be hard to get off it'.

The mothers' frustrations and the 'hard work' involved in accessing their daily methadone was acknowledged and discussed by health professionals.

Like the issues that they face with transport, and how much methadone actually rules their lives... I mean, someone said to me the other day, "methadone is like liquid handcuffs", because every day they have to go and get their 'done... But you know, when it's 40 degrees outside, or it's raining, and they've still got to pick up their 'done and they may not have a car to get there. It's hard work, the practicalities with a new born baby and other children is huge, and it's every day. It's quite a commitment for these mums.

Although the intention of mothers in this study, when commencing a treatment program, was to scale down as quickly as possible and cease, maintenance of opiate dependence was common. Although most did reduce their dose it was extremely difficult to wean right off methadone. The physiological discomfort experienced when reducing methadone was a major issue. Susie commented:

I remember when we were on 60 mg and someone told me he was on 7 mg ... I said, "Why do you bother?" And he said, "Well, you wait and see". And sure enough, I'm on 12.75 mg and it's hard.... And it's not in your head because your body starts freaking if you don't have it.

Methadone and buprenorphine are both long acting opiates and are central nervous system depressants. Some outcomes of depressants on the central nervous system include decreased neurone activity, drowsiness, mood changes, and mental clouding (Petroulias, 2002). These are desired effects in some circumstances however, the mothers in this study found these effects to be debilitating and restricted their daily activities as a mother, thus contributing to their loss of freedom. Anne spoke of the reduced alertness caused by methadone, and said, 'the methadone knocked me right out. I was like a zombie.... I'd be fine during the day, but at night time, I'd be zonked'. Those effects resulted in difficulty providing care for the baby.

I didn't really go to the Child Health Nurse, and I didn't keep up with his appointments... [or] immunisations.... I used to get out of bed late.... [and] I wouldn't get up and feed him properly, stuff like that. [The methadone] made me really tired.

Similarly, Laura felt so debilitated and unable to cope with her three year old that she took amphetamines to counteract the effects of buprenorphine that was making her feel so fatigued. She remarked, 'In order to...take care of Robyn [3 year old] and keep up with her as well as all the other things that I needed to organise, I felt like I needed amphetamines to keep me going'. Others also said, 'I'm on a methadone program but I need speed to get up and get the kids off to school or to clean the house in the morning'.

Mothers described how maintenance treatment ruled their lives and inhibited their freedom. Due to restrictions on access to the prescribed medications they were not free to move about as they pleased, to exercise spontaneity, or to make choices

without consideration of their daily dose. This restriction was akin to a curfew which created frustration and a *loss of freedom*. They spoke of an inability to go on holiday, and of having to make specific and additional arrangements ‘if you want to go away’.

#### **4.4 Damaging myself and damaging my baby**

The consequences of using illicit drugs, as a mother, include risks to one’s health and to the health of one’s fetus during pregnancy, to one’s baby following birth, and to one’s children as they grow and develop. Most mothers were more concerned about the potential loss of health to their fetus/baby and children than to themselves. Despite awareness and efforts to modify their drug use, the risks to the health of the fetus/baby and children remained and caused considerable psychological distress for the mothers and negative physiological outcomes for the babies.

##### **4.4.1 Damaging myself**

The greatest threat in relation to health issues experienced by the mothers in this study was their fear of damaging their fetus/baby or children. However, they were also at risk of losing their own health as a result of their drug use. The major health issues discussed by mothers were depression; hepatitis C; and dying from an overdose.

###### **4.4.1.1 Having depression**

Data recorded in the medical records indicated that 13 (92%) of the mothers had current or previous diagnoses of depression. Health professionals providing care for these women also reported that, ‘most of the women have got some mental health issues, depression and anxiety usually, but some have bipolar disorders, personality disorders, you know, a huge number of psych problems’.

The diagnosis of depression is a role for qualified health professionals and patients must meet certain diagnostic criteria to achieve that diagnosis. There was no attempt to formally assess the mothers for depressive symptomatology at the time of interview. ‘Depression’ was also a term used by mothers to describe their perception of how they felt at certain times in their lives.

Many of the mothers commented on how common depression was amongst their drug-using peers. Beth and others commented, ‘you do go through [depression] with drug taking’; and, ‘I think everyone who uses drugs has gone through

depression in their lives, you do.... I wouldn't doubt that anyone who has had a drug addiction could say that they have never had a period...[of] depression'.

Despite the prevalence of depression, the fear of being diagnosed with a mental illness was a concern for many of the mothers. Although the responsibility of mothering and coping with life's stresses was overwhelming at times, being identified as having a mental illness was not acceptable. Beth commented:

When I was pregnant...they were concerned that I might have postnatal depression.... They told me I had a very high risk of being postnatal [having postnatal depression], and that scared me a bit... I was always afraid of depression, having to put you on medication and stuff. That to me was really fearful.... [Some days] I've noticed...I don't want to function like normal I just can't be bothered cleaning the house, and I can't be bothered...even when your kids come to get you.

Some mothers did not realise that depression was the cause of their distress, believed they were at fault for not coping, and questioned their own sanity. Kaye reflected:

I just got so depressed, even though I didn't realise at the time that it was postnatal depression that I was probably suffering.... I thought there was no way that that's what was wrong with me, and I just figured that I wasn't coping....I just thought I was going nuts. I was diagnosed with depression just before I fell pregnant with Aaron.

Others never sought help and struggled on. Anne recalled, 'I think I might have suffered a little bit [from depression] with my first baby because I was on my own, I was doing it hard'. Others described their tearfulness and sense of hopelessness. Carol lamented the loss of her spirit and said, 'Yes, I used to cry every day.... My life was so empty. I lost my spirit'.

The diagnosis of depression was more often as a result of a crisis where one was thrust into the health care system because it became obvious to significant others that there was something wrong; through routine assessment during antenatal care; or through suicidal attempts. Seeking help voluntarily was not the usual course of action. Kaye remembered:

When you are pregnant everything is going up and down. But I think when Pete came home from work and I hadn't cleaned any of the house, the kids



hadn't had their baths and I hadn't made dinner and I was crying on the lounge, he knew that there was something wrong... He's going, "right, something is definitely wrong", and all I would say is "I think I'm going insane".

For some, the diagnosis was first made in relation to childbearing, either antenatally or postnatally, whilst for others depression was a long term condition that was precipitated by major life events. Although the course of Candice's illness was probably more protracted than is recorded, her diagnosis of major depression was made during her fifth pregnancy, with the precipitating event being identified as the death of her four year old son seven years earlier. The medical records indicated that she was experiencing a 'delayed grief reaction', however, she was non-compliant with treatment. Although two subsequent diagnoses of major depressive illness with anxiety were made during successive pregnancies she remained non-compliant with treatment. At interview Candice explained how her depression was 'an ongoing thing' and how she lost the will to live towards the end of her last pregnancy, 'I was so depressed and stressed out and mentally tired, physically tired'. She did not feel suicidal but, 'was crying for no reason.... I was just mentally drained'.

At times, since they had become mothers, life stressors had become so overwhelming that some had attempted to end their own lives. Carlene experienced many periods of major depressive illness and had been on selective serotonin reuptake inhibitors for 12 years. However, she had also made numerous suicide attempts. She recalled, 'Six on purpose; really, really on purpose.... I haven't wanted to be alive a lot, since my early 20s'. Kerry also spoke of suicide.

Yeah, it was a lot of depression. Basically I thought my kids were better off if I was dead because I was a useless mother, I couldn't look after them.... I thought I was better off dead. I thought everyone else was better off with me dead. I just felt completely worthless.

Depression at any time in life negatively impacts on one's perception of self and on one's ability to perform routine tasks and maintain functional interpersonal relationships. When one is suffering from a depressive illness some of the symptoms experienced may include sadness; tearfulness; loss of interest or pleasure; loss of energy; loss of hope; anxiety; fear; feelings of being overwhelmed; insomnia; impaired thought processes; and at its extreme even suicidal ideations or

attempts (American Psychiatric Association, 1994). It has been reported that women with a previous history of depression are more vulnerable to childbearing related episodes of depression as well as further episodes of depression at other times in their lives (Cox & Holden, 1994; O'Hara, 1995; Pope, Watts, Evans, McDonald, & Henderson, 2000). Postnatal depression is a phenomenon experienced by 12 to 15% of all childbearing women (Pope et al., 2000), and this figure is likely to be grossly underestimated. One longitudinal randomised controlled trial of  $n=152$  mothers who use illicit drugs conducted in Western Australia estimated that at recruitment (>36 weeks gestation), 2 months, and 6 months postnatally the Edinburgh Postnatal Depression Scale (EPDS) at  $\geq 12$  to be 19.5%; 17.5%; and 21% respectively (Bartu et al., 2006). There is an increased co-morbidity of depression with substance use, dysfunctional relationships and histories of developmental adversity (Pope et al., 2000), which parallels the histories of mothers in this study.

#### **4.4.1.2 Being infected**

Seven (50%) of the mothers in this study were hepatitis C positive at the time of their first antenatal visit for their most recent pregnancy. This is consistent with the randomized controlled trial of  $n=152$  Western Australian mothers who use illicit drugs where 46% were hepatitis C positive (Bartu et al., 2006). As injecting drug-users these mothers appeared to accept their diagnosis as something that was inevitable, and this finding is supported in work done by Faye (2000) on people who have hepatitis C. Also, health professionals commented that, 'some of the women that know they are Hep C positive and have regular testing are quite comfortable, I think, with it'. At interview the mothers did not demonstrate distress, shame or fear of this blood borne virus. Carlene spoke of how she contracted the disease in such a matter-of-fact manner.

I found out that I had Hep C, somebody gave it to me. Somebody actually...stuck me with a needle, out of jealousy. Otherwise I may never have caught it. I can't say but I'd been using for nine years and never caught it, so that's a shame.

Whilst mothers did not articulate any distress regarding their own health in relation to hepatitis C, they were fearful for their children. Kaye spoke of the fear of her children contracting the disease through horizontal transmission at birth and of her relief that they had not become infected. She said, 'I would just cry all the time because I was scared the children would have Hep C...because I wasn't sure that

the antibody wasn't still active in my system - they are all OK but'. Carlene discussed fear of transmission of hepatitis C through her 'contaminated breast milk'. Health professionals also reported that the mothers had, 'concerns about whether they should breastfeed or not and some of the women come to the clinic having already made their decision that they definitely wouldn't breastfeed because they were Hep C positive'.

At times the diagnosis of hepatitis C was made during routine antenatal blood work and the clinic midwives were 'landed with having to give them the result'. Health professionals reported that:

We have to tell people that they are Hep C positive and that has been really difficult for the women. Difficult in that it is a shock, I think for most of them, when they have been intravenous users, I imagine it must be at the back of their mind anyway. But when the hard result is presented to them, then they obviously, it's something they didn't want to hear. It also means that they have to make changes that they are going to have to include in their own lifestyle to actually cope with living with Hep C.

For mothers, living with hepatitis C has ongoing health issues that impact on their wellbeing and on their ability to cope with the day-to-day challenges they are faced with. Health professionals reported that:

The girls in the home visiting intervention often found that they've had ongoing problems with Hep C. So they might, in fact, be feeling really tired over and above what would be acceptable in the postpartum period, that they've got abdominal discomfort, they are anorexic or not anorexic but their appetite is suppressed and then it's been worthwhile for us to say, "well, you probably need to go and have your LFTs done, you need to, perhaps, get your GP to refer you onto a hepatology clinic".

#### **4.4.1.3 Dying from a 'hot shot'**

Mothers also articulated how their illicit-drug-use put them at risk of intoxication, overdose and death, which in turn put the baby at risk of neglect and possible death. The realisation of these threats helped put the responsibility of mothering into perspective. Judith recalled:

One night I used and it was probably too much for me...like, I was very stoned from [heroin] and it scared me a little bit. I thought, "Oh God", you know, I can't do this because, yeah, I can't afford to, like, "think it

through"... I can't overdose because I've got this little baby, you know...not worth the risk. You could be in your house, you could overdose and no-one would come around for days... Xavier wouldn't eat for days.

Mothers were also aware that the quality of the substances one is inhaling, ingesting or injecting is unregulated and has the potential to contain mixers or fillers which, in addition to the drug, could have a deleterious effect. They were cognisant of the high degree of gamble in accepting substances from unregulated sources when the strength and additives can vary from batch to batch. Vicki commented:

A lot of the amphetamine was not good quality, so, it's not making you do the same thing. Suddenly you think, "Oh, I'm feeling a bit sick".... Or you think that when you take it, "Oh, I'm going to feel good soon", and it would be alright, but there was a lot of times when you weren't.

Similarly, due to the variability of the substances Candice had access to she spoke of her fear of having a 'hot shot' and the possibility of losing her life as a result. She said her fear was, 'having a "hot shot" and dying and my kids having to walk in and see that.... I don't think that's something that the children should be exposed to. Also, the children being separated afterwards is a fear too'.

#### **4.4.2 Damaging my baby**

Whilst risk to the mothers' health was a real phenomenon the mothers were more concerned about *damaging their baby*. The issues of greatest concern were exposing my baby to drugs in the womb; it's all my fault; hurting my baby; abusing the kids; and screwing with the kid's heads.

##### **4.4.2.1 Exposing my baby to drugs in the womb**

The mothers knew that there was risk of damaging their baby because of their illicit-drug-use. Most did not have their pregnancies confirmed early so that when they eventually knew they were pregnant they were fearful that the fetus could have already been affected by their drug use. Carol did not have her pregnancy confirmed until she was at 28 weeks gestation, had used regularly to that point and was very fearful of the consequences of her use. Cath commented that she did not know until, 'eight weeks, so damage could have been done'. That fear and guilt was universally felt by all of the mothers. Kaye articulated their common fear when she said, 'I was so scared that my babies were going to have something wrong with them because of what I'd done to my body'.

Whether using street drugs or on maintenance treatment there were real risks to the wellbeing of the fetus/baby which caused concern for the mothers. Additionally, risks were reinforced by health professionals who contributed to the mothers' psychological distress. Anne's fear was reinforced by a health professional who said, "Wouldn't you rather be on methadone than still using, and he come out deformed or anything". This comment was unhelpful to Anne's decision making process as she was aware that the baby could still be affected and said, 'But there is no guarantee that he was going to be OK coming out on methadone, there's no guarantee'. Mothers made choices in relation to their use but some mothers did not commence treatment programs until their pregnancies were quite advanced and this was discussed by health professionals. They suggested that this was due to using mothers often not having their pregnancy confirmed until late or because 'they want to try and do it by themselves to start off with, but they find that it's just too hard. [Eventually]...they say, "OK, I'm prepared to go into a treatment program now".

However, despite making the decision to continue with their drugs of choice, to commence methadone, or remain on methadone or buprenorphine during the pregnancy, the fear of *damaging my baby* remained. Many mothers felt 'guilt associated with having a baby and being on methadone' and were worried about the effects on the baby. Their previous obstetric history had considerable influence on how they felt in relation to continuing drug use during pregnancy. Candice had previously had a child with cerebral palsy and was very fearful about the potential for a similar outcome and this created a dilemma for her. She said, 'Up until the last stages of pregnancy, the more worried and stressed out I got about the placenta...the more I used, which was a bit ironic...[and] the closer it came to the end of pregnancy the more I'd worry'.

These mothers were aware of potential risks to their baby from various drugs. Many had also experienced or had heard of neonatal abstinence syndrome and wanted to 'avoid that at all cost'. Health professionals also discussed the concern that mothers had expressed regarding potential risks to their baby. Midwives observed: 'The fears that they have is that they have harmed their baby.... I think their guilt is huge. I think that is with all of them really, and that's a burden to carry'; and 'they are genuinely worried about the baby'.

#### **4.4.2.2 *It's all my fault***

For any mother the thought of having a baby that has a congenital abnormality is a frightening phenomenon. One does not know how they will react to such news or how they will manage the child. Some mothers had babies who had congenital abnormalities and each felt that they had caused the condition despite being reassured that the condition and their drug use were not related. Cath's son was born with Pierre Robin Syndrome. She recalled, 'I just thought that it was all my fault, I mean, I was preparing myself for a Down's Syndrome, just because of my age [37]. I was preparing myself for something to go wrong...because I used throughout my pregnancy'. Then, due to an undiagnosed cleft soft palate she experienced substantial feeding problems and again believed she was at fault.

I felt that I was doing something wrong... He wasn't picked up with the cleft straight away....it just added to my guilt. Oh, it's my fault, that he has this problem, it's my fault that...I can't breastfeed...that whole experience was pretty scary and I felt really guilty.

When the cleft palate was diagnosed staff pressured Cath to breastfeed but she was not sure of the implications of the diagnosis. She recalled, 'I didn't really know what that all meant....all I thought was, my usage has caused a problem and, I've failed, and I'm a 'bad mother'.

One of Kerry's babies had a kidney disorder which required surgery to remove the dysfunctional kidney. That incident made her more aware of the possibility of complications and influenced her drug use and choice of hospital in subsequent pregnancies. Kerry related:

Alex was born with two kidneys but one stopped working half way through the pregnancy. By the time he was two months old he had his kidney taken out. I don't know whether it was from the drug use or just a freak thing. The doctor seems to think it was a freak thing, but it's still in the back of my mind.

Other complications distressed mothers who did not feel that they had the ability to cope with the vulnerability of the baby. Some reported their babies being fractious; having a hernia; being preterm; having a heart murmur, however, regardless of the diagnosis mothers experienced extreme guilt and believed they had caused harm to the baby. Susie and her partner were mortified when, at ultrasound examination at 32 weeks gestation, they were informed that their baby had hydrocephalus. Her

partner recalled, 'That was a stressful time too with the fluid on her brain.... Susie rang me up in hysterics, and straight away I thought it had to do with methadone'. Fortunately, examination of the baby post delivery revealed no sign of hydrocephalus, however, the stress and guilt induced by the threat of such a condition was traumatic.

As well as physical anomalies, learning and behavioural disorders were discussed by some mothers. Four of Kerry's children were struggling intellectually. She related, 'basically my other two girls have got learning difficulties and it looks like the boys have got learning difficulties too'. The belief that exposure to illicit drugs in utero may have contributed to delays in their children's development was an issue. When this belief was reinforced by medical staff it acted as assurance that it was 'their fault', thus contributed to their distress and guilt. Kaye recalled:

I have been told by a doctor...that...babies...born on methadone and who have been put on phenobarb[itone], that they seem to have a lot of attention deficit disorders or short attention spans. I have had both problems with these two girls.... The doctor said...that that seems to be a thing that they are finding.

Candice blamed exposure to amphetamines as the reason her children were having problems. She pondered:

Amphetamines must affect them somewhere, the children afterwards. Like, the children have needed speech therapy. But Danielle was the one that I used most throughout, and I drunk as well... They say that Danielle is intellectually disabled but I can't see it. She is delayed in her speech, which I put down to drugs, and also because of dramas that happened to her in her early childhood.

Concurrently, mothers were distressed by the fact that they may have 'damaged their baby', but at the same time the burden of care was increased as a result of the health issues, thus adding to their mothering responsibilities.

#### **4.4.2.3 Hurting my baby**

Whilst mothers were cognisant of the possibility of their baby experiencing NAS following the sudden cessation of psychoactive drugs after the birth, they were often surprised by the painful emotions the realisation that they had caused harm to their baby, elicited in them. The majority of mothers whose main problem drug was

heroin were maintained on methadone. However, some mothers were on buprenorphine for their heroin addiction and some mothers were using amphetamines. For those on maintenance treatment programs, the potential for NAS was increased because methadone and buprenorphine are long acting opiates. Of the 13 index babies 10 (77%) exhibited signs of NAS and mothers had experienced NAS with previous babies. All of the mothers, whose babies had had NAS, were distressed because they had caused their baby to suffer. These mothers were knowledgeable about withdrawal per se and how it made them feel so could empathise with their baby when they could see the signs of withdrawal.

Ruby spoke of when her son started to withdraw from methadone and related it to her dose times.

He didn't start getting withdrawals until way over 24 hours after my last methadone intake.... Usually by the time it gets to 24 hours, you pretty much need your next dose. So, he had [the birth] to contend with and he went all the way through another [day]... He went a very, very, very long time before he started getting sick.... I feel so guilty about him being born and having to deal with withdrawals, cos I wouldn't wish them on anybody and here I am making my son go through it. I feel like the worst mother on this earth, I feel so guilty.

Kaye was on long term MMT and recalled the distress she felt when her daughter had NAS. She said, 'I remember Imogen withdrawing, I remember almost throwing her at Pete when he would come home from work, and "just get her away from me", because I couldn't stop her crying'. Similarly, Beth, with her first baby, was on methadone and using heroin concurrently and vividly remembered the experience. She said:

Claire was on phenobarb, because of the methadone...more than the heroin... But I felt the methadone did affect her a lot more than I was expecting. I was very unprepared cos I was told, all the time through the pregnancy, "Oh, you are doing really well, not using".

These comments were similar to those reported by Klee in the UK. In relation to one mother's unpreparedness for NAS, she wrote, 'I was really shocked when he had to start on the morphine because I wasn't expecting it at all. I was surprised because the clinic and the hospital said he would be OK on only 20 ml a day' (Klee, 2002a, p.134).



The guilt associated with a baby having NAS was articulated by all of the mothers whose babies had withdrawn. Common sentiment was:

If I hadn't had a heroin addiction I wouldn't have given [him]/her withdrawals, which means [he]/she wouldn't have had all that pain and stuff....and 24 hours of screaming. I mean, even that must be distressing for a baby, even a newborn baby, just to scream for 24 hours...and of course it affected [his]/her feeding.... I felt guilty because I had hurt [him]/her.

For some mothers, signs of withdrawal were not always evident until after their baby was discharged from hospital. With her first baby Anne recalled, 'After I went home from hospital, he had little shakes...it wasn't all the time but three or four times a day, full on shakes for about 2 or 3 minutes'. With her second child, 'he didn't really start withdrawing until I got home [either]'. She explained how, 'he was...grumpy for the first couple of days and a little jittery'.

The experience of a baby withdrawing from buprenorphine was also difficult, causing distress, feeding problems, a need for medication, and prolonging the baby's hospital stay. Laura reflected on buprenorphine withdrawal.

He had mild withdrawals, so he was in [hospital] for about two or three weeks after [I went home]... After the birth, he was fine, but I wasn't due my next dose until the day after that... He was very distressed.... Then the nurse...explained, "It's a mild withdrawal".... Yeah, he came home on Morphine [and was on it for] about seven weeks.

However, the problems did not cease there. Laura explained how the medication had made him sleepy and when he ceased that he was very alert and wakeful. At four months of age the baby's hyperirritability and sleeplessness reverted to normal sleeping patterns which probably indicated that his NAS was much more protracted than originally believed and he would have benefited from further therapeutic management.

Carlene also described her baby's acute withdrawal from buprenorphine as being 'very severe' and how the baby 'screamed and screamed and screamed' and required morphine to relieve his symptoms. He remained on morphine for 10

weeks. Her first child had withdrawn from methadone but she believed the withdrawals from buprenorphine with her second child were much more severe.

Amphetamine users were not exempt from the fear of their baby being affected by their use. Babies born to mothers who use amphetamine do not experience withdrawal symptoms but symptoms of intoxication. Whilst there is less known about the onset, course and duration of the effects of amphetamines in neonates than there is from opiates; what is known is that these babies also exhibit signs of central nervous system hyperirritability, gastro-intestinal dysfunction, respiratory distress and autonomic hyperfunction (Sharp et al., 2007a).

Health professionals and authors, in the substantive area, commented on the unpredictability of NAS and on the guilt felt by mothers in relation to NAS. One health professional commented, 'some of them are very guilt ridden and very upset over any slight little problem that they think they might have caused the babies, especially NAS'. Another went on to say:

The mums that deliver after 36 weeks, those babies, in fact, may be at higher risk of developing withdrawals as opposed to babies before 36 weeks. Not many babies before 36 weeks actually have withdrawals. So there are differences in the outcome of babies depending on when they are delivered. The other interesting thing that comes up all the time with the girls is predicting which bubs are going to have NAS, and as you know, we can't. And the fact that, and it is a mystery, that you can have somebody on 100 mg of methadone and their baby sails through, and you can have someone on 20 mg or 10 mg and the baby has NAS. It isn't all that they are using on top of their methadone, you know what I mean. I would love someone to solve that, because I know the girls really struggle with it. And [during pregnancy] they will be starting to withdraw, the "dones" not holding them and they won't put their dose up because of the baby. And I say to them, "look, 2.5 mg, 5 mg is not going to make any difference at all". Yeah, it is interesting.

Murphy and Rosenbaum (1999, p.6) also said that, 'Women reported feeling responsible for the baby's withdrawal, although there was no way of predicting severity of withdrawal or even whether or not it would occur'. Klee (2002a, p.133) made similar comments when she wrote, 'The unpredictability of the effects of drugs used by the mother during pregnancy is well known and there is no straightforward

association between reported illicit drug use or methadone dose and the baby's health'. In addition she commented in relation to NAS, 'It is also observed that reassurance may be needed for mothers in order to alleviate the guilt that the majority of them experience' (Klee, 2002a, p.134).

#### **4.4.2.4 Risk of abusing the kids**

Some mothers found themselves in situations where abuse and harm to their children was possible. Whilst physical abuse to the mothers was reported often, the potential for a violent partner to harm a child was ever present, especially if he was withdrawing from opiates or 'coming down off speed'. Kerry explained that her partner 'bashed the kids'; whilst Carlene described how she had broken free from her husband because of the recurring pattern of 'physical abuse on both of us'. Ruby's ex-partner was violent throughout her first pregnancy and his ongoing violence continued to threaten Ruby and the baby following the birth.

The day I was sent home from hospital...when Isabella was three days old, I was holding her [in my arms] and he, just out of nowhere, turned around and went, whack and elbowed me in the stomach.... And there was many, many, many times when I had her in my arms whilst he was beating me.

There was also potential for harm to the babies due to frustration, irritability, and anger by the mother from withdrawals, intoxication, or from 'coming down off speed'. These risks were also reported by Klee and colleagues (2002) in the UK. Ruby related that she became frustrated when she was withdrawing and was awaiting her next dose of methadone. This frustration put the child at risk of physical harm.

Everyday I'm sick for probably about 2½ hours...which isn't long at all but it's enough, if I was so inclined, to become abusive towards my daughter.... I do get frustrated with her and very impatient and I lose my temper...quickly.

Beth was a survivor of childhood sexual abuse and was aware of the potential for the perpetuation of this cycle within her family. She commented, 'So, I don't want my children to be subjected to [sexual abuse]'. Similarly, Candice expressed her greatest fear as being, 'one of my children being molested'.

[Molestation] is a fear of mine because in this lower level of humanity, I suppose, it's a lot more predominant.... That's another part of the reason I haven't had a man in my life or won't let a man move in with me... I don't believe you ever know a person well enough to know whether, yes, they

will do it, or no, they won't, 100%. And, just in case...I don't want to put temptation in temptation's way.

The potential loss of health through neglect to a child from inappropriate or irresponsible caregivers was also a source of real concern for some mothers. Even the child's father was considered a risk to the child's wellbeing. When Anne was incarcerated she was frantic about her baby's safety. She recalled, 'Sean [baby] ended up staying with my partner...which wasn't a good time for me, because at the time Kevin was using, stealing and whatever, and I knew the baby wasn't being taken care of'.

#### ***4.4.2.5 Screwing with the kids heads***

The long term psychological effect on children caused by living in dysfunctional families where drug use is occurring is a little known entity. Even in their own home the children were at risk of exposure to: drug paraphernalia; observation of drug preparation and use; alteration of the mood of adults in the household; the effects of withdrawal; and other users, dealers, and the sub-culture. Drug use impacted on the availability of money for purchasing essentials for a family such as food, clothing, and accommodation which could potentially affect their physical and psychological health. Those risks sat poignantly on the mothers and they were fearful of being 'bad mother'. They also knew that children are observant and miss very little of what happens within a family.

For Kerry, the threat of psychological damage to her children and her powerlessness to intervene had substantial emotional impact. She had lost custody of four of her children and related numerous incidents where she was constantly being undermined by the children's guardian. The psychological manipulation of the children, over which Kerry had no control, was distressing.

I know they are physically getting looked after, but emotionally they are screwing with the kids heads.... They are not allowed to call me Mum... They are not allowed to hug me; they are not allowed to give me a kiss. When they do arts and crafts they are not allowed to make me anything.... Every gift I give them gets taken off the kids.

Additionally, the harm caused by witnessing physical violence directed at one's mother, hearing verbal abuse, and taking on responsibilities which are beyond a

child's experience and ability also has the potential to affect a child's psychological wellbeing. Carlene related an example of her son parenting her:

My child [aged 9] has had to parent me many times, with a mental illness that I can't explain to him yet. He is still too young for him to understand. He can just see what he sees and, plus the fact that his parents fought a lot. He has blocked out a lot... He will never forget the fighting.

Damaging themselves and damaging their babies as a result of using illicit drugs resulted in loss of health for these mothers and their children. However, the mothers were more concerned about the baby's health than their own and experienced shame and guilt in relation to what they had done or were doing which resulted in harm to their babies/children. Depression, hepatitis C, and the risk of dying from drug use were the issues raised in relation to their own health. For the babies, exposure to drugs in utero and the resultant risk of NAS, birth defects, and learning difficulties were the major issues for which mothers took the blame. Additionally, mothers were concerned about the risk of physical and psychological harm to their children but often felt powerless to avoid such harm.

#### **4.5 Losing my baby or having my baby taken off me**

For the mothers in this study, the threat of losing their baby was real. Loss of child occurred in various forms and included 9 (15%) first trimester spontaneous abortions; 13 (21%) terminations of pregnancy; as well as shared custody (2); apprehension (4); abduction (1); death in utero (1); and death of a child (1). The loss of a child for any mother has emotional consequences with psychological sequelae. The psychological impact of loss of a pregnancy through spontaneous abortion or elective termination is not well researched however, it has been reported that women experience depression (Price, 2008), grief (McCreight, 2008), anxiety, guilt, disappointment, regret, anger, feelings of loss (Frost, Bradley, Levitas, Smith, & Garcia, 2007; Harris, 2004), and increased substance abuse (Reardon & Ney, 2000). Other loss events in this study were referred to by the mothers as: the baby being taken off me; family taking the baby; and your baby is dead.

##### **4.5.1 The baby being taken off me**

The fear of having their babies 'taken off' them because they could be classified as being unfit to be a mother was a harsh reality for mothers who use illicit drugs. This threat demanded that they comply with the expectations of society, health

professionals, and child protection authorities to be allowed to 'keep' their child.

Beth explained her perspective:

If you are worried about things like the baby being taken off you, cos you haven't got a house to stay in, that's a big thing.... It's best that you don't use, but you can moderate your use a bit and get yourself a house... instead of being fearful of having the baby taken off you before it's even born.

Kaye expected her baby to be removed from her care and described her feelings in relation to being allowed to keep her baby when she was aware of other mothers who used illicit drugs who had had their babies taken off them. She said:

I was still an idiot kid trying to get my life together when I fell pregnant...[and] I didn't think I was fit to be a mother.... I knew a girl; she had her baby taken off her... We fell pregnant at the same time, she continued to use and I...went up in my methadone instead. [But]...I didn't want to take Imogen home cos I didn't think I deserved; I couldn't believe that I'm supposed to take this small thing home... It's like, "You're going to let me take this home?" Do they trust me with this baby?

For some mothers, fear of losing the baby acted as motivation to not put their child at risk. Judith explained how she felt when she attempted to find drugs when her baby was very small.

It felt like I was being a bad mum...putting him in a really dangerous situation. You don't think, but if you are going somewhere to buy drugs...you could be walking into the middle of, like a police operation ...and you could get caught and then, bang, you've gone, and they would take him away from you.... It's not worth the risk.

Kerry experienced the pain of apprehension and remembered her anguish. She recalled, 'When I had...baby number three...DCD came; he was less than 12 hours old and they came and said, "Oh, we are taking the baby off you". She proceeded to say, 'How would they know what a mother is going through if they come within 12 hours saying they are taking the kid off her'.

Health professionals related many incidents of apprehension and all of them were traumatic for the mothers and staff. They told that 'some mothers have such high, such high levels of fear around involvement by DCD' and that 'they have often got

DCD and people on their backs'. It was explained that, 'DCD makes the decisions about the child; all I do is refer concerns to them. I don't make the decision to remove the child, but I will let the mother know that, "The Department is concerned about your baby". When apprehensions did occur health professionals said:

We do work with DCD in a measured way. We always try to do apprehensions either in my office or away from the hospital, but in this office not on the wards disturbing everybody. We try to support the mother...so that the baby is the Department's role and we support the mother, as best we can.

Health professionals also spoke about the 'power games', police involvement, the mothers' distress, and the loss of mother identity.

It's a power game that goes on, whether it's the State or the male partner or the parents or whatever. But there is some power game going on here and [the mother] has lost out. Now the reason that is usually given to her [for them taking the baby] is drug and alcohol. They say, "Because you are a drunk or because you are an addict, you can't..."

Some women, who had not had antenatal care through the ACDC and were living chaotic lifestyles where aggression and anger were commonplace, were deemed unfit to keep their baby and they ended up in apprehension. A typical scenario was explained.

Mothers that come through the clinic are easy; it's the ones that come kicking and screaming into delivery suite [with no antenatal care] who are telling everyone where to go, with a partner who is equally as obnoxious and perhaps violent. And then the police come and the baby gets dragged off the mother and the police walk out with the baby and it's just awful. It's just terrible.

These mothers were pretty well assessed by health professionals and DCD prior to discharge, and whilst most of the babies that went home with their mothers remained in their care, it did not rule out apprehension at a later time if situations changed or the authorities deemed the baby to be at risk. One home visiting midwife commented:

I think only one I've known that was actually taken away after they had gone home, because it was one where DCD were very involved and mum

had contracted to have somebody staying with her and then it had all fallen apart when we came in and baby got taken into care.

Other mothers realized that they were not in a position to provide appropriate care for their baby at that time but had difficulty relinquishing their baby to the authorities.

The following story, related by a health professional, exemplifies that situation:

And she was quite chaotic really and that went into an apprehension. It was quite difficult as well. She sort of talked about having the baby placed for adoption, so she sort of knew she couldn't actually care for the baby. But when it came to actually parting from the baby, that was quite difficult and it meant, I think she needed an authority to say, "The baby's not going to go with you", cos she just couldn't make that decision herself... she just couldn't do it, couldn't let go. She was devastated...but to relinquish that baby was still very difficult.

And to relinquish a baby either involuntarily or voluntarily had a significant impact on who they were, and how they responded. One health professional summed it up:

The loss of a child is a significant impetus to drug using and alcohol misuse. That is yet another shameful event in their lives of shame. Because, I think, socially, no matter what we do, socially it is still a mother's responsibility to bring up a child and it is important as part of a woman's identity to be a "good mother". And, for a mother to have lost her child [as a result of] her own actions with drugs and alcohol, that is a huge source of shame. You lose a big part of your identity...they go through tremendous shame and grief, which they hide through their further use.

However it happened and for whatever reason, the apprehension of a baby was traumatic for mothers. Many were fearful of apprehension of their baby and all were aware of other mothers who had lost babies to the authorities and some had experienced the loss themselves. When a mother loses her baby she also loses her identity as mother which impacts on self-esteem, respect for self, health, and often the response is to alter one's reality by escalating drug use to ease the pain of loss. These findings are not unique and observations of loss of child have been made repeatedly in the literature on mothers who use illicit drugs (see for example: Hardesty & Black, 1999; Kearney et al., 1994; Murphy & Rosenbaum, 1999; Pursley-Crotteau & Stern, 1996; Richter & Bammer, 2000; Roberts, 1999; Rosenbaum, 1979).



#### **4.5.2 Family taking the baby**

Not only was loss of the baby to DCD a major threat, some mothers were threatened by a loss of their baby to family members. This loss came about either because they felt they were unable to care for their baby; because other family members believed they could provide a better environment for the child; of a breakdown in the relationship with the baby's father; because custody was officially given to another family member; or because of abduction. Vicki, when she was pregnant with her first child believed she was unfit to be a mother and, despite attempting to make suitable arrangements for her child, 'got lost in it all' and other family members dominated the decision making. The loss of her child 'was really hard', although she regained custody when the child was 18 months old.

For Carol, the shared custody of her child was a personal arrangement between her and her ex-partner. However, the burden of sharing custody was stressful and expensive and she was anxious about her ex-partner's ability to provide suitable care. Threat of losing the baby was often incentive to avoid such an outcome. Ruby perceived that she was neglected by her own mother and thus vehemently defended her right to raise her own child and took steps to realise that. She related how, 'I overheard [my mother] talking, I heard her say, "If I find out that Ruby is using I'm going to take her child from her". And I thought, no, there is no way I want my child to be brought up by my mother, cos my mother is not a Mum, you know'.

The loss of children, in some cases, occurred against a backdrop of abuse, manipulation, and lies, and remained a source of emotional pain and grief. The grandmother of Kerry's children gained custody through the legal system and because Kerry had no money and was psychologically distressed by incidents leading up to the apprehension, she was unable to demonstrate her ability to provide suitable care. Others also went through the court system. Candice's experience included the abduction of a child by an estranged father and her protracted and expensive battle, through the Family Law Court, to regain custody. The circumstances leading to this outcome included a dysfunctional relationship; broken promises; the pain of desertion by her partner and his overt sexual liaison; and a violent retaliation by Candice. She related her story:

He didn't uphold any of the promises he had previously made and I lost it. I wrote off his car, wrote off his moll's car, and accidentally smashed up his mother's car...and they took Danielle, when I was going mental.

Carlene also lost her first child to her estranged husband. She said, 'it's not a custody issue more than it's just the fact that I haven't fought for him, well, I haven't been able to'. This did not diminish the loss of her child and she was tearful and distressed whilst relating the story. Carlene felt overwhelmed trying to get more permanent access to her child. She explained:

I'd do anything just to get my child for three consecutive days a week...that's all that mattered.... But trying to get legal aide, trying to do the custody things, trying to get the police reports, going through Freedom of Information, and all those hassles, I just couldn't, I couldn't keep up with it. I couldn't answer things in time or if I did things would get lost in the post. They asked me all these questions, why, why, why.

Carlene felt that she had reached an impasse and was frustrated by a system she considered unsupportive. She explained:

Financially I can't [pursue custody] because legal aide won't give me any more money. At first they thought my case wasn't complex enough. They thought it would be easily solved through mediation. They didn't realise that the abuse just keeps going on and on and on, even though...it's at a distance, and I am protected by someone else now... But we can't stop [ex-husband] manipulating me, it's full on manipulation.

Others voluntarily transferred the care of their children to a family member. In this way they had more input into the decision making, felt that they were in some control and were fulfilling their mothering responsibility as best they could. It is reported that voluntary loss of a child carries less guilt, is less permanent, and their mother identity and self-esteem remain more intact, yet they still grieve their loss (Hardesty & Black, 1999; Kearney et al., 1994; Richter & Bammer, 2000). A voluntary placement of children was related by a health professional.

When she was leaving the clinic and she was going to put herself into the police, because there was a bench warrant out for her. She would have been put straight into Bandyup [Women's Prison]. Her children, she had taken them around to relatives to look after them.... The reason was for non payment of fines and she owed \$8000... And, you know, the family breakdown of her having to do that, of having to be in prison whilst she was pregnant, you know, I just thought it was terribly sad.

### **4.5.3 Your baby is dead**

The ultimate loss of child is through death. Two mothers in this study experienced the pain of death of a child and their grief remains profound and protracted. Ruby's experience was a fetal death in utero of a normally developed boy at 37 weeks gestation. She had 'done everything right', had regularly attended antenatal care and was on MMT. Ruby had noticed that her baby was not moving as it usually did and she and her partner went to the hospital for assessment. Although she did receive the appropriate assessment she explained that there was a, 'breakdown in communication' and was discharged home but, she said she knew her baby was 'not moving as much as normal'. Two days later, 'I woke up to labour pains' and returned to the hospital. 'They put the monitor on me and tried to find his heart beat, but they couldn't find it', she explained. This was followed by the blunt disclosure by a senior obstetrician, who said, "Your baby is dead. There is no heart beat. It is not alive". Similarly, McCreight (2008) reported this tendency by medical personnel for unsympathetic, abrupt, and heartlessly blunt disclosure of bad news in the area of perinatal loss.

Ruby proceeded to say, 'That just blew us, it completely blew us because we were there to have our baby and we'd been told [two days earlier] that he was perfectly healthy, and I had heard his heart beat'. She recalled her anger at what happened to her and her baby and the difficulty she and her partner encountered in trying to find answers. McCreight (2008) also observed the difficulty grieving families had trying to find answers. Subsequently, the death of Ruby's baby profoundly affected her wellbeing, her relationship, and how she managed her next pregnancy. She said, 'My partner and I didn't think we would be able to get through Ross. We did get through Ross. It amazed us as we didn't think we would be able to get through another stillborn, you know'. Their grief was protracted and Ruby's recovery was complicated with dependence on her partner, enmeshment with her first child, depression, anxiety, panic attacks and agoraphobia.

When Candice was pregnant with her second child she was not using illicit drugs. The pregnancy was complicated with an abruptio placentae, she had an emergency caesarean section and the baby was resuscitated but experienced severe hypoxia which resulted in cerebral palsy. Candice explained, 'He was on life support for four days...and then turned off, expecting him to die. I looked after him until he was nearly four [years old], when he passed away. It was during...those years that I started using amphetamines'. Following Marc's death she had five successive

pregnancies, two terminations and continued to use amphetamines. The psychological distress related to that loss did not abate over time but contributed to high levels of “pregnancy anxiety” (Price, 2008) with depression, fear, and recurrent distressing dreams about the babies, excessive alcohol consumption, and an increase in her amphetamine use towards the end of her subsequent pregnancies.

Hardesty and Black (1999, p.608) wrote that ‘The death of a child brings unspeakable loss, a loss of self’ and quoted one mother as saying:

My baby died, crib death... I found her dead in her crib. It was too much for me.... I was frustrated. I was feeling lonely.... [Drugs were] really fantastic. It was like going out of this world, forgetting everything, and that was exactly what I was looking for, to forget everything.

#### **4.6 Having a sense of not belonging**

Loss of identity results from having a sense of not belonging. From the data, identity was defined as ‘who I really am’. However, these mothers were often confused in relation to their identity as it was not constant and often the question arose of ‘who am I?’ They often felt that they did not ‘fit’ within certain groups; that others ‘looked down their noses at them’; they were ostracised; and in some situations, treated as if they were only a drug user. Yet each one was a unified aggregate of characteristics that were unique, had evolved over time, and were influenced by their life experiences. Their identity continued to evolve as they accepted new challenges such as motherhood and with each subsequent child. Each aspect of their identity was just that, one aspect of a complex whole. For the mothers in this study, the aspect of ‘illicit-drug-user’ was only one facet of the self and not an overriding independent entity as is often assumed by those who judge and censure them. In addition, these mothers were able to interpret interactions and situations and modify their behaviours in an effort to elicit favourable responses from others and to be comfortable with self.

##### **4.6.1 The need to belong**

It is important to one’s identity to belong, to have a connectedness with other human beings, to be part of a group. Maslow (1954), in his seminal work on the hierarchy of human needs, identified belonging as a basic human need after physiological and safety needs. Hagerty et al. (1992) define ‘a sense of belonging’ as the experience of personal involvement in a system or environment so that persons feel themselves to be an integral part of that system or environment. They identified the dimensions

of 'a sense of belonging' as: (1) valued involvement: the experience of feeling valued; needed; accepted; and (2) fit: the person's perception that his or her characteristics articulate with or compliment the system or environment (Hagerty et al., 1992). From a psychological point of view it is one's perception of being accepted and respected by other human beings that affirms belonging.

From the point of view of the mothers in this study there were cases demonstrating a fit with various people or social groups within their sphere of interaction. For example, Beth described how she felt with her father who accepted her complete identity. She stated, 'Yeah, he's never negative towards the problems, and I found that actually promoted more of me... You didn't feel like you had to be someone that you weren't, around him, even when you are on drugs'. Judith was also able to be herself with her aunt. She said, 'My aunt is just wonderful. Nothing is too much trouble for her, she's just lovely and, as she said, it's just like I'm her daughter'. Whilst there were limited cases of fit for the mothers of this study, there were numerous cases of misfit or a sense of not belonging. This sense of not belonging had a profound effect on these women's sense of identity.

#### **4.6.2 Not belonging**

For the mothers, identity development commenced in childhood where most experienced developmental adversity, including being raised within dysfunctional families where abuse and alcoholism were commonplace. As children or adolescents many became victims of sexual, physical and emotional abuse, many felt a sense of abandonment, and betrayal, whilst others were thrust into roles of responsibility. The effect of developmental antecedents, as they matured, was to feel different from others within the majority group. In response, they developed their identity as 'different'. Being different also brought a perceived exclusion from the majority group.

When these women were learning to 'be different' and commenced interaction with drug-users, they conformed to the expectations of that group. Over time their drug use escalated from smoking, sniffing, and snorting to injecting. They associated with other drug-users and engaged in the activities of the sub-culture. Some moved from small-time intermittent use to dependence and illegal activity such as stealing, dealing, and prostitution to support their habit. Many were estranged from their family of origin and most were unemployed and living on social security benefits.

Associated with drug use was the personal appearance of users which differed from mainstream society, thus maintaining a 'different' status. Kaye recalled, when she was engaged in the sub-culture, how she presented and the effect her appearance had on others. She said, 'People just couldn't look me in the face when I looked like a freak. Once you got to know me I wasn't a freak, it was just, first appearances'. Before she became a mother Lisa used to wear, 'groovy clothes, hippy stuff...and I used to have lots of piercings as well'. Candice related how she felt ostracized by teachers and parents at her children's school based purely on her appearance, 'when you could really tell I was on drugs'.

Being labelled also contributes to one's identity. When one is a 'junkie' or a 'smack-head' one is no longer a member of mainstream society. The labelled person is different, unacceptable, and there is a perceived loss of all other facets of their identity, they become only the 'drug-addict'. This is particularly prominent in the health care system when the labels of 'drug-user', 'methadone', 'buprenorphine' is attached to their medical records. These labels are stigmatizing and as a labelled user one takes on the 'master status of drug-user' (Banwell & Bammer, 2006, p.511; Becker, 1963). The master status phenomenon was confirmed by health professionals who commented, 'I think the greatest challenge in my role is... trying to get staff to see these women as more than just the drug, trying to get a bit of an insight into where they are coming from'. Whilst others may not see them as anything but the drug, they are fully aware of other facets of their identity. Vicki commented, 'I guess that anyone who uses drugs is probably a junkie, but, you know, they talk about junkies, users, but I'm not a junkie, I'm more than that'.

#### **4.6.3 Being and remaining different**

As most of the women established themselves as 'different' they developed relationships with other 'differents' and disengaged from their mainstream friends, their careers and life goals. Carlene described how she realized she had become 'different' when her addiction became apparent to her. She said, 'I was the first addict I ever saw, it was me, and I said, "Oh, that's what a heroin addict is". Then I started noticing them all around'. Although Carlene missed her previous privileged life she realized that she no longer fitted that identity. Her discussion showed ambivalence, sadness, hurt, yearning, and regret for the loss.

Where my family were "pork up the arse", white Anglo-Saxon, middle class, double income, white collar, you name it, private school, liberal

voters. You can fit them right in a nice little box. Oh, yeah, it is lovely to be able to label them back [laugh].

As 'different', intimate partners became part of their circle and many of those 'different' partnerships progressed into dysfunctional relationships with IPV, abuse, and manipulation being commonplace. Over time, their drug use escalated, they became dependent and their lives became chaotic. They found they were unable to stop using and they neglected other psychosocial pursuits. Somewhere in this trajectory they also became mothers. Many faced a loss of their health through hepatitis C and depression and some attempted suicide. One of the repercussions of this trajectory was to be rejected by their non-using friends. Lisa remembered her friends' warnings and how, when she was using, did not belong with her mainstream friends.

I've had friends since I was in primary school who aren't users, like very close friends, friends that I've had for...nearly fifteen years. That group of friends was very upset the whole time I was using...like, they told me not to see them when I was using.

However, belonging within the drug-using community was precarious as there was often a lack of trust between members; they described their liaisons as acquaintances not friends. Vicki explained, 'not like good friends, it's probably just the people that [take drugs] and we associate with them because we'll get [drugs] through them'. Candice commented, 'you don't have a real friend in the drug scene; it's just the way it is'. Usually there was mutual benefit with relationships but not necessarily a sense of belonging. If users overstepped the boundaries of what was acceptable within their group they were again rejected and alienated.

Unfortunately, life was not lived in isolation from the judgment and disapproval of mainstream society or the influences and consequences of illicit-drug-use. Their histories, their sense of identity, their self-esteem, and those they encountered continued to make them feel different, to not fully belong within either facet of their lives. When they had a sense of not belonging adequately their sense of identity was ambiguous. Who were they? Where did they fit? They lived on the fringe. Lisa told of her isolation and her narrowed life perspective. She was a mother but what else? She reflected, 'I don't go out as much, like, I keep away from any bad areas and basically I'm a housewife [laugh], not even a wife, I'm a home body'.

Although Ruby was now in a relationship where there was mutual respect, she continued to feel different; she believed people saw her only as a user. Although comfortable within her relationship she did not belong in mainstream society but she also did not belong within the sub-culture. She was on MMT and she kept her whereabouts secret to prevent drug-using acquaintances from finding her. Ruby said, 'We don't tell anybody where we live just in case it gets around to people that we know...cos you can never fully get away from the scene, especially when you live [in Perth]'. She went on to say:

I just find that every time we've tried to get sociable and have friends and stuff, it just causes problems, because, people are jealous...or try to pull [our relationship] apart by doing and saying things. So, then we figure out, well shit, that's not really a decent friend, we don't want them for a friend.

As the mothers felt that they had little in common with others, they tended to not engage with those people. Vicki avoided socializing with mainstream mothers and said, 'I don't go out of my way to socialise with any of the mothers.... Their lives are different'. When Anne's first child went to playgroup she too felt uncomfortable mixing with mainstream mothers. She commented, 'I felt weird because they were different to me.... They...made me feel welcome, but I think it was just me being paranoid... I felt weird, and felt like I didn't fit'.

On-the-other-hand, Kaye described how she instinctively sought out or gravitated to others with similar experiences as she felt that she had more in common with that group than she had with mainstream mothers. She described how she recognized and accepted in others the same attributes she possessed. There was better 'fit' with the 'different' group. She explained:

Because...most of my life has been around people who have used drugs... I think it's just a subconscious thing, you feel more comfortable with people you know you can discuss things that you can relate to... It's that or me going towards them... But for some reason the friendships that I have struck up, without even trying, [is with] other parents who have gone or are going through similar things.

Anne also felt more at ease with people in similar situations as herself. She said:

I used to hang around a lot of people that are still using. Even though I wasn't using they were using 'speed' or whatever. I just tended to make friends with them and stuff. Most of them had kids and...I think that's what



it is because they know what I felt like...when I was going through that, and I know what it's like to be where they are at and stuff.

Although some of the mothers were on MMT and had disengaged with illicit-drug-use and the sub-culture, they still related comfortably with others who have encountered similar experiences. Judith explained, 'Some of my friends know [of my use] because [they] are on methadone themselves, and that's good because you can really talk to people about it who know exactly where you are coming from'.

This phenomenon was observed by health professionals as well.

What amuses me so much, working here, is how our patients link up with each other. I obviously know which ones are which, and then you'll see them all, they've not met each other before, and you'll see them all having a fag outside together. And you think, so-and-so has met up with so-and-so. I don't know how they can pick another user in a crowd, I can't.

No matter how far along the trajectory of recovery from illicit-drug-use and the consequences of identifying as user, prostitute, or thief, these mothers perceived that they were different and found it difficult to assimilate into mainstream society. Kaye still carries a fear of being seen as a junkie; it is her perception that others would recognize the signs that classify her as a user. She said, 'I've always got this fear of looking like a junkie....because, you look at...some mothers and you can tell straight away'. Similarly, Ruby explained:

I always think people look at me and see a drug addict. When I walk into a store, I think everyone is watching to see if I'm going to steal... I try to make sure that [we] always are nicely dressed...and look like everyone else.

Health professionals also commented on the perception that the mothers felt 'very, very different, very separated from the general population' and that they 'don't fit in or belong'. Their differentness was a combination of several issues:

There is the drug use, there is a very poor self image, there is being poor in a world that doesn't have much tolerance for poor. There is still a lot of judgement attached to being poor, and also the mental health problems. You know what I mean about all of those types of things that make them feel more and more different to mainstream.

For the mothers there was a realisation that they differed from mainstream society. They, like no-one else, understood that there was an incongruence between two aspects of their identity, that of mother and of being an illicit-drug-user. The process of identity development from childhood to motherhood and beyond for the mothers in this study was constrained by external variants impacting upon their self concept. Judgment by external referents such as health professionals, significant others, and friends was a constant impediment to their sense of belonging, or a comfortable 'fit', where one was accepted and respected for who they were. Judgment by others was influenced by a lack of knowledge and understanding; by the perceived incongruence of mother and illicit-drug-user; by the erroneous stereotypical image or category based judgment of illicit-drug-users as dangerous, violent, and depraved individuals by much of society (Rasinski, Woll, & Cooke, 2005); and the social injustice brought about by the effects of stigma. Add to this the internalized stigma of the mothers who use illicit drugs and questions of: Who am I? Where do I fit? are raised. Ultimately, despite much effort and a desire to fit, these mothers remained different and felt excluded or existed on the fringes of society.

Anselm Strauss (1969, p.9) wrote of identity in his book *'Mirrors and masks: The search for identity'*.

Identity as a concept is fully as elusive as is everyone's sense of his own personal identity. But whatever else it may be, identity is connected with the fateful appraisals made of oneself – by oneself and by others. Everyone presents himself to the others and to himself, and sees himself in the mirrors of their judgments. The masks he then and thereafter presents to the world and its citizens are fashioned upon his anticipations of their judgments.

#### **4.7 Not trusting others and not being trusted**

Through life, the mothers experienced numerous challenges which influenced their belief in others to do the right thing by them. Their trust in others was compromised, making them wary and vulnerable. Trust, in this study, is the confidence mothers had that others would act in their best interest and do no harm to them and all they considered theirs – 'all that is mine'. Trust implies: respect for them as human beings; trustee competence; the belief that the trustee will care for them and all that is theirs; and that trustees will act faithfully and truthfully. To trust also means to surrender self to the trustee, thus placing self in a position of vulnerability.

As demonstrated in this thesis, most of the mothers were raised within dysfunctional families and experienced abuse, abandonment, and many were expected to take on responsibilities beyond their experience or knowledge. Those traumas had potentially devastating effects on them as children with the irretrievable loss of their childhood innocence and the loss of trust in the adults in their lives. As they matured and moved into intimate relationships their trust was again betrayed by those they entrusted themselves to and those who should have loved and protected them.

When one has lost trust in someone there is a belief that the risk of harm is greater than any potential benefit resulting from an interaction or relationship with that person. In some circumstances, the mothers perceived that some detriment would occur if they entrusted themselves or their children to potential trustees. From past experience they believed certain people to be incompetent, unreliable, and untrustworthy and therefore would not risk disappointment or potential harm. This resulted in forfeiting any potential benefit which could arise from taking the risk to trust others.

For these mothers, loss of trust was distressing and challenging as it placed increased pressures on them as they were reluctant to relinquish their control. If they were placed in situations where they had to concede control their vulnerability was increased and they were fearful of sustaining harm as a result of conceding that control. If their fears of trust betrayal were realized it reinforces their doubt, making them more suspicious, less trusting, more vulnerable, and at greater risk. The mothers in this study had a loss of trust in a range of people with whom they were expected to interact. Distrust was expressed in relation to their: mother; partner; family; friends; potential care providers for their children; and health professionals.

#### **4.7.1 Will I ever be able to trust them?**

As a dependent child one expects their mother to provide unconditional love and protection against harm. When Cath was sexually abused by her adoptive father she believed her mother should have protected her. Now, as a mother herself she has still not forgiven her mother for what happened and no longer trusts her to be there for her. Cath lamented, '[Mum] chose not to...find out what was happening.... Mum didn't do anything.... [Will] my Mum ever be there [for me]?'

Beth was also a victim of childhood sexual abuse. When she was old enough to speak out she was not supported by her mother because, she believes that, her mother could not adequately deal with the gravity of the situation and attempted to play down the seriousness. Beth reflected:

I've had a difficult upbringing and being the oldest of four children and my father leaving when I was six...and I also suffered sexual abuse... So, yeah, I've been through a lot, it has taken me years to...get to that stage of really getting to know who I was.

Ruby was placed in a position of extreme vulnerability as a child when she was expected to care for her younger siblings from the age of eight because her mother was unavailable and ambivalent. She was also sexually and physically abused by her stepfather and not protected, but blamed, by her mother for the abuse. A long term consequence of these antecedents, in addition to Ruby's extensive history of illicit-drug-use and prostitution, is that she has lost trust in her mother and her mother's ability to nurture her children. Ruby explained her distrust:

She...should never be a mum.... [She] doesn't understand children, doesn't understand that you have to get down to their level and think like a child to understand where they are coming from.... When we were little she... wasn't there for us.

Not only was it mothers they could not trust but the mother of their partner, partners, and potential care providers. When Vicki was openly criticised by her partner's mother the hurt she experienced diminished her trust. She explained how Patrick's mother told him that, 'he was too good for me... [But] he made it quite clear that he loved me. How dare she tell us this after I had been seeing him for four years? Now...I'm very wary'. Likewise, Kerry's trust in her ex-partner's mother was irretrievably lost. Kerry approached each access visit with her children with extreme caution, believing something untoward would happen. She said, 'Oh, I don't trust them at all. If there is a special occasion they will keep the kid away from the visit, according to the special occasion...it's in their nature'.

Judith recalled how her trust in the father of her children was finally destroyed. She 'stood by him' when he was incarcerated but her trust was repeatedly betrayed through deception and manipulation. After he was released from jail there was a series of incidents which further betrayed her trust. 'I...realised how stupid I was,

and I don't care what he does, he'll never, ever, ever, ever make me believe him again. There's nothing he can say that I'd ever believe again'.

Having had their trust in others repeatedly diminished and then reinforced, these mothers were unable or reluctant to trust others. Their ability to trust was further reduced when it came to entrusting their children to the care of those who had already proven untrustworthy. Similarly, when one's experience of trust with significant others was so diminished, to trust strangers to provide appropriate care for their baby was unthinkable. Carol commented, '[There's no-one] I can really rely on or would even try to rely on when it comes to Jemima'. Reluctance to entrust their children to day-care-centres, crèches, and play groups was a combination of an inability to integrate with mainstream mothers because of their belief that they were different and did not fit, and their fear for the wellbeing of their children. Ruby explained how she was enmeshed with her daughter and how hard it was to entrust the child to the care of others. She said, 'I've had her booked into a million different day-cares but she was always very, very clingy to me and me to her... Every time I put her into day-care she'd crack up...and...I'd have to go and pick her up'.

When comparing the hypotheses of loss of trust to other research, it was apparent that this phenomenon was identified by other authors who studied mothers who use illicit drugs. Banwell and Bammer (2006) stated that the relationships of these women were 'characterized by a sense of distrust'.

#### **4.7.2 Not trusting health professionals**

Trust is an important element in the health professional-patient relationship. However, the opportunity to develop rapport with health professionals is diminished as a result of short hospital stays. However, if health professionals are competent, knowledgeable and show respect for their patients, trust is usually afforded. Conversely, if competence, respect and knowledge are not demonstrated, the fragile nature of trust is compromised.

Health professionals in the ACDC were aware of the suspicion of mothers and commented on their defensiveness.

I think, when the mothers initially come to the chemical dependency clinic...they may feel resentful about coming...because it labels them with a problem. It's a problem that they may want to conceal, deny, but because they are in that clinic it means that the problem is there and they've got to

deal with it. So, initially there may be a degree of defensiveness. Sometimes they are defensive and you sense that...so you are very aware, how important it is to make them feel comfortable, to make them feel that you are not judging them... but there to help them and to achieve a healthy baby at the end of their pregnancy.

In other health care environments the fragile nature of trust in health professionals was often compromised. Cath's baby was experiencing difficulty feeding due to having a cleft palate. He was also being assessed for NAS because of his exposure to heroin in utero. His Finnegan Scores had been low and the baby had not required treatment. Cath recalled:

The day before...the score was low...between 1 and 4. Then the [agency nurse] did it. Now the one about the poo is 3 points and she had already scored 8 and she said, "How was his poo?" I said, "It was fine, it was a breastfeed poo". She said, "I'm going to change that to runny stools". I said, "But it wasn't, it was normal, it wasn't out of the ordinary". She hadn't even seen them and it was a normal poo...it was his little peanut paste poo that they have at that age... I said, "It wasn't a watery stool". "No, no, I'll put that, and I'll put down this point as well". She put his score up to 11.

Shortly after that incident the baby was medicated with phenobarbitone without consultation with Cath which devastated her and destroyed her trust in health professionals. Ruby's confidence and trust in health professionals was also severely damaged following the fetal death in utero of her 37 week old fetus. The competence of the staff at the hospital was under question and she believed that there was a 'cover up of the facts' in relation to the baby's death and a lack of professionalism in dealing with her and her grieving partner. She recalled:

[To start with] they took full responsibility; they actually said that it was their fault.... But then, when they realised that we had hired a lawyer, a couple of months later we hired a lawyer cos they weren't letting us see the autopsy report.... But once they found out that we had hired a lawyer they decided that their entire story was going to change. Their stories just full on changed.

Unfortunately, with Ruby's most recent birth, even though the care throughout the pregnancy was exemplary, the competence of health professionals was again put in question and reinforced issues of diminished trust. She described how:

They had a lot of problems with the caesarean section... They...couldn't get him out. He was flat lining, he had fluid on the lungs from them opening my stomach up and everything and they just couldn't pull him out... Yep, it was all a big, big, big stuff up.

Carlene's was also distrustful of health professionals. During her caesarean section she believed that health professionals were not acting in her best interest. She experienced severe pain during the procedure and alternative interventions did not provide relief. Carlene recalled:

The morphine wasn't working for me and my epidural hadn't worked. They had put another one in during my operation. I'd got knocked out [General anaesthesia] half way through...cos I felt everything.... They said they would give me the gas but all I could taste was saline, I know what nitrous oxide tastes like and it wasn't nitrous oxide, it was just saline. So, maybe they were trying to see whether I was for real or not. So, they tried giving me a placebo type thing and I said, "Look, this is just ridiculous". I was writhing around, I was being ripped and torn on the table, and they were very heavy handed.... I felt pain as well as the tugging and pulling.

Actual experiences these mothers had had in the past; hearsay from other mothers about what could happen to them; fear of judgment and disapproval; and fear of their baby being 'taken off them' were all deterrents to mothers seeking and accepting help from available services. Thus, on many occasions they did not seek help, but struggled with their responsibilities under the most difficult of circumstances. One health professional commented, 'My experience was that they were not naïve as consumers. They know about services but they don't trust services'. Another commented:

They often see agencies as authority figures that are going to judge them and take their children off them or evict them or do things to them. They don't see that they can get help from professionals. They don't see that as an option.

Trust was also an issue in the community with government agencies and social services. When Carlene attempted to secure priority housing she felt that she was being interrogated. She described how one social security employee behaved:

[She] gave me...the third degree and tried to catch me out but she couldn't cos every answer I gave her pretty much came down to: "I was trying to look after my child at the time". I was just trying to do the best for my child.

The concept of not trusting health professionals is supported by Roberts (1999, p.634) in her descriptions of drug use among inner city African American women where she stated, 'Women mistrusted health professionals and avoided seeking help whenever possible'.

#### **4.7.3 They don't trust mothers like us**

Being trusted was also important to the mothers as this demonstrated respect for them, so when they were *not being trusted* they felt that they had to constantly prove themselves. When Cath reported to her antenatal midwife that she had not used drugs in the two weeks prior to her appointment she expected some praise and acknowledgement. Instead, the response was 'Oh, yeah, fine', [and] she sort of didn't look at me when she said it'. Cath was angry about this response and felt that the midwife did not believe her. Similarly, others felt that the staff did not believe them when they were telling the truth. Incidents of midwives not believing the mothers were reiterated by health professionals.

Sometimes I have found that the midwives accuse the mothers of using amphetamines, and the girl says, "But I'm not using amphetamines". And the midwives say to me, "Oh, yeah, but you can't believe them". So, that is difficult. I mean, how can you argue... And they say to me, "But you're a bleeding heart and believe whatever they say". I don't know, some of the staff, not all of them, but a minority [have this attitude].

Similarly some staff did not trust mothers to provide adequate care of their newborn, even when support systems were being put in place and they had been assessed as able to be the primary carer. One health professional explained:

I'm arguing in my role, with the staff, usually they are looking at me and saying, "Well, why isn't this baby going into foster care?" "Why aren't you doing something? Oh, she's a heroin addict". So, I have to fend off this attitude and say, "But, no, she is still quite a good mother". We'll put in some support and we'll talk about safe using and we'll try and get this mother to feel positive about this baby.... But there is an attitude that like, "Oh, you can't send that poor little baby to this dreadful woman".



## 4.8 Summary

The central problem experienced by mothers who use illicit drugs was *the threat of loss* emanating from (a) *judgment and disapproval by self and others*; (b) *being abused, manipulated, overwhelmed, and dependent*; (c) *damaging myself and damaging my baby*; (d) *losing my baby or having my baby taken off me*; (e) *having a sense of not belonging*; and (f) *not trusting others and not being trusted*. These problems resulted in loss of respect; loss of freedom; loss of health; loss of child; loss of identity; and loss of trust. Each loss experience had distinct characteristics but each was interconnected to other loss experiences where a loss in one area influenced or had a cascade effect to other loss experiences. Whilst any one of these loss experiences could be debilitating, the synergistic effect of multiple cascading loss experiences was difficult for mothers to manage.

These mothers were subjected to *judgment and disapproval* leading to rejection by people whose respect they yearned which in turn minimised their self-esteem and self-worth. They suffered *abuse*, were *manipulated* by intimate partners, significant others, and at times by health professionals; they were *overwhelmed by mothering* and at the same time had to grapple with their *dependence* on psychoactive substances. The result of their dependence on psychoactive substances also contributed to them *damaging self and damaging their baby*. The psychological and physiological sequelae of their use contributed to feelings of shame and guilt for what they had done and how they had 'hurt their baby', yet, at times, their need to use remained compelling. Their ability to adequately provide for and nurture their children was also under scrutiny from health professionals, family members, and the authorities, and the threat of having their baby removed from their care was ever present. For these mothers even their *identity* was tenuous as it shifted over time with transitions in relation to changing interpretations of the self, new expectations, and *their sense of not belonging*. Finally, *not trusting others and not being trusted* were elements that impacted on symbolic interactions with others. These mothers learnt not to trust through experiences of betrayal over time. Their trust was tentative and they often could not even trust those closest to them. Similarly, in the health care environment they were fearful to entrust themselves to health professionals, however, at times they could not accomplish their goals without reliance on others. This tentative relationship with health professionals also influenced health professional's trust in them and compromised the health professional-patient relationship.

By providing a detailed interpretation of the scope, complexity, and interrelationships amongst different loss experiences, a better understanding of the lives of mothers who use illicit drugs has been achieved. This interpretation has provided a platform on which to articulate the basic psychosocial process these mothers used to manage the multiple forms of loss that were problematic to them.

## Chapter five

### Limiting loss through a process of safeguarding

#### 5.1 Introduction

This chapter presents the basic psychosocial process of *limiting loss through a process of safeguarding* which was used, by mothers who use illicit drugs, to manage, overcome, counteract, and subjugate the *threat of loss*. The mothers engaged in this core process through three sub-processes: *safeguarding during pregnancy*; *safeguarding as mother*; and *safeguarding to preserve integrity*. Depending on the perceived nature of the threat, the influencing conditions, and the resources, knowledge, and experience of the mothers, the safeguarding processes employed oscillated between reactive responses of *struggling* and proactive strategies of *taking back control*. When struggling reactively, mothers only temporarily managed, modified, or negated crises. However, when being proactive and taking back control the mothers were able to modify the nature or scope of the threat with sustainable strategies which were more effective than reactive responses. In this study safeguarding involved actions taken by the mothers, deliberately or subconsciously, to lessen the potential for: judgment and disapproval by self and others; being abused, manipulated, overwhelmed and dependent; damaging self and one's baby; losing one's baby or having one's baby taken off them; having a sense of not belonging; and not trusting others and not being trusted. These problems result in multiple forms of loss such as loss of respect, loss of freedom, loss of health, loss of child, loss of identity, and loss of trust.

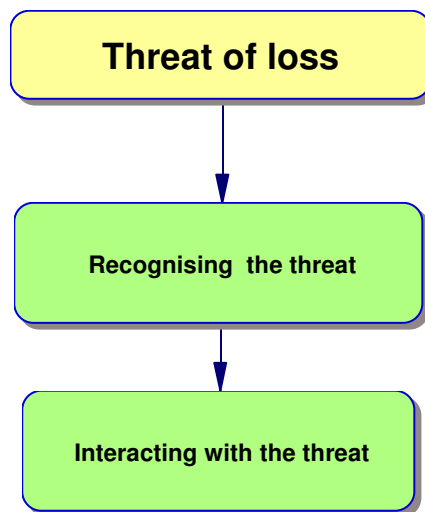
Although threats can be considered discrete, within this study it was the threat of multiple losses that was problematic for the mothers with the threat of loss in one area influencing or having a cascade effect on other loss experiences. Mothers often responded reactively to threats and struggled to cope. However, repeated episodes of struggling had the capacity to strengthen one's ability to withstand other threats by increasing knowledge, experiencing success, and improving confidence in one's ability. Increased confidence allowed mothers to take back control of aspects of their lives and modify the nature or scope of threats and make positive adaptations in their lives. Candice explained, 'I suppose all that I have been through has made me the person that I am now though. It has made me stronger'. Judith also reflected on the benefits of the struggle:

What doesn't kill you only makes you stronger, so I think of everything that has been difficult, like, I'm much more capable of doing a lot more things and coping with a lot more situations than I was, say a year ago.

## 5.2 Structural components of the theory

The basic psychosocial process was to safeguard in an effort to limit loss and commenced with the perception of threat which could lead to loss of elements deemed important to the mothers. Indeed, safeguarding would not have been necessary if the mothers had not had a perception of its need.

Having recognised the existence of a threat or threats and to some degree, either consciously or at a subconscious level, evaluated that threat, the mothers engaged in the process of safeguarding. Safeguarding required interaction between the mother and the threat in an attempt to manage the situation, secure one's safety and minimise any harm to self and one's children. The preliminary structural components of the theory are presented at Figure 5.1.



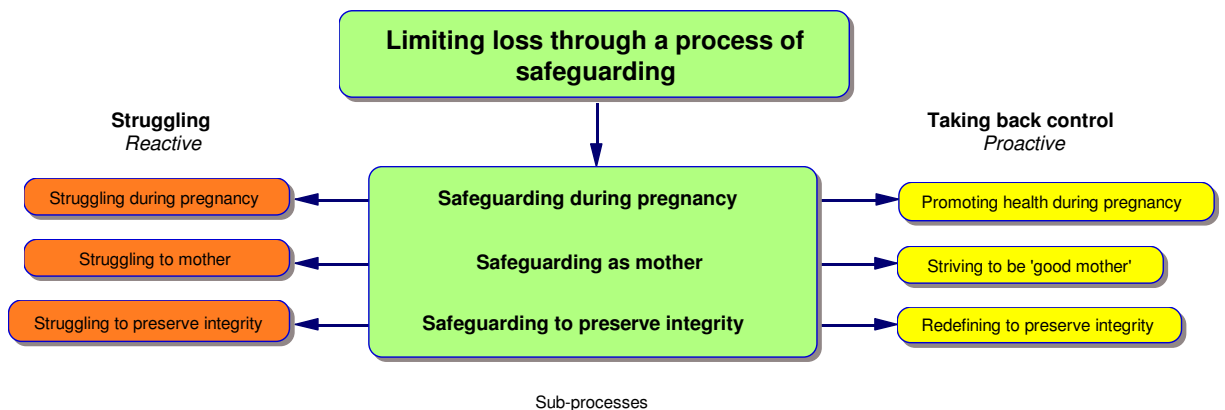
**Figure 5.1: Preliminary structural components of the theory**

The processes of safeguarding, that the mothers ultimately engaged in however, oscillated between being reactive to situations where they struggled with and against the threat; or being proactive where they worked at taking back control and modifying the nature or scope of the threat. To respond in the proactive genre the mothers actively took back control by implementing strategies which were sustainable and more effective than reactive responses. These strategies required

a change in the attitude of mothers where they thought about and worked through the process. Whilst the mechanisms within the process mothers engaged in to manage or cope with the threat differed the motive was always *safeguarding to limit loss*. At any one time the mothers could be seen to be engaging concurrently in a number of safeguarding processes.

### 5.2.1 Sub-processes of safeguarding to limit loss

The mothers engaged in the core process of *safeguarding to limit loss* through three sub-processes. *Safeguarding during pregnancy* involved struggling as one made decisions and found a way through multiple challenges, whilst simultaneously promoting health of self and the fetus. *Safeguarding as mother* encompassed the struggle of mothering with limited resources whilst endeavouring to attain 'good mother' status. *Safeguarding to preserve integrity* focussed on preserving integrity of self and one's children against physical and emotional harm whilst redefining, or making different that which was, and striving to create a better environment in which to live and raise their children. Figure 5.2 presents the key elements of *limiting loss through a process of safeguarding* demonstrating the variation in safeguarding processes employed whilst oscillating between struggling and taking back control.



**Figure 5.2: Variations in safeguarding**

A table is presented at Appendix 6 providing an overview of the process, sub-processes, categories and their properties. In implementing the processes of *safeguarding to limit loss*, the course was not linear or staged but was characterised by oscillation with multiple strategies being enacted concurrently to address multiple threats.

### **5.3 Safeguarding during pregnancy**

The mothers in this study worked hard to reduce the negative impact of drugs and lifestyle on their unborn babies, yet, at times it was very difficult for them. Of particular concern for the mothers was the potential for loss of their baby's health. However, there was also the potential for loss of respect if others judged their drug use and pregnancy as incongruous; and the potential for loss of child if it was deemed that they were unfit to provide appropriate care for their baby. Pregnancy therefore provided the opportunity to modify their lives as they transitioned from drug-user to mother and the opportunity to demonstrate their abilities, their commitment to the baby, their trustworthiness, and to build rapport with health care providers during the antenatal period.

In the process of learning of their pregnancy and then wanting to minimise any harm to their fetus the mothers were often reactive and *struggled during pregnancy* but simultaneously tried to be proactive and *promote health during pregnancy*. When struggling during pregnancy they *struggled to make decisions* and *struggled to find a way*. Conversely, when they were more experienced or knowledgeable about what to do during pregnancy, and were supported and engaged in antenatal care at the ACDC, they were more able to promote their own health and that of their fetus by *changing priorities*; and by actively *taking care of self*. However, implementing these strategies required significant changes to lifestyle and was not easy and, at times, their resolve waned and they oscillated back into a pattern of struggling and gave into the need for drugs to help them cope with other issues, thus putting themselves and the baby at risk.

#### **5.3.1 Struggling during pregnancy**

As the majority of pregnancies experienced by women in this study were unplanned and some did not realise, acknowledge, or have their pregnancy confirmed until well into the second trimester, their initial response to the pregnancy was reactive. On learning of their pregnancy they needed to *make decisions* in regard to what they were going to do. Six mothers terminated some of their pregnancies ( $n=13$ ) in preference to proceeding. Candice remarked, 'I've had two abortions...because they were just so wrong because of the person they were to. I mean, they were only just one off sexual encounters and that was it'. Carol felt that she was unable to be a good mother and terminated to protect the unborn children from her supposed incompetence. She explained:

I had four abortions before her, you know, cos I just didn't feel like I was ready, I wouldn't do a good enough job. I didn't deserve to have a child or bring a child into the world, and then she come along and I didn't have any choice in the matter.

Health professionals also explained some dilemmas this group of mothers face on learning of their pregnancy and making decisions in relation to that knowledge. One health professional commented, 'They have often gone through the indecision of, "Shall I terminate?" There are also dilemmas of, "who is the father of the baby?" I mean, it's huge'. Another explained:

Some women have had a lot of TOPs, but, more, it would be apprehensions, or they keep the baby and do quite well. They either don't want to terminate their pregnancies or they just don't realise they are pregnant until it's too late. And, I think that's probably more to the point, they just don't realise that they are pregnant until it's too late to terminate. They just can't get themselves together to go and see a doctor and, to even think about, "What am I going to do?" There are too many other things in their lives, you know, where they are going to get drugs?, paying fines, trying to keep out of the way of the police, domestic violence, you know, there is all those sort of things going on in their lives. And, I think that they sort of can't organise themselves to do something about it.

Those that chose to proceed with the pregnancy, or it was too late to terminate, realised that damage could have already occurred. Cath commented, 'You never know you are pregnant early on...and...we had used amphetamines on that time of conception'. Beth said, 'by the time I found out I was pregnant I was five and half months....I'd already gone through the stage of, you know, the most important stage when you should stop taking drugs and stuff like that'. With the realisation that they were pregnant, and the knowledge that their illicit-drug-use could contribute to harming the fetus they attempted to *find a way* to minimize harm to their fetus so *sought information; made drug choices; sought referral; and got checked out*.

#### **5.3.1.1 Finding a way**

Often the mothers reported that they had not known what to do or what to expect in relation to issues considered important to their unborn baby's wellbeing. *Seeking information* was a strategy employed to address their knowledge deficit and guide their decision making process. Some of the mothers had heard, and others knew

from experience, of negative consequences of illicit-drug-use on the pregnancy; and of loss of health for the baby; and all were aware of the potential to have their baby taken off them if they were deemed to be unfit to parent. The fear of losing their baby or of negative outcomes was sufficient incentive to urge them to seek information about what to do. Of immediate concern for some was whether they should cease drug use and detoxify and how they should approach any modification in their use. Lisa explained how she sought opinions from medical personnel but that the information was contradictory and confusing.

The first thing I wanted to do was try to detox...so I saw some doctors. One doctor said you can do it, you know, no harm will come to the baby but I checked with another doctor and the other one said that [the baby] would more than likely die if I did.

Lisa then sought advice from the central drug and alcohol service where she received appropriate direction.

I talked to different people. I went to see the unit in Perth and like, asked if I could detox with them because they have different...places to go to do that and then they said, "we don't suggest it", and they said that I should go on the methadone program and they set me up with a doctor in that area.

Whilst all of the mothers knew they should modify their drug use because of the pregnancy they struggled over what was best. *Making drug choices* regarding which to cease or modify and which to continue to use was based on information that was often inaccurate. Often mothers chose to decrease or modify their use in response to unreliable information. Others spoke to medical personnel but took away only information that supported their beliefs. They reached conclusions in relation to their choice of drugs, believing they were making sound decisions that would minimise harm to their fetus and the pregnancy. Cath was a polydrug user and ceased amphetamines during pregnancy but continued to use heroin. She commented:

I went to Next Step and spoke to this Doctor, and he told me the thing with amphetamines was the rush of blood through the placenta to the baby could mean the placenta separating.... So, I didn't want to use speed through my pregnancy...to me that was more damaging, so...I stopped using speed.



Conversely, some chose amphetamines over heroin because they believed the risks from heroin were greater. Beth was using heroin and on a methadone program when her first child was born and that baby had NAS. To avoid the potential of her second baby experiencing NAS she switched to amphetamines. She explained:

The only problem was like being an amphetamine user most of the pregnancy and then not, you know, in the last few months, and he was fine...but I knew I didn't want a withdrawing baby...I knew I wasn't going to put him through that.

Amphetamine users found reducing amphetamines was difficult because they perceived benefits in using and there was no treatment program where substitution or controlled dosing was available. Many spoke of how amphetamines helped them manage their low mood and stopped them thinking, or helped them increase their energy and cope with their daily chores. Others spoke of amphetamines helping them stay in control, or stay awake when they were tired or their other children or partners were demanding. Therefore, there was incongruence between their desire to safeguard their fetus and their perceived need for amphetamines. Indeed, most amphetamine users moderated their use to reduce potential harm to the fetus but were unable to cease completely. Others had similar stories with the underlying principle being their desire to do what was best for the baby, despite the difficulty they faced personally. Vicki related:

I did cut down...and my partner pushed me a little bit, which was hard. I'd say, "You need to help me, you do it too". And, he did. I cut right down to ¼ of what I used to take.... [I did it] for my baby.... You think about it and go, "Agh, look what you are doing to your child".

Candice tried hard but was unable to sustain her reduced intake and relapsed.

Once I realised I was pregnant I just started to decrease my use and maintain it.... I got it down to once a week from using daily.... I didn't want to use because I wanted to...help the pregnancy, kind of help him.

Candice had lost a child at four years of age and the psychological distress related to that death did not abate over time but contributed to high levels of anxiety, depression, fear, and recurrent distressing dreams about the loss and about the welfare of subsequent babies. Excessive alcohol consumption (50-60 units per week) and an increase in her amphetamine use towards the end of her pregnancies were strategies she employed to attempt to deal with her pain, fear, and the threat of

a similar loss. Candice commented, 'Up until the last stages of pregnancy the more worried and stressed out I got about the placenta and about my previous problems the more I used...and the alcohol was something for me coming down too'.

As some of the mothers struggled they found it hard *seeking referral*. Laura knew she should seek appropriate care but was unsure of what to do. She said:

I thought I could just call up [maternity hospital] straight away and I'd get through to the clinic but they said that I had to be referred by a doctor. And I went to my doctor, but something happened and he tried to refer me, but they never got back to him. It took me a couple of months; I would have been about four, nearly five months when I actually got into the clinic, for my first ultrasound.

Carol was at 28 weeks gestation before her pregnancy was confirmed. She explained:

I went and had an ultrasound and I was 28 weeks. And I think it was because I was using so much that I wasn't really in touch with my body... so, I think that's why I was oblivious to the pregnancy.

As the mothers progressed through their pregnancies some encountered problems that they did not understand so *got checked out*. Seeking reassurance through the health care system contributed to allaying their fears. Whilst some issues were minor, others were more serious. Cath related two episodes of *getting checked out*. The first was:

I had this pain...that hadn't gone away. I'd had it for one day, but then a week later I'd had it for the whole weekend.... I went to the...labour ward to get checked out, and I'd just pulled a muscle.

On the second occasion Cath has used \$50 worth of heroin and it was enough that she, 'felt it, then I was bleeding that night, and I immediately thought I was bleeding because I had used, so I rang the [hospital]'. Candice explained, 'I had a lot of bleeding and leaking of the waters from around the baby. Yeah, I went to emergency a couple of times'. Ruby also sought assessment:

I had noticed that [baby] wasn't moving very much and he was a very, very active baby. And so, for him not to be moving was quite strange. So...we [went to the hospital] and we had to go straight to fetal monitoring and get the things on my belly and stuff and get all the CTGs.

### **5.3.2 Promoting health during pregnancy**

Although mothers struggled with some issues, where possible, they also took proactive strategies to ensure the best health outcomes were achieved for their babies by *promoting health during pregnancy*. Promoting health meant that mothers worked at improving their health and that of their unborn child and in doing so modified the nature and scope of threats and limited potential harms. The health promoting activities primarily focused on the babies and helped mothers strive for more control over their lives. As they took back control the proactive strategies they employed required significant and sustained modifications to their lifestyle and behaviour. Consequently, the mothers *changed their priorities*; and engaged in *self care*. Within the scope of *changing priorities* the mothers worked hard at putting the wellbeing of the fetus above their own needs; modified their drug use which included reducing amphetamines, opiates, and other drugs, as well as modifying their cigarettes and alcohol consumption; and under obstetric management commenced, monitored, and/or adjusted their maintenance treatment. These mothers were prepared to strive for the best outcomes for their babies despite knowing they would come under scrutiny within the health care system; that they would struggle at times when forfeiting the benefits of illicit drugs; and that there was potential for their babies, following birth, to withdraw from the long-acting opiates used in treatment regimes.

#### **5.3.2.1 Changing priorities**

When changing priorities, *putting fetus first* was important for the mothers and they consciously put the baby before their drug use. Kaye's sentiment resonated with other mothers when she said, 'OK, it's one thing to do the damage to my own body, but not to my little baby'. As a result of their concern, all of the mothers in this study attended antenatal care at the ACDC and made significant changes to their drug use. Health professionals recognised the mothers' commitment and made comments such as, 'This baby has come along and she is re-evaluating her life. So, yes, babies and pregnancies definitely are an incentive to change'; and 'Once she found out she was pregnant she knew that she was going have to sort all of this out or she wasn't going to have this baby'. Another made the following observation:

They are concerned about their babies and want to achieve the best outcomes. And, I'm sure that that's the reason these mothers come to the clinic, because, you know, they don't have to come, they can just front up at delivery like they might have done in the past. But, I think they are

genuinely concerned. And, I think that we have always got to remember that the drug has been there a lot longer than the baby has, and it's so intermeshed with every facet of their life... It is a big thing for them to have to give up drugs or reduce their intake or go onto a treatment program, and most of them do... They definitely reduce their drug use whilst they are pregnant and in the immediate postpartum time, and I think...they do have concerns. Even the most hardened girls I've seen here, you know, really that is the reason that they're coming here, because they are concerned about the baby.

Other research has identified that women who use drugs prior to and during pregnancy tend to use less antenatal care than women who do not use drugs, and that they are at greater risk of undetected pregnancy complications (Brady, Visscher, Feder, & Burns, 2003). Yet, the mothers in this study attended antenatal care for the index pregnancy, albeit that some did not attend until the second trimester. It is known that good quality antenatal care is associated with improved pregnancy outcomes, even with continued drug use (Burkett, Gomez-Marin, Yasin, & Martinez, 1998; Department of Health, 1999), and it is on that foundation that the goals of antenatal care at the ACDC, where these mothers attended, are built. One health professional articulated those goals as: 'to minimise risk of complications; stabilize or reduce drug use to the lowest possible dose; and allow health professionals to develop rapport and a comprehensive program of care to support the woman through her pregnancy'.

When it was evident that they were going to have a baby these mothers set about *modifying their drug use* in an effort to safeguard the baby and minimise potential harm. Indeed, all of the mothers decreased their illicit-drug-use during pregnancy and cited the baby as being the reason for making the change. One health professional noted that:

Women put a lot of effort in actually trying to keep their drug use separate, they might not be able to get rid of their drug use but they certainly spend some time trying to keep their drug use separate and minimise any kind of impact it can have on their children.

Many of the mothers were polydrug users and whilst they may have decreased some drugs they may have increased others. For example, Judith ceased heroin, other opiates, cannabis, amphetamines, benzodiazapines, and tobacco, and

commenced MMT which was increased towards the end of her pregnancy. Beth, on-the-other-hand ceased heroin and alcohol but increased cannabis and amphetamines, her tobacco use remained the same, and with her second pregnancy she was maintained on buprenorphine. Those whose main problem drug was opiates were encouraged to commence MMT as this is currently the only treatment program in Western Australia recommended during pregnancy and breastfeeding (Fischer, 2000). Within this study, with the index pregnancy, only one heroin user opted to remain on heroin and she maintained a small but steady habit, whilst five mothers were on MMT, three were on buprenorphine, and one had a naltrexone implant with a previous pregnancy. However, across their childbearing years many oscillated between heroin and amphetamine use and/or were polydrug users and their patterns of use were characterized by periods when they were recovering and periods of relapse. Pregnancy was the catalyst for making significant and sustained changes and many of the mothers saw it as a good opportunity to 'get [their] act together'. They realized that they could be supported on a treatment program which would remove elements of chaos and danger from their lives and free up funds that could be used legitimately for their mothering role. Laura related how she modified her use and lifestyle because of her pregnancy.

Oh, I've calmed down a lot. Yeah, it was pretty hectic.... I was staying up for weeks at a time and just, the people I was hanging around with, and problems with [partner]. It was just very crazy, crazy isn't the right word, chaotic, pretty much chaotic, irresponsible, yeah.

Commencing maintenance treatment was often the first step towards promoting the health of self and baby that opiate users in this study took. Whilst it maintained their chemical dependence it did allow them to stabilise their use and settle an often chaotic lifestyle of seeking drugs and being intoxicated. Beth related that with her first baby, 'I didn't use once I found out I was pregnant with Claire, I went straight onto the methadone'. For Kaye, pregnancy was the catalyst that moderated her use. She said:

It wasn't really until I fell pregnant that the thought of continuing to use; that would be the most selfish act ever, and just the thought of having something wrong with this baby, yeah, I can't stand that...[so] I stopped [using] and went up in my methadone.

Although, in the early stages of pregnancy, some mothers were able to maintain or even reduce their methadone dose; towards the end of pregnancy most needed to

have their dose increased to manage withdrawal symptoms due to the growth of the baby resulting in increased maternal blood volume and increased metabolism (NSW Department of Health, 2006a). Judith 'had to put it up several times from...the weight increase [towards the end of pregnancy]'. Similarly, Susie was, 'doing fine until the last two months of the pregnancy and then it just got too hard'. Whilst MMT provided many benefits to mother and baby during pregnancy and beyond, the mothers experienced conflicting emotions because they knew that NAS was likely to be more severe if they were on methadone and that harm could have already been done. One health professional said:

[When a mother sought reassurance] I'll say to them, "well, I can't tell you that you haven't [harmed the baby], but, you know, there are people out there that aren't using drugs and drinking, and things go wrong for them too". It's just trying to keep that balance and support them through the pregnancy and monitor their health and address issues as they arise, they are still better off'.

Although MMT is recommended for opioid dependency during pregnancy, other pharmacotherapies are available and buprenorphine is used. However, in Australia, buprenorphine is not recommended for use in pregnancy or whilst breastfeeding. Some women who were on buprenorphine prior to pregnancy were reluctant to cease and revert to methadone as they found buprenorphine effective and more convenient, and according to some authors, the NAS experienced by the infant is generally less severe than that associated with methadone (Fischer, 2000; R. E. Johnson et al., 2003).

Anne commenced methadone when she was four months pregnant with her first child. She said, 'I wanted to get clean and stuff. And that's when I first went on the methadone program, because buprenorphine wasn't out then. And I got my act together'. By the time she was pregnant with her second child she had swapped to buprenorphine.

When I fell pregnant with Cameron [the doctors] wanted me to go back on methadone and I said, "*No, I'm not doing it*" [italics added]. And they said, "You won't be able to have pain relief", and all that sort of stuff. That's what I was getting told.... and I think it was because Subutex [buprenorphine] has only been around for a little bit. They are not too sure what it does to the baby.... I just said, "I don't want to go onto methadone". I was just really persistent that I didn't want to go on methadone again....

So, before I had him I went right down in my dose...so it would affect him less, and he was fine.

Laura's experience of buprenorphine was not dissimilar but her baby did experience NAS.

I was on Subutex [buprenorphine] for about two years before I got pregnant. I was slowing down...I dropped pretty rapidly once I found I was pregnant. I wanted to be completely off it before the baby was born, but.... I was pretty low [dose] towards the end of the pregnancy. [Health professionals] said, "You most probably would be best not coming right off it now because it might send you into early labour".... It was just finding out at the beginning that he had NAS, it was just the shock, it was just like, if I had known before, I would have done a little bit more than I had to have gotten off it.

The mothers also spoke of their attempts to quit cigarettes and alcohol during their pregnancies. One mother commented, 'I quit smoking, I didn't drink, I didn't smoke cones'. These health promotion targets were encouraged by health professionals and also through popular press and media campaigns so the mothers were aware of the health risks and the benefits of quitting. Lisa related her experience:

We tried to give up cigarettes as well. We used to smoke 12 milligram [cigarettes] and we went down in [strength] first, which is what we were told to do. We were able to reduce slowly... We smoke a lot less and we don't smoke in the house or in the car or anything like that, just tried to keep it away from her and that sort of thing.

Whilst modification in drug use was an admirable outcome health professionals commented that it is not only issues of drug use that indicates success but the mothers' ability to maintain custody of the baby and to successfully mothercraft and nurture their baby.

Yeah, and, you know, we don't sort of see them stopping their drug use as being the only positive outcome. Seeing them be able to take their babies home and be able to care for their babies and understand what parenting involves is, sort of, the important thing. We've had a couple of women, recently, that we were feeling really down about that we just felt that we weren't getting anywhere, and in the last three weeks of their pregnancy, things just changed so dramatically, and they are the sort of women who

would never had had their babies to take home with them. Those babies would have been apprehended. But, what we've seen happen is that they have stopped using, they've gone...and of course, once they've stopped using amphetamines, they are quite reasonable people to live in your house, so they've got their parents, there is usually somebody in the family that is very supportive. You know, who will take them in. Their whole demeanour changes, and, you know, they get the DCD involvement in Best Beginnings and all of those things are put into place and they are taking their children home. And they might be women who have lost three other children who they don't get to see. But, they have actually taken babies home and have done very, very well.

#### **5.3.2.2 Self care**

*Self care* was an important component of safeguarding during pregnancy for many of the mothers in their determination to 'do the right thing' and give the baby the best opportunity to be healthy. Where previously they had difficulty in 'looking after...self', when taking back control and promoting health during pregnancy they *improved their diet; rested; sought care; and adhered to treatment.*

Lisa related how she previously had not eaten meat but improved her diet for the sake of the baby:

I was a vegetarian for seven years before I fell pregnant and I thought I'd better start eating meat because I wanted her to get iron and I couldn't afford to be anaemic; and I continued that, like I'm still eating meat now, not as much now but, because I'm still breastfeeding as well.

Others also spoke of eating well. Ruby commented '[I] made sure that my pregnancy was extremely healthy. I didn't drink, I didn't take pills, I ate really, really healthily, and went for long walks'; and, Carlene said, 'I ate better in the first trimester...my cravings were all healthy and I ate really healthy'. Not only was it their diet that improved but some mothers reduced their work load and those with other small children *rested* when able, and made arrangements for the care of the children to permit rest periods.

Cath was doing some heavy manual work when she was at 31 weeks gestation and her manager did not understand the limitations a pregnancy can present. She



needed to provide her manager with greater understanding of her status which allowed her to do less arduous tasks. She recalled:

He went off at me, and I had to tell him I had nine weeks to go before birth, and saying that you are seven months pregnant, and saying that you've got nine weeks to go is completely different. And I'd always said, I'm seven months pregnant, but to him, I had to say, *look! I've got nine weeks to go* [italics added].

When Judith finished work just prior to the birth of her second child she 'booked her 12 month old son into day care for five days' to allow time to rest. She said, 'I would really value my time next week, to myself...I'm pretty tired actually...so if the baby holds off for at least another week I'll have five days [to rest]'. Judith went on to say, 'I've got a lot of things to do today and I'm thinking, no stuff it, I can go home to sleep because I deserve to'. Ruby spoke of her routines that allowed rest: 'When Isabella napped, I napped, so after she and I had a nap I'd just get up and do some housework, just potter along'. Similarly, Kerry rested when able and said, 'after lunch it's...rest time. Bubby goes in her room and I go into mine [until] Stuart gets home and it's time for everyone to get up'.

In the mothers' efforts to promote health during pregnancy for self and fetus they needed to make important and difficult decisions regarding where they would *seek care* antenatally and birth their baby. All of the mothers chose the tertiary referral hospital over peripheral maternity units because of the level of expertise available and the dedicated Antenatal Chemical Dependency Clinic (ACDC). In addition, mothers were aware that, due to the high risk status of pregnancies to women who use illicit drugs and the potential for adverse neonatal outcomes, the peripheral maternity units refer these mothers to the tertiary hospital if/when they become aware of their drug use. However, as one health professional commented, there were consequences of attending the ACDC and the tertiary referral hospital.

I always think it is a really big step for them to come to the clinic. Because, they are fronting up and they are accepting that they've got a problem with drugs. And, you'd have to be pretty brave, I think, to come in and say, "Well, look, this is, I've got children and this is the drugs I'm using, I'm pregnant". To have to divulge all that information, you'd have to be pretty brave to do it with the risks of legal action; the reaction of the health professional that you are going to, you know, talk to; DCD involvement, all of those sort of things; having to give up the drug; OK, the potential for

relationship breakdown if you give up the drug when it is a part of your relationship with your fella; and, you know, all those sort of things. I think that they've got to be pretty brave, to do it.

For these mothers, having voluntarily made the decision to attend the hospital where they felt they would receive the best care, some women were fearful of their families becoming aware of their use. A health professional related one vignette:

I was talking to a woman the other day, she came in, she is a middle class user and her family is involved in the medical field so she is terrified around confidentiality. So she is picking and choosing where she can go and that. I feel quite sorry for and she, this is her first pregnancy and stuff. She feels like that if her family finds out, she feels, she has good support from them but believes that it is conditional, that they would withdraw [their support] if they knew.

To limit loss of respect, some made excuses and told lies about their choice of hospital to protect against judgment from family and friends. Others chose to inform significant others of their drug use and explain the reason for attending the tertiary referral hospital. This placed them in a vulnerable position with the potential for judgment, disapproval, and loss of respect. Lisa explained, '[My Mum] wondered why I wanted to go to [the tertiary referral hospital] instead of [a peripheral one], but, I told her, if something had happened I would have got sent [there anyway].... She was upset but she has always been supportive'.

Those that attended the ACDC during their pregnancy attempted to comply with the recommendations of the attending health professionals. This comprehensive service has dedicated midwives and an obstetrician, social worker, and a drug and alcohol specialist. Other services such as dietary, dental, psychology, and paediatrics are available and referrals made as necessary. In relation to her experience at ACDC Vicki commented:

We had the tests and saw a lady from Next Step [Drug and Alcohol Service], she was lovely. I'm glad [I came here]. It was a bit of a travel, but...I got here alright.... It was the best decision I made. If I didn't tell my doctor what I did, I probably would of just went to XXXX, cos I wouldn't have said anything.

Whilst some mothers did not enjoy all services provided on a regular basis they chose to attend and therefore accepted in principle. Candice said, 'I haven't always agreed with the people I have to see but that is part of their list and so, to be part of the clinic I have to agree'. Furthermore, Candice was a regular patient of the clinic and believed it was to her advantage to attend, thus promoting her health and that of her unborn babies. She said:

I've been involved with the ACDC since that first pregnancy because I believe that you are better off telling what you use and what you do as opposed to not, so that if anything does go wrong they are better equipped to deal with it.

Some mothers were considered high risk and received intensive antenatal monitoring. For example, when Ruby was pregnant following a previous fetal death in utero, her care regime was intensive.

I ended up having to be in here once a fortnight, then it changed to once a week and then it changed to twice a week, twice a week every week up until he was born. So they did do really well this time. They did, but I was really freaked out.

In addition Ruby was, 'admitted to hospital [multiple] times because [the baby's] trace wouldn't come up to standard. He wouldn't have enough accelerations or whatever.... They really went overboard this time, but it made me feel, at least my baby is safe'. Other mothers also received additional antenatal monitoring, or were hospitalised for monitoring, rest, and focused care. Carol was hospitalised due to pre-eclampsia. She explained, 'I was really sick so, I stayed in hospital. That helped me stay off the drugs. Because I knew I was pregnant I didn't want to touch them, so being in there, I couldn't, so that was helpful'. Without the enforced hospitalisation the task of modifying her use, in an effort to protect the wellbeing of the fetus, would have been far more difficult. Indeed, Carol remained in hospital until 35 weeks gestation when she was delivered by caesarean section. She recalled how the decision was made: '[The pre-eclampsia] got really bad and the blood pressure tablets weren't working and I was feeling sicker and it was starting to affect [the baby]. They said, "It's time we took her out". Others also happily accepted the recommendation of caesarean section. Anne related how, 'they said, "Because he is really big we'd prefer that you had a caesarean", which was good because I'm a bit of a scaredy-cat, I didn't know what to expect, having a natural birth'. In general, adherence to recommended treatment was not an issue for the

mothers because they wanted the best outcomes for their babies, had by this stage developed some trust in the attending health professionals, and had entrusted themselves to the expertise of the obstetric and midwifery teams.

As the mothers became aware of their pregnancies initially some struggled to come to terms with the news, to make decisions regarding what they would do, and struggled to 'get their act together' and make changes to their lives in an effort to safeguard their unborn baby. However, they did make decisions, did change their priorities, sought antenatal care, and promoted their health and that of the fetus. The strategies they employed were effective in limiting loss of health to their fetus and to themselves; in demonstrating their commitment to the baby; and in building rapport with and trust in health professionals. These strategies of promoting health were consistent with the ideology of health promotion espoused by the World Health Organisation who state that "Health promotion is the process of enabling people to increase control over, and to improve, their health" (World Health Organisation [WHO], 1986, p.267).

#### **5.4 Safeguarding as mother**

Safeguarding as mother encompassed the oscillating struggle of mothering with limited resources whilst endeavouring to attain 'good mother' status. Within this study, safeguarding as mother was a process of providing the day-to-day care of infants and other children which included but was not limited to love; nurturance; food; sleep; treatment; stability; stimulation and guidance necessary for children's growth, development and wellbeing. The mothers in this study had similar ideals to mainstream mothers on how they should care for, interact with, and provide for their children, as well as manage the household, and cope with the day-to-day work involved in raising a child. However, these mothers were attempting to achieve the same goals but at the same time were being judged and disapproved of because of their drug use and the incongruence between drug-user and mother; were often in dysfunctional relationships where they were abused and manipulated and they had limited financial resources and social support; they were dependent on psychoactive substances and needed to dedicate some time to accessing their drug, either through illegal sources or through pharmacotherapy programs; their health was compromised with withdrawals, intoxication, depression, and/or hepatitis C; their babies were often unsettled and demanding as a result of exposure to psychoactive substances in utero; they were fearful of losing their baby to the authorities if they were judged to be incompetent or putting the baby at risk and were under scrutiny to

perform at a high standard; and they were often inexperienced in the mothering role. Despite their circumstances or experience, the role of providing care for children still needed to be achieved.

Whilst the overall goal of these mothers was to strive to be 'good mother', at times they *struggled to mother*. When struggling to mother they engaged in *trial and error nurturing*. However, struggling to mother was not a constant or static state and as they experienced success in certain tasks, developed confidence in themselves and their ability, utilized trusted support systems, and limited threats they were more able to be proactive and *take back control*. When they took back control they were able to *strive to be 'good mother'* through nurturing and by increasing their capacity. Whilst the proactive strategies employed were primarily to be 'good mother' and safeguard their children, they also acted as a way for them to earn respect from observers such as health professionals, DCD, and drug and alcohol personnel, as well as from significant others and friends, this in turn limited the potential for loss of child.

#### **5.4.1 Struggling to mother**

At times the mothers struggled to mother with the reasons ranging from their own knowledge deficit, to being affected by drugs and withdrawing or being intoxicated, being unwell, the babies being fractious or unwell, or from being physically and emotionally fatigued and being unable to respond adequately to the unrelenting challenges of mothering. In addition, the mothers worried about their ability to mother, about losing their baby, and about potential harm to their children. For these mothers the work of worrying was useful as it raised awareness of risk and forced them to think about the potential of their fears being realised. To manage in those circumstances, their reactive response was *trial and error nurturing* which included *meeting only basic needs* where they achieved only the bare minimum; they *struggled with care provision*; were *[over]protective*; needed to *abandon their ideals* and lower their standards; and at times, resorted to *chemically enhanced mothering* to help them cope.

##### **5.4.1.1 Trial and error nurturing**

If mothers had limited knowledge of how to perform certain tasks related to caring for infants and other children and did not have reliable or available support systems they attempted to work it out by themselves by a process of trial and error. Trial and error is a method of finding a satisfactory solution or means of doing something by

experimenting with alternatives and eliminating failures. This process can be successful but is often frightening, time consuming, and frustrating. Carol commented on how she was never taught, 'what to do as a mother but I was taught what not to do, by what happened to me. So, I know what not to do, which is just as good, if not better than knowing what to do'.

Often the mothers struggled to *meet the most basic needs* of their child. First time mothers, like Judith, had to 'learn the ropes' and adapt to 'a lot of change, cos it's a lot different to anything I've ever done before'. Others were parenting alone and, 'not having support in some situations that it would be good to have it in', made their task more difficult. Carlene explained how, 'my goals are basically to have us fed, cleaned, and make sure we eat, excrete, and sleep...[sometimes] I can only do the absolute bare minimum'. Kaye and others reported that, 'I've always made sure that we've got food for the kids and nappies and things'; and, 'Yeah, they are all fed and clothed'.

When their children were unwell it added another dimension to the role of mothering and stretched their capacity to renewed limits. When Judith's twelve month old son had gastroenteritis she explained how she dealt with the episode by doing just what had to be done whilst keeping him safe.

Xavier had diarrhoea, I put him in the bath...and he did it in the bath, so I cleaned the bath, ...I cleaned him up and popped him down on the ground so he could crawl around so he wouldn't fall...and he pooed on the carpet, so, whilst I was cleaning that lot up he did it again on another spot so I had to clean that lot up, for about six lots of it.

The mothers' health also impinged on how they were able to manage their mothering role. Anne recalled how she was on methadone when her first child was small. She was depressed and isolated from her support systems and struggled to accomplish even the basics needs for her baby. The methadone made her sluggish, 'I used to get out of bed late, or I'd get up, get a bottle and lay back down and lay next to him and put it in his mouth. You know, I wouldn't get up and feed him properly'. Others also struggled to achieve basic tasks and attributed some of it to their MMT because of how it made them feel.

Mothers also *struggled with care provision* and experienced particular problems with breastfeeding; establishing sleeping patterns; problems they had previously not

encountered; and disciplining older children. Skills as basic as burping a baby had to be learnt. Carol told of a time when:

Jemima cried for about three days straight, she would not stop, no matter what you did. I thought she had colic, and we just couldn't get her to sleep. We were just taking turns, taking it in shifts, "Oh, God, your turn". Then we went to his Mum's and she burped her. We didn't know that. Once we learnt that she come good.

Breastfeeding posed a significant problem for some mothers. Some felt that breastfeeding was synonymous with 'good mother' and tried hard to breastfeed. However, they felt they did not know if the baby was getting enough milk, their nipples were often sore; they were discharged home before their feeding patterns were established, and they felt pressured to feed when they were not sure if that was what they wanted. These issues were also exaggerated if the baby had mechanical feeding problems and could not attach properly or if the baby had NAS, thus making feeding a traumatic time for mother and baby. If the baby was receiving medication for withdrawals it was often sleepy, again making feeding difficult.

Cath struggled to breastfeed but her baby had a mechanical feeding problem. With help from midwives they repeatedly, 'tried putting him on the boob and I was expressing'. Others attempted to comply with the demands of health professionals to breastfeed but lacked the courage or knowledge to challenge those demands. Carol did not understand that she had choice in whether to breastfeed or not. She explained, 'I didn't like being pressured to breastfeed'. Babies that were on medication for NAS were often sleepy, had to be woken for feeds, and took longer than usual to feed. Lisa's baby was on Phenobarbitone, 'because she was on that I had to wake her up every three to four hours to feed her, otherwise she wouldn't wake up for her feeds'. These issues added to their challenges as they attempted to establish breastfeeding. Later, decisions regarding weaning also had to be made. Beth explained, 'I wanted to breastfed her longer but I went back to work and put her on the bottle. She wouldn't take the boob, even though I was expressing for a while'.

Establishing sleeping patterns was also a trial and error process. However, sleeping patterns were not static and changed as children grew and developed. Carlene struggled when her son required less sleep during the day and would not put him down to sleep but held him in her arms. She said, 'he's in my arms all day. He

doesn't sleep much. Some days he'll have three five minute sleeps in the day'. Cath's experience was that her baby, 'changed his sleeping, but just like a month ago it was a problem, sleeping, and I was feeding him of a night when he really should have been sleeping, so it was just working out the little things'. Similarly, Laura had problems with her son not sleeping and she struggled to manage him at night and cope with her daughter during the day when she was exhausted, but he too changed. 'He went from not sleeping at all to sleeping right through. It scared the hell out of me the first time cos I woke up the next morning, and thought, Oh, my God, because he had slept through the night'.

Despite efforts to establish a routine, issues arose and they were compelled to trial innovative ways of dealing with distressed babies. These strategies did not differ from those employed by mainstream mothers. Some used controlled crying techniques whilst others found different ways to settle their babies. Carol explained:

[Mothering] has its moments....once when she was crying and she wouldn't stop...I just put her in her pram, wheeled her in and shut the door. Then I went outside and had a cigarette and come back and she was still crying but I was composed enough to deal with her.

Judith had back-up plans and if all else failed, 'Mum sometimes comes over'. However:

I can't do controlled crying, I can't listen to him crying for that long, it upsets me, so...we jump in the car and go for a drive, 10 minutes later he's asleep and we go home and there's no problem.

As children got older, disciplining was a problem that many struggled with. Beth struggled over how she dealt with what she said to her children. She related, 'we do time out with discipline and things like that. Sometimes I tell them negative things and I think, "Oh, I shouldn't say that". Carol was frustrated by her six year old and used threats and physical punishment in an attempt to gain control.

[Sean] is back chatting, being rude to everybody, and hitting. So, I've told him that I'm going to take him to see a Doctor if he's going to keep that up.... When I smack him, I don't like smacking him but it's getting to the point where I have to now, and it hurts my hand and it does nothing to him. He just laughs it off.



Some related that they struggled with inconsistency and disagreement between partners in relation to behaviour and discipline. Carlene said, 'We could never agree on a particular form of punishment; we could agree on a form of punishment for wrong doing but there is always a blurred line as to what was wrong doing'. Others used unorthodox techniques to try to gain some control. Laura's toddler had been toilet trained but regressed when the new baby arrived. Laura's response was reactive as she could not cope at that point. She recalled:

I would tell her off every time she would do a poo in her nappy. I would say, "you know how to do it; you do it on your own". And I said that, "next time you do a poo in your nappy I'm going to take you outside and hose your bum clean, cos I'm sick of it". Yeah, she did a poo and I took her out the back and hosed her bum clean with the hose and...from then on she used the toilet.

As mothers struggled in their efforts to safeguard their children they sometimes overcompensated and *[over]protected by not trusting or relying on others* and by *being hypervigilant*. When *not trusting or relying on others* they were wary and cautious in their monitoring of the children in an effort to safeguard against potential threat. As a result of antecedents the mothers were wary, distrustful, suspicious, and vigilant and their fears were projected onto their mothering role. Many of the mothers spoke of their limited trust of significant others who had previously betrayed them, or had placed them or their children at risk. As a result they limited exposure to these people in an effort to avoid similar situations. Ruby did not trust her mother to nurture the children and explained her wariness of her mother's ability:

My daughter says to me, "Please don't make me go to Grandma's house". She doesn't like it cos my mum is so harsh.... My daughter will say, "I miss mum and dad, I want to go home". And it will be night time, and Mum will say, "There's the front door, get your bag and walk home". That's not the thing that you say to a little girl. She bursts out crying and saying, "I'm scared, I'll stay here". It breaks my heart to think of what Mum has said to her.

At times, the mothers perceived that risks of entrusting their child to the care of others exceeded potential benefits and chose to err on the side of caution. However, this in turn limited the social support available and increased their mothering work, and their psychological burden. Kerry commented, 'I get pretty anxious about what Emma is doing and if she's OK. There's only a very few people

that we will allow to look after Bub'. Even the child's father was considered a risk by some, who believed they did not focus adequately on the child, did not give medications as instructed, and felt insufficient care of the child was being taken. Carol had recently broken free from the father of her baby. She did not trust and was unwilling to allow anyone else to care for her daughter. The father of the baby had shared custody and she was fearful for the baby's wellbeing when the child was with him. To counteract this she often stayed over during access visits to be with the baby and thus, exposed herself to physical and emotional harm. Carol commented, 'I have a few friends but none that I can really rely on or would even try to rely on when it comes to Jemima.... I don't really want to rely on anyone.... I'll manage'.

Some mothers used the baby's age, size, and limited availability and willingness of potential support persons as impediments to entrusting their child to others. For example, Anne commented, 'I wouldn't leave Cameron at the moment because he's too little'; whilst Carlene said, '[The grandparents] can't hold Jeremy for a long time, so they can't babysit. When he's older they'll be able to babysit'; and 'I would love a break, but I just can't think of anyone I trust'.

Many of the mothers demonstrated a lack of trust in external sources to provide appropriate care for their babies. Reluctance to entrust their children to day-care-centres, crèches, and play groups was a combination of their inability to integrate with mainstream mothers, because they believed they were different, and because of their fear for the wellbeing of their children. Carlene monitored one service provider until she was satisfied of their trustworthiness, after which she permitted the child limited access but remained in close proximity. Carlene related, 'I trust [Crèche attendant] very well but that is really through being there and hanging around with her, and then I know to trust her... And she also knows when to come to me with him'.

As a result of their lack of trust mothers were *hypervigilant* in their monitoring of the child, the environment, and those who came into contact with the children. These reactive responses gave mothers some sense of control, however, it increased their mothering work and levels of stress; and contributed to overprotection and enmeshment. When being hypervigilant some mothers found it difficult to leave the baby in the care of others and chose instead to be the sole provider of the baby's care. For some this was related not only to an inability to trust others but to a

distorted connectedness (Bretherton, 1985) to the baby. Beth commented, 'I still take the whole responsibility of their care, yeah. I suppose if I really wanted to I could ask for help'. Lisa reported, 'I'm not really ready to leave her with anyone. I did it once and it was only for a couple of hours.... I rang and could hear Evelyn crying... [so] I went back to get her. I felt guilty....[like] I'm abandoning her'. Lisa was aware of her caution and commented, 'I'm a bit [over]protective of her'.

Extreme threat to a child or loss of a child also resulted in overprotection of the threatened child and subsequent children. Ruby explained how hard it was to entrust her daughter to another's care:

I had this psycho, beating boyfriend. I kept my whole family away...so I didn't have anybody except my daughter... I was extremely clingy to her...I needed her just as much as she needed me... It took me until...she was almost three to get her out of sleeping with me.... I've had her booked into [many] different day-cares but she was always very, very clingy to me and I to her because of the relationship I was in when I had her.

Kerry continues to grieve the loss of her children through apprehension, has distorted connectedness to her youngest daughter, and is fearful of losing her too. Kerry said, 'After what happened to the other kids I usually don't let Bub out of my sight.... I have kept pretty tight reins on Bub'. On the rare occasion she allowed others to care for her daughter, 'We have separation anxiety... She gets upset until she gets to auntie's house, but Mummy is upset for a couple of hours'. Similarly, Candice lost a child through abduction and after regaining custody she was overprotective and enmeshed with the abducted child. She explained that after the abduction:

Danielle was then always overprotected.... She didn't go to day-care; she didn't have all the extra outlets.... I worried that if her father had access to her he could quite easily leave the State, and then I would have to go through it all again, just to get her back.

Carlene also demonstrated an enmeshed relationship with her second child and had issues regarding trust, separation, and fear of being 'bad mother'. She was reluctant to separate from her child, even to have some respite for herself. This overprotective behaviour, in effect, exacerbated the potential to be overwhelmed by her mothering role and contributed to her loss of freedom. However, she defended her stance explaining that, 'He wants to be in my arms all day', and continued:

Neither of us is ready [to separate]... He is very clingy...very attached to me. Yeah, we are joined at the thorax.... I am going to have to move him away; I am going to have to move away from him eventually too. Give him a chance... It's just amazing to have so much influence over another person's life.

At other times mothers felt that the safest and easiest way to deal with their challenges was to *abandon their ideals* and lower their standards. Carlene spoke of how she felt 'impotent and unable' and, 'it's not so much the state of the house as it is the way it has become. I could do a lot...if I had the energy and the help'. Laura had, 'given up on the fact that I can't...do the housework and try and get things done'. Beth also explained how she yearned for but was unable to have, 'that day where you could just get the housework done without kids screaming or a kid crying all the time where you have to hold her on your hip or pick him up all the time'. Many spoke of the need for a break, 'Not so much break from them, just, let's face it, not constantly always having you to [provide their care]'

Abandoning ideals was also expressed where they complied with others' demands despite those demands being contrary to their opinion or the best interest of the mother or her children. Under threat of physical harm and manipulation by significant others the safest option for some mothers was to allow someone else to dominate. Kerry found herself in an untenable situation where abandoning her ideals limited potential harm. Despite her desire and attempts to breastfeed she was not 'allowed to breastfeed'. She explained that when she was breastfeeding one of her babies her partner's mother, 'told [X] that my breast milk was poisoning the baby. So, he said that if I got caught breastfeeding again he was going to break my nose again, so I had to stop'.

In the hospital setting mothers sometimes had to abandon their ideals and allow health professionals to dominate. This scenario usually occurred in the NICU in relation to infant care and feeding regimes. Babies were transferred to NICU when they were experiencing NAS or had a congenital anomaly. Mothers often felt disenfranchised and did not know the rules and routines within the nursery; they felt very guilty and ashamed that their baby was withdrawing; they attempt to conceal the reason for the baby being there from family and friends; and believed that they were being judged by health professionals. Often they were tired, and found it difficult to get to the nursery, especially if they had already been discharged from the

hospital. They were expected to make the journey from home to interact with, provide care for, and feed the baby on a daily basis. Laura also had a toddler to care for and explained the dilemmas of getting to the hospital:

[Baby] was feeding every three hours, like, and I was actually hoping I could stay in [hospital] with him, but they said that I had to go home. I wasn't well... It was a pain in the arse, like cos, I had to make my way down there every single day.

All of the mothers struggled at times in their endeavours to be good mothers; however, when the struggle overwhelmed them, and they had exhausted their available resources they sometimes resorted to *chemically enhanced mothering* to achieve what they believed was important. Very few had help in the home and many spoke of using amphetamines to 'get the housework done' and 'cope with the demands of the baby'. Candice had a large family and explained that she, 'used amphetamines to help her cope'. Laura had little social support, was young and had limited mothering experience; she had a toddler and a newborn; she was on a treatment program that 'made me really tired', so, 'in order to take care of Robyn [toddler] and keep up with her as well as all the other things I needed to organise, I felt I needed amphetamines to keep me going; just to get off my arse, basically'. Also, in the early months of her son's life he was experiencing NAS and had very poor sleeping patterns. At that time Laura relied on amphetamines to help her cope.

I would not get any sleep, not even little naps; it just wasn't even worth me going to sleep....I was just like a walking zombie.... I might as well just stay awake all night because I'm not going to get any sleep anyway. I thought, while I'm really tired and I'm shitty with both of them, I might as well just take the speed, at least I'm not tired.

Candice's second child had cerebral palsy and it was because of the struggle to provide the day-to-day care for him, on her own, that she commenced amphetamines and has been a user ever since. She recalled, 'I looked after him until he was nearly four, when he passed away. It was during that time, those years that I started using amphetamines'. Now she manages her energy levels and her labile moods with amphetamines. 'I had the energy and I'd move rooms around and it wasn't a problem to do housework'. She went on to explain how:

I used to go through the typical down that everyone goes through when coming down off amphetamines, but ...I know the stages...and that was a

way for me to combat the downs so I didn't get angry with the kids, so I didn't get moody....to avoid coming down you just use again.

Chemically enhanced mothering was also discussed by health professionals who commented:

The girls using speed, so often they are using just to get through the day; to get out of bed; to get their kids to school; to tidy the house; to elevate their mood; it is self medication, not getting off and having a party and being able to drink more and all the things people think speed is used for.

Whilst the reactive responses employed helped mothers cope temporarily, and at times they found satisfactory solutions to problems through their experimentation, these responses were not long term sustainable strategies. Unfortunately, as mothers struggled with trial and error nurturing they remained extremely vulnerable to: scrutiny from observers; loss of respect from those who considered their drug use and mothering roles were in conflict; loss of freedom if their mothering role became overwhelming, and if they remained reliant on psychoactive substances; loss of health from intoxication and withdrawal if they were using psychoactive substances to help them cope, and loss of health from psychological distress; potential loss of child if it was deemed they were unfit; and their trust in others remained compromised and was often reinforced. However, they did experience success in certain tasks, developed confidence in their ability, and limited some threats and thus they were able to become more proactive and *take back control*.

#### **5.4.2 Striving to be 'good mother'**

When the mothers were stronger and more competent they were able to be proactive and strive to be the best mother they could. Their desire to mother adequately and to be considered 'good mother' motivated them to engage in *nurturing and increasing their capacity*. When nurturing they were available for their children; were able to provide appropriate care; could love and protect their children; and provide stimulation and guidance. When increasing their capacity they increased their knowledge and skills and were organised. When they were able to demonstrate their mothering capacity it gained respect from those who judged them and disapproved of their drug use; it helped maintain the health of their baby/children; it bolstered their 'mother' identity; and diminished the potential for loss of their child to the authorities or to other family members. The proactive

strategies they employed also helped them gain control which diminished their loss of freedom.

#### **5.4.2.1 Nurturing**

As the mothers became more familiar and competent with their mothering role they were able to *take back control* and focus on *nurturing*. Nurturing is putting children's needs before their own, providing tender care, protection, encouragement, stimulation and guidance, and being alert, available, and responsive in an effort to help them thrive, grow, and develop. The mothers believe that nurturing their infant/children is integral to the ideal of being 'good mother' and they worked hard to nurture their children.

*Putting children first* was a process of priority setting and shifting from an egocentric focus to an inclusive focus with the children's needs being met before their own. Mothers were cognisant of the need to be alert, available, and responsive to their children. Judith managed her methadone so that she was not drowsy. She said, 'I couldn't stand being on too much [methadone]. I need to be able to focus on what I need to do really. I can't afford to be tired all day'. Cath told of her shift in thinking and how, 'you have to respond to the baby and be there.... I'm never off my face enough to not respond to him or put him in danger, but I have to keep evaluating that'. Laura went into a treatment program but still used speed to help her achieve her daily goals. She commented, 'there's no way I wanted another heroin habit, it was just too much, especially with a baby, you can't be hanging out for the heroin. Speed's a bit different'. Similarly, others spoke of how their life had changed as a result of their role as mother. Beth commented, 'My life has changed in the sense of being... I don't really think about myself much. In a way that's part of being a mother, you know.... I was a little bit self-centred when I was taking drugs'.

Many of the mothers spoke of their commitment to their children. Anne commented, 'I'm living for my boys. You know, everything of my life revolves around them'. Likewise, Ruby declared, that, 'being a good mum...means making sure that everything automatically, without even thinking, that your child comes before, absolutely before, everything else'. This sentiment overruled even intimate relationships for Candice, who explained:

That's why I have been without a male in my life most of my life...because it's just another person to have to spend time with and a lot of times I'm not

willing to take that time away from my children because I believe that they deserve it first.

The mothers were conscious of the impact of their decision making and took the children's needs into consideration. Judith explained, 'both these babies come first really, it doesn't matter, I mean, if they aren't happy, then I'm not. I'd do anything for them..., all my decisions that affect them...I have to consider very carefully'.

Ensuring their family was adequately provided for was also a priority for the mothers and meant they must put the children first. Beth's attitude was shared; she said, 'I wasn't going to my family for money or not clothing or feeding my children first. [Feeding and clothing the children] was always priority number one and number two was the drug'. They realised that they could redefine their priorities and reallocate funds, previously spent on drug-using pursuits, to family orientated needs. Some reduced their drug use thus freeing money for basic needs, whilst others commenced maintenance treatment programs which circumvented the need to purchase illicit drugs. Laura reduced her amphetamine use to provide for the children. She explained:

I didn't bother about cooking dinners or making sure there was food in the house; I'd spend all my money on drugs. But now, I spend whatever money I have to on...things for the kids so I don't have as much money to spend on drugs, so basically I have had to cut down a lot on drugs.... I always make sure I've got enough left over in case I run out of something. And I've always bought what they need first before I've bought drugs.

Commencing MMT or other treatment programs effectively reduced the cost of maintaining a heroin habit. Lisa went onto MMT and was surprised at their disposable income: 'We knew we had to change and we knew we would need money... When we first went on [methadone] we were so surprised at how much money we actually had...we didn't realise how much we were spending on drugs'. Similarly, Ruby found methadone to be helpful. She explained:

I really like methadone as it gives you the chance to be a good parent and start a normal family life, just a normal life. It gives you the chance to be able to budget and pay your bill and make sure that you and your partner and your kids are happy and healthy.



However, being proactive and taking back control was punctuated with gains and setbacks and when the mothers erred in their resolve to not use they were remorseful and guilty. When using, Ruby reflected that, 'God, this money could be going towards clothing for my daughter'. Unfortunately, each setback took time to regain the progress previously made. Vicki commented that they were, 'just starting to come right again.... When I got pregnant we slowly cut down and now I think, even that \$100 we spend, we could have bought something for the kids'.

As mothers gained more confidence, knowledge and experience the *provision of tender care and protection* became a source of pride in their achievements. Care provision included the day-to-day management of children. Whilst some mothers struggled in the early days attempting to breastfeed most went on to successfully breastfeed their babies, some, for periods exceeding six months. Only 2 (12.5%) of the mothers chose not to breastfeed the index baby, with ( $n=12$ ; 87.5%) initiating breastfeeding. Multiparous mothers reported that they had also successfully breastfed their previous children. The mothers were aware of the multiple benefits of breastfeeding but were also influenced by their personal and social context, their choice of drug and their using patterns; their experiences with initiating breastfeeding; prior experiences relating to breastfeeding; and some, by their decision to return to work. Those who chose to breastfeed were concerned that drugs would cross into the breast milk and affect their baby and they took proactive strategies to address this problem.

To successfully breastfeed the mothers had to consider issues in addition to those issues encountered by mothers who are not using illicit drugs. They understood that feeding times needed to be considered in relation to their dose of methadone or buprenorphine, and their use of amphetamines or other drugs. The mothers spoke with pride of the success they enjoyed with breastfeeding. Laura reported, 'I was making heaps, I was filling up a 250mL bottle from each side.... I fed Robyn for six months'. Beth was an advocate for the benefits of breastfeeding and explained how, when on methadone she successfully breastfed her daughter. Her drug use had changed when her son was being breastfed and she again reported success. She said, 'I was on methadone with Claire and I was still breastfeeding her and she was doing fine. With Kieran I breastfed, you know, even with the amphetamine use, a couple of times I used. He was still...doing fine'.

Mothers also enjoyed the repose and closeness breastfeeding afforded them. Beth explained that, 'I'm very loving and always would be with my children, very loving and nurturing, in that aspect. I found breastfeeding brings a really nice closeness to them. Claire was breastfed for seven months and Kieran for nine'. Kerry spoke of the convenience, 'Oh, it is a lot easier, not having to carry bottles around everywhere. I've got no worries about flopping it out to feed the kid in public'. But most accepted that breastfeeding was the best option for baby and it was implicit with being 'good mother'.

In relation to breastfeeding the mothers accepted guidance from health professional on harm minimisation strategies as they could 'notice the difference in the baby if you feed them while you've got the drugs in your system'. Cath and others told of how the visiting midwife advised them on and how to, 'give a feed and then have [the] drugs, then express for a couple of feeds after that'. Being armed with that knowledge Cath felt, 'like I'm a good mother and I think that Andrew is a good example of me being a good Mum. He's happy, healthy'. Breastfeeding was also a good deterrent for mothers not to resume their drug use. Vicki was proud that she had significantly reduced her use. She said, 'I know that even if I did try it probably would affect my baby, cos I'm breastfeeding. [The midwives] have warned me about the breastfeeding, they have even told me what to do if I do use'.

The mothers on MMT were also concerned over what was the best approach to feeding their baby. They were generally well informed of what licit and illicit drugs they were on and what actions those drugs had. They did not want their baby to suffer either from the effects of the drugs or from withdrawals and took proactive steps in, what they believed, was the child's best interest. Carlene's son was being treated for NAS but she believed breastfeeding could also relieve his NAS:

[I was on] 12 mg of buprenorphine, which is more than I was taking in the beginning when I first started taking the little Temgesic pills and they had a big effect on me, so why would it not [have an effect on the baby] when I breastfeed him. [He was withdrawing] and the small amount of buprenorphine that goes through me might settle him down.

The fear of causing harm and loss of health to their baby was very real and influenced how these mothers approached breastfeeding. If they had used they felt guilty and chose not to breastfeed at that time. Kaye explained, 'you go through the guilt of, oh, no, I can't breastfeed now, I can't, what if it's going to have an effect on

her'. Similarly, Judith said, 'I had to bottle feed for a couple of day cos I didn't want to breastfeed...I didn't want to get any [drugs] to him'.

For some mothers the risk of the baby receiving breast milk containing drugs was not their only concern. Almost half of the mothers ( $n=6$ ) were also Hepatitis C positive and whilst breastfeeding was encouraged in this group, provided their nipples were intact, one mother took extra precautions. Carlene explained:

I really loved [breastfeeding].... The amount that he sucks and everything, he is very strong, I thought, well, I don't want the cracked nipples and the transfer of blood, so I used a nipple shield to make sure no Hep C got through.

With the knowledge of their hepatitis C status, others opted not to breastfeed in order to protect their baby. A health professional related:

Hep C is a huge issue for a lot of them. I mean, one poor girl, I had to tell her she had Hep C...she is devastated. We had to tell her because she was due to have her bub. And then, I went to see her on the ward...and she has made a decision that she won't breastfeed. She is going to express her milk into a bottle and bottle feed her breast milk. I sort of danced around that a bit, but this is her way of coping at the moment, because, it is all new. And even though she has got all the information, she is trying to make it even safer.

Minimising harm from drugs by their method of feeding was a proactive strategy that required planning, consideration, and vigilance to uphold. Some mothers opted to formula feed from the outset to avoid the potential of their baby receiving drugs or blood borne viruses through breast milk. They were adamant that it was in the baby's best interest that they did not breastfeed. Anne explained that she was, 'bottle feeding because of the buprenorphine. I have done since day one; I've never [breastfed]'. Ruby was on methadone and was Hep C positive, she explained her decision:

I have not breastfed, no, not at all. Everyone was telling me that I should because the methadone will help him, if he gets withdrawals. Well, I just feel that you guys are working hard at bringing him down off the methadone, he's working hard and having to deal with feeling crappy and coming down off his morphine, so, wouldn't it just be throwing a big spanner in the works if I was to come in and give him a little bit of

methadone [in my breast milk]. It made *no* [italics added] sense to me to keep him addicted, while you guys are trying to unaddict him, and he is trying to unaddict himself.

As the mothers became more familiar with their babies, and more confident in their knowledge, they learnt to read their baby's signals. Through those signals they were able to respond appropriately to their baby's needs and felt proud that they were in tune with their baby. Kaye explained, 'You get to know your babies after awhile and even though he's a newborn you still, the movements and things. I just feel...mothers can sense what is up with their babies... You feel what they are doing'. She also told how, with her third baby, she was 'better equipped to cope with [the baby]', she understood his cries better and 'right from the beginning that real contact, eye contact with him, I sort of felt maybe...I bonded with him better'. Carol described how, 'she tells me what she wants. Like, she will cry if she's hungry and you can tell; you know that it's that'. Similarly, Cath was a first time mother and told how:

I like it when I get to know Andrew more... I feel good when people will say [when he cries], "oh, it's this, or it's that", you know, and to be able to say, "no, he's tired or no, that's his attention seeking cry".... That's good, that confidence, yeah, Mum does know best, because I'm with him all the time.

To be observed to be 'good mother' was important and the mothers were all conscious of others' opinions of their care of their children. Kaye prided herself in the presentation of her children; they were clean, groomed and well dressed, she interacted with them quietly and with care, focussing on their requests and meeting their needs. In response the two older children listened to their mother, responded to her direction and played quietly with their toys and colouring books that Kaye had provided for their amusement during our interview. She related that she was often told she was a 'good mother' and painted a picture of a happy, normal family. She said, 'We'll be going for a walk..., Imogen's pushing Aaron in the pram and Angela is skipping next to her and I think, this is the best thing I've ever achieved in my life'. Additionally, to receive praise of one's parenting ability was encouraging, elevated Kaye's self-esteem, and demonstrated others respect for her.

Lisa spoke with pride of how she and her partner provided care and nurturance to their baby. She explained how Rodney was, 'really involved in' the provision of care: 'Evelyn loves him, like, I do all the messy stuff and he makes her laugh and

she loves him, she loves playing with him'. And, mothers were aware of and took delight in their children's development. Carol was enjoying her baby and the wondrous things she had achieved.

She has started crawling, she smiles heaps, she laughs, she is saying Dad and Mum, and she is saying other words but they aren't words, but it sounds like a word. She is eating, she is holding her own cup, playing with her toys and swapping them between hands, picking up little bits of whatever, putting her foot in her mouth.

Kerry's love for her daughter was evident as she described the goal of her caregiving, 'Making sure your kid is happy, content, and knowing that they are loved. And you can see that on Emma. Mother's little pride and joy'. She described her as, 'a joy to have around', and attributed her contentedness to the environment that she [mother] had created. Others also referred to the love they gave their children and Carlene spoke of, 'the mothering that I probably have the most confidence in, and it is what is most important to me and my values, you can't give a child too much love, especially a baby'.

When a child was unwell and needed additional care, medication, vigilance and understanding, routine care provision was extended and required extra effort. They did not want their child to suffer and made exerted effort to bring about resolution of the illness. Judith explained:

As long as he's happy, that's really all that I'm worried about. I don't want him fretting. I was hoping that [I would not go into labour] yesterday [when he wasn't well] so that he wouldn't be sick and then be without his Mum, cos when you're sick you need your Mum.

Others also spoke of caring for their children through illness, minor accidents, bumps and scrapes of childhood. Beth told of the extra work, 'when your children are sick you seem to have to give them medicines and you have to do, just those little extras'. They told of their vigilance in seeking medical attention and making sure they 'did the right thing' when their child was hurt or unwell. When Carol's daughter, 'hit her head on the tiles and she screamed like blue murder and I raced her down the doctors and they checked her over'. The doctor reportedly said, "There are going to be more bumps on the head, you know. This is the first time but it won't be the last... But it's good that you...have done everything right". Carol

said, 'I had put ice on the lump, like kept her awake, then I took her to have her checked over'.

These mothers also wanted to demonstrate competent care provision of their baby in the hospital setting. This was important for them as it gained respect from health professionals and a platform on which to judge their competence to be allowed to keep their baby. To receive positive feedback from health professionals bolstered their self-esteem as well. Beth explained, 'I mean I was up straight away wanting to do everything normally, breastfeed, you know, prepare, you know, bath and do all the normal things, just holding him, all that sort of stuff', and 'I know that deep down underneath I'm a really good person and a really good mother'. Kerry, too, was encouraged by how staff demonstrated their confidence in her ability as mother; she related an experience with the night midwife who said, "I'm doing the shift for tonight. If you need anything just buzz me..." They knew I knew what I was doing, like, writing down all the times for the feeds, cos I used to fill out the sheets myself'.

Beyond the provision of tender care and protection, the mothers actively engaged in *stimulation, guidance, and socialization* to enhance learning and development of their children. The joy these mothers derived from interacting with their children and *teaching/guiding* them was enlightening. Evelyn brought Lisa such joy, 'She's beautiful, I love the fact that she is mine and I'm teaching her things, everything she does, you know...I've taught her how'. All of the mothers spoke of activities such as singing, reading, playing, drawing, and providing educational toys for their children, and these were evident on field observations. 'I sing ABC to her and put her on my knee and bounce her and do horsey rides and play on the floor with her', said Carol. Like mainstream mothers, most of the mothers in this study believed that their baby was exceptional in some way, demonstrating their pride in their offspring. Lisa spoke of how her infant receives a lot of attention. 'She's spoilt, but in a way I think that's attributed to how clever she is and, cos I'm always trying to teach her something and, you know, letting her crawl around, trying to make her walk but not pushing her'.

Judith, and others, felt that being a single mother had some distinct advantages in that it afforded more time to interact with their babies. Judith told how, 'He's very bright actually...like, I spend a lot of time with him.... I think it's to the advantage of a single parent family, because you really have a lot more time for your children'. Others felt proud of their parenting abilities and Beth told how she did, 'lots of

mother things, you know, play groups and story times and parks and I provide my kids with a normal sort of upbringing.... I do a bit of pre-education with Claire and things like that'.

Those mothers who had limited access to their children still embraced the teaching role of being 'good mother'; however, it was more difficult and was punctuated with anger at the father of the child for not 'pulling his weight' and 'neglecting important issues'. Carlene took responsibility for these issues but spelt out her frustration.

He doesn't bath my son as much as he should or supervise him when he cleans his teeth; hence my son's teeth are bad. So I am trying to see my son more often so I can instil those things into him..., so that he doesn't get too lazy for too long, because cleanliness is a fairly big issue. His father has taken over the schooling side, the education, and I just do the weekend education, the tutoring, the sort of propping up where I can and filling in what the system doesn't allow for.... It is up to me to teach them everything they need to know.

Like most healthy children the children of mothers who use illicit drugs were inquisitive and 'into everything'. Allowing them to explore but setting boundaries and guiding their activities was part of the mothering role that these mothers embraced. Rules helped keep households in order, especially as children got older. At times they needed to discipline their children but to remain consistent and fair was never easy. Teaching children what is acceptable and what is wrong in relation to behaviour and language required patience. Patiently teaching toddlers to occupy themselves was also part of their education and in preparation for the arrival of the new baby Kerry explained:

Because I'm going to have to deal with [the new baby] I'm going to need a bit of time with him. If I am changing him or feeding him, Bub needs to be able to occupy herself at home. So we started off with, like, 5 minutes, I'll go and sit in another room for 5 minutes, 10 minutes, I've gotten her settled for  $\frac{3}{4}$  hour. I'll go and play a game on the computer whilst she is playing with her Barbies.

Mothers described their approach to teaching and guiding their children. Ruby explained how she sets boundaries, 'Yes, and discipline, like, boundaries, a lot of boundaries. Things like, my daughter is 3½ and when she gets into trouble, sitting down and explaining why she is in trouble and things like that'. Similarly, Candice

had basic rules within her household to manage a family of six. She said, 'I'm a vegetable person, eat meat and vegetables and then you'll get dessert. But if you don't eat your dinner, well, you go to bed with nothing. I don't have many rules but the couple I have I enforce strictly'.

When children used language that was not acceptable in society or they behaved in ways that were not appropriate mothers needed to 'bring them into line'. However, children learn this conduct within the environment in which they are being raised. Often it is not until they are removed from the negative influences that mothers can begin to address the offensive behaviour. This was the case for Vicki whose daughter, at three years of age, was saying, "Mummy's a druggy", and was swearing. After breaking free from her abusive partner and relocating she was able to address the issues with her daughter. Vicki described how, 'we used to growl at her and she used to say, "Fuck off, get fucked". And in six months we had her, a delightful little girl again because we were away from that [influence]'.

As children grew and developed, building relationships with children was an important extension of nurturance. When children were young, mothers attempted to provide tender care and protection; stimulation and guidance; and a safe environment in which they could grow and develop. The mothers attempted to limit children's exposure to threat by not trusting others; by their vigilance; and by protecting them against physical and emotional harm. However, as children got older and had some independence they needed specific guidance in relation to behaviour. Additionally, some were placed in situations where they could be exposed to potential harm. To safeguard against these situations mothers provided explanation or forewarned them. With younger children it may have been just an explanation of why certain behaviour was not appropriate. Vicki explained, 'at the end of the day we always sort of chat about [why I was angry]. You know, why she made me feel that way, cos she is at that age that I can talk to her'. Others simply encouraged dialogue in their effort to build confidence in their children to develop open communication and trust in them. Kaye explained:

Imogen talks to me about anything now, and already I've got a relationship with my eldest daughter that me and my mother just *never* [italics added] had, and still haven't got. But that's just the way we were brought up...but I decided to change certain things.



In relation to drug use and behaviour there were times when it was necessary to discuss issues with older children. Candice related a story of her oldest child with whom she has a strong relationship.

I felt I had to tell her [about my use] because her best friend's parents were selling and that's where I was buying it from as well. She was seeing the moods of people up and down and they would quite often leave fits [syringes and needles] around and so, I felt it better to tell her so that she could see, first hand, how drugs affected people, in the hope that she would then be deterred from them later on, herself.

*Socialising* was also an activity from which mothers and their children gained significant benefit. Many of the mothers had withdrawn socially from acquaintances in an effort to reduce exposing their children to the drug-using culture and to avoid judgment and disapproval. Additionally some had excluded themselves from group mothering activities, a finding supported by Banwell and Bammer (2006). Nevertheless, they appreciated that it was important for their children to interact with other children, to play, to share, to be exposed to different stimuli and activities, and to be separated from mother in a safe and supportive environment. Within Australian society these activities have become normalised (Banwell & Bammer, 2006) and are synonymous with being 'good mother'. Candice commented, 'All my children have been to day-care except Danielle [who had been abducted] and I have noticed the difference in them, how much they learn'. Many also appreciated the respite childcare and playgroup activities afforded them. However, the ability to engage their children in such activities was often compromised by cost. Additionally, choosing an appropriate socially enriching group and allocating time and funds to engaging in those activities for someone, who themselves may have felt socially inept, was a challenge for some of these mothers. Some were more comfortable than others and utilised mainstream venues; others chose programs specifically for drug-using families; whilst some arranged for their children to attend but chose to remain removed from the activities themselves. Beth felt comfortable enough to pursue mainstream activities. Her opinion was, 'I try to provide them with normal things that other kids do. Just cos you take drugs doesn't mean you can't go to play groups and things like that...doing parks and birthday parties and all that sort of stuff'. Anne too pursued mainstream playgroup but initially felt as if she 'did not fit'. She explained:

I didn't like going there, just because of the way I felt, but I couldn't not go, because Sean missed out; so I had to go. But, in the end, I started to feel a bit more involved and feel a bit more a part of it.

Kerry, on-the-other-hand felt more comfortable in a controlled environment specifically for mothers who use illicit drugs and their children. She said:

Originally Stuart [husband] had a bit of problem with me going [to PEPISU] cos a lot of the mothers are ex-drug-users, ex-street-workers. But he has finally realised that they don't push nothing on ya. I get to socialise with people, Bub gets to socialise with other kids.

Whilst socialising was usually conducted outside the home, *engaging with children* was usually conducted at home and was an important component of the mother/child relationship. Throughout the interviews the mothers portrayed themselves as 'good mother'. They represented themselves as spending unlimited time with their little ones, of playing with them, of making them laugh, and of listening to and talking to their children. These attributes are consistent with work done by Brown et al. (1997) on 'Being a good mother'. Whilst there was some frustration in not being able to 'do housework and try and get things done', Laura told of how, 'at the moment I just sit and play with him, all day, mainly'. Carol told of how, 'I read to her and talk to her and sing nursery rhymes to her and sing the alphabet'. Others spoke of the 'special moments I spend' and of how 'there are a lot of times we just spend talking to each other and playing'. Kerry explained that, 'reading time is any time during the day, just whenever she pulls out a book. We don't have a set reading time. Whenever she wants to read she'll bring a book, so we'll just sit there and read a book'. These vignettes of 'good mother' were important for the women to project, and allowed them to claim 'good mother' identity and to be judged by others as meeting societal standards.

When *nurturing* the safeguarding strategies used by the mothers in this study were closely aligned to attachment theory as espoused by Bowlby, beginning in 1958 and continuing into the 1980's; Ainsworth who worked independently and collaboratively with Bowlby over many years; Bretherton (1992); and Bell and Richards (2000). Those authors assert that "the ultimate functions of behavioral systems controlling attachment...are survival...and protection" (Bretherton, 1992, p.766) and that, "attachment behaviors are believed to have the biological function of protecting the attached individual from physical and psychological harm" (Bretherton, 1985, p.6).

Bell and Richards (2000) described attachment as a behavioral control system of the child that is dependent on nurturance from a consistent caregiver. They also assert that caregiving is the corresponding behavioral control system of the [caregiver/mother] that provides the nurturance to the child. This dyadic caregiving system of nurturance is a complex multifaceted process of interaction between the child and its secure attachment figure where connection and sensitivity provides the motivation for interaction.

These mothers derived pleasure from the dyadic caregiving/attachment relationship they enjoyed with their children, which in turn reinforced the connection between the caregiver/attachment figure and child. This is consistent with Bowlby's (1951) statement, "the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment" (Bretherton, 1992, p.761).

In their attachment relationship, the mothers spoke of the warmth, softness, and contact they enjoyed, and of their pride in their children. Kaye told how her youngest child is, 'very cuddly and gives me lots of cuddles', of how, 'the girls are really happy and Aaron is just a happy little baby', and how, 'when I get really depressed I just look at the children and they just make me smile and make me feel better'. They spoke of the love they had for their children. Vicki was proud to be mother and said to her newborn, 'Call me Mummy.... Each time he wakes, I'm enjoying it more, like I'm looking forward to it. I'm like, "Come on darling wake up"'. Vicki also recalled her experience with her daughter, 'When Bianca was born, I loved having her.... She came out normal and everything was beautiful, I loved it. I used to wait for her to wake up... I loved it'. Judith was concerned about how she would be able to give as much love for another child as she did her first. She commented, 'God, how can I give as much love and attention to two as I do already for Xavier? I don't want to feel like I'm giving him any less'.

#### **5.4.2.2 Increasing capacity**

When functioning reactively mothers learnt many of the necessary skills of mothering through a trial and error process. However, when they were proactively taking back control they endeavoured to *increase their capacity* to attain sustainable knowledge and skills necessary to mother to the best of their ability. *Increasing capacity* is the process of gaining enduring knowledge and sustainable skills that strengthen their ability, competence, and the scope of their expertise. Increasing

capacity is a continuing process of development over time that increases not only competence but also confidence in one's ability. Whilst increasing capacity mothers strove to *increase knowledge and skills; and be organised*.

In hospital, after the birth of their baby, there was an opportunity for mothers to increase their knowledge and learn new skills. The mothers spoke of listening and learning, and of asking questions and seeking answers to gain understanding of issues where they felt they were not competent or knowledgeable, or where they lacked understanding of events. Similarly, for health professionals there was an opportunity to engage these mothers and to teach; guide; answer questions; observe and provide feedback. Unfortunately, the prevailing conditions of time constraints; poor staffing levels; the knowledge, experience and expertise of staff; early discharge policy; the master status as drug-user; and the receptivity of some mothers influenced how effective the teaching/coaching role was enacted. However, when mothers were functioning proactively they sought knowledge.

Areas of particular interest in which the mothers sought information were the effects of drugs on the baby; breastfeeding; NAS; and infant and self care. Cath described how she gathered information, 'I was listening, I listened, I take it on, my goals were clear about where I was heading and what I'm trying to do and I'm older, too, I'm an older mother'. Similarly, Candice described how she managed the information seeking process, 'I know what sort of questions I want to ask so I always ask the appropriate person. And I don't ask the question more than once to different people'. Others observed, read available information, and read the medical records. Cath explained, 'I was reading; at [the hospital] I was focused on that because they were doing the NAS score and you were allowed to read the file'. Susie described how she and her partner gathered information, to put their minds at rest, in relation to an anomaly with the baby. Susie said, 'I was devastated...but then when I learnt a bit about it and spoke to some people and then got the results back it wasn't so bad'. Each of these methods of information gathering acted to increase their knowledge and understanding of issues which assisted in the transition to mothering their newest child.

Multiparous mothers had learnt many skills through experience but first time mothers were in urgent need of skill acquisition to give them the confidence to cope when they were discharged. Lisa commented, 'I had to learn things before I left, like, I hadn't given her a bath till day four or five', and, 'they had to teach me...how to

give her medicine'. Although not primiparous, Carlene prolonged her hospital stay because she felt uncertain of the child's management. 'I didn't want to go home...with a baby that was fractious and was going through withdrawal'.

Some mothers increased their knowledge, skills, and understanding through their own experience over time and explained how they were much better prepared with their second and subsequent children. Judith explained the difference between the hospital experiences with her first child to what she expected with her second child.

[Last time] I really couldn't see what the [midwives] were looking at [when Xavier had NAS], but this time, having had a baby before, I'll know what to look for, and I'll know what a normal newborn baby looks like, so I'll be [better informed].

Mothers in the hospital setting asked questions and sought answers. Ruby, continued to seek answers to give meaning to her experience of loss and to increase her capacity to heal. Her questions were pertinent and she needed to understand. For example, 'We had asked, "Did methadone have anything to do with my son's death?", and, "Why did he come out with blisters and stuff all over him?"

For those who were first time mothers they needed to learn the skills necessary to provide day-to-day-care of an infant whilst juggling the other tasks of running a home. Again, Lisa commented:

I knew as soon as I got home I would be able to handle it better. [In hospital] the nurses...offered me help [but]...it didn't seem right because I knew that once I got home that wouldn't happen.... When I got home...it was a lot easier...just making my own regime.

Other sources of skill and knowledge acquisition included direction from significant others, for example, one's mother, medical and nursing personnel in the community, reading, television programs, and through community services. When engaged in increasing knowledge mothers took presented opportunities to learn about issues with which they were struggling. Many spoke of reading about issues such as child care, domestic violence, incest and depression. Reading, and exploring issues that the mothers found difficult, distressing, or were particularly pertinent, increased their understanding and knowledge. Candice was reading about depression, she said, 'I've got a book, which I've started reading, which is called "Hand-me-down blues", because of my fear of passing my depression on to my children'. Others like

Carlene, sought knowledge through television programs and commented, 'I found it really good to learn how to cope with the different behavioural issues with my child; which I could never do, you know, I could never figure it out'. Some, like Kerry, completed programs within the community like the Positive Lifestyle Program; whilst Carol said:

I'm on this outreach program at the moment, so [psychologist] comes out once a week; and I have Best Beginnings. The lady from there comes out every Thursday, she's really helpful, brings me books, videos and brochures, things like that. She tells me what to expect next and what I shouldn't do.

Mothers also spoke of having a general practitioner for themselves and their children where they would seek information, and of attending the Community Child Health Centre when necessary for immunisations, baby checks, guidance, and to seek reassurance. Lisa commented, 'I see her whenever I need to know something'.

When I was putting Evelyn on solids I wanted to know whether I should wait or not and [Community Child Health Nurse] said, "you shouldn't do it too soon because it...can cause allergies or whatever". But, if that's what she wants, I've always just gone with whatever Evelyn wants really.

Mothers also spoke of building confidence over time. Cath commented, 'I'm getting more confident, and a lot of it is common sense, being a mother, and a lot of it's, just, you learn as you go'. Beth explained, 'I mean...my plan, as I get older, I have to get wiser, by experiencing and learning and establishing myself... I am learning'.

*Being organised* and prepared physically and emotionally for the mothering role also increased mothers' capacity as management and organisation are skills that need to be learnt. Those mothers who had already had a child had a better concept of what to expect. Kaye described how, with her youngest child she, 'felt quite armed with the goods I would need to sort of deal with it without losing it'. She had previously had postnatal depression but was on antidepressants, had a strong support system and had the experience of mothering two previous children. Judith told how she was physically preparing for the pending birth. She had just commenced maternity leave and was looking forward to:

Doing all my cleaning at home and organising stuff and putting my feet up, so, I'm going to have a couple of days of sleep, hopefully, and then really

tidy up the spare room and do all of the last minute things you do before you have your baby.

She had already, 'had the capsule installed in the car for the new baby', 'had the little bassinette set up', and felt that she was, 'starting to get into it, you know, thinking about it'. She explained how:

I'm just getting [organised] with a lot of the clothes, like little baby clothes ...and, oh my God, I can't believe how small they are....I'm used to carting around this huge, huge little toddler and now I'll have this tiny baby.

Later, when they were able to develop a routine around the baby's needs it provided some structure to their lives and a sense of achievement and control. Mothers knew that, 'It makes it easier when you're organised. I don't know how people get by if they're not organised', explained Candice. Beth said, 'My children have good structure'. Similarly Judith told how:

I've got a really good routine with Xavier...we always do things for him in the same order, you know. We get home from work, he has his dinner, then he has his bath, then he'll go to bed. And then, I just do everything...for the next day.

Judith went on to say, 'It's good for them too, because he knows after his bath it's time to go to bed.... Once the new baby is here then we'll be able to get a routine that includes her as well'. Others found the routine around their baby helped to keep them going. Ruby had experienced a devastating stillbirth and their toddler became the focus of their lives. 'Without Isabella [toddler] we would have found it difficult to keep going. With her we've needed to get up and keep to a routine'.

By increasing their knowledge and skills and by being organised mothers increased their capacity to develop competence, the scope of their expertise, and confidence in their ability.

## **5.5 Safeguarding to preserve integrity**

The third sub-process was *safeguarding to preserve integrity* which focussed on preserving integrity of self and children. Integrity is a human state of dignity and wholeness recognizing one's physical, psychological, social and spiritual aspects. Integrity implies that as an autonomous human being one is worthy of respect; entitled to self-determination; and has the right to safeguard one's interests. Again

the mothers oscillated between responding reactively to challenges and when possible, proactively taking back control. When responding reactively they *struggled to preserve their integrity*. They worked hard to *limit physical and emotional harm* and felt they needed to *alter their perceptions* and the perceptions of others. When taking back control the mothers engaged in *redefining to preserve integrity* where they actively *created a better environment; controlled events; accessed support systems; and remodelled self*.

These mothers lived in environments where the *threat of loss* was a reality. In particular they feared the *loss of health* of their child through physical and emotional harm, and the *loss of child* through custody battles and apprehensions if they did not meet society's expectations of mothering. This, in turn, had implications for *loss of identity as mother* if the child was removed. They feared others would *not respect* them or their children if they knew of the mothers' drug use; that others with whom they associated could potentially harm their child physically, emotionally, or sexually; and they *lacked trust* in others to provide care and nurturance to their children. Their *freedom* was also compromised when they remained in abusive and manipulative relationships, when they were dependent on psychoactive substances, and they were often overwhelmed by their mothering role. Throughout the interviews the mothers raised issues in relation to their safety and that of their children. The scope of threat meant that they needed to be wary, cautious, and vigilant. However, to live in a state of heightened awareness was stressful and emotionally draining. Mothers discussed triggers that alerted them of the need to safeguard, and their responses to threat and the strategies they employed whilst *safeguarding to preserve integrity*.

### **5.5.1 Struggling to preserve integrity**

Often the mothers *struggled* in their efforts to safeguard self and their children and preserve their integrity and reacted in response to events or situations. Their responses changed or moderated their immediate situation and facilitated short-term gains; however, those responses were often ineffective or resulted in negative consequences which increased their vulnerability. Struggling to preserve integrity included reactive responses to real or potential physical, verbal, and emotional assault in an effort to *limit harm*. *Altering perceptions* through dissociation was another reactive response in an effort to preserve integrity. When altering perceptions they also employed activities to minimize judgment through



concealment, excuse making, and demonstrating acceptability; and they positioned self in context to alter their subjective interpretation of self.

#### **5.5.1.1 Limiting physical and emotional harm**

Limiting physical and emotional harm included *safeguarding against abuse and neglect, minimising contact with drug-related activities and environments; and defended*. Many of these mothers had previously been or were still being abused and manipulated and were determined to safeguard their children from a similar fate. The sources of potential harm were the physical environment in which children were being raised; the social environment of the dominant and sub-cultures that the children moved in, or were exposed to; and the behaviour of significant others, for example, partners and ex-partners. Safeguarding against abuse and neglect in an environment where physical violence between intimate partners was a reality posed a genuine risk to children.

Whilst no-one discussed neglect, three mothers were investigated for neglect by the Child Protection Authority and were found to be providing adequately for their children and not posing significant risk. All three mothers felt vindicated that they had been judged against prescribed standards and were found to be adequate mothers.

As abuse was an issue in the lives of these mothers, when thinking of the future they considered avoiding the potential for abuse as being a high priority. Judith conveyed her fear, 'I need to think of [the children]...if I started seeing someone new, it...would have to be someone that I'd know they'd like, and someone that I'd know would never ever, ever even conceive of doing anything horrible to them'. Physical violence was often perpetrated by intimate partners and the risk to children was real. Ruby related how her partner beat her and put the baby at risk. She said:

I didn't really register the pain, I just registered that I had to keep her safe.  
If she wasn't in my arms he was going to run away with her, so she had to be in my arms. I kept her so she never got touched.

Emotional harm was more insidious than physical harm and mothers were patently aware of the risks of their drug use, behaviour, and lifestyle on their children. Immersion into the using mother's life and any exposure to the sub-culture had the potential to influence the child's understanding, attitudes, and behaviour as they grew and developed. The process of learning through role modelling shaped the

identity, values, and beliefs of children that could later conflict with values and beliefs of the dominant culture when children entered mainstream society through the education system and community activities. The mothers were fearful of others becoming aware of their use and of the potential for the children to be ostracised by their peer's parents and then by their peers. The mothers thus made decisions on how to limit intrusion of their drug use on their children's lives. The reactive response they employed contributed to containing the problem but did not negate the potential for harm.

Of particular importance to mothers was to *minimise contact with drugs-related activities and environments*. This was attempted through concealing their own drug-related activities thus limiting children's knowledge of their use; avoiding risky environments where drug-related conversations could potentially be overheard, or drug-related activities such as injecting, scoring, or prostitution were being conducted; and limiting exposure where avoidance was not possible. However, mothers were also realistic to the potential that children would accumulate sufficient knowledge from their day-to-day exposure that they would become aware of their drug use, which potentially would influence the children's self-esteem and identity as well as their relationship with their mother.

Fear of their children knowing of their illicit-drug-use was a significant problem for the majority of the mothers, thus, concealing drug-related activities was aimed at protecting children from that knowledge. Many mothers spoke of how they had, 'tried to protect [the children] from it...'; 'I could never do it in front of Xavier and I never would, quite honestly. No, it's not worth it'; and, 'I can't recall a time when Kevin used in front of Sean.... Kevin was insistent in making sure that Sean went out of the bathroom. I had to keep an eye on him'. Beth explained how they managed their use and attempted to protect the children.

I don't choose to use much in front of the children. So, I do take more responsibility, even if we have had the occasional use we do it when the children are in bed.... So I keep everything normal, providing that they don't see it.... It's the same, like, occasionally I smoke pot and I don't do it until they are asleep.

Others using in their home and around their children also had an impact on families. Beth explained how she attempted to limit such activities:

I approached these people and I told them I don't really like them coming over and if they do I don't want them bringing drugs.... I don't allow people to do things in front of the children...it just affects everything... I just knew it's not a good environment with them being around.

Avoiding risky environments was also an important process to limit potential harm to children from their knowledge of such activities but also from the potential of something untoward happening to the mother. Discussion about drugs and drug induced behaviours was a potential hazard for mothers who were attempting to safeguard their children from exposure and harm. The mothers commented on stories they had heard that, 'send shivers down my spine', and, '[I'm fearful] because of what you hear and what you see...in the drug scene'. Within their immediate environment they could limit exposure to drug related conversations. Kaye commented, 'I'm really aware of how people speak around the girls and what they say, there's a lot of places that I wouldn't go, people who I wouldn't visit'. Kaye proceeded to say, 'I despise yakking about drugs and I won't... I just can't get into that sort of thing...especially if the kids are around'.

Scoring safely was a high priority for mothers in relation to their children's safety. Two mothers conducted drug related dealings whilst the researcher was in their homes and whilst this negated the need to take small children out and into potentially risky environments, it did expose children to users/dealers. In one home, as well as a baby, one child was 3 years old and such activities would not go unnoticed.

Candice discussed issues regarding scoring and making sure she was safe because of her children.

I take care...about where I score from. In the past, if I wanted a taste, I would go to an open house. But then, the more the fear grew in me, of it being mixed with something, I picked my dealer and that is the only place I go. And if she's got nothing, well, I wait.

Limiting exposure where avoidance was not possible was another safeguarding activity employed. Unfortunately, it was not always possible to prevent children from being exposed to elements of the sub-culture, as there were times when there was no option but to take their children. When Judith went for her daily methadone, 'Xavier goes in with me when I have it, he always looks at the cup, you know, I think

he thinks it's for him'. Ruby said, 'now that I've got him, I'll be taking him and her to the chemist with me every day'. Whilst babies were inquisitive, older children were more perceptive. Kaye explained:

Um, and now because I'm still on methadone, it's so frustrating and, you know, often I'll have to bring the kids into the clinic with me. I don't like them coming with me and I would do everything I can to avoid that but often, on the school holidays, I can't, but I'll usually make them stay in the car and now that Imogen's a bit older I can, they can stay in the car with her...while I run in, I'm only in there for a minute or two, and run out.

The social environment to which children were exposed was difficult to control despite the mothers being aware of the potential exposure of their children to drug-related activity, conversations, interactions, and behaviours. No matter how much mothers attempted to safeguard their children, most children, irrespective of age, are perceptive, inquisitive, observant, and over time accumulate sufficient information to become aware of the reality of what is happening around them, especially in relation to their parents. The home environment is easier to control by having and abiding by rules and boundaries; concealing drugs and drug paraphernalia; and limiting visits by users and dealers. However, the total immersion of a child into the home environment and the role modelling and behaviours of parents made it difficult to safeguard children from the knowledge of their parent's drug use. Furthermore, the accumulating knowledge of their parent's drug-related activities is confounded by the daily barrage of sensational commentaries on television and in the press on the negative effects of drug use; on drug seizures; incarcerations; and drug-related crimes. For mothers whose children are old enough to understand these commentaries it exposes them as deviant and threatens the mother-child relationship. Additionally, it potentially destabilizes the child by threatened their security, especially if they have accumulated sufficient knowledge to understand their mother's/parent's involvement.

The efforts of mothers to minimise their children's exposure to the drug culture were also observed by health professionals who commented:

I find women that are...almost paralysed with guilt about their drug use, and whilst they might not be able to get rid of their drug use, they certainly put a lot of time and effort in trying to keep this drug use separate and minimise any kind of impact it can have on their children.

*Defending* was another reactive response used against attack, harm, or danger. When faced with criticism or threat the mothers defended themselves. Kaye explained, 'if anyone was to confront me about [using], ...then I would defend myself and I would justify my choices as well as I could'.

I say I don't give a shit what anyone else thinks, but you do, and you get hurt if someone says something nasty. But I've always been very quick to defend myself and, how I might behave on the outside is quite different to how I feel on the inside.

Some mothers also defended themselves physically from attack. Anne explained how her partner didn't always treat her well but he does now because she stood her ground and fought back. She said, 'the last time he hit me would have been about four years ago, and he won't do it again, because I'll hit him back. But I think he has that respect now'.

At times the mothers also found it necessary to defend themselves within the health care environment. When under threat, retaliation was justified. Lisa explained how Rodney, as her advocate, 'had a go at one of the nurses because she had a go at us'. Beth also related an unpleasant encounter and said, 'the first time it shouldn't have happened, then the second time, I wasn't going to let it happen'. She went on to say, 'But, after that they were very nice, because I stood my ground'. Others also 'stood their ground' and challenged remarks that implied diminished respect for them as human beings.

Kerry defended herself and refused to have her membranes ruptured during labour due to abject fear. She had been told by her support person that, 'it feels like they are ripping your insides out when they are breaking your waters'. Soon after, the midwife advised, "We need to break your waters or your labour is not going to progress". I said, "*No, you are not* [italics added], you're not touching me". I held off for four hours until I finally [allowed the procedure]'. Whilst refusing treatment initially preserved integrity, ultimately it put Kerry in a position of heightened vulnerability, diminished her quality of care and threatened her wellbeing.

Also within health care settings the mothers, at times, needed advocates to defend them when they were most vulnerable. Some health professionals were perceived to be so threatening that the mothers did not want to see those staff members alone. Cath commented how she found one staff member to be so damaging to her that, 'I

was at the point where I didn't want to see her alone again, I wanted someone with me. When I saw her at the clinic, I preferred the midwives or [the drug and alcohol person]'. When in labour others sought a trusted partner, family member or friend to be with them. Vicki told how, 'my partner came over and sat with me all day and his mum ended up calling over and she sat'. To have a loved one supporting and encouraging during labour was welcomed and those people could also monitor care and seek help as necessary if health professionals were not immediately at hand.

After Ruby's second child had died in utero she and her partner were negotiating with hospital administration and had engaged a lawyer. To defend them through that threatening process Ruby's father acted as advocate. She said:

My dad lived in Malaysia and he actually flew back so that he could be in those meetings [with lawyers and hospital administration] with me and my partner. I was on methadone so I was really drugged out and they wouldn't lower my dose, to keep me basically all knocked out, so I didn't have to think about myself.

When Ruby was pregnant again, following the stillbirth, the thought of re-entering the same hospital and entrusting herself to their care was untenable. She sought alternative care but 'this was the only place that would take me'. Ultimately Ruby spoke to a Social Worker whom she had encountered on her previous admission.

I told her that I was pregnant and really, really scared... The [Social Worker] said, that...if she could guarantee that I only saw one doctor and one of each person, the same ultrasound person...would I feel more comfortable. And I said, "Well, yes, I would"... [So] I had the same person over and over and over again, right down to ultrasound.

Some situations were so volatile and carried a tangible threat of loss that without an advocate the experience would have been more traumatic. Kerry recalled how the Social Worker defended her from a representative from DCD, '[The Social Worker] was...the one that helped me out when I had baby number three. She's the one who wouldn't let DCD anywhere near me unless she was in the room'. Other achievements were also made easier or possible when health professionals advocated for them. Instead of struggling with bureaucracy and not knowing how to approach certain situations, some mothers were guided and helped to achieve their goal.

As some mothers struggled with other threatening life situations it was necessary to access legal services to help them settle disputes. Kerry and Candice needed to go to court to defend against accusations. Candice was accused, by an ex-partner, of alleged violence towards him and a friend, of possessing a knife with intent to stab, 'and a lot of other bullshit'. She said, 'I opposed those in court and in the end they had to drop [the charges] because the judge saw that their story was full of bullshit'. Similarly, Kerry and a supervisor, at one of her supervised access visits, were accused, by her children's grandparents, of assaulting one of her daughters. She said, 'The police threw that out'. However, the emotional and financial cost of defending such allegations through the court system severely compromised their financial stability and added significant stress to their lives. If they had been found guilty it could have threatened their freedom if they were incarcerated; they could have lost their children with subsequent loss of mother identity; their health could have been compromised; and any trust in the plaintiffs and the judicial system would have plummeted.

#### **5.5.1.2 Altering perceptions**

*Altering perceptions* were reactive responses these mothers employed in an attempt to modify their reality; to alter the perceptions of others; and to place them and their position in perspective in an attempt to preserve their integrity. To help them alter their perceptions the mothers used psychoactive substances to *dissociate* from their immediate reality; worked at *minimising judgment*; and *positioned themselves in context*.

##### **5.5.1.2.1 Dissociating**

*Dissociating* by taking psychoactive substances is only a temporary respite from a burden of threat but one with which these mothers were familiar. Using drugs to alter their state of reality was a reactive response widely used by these mothers. Carlene expressed common sentiment when she said, 'I would take any drug I could, just to alter my state of reality, because I couldn't handle [XYZ]'; whilst Kerry said, 'I wasn't trying to deal with anything. I just wanted to forget about everything'. The use of stimulants or depressants achieved different goals for users, however; the overarching goal was to temporarily alter their mental or physical state to ease their immediate burden. Some mothers reported the effects of stimulants that they desired were, for example, to sharpen awareness; elevate mood; increase and sustain energy levels; and sustain wakefulness. Ruby cited protecting her baby as being the catalyst for resorting to amphetamine use.

I couldn't sleep at night after Isabella was born.... He always said, "I'm going to kill the baby when it's born..." I was just so scared...I actually started using amphetamines...to try and stay awake so...he couldn't touch my child.

For some mothers who were depressed, central nervous system stimulants elevated their mood and allowed them to function. Candice said, 'amphetamines have always been a coping mechanism for me'. Carol's and others' reasons were similar:

[Speed] was the only thing that made me happy or feel good, or be able to ignore those things properly and not eat at me and drag me down. It was the only thing, so it made my addiction even harder, and when I went without it, I just wanted to escape that sadness.

Depressants on-the-other-hand dulled awareness and allowed the mothers to cope in different ways. Indeed, some were unable to function without opiates, alcohol, and/or cigarettes. Judith's comparison between stimulants and depressants was interesting. She said, 'With heroin...you're just disorganised, you are all over the place. It's an interesting comparison actually, because it is just one extreme to the other. One you're wide awake and the other you're a bit drowsy'. Some used heroin to dull their psychological pain. Beth commented, 'Drug use, it's funny but I think in a way I was numbing myself'. Numbing themselves allowed dissociation from painful stimuli such as discordant relationships; loss of a child or children; loss of attachment and identity when breaking free; and profound betrayals of trust.

Health professionals also told of mothers using drugs to alter their reality. One spoke of a mother who had been in a violent relationship, 'She got out of it but he kept the kids. But, I don't think that was a source of joy for her, but that was a source of using for her. Desperation'. Another told of mother who had just lost her child to the authorities, 'She obviously used straight after... But, of course, I understood why she used, I mean, why wouldn't she use, it's a coping strategy to help her deal with the guilt and the grief'. Yet, another commented on mothers dissociating with drugs:

It's a quick fix for if you are feeling bad, especially amphetamine, it will soon make you feel good. And these girls spend a fair bit of their time feeling bad, so anything that is going to make them feel better about themselves and be able to get through their day, I think, they are probably going to go for.



Even in the hospital setting Cath was so upset by distressing interactions with a staff member that it induced her to seek and use heroin to help her cope with the experience. She recalled, '[nurse] actually had me to the point, I went and used. I went and got heroin'. Again, in the hospital setting some mothers experienced poor management of their post-operative pain and felt it was necessary to take matters into their own hands. Carlene explained:

I was in huge amounts of pain. I actually asked my husband to bring in marijuana, anything...anything he could that could kill my pain. And in the end I said [to staff], "Look, I'll just take Panadol and anti-inflammatories, and my buprenorphine" [and managed my own pain].

Illicit-drug-use did alter their reality but it did not address the problems from which they were trying to escape. The temporary respite they achieved only exacerbated the problems they were experiencing, maintained them in a cycle of dependence, and added extra pressure on them to conceal their drug use in an effort to minimise judgment.

#### *5.5.1.2.2 Minimising judgment*

In anticipation of others' judgment, *minimising judgment* was employed by mothers to alter the perceptions of others in an attempt to convince them of their worth; to counteract any slight on their person; and to preserve their integrity. The predominant behaviours employed to *minimise judgment* included *concealment; making excuses and telling lies; and whilst engaged with the health care system, being a good patient; and proving oneself.*

*Concealment* was used by all of the mothers as a way of safeguarding themselves. They preferred to conceal what they considered to be failures or transgressions than expose themselves to potential judgment. Not only was it their drug use that they attempted to conceal but other aspects of their lives including, their pregnancy, being on MMT, depression, and an inability to cope with their mothering role. The mothers concealed information from their parents, partners, friends and acquaintances, and from health professionals, as to avoid judgment and be respected by those people was important to them. Many perceived that to conceal information that could threaten them or their children was more beneficial than to divulge this potentially threatening information.

To avoid the threat of being judged, considerable effort was taken to conceal their drug use. It was generally viewed that illicit-drug-use was a private matter and best not to be spoken about, 'I mean there is no reason why anyone has to ever know', said Judith. Kaye commented, 'I don't really say much to anyone else; it's one of the things you keep to yourself'. Beth spoke of how she concealed her drug use from others where she perceived they would not accept her or her children if they knew. It was important to Beth to be accepted as any other mainstream mother. She said:

You [conceal from] people that can't accept you..., you have to behave.... Overall I wasn't being anyone different and that's why [mothers from playgroup] accepted me... They just weren't aware that I was a heroin addict... [If they knew] they wouldn't let you near their children. It would have put [us] in a very vulnerable spot.

Beth went on to explain how she felt 'damned if you do' and 'damned if you don't' in relation to divulging the information. On-the-one-hand, to conceal safeguarded her and her children from judgment and disapproval but on-the-other-hand, she felt guilty about lying to her friends. However, from previous conversation she had had with her friends she perceived that they would not accept her or her children and would not respect her if they knew.

Beth's scenario was reiterated by a health professional who commented:

And they don't tell anybody in those playgroups about their other life. And I'm sure there are other mums in that playgroup that have got their own little secrets. This also makes them not want to go, they don't want to participate often because they feel like that they are going to stick out and not going to fit in. Not fitting in is a big one, ah. And they are terrified of others finding out.

Susie explained her decision to conceal her drug use from significant others because of the perceived threat of disapproval and how she perceived the news would negatively affect her loved ones. So, not only was she safeguarding herself and her children by avoiding judgment but she was protecting her family from distressing news. Susie explained, 'personal guilt and secrets and trying to hide [drug use] from everybody. We are still hiding it from our family that we are on methadone'.

Health professionals were also cognisant of the mothers' desire to conceal information in an effort to preserve their integrity. An example was:

Sometimes you get the impression that the women aren't prepared to tell you things and you just; I think you pick that up by perhaps their body language.... So, there is always that time when you do come across people not disclosing what they are using, but if that is their choice, then that's their choice. I can't demand that they tell me what they are using, and I don't. That's the way it is.

Others health professionals became aware of the efforts of mothers, to conceal from family and friends, whilst on home visits.

I had one girl who, she was spending a lot of time at her mother's, but she would catch me outside and just make sure I wasn't going to mention the medicine cos grandma thought the baby was on antibiotics; just in case grandma caught onto the drug taking. And another mum, she actually, cos I say to them, "are you storing the morphine safely", and it was tucked away in the laundry basket so nobody visiting would find it in the fridge. Another mum managed to keep her methadone use concealed for a couple of weeks, from her in-laws, who were visiting from over East. It must have been quite hard to pop off every day to the chemist to get her dose. But she managed to ride it out because she didn't want the judgment side of it.

Not only was it their drug use they concealed but some mothers physically hid from those whose respect they wished to maintain. Carol spoke of hiding from her friends so that they would not see her in a compromised state as she was fearful of their loss of respect. She said, 'When I was first pregnant and using really bad, I didn't see any of my friends. Didn't ring them, like, I hid from everybody cos I didn't want anyone to see my like that, I didn't want to be judged'.

Although engaged in treatment programs, some of the mothers felt that that concept was not well understood and that they could still be judged as if they were using illicit drugs. To preserve their self image, avoid judgment and maintain respect they opted, where possible, to conceal the fact that they were on methadone. Judith spoke of concealing her MMT from work colleagues and explained that 'no-one [at work] knows about [my methadone] of course.... It's just something I choose not to tell people'. This opinion, 'that it was no-one else's business' was reiterated by

others and although Susie could justify her choice to commence methadone to achieve the best outcomes for herself and her baby she explained, 'I view it as if it is my business and it is my secret I guess'.

The mothers also spoke of concealing their use and treatment from significant people in their lives. These were the people whose respect they yearned for most and who they also wished to protect. Vicki explained how her family would be shocked by knowledge of her use, especially when she was pregnant. To protect them from that knowledge and retain their respect, it was safer not to divulge that information. She said, 'I know [my Mum] would be devastated if she knew I was injecting'. Lisa attempted to avoid judgment and maintain the respect of her partner's parents. She said, 'People are going to look at us differently if they know and we don't want that. Yeah, we don't want them to think that we are bad parents [because] a lot of people view methadone as still using drugs'.

Kaye was a long term user and had been on methadone for many years. As a result of her MMT her baby had NAS and needed medication to treat his withdrawal. She had concealed her use from family members whose chagrin she could not tolerate and whose respect she wished to retain. She said, 'No-one except my husband knew that [Aaron] was on Phenobarb.... None of my side of the family, except my sisters; my parents didn't know that I was even on methadone.... I just couldn't bring myself to tell them'.

Concealing within the health care setting was also a safeguarding process used in an effort to moderate potential judgment and disapproval by health professionals and from family and friends who were visiting. In treatment situations one has little control over questions and discourse initiated by health professionals providing care.

The threat of being exposed to family and friends was frightening. Vicki said:

[When I] was in labour...the anaesthetist came in and she asked me all these questions... I thought, "Oh, God, please don't ask about my drug use", cos his mum was there... But they didn't ask, thank God. I would have said no, cos she was there.

Whilst health professionals should be able to provide non-threatening care to mothers who use illicit drugs and to their babies, previous traumatic experiences impact strongly on one's decision to conceal information from health professionals.

Because Kerry's three eldest children had been "taken off her", when she was admitted for the birth of her fourth child she concealed her drug-using history.

I basically kept it quiet [from health professionals]. With my fourth one I went to XXXX Hospital to give birth, so I wasn't...where I had all the others... I basically didn't want anyone to know.... I thought that the less they knew the less DCD would know.... [I was afraid of] them removing the last little one off me.

If others did not know that they were using drugs or were on maintenance treatment for their addiction it reduced potential for loss of respect through judgment and disapproval for what they knew was interpreted as unacceptable behaviour, especially when one was pregnant or parenting. As a result, some mothers even concealed their pregnancy. Kaye iterated, 'I was embarrassed and ashamed of it myself and didn't feel good lining up for methadone and would hide my pregnancy for as long as I could'. Whilst this strategy postponed others' knowledge of the pregnancy and temporarily allayed potential judgment, it also delayed seeking antenatal care thus putting mother and baby at risk.

Vicki also concealed her pregnancy, not because of her drug use but because significant others did not approve of her. She explained, 'We hadn't told [Patrick's mother], but, 'she had already found out earlier through a cousin'. It was then necessary to explain the deception and face the matriarch's wrath. Candice concealed her pregnancy from family members whilst she made decisions regarding whether she would keep or terminate the pregnancy. As she had concealed her pregnancy from her older children she then had to deal with the consequences of them overhearing a conversation where she revealed news of her pregnancy. This effectively removed some of her control as she then felt obligated to include her children in the decision making process.

The mothers also attempted to conceal their inability to cope and their depression. The stigma attached to mental illness is well reported (Corrigan, 2005), so it is not surprising that concealing one's depression was a safeguarding process that some mothers employed to avoid judgment and loss of respect. Beth, who had been depressed, explained how, 'I've always been afraid to associate myself with depression... I was very afraid to say depression. It scared me'. Kaye suffered from postnatal depression for many years before her husband became aware of her condition. She explained, 'I'm not the depressed person who would cry all the time.

Never in front of anyone else; Pete [husband] didn't even know that there was a problem for years because I would just break down and cry when he wasn't home'. This approach to dealing with distress postponed accessing appropriate management.

When the mothers were engaged with health professionals or confined in a health care facility, other behaviours to minimise threats were sometimes needed. To avoid certain staff because they had upset the mothers or had caused some distress or harm was difficult and they had to interact with them. One way to conceal their fear and discomfort was to disguise true feelings and present a façade to safeguard. Cath spoke of how under threat her, '[Façade] goes up, I'm so strong that people don't see how weak I am... [They don't see] that your strength is a weakness. [I was] having to be very strong [and the nurse] was not seeing how vulnerable I was'.

The stratagem of concealing was, at best, only a temporary solution and did not deal with the underlying problems. There was always the risk of their concealment being exposed and having to face the consequences of explaining their position and the risk of further loss of respect. This process added to their vulnerability and whilst they may have maintained respect from some people, it remained only an interim safeguarding process.

*Making excuses and telling lies* was also used by the mothers to minimising judgment. Excuse making is a conscious and intentional process that the mothers applied to situations where they perceived that they would lose respect if the truth was known. Considered an extension of the concept of concealment, excuse making allows one to modify their reality to a more acceptable version of events which is less likely to elicit disapproval and be less threatening to one's self-worth, self-esteem, and self-respect. Excuse making is influenced by one's need for approval and respect from others as well as a need to tolerate oneself (Black, 2006; Snyder & Higgins, 1988). Lisa and Rodney found that they made excuses about activities in relation to having their daily methadone. Lisa explained, 'Sometimes there were a few excuses to his parents, who don't know. We'd have to say...we've got to do this first, or we can't do it until 9 o'clock'.

Vicki made excuses about why she was going to have her baby at the tertiary referral hospital. She could not tell her family that the choice of hospital was because of her illicit-drug-use.

Patrick's mum and his sister went to XXXX hospital, and they said, "Why don't you go there?" I said, "Oh, it is because of my maternal age". That was my excuse and I said they just want to make sure everything is fine and cos there was a 1% chance of Down's syndrome.

Lying was also an extension of the concept of concealing in that it prevented the receiver from knowing the reality of what was actually happening and thus, potentially but not necessarily, safeguarding the liar from censure and disapproval. Like concealing, lying was only an interim protective process and there was an associated threat of exposure which made the liar very vulnerable. However, the distortion may have gained some temporary respect from others but it appears that self-respect and self-esteem were compromised by lying because of the guilt that it induced. Kaye was anguished by her lying and hated herself for doing it. Her avid description implies her guilt:

When you are using you just, you lie to everyone and I hate that, I hate it. I just felt I was a compulsive liar; everything you say is a lie, why you were late, where you were going, what you are doing with the money, why you need to borrow money, whatever, you are always making up bullshit and lies.

With concealing, making excuses, and lying in an attempt to safeguard self and one's children from a loss of respect, vulnerability was increased as one had to not only remember the falsehood but one had to remember who one had told or not told. The mothers had to continually evaluate the effectiveness of the process and ascertain if modifications were necessary to maintain the guise. These extra considerations complicated the process and did little in the way of safeguarding against judgment and disapproval. Indeed, when the shroud of concealment was ruptured consequences also needed to be addressed.

*Being a 'good patient'* was also employed by the mothers whilst engaging with the health care system in an effort to minimise judgment and any threat to their integrity. Some mothers worked on the premise that by being a 'good patient' and not calling attention to oneself there was less likelihood of judgment and disapproval and the loss of respect from health professionals. Because the mothers did not know what the attitude or practice standards of individual health professionals would be, to avoid them was a safe option. Avoiding interaction by not ringing the call-bell was a common strategy. Vicki was pleased that she had not rung the bell and explained,

'[Staff] just come in and do their job and I know they are there if I need them. And I have only used that [bell] once, to say, could I bath my baby'. Others also avoided using the call-bell as much as possible, even to their own detriment. Ruby recounted one incident where, 'I had these incredible pains in my stomach that felt exactly like contractions.... Anyway, I rang the bell, and I never touch that nurse's bell, I feel really guilty about making them come in here'. Whilst this behaviour may have compromised their care, these findings parallel those of Irurita (1999, p.14) and Irurita and Williams (2001, p.586) who found that being a good patient involved "not complaining, demanding, or ringing the bell too often...".

Other aspects of being a 'good patient' included demonstrating one's trustworthiness; keeping health professionals informed of one's whereabouts; and being readily available to provide care to their baby. When Cath's baby was in NICU, she kept the nurses informed so they could find her if the baby needed care. 'Well, I'm going to go and eat first and then I'll have a nap, or I'm going to go down stairs and have a cigarette. I told them everything I was going to do'. Similarly Laura made herself available exclusively to meet her baby's needs. She explained how, 'they would call me down every time he needed a feed. And sometimes he would just want a cuddle, so they would call me when he got a little bit upset and I would go down and give him cuddles'.

To minimise judgment and preserve integrity some mothers believed they also had to *prove themselves* to critics. Within the hospital setting, having to *prove oneself* was very pertinent as some mothers felt that their drug use history carried a 'master status' (Banwell & Bammer, 2006; Becker, 1963) and immediately raised the ire of health professionals who applied negative stereotyping, thus increasing their vulnerability and threatening their integrity. On admission to hospital in labour, Beth felt that as soon as staff realized she had a history of drug use they treated her with 'total negativity straight away'. Thereafter she had to defend herself and prove her trustworthiness. Similarly, when Ruby sought assistance, instead of receiving the care she needed, she was interrogated by a midwife who challenged her intent. This treatment diminished Ruby's integrity, and made her vulnerable and angry. She commented, 'that lady just made me...like, *fuck* [italics added], like two in the morning and I still have to prove myself'.

Some mothers needed to prove themselves in relation to care provision for their children when they were reported to DCD. Beth's mother raised the alarm and



placed Beth in a position of having to prove herself. She related, 'That was when my mother decided that...I was abusing Claire, which wasn't happening. Anyway, she found [I was still using], and rang Social Services and of course they came and had a look and there was nothing wrong'. This degree of social surveillance, which mainstream mothers are not subjected to, increases stress and vulnerability and reinforces social stigma, which is consistent with findings from Arendall (2000) and Banwell and Bammer (2006).

When attempting to *minimise judgment* through concealing; making excuses and telling lies; being a 'good patient'; and proving self, those responses safeguarded in the short term. However, the same responses increased their vulnerability and if deception was detected, diminished other's respect for them, and negatively affected their shame, guilt and self-esteem. However, it is an innate response that humans attempt to safeguard themselves against judgment and disapproval and from affronts to their self-respect, self-esteem and self-identity (Black, 2006), and these mothers were no different.

#### *5.5.1.2.3 Positioning self in context*

Another response used extensively by the mothers, to place their position in perspective in an attempt to preserve their integrity, was *positioning self in context*. Positioning self in context is a subjective evaluation of self and one's behaviour, judged against one's interpretation of an ideal self and with aspects considered important, and compared to the behaviour of peers and acquaintances. When employing this strategy the mothers *made comparisons and judged others; rationalised* their position; *assigned attribution*; and *sought reassurance*.

*Making comparisons* was not unique; indeed, it is a common human activity. In the context of the using mothers' lives they compared aspects of their life that were important to them. In most cases they positioned themselves in a positive light. Ruby compared herself to other addicts and believed she was better than those who did not present well. She judged them and evaluated herself above them as she took considerable care to present well in public. Ruby said, 'You see families out there where you can spot that the parents are addicts and their kids have got no shoes and have big matted hair. You can spot it and it looks disgusting'. Carlene attempted to put her use and her role as a using mother into perspective by comparing herself to a prominent Australian. She said, '[Name] was 'Father of the Year' and...managed to bring up a brilliant heroin addict.... Alcoholism was hard for

him and he became “Father of the Year”. I find that fascinating...and alcohol is a drug’. Carlene considered herself intelligent, highly emotional, artistic, and somewhat chaotic, but, ‘really, like anybody, I’m just a human being that is just somewhere in between [the extremes of human behaviour]’. The mothers compared themselves to users who were homeless or freeloading and considered they were of a far better calibre. Beth explained:

I like a roof over our heads and somewhere to sleep, you know, where some people can allow themselves to get right down there and not have that. I have friends that don't know where they are living [from one day to the next].

Some compared their drug-using patterns and believed they were within acceptable limits whereas others were out of control. Vicki justified her pattern of use by comparing to someone she knew. She said, ‘This girl that I met...she was a heavy user.... but, she lives for drugs. For us, we used to look forward to the weekend cos we used to have it on the weekend’. Those on methadone viewed peers who abused methadone as deviant. Judith said, ‘a lot of people go on it for the wrong reasons’. Ruby also commented, ‘There are people out there who use it as a crutch if they can’t score their heroin for the day, they can have their methadone... I’ve never been one like that at all’. Whilst many of the evaluations positioned the mothers positively compared to others, in some areas of their lives they considered they did not come up to scratch. Laura compared herself to her mother and said, ‘She’s really organised, her house is...spotless, and my house is such a mess, dishes everywhere, toys everywhere, rubbish everywhere’. Others believed that some peers were more in control, more organised, and more able to cope. Carlene lamented, ‘Oh, to be like that, not so!’

Making comparisons to other mothers was common practice and helped build a case towards considering self ‘good mother’. However, by comparing oneself to other mothers it provided some perspective on how others coped and positioned them along a continuum of mothering ability. Cath observed that, ‘there’s not a lot of difference between my life as a mother and non-users.... Yeah, there isn’t much difference between just being a Mum and being a using Mum’. Kaye believed she was not ‘the best mother [she] could be’ and said, ‘I lose my temper and patience easily but then, so do other mothers’. She was also aware that others struggled with adjustment disorders and depression. Again Kaye commented, ‘A friend ...who...doesn’t use drugs at all, has gone through basically the same thing of this

[postnatal] depression and things, almost identical, she's felt and responded the same way to things as I have'.

The mothers observed how other mothers provided care for their children and judged acquaintances on what they considered 'bad mothering'. Judith was proud of how she was mothering and considered she was doing a good job. She remarked, 'A lot of babies just sort of get shuttled around...from what I've seen... Sometimes [other peoples'] babies are like a bit of an inconvenience to them. I'd *hate* [italics added] to ever feel like that, I never have'.

Finally, they considered their children and how they compared to other children. Candice was proud of her children and commented how, 'they are pretty good kids. I'm happy. You see a lot of kids which have two parents which are doing a lot worse than mine'. She went on to say, 'There are a lot of people which use drugs which aren't interested in...[how] they bring up their children. I'm different I suppose'. By comparing one's child to others it provided a benchmark on which to judge their mothering. Kerry commented, 'Emma has...made me realize that I am a good mum... She's the brightest out of all my kids and I think that has a lot to do with mummy's influence'.

As they compared their lives to others they judged and attempted to give meaning to their experiences. Where possible they positioned themselves in a favourable light, and endeavoured to find good in their existence. By finding fault in others they elevated their own status and decreased threats to their self-esteem, self-respect, and self-worth. At times their experiences provided new meaning and new understanding to aspects of their lives. For example, Kaye explained that, 'before I was an addict myself, I remember despising [drug-using] mothers for having babies [and them withdrawing], where as now, I totally can sympathise'.

*Rationalising* was also an element of positioning self in context. Rationalisation is an unconscious defense mechanism where a person finds plausible explanations for specific behaviour while remaining ignorant to rational understanding. It serves the purpose of making unpleasant feelings and behaviours tolerable which would otherwise cause emotional disequilibrium, distress, shame or guilt (Cramer, 1998; B. F. Miller & Keane, 1987). Some of the mothers saw illicit-drug-use as a sickness and rationalised that it is no fault of their own that they continued to use. Kaye defended herself and her peers and said, 'But they are sick with an addiction and it

really is a sickness. I'm not making excuses for myself or any others [but]...it's a sickness'.

In relation to MMT Judith was able to rationalise her dose but criticised others and implied that others were rorting the system; something she would not contemplate. She said, 'I'm on 35 mg, ...that's a reasonable amount, that's not too high, not too low, it's average.... Some people [get stoned] because they are on too much, but, I'm not...on too much'. On-the-other-hand, earlier in Kaye's drug using history, she commenced a treatment program but continued to use heroin. Her justification for doing that was distorted but she was able to rationalise her decision, thus making it acceptable to her. She explained:

Because I kept using [heroin] I thought there's no point in getting off [methadone] until I stop using. And then I'll stop using so I'll start reducing and once I started reducing, I'd think, "Oh, I'll feel it now if I start using heroin". So, I started using again, so to stop using I'd go back up in my [methadone] dose.

The mothers also rationalised and found plausible explanations for the symptoms their babies were exhibiting when they had NAS. They did not want to accept that their use was causing their baby to experience withdrawal symptoms. To say that their baby was colicky was far more acceptable to them than to accept responsibility for the baby having NAS. Kaye remarked, 'Aaron...seemed to have a lot of problems but it was just colic...because he got colic straight away, as soon as he was born'. Susie explained that the diagnosis was wrong and her baby had 'low blood sugar, was a little bit jittery, and she went for monitoring in the special nursery... She is very colicky, that's the main problem'; whilst Lisa's baby, 'was having trouble feeding'.

Health professionals were aware of mothers rationalising in relation to NAS and one made the following comment.

But I think...some of them will use colic as an explanation and that it is not something they have inflicted on the baby. Depends on how guilt ridden they are.... I suppose some of them will, kind of, block it out, saying, "Oh, it's colic".

Mothers rationalised their failure to comply with treatment programs; relapsing; their choice of drug; their decision not to modify their use; their choice to self medicate;

and their enmeshment with their child. In each case the plausible explanations they provided served to ease their own distress and reduce the emotional consequences of being engaged in something they knew to be on the margins of their own and society's boundaries of acceptability.

*Assigning attribution* was another practice mothers used to explain events that happened to them and others. These mothers had varying attributional styles however, most adopted an external locus of control (Neill, 2006) when perceiving the cause of life events that impacted on them. Some believed that external forces (Briscoe, 2001) were attributable for what happened and they personally had no control over the outcome. Some had a strong belief in the supernatural and held credence in their interpretation of events.

Kaye felt ashamed and guilty because she was on methadone and pregnant until she was told by a psychic, "Don't feel guilty because all your kids are so forward that they literally pushed themselves to the front of the line to have you as a mother, you are meant to have these kids". The concept of a child choosing its mother was not isolated but expressed also by Cath. She said, 'I feel really special that he has chosen me as a mother'. For Cath, external locus of control was also attributed to other aspects of her son's birth and she believes him to be fortunate. She explained how he was born in a caul and how this was a good omen. Additionally his numbers 'lined up', 'he came out in this caul, and he was born on a blue moon, which is really good, and in delivery suite number 13. His birth dates are 3,3,3 in numerology, 9, and that's good'. Others attributed external forces such as God/s and karma to events in their lives. Candice believed that, 'Children are a gift from God and they are not ours to keep. They are only ours for a short while to mould as best we can....to the best of our abilities'.

*Seeking reassurance* was another way of receiving reinforcement and if that reinforcement was not offered spontaneously some asked for it. Receiving reinforcement acted to bolster their self-esteem, self-respect, and self-worth. As the mothers related their stories they were seeking reassurance by demonstrating that they were 'good mothers', and 'good people'. Kaye told how she often asked her husband for reassurance, 'I've always got this fear of looking like a junkie, and I often say to Pete, "I don't look like an ex-drug addict or junkie do I?". Vicki sought reinforcement about her appearance by prompting her partner, "Oh God, look at me, I look bloody fat..." And he said, "You look beautiful". To receive positive feedback

helped them position themselves in context and feel better about themselves. Cath spoke of how she is, 'gentle, maternal for other people, good with kids, all kids love me and I just felt like I would be a good mother. I've been told that I would make a good mother. And, I think I have been'.

Reassurance was also sought by devious means. Cath commented that, 'I needed to have some acknowledgment'. To achieve this outcome she modified the truth to test the reaction of health professionals. Even though she 'used throughout pregnancy...I just wanted to see what would happen if I said I hadn't used'.

It didn't make any difference. I think I wanted...to see if they'd give me a pat on the back.... The second time, I really had to make the point, "I really haven't had anything". [The response] was pretty finite, "Oh, yeah, fine". It wasn't...a real acknowledgment, it was sort of very basic...and [midwife] didn't look at me when she said it.

Receiving reassurance from health professionals was very important to the mothers and they valued the reinforcement. When Ruby's baby was in NICU with NAS she recalled:

I felt like the worst mother on this earth, I felt so guilty. But all the nurses down in Special Care were telling Matt to tell me that he's done really well because his immune system is really, really, good because I made sure that we were really healthy.

In interactions they attempted to position themselves in positive terms, whether it was with significant others or with relative strangers. At times they had to seek a positive response whilst at other times they provided positive anecdotes with the purpose of creating a positive impression. These reactive responses preserved their integrity in the short term, however, created potential for censure by those who became aware of any deception.

### **5.5.2 Redefining to preserve integrity**

When the mothers were stronger, more knowledgeable, and more able to implement proactive strategies, they took back control of some situations. This process has been labeled *redefining to preserve integrity*. Redefining to preserve integrity is making different that which was and includes *creating a better* environment in which to live and raise their children; *controlling events* to achieve that which is best for

one's family; *accessing support* systems to ease one's workload; and *remodeling self* on accepted societal norms thus causing self to be understood differently.

#### **5.5.2.1 Creating a better environment**

The environment has a major influence on a mother's ability to safeguard herself and 'all that is mine'. For children to grow and flourish they require an environment where they are respected, where they can play and explore in safety, and where they have rules and boundaries that are consistent and fair (McCain & Mustard, 1999). The mothers spoke of working at *creating a better environment*.

At times the safety and wellbeing of mother and child was sufficiently jeopardised that action to secure safety and support was necessary. Mothers believed they could benefit from *breaking free from their partner* and from *isolating self*. When the potential for harm to self and one's children reached a critical state some mothers, with their children, relocated to extricate themselves from an environment where they felt threatened, especially from a partner who was abusive and manipulative. This process of *breaking free* took considerable courage, time to organise, effort to conceal their whereabouts, and most often they left with nothing so had to rebuild their lives in a new location. Vicki's history included violence in two previous relationships.

My daughter's father was very abusive. I left XXXX to come here because of him, which is the best choice I made.... My daughter doesn't know her father.... She knows...bits and pieces; she knows she's got a father.... But, she's a happy kid now, and she's doing really well, cos she doesn't [witness the violence].

Anne also spoke of relocating, 'I moved up to Kwinana when I got my act together. Went there on my own, just me and my son'. Carol explained, after she broke free, how she, 'really wanted to have a nice place to have Jemima in and for me, so we are both comfortable and safe'. Kerry finally disentangled herself from an abusive and controlling relationship and broke free but in the process, lost custody of her children. Over time, and with help, Kerry rebuilt a life with a new partner in a safer environment.

When Ruby had her first child her relationship was volatile and dangerous. She said, 'Isabella was about three months old when I got out of there.... I actually went to a women's shelter and all that kind of thing'. She explained how, in the process

of leaving she lost her material possessions. 'He had gone completely loco and he burned everything that my daughter and I owned'. The ensuing enmeshment was intense and enduring. However, over time, she was able to start unravelling the mesh she had created in an effort to safeguard from physical and emotional harm. Ruby related:

It took me until...Isabella was almost three to get her out of sleeping with me.... It took until Matt entered our lives for me to slowly let go and her to slowly let go.... We have now, now I just put her to bed and say, "Goodnight sweetie", and she goes to sleep.

Whilst breaking free from a violent relationship has immediate benefits in relation to gaining freedom, being safer, and having less negative influences, it also results in significant losses. Losses include loss of identity as someone's partner or wife; loss of material possessions, as when one moves to escape violence it is usually done secretly; loss of security and income; and at times, loss of one's children and the subsequent loss of mother identity. One also loses friendships and networks, familiarity with one's environment, and remains fearful of a partner's ongoing threats. These findings resemble those found by Merritt-Gray and Wuest (1995) on mothers after leaving an abusive partner.

Another proactive strategy employed by mothers to safeguard themselves and their children and preserve their integrity was to *isolate themselves*. Physically disengaging or moving away from environments where violence was evident and observed by children; and away from where practices such as using, injecting, dealing, and drug paraphernalia were visible, provided a safer place to raise children. When *isolating self* mothers spoke of 'giving up' former friends; 'cutting everyone off'; 'ceasing contact' with their parents; 'avoiding' people and places they considered threatening; not pursuing contact with family or friends; and restricting their children from bringing friends home. They considered it was more prudent to avoid through isolation, disengagement and withdrawal than to risk exposure and possible harm. Health professionals also noted that mothers who use illicit drugs used isolation as a safeguarding strategy and stated, 'A lot of the women retreat and isolate themselves...when drug use is involved, and often times when domestic violence is a big issue'.

The mothers' efforts to avoid contact safeguarded them and their children from scrutiny; judgment, disapproval and the possible loss of respect; the opportunity for



betrayal of trust; and from exposure to elements from which they wished to protect their children. However, the choice to isolate self, possibly forfeit one's possessions, and have to rebuild one's life had a financial impact on mothers and often catapulted them into financial hardship. Isolation also diminished social networks and support bases thus making these mothers more vulnerable to loss of freedom and being overwhelmed by mothering in isolation; and to loss of health from stress, anxiety, and loneliness which impact on mental health. These findings are comparable to Black's (2006) findings on the effects of lack of social support, however, he also claims that isolation lowers self-esteem, and diminishes the immune response.

Ruby explained that in response to the untrustworthiness of potential friends she and her partner, 'just stopped being friends with people [because] every time we've tried to get sociable and have friends, it just causes problems'. Others also withdrew from social interaction to avoid exposure to potential threat and the temptation of using drugs. In relation to drugs Lisa said, 'If it was there, or if it was free, it used to be if someone offered me something I'd have it, no matter what it was'. To avoid this pressure some cocooned themselves in an insular life revolving around their new baby. On reflection, Lisa could see they were isolating themselves. She commented, 'Even people who do have kids still go out every now and again. Maybe I could leave Evelyn with my Mum and go to the pub or see a band, but we don't even do anything like that'.

Isolating was commonly used by the mothers in an effort to safeguard self and their children. Interaction they did have with others was often task specific and did not provide social support. Where possible, Candice actively avoided interacting with others so as to limit their ability to cast moral judgment which could impact on her and her children. She said:

Mostly I don't interact with [other mothers] because of the different social life.... I will converse with the parent or with the teachers as much as I have to in relation to Darren and his school work, but otherwise no.... Whether I'm being judged or not, it's a wall I've built up around myself.

Candice went on to say, 'my children's friend's Mums I hide [my use] from, only because of judgment that may be passed onto the children'. She proceeded, 'So, [in] small ways I try and prevent the other parents from knowing, and that's to protect myself but also to protect my kids as well'. Also to protect children from

judgment, mothers limited the children's interaction with other children and discouraged other children from visiting in their home. Vicki commented, 'I only let my daughter bring her friends over every now and again, not all the time'. However, for the children, this process of limitation diminished opportunities for socialisation and integration.

### **5.5.2.2 Controlling events**

For these mothers, as they were redefining to preserve their integrity, they began to control events to achieve that which was best for their family. Controlling events for many of the mothers was an alien concept as they had been controlled and manipulated by too many people for too long. Controlling events included *pre-empting* to subverting threats; *being assertive* to protect self and children; and *interacting differently*. By implementing these safeguarding strategies they built confidence as each success increased their competence and improved their self-esteem, providing building blocks on which to develop further confidence. When the mothers *controlled events* and made independent decisions they were able to shape their own destiny and that of their children.

*Pre-empting* was a deliberate act that made it difficult, pointless, or impossible for somebody else to say or do what he or she intended and therefore it safeguarded by preventing the occurrence of an unwanted event. To be able to pre-empt one needed to be aware of potential events, anticipate the actions of others, and plan alternative outcomes. When emotionally strong enough, many of the mothers used the strategy of pre-empting to safeguard from unwanted intrusion and threat. Vicki pre-empted the researcher's curiosity and the potential for moral judgment by explaining that a bruise, in her left cubital fossa, was the result of a medical procedure. She said, 'that's not from using, truly. It's shocking isn't it...? Must have been from when I was in [surgery]'. Kerry pre-empted DCD's involvement in surveillance of her mothering after the birth of her fifth child. She anticipated the paternal grandparents, of her other children, reporting her to DCD. By using her initiative Kerry averted intrusion and gained valuable support from the Department.

I told DCD to expect phone calls [from the grandmother]...saying the baby was getting mistreated. And of course, after about the fifth phone call, they called me up and said, "You were right, we are getting phone calls, but we know what sort of a parent you are".

Similarly, Judith pre-empted the potential for violence when her ex-partner was released from jail. To protect herself and her son from the possibility of her ex-partner intruding and causing physical or emotional harm she called a trustworthy aunt the night he was released from jail. Judith related, 'She came and stayed with me the night Steven was being released, cos I was a bit scared'. For the birth of her second baby, Judith registered herself under a pseudonym at the hospital to prevent her ex-partner, and father of the baby, from finding her when she was admitted. Also, as a result of being treated badly when in hospital for the birth of her first baby, Judith anticipated similar problems and pre-empted such an event. She prepared a letter to give to staff who offended her. She explained:

I've thought about how I'm going to deal with that this time around... I've written a letter. If anyone is mean to me like that again I'm going to hand them the letter and say, "please leave". And the letter says, "If you're reading this, you've obviously upset me and I don't want you to come back into my room. I'd rather someone else come when I press the bell, thank you".... I probably won't have the guts to say anything, so that's why I've got my little letter.

In addition to pre-empting mothers were also assertive. When *being assertive* to protect self and one's children mothers put themselves forward boldly and insistently when stating a position or making a claim. However, the mothers needed to feel confident, not anticipate retribution or retaliation, and feel sufficiently safe to be assertive and be able to speak out. At times the assertion needed to be confrontational. Candice was being stalked and the stalker was causing considerable fear for her own and her daughters' safety. He was prowling the yard and entering her home at night, leaving tell-tale signs of his intrusions. She was not sure who the stalker was but was suspicious and was desperate for it to stop. She believed the only way to gain control was to be assertive. Candice related:

I sent him a text saying, "How are you going stalker? Aren't you an obnoxious prick, all the times that you are in the area, you don't even stop in to see how we are". He sent back a text saying, "I don't have to call in to see how you are". Then a couple of weeks later he turned up on our doorstep saying that he wanted to be a part of our lives. And the stalking stopped.

As the mothers became more assertive they were able to set boundaries for those with whom they interacted. Anne told how she laid-down-the-law to her partner

about what was acceptable and what she would not tolerate. 'I told him before he went [to jail] and I've been drilling it into his head ever since'. Others took control of the distribution of family funds and needed to be assertive to maintain control. Carlene explained how her partner pleaded for money to buy drugs which would have compromised the money available to provide for their child. 'He comes in and says, "[friend] has got \$80, if you've got \$70 we can go get something". I look at him and say, "*No, you are not taking any of my money*" [italics added].

When they had developed sufficient confidence, were mature enough, and had sufficient courage some mothers spoke out about past abuse and confronted perpetrators in an effort to protect themselves, their children, and others more vulnerable than themselves. Beth needed to defy other family members to take a stance against her perpetrators. She approached a vulnerable family member with:

Look, I'm not saying that [perpetrators] are doing this now to your children but I would just like you to be aware of what happened to me when I was younger, so you can take the responsibility for the protection of your children.

Some took a stance to dissociate from people they considered detrimental to their wellbeing. Beth recalled how, 'I stood up for myself...to a big guy... I just had to say, "If you are going to come over, don't bring [drugs]". Ruby spoke out in response to betrayal by a formerly trusted friend, 'I told him to bugger off because I didn't need his crap; I didn't need his lies'. However, being assertive also had the potential to change and lose relationships, especially when there had previously been a power imbalance. Kerry had broken free from one abusive partner and was involved with another man. She was taking control of her life by being assertive and her new partner was upset and violent, 'because he reckoned I'd changed, I was a different person, because I wanted to do what I wanted to do, not what everyone else wanted me to do; for the first time since I was 15'.

In the health care environment, some mothers were able to be assertive to protect themselves from undue intrusion from visitors and also felt assertive enough to complain about inappropriate care; negotiate care; and refuse treatment that they did not desire. Lisa, a first time mother, was tired, anxious to focus on learning new skills in relation to caring for her baby, and inundated with well-meaning visitors. She, 'told [her] family not to come in any more, I made sure they all came once and said, "I don't want any more visitors". This assertiveness freed her to concentrate

on what she considered her priorities. Some mothers felt sufficiently affronted to tackle issues by complaining to preserve their integrity. When Cath witnessed the fabrication of assessment data on her son's medical record, 'Well, I complained after that...because...an agency nurse said, "Oh, I've never done that before". You know...the neonatal abstinence score, "Oh, I've never done one of them before". I said, "*Well don't do it then*" [italics added]. However, from then on she felt it necessary to be more vigilant whilst she and her baby remained in hospital.

Other mothers were able to negotiate to reach mutual decisions on appropriate care with their health care providers. The specific areas where negotiation was used most often related to birthing options, pain management, infant feeding, and discharge planning. Having been in early labour over two nights Vicki negotiated with staff. 'I just said, "No, I don't really want to go home. I'd really like to stay and have the baby". They brought the doctor in...and she said that we could do...the induction'. This outcome met Vicki's needs and did not unduly compromise the baby or the health professionals.

With a policy of early discharge some mothers felt compromised but were able to negotiate longer hospital stays because they felt unprepared to take their baby home. Alternatively, because the baby was remaining in care and they did not want to be discharged without the baby they were permitted to stay. Their status as illicit-drug-user identified them as high risk which eased policy implementation.

Judith explained how she negotiated split doses of methadone with her dispensing chemist.

I was having problems; having [my methadone] in one go was too much for me. I'd have it in the morning and I'd be really tired and really drowsy...a bit slow, and then in the evenings I'd be hanging out for it, I'd just need it again and feel really sick. [They said], "fine, we can put your dose up", and I'd say, "No, I can't because it'd be even worse in the mornings". That's when they split it and I haven't needed to put it up since.

Health professionals often found the mothers to be assertive when they felt safe and confident. They regarded assertiveness as progress in the mother's personal trajectory. One health professional related:

I mean some of them are quite forthright. We get sacked on occasion, you know, by women who feel that we haven't done the job. When they are

able to tell us, "I don't want to see you anymore, I want to see [another health professional]", well I think, at least you must feel OK, cos it's pretty hard to do that, to be able to actually come out and say that, to have the courage to be assertive enough to say it. And you know what, often times, they are right. No, really, they would be better off seeing someone else. So they can be very assertive, some of these women that come in, but not usually when they start off.

When being assertive mothers also took risks which could have negative consequences. A health professional provided one vignette:

One of our mums has recently [informed her children's school of her drug use] and it's OK, but she has to continue to stand up for herself, because, I think in a way it made them think that they could tell her what to do a bit more. And in actuality fact, what she was telling them really was just giving them notification that she was back involved with the school and that they would probably have to deal with her in some ways on a more equal footing, than in the past. That's part of her program, I mean, she's involved in NA and it's about honesty and stuff like that.

Whilst endeavouring to control events through assertiveness mothers often needed to advocate for their children. Cath said, 'I just wanted the best for my baby and was prepared to speak out to achieve that'. These mothers needed to advocate for their babies in hospital, their children at home, and their children in the wider community. It often took courage to speak out but for them it was part of mother-work. In the hospital setting it was experienced mothers who felt able to ask specifically for intervention for their baby. Beth fought to have her baby medicated because she knew the baby was withdrawing. She said, "I know she's withdrawing"... I knew she was withdrawing but they had to do her Finnegan score...it was so frustrating cos I just wanted her symptoms relieved'.

In the family arena, the mothers often felt they had to advocate for their children, particularly with the children's father and with grandmothers. Some grandmothers proved to be untrustworthy and unreliable and this had significant impact on the children, requiring mothers to advocate to safeguard them. Challenging grandmothers and setting boundaries when they frightened or distressed their grandchildren or 'made promises' that they did not keep was part of the advocacy role. Similarly, mothers had to direct fathers in how to interact appropriately with the

children. Kerry's new partner was a first time father. She explained, 'Sometimes he might get a bit hard on her, like, [if she swears]. It's like, "Stuart, just ease up a little". And he will say, "Oh, what am I doing?"'

Within the wider community, pursuing health issues until a satisfactory answer was received or dealing with issues within the school setting were typical examples of where mothers needed to advocate for their children. However, persistence was required to safeguard against a child's health issues being disregarded. Susie believed her son was having difficulty hearing which was affecting his school work. She trusted her intuition and pursued the matter to achieve a satisfactory outcome. She said, 'he was having problems with his hearing and eyesight... I was taking him to doctors...and they kept saying that there was nothing wrong. Then we had a hearing test done and that proved that there was something wrong'. Achieving the best outcomes for their children was on-going and challenging. However, when functioning proactively the mothers achieved considerable success which was generally made easier with help.

### ***5.5.2.3 Accessing support systems***

When *accessing support systems* to ease their workload, mothers carefully selected those whom they knew were trustworthy to provide safe care for their children and support them in their mothering role. *Accessing support systems* included *working together*; and *activating support networks*.

*Working together* for couples provided a raft of positive affirmations; strong affect or emotional support including respect, love and appreciation; and tangible aid. When tangible and functional assistance was forthcoming from one's partner mothers enjoyed working together in their parenting role. Lisa spoke with pride of her partner's commitment and said, 'Evelyn has also brought us closer together and I am really proud of Rod because, when I look around at other fathers they're not as involved as he is, he's really, really involved in it'. Ruby and her current partner also worked together and shared their load to achieve the best outcomes for each other and the children. She said:

My partner, for a start, is brilliant. He took my daughter on when she was 12 months old; took her on like he was her dad, like his own flesh and blood. So, he has been the best father that anyone could ask for.... He has his faults as well, but he's amazing. So, I can rely on him 100%.

Some mothers reported receiving assistance with cooking meals, entertaining the children, bathing and changing the baby, and getting some respite. If one's partner contributed to their financial security by working it made a substantial contribution to the wellbeing of the family. Beth's partner had not always worked. She explained:

[Harry] works and he provides [financially], but that's only been in the last six months, so that's new for us.... This is the first time he's worked since I've known him. It's good that he's taken on that role so I can concentrate on the children.

For those mothers with no partner, other sources of support were available and some mothers utilised family and friends as sources of safe social support, thus lessening the rigors of mothering work. *Activating support networks* was an effective process utilised by all mothers at times. Most had some family and friends who could be called upon to help them meet their needs and the needs of their children. Work done previously to create, develop and maintain social networks was the foundation on which to request and accept social support (Hupcey, 1998). However, it was necessary to determine who was the most appropriate from their support network to meet specific needs and who to avoid in certain circumstances.

Some could call on their mothers to help out, for example, to take a labouring woman to hospital, or care for a child when the mother was in labour and hospitalised. Anne relied on her brother to meet both those needs, whilst others called on their partner's mother to care for a child. Significant others were able to offer support and encouragement in times of transition. Judith recalled how her mum had helped when she broke free from her partner and needed help in finding accommodation, moving, commencing a treatment program, and finding employment. She said, 'it was a really dramatic change very suddenly, but I was lucky that I had my mum there to help out. If she hadn't made that offer, I don't know where we would be now'. Anne related how she has a strong family support base. She said, 'I get a lot of help from Mum...like with her just being around the corner. If I just want to go to the doctors or something I can leave Bubby with her, no problem'. Friends too were a good source of social support. Having maintained, developed, or re-established friendships they had created a safe source of social support. Carol spoke of her friend as, 'A really good friend of mine, almost my best friend, my sole mate, he's always there for me if I need a hand and only happy to help'. Ruby, spoke of 'rely[ing] on my sister, I can rely on my female best friend as well'; and Judith spoke of, 'being comfortable with Xavier being with any one



of...three people. Mum or my Aunt might stay with him for a bit, or one of my friends. He genuinely likes [my friend]’.

Outside of partners, family and friends, there is a network of available public and private resources to assist families in need. However, impersonal trust, as one has in a professional-client relationship (Gilbert, 1998; Shapiro, 1987) is built on a different basis than that of interpersonal relationships where the trust that is developed, over time, between family and friends is tried and tested through progressive exchange relationships (Shapiro, 1987). Indeed, professional relationships are governed by laws, regulatory statutes, professional conduct, ethical principles, and standards of practice, and rely on role competence and duties of care. Those accessing the services of professionals expect role competence and positive behaviour (Johns, 1996).

Accepting and responding to the support available within the community had the capacity to influence the mothers’ wellbeing. Mothers appreciated home visiting services that were available to them and some accessed more than one of these services concurrently. Home visiting was appreciated as it removed the stress of getting ready to go out, which can be a complex task with a baby and young family, especially when the mother is not coping well. Home visiting also moderated the power imbalance between health professional and the mother by meeting in the mother’s home. Cath commented, ‘I find the [home visiting] really good, like with [midwife] coming out and talking about...things is great. She's good, that's one of the first things she said, like, being safe and what that means’. Carol was receiving home visiting services from three separate agencies. She said:

I don’t have [any support] which is why I’ve gone to Women’s Health Centre and stuff like that, because I don’t have anywhere else to turn. And, I realize that things could go either way for me and I need some help from somewhere to help me go the right way.

Others used a range of community outreach programs tailored specifically for socially disadvantaged clients and were at no cost. For some it was a life-line and gave purpose to their week. Carlene commented, ‘if I haven’t got the yoga mornings or the coffee mornings, if I haven’t something to aim for, a time limit in the morning, then, [I struggle]’. Those services also offered psychosocial support and counselling. Kerry commented, ‘I had a counsellor for two years there, just in case I got postnatal depression again. And they were a big help’. She went on to explain

how, 'they would come to your house, take you out for coffee, no matter what time of night, if you needed to talk to somebody..., call their pager service and they [came] straight away'.

Selecting trustworthy child care was also part of activating support networks and was undertaken by some mothers. Just as some mothers needed to look outside the social network of family and friends for support, they also needed to seek independent services for child care. Childcare is now considered a mainstream service and it is within socially accepted norms to engage one's children in activities that will promote socialisation, cognitive stimulation, and provide early learning opportunities.

Utilising childcare, for some mothers, allowed them to pursue other aspects of their lives and provided respite from the relentless responsibility of parenting, especially for those with limited social support. Family and friends could not be called upon for ongoing childcare but could be utilised for emergency or occasional care. Candice commented, 'Mum has helped me out with the kids in the past, like coming over and caring for them so that I can go to the movies or something. [She] assists...as she can'. With six children at home, Candice needed some respite from her three year old when her new baby was born. The three year old was attending childcare for only two days a week but with help from the ACDC social worker, she was able to extend her allocated funded time to 50 hours a week, 'which means I can send her every day'.

Judith, on-the-other-hand had utilised childcare from early in her son's life and she intended to utilise the service more when her second child was born. She related how she trusted the childcare centre and how, 'He's been going there since he was five months old'. Judith explained, 'Xavier really enjoys day-care; really enjoys going there...and is so used to it already. So, I feel, at least I'm not having a baby and then dumping him at day-care'. She spoke of how utilising childcare will 'help me, because there's no way I can have two all day every day.... I just don't get anything done when he's at home with me'.

As mothers took back control and redefined their lives to preserve their integrity they were able to create a better environment in which to raise their children. When they were successful in safeguarding their children this contributed to increased confidence and increased self-esteem, increased respect for self and from others,

increased wellbeing, and increased resilience. When comparing these conceptual hypotheses with the literature, it is apparent that social support has positive impact on the physical and emotional wellbeing of humans (Bell & Richards, 2000; Black, 2006; Bretherton, 1985, 1992; Hupcey, 1998; Hupcey, Penrod, Morse, & Mitcham, 2001; McCain & Mustard, 1999) and is known to reduce stress, loneliness, anxiety, and improve one's immune system and overall wellbeing (see, for example, Keeling, Price, Jones, & Harding, 1996). Black (2006, p.203) described how social support is indispensable 'for the effective functioning of self' and how humans 'cannot operate effectively in isolation'. Within the attachment genre it is stated that maternal nurturance is significantly enhanced by spousal or social support (Bell, 2001; Bretherton, 1985, 1992). According to Kahn (1979) and Tarkka and Paunonen (1996), social support is intentional and positive human interaction or helpful behaviour that involves significant sources of emotional support, tangible aid, and affirmation.

#### **5.5.2.4 Remodelling self**

*Remodelling self* is making something different by changing the nature or scope of something or the character or role of somebody, or to cause something or somebody to be understood differently. When *remodelling self* it was an individual pursuit of establishing an identity more akin to one's ideal self and of how one wanted others to know them. Mothers who use illicit drugs are cognisant of stereotypes and stigma related to the disparate identities of drug-user and mother. They are aware that they are the objects of moral judgment and that scrutiny by external observers can be biased and punitive. Even those who were abstaining from illicit-drug-use and had been on long term methadone carried the fear of being identified as drug users. They could identify users by their appearance and behaviour and they were fearful of being identified and judged themselves. Consequently, as they took back control of self they embarked on a process of remodelling their image. Whilst *remodelling self* the mothers *interacted differently; modified their presentation; and reconciled personal and societal boundaries*.

*Interacting differently* was a safeguarding strategy where mothers changed their established behaviour and practices to achieve new ideals. Often previous ways of interacting were dysfunctional. They had developed those patterns growing up in dysfunctional families where members were disrespected; and being in intimate partner relationships where they were subjected to disrespect, violence and abuse. Some spoke of being 'conditioned' to interact in certain ways and had not realized

that those ways were not considered normal until they sought counselling. With help they worked at replacing poor ways of interacting with new ways of interacting where they attempted to meet new ideals of normative interaction. Beth's tale of being poorly treated by her mother inspired her to embrace new ways of interacting with her children. However:

It's so hard when you've been conditioned... It wasn't until I had counselling...that I realized that was the wrong way to be spoken to.... And it does worry me at times because I'm aware that that was not the way to approach the children.

Although counselling often commenced in relation to drug use, the issues that emerge were usually not drug related. Beth told how, 'it had nothing to do with the drugs afterwards anyway'. In counselling Beth explored her developmental adversity to discover that sexual abuse, betrayal, and emotional abuse were what was maintaining her low self-esteem, sadness, and vulnerability which were all influencing her mothering role. With counselling she learnt new ways of interacting, faced her perpetrators, and has been able to increase her capacity.

Others also undertook counselling and learnt new ways of interacting. For many years Kaye had tried to address the underlying issues maintaining her drug use and low mood. She explained, 'I started seeing a counsellor for the first time in my life ever, cos I have always tried to give up my drugs on my own'. With counselling and concurrent treatment for postnatal depression Kaye was 'actually enjoying [motherhood]' and reducing her methadone.

Anne spoke of how she and her partner used to argue and how it had escalated to violence which placed her and her children at risk. She explained how:

He did hit me a couple of times...and when we argued I kept going and going and going and going and he'd shut up and sit on the lounge and I'd just keep going at him until he just blew his top. I've sort of learnt to not do that now. We can disagree but it's not worth arguing about it, just get over it, why fight over something small.

Not only did they adopt new ways of interacting, they also *modified their presentation*. When some mothers were heavily involved with drug use and identified as drug users their appearance differed from that of mainstream women. To conform to their drug-using identity and 'fit' they explained how they, 'dressed

outrageously'; 'had green hair'; 'wore chains'; 'had multiple piercings and tattoos'; and 'hung around' with other users. These behaviours offered some degree of defense against shared threat. Personal appearance is a very powerful tool which is used as a means of identity and as a protective mechanism, thus, when these mothers looked so different it had the effect of intimidating others.

When Kaye became a mother she chose to be more conservative and wished to identify as a mainstream mother. As mothers generally do not have green hair, piercings, and wear strange clothing, she modified her appearance. She explained, 'I'm more approachable now, whereas before I wasn't when I looked like a freak'. To be conservative in appearance she was trying to fit in, be acceptable, and be normal. Lisa also told of how she changed her appearance when she became a mother. She explained, 'I used to have piercings as well, [but] I've taken most of those out'.

Further along the adaptive trajectory it was important to maintain any gains. To do that one must be aware of what is acceptable within society and avoid what is known to be unacceptable. Ruby was acutely aware of identifying other users and made conscious and intentional effort to appear respectable. She explained, 'I make sure we are nicely dressed, always have nice clothes and we don't go out looking like dregs.... I try to make sure that we look as everyone does'.

Again, as mothers worked at remodelling self to 'fit' as a mother, they narrowed the gap between disparate behaviours. *Reconciling personal and societal boundaries* was constructive and helped in safeguarding self by moderating one's behaviour and conforming to society's expectations. Implementing personal restraint contributed to building personal confidence; gaining respect from self and others; and improving self-esteem. Beth described how she needed to keep her behaviour in check.

I've always been working and I've always been doing normal things, so I always had to keep a limit, like, I couldn't hold a job...exceeding a limit that people wouldn't tolerate in society or would make me look different, or you know, wouldn't make me cope with working and things like that.

Some of the mothers set stringent limits to aspects of their lives as to transgress in those areas was intolerable for them. Stealing was a pursuit that was unacceptable for some. Ruby articulated how theft was taboo and how not stealing had

maintained some respect from her mother. She said, 'I was always able to rely on my mother...although I think if I had stolen off her I think she wouldn't have helped me'. Beth too, could not bring herself to steal and as a result had to work excessive hours to support her habit. She explained, 'I worked 60 hours a week to provide myself with enough money to use and pay the bills.... I didn't want to end up in jail...cos as a mother that's the last thing I would like to do'.

To be respected by specific people one also modifies one's behaviour. Not only does this show respect for those people but it elicits reciprocity. Carlene spoke of how she acts in the presence of her partner's parents.

We get along very well.... They are in the same generation my parents were...and I was taught to behave in the same way.... I may act differently around them and I may parent differently around them, but the good thing is, they bring out the best in me.

Maintaining one's personal boundaries also applied in the health care setting, where truth telling, honesty, respect for others, and enacting constraint helped to build a more trusting health professional-patient relationship. Controlling behaviour and maintaining societal boundaries has a profound impact on how others view and respect their fellow human beings. Striving for respect can be effectively achieved by integration into one's environment. When one is assimilated one becomes invisible, one blends in, and does not attract attention. This process can be likened to concealment but is more sustainable and more acceptable. By being normal and doing normal things one also lives up to one's normative self concept, which in turn allows a healthy respect for self because one meets their own expectations and they have congruence with their ideal self. This process is further reinforced by positive feedback, or a lack of negative feedback, from others. Anne explained, 'I was doing really good, you know, just living normally, doing normal stuff, like paying bills and whatever'. Judith reiterated this sentiment when she described how, 'by the time I had Xavier I felt, apart from going to the chemist everyday, there wasn't really much left of me that you could...[identify] as someone who used to use drugs'. Later, Judith described the value of work for her and how controlling her behaviour was vital for that pursuit:

Work is a really good lifeline for me, it keeps me busy... I'd never use to go to work because it would jeopardise what I do. I don't want to do that, I've got a really good job and a really supportive workplace and a lot of friends at work.

Similarly, when Lisa and Rodney found they were expecting a baby they realized they needed to modify their behaviour, 'We knew we had to change... [We] didn't want to live like that any more...and want to lead by example'. Whilst some mothers voluntarily controlled their behaviour some arrived at that juncture through misdemeanour, however, that acted as a catalyst and encouraged them to remodel self. Anne was incarcerated when her first born was only five months old. So that she could get out of jail she reconnected with her family. She said, 'I had to live at my parent's house, which was the best thing... The magistrate said I had to go to Mum and Dad or go back to jail'.

Candice, on-the-other-hand, was able to control her behaviour and maintain societal boundaries as a means to an end. At one stage her middle daughter was abducted by the child's father. The loss of her daughter impelled her to demonstrate her abstinence in an effort to regain custody. Candice explained:

I went to Family Law Courts and it took me three weeks to get her back. But the judge ended up giving her back to me. During that stage I gave up all drugs. That was my choice to be able to get my daughter back because I knew [the father] was taking drugs too, so I went for drug tests and made that a condition of access and everything. I got my 13 clean ones and he couldn't even come up with one.

## **5.6 Summary**

*Limiting loss through a process of safeguarding* was the overarching motive of the mothers in this study. For the mothers, the fetus, baby, and children were an extension of self and fell within the mother's protective sphere. Safeguarding began from the time they were aware of their pregnancy through the childhood years and into adolescence. In implementing the basic psychosocial process of limiting loss through a process of safeguarding the mothers engaged in three sub-processes: *safeguarding during pregnancy; safeguarding as mother; and safeguarding to preserve integrity*. Safeguarding was an oscillating process characterised by reactive responses of *struggling* and proactive strategies of *taking back control*. When struggling reactively mothers only temporarily managed, modified, or negated immediate crises. However, when being proactive and taking back control the mothers were able to modify the nature or scope of the threat with sustainable strategies which were more effective than reactive responses.

*Safeguarding during pregnancy* involved struggling as the mothers made decisions about themselves and the pregnancy and attempted to manage new and multiple challenges, whilst simultaneously trying to promote their health and that of the fetus. On becoming aware of their pregnancy the initial response was often reactive and many mothers struggled. Their struggle often resulted in late antenatal care and some struggled with the uncertainties of pregnancy related discomfort, complications and illness, and managing their drug use. However, being aware that their drug-use was contributing to potential harm provided incentive to try to safeguard their fetus. Mothers who were more experienced were better equipped to be proactive and promote their own health and that of their fetus during pregnancy. Thus, mothers modified their lifestyle and behaviour and *changed their priorities*, putting the fetus before their own needs and making significant and sustained changes to their drug use whilst *caring for self* and attending antenatal care.

Following the birth of the baby, *safeguarding as mother* encompassed the struggle of mothering with limited resources whilst endeavouring to attain 'good mother' status. Again, this was a process of oscillation between *struggling to mother* and *striving to be 'good mother'*. When struggling they engaged in *trial and error nurturing* where they were able to *meet only the basic needs; struggled with care provision; were often [over]protective; had to abandon their ideals; and often resorted to chemically enhanced mothering*. Whilst some of these behaviours fed back into the *threat of loss* loop and maintained their vulnerability, they did experience success in certain tasks, developed confidence in their ability, and limited some threats and thus they were able to become more proactive and *take back control*. Their desire to mother adequately and be considered 'good mother' was a powerful incentive which encouraged them to *nurture* their children and *increase their capacity*. Nurturing include putting children's needs before their own, providing tender care, love, protection, encouragement, stimulation and guidance, and being alert, available, and responsive. Mothers also *increase their capacity* through knowledge and skills acquisition which strengthened their ability, competence, and scope of expertise.

*Safeguarding to preserve integrity* focussed on preserving integrity of self and children which was again, an oscillating process of struggling and taking back control. When responding reactively mothers *struggled to preserve their integrity* and attempted to *limit* their own and their children's *physical and emotional harm* and endeavoured to *alter their perceptions* and others perceptions of them. Limiting



physical and emotional harm focussed on safeguarding against abuse of self and children; on minimising children's exposure to drug-related activities; and on defending self and children from threat. When altering perceptions mothers used psychoactive substances to dissociate from their immediate reality; minimized judgment through concealment, excuse making, and demonstrating acceptability; and by positioning themselves in context. Positioning self in context includes subjective evaluation where mothers compare themselves and their behaviour to others in an effort to place themselves above the status of peers; rationalising their behaviour; assigning attribution; and seeking reassurance. The reactive responses used when struggling to preserve integrity were, at best, temporary and whilst moderating the threat potential in the short-term, the mothers maintained or increased their vulnerability with their behaviours feeding back into the basic psychosocial problem of the threat of loss. However, when the mothers were stronger, more knowledgeable and experienced, and could access trustworthy social support, they were able to be proactive and take back control by *redefining to preserve their integrity*. In this genre the mothers actively took control by implementing sustainable strategies to *create a better environment* where they broke free from abusive partners and isolated themselves from negative influences. They also *controlled events* by pre-empting and being assertive; and *accessed support systems*. Finally mothers *remodelled self* and made significant changes to their presentation and behaviour in an effort to re-establish an identity more akin to their ideal self and how they wanted others to perceive them.

## **Section 3**

**Influencing conditions**

**Implications and conclusion**

# Chapter six

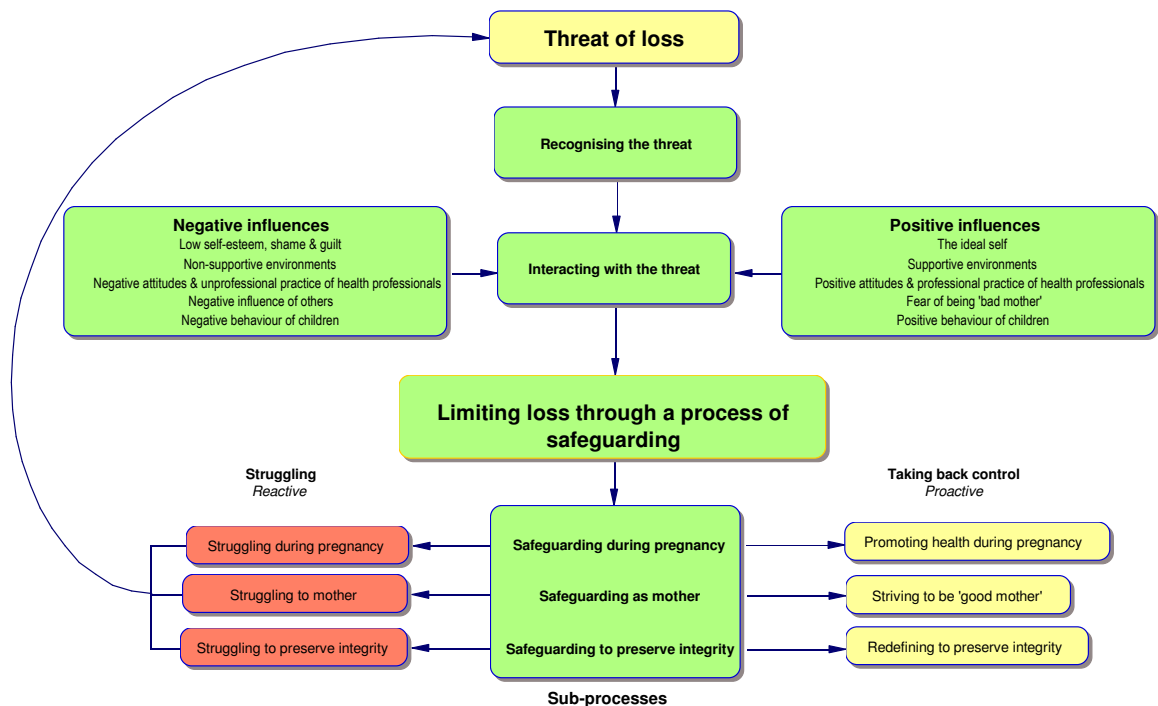
## Influencing conditions

### 6.1 Introduction

This chapter focuses on the conditions that influenced the *threat of loss* experienced by mothers who use illicit drugs, and the process they employed in an effort to *limit loss*. The influencing conditions were identified from the data as: *the self; the nature of support from significant others; attitudes and practice of health professionals; the negative influence of others; fear of being 'bad mother'; and maturation of children.*

### 6.2 Positioning conditions in the theory

The following diagram (Figure 6.1) incorporates the influencing conditions into the structure of the theory. The threat of multiple losses was identified as the basic psychosocial problem experienced by the mothers and they all attempted to limit that loss through a process of safeguarding. However, there were positive and negative influences that impacted on their lives and either supported and encouraged their efforts to address multiple threats, or inhibited their efforts and exacerbated their problems which fed back into the threat of loss. The diagram depicts the negative and positive influences impinging at the point of interacting with the threat and thus influencing the outcomes of implemented strategies.



**Figure 6.1: Incorporation of influencing conditions into the theory structure**

### **6.3 The self**

One develops an implicit understanding of *self* through experiential exposure to interactions with others over time (Dillon, 2003). The mothers in this study had experienced many challenges throughout their lives with their adversity often commencing in childhood and perpetuating through their adult lives. As a consequence of their adversity they formed subjective perceptions of self in relation to aspects of their lives, often towards the negative end of the self-esteem continuum. As a consequence they evaluated their character and conduct as 'not up to scratch' and developed *low self-esteem* and experienced strong emotions of *shame* and *guilt*. Over time they learnt ways to manage their lives within the constraints of their environment but the strategies they used often perpetuated their low self-esteem and exacerbated their shame and guilt. Thus, they developed and maintained beliefs about who they were, what they had become, appraised or reflected on their worth, and attempted to present self in ways to limit negative appraisal by others.

#### **6.3.1 Low self-esteem**

*Self-esteem* can be measured on a continuum from high to low where one has a low self-esteem if one has a diminished opinion of self (I'm not OK). Conversely, one has a high self-esteem if one has a positive regard for self (I'm OK). Self-esteem is based on how one judges self on aspects considered important (Butler & Gasson, 2005) and includes beliefs about one's character, one's competence, or one's acceptability (Lefkowitz & Tesiny, 1984; Younge et al., 1996). One may believe and be proud of specific attributes such as 'I am a good mother' or 'I am a talented dancer or artist', yet be ashamed of who one is as a person or of what one has done or become, such as using illicit drugs during pregnancy, or being engaged in crime or prostitution. Self-esteem is not a static state and one expects to oscillate along a continuum in relation to one's behaviours. Although one judges one's own worth, it must also be recognised that one's opinion of self is influenced by the opinions of others (Goss, Gilbert, & Allan, 1994).

The data revealed a strong sense of *low self-esteem* amongst the mothers where there was a propensity to self castigate and devalue self. Kaye commented, 'I am always bagging myself and bringing myself down and saying what a hopeless mother I am and I don't deserve to have [children]'. Kaye also referred to herself as a 'selfish bitch' for continuing to use and for being 'so pathetic, I'm so fuck'n weak'. Indeed, many mothers referred to themselves as weak willed and pathetic. This

notion was reiterated by a health professional who commented, in relation to an incident, 'she was talking about herself as being weak and inadequate'. Others referred to their appearance as being unacceptable and Judith commented, 'Oh, I was disgusting...I was just disgusting'. Lisa made comparison to a friend to belittle herself, 'she was a beautiful girl, unlike me'. Mothers also spoke of being worthless. For example, Carlene said, 'I feel like I...don't belong, don't do anything for anyone so I am not really needed.... I feel like I've let myself down, let everybody down.... My self-esteem has become very low'. Carlene felt that her mother disapproved of her and that she had emotionally withdrawn, thus confirming Carlene's damaged self-esteem. She related, '[Mother] basically thinks that I have failed hugely'. These findings are consistent with the self-esteem literature that indicates that people with low self-esteem tend to treat themselves badly (Emler, 2001).

When evaluating components of self-esteem, such as 'being mother', and 'illicit-drug-user' against the normative self-conception of those roles, the mothers in this study found an incongruence that they were unable to reconcile, thus further diminishing their self-esteem. Because of the incongruence they anticipated judgment and disapproval and were surprised when it did not happen. Lisa told of how she was treated at the antenatal clinic, 'I seemed to be treated the same [as mainstream mothers], like even the ACDC mothers got treated really well'. Low self-esteem was so embedded for some, that even though they no longer lived the life of an addict, they maintained a strongly negative self-esteem, anticipating that others would suspect and judge them. And indeed, these mothers were repeatedly judged and disapproved of, which was consistent with their anticipation of such treatment, thus reinforcing their perception of self as 'not up to scratch'. Even when the mothers were praised they doubted positive feedback and maintained their low self-esteem and lack of respect for self. Kaye explained:

People are always telling me what a good mother I am, and I appreciate that they are saying that, but then I wonder: if they didn't know that I was on methadone and they didn't know about my drug past, I wonder if they would still think that.

Having a low self-esteem also contributed to mothers' perceptions that they were undeserving of good things and 'did not deserve to have a child'. They expected things to go wrong and felt guilty when they didn't. Again, Kaye explained:

You think about all the healthy women who have...babies that have got...awful things wrong with them, and I just think, "It's not fair".... I feel

really guilty because I did everything wrong, and I had healthy kids. It seems wrong.

A diminished respect for self and one's needs was also played out in a reduction in self care by many of the mothers. They spoke of not 'eating properly', of their health deteriorated because of 'a lack of food in the house', and of 'jeopardizing their health'. Lisa explained how she neglected her own health, indicating that she was not worth worrying about.

I have had a few health problems since [the birth of the baby] but I don't find them important enough to bother about. I'm always saying I can't afford to be sick, you know, I've gotta be well for Evelyn but at the same time obviously gotta sort things out so I don't get worse.

Depressive symptomatology, which was experienced by the majority of the mothers, also exacerbated their low self-esteem. After her baby was born Carol 'felt so low' that she neglected even the most basic activities of daily living. She said, 'I used to cry every day...and I wouldn't even have a shower. I used to think, "What's the point". Additionally, Carol said, 'I tried to ignore [my problems], deny them.... It felt like a really hard thing to face or deal with or fix, you know, so I kept putting it off'. Similarly, Lisa neglected her appearance and said that she 'didn't care'. However, from other conversations she spoke about her 'groovy clothes', her body adornments, exercising and wearing makeup which indicated that she had previously taken a keen interest in her appearance. She said, 'I've never really cared what other people think, but I don't feel good in myself sometimes'. Some mothers also spoke of their neglect to seek medical intervention for their altered mood and believed that they were at fault, were incompetent and were 'losing their mind'. Anne said, 'I don't think it was bad enough... I was just losing my mind and wasn't coping'.

Health professionals also commented on the low self-esteem of the mothers with typical comments being, 'Their self esteem is pretty low and the guilt that they feel is huge'. One health professional reflected:

Oh, the self-esteem issues are massive. Pretty close to zip. But a lot of the women hide it with a bravado, you know, where they appear uncaring or they are tough or whatever. But it doesn't take much to get underneath that. And most of them really don't think much of themselves. And they are surrounded by people who don't think much of them, you know.

Diminished self-esteem was often reinforced by significant others. One health professional reported that mothers told her that their partners ridicule them with derogatory comments such as, “You’re a bad mother and you’re a lousy mother”. So, of course she feels bad about herself...because...he is telling her she is so bad, so...it must be true’.

Through the evaluative process of self and the reinforcement by appraisals of others, at times, the mothers lacked confidence in themselves, their knowledge, and ability and believed they did not ‘come up to scratch’ according to their own standards and expectations. They were often critical of themselves and did not feel confident to be able to perform to what they perceived to be a normative standard. Carlene commented that she was fearful of her ‘own competence, and [her own] abilities’. This diminished sense of self was also aligned to the emotional responses of shame and guilt.

### **6.3.2 Shame**

*Shame* is felt as a result of failure to achieve a goal or ideal that is integral to one’s ideal self-conception (Deigh, 1983) and surpasses the shaming incident and affects *who one is* (H. B. Lewis, 1971). Indeed, shame is about *who one is* and therefore it is part of one’s identity (Deigh, 1983). This complex human experience is a source of low self-esteem, self-doubt, insecurity, diminished self-confidence, feelings of inferiority, and disturbances of self functioning (Kaufman, 1996). To counteract shame one attempts to change *who one is* or the self. However, whilst shame threatens who one is and how one feels (Deigh, 1983; Zupancic, 1998) it is also a self-protective emotion that functions to protect one’s worth and is activated when one fails to live up to one’s own standards and expectations (Dillon, 1997; Zupancic, 1998). Not only does shame signal one’s limits and thus moderate one’s behaviour, it also induces one to conceal shameful experiences from others who may make moral judgment (H. B. Lewis, 1971; Reimer, 1996). This phenomenon of concealment was used extensively by the mothers in an effort to preserve their integrity and was discussed in the previous chapter.

At times, the shame experienced by the mothers in this study was not debilitating but was acute, transient and expressed as embarrassment where one would rather conceal one’s specific failure than expose oneself to judgment. Carol was embarrassed when she experienced a period of incontinence following her

caesarean section. She told of how, 'it was horrible, I remember once, standing at the elevator and there was this little puddle, [I was] so embarrassed'. When Susie first attended the antenatal clinic she was 'too embarrassed to inform the midwife' that she is on methadone. When Ruby was being physically abused by her intimate partner she too was embarrassed that others saw her in that situation. She recalled the midwife doing home visits after the birth of her first baby and although she appreciated the support, she was acutely aware that the situation was not acceptable. Ruby stated, '[Home visiting] was good but it was embarrassing cos [the midwife] could see that I was getting beaten...and she could see me just going...down hill so fast, and it was embarrassing to let her see that'. However, for the majority of the mothers in this study their shame was far more internalised than this *state* shame.

State and trait shame are at the negative end of the self-esteem continuum. Whereas shame can be constructive and protect one's humanity, when shame becomes pathological it is a debilitating phenomenon distorting one's expression of appropriate feelings and behaviours (Deigh, 1983; Zupancic, 1998). Known as *trait* or *toxic shame* debilitating shame also causes one to view self with immense personal dissatisfaction with the belief that one is inferior to others (Bradshaw, 1988; del Rosario & White, 2006; Dillon, 1997; Feiring, Taska, & Lewis, 1996).

Mothers in this study experienced adverse events during their childhood and adolescence such as abandonment, abuse, and betrayal which could be attributed to the development of a low self-esteem and internalised shame. Cath had been a victim of childhood sexual abuse but was, 'unable to forgive [herself]' for what happened, believing that in some way she was to blame, and was shamed by the memories of the perpetration. Her ideal self was damaged and it was the damaged self that she recognised. Other sexual abuse victims also could not separate the perpetration from their identity and referred to being 'maintained as a victim'. One health professional discussed typical mothers who use illicit drugs that she works with regularly. She reported that:

The unresolved business of a woman who, as a child, has been abandoned by their parents and abused by their parents or significant adults in their lives, sometimes for lengthy periods of time...is hard to undo. So, the rape or the abuse as a child or the Mum's drinking and Dad's violence, all that stuff, they usually feel very responsible for, and if they were a "better girl" Mum wouldn't have gone, and if they were a "better girl"



Dad wouldn't have got angry... So they have this very powerful sense of shame about themselves...and feel they are the cause of the problems. So when their husband or their partner beats them or does dreadful things to them...they believe it is their fault and that they are responsible and that he wouldn't do this if they were a better person. This is all about their shame. They hold this whole identity of themselves around a huge guilt and shame.

The adverse events identified in this study were consistent with adverse events causing damaged self-esteem and internalised shame that are widely reported in the literature (see Bickhard & Christopher, 1994; Bradshaw, 1988; Claesson & Sohlberg, 2002; del Rosario & White, 2006; Dillon, 1997; Reimer, 1996; Zupancic, 1998). Additionally, the shame belief can be reinforced by new shaming experiences, by continued negative self evaluation, and by the judgment of others. On reinforcing the shame belief one health professional stated:

Well, you get the moral judgment which reinforces the shame belief, you know, because some nurse on the ward or a teacher at school will turn their nose up at them. Well, they know that because that is how they feel about themselves, this person is only telling what they already knew.

Moreover, as mothers accumulate more shameful experiences and harbour more painful secrets their internalised shame becomes more stable. This is similar to the description of internalised shame offered by Bradshaw (1988) and was articulated by a health professional.

Because they often thieve to get the money to buy drugs, prostitute themselves, and do some pretty awful things that ordinary people would say is pretty dreadful stuff, they are ashamed about that, and they feel bad about it. They don't approve of thieving and they don't approve of prostitution and it's just something they do, their guilty little secret.... It is all part of their shameful world.

In discussion with the mothers they told of their shame about drinking and their shame about their drug use and multiple other shaming experiences that were going on in their life, for example, their partner's violence, stealing, dealing, and prostitution. Some even spoke about being raped, abandoned, and abused when they were children. And it was on those platforms that they evaluated their performance and found themselves lacking. Carlene's evaluation of self was based

on shame. She identified that 'deep down I was intelligent, loving, caring' yet she had not met her own or her significant others' expectations and as a result had, 'a huge spiritual void that I tried to fill'. Kaye had been ashamed to be using and to be pregnant, it did not meet her expectations and she was aware that it did not meet the expectations of others. She said:

I remember despising other [drug-using] mothers for having babies.... I was stupid and ignorant, just as ignorant [about addiction] as people who don't use and yet I was a user... Then...I was pregnant...and I was embarrassed and ashamed of it.

The fear of others knowing of their drug-use did not diminish with time but remained an impediment to being congruent with their ideal self. Anne felt that she was living beneath her dignity and was ashamed of who she had become. She said, 'It's hard to explain... I don't like being [a drug-addict] because I had a good upbringing. I just don't like it'. She was trying hard to change who she was, to return to her ideal self, but her maintenance treatment was tying her to a past of which she was ashamed. Anne said, 'I want to be off [buprenorphine] soon. I just want to get off it because that is the only thing that I feel still ties me to my drug past'.

Ruby's shame was internalised, she knew her self-worth was diminished, she knew that others did not approve of her and she tried to change who she was, to try to conform to what she and others expected of her. She had been a prostitute, a drug user, a dealer, these traits were part of who she was and she did not want to be those things. She said, 'I was sick of being a "working girl" and my body not being my own'. Yet try as she may, she remained who she had become and her shame was internalised. Similarly, Candice was a long time user and was resigned to the fact that this is who she is, yet she was still not happy with the stereotypical image of drug users held by many in the community. She said, 'I'm not happy that I use drugs, because of the...image'.

These mothers were shamed, felt inferior and their damaged self-esteem was enacted in their addictive behaviour; depressive symptomatology; style of interacting; and interpretations of interactions. One health professional summarized this phenomenon.

I think the shame is very deep seated and I think, for a lot of them, they wouldn't know that they do feel so ashamed. I think, if they are using, their

awareness of that probably isn't very high. I think that's part of, if you get involved with them, that is part of the work that you do, is to unravel that.

### **6.3.3 Guilt**

The mothers in this study were not only ashamed by failing their own standards and expectations and the perceived expectations of others, they also experienced feelings of guilt. *Guilt* manifests when one evaluates their behaviour as being unacceptable to themselves and others (Feiring et al., 1996) and is induced when one oversteps a moral boundary and commits a wrongdoing or transgression. Unlike shame, guilt is focussed on the action not on the self (Tangney, 1996; Woien, Ernst, Patock-Peckham, & Nagoshi, 2003) and is about *what one does* (H. B. Lewis, 1971). To counteract guilt a change in behaviour is indicated.

The mothers in this study were experienced in transgression and had done many things that induced guilt. They were guilty about stealing, dealing, and prostitution but the transgression of using illicit drugs in pregnancy and beyond had a significant impact on them as persons. The feeling that they were responsible for any problem the children encountered was, at times, distressing. The thoughts that kept plaguing them about what they had done were upsetting and they tried to make reparative actions to correct their transgressions.

#### **6.3.3.1 Generalised and specific guilt**

All of the mothers expressed that they felt guilty about things they did. Their strongest feelings of guilt were in relation to their baby and how their actions had such an impact on their baby's wellbeing. Kaye spoke of generalised and private guilt in relation to her drug use and her mother identity. She said, 'But for me the main thing is the guilt....it's just private guilt you feel quietly inside'. She went on to say, 'But, I think...with a lot of [drug-using] mothers that would be the big thing, the guilt. Well, for me it was, especially during pregnancy and just after you have the baby'. Kaye was also able to reflect on the potential usefulness of guilt and said, 'The main issue...is just the guilt, which is a self-indulgent, a self-pitying sort of thought, because what good is guilt if I didn't follow the action through to change that. And...I feel guilty about that too [laugh]'. These generalised feelings of guilt were also mirrored by other mothers, who made comments like, 'but it was tied up with just the general guilt...which all using mothers have'.

Health professionals also commented on the guilt expressed by the mothers with one of them saying:

I think they feel very guilty about their situation and they would have liked it to be some other way, and not be using drugs. They have a desperate need to be a normal mum and a normal person as they see it, you know, living in a normal world and I think they would love it be that way.

However, the inability to respond to the guilt and make reparative actions was in itself guilt inducing. Kaye commented, 'And you feel guilty enough that you didn't have the willpower to kick yourself in the bum and get your act together'. Judith felt guilty when she relapsed and started using illicit drugs concurrently with methadone but her guilt was sufficient to induce reparative action and she curtailed her behaviour. She recalled:

[I felt] very guilty actually, it wasn't while I was pregnant, it was after I had Xavier, because I wouldn't use whilst I was pregnant... When Xavier was about two months old it was the first time I'd used again and, I went over to a friends house and they were using... Yeah, I didn't really think before I did it and afterwards... [I had] a lot of guilt for doing that around Xavier.

Being 'too weak to resist the temptation' of using was also guilt inducing and was widespread amongst the mothers. Ruby castigated herself about using and being on methadone and described herself as, 'being weak'. Meanwhile, Vicki explained that during the pregnancy, 'I got to the stage where I was so weak and I [was easily enticed]'. Whereas, Carlene related, 'I can say from having talked to a lot of [mothers who use drugs]; using makes us very disappointed in ourselves, we don't want to go there again and again, but we do'.

However, the responsibility of the children was a powerful catalyst to moderate mothers' behaviour and guilt was a natural strategy to effect change. However, guilt also fed back into the low self-esteem - shame continuum which made it hard to make reparative changes to one's behaviour. Kaye's description of how she felt was revealing.

When your little baby is born and you look at it, all I could really feel for it was [pity]. I just felt sorry for my babies always when I see them laying there in their little cot I would just think, "those poor little buggers", if they'd maybe had a better mother...what a better chance they would have.

The most commonly articulated guilt was in relation to the baby experiencing NAS in the early days and weeks following the birth. Lisa explained, 'I felt very guilty because she was withdrawing. I felt really, really, really awful and guilty and just thinking that our actions had affected someone...who relied on us'. When Beth's baby was withdrawing she too felt guilty and ashamed for having caused her baby to suffer. She said, 'I'll never forget it... I hope she never remembers it.... I was very upset about what I'd done'. And the pain of their guilt remained with some mothers. Laura, when asked how she felt when her baby required treatment for his withdrawals said, 'Oh that was heartbreaking'. Her eyes filled with tears and she could not speak for a few moments. She was obviously still distressed by the memory. Similarly, Susie said, 'Oh, horrible, horrible! I cry when I even think about it, so guilty'. Guilt was also experienced by some mothers in relation to separation from their baby, especially if that separation was as a result of a loss of the baby's health which could be attributed to 'something they had done'. This usually meant that the baby was being cared for in NICU whilst the mother remained on the ward or the mother had been discharged home whilst her baby remained in the NICU.

Because of their illicit-drug-use, many of the mothers also reported being made to feel guilty by significant others and by health professionals. Insensitive comments, misinformation and manipulation often caused the mothers to experience intense feelings of guilt over which they were powerless to make reparative actions, thus were left with the burden of guilt which also reinforced their low self-esteem and shame.

### ***6.3.3.2 Glimmers of pride amongst attributes of shame and guilt***

Although the mothers often did not feel good about themselves and felt ashamed of their illicit-drug-use, who they had become, and what they had done, they could also reflect on their achievements and feel justifiably proud. These mothers were making significant changes to their lives in their bid to promote health during pregnancy; whilst striving to be good mothers; and when redefining to preserve their integrity. Lisa reflected, 'It makes me proud that I can look after someone else, where as I couldn't even look after myself a little while ago, so...it does make me proud that I'm good at being a mum'. Candice reflected on doing her best and said, 'Most of the time [I feel] proud. Some of the time I feel like I haven't done things right but I believe I've done the best that I could do, you know, with my knowledge and my abilities'. Similarly one mother said, 'We are all people and when you meet a lot of

the [drug-using] women they love their kids and they do everything they can to do their best'. Kaye also reflected:

I didn't think I was fit to be a mother, but I've surprised myself... I don't think my kids are too damaged...from what I've done... I don't feel as guilty anymore... [Being a mum] is the best thing I have achieved in my life. I feel...proud of myself.

Beth spoke with pride and explained how her proudest moment is birthing. She said, 'I feel very privileged and very, very accomplished of my birthing, cos they have been so wonderful, both of them and I have survived them both easily.... It's one of the best things I have ever done'. And, despite the challenges of being a mother and difficulties breastfeeding Cath also felt proud. She commented, 'He's [son] a handful. But I felt sort of special as a Mum'. Other mothers articulated the pride they felt as a mother but tempered that emotion with the challenges they encounter on a regular basis.

Mothers were also proud of what they had achieved in changing their lives to be more consistent with their ideal self. Anne was raising her two boys on her own as her partner was incarcerated. Whilst she was still ashamed of being on buprenorphine her life was under control and she knew that if her partner did not do the right thing when he was released, 'He'll lose me and his two boys. I'll take full custody and I'll get it because I've done the right thing'.

Health professionals also commented on the pride of some of the mothers and told how, 'some of the mothers come back [to ACDC] to show us their babies. They will make a special trip in on a Friday morning just to show off the baby'. Others explained how mothers liked them, 'coming to their home because they like you to be able to see how they interact with their baby at home. A lot of the girls will be very proud of their parenting at home'. Similarly, others explained:

With some of the home visits that I've been doing, their house may be quite chaotic yet the baby's room is immaculate, and where the baby's things are, it has all got its place and everything. And you can see, they are very proud of that and they like to show you.

#### **6.4 Nature of support from significant others**

The second condition that influenced mother's experiences of the threat of loss and the process of *safeguarding to limit loss*, was the *nature of support from significant*

*others*. Interpersonal relationships are important to a person's wellbeing and functioning and the quality of those relationships influences who one is, what one does, and how one perceives self. Most of the mothers had previously been, or were in dysfunctional relationships. However, not all relationships were dysfunctional and even those that were, were not dysfunctional at all times. As a result, there were positive interactions that created *supportive environments* and negative interactions that created *non-supportive environments*.

#### **6.4.1 Supportive environments**

Positive interactions creating *supportive environments* included being *accepted and respected* and *being supported and encouraged*. To know that one is accepted and respected by those whom one cares about, to whom one is attached, or who one classifies as family or friends is important as reciprocity and understanding are cornerstones of functional relationships. Only a few of the mothers reported that they felt accepted and respected by others and some of those relationships were tentative. Although Anne had previously had relationship problems she felt that her partner respected her now. She explained, 'He just learnt...to walk off...and cool down....I think he has that respect [for me] now'. Similarly, the father of Vicki's youngest baby was treating her with respect and understanding, which she was enjoying. She explained, 'We got on so well; wish I'd met him years ago.... I'm as happy as I can ever be, even though I have nothing; because I've met someone that doesn't [abuse] me'.

To be accepted and respected by one's immediate family is fundamental to one's sense of self, one's identity, and one's place in the world. Despite what one has done or how one behaves, it remains important to be accepted unconditionally by one's family. Now that Anne is a parent herself and is moderating her drug use she has a better understanding of the distress her parents must have endured when she was using heavily and taking no responsibility for her actions. She appreciates their support and their respect for her as a person. Anne said, 'they have forgiven me and yeah, they don't throw it back in my face, which is good'.

After an absence from family interaction, to be embraced by people who care makes a difference to how one feels and to one's identity. Ruby related, 'I just stopped seeing everybody that I knew and started hanging out with my sister and her friends....and realised that normalcy was just the best thing on this earth'. Judith

was also accepted, respected and supported by her aunt. She said, 'My aunt is just wonderful. Nothing is too much trouble for her... She's very, very supportive'.

Relationships with friends are also important components of one's support network. Susie felt confident that she could rely on her friends in times of need. She explained, 'We've got friends that I could always count on in emergencies and who have got kids and we associate with them. We don't feel isolated'. Others spoke of the common experiences they shared with friends which created a foundation of understanding and empathy within the relationship.

Whilst being accepted and respected is a condition that is appreciated, a more tangible expression of respect is being *supported and encouraged* by significant people in one's life. It is well established that support from one's partner or spouse, one's mother, others family, and close friends play a significant role in a woman's birthing and parenting experience (Gibbins & Thomson, 2001; Leahy Warren, 2005; Melender, 2002; Schneider, 2002; Tarkka & Paunonen, 1996). Within this study the nature of support and encouragement varied between mothers but that support and encouragement made a considerable difference to their experience.

Although support was discussed by many mothers, the type of support was not always described; however the perception of being supported or at least having someone to turn to in times of need was real. Carlene's partner did not help with household tasks or with the baby but she appreciated having someone in whom to confide. She said, 'I really don't have anyone other than my partner...who I can confide in...[about] those areas where I'm just not keeping up'. Lisa spoke of her mother's support and said, 'my Mum has always been really supportive....when it came time for [my mother] to help me she did and, seems with my family, whenever you need them they do come out of the woodwork, so, that's a good thing'.

Others were able to rely on their mothers to 'be there for them'. They spoke of their mothers taking them to the hospital when they went into labour; babysitting the children when they needed respite; advocating for them; and allowing them to 'move back home' when they were...in crisis. Anne explained, 'Yeah, I've gone back [home]...a few times...when things haven't been going well'. Ruby could rely on her mother for support under certain circumstances. Although she was wary of letting her mother care for her children, she could depend on her mother to support her



during other crises. This raises the concept of discriminatory trust where someone could be trusted in certain circumstances but not in others.

Although support from one's partner in caring for the children, doing household chores, and shopping was rarely discussed in the interviews, when support was given freely and compassionately, it was appreciated, and gave the mothers some respite. Ruby's current partner demonstrated a compassionate nature and tried to support her in her mothering role. She explained:

Matt and I help; we basically just share it between us.... If he sees that I am really tired...he says, "You go and sit down, I'll do dinner". We've got a really good relationship like that; he doesn't expect anything...out of me.

Anne spoke of how her parents ultimately accepted her partner which meant a great deal to her and her children. By actively seeking information about drug use and management, and ways to deal with a loved one who was using, they demonstrated their commitment. Anne spoke of her parents' dedication.

They went to all these drug programs, to find out about it.... It's taken a long time, but my parents get on good with Kevin now.... I mean, going from totally hating each other...to, "I'll support you", and putting your house up as surety [to keep him out of jail].

The majority of the mothers struggled financially and, at times, relied on significant others for financial assistance. Anne explained, '[Mum and Dad] have helped me so much over the years, especially with money. Always been there for me, it's good'. Kerry's, 'Dad cashed in his superannuation...to help pay for a lawyer and my court costs.... [My parents] have done what they can to help me'. Without help from significant others, for some, it was not possible to achieve certain goals. When Carol, with her baby daughter, broke free from an abusive and manipulative partner she could not have done so without financial help. Her friends were generous and supportive.

I've had extra help through friends, with finance, to move in here, cos I don't have the money myself. It was \$1260 to move in here, then there was food, and like, I had to buy everything. I didn't take anything [when I left him].

The data also revealed that those on opioid treatment programs, especially methadone, managed better if their partner was also on a treatment program and

they could support each other in reducing their drug use and their methadone. Lisa explained, 'We did everything together.... We couldn't have done it without each other, that's for sure'. This attitude was reiterated by other mothers. Ruby commented, 'It's good that my partner is on methadone as well because we understand each other, perfectly. We have an agreement where we tell each other if we feel like using but that is as far as it goes'. Comparable to achieving better results in reducing methadone if one's partner was also on a program and reducing, women found it easier to modify their amphetamine intake if their partner was supportive and encouraging.

In itself, a functional and loving relationship created a safer and more supportive environment. Simple endearments lifted one's mood and made mothers feel loved whilst positive feedback about their parenting ability or their children bolstered their self-esteem. Kerry recalled her husband saying, "Listen, you are a good mum. Take one look at Emma. You've done most of the raising because you know what you are doing".

However, people who were willing to support these mothers often had responsibilities of their own and therefore were not always available but did help in small ways. Laura explained how her parents helped when they could but they both still worked. She said, 'I mean, people who are there to support me, like my Dad and my Mum, they have both got jobs..., and my friends have got their own kids to look after'. Candice was in a similar situation where her parents supported her as best they could.

My [stepfather]...he's a truck driver.... He helps me out when he can.... If I'm not seeing [my mum] every week, then we talk every week. She can't [help much]; she has a full-time job...and travels. She...does assist in small ways, as she can.

#### **6.4.2 Non-supportive environments**

Despite some mothers reporting positive interactions and good relationships with some significant others, there were times when they experienced negative interactions and poor relationships that contributed to the creation of a *non-supportive environment*. Lack of support during pregnancy, labour and birth, and limited support whilst mothering contributed to the basic psychosocial problem of the *threat of loss*. This necessitated the implementation of strategies to manage or counteract real or perceived threats to limit loss.

*Pregnancy* is a time of physiological, psychological and social change during which expectant mothers need support and understanding from those with whom they interact (Tarkka & Paunonen, 1996). Some mothers felt that they did not receive the help and understanding that they expected from their partners, family, and friends during their pregnancy and birth, which profoundly affected their experience. Cath was unsupported; she did not have contact with the father of her baby, was estranged from her adoptive parents and her brother had his own family. Laura was similarly unsupported by the father of her babies. She said, 'I was going through relationship problems with John; he wasn't very supportive of me when I was pregnant'. When Candice was experiencing complications with her pregnancy she also had no support from the baby's father as he had abandoned her. She explained, 'The first half [of the pregnancy] was very hard; I had a lot of bleeding and leaking of the waters.... His father...didn't want anything to do with the pregnancy or the child'. As a result of having limited support the struggle of pregnancy was exacerbated as all decisions had to be made independently. Similarly, it was also more difficult to promote their health and that of their fetus without encouragement and tangible support.

It has also been identified that one's experience of *mothering* can be enhanced through social support and that regular interaction with relatives and friends can enhance the experience (Leahy Warren, 2005). However, when one has limited support the burden of parenting is increased as there is limited opportunity for encouragement, feedback, advice, emotional support, respite, help with one's tasks and infant care, or nurturance and enjoyment (Keating-Lefler & Wilson, 2004). All of the mothers reported some issues in relation to social and functional support to assist them in their role. Five of the mothers classified themselves as single at the time of the interview, two were married and the remaining seven were in common-law relationships. Many of the mothers were estranged or isolated from their own mother and siblings and some had chosen to isolate themselves from family and former friends. The extent of their support networks was limited and this did influence the quality and availability of support.

Judith was a single mother and commented that it was, 'difficult doing it on my own'. Similarly, Laura was trying to manage two children and her partner did not help her at all in the home. She said, 'I get no help from John, none, none at all'. In fact, she reported his behaviour was inconsistent and often he refused to assist, even when

asked. Even when he was home she had to arrange a babysitter if she needed to go out. Since the birth of her second child Laura was finding it more difficult to cope without support. She remarked, 'Since I've had Anthony and...with the amount of work I have to do, you know how demanding he is...it's a bit hard to get anything done around the house'. Beth also commented:

I don't get any help from my partner... He doesn't do any housework..., no providing for the children, I mean, he likes playing with them and things... Yeah, he doesn't bath them and doesn't feed them or do anything like that, unless he's made to [and then it's] begrudgingly.

Sometimes it was easier to be alone and have no expectations of one's partner. Judith was essentially a single mother but at one stage she allowed her former partner to return home. She was used to mothering alone and was coping well. When her partner came home it added to her burden. Judith commented, 'Bar a few weeks of dad being there but, even then it was more difficult with his dad there because I had two babies to look after [laugh]'.

Some mothers also spoke of resenting the involvement of others which also contributed to the creation of a non-supportive environment. Lisa resented advice in relation to her mothering as she believed it to be intrusive. She explained, '[The grandmother] will tell me what to do...and give me advice'. Kaye also resented the intrusion that living with her husband's parents created.

Finally, some people the mothers would have liked in their lives and the lives of their children had not engaged and were therefore not available. Anne lamented the lost opportunity with her son's grandmother. She said, 'I don't know why [Kevin's mother] is the way she is. I try to give her chances and...invite her over to dinner and that, but she just always makes excuses not to come'. Judith's mother, who had previously been a source of support had other priorities in her life and had effectively withdrawn, which was also distressing. Judith mourned the loss and said, 'My Mum lives close by but she's not really involved... Yeah, she's got a new boyfriend...so there's not much time for us at the moment'.

Limited support whilst mothering contributed to the overall burden experienced by these mothers, with the potential for them to be overwhelmed by their responsibilities. Moreover, as they attempted to safeguard as mother they struggled

without support and had difficulty meeting their 'good mother' ideals which further exacerbated their burden.

## **6.5 Attitudes and practice of health professionals**

The third influencing condition was the *attitudes and practice of health professionals*. Health professionals are expected to respond to all patients in a positive, unbiased and non-judgmental manner, despite their personal opinion of the moral value or worth of the person. Unfortunately, one's personal opinion and society's predominant attitude does influence how one approaches and interacts with people considered deviant, which can influence the level of care provision. The moral stance taken by some health professionals is also influenced by the quality of information available to them, and their knowledge and experience of working with certain patient groups. Health professionals have a 'duty of care', and by law, every patient is entitled to a 'reasonable' standard of skilled care and treatment and to the avoidance of acts or omissions that may cause harm (Staunton & Whyburn, 1997). To this end, health professionals who work with people who use illicit drugs are expected to have the skills and knowledge needed to provide a 'reasonable' standard of care.

Over time, the mother in this study had encountered a variety of health professionals from many agencies. The interactions they had with those health professionals had a significant influence on how they felt about the health care experience and about themselves. Attitudes ranging from extremely *positive* to extremely *negative* were discussed by the mothers, whilst practice ranged from *professional* and supportive to *unprofessional* and threatening.

### **6.5.1 Positive attitudes and professional practice**

Positive attitudes and professional practice were demonstrated within health care environments by the mothers being *accepted and respected*; and by them being *supported and encouraged*. In the community setting some mothers reported that being *accepted and respected* by health professionals was an important element of positive interaction in which trust was an element. Lisa spoke of her relationship with her methadone prescriber. She said, 'we have a pretty easy going doctor... But I think we've always come across as honest and they know that we're not going to do anything stupid. He does trust us'. Others had to build trust before rapport was established. Ruby explained that by presenting well, being polite, honest, and adhering to the dispensing rules in the pharmacy she was now trusted.

My chemist...is a really top guy, but, when I was pregnant with Ross I had only just signed up with that new chemist and he didn't know that I'm not a devious person, he didn't know that I'd never try to double dose myself....  
But...he knows now.

When health professionals engaged with the mothers it demonstrated acceptance and respect for them and the framework for positive interaction was established. Beth felt respected by the way her counsellor engaged with her. She recalled, '[Counsellor] didn't really counsel, she just guided more than anything'. Similarly, Carol articulated the process of engagement, 'My outreach worker comes out every week and we have a chat about my life and my past and everything, my feelings, and what's happening, until she gets a bit of an understanding of me... She...makes me feel good'.

Within the hospital environment, to be accepted and respected by staff made a significant difference to the mothers' experience. As a result of their embarrassment, shame, guilt, and fear of being judged, several mothers found it difficult to divulge information about themselves to health professionals. However, this was made easier if the staff accepted and respected them. The rapport that the staff, who worked in the ACDC, had with the mothers was generally very supportive. One health professional explained her approach.

I sort of make it quite clear to the women, right from the word go, that I am not here to punish them or smack them for being naughty girls. It is their baby, it is their behaviour and they have to deal with it, and deal with it in whatever way they need to deal with it. I am really just here to give them information and support.

Susie was very upset when she presented at the hospital for antenatal care, however, following a discussion on the need for specialist management during her pregnancy she disclosed her history to the midwife. Susie recalled, 'They were lovely; they were great. It took me a while to get the nerve up to actually tell them that I was on methadone, but once I did it I was relieved'. Lisa commented, 'I was grateful for the way I seemed to be treated'; whilst Anne said, 'I was so unsure at first, [but] the doctors made me feel really at ease'.

Health professionals also spoke of disclosure and the value of building a trusting relationship.

I'm aware of the women that can be very manipulative and um, there are some people, I accept what they tell me and if they chose to tell me what they think I need to know, I'm not going to challenge them on that. So I couldn't say that I actually trust everyone wholeheartedly, it's really a matter of what they chose to disclose and, but by the same token I certainly strive very hard to...encourage an open and friendly relationship which will build on trust rather than one which is defensive where we are not going to achieve that trust.

Some mothers had attended the ACDC for more than one pregnancy and had become familiar with the staff. They felt comfortable re-entering that environment. When Laura presented for her second pregnancy she remembered, 'It was good actually, all the nurses, from when I was pregnant with Robyn, remembered Robyn and recognised me, and made me feel quite at home'. Similarly, Ruby explained:

It was excellent. They all know you by your first name and they know your child, they know your history so you don't have to go through your history all over again. They see the progress in you and your child...and say, "Oh, you are looking great, and wow, your daughter looks beautiful", and things like that and you can see that it's genuine.

Often the finest compliment is for a service to be recommended by those who use it. Carlene demonstrated her appreciation for the ACDC by her willingness to encourage her peers to also access the service. This "pay it forward" phenomenon was testament to the supportive environment created for mothers who use illicit drugs. Carlene said, 'Some girls who were too afraid to come out with the truth, I've been able to get them help by just telling of my own experiences through there'.

During their hospital stay some mothers were surprised at being accepted and treated with respect. Vicki commented, 'Yeah, I just can't get over how lovely the people have been; the nurses, the midwives, everyone'. Kerry also commented, 'I was treated pretty good'. However, of particular importance to the mothers, whilst in hospital, was staff maintaining confidentiality. Health professionals were cognisant of this need and remarked, 'Sometimes their mothers come in with them and they don't know anything, you've got to be very aware of confidentiality'. Maintaining confidentiality was considered a sign of respect for them as persons and was highly valued. Due to complications Carol spent a prolonged period in hospital during her pregnancy. She explained, 'They were really helpful and non-discriminative... It

was all quiet and it wasn't broadcast to the world about my usage and stuff'. Others were fearful of their significant others learning about their drug use and were grateful that staff honoured their requests by keeping their charts secure and not breaching confidentiality. Susie's family had no knowledge of her use or her being on methadone. She commented, 'they have been really good about keeping the files away and keeping it private'.

In addition to being accepted and respected, when *support and encouragement* was given rapport and trust was built. Health professionals involved with the ACDC were proud of the support and encouragement they offered mothers who use illicit drugs. One health professional articulated this phenomenon.

And that is one thing they like about the clinic, they are treated as a mum or as someone who is going to become a mum and they get the support that they need, where they might not get it in other places. You know, they have usually got other people telling them how hopeless they are. So, you know, it is a place where they come and we give them a little bit of encouragement and support to try and be a good mum. Because, their self-esteem is pretty low and the guilt that they feel is huge. So, I think that is one of the areas we try and help them with and try and make them feel that there is a chance of them being a good mum.

When staff developed rapport the mothers began to trust them and their help and interventions were more readily accepted. Kaye remarked, 'More than seeking help I probably accepted the help that I was offered more, where as before I didn't'. Part of being supportive included setting realistic expectations of what was achievable; and not expecting too much too soon. When mothers' efforts of positive behavioural change were acknowledged it was appreciated and acted as further encouragement. Lisa told how, 'I wanted to quit smoking and they said not to do it yet cos I'm dealing with so much... I felt guilty about smoking [but] they said, "just do one thing at a time". They were really, really supportive'. Vicki also spoke very positively of a midwife's response to her achievements which helped put her drug use into perspective and allowed her to strive for positive change.

[Midwife] was really great. She thought I was doing pretty well.... Even when they asked me about my marijuana use, she said, "How many cones do you have a day, 20?" And I said, "Oh, no way". That shocked me... So, I am not so strong on that as well.



Mothers reported that staff that recognised, believed, and applauded their achievement were trusted and sought out to provide further support and direction. When Cath had abstained from amphetamines, 'I went back to the clinic...and [one staff member] really patted me on the back'. Positive feedback was appreciated and embraced and it appeared to lessen anxiety and increase self-esteem. One vignette from a health professional encapsulated this concept.

The woman I was telling you about, she is involved in the court procedure right now and is under a lot of pressure and everything like that. She was talking to me about juggling the stuff and I find her someone who is very, very eager to try and put stuff into place. She is desperate not to use drugs and she tries hard...at preventing it from coming into her life. But one of the things I said to her last week when I was talking to her about all the things she is trying to juggle right now, she has very little money and very little support, "I wouldn't last 5 minutes living like this, you've got a really, really hard life with a lot of big stuff on your plate"..... And she was really surprised when I said that. She said, "What?" And I said, "No, we are not talking here about somebody being weak or inadequate or any of those things, you have got a lot on your plate and there is not that very many of us that would be able to do what you are doing anyway, with all of these barriers in your path". And she was really surprised. She actually commented about it today when I talked to her, she said, "You know when you said that, it made me think". It made her look at things in a slightly different way and she actually repeated the words to me today when she said, "I think I'm doing something that a lot of people wouldn't be able to keep doing". And I said, "Yes".

Even the smallest acts of kindness from staff were appreciated and made a difference to the experience the mothers had within the health care system. Vicki expressed her appreciation of the care provided by a midwife during labour. In relation to what would be considered routine care of a labouring woman, Vicki remembered, 'I'll never forget [midwife], she was excellent, she knew exactly where to rub me, and showed me what to do, cos I was hanging over the edge [in pain]'. Following the birth, Vicki relayed her joy at receiving an unexpected gift from another staff member. She said, 'Yesterday, [the social worker] bought me a little parcel. She came in with a parcel and I said, "Oh, my God, thank you very much". In keeping with this kindness, a health professional explained how she attempts to normalise the experience for these mothers. She explained:

I'll refer to the bump, or ask them what nicknames they have, and encourage a lot of, you know, the normality of people having babies in my world – there's a lot of laughter and fun and cheekiness. I try to do that and always, always congratulate them when I go up to the wards. There is all that lovely stuff that most of us have experienced in our lives, and for them, sometimes they haven't.

In the community environment, the support offered by the visiting midwives, following discharge, made a tangible difference to the ability of some mothers to cope. Cath enjoyed the support of the visiting midwife as it allowed her to seek, 'information and guidance'. When Carol took her baby home after she had spent 19 days in hospital, she was anxious about providing care but was reassured by having the visiting midwifery service. She said: The day I did get to take her home, I went, "Oh, no, there's no-one else here. I've got to do it on my own. What if I make a mistake, I can't ask anybody". But...the midwife come and did a home visit.

Other elements of a supportive environment included health professionals acting as advocates. This role is generally undertaken by social workers and midwives who assist the mothers to liaise with welfare agencies, assist with care planning, and provide support in the face of threat. Often the threat is from other health professionals, government agencies, and the mothers' significant others. One health professional related:

And, we are finding that we often have to go up [to the wards] and say, you know, "Such and such tells me that a midwife told her she couldn't breastfeed, and she is really upset about that". We then have to go and talk to the midwife involved and ask her why she gave that information and tell her that is not actually right.

Another spoke of the advocacy role in care planning and securing housing and other tangible supports to enable mothers to keep their babies.

A lot of it is pulling together a plan with the mother, about how she is going to manage this baby at home. That could involve, either her family, or it could involve community services, depending on the circumstances. So, I need to assess the situation and discuss my concerns...with the mother, or be looking at ways of helping her manage. Usually we end up getting involved in welfare issues around housing and finances, practical stuff.

But I see that as part of the role of supporting the mother to ensure that she keeps the baby, because homelessness is a huge factor in losing the baby.

At times some mothers were too vulnerable, uncertain, or too afraid to speak up for themselves and needed others to advocate for them. Often there was a power imbalance and it needed a health professional or someone who held authority within the health care environment to speak on the mother's behalf. Without an advocate, in certain situations, outcomes could have been very different, thus placing mothers at greater *threat of loss*.

Mothers reported that they were generally satisfied with care provided by many health professionals and this positively influenced their experience. Anne commented, 'the doctors and that there that I was seeing were really good. They took good care of me [antenatally] and when I had the baby'. Vicki also expressed her satisfaction, 'I think they are good'. Candice commented, 'I had no problems with [staff] at all. They have always assisted me the best they can'. Even Ruby, whose second baby was stillborn, spoke very positively about the quality of care. She explained:

We got the upper class treatment. The after care was great, I can't say enough about it, the after care. After Ross [stillborn] was born and I was in hospital, they were just amazing, they were so good. The chaplain there is amazing, he is just a really, really, good, good person.

Positive attitudes and professional practice by health professionals contributed to creating a supportive environment and limited some threats under certain circumstances but did not eliminate the necessity for wariness, caution and vigilance and of enacting the process of *safeguarding to limit loss* under other circumstances.

### **6.5.2 Negative attitudes and unprofessional behaviour**

Although some mothers reported certain interactions with health professionals as being very positive, there were times when interactions with health professionals were negative and created an environment where they felt threatened and vulnerable which worsened the threat of loss. Negative attitudes by health professionals were demonstrated by *an attitude of distrust* in mothers who use illicit drugs; and by *conveying disapproval*. Additionally, unprofessional behaviour was demonstrated by *giving mothers reason to doubt their credibility*.

### **6.5.2.1 An attitude of distrust**

In this study the data revealed that some health professionals did not trust mothers who use illicit drugs, thus jeopardizing their ability to accept and respect them or to comfortably engage with them in an effort to support and encourage them. One health professional reported that her colleagues, who have not worked extensively with these mothers but who encounter them on the postnatal wards, tended to be judgmental and viewed them with distrust. She said:

But I think, for a lot of the nursing and medical staff, it's an area of the unknown, um, and drug use is pretty emotive in today's society. I think the perception of drug-users generally tends to be one that is...fed by the media. I think people's perception of the drug-user is someone who presents in a way that is not acceptable, in a way that they dread, the way that their behaviour is; but in reality that might be very different to the women that we see in the clinic, cos, in fact, it could be someone that you would walk past in the street and wouldn't even realize.

This notion was exemplified with an incident in the ACDC. A midwife reported:

I had a graduate midwife here and one of the girls came to the ACDC and when she left this midwife said to me, "Was she coming to your clinic? She's one of the Mums at our school. I would have never have thought that she was a drug user or anything like that".

Health professionals also described how difficult they find working with colleagues who do not trust mothers who use illicit drugs. 'But the attitude is that these women will somehow deliberately hurt their babies, is what we have to deal with'. Similarly, 'some health professionals think the best solution is to get the baby away from them'. Other stories also highlighted distrust. One mother who had been discharged home with her baby who was being medicated on morphine syrup for NAS was compromised by the distrust of a health professional. A midwife related:

One poor mum couldn't find her morphine one night and she phoned in, and somebody said to her, "Oh, well it's a narcotic, we'll probably have to involve the police".... You know, it was that instant judgmental thing, of not, "Lets do the best for the baby and get you an ongoing supply". The instant reaction was, "Well, this is a narcotic so we are going to have to involve the police".

Other incidents that portrayed health professionals' distrust in these mothers included: disregarding or not believing information provided by the mothers, making judgments, and 'making assumptions that these mothers don't want assistance' (HP). Similar findings have also been reported by other authors who claim that this lack of trust is often established purely on the basis of the stereotypical image of mothers who use illicit drugs (Klee et al., 2002). However, as one health professional said, 'the stereotypical image is an enigma and is a very difficult thing to tackle. Society is comfortable holding onto that, it protects them'.

Unfortunately, the stereotypical image is often perpetuated in the literature, and at social and scientific and meetings. One health professional, who has worked exclusively with these mothers for many years, reported.

The women that are described in the research and sometimes when I have been attending different types of health conferences or even case conferences, I hear a description of the women, often times, that doesn't match my experience. I hardly ever find those women that are described, I mean, that are frequently described to me as being: that they don't care about their children; they put their drug use at the very top and that wipes out any other concern they've got; and it interferes with their ability to put the interest of their children first. I hardly ever have that experience, and I don't have an experience of the women being uncaring about the effects of their drug use on their children. I find, actually, quite the opposite.... The fact that they actually do try and reduce the harm connected to their drug use has been lost or has never really been gathered.

However, there are times when some mothers reinforce the stereotypical image and jeopardise the trust relationship between health professional and patient. Such incidents only serve to reinforce the negative image and 'tar everyone with the same brush', thus making it more difficult for other mothers who use illicit drugs to be accepted, respected, or trusted. One mother was, 'discharged from hospital because she was using. The ward staff were very upset because she was using. She actually told them and had put her needles very carefully in her bag, so, she was being quite honest and careful'. Other incidents were more volatile as this health professional reported.

But, on-the-other-hand, we've got girls who, unfortunately, are still using. They choose to use in the hospital, and have partners who become aggressive with the staff. We had a situation last week where we were

called up to see an antenatal patient, it was diabolical. In the end they opened the door and she was sitting in the en-suite with the syringe in her arm, and her partner; they had to call the police. So, there are situations that the nurses, rightly, feel let down.

Nurse-patient trust has been defined in the nursing literature as 'nurses' [health professional] belief in the expectancy that patients could be trusted' (Johns, 1996, p.77). Moreover, nurse-patient trust was identified as a 'necessary element in establishing a connected relationship between nurse [health professional] and patient' (Johns, 1996, p.77). If health professionals hold an attitude of distrust this can severely threaten mothers' trust in health professionals and make them very wary of interactions with them. As one health professional said:

Trust is a big issue because they have been betrayed so many times, up to this point, that they have to know that they can trust you. It's huge, but it's part of the image that the health care provider portrays. I don't know how you portray a trustworthiness, but, these mothers are pretty astute.

When health professionals did not trust these mothers they created a tense atmosphere where health professionals and mothers were guarded and cautious. The mothers attempted to preserve their integrity in the light of the stigma of their status and stereotypical interpretations of what others perceived a mother who uses illicit drugs to be.

#### **6.5.2.2 Conveying disapproval**

Words do not have to be spoken to *convey disapproval*. At times the body language of health professionals was sufficient for the mothers to understand that the attitude towards them was negative. Mothers related stories of negative body language in relation to doctors, midwives, nurses, and social workers. They spoke of staff going 'cold straight away'; 'a wall going up'; 'charts being thrown down'; a 'stance that was defensive'; staff 'not looking me in the eye'; and of 'cold facial expressions'. Other manifestations of a negative attitude towards the mothers included being avoided as Candice experienced:

[It was] just a feeling that you get, she didn't approve. Based on how quickly she left the room and the standard of care from her. She didn't answer the bell rings, she did eventually but it took about an hour.

Others reported similar avoidance experiences which ultimately compromised their care. Lisa was a primigravida with limited knowledge on how to care for her baby. Staff avoidance meant that she did not receive adequate education. She commented, 'It was just weird....they just hardly got to me, you know, I didn't actually have anyone spending a lot of time with me'. Delays in staff responding to the mothers' needs also caused distress and even when they did respond their attitude and practice was, at times, unsatisfactory. In fact, there were many opportunities when staff missed the chance to engage with these mothers. Mothers often felt they were being 'fobbed off', 'not listened too', and 'dismissed'. When asking questions of the staff, Cath 'kept getting told to talk to the doctors about it, and you could easily miss the doctors'. Carlene felt that she was being devalued and that her opinion did not matter.

Instead of providing a safe and supportive environment where holistic care was provided, some staff dwelt on the drug use and ignored other aspects of the mothers' needs. Judith explained that, 'once [staff] see your little file and the word methadone they start looking for problems'. Cath reiterated this experience when she said, 'the focus was only on drugs. And that's what I come away feeling. That's what I'm left with'. She believed the focus of care was too narrow and although she agreed that the baby's wellbeing was paramount, 'for it to be about the baby it is about the mother as well'. This observation was reiterated by health professionals who said:

A lot of the women, one of the complaints about traditional services that they have brought to us is, "They feel as if their unborn baby, or their children are cared about, their babies are and they are not". Somehow they are divided up where the babies are top priority and they are not really cared about, and they notice that and it makes them suspicious that they can be, sort of, pushed aside, so to speak.

### **6.5.2.3 Giving mothers reason to doubt credibility**

Some health professionals also gave mothers ample opportunity to doubt their credibility. Issues of credibility ranged from the provision of *conflicting advice*; *mismanagement of health issues*; to *deficits in knowledge*. Issues as basic as determining if a woman was pregnant brought into question the credibility of health professionals. Carol was 28 weeks gestation before her pregnancy was finally confirmed. She told how, '[baby] was kicking and...I thought I was pregnant and I went to the doctor and he said, "no, no, you are on the Depo-Provera...." So I went

and got a second opinion and....I was 28 weeks'. Cath's baby was born with a cleft soft palate. It was not until day three that the cleft were diagnosed, thus, in Cath's mind, raising questions as to the credibility of staff.

The *conflicting advice* offered by health professionals created confusion for mothers regarding their pregnancies, their drug use and how to manage their health. Ruby was told by her doctor that she was, "killing her baby" by reducing her methadone. She commented, 'There are too many people – too many opinions; it's hard to know what's important'. Health professionals also commented on the conflicting advice and reiterated similar issues. For example, one health professional commented, '[Advice] is conflicting and they get misinformation at various places in the health care system. They might get told something at their GP clinic, and then something different at the ACDC, and again something different on the wards'. This concept was further reinforced: 'Coming to our clinic, they are only seeing a couple of people obstetrically; they are not getting a lot of conflicting information through the pregnancy. But they certainly get conflicting information once they get up on the wards'. That conflicting information then had to be corrected and accurate information provided. However, from the patient's viewpoint, who does one believe? An example was provided:

The problem with this particular lady was that the information that she'd been given about breastfeeding and speed use was actually incorrect, and so, you then have to re-educate the women about, you know, about their current use and breastfeeding and it's sometimes very difficult when a health professional has given them inaccurate information, to then try and override that and provide them with correct information because there is already then an example of, "then who do I trust?". And that's hard.

Many mothers experienced similar incidents where conflicting advice made it difficult for them to make informed decisions based on accurate information. This, in turn, contributed to them struggling during pregnancy and struggling to mother as they had to find a satisfactory solution by experimentation with the alternatives.

The *mismanagement of health issues* also had significant impact on the mothers' health care experience and again contributed to their struggle. On reflection some mothers did not like how they were treated and felt that it was not appropriate that some health professionals should treat them with such disrespect. Not only did it hurt them, it set the scene for them to be defensive in an effort to safeguard



themselves. Lisa related an incident when her baby had NAS. Instead of being caring and offering support and encouragement, a comment from a midwife reduced her to tears, intensified her distress, and increased her vulnerability. She said, 'I just broke down and cried'. This was not an isolated event but one expressed by many of the mothers. Health professionals were also aware of the mismanagement, lack of compassion, and unprofessional behaviour they had observed in their colleagues and were embarrassed by it. An incident shared demonstrates this behaviour.

As a nurse, I feel, "Oh my God, where's the compassion and the professionalism?" An example of that for me is: We had a very difficult girl to manage, I really liked her, she was a challenge, but she was quite a likeable challenge, and she was being difficult to manage up on the ward and I went up, and she said to me, "I can't breastfeed", and she was wanting to know about formulas and bottles, and I said, "Oh, I'll go and ask one of the midwives". And I went out and I couldn't believe it, they flatly refused to speak to her about that. What, they completely missed was that it was an opportunity to engage with this girl.

Pain management and the management of their dependence on psychoactive drugs in the postnatal period were also often mismanaged. Carlene was angered by the mismanagement of her pain after the birth of her baby. She recalled, 'They put me on...20 mg of Oxycontin, which was really nothing, so I was in huge amounts of pain'. Others also complained about the management of their pain. After the birth of her most recent baby Ruby was experiencing intense after pains; instead of showing compassion and understanding the midwife berated her and implied that she was seeking opiates. Ruby explained, 'The baby was screaming and I could not, for the life of me, I tried so hard, I could not turn to pick him up or to do anything, I was in that much pain'. This mother was offered Panadol.

One health professional related her experience of the trouble she encounters in dealing with colleagues in relation to the mothers' pain, withdrawal, and stabilization of treatment regimes, in the first few days following the birth. She explained that, 'post delivery, the mothers usually have an opiate based pain medication, and if they had a caesarean section, they would have opiates intravenously or in their epidural'. She continued:

If they are on maintenance, we are trying to start them back on their methadone or Subutex... We've got about two or three days from birth...to coming off whatever they got through delivery, to...stabilise them on their

drug regime. A lot of times they are really in withdrawal and they can be quite noddy, it's not just shakes and sweats.... They can be bad tempered, they can't sleep...and the ward staff are saying...they have gone off and used. They are being accused and they are actually in withdrawal. They are going through tremendous stuff for a day or two for the sake of the baby. They are not going out shooting up or what-have-you but they are being judged as if they are. And I find [in their notes] "Poor mother crafting". We get all that sort of attitude, "Oh, she's a f...ing useless mother", told to me by midwives. And this woman is just going through withdrawals and I'm saying, "Let's see how things are in a couple of days", and often things are fine. They are judging them on what they see on the day and what they are looking at is a sick woman who is not looking after her baby or herself very well. They don't see the sickness, they see "drug addict".

However, the poor management by health professionals, of pain and withdrawal, can lead in mothers taking matters into their own hands which can result in very negative consequences ranging from judgment to eviction. One health professional commented in defense of the mothers' behaviour:

Oh, yes, and withdrawal; you are going to do something if you are going to withdraw. You've got to manage. That's why they take it. They've got to manage through the birth and whilst in hospital. But then the attitudes from the staff, instead of getting support and understanding and offered alternative medication, it's this dreadful judgmental attitude.

In addition to the mismanagement of health issues mothers and health professionals considered that there was a *knowledge deficit* amongst many health professionals and that addiction was not well understood. One health professional commented, 'The diabetic patients get more understanding. We know that diabetics go through hyper and hypo and they don't always eat what they should eat and do what they are supposed to do, but there is a different attitude towards them'. In addition, it was reported that some, 'health professionals lack understanding of what withdrawals are all about.... They don't realise that what you are talking about is something that is physically quite dangerous and physically unpleasant'.

Health professionals also reported a knowledge deficit in relation to some practitioners. During Susie's pregnancy she attended a GP for management in the early months and was advised by her GP to stop methadone. This was explained:

If GPs haven't had much exposure, and I think that's where it might be a problem; if women present and are on treatment programs such as methadone, the GPs, if they're not used to looking after women who are on a methadone program, the information that they may give them about being on methadone and pregnancy may not always be accurate with regard to reducing their methadone or increasing it [towards the end of pregnancy].

Fortunately Susie booked at the ACDC and was managed appropriately, thus avoiding withdrawal and the potential for spontaneous abortion (Drugs and Poisons Unit, 2000; Hepburn, 2002). Such incidents required the ACDC staff to provide education and support to patients but also liaise with and provide information to the attending GPs. However, it provided Susie with reason to doubt the credibility of her GP.

When it came to illicit drugs, the consequences of use, and the signs and symptoms of withdrawal in the mother and the baby, some mothers had more experience than health professionals who were providing their care. When Kaye's baby had NAS she spoke of how, 'the doctors that were looking at him were young...who...hadn't had a lot of experience [or]...training'. She therefore doubted their credibility and reached her own conclusions regarding her baby's condition. Similarly, health professionals spoke of the mothers' doubting the nurses' assessment skills.

We've often found mums will say, when it has been reported that the baby has a high NAS score, "Oh, the nurses didn't know what they were doing". And they know, that maybe somebody has given a high score but they know that the baby is no different to the last time when somebody had given it a low score. The mums get quite clued in without actually looking at the scores.

Mothers' knowledge about some issues was recognized by health professionals as being informed. One health professional commented, 'they are quite knowledgeable often times about drugs...they have a good knowledge base and some of the medical people they deal with, don't'. Others also commented:

[Many health professionals] haven't had much exposure to this specialized area. People don't have the knowledge and that makes the difference, if they don't have the knowledge it makes it harder to be confident in knowing how to actually handle these people...and the information that they may give them... may not always be accurate.

And, whilst there is a recognised knowledge deficit, unfortunately it was observed by health professionals that some of their colleagues chose not to address that deficit.

They are the ones who never come to the in-service programs or anything like that. And you talk to those people and they just give you this look as if to say, "Yes, you're the bleeding heart". You give them the proper information that we know is out there and they just raise their eyebrows and dismiss it. They chose not to know, they are not interested, they don't know about it so there is this barrier put up and they make a judgment about it and they just don't want to know. So, this has nothing to do with me so I'm not even going to bother learning about it.

Some mothers also found that information provided by health professionals was inconsistent, biased, inadequate, or withheld thus also causing them to doubt the credibility of health professionals. Lisa commented, 'I felt that not enough was explained to me...[they were] not telling me what was going on'; whilst Vicki said, 'I haven't really got the true answer for...'. At other times mothers perceived that the information was deliberately biased to create fear in the attempt to modify their behaviour. Cath commented:

[The social worker] was the one that went on and on about drugs and problems at birth...and, I thought..., she's a social worker, she's not medical [staff]... If the focus is going to be on drugs use then, don't just have it as fear.... The pats on the back need to be as obvious as...putting the fear of God into us.

Some health professionals' negative attitude and unprofessional behaviour towards mothers who use illicit drugs caused the mothers to feel afraid, distressed, uncertain and unable to trust health professionals which led them to be defensive and required that they safeguard themselves. This contributed to them struggling during pregnancy, struggling to mother, and struggling to preserve their integrity. Whilst it was only some health professionals that evoked such feelings, mothers found it

necessary to be vigilant and wary until rapport was established and the credibility of care providers ascertained.

## **6.6 Negative influence of others**

The fourth condition was the *negative influence of others* which often maintained use, precipitated relapse, impacted on the mothers' lives and affected their mothering role. Using was not usually a singular pursuit but something the mothers did with their partner, friends, or acquaintances. Often it was not a calculated decision but a spontaneous choice in the circumstances. Judith explained, 'when I'd gotten back together with Xavier's dad, he was just out of jail and he wanted to use. [Even though I had Xavier] I didn't even give it a second thought...he started using so I started using as well'. However, Judith was able to see that using and the process of getting drugs did affect her mothering so she did not continue. Beth reflected on her and her partner using and said that even though she had to consider her children in her decisions, 'There's no way I could live with or have a partner that uses and [not] use [myself]'. Similarly, before Laura went onto buprenorphine she found it difficult to abstain whilst her partner was still using, especially as she was the one who sourced the drugs. She said:

I would still get [the drugs] for him...because he wouldn't buy it.... Just to shut him up, I would go and get it, cos he was a bigger baby than [the baby] was.... When you're living with someone, hanging around with someone every single day that's doing it, it's very hard to watch them doing it. And considering I had to drive [50 kms each way to get it]; I wasn't going to drive all that way for him and not use myself.

Others spoke of the coercion and manipulation by their partner in relation to drug use and how drug use was a part of their relationships. However, it was not only their partner but also friends and acquaintances that influenced their decision to use. For Lisa, when she became a mother she isolated herself from those negative influences because she knew she was easily influenced. Friends popping in also had an effect on the mothers' decisions to use. Carol and her baby lived alone and when friends dropped in she could be tempted. She related one incident and said, 'Friends came over and they had some speed and said, "Oh, come on", and I said, "Oh, God, yeah alright". But, as Beth pointed out, others not only influenced their drug use also negatively affected mood and behaviour. Beth commented, 'People may pop in...and bring stuff with them...[and] it's very difficult to say no.... Others do have a big influence'. She went on to say, '[And] it's hard not to feel down [around]

these people.... The way they talk and the things that happen to them always seem so negative'. For Beth, those negative influences did intrude on her mothering. She related, 'But...I found it was affecting me and my kids, the last couple of times people came over and I thought, no, I don't like this'.

When these mothers did attempt to modify their behaviour some felt that others tried to negatively influence them. When Ruby became a mother and initially gave up heroin, dealing, and prostitution she believed her former friend was jealous of her 'new life' and tried to 'get me to [use again]'. She said:

He would come over...and he'd pull out all this heroin and put it in front of my face.... I was in the state of mind that I just didn't want a bar of it, had I been...a little bit tempted it could have brought me down.... He kept trying to pull me down, pull me down.

The mothers also spoke of 'being in the wrong crowd' and those people affecting their choices; of others trying to 'bring me down'; 'others having a big influence'; and implying that it was other people's fault that they continued to use or relapsed. As is discernable the mothers perceived the locus of control was external and claimed diminished responsibility.

Health professionals were well aware of the negative influence of others and remarked on the power of that influence. One commented:

And I mean, some of them are in situations where we underestimate the influence of partners and some the situations they are in. They don't always have a say whether drugs come in or out of the house, or even...in whether they use them. It is often someone else who calls the shots.

## **6.7 Fear of being 'bad mother'**

The fifth condition was a *fear of being 'bad mother'*. Copious portrayals of motherhood through the media, in social and scientific literature, and in the popular press, communicate ideals and stereotypes on which mothers base their interpretation of the concept of the ideal mother. However, contradictions abound and the ideal mother is an enigma, yet mothers continue to strive for the socially constructed elusive 'good mother' ideal (Banwell & Bammer, 2006; S. Lewis, 2002). In discourse on concepts of motherhood Lewis (2002), Hays (1996), Brown, Small, and Lumley (1997), Arendall (2000) and others provide interpretations of the enigmatic contemporary stereotypical mother. This self-sacrificing superwoman is

supposed to: provide and experience unconditional love; be naturally caring and nurturing; be child centred and ever responsive; and instinctively providing the best care for her children. Furthermore she is expected to do this irrespective of her social context and will never feel any ambivalence towards her children or her role (S. Lewis, 2002).

The assumptions that mothers naturally bond with their infant at birth; that they instinctively know what to do; that they are devoted to and protective of them hence forth are admirable. However, the reality is that motherhood is a challenging and demanding experience (Hays, 1996; S. Lewis, 2002; Marshall, Godfrey, & Renfrew, 2007) and the context of the lives of mothers contributes to their capacity to strive to attain the 'good mother' ideal. It was with a backdrop of social disadvantage and unrealistic expectations that the mothers embarked on their pursuit of being the archetypical 'good mother' when many of them found it difficult to look after themselves, thus they struggled to mother whilst still endeavouring to attain 'good mother' status.

Mothers who violate the axiom of intensive mothering (Hays, 1996) and fall short in their own or others estimations are judged and judge themselves to be 'bad mother' as the dichotomy of 'good mother' (Brown et al., 1997). The mothers in this study commenced their mothering journey from a position of social and economic disadvantage, extreme conditions, and limited support where they struggled to meet day-to-day challenges. Their illicit-drug-use positioned them as deviant and they were therefore under intense scrutiny by all who knew of their drug-using status. They were acutely aware that they did not fit the socially constructed concept of 'good mother' or even 'good enough mother'. However, illicit-drug-use is not in itself a barrier to good mothering.

As mothers in this study did not fit the hegemonic stereotypical ideal of 'good mother' they were instantly under pressure to measure up. The mothers were also concerned that their parenting would be under such scrutiny that they could be deemed inadequate and that those observations could result in *loss of respect*, *loss of child*, and *loss of identity*. As a result, it was the fear of being 'bad mother' that was the motivational force behind them striving for 'good mother' recognition. The motivation to be 'good mother', driven by the fear of being 'bad mother' was a powerful thrust for all of the mothers in this study. Yet, without tangible and emotional support to enable them to achieve the best outcomes for their children

and for their own wellbeing, the task was challenging. When they did fall short of the ideological expectations of 'good mother' they experienced feelings of anxiety, failure, inadequacy, shame, and guilt.

In their discussions on their fear of being 'bad mother' the mothers identified *pre-birth anxiety; not knowing what to do; scared of doing the wrong thing; falling short;* and being *good enough* as significant issues. *Pre-birth anxiety* was expressed by many mothers. Carlene commented, 'Both times I thought, "Oh, God, I'm going to be a terrible mother", and I didn't want to be a terrible mother'. Cath's awareness of needing to respond to the baby and questioning her ability to do that prompted attitudinal change. Her thoughts were, 'when you have the baby you are going to have to do things whether you want to or not...you have to respond to the baby and be there'. All of the mothers cited 'wanting to be a better mother' as their motivation to modify their drug use during pregnancy. They 'didn't think it was fair on him [or her] to be subjected to [drugs]'.

After the birth many struggled to mother because they *did not know what to do* and were fearful of 'doing it wrong' (Lisa). Many of the mothers also felt isolated and not sure of themselves. Carol recalled the early days of parenting when she wondered, 'What if I make a mistake, I can't ask anybody'; and Cath commented, 'there's just no book to check on. What if I'm a failure as a mother, or I'm not good enough?'

For most mothers their primary source of parenting knowledge was the role modelling within their family of origin and especially that of their own mother. The mothers spoke of the poor example they experienced and how it frightened them that they may perpetuate 'bad mothering' as a result of their knowledge deficit. They were *scared of doing the wrong thing* and felt they were conditioned. Beth related how, 'I'm a bit frightened of how I'm going to bring up my own kids because [of] how I'm used to [being treated]'. She continued to say, 'I'm conditioned to how my mother...spoke to us, which makes it very difficult for me not to approach my children like that.... It's so difficult...to change these things that are so in-set'.

When the mothers *fell short* of their own expectations of mothering they felt anxious, inadequate, ashamed, and guilty, and believed they had failed in their quest to be 'good mother' and therefore were 'bad mother'. Their feelings of inadequacy were based on the unrealistic expectations of the ideal mother. Laura expressed how being mother to two demanding children with minimal support was difficult. She



said, 'if I've got to go out and do something or stay at home and do something and try and give them both attention, it's difficult'. She recognised the competing demands but felt inadequate that she could not balance them effectively. She continued to say, 'You feel like a bad Mum when you're on [drugs], but when you're not you can't get off your arse to clean the house, so you feel like a bad Mum anyway'.

Others spoke of their perceived inadequacies with their lack of patience, and their ambivalence towards the children when their affect was low. These feelings are not inadequacies when judged against reality (S. Lewis, 2002) but when judged against the ideological 'good mother' they induce 'bad mother' feelings. Beth's ambivalence worried her, she said, 'I have down days...where you just can't be bothered doing your normal stuff; even when your kids come to get you'.

As Lewis (2002, p.39) articulated, "there is a need for mothers to find ways of rejecting impossible and contradictory social directives, to recognise mixed feelings about motherhood as natural and to seek ways of mothering which fit their own capacities and circumstances". As mothers struggled with the 'good mother' dictum some were able to find perspective and be satisfied with '*good enough mothering*'. Mothers made observations as, 'I believe that I'm a good mum most of the time'; and 'I have done a good job with her'. Those observations of 'knowing I'm a good mother' helped mothers deal with their fear of being 'bad mother', although there were always the nagging questions of 'what if' that remained unanswered. In relation to being 'good mother', Beth said, 'Well I hope so, I don't know, I'll find out later on when they are older and they tell me that I haven't...done a very good job... But overall, I try'.

## **6.8 Maturation of children**

The sixth condition that influenced the experience of mothers who use illicit drugs was the maturation of children. The age and developmental stage of children had a significant influence on being mother; on one's roles, one's workload, and one's necessity for adaptation and redefinition of goals over time, and with each successive addition to the family. Being mother is not a static state but a fluctuating process where both the mother's and each child's evolution and development are independent and interrelated. It is necessary for the maternal role and maternal behaviour to change as the age, development and requirements of each child changes (Mercer, 2004). Each developmental stage for each child requires new

skills, and brings new challenges and joys. For example, an eight month old child will demand greater surveillance as it becomes more mobile, more inquisitive and wilfully explorative, yet remains oblivious to hazards (Mercer, 2004).

Maternal competence is also an evolving process with the necessity to learn new skills as an infant changes and matures (Mercer, 2004). In the early months, for the mothers in this study, issues of sleeping, feeding, and developing routines were prominent, demanding, and time consuming. However, as Cath identified, her confidence was improving and the infant also changed. She remarked, 'It's ongoing and it's changing all the time, because he changes'. Laura spoke of the changes in her son. She explained how he is, 'more alert as he's getting older and he's into everything and wants to get into everything. He's not happy to sit there and watch you anymore'. Carol too was animated as she told of her daughter progress and the joy she gained from their interactions. As to be expected, as infants matured they slept less during the day and become more inquisitive and interactive.

Further maturation again altered the mother-child dynamics as communication and motor skills developed, thus changing the mothering work required. Children began independent play and were able to dress and feed themselves as they matured. Ruby commented, 'Isabella's at the age where you put her clothes out and she dresses herself, but with [baby] I've got to do a million different things...'. Laura spoke of her child being able to, 'entertain herself for half the time'; and Kerry related, 'she's getting better at occupying herself'. Laura realised that things would change: 'I know that it's going to get to the point where they are both going to be old enough...to play together while I get the stuff done that I need to get done'.

As children got older, their capacity to communicate, interact and comprehend improved, and older children were capable of helping in small ways. Mothers spoke of children putting away toys, tidying up, helping with dishes, and older ones shopping. They also spoke of being able to reason with their children, being able to explain things to them, and involving them in decision making that affected the whole family. This level of maturity assisted mothers with household chores, made communication easier, and lessened their burden.

However, some mothers also reported that as their children got older they were becoming obnoxious and of the need for discipline. Candice related how she was very upset with her son when she learned that he was asking neighbours for food.

'He was going over to his friends place and saying, "Mum's got no food again, and I'm hungry". Others reported their children being cheeky, rude, and antisocial and of confronting their mother with their knowledge of her drug use. These children were acutely aware of household dynamics, activities that were occurring in the home, and of the mood and behaviour of their mother. Kaye related that her daughter (7) asks, "have you taken your head pills Mummy?" These dynamics only increased the mothers' concern for their children, exacerbated their shame and guilt, and added further burden to their ongoing challenges thus feeding back into the threat of loss.

## 6.9 Summary

Conditions that influenced the central problem of the *threat of loss* and the process of *safeguarding to limit loss* include *the self*; *the nature of support from significant others*; *attitudes and practice of health professionals*; *the negative influence of others*; *fear of being 'bad mother'*; and *maturation of children*. *The self* and one's experience is central to all interactions with and all interactions initiated by a person and to the interpretation and response to those interactions. The mothers in this study often felt ashamed of who they were and guilty about what they had done. These painful emotions resulted in mothers exhibiting low self-esteem and diminished respect for self. The condition of having low self-esteem had a significant influence on how the mothers perceived themselves and how they interpreted interactions. They anticipated judgment and disapproval, doubted positive feedback, and believed they were undeserving. Often they had an inability to respond appropriately to threat and lacked confidence in their abilities.

The *nature of support from significant others* created either supportive or non-supportive environments. The major conditions that contributed to creating a supportive environment included being accepted and respected, and being supported and encouraged. For some mothers these conditions lessened the *threat of loss* in specific circumstances; however, due to the complexity and range of interactions with many people, the *threat of loss* remained real and required the mothers to employ strategies to safeguard self and 'all that is mine'. Conversely, a non-supportive environment was experienced by many mothers where they received limited support from significant others during pregnancy, labour and birth, and limited support whilst mothering thus exacerbating the threat of loss.

The influencing condition of *attitudes and practice of health professionals* also profoundly affected the mothers. Whilst *positive attitudes and professional practice* contributed to creating a supportive environment, *negative attitudes and unprofessional behaviour* contributed to a threatening environment. Some mothers found that under certain circumstances and with individual health professionals their experience was enhanced by being accepted and respected and supported and encouraged. However, these conditions were not constant or even to be expected and under different circumstances and interacting with different health professionals, the mothers experienced *negative attitudes and unprofessional behaviour* where they believed they were not trusted and the actions and behaviours of health professionals were interpreted as judgmental, disrespectful, and unprofessional. As a result mothers lost confidence in the knowledge and credibility of health professionals, their vulnerability increased and demanded that they enact a process of *safeguarding to limit loss* in an effort to maintain their integrity.

The fourth influencing condition was the *negative influence of others* which often maintained their drug use, precipitated relapse, and affected their mothering. The mothers found themselves in positions where others influenced their decisions and they interpreted that their locus of control was external, unstable, and beyond their control.

The *fear of being 'bad mother'* was a strong motivational force driving the mothers to protect the functional integrity of their role as mother. The mothers and others judged their performance of mothering on the hegemonic stereotypical 'good mother'. They were acutely aware that they did not fit the 'good mother' image on the basis of their drug-using history and knew that they were under scrutiny. In an effort to safeguard against loss of respect; loss of child; and loss of mother identity, the motivational thrust of the fear of being 'bad mother', whilst adding pressure to the role, provided incentive to achieve 'good or good enough mother'. However, being mother is not a static state but a fluctuating process where both mother and child evolve and develop through interrelated and independent processes. The age and developmental stage of children had a significant impact on mothering demands and mothering work as one adapted and redefined goals to address the changing needs of the family. By elucidating the conditions influencing the central problem and basic psychosocial process it provides an understanding of the issues and places the theory in context.

## **Chapter seven**

### **Implications and conclusion**

#### **7.1 Introduction**

This final chapter brings to a conclusion the exploration, analysis, conceptualisation, and explanation of this study of mothers who use illicit drugs. The substantive theory explains the processes employed by these mothers to manage the psychosocial challenges they experienced. The theory has been written using the mothers' voices to bring authenticity and understanding to the mothers' experiences.

This chapter goes beyond the theory and positions the hypotheses within related theories, looks at limitations of the study, and discusses implications of the findings. The health and wellbeing of mothers who use illicit drugs, their children, and families can be improved and ways to achieve that should be considered. Accessible services specifically for mothers who use illicit drugs is important, especially as the number of those childbearing women seeking care is increasing. Education and training for health professionals who provide care for this group of women should be increased to improve practitioner knowledge and competence, not only in medical/obstetric and midwifery care but also in social and psychological care, to meet these mothers' specific needs.

#### **7.2 Positioning the study within related theories**

There have been few attempts to empirically conceptualize and articulate the experience of mothers who use illicit drugs with none previously being conducted in Western Australia. Of the seminal qualitative work much has been conducted by social scientists in the fields of medical sociology (see Banwell & Bammer, 2006; Banwell, Denton, & Bammer, 2002; Murphy & Rosenbaum, 1999) and psychology (see Klee, 1998; Klee et al., 2002; Suchman & Luthar, 2001), with only a few nurses such as Kearney, who worked extensively with Murphy and Rosenbaum as well as independently (see Kearney et al., 1994; Pursley-Crotteau & Stern, 1996; Roberts, 1999), publishing in the area. There is limited qualitative research on mothers who use illicit drugs in the midwifery literature.

In keeping with the expected contribution of qualitative research, the findings from this research have enhanced the understanding of mothers who use illicit drugs. Mitchell (1996, p.143) articulated that explicitly or implicitly, "all research is

embedded in a theoretical perspective". Whilst a theoretical perspective was not chosen to guide this research, theories bearing similarities to aspects of the resultant theory are evident and support the adequacy of *safeguarding to limit loss*. Theories compared with the resultant theory include theories of motherhood (Arendall, 2000; Kearney et al., 1994; Lupton, 2000); theories of stigma (Goffman, 1963, 1974); theories of stress and coping (Lazarus, 1966); theories of self-protection (Black, 2006; Shearer, 2002); and theories of vulnerability and resilience (Rutter, 1987, 1993).

### **7.2.1 Theories of motherhood**

For the mothers in this study their values in relation to pregnancy and motherhood were solidly conventional and this has been identified in other research involving mothers who use illicit drugs (see Banwell & Bammer, 2006; Hardesty & Black, 1999; Kearney et al., 1995; Kearney et al., 1994). Motherhood and mothering are the subjects of an expanding body of literature that is still influenced by idealized notions of 'good mother' and, according to some commentators, of the family as: White, middleclass, heterosexual nuclear family with its children, living in a self-contained family unit (Arendall, 2000; Lupton, 2000). This concept is reinforced by law and social policy, literature, film and television, and supports the traditional gender-based division of labour (Arendall, 2000). However, whilst those notions still abound, the social context of living in the 21<sup>st</sup> century has altered. With the feminist movement, the need for economic contribution from men and women, and the desire for personal and professional stimulation outside the home, many mothers are not stay-at-home primary carers. As such a marginal shift in the interpretation of mothering to a more egalitarian model is slowly emerging however, mothering still carries greater responsibility than fathering (Lupton, 2000), and mothers still aspire to the ideal of 'good mother'.

There are numerous definitions of what mothering is and what 'good mother' means. For example, Forcey's (1994, p.357) definition states, "a socially constructed set of activities and relationships involved in nurturing and caring..." Hays (1996) created the *intensive mothering* ideology that mandates mothers as devoted, self-sacrificing women who subordinate to their child's needs. Lupton (2000, p.55) conceptualised 'good mothers' as "selfless, able to give unstinting love and time to their children and as having the ability to regulate their emotions so as to best interact with their children". However, it is ideals such as this that shape the preconception of women who are in the throes of providing primary care to their children. Lupton (2000, p.55-

57) identified that, in reality, it was “difficult to live up to the ideal” of ‘good mother’; that mothering was “an all consuming thing”; that mothers were, “highly aware of their own lack of knowledge in practical matters of infant care”; that mothers “struggled” to do their “best for their infant”; and that mothers experienced a “loss of freedom” from the demands mothering placed on them. Parallels can be drawn from these descriptions to the mothers in the current study. Indeed, the *fear of being ‘bad mother’* was an influencing condition within this study, and the same frustrations, struggles, knowledge deficits, and fears were articulated. They too struggled whilst striving to do their best to be ‘good mothers’. However, whilst the mothers in Lupton’s study were mainstream middleclass mothers, the mothers in this study were socially disadvantaged, stigmatised, mothers who use illicit drugs and who lived under *the threat of loss*, making their task more arduous.

This theory does not espouse to conceptualise what contemporary mothering or motherhood is or should be but focuses on the experience of mothers who use illicit drugs. Whilst all the mothers aspired to achieve ‘good mother’ status, they oscillated between *struggling* and *taking back control* as they tried to be the best mother they could. Similarities can be drawn with other theories on mothering practice. Kearney et al. (1994) studied mothering on crack cocaine using grounded theory analysis. They reported crack mothers demonstrating a strong *responsibility and pride* in their children which was also identified in this study; mothering goals of *nurturing* and *modelling* described in Kearney et al.’s study were also found in this study with *nurturing* and *teaching/guiding* being properties of *striving to be ‘good mother’*. Whilst *defensive compensation* was the label applied to the basic psychosocial process in the crack mothers’ study, *safeguarding to limit loss* was the label applied in this study, with both titles symbolizing a protective nature to the process. As with the mothers in the current study the crack mothers were stigmatised, felt guilty about what they were doing and worried about violating the maternal altruism and responsibility ideology. However, differences were also identified in that this study identified multiple loss experiences being problematic for the mothers. Yet, Kearney et al.’s study did not articulate an inductive central problem but appears to have used the precursor problem of *mothering on crack cocaine*, which implies a moral judgment. Drug use in the current study was a strategy within the basic psychosocial process, which however, did produce negative consequences, but it was not the subjective problem articulated by the mothers. Additionally, the influencing conditions between the two studies differed in

some aspects in that the social context and the health, welfare and justice systems varied significantly between the Australian and US experience.

### **7.2.2 Theories of stigma**

The mothers in this study and mothers who used illicit drugs and were studied by others (see Kearney et al., 1995; Kearney et al., 1994; Klee, 2002b; Murphy & Rosenbaum, 1999) have been identified as being highly stigmatised. The origins of contemporary perspectives on stigma have been attributed to Goffman's (1963; 1974) ethnographic study which resulted in his classic book "*Stigma: Notes on the management of a spoiled identity*". Since then there has been a proliferation of research and publications on stigma and how it affects stigmatised individuals and groups; and on the processes the stigmatised use to overcome or cope with the consequences of stigmatisation. Stigma is "an attribute that is deeply discrediting" (Goffman, 1963, p.3) and reduces the stigmatised, "from a whole and usual person [or group] to a tainted, discounted one" (Goffman, 1963, p.3). Stigma is not an attribute of the individual or group but arises from the symbolic interactions between persons considered different and those who evaluate or judge that difference negatively (Goffman, 1963; Susman, 1994). Stigma is a social construct and resides in the social context of society, not in the person or group who is stigmatised. Unfortunately, the stigmatised are seen to be different and that differentness contributes to judgment, disapproval, rejection and the creation of a 'master status' (Banwell & Bammer, 2006; Becker, 1963) where one is seen only as the unacceptable attribute which overrides all other status characteristics (Markowitz, 2005).

Major and O'Brien (2005, p.393) state that, "Stigma directly affects the stigmatized via mechanisms of *discrimination*, *expectancy confirmation*, and *automatic stereotype activation*, and indirectly via *threats to personal and social identity*". Consistent with the preceding brief overview of the theory of stigma, the mothers in this study were stigmatised and experienced discrimination within society as a whole and even within their own family, at times, because, among other things, of the incongruence between their illicit-drug-use and their status as mother. Within the health care system they were also discriminated against by some health professionals and carried the 'master status' of drug user and thus lost other status and identity characteristics that were important to them. They believed that, at times, they were negatively treated because of their stigmatisation and this activated



the need to safeguard self and 'all that is mine' to guard against courtesy stigma (Goffman, 1963).

Stigma also influenced the mothers via expectancy confirmation processes where they expected to be judged by all who knew of their drug-using status and were surprised when they were not treated badly. Because of the cultural stereotypes of drug-users some interactions, either conscious or subliminal, with dominant culture groups, for example, health professionals, promoted stereotypical behaviour in these mothers thus confirming the preconceived perception of their differentness and promoting further discrimination. Finally, in alignment with Major and O'Brien's (2005) model, in the current study, stigma created a threat to personal and social identity by the mothers' interpretation of how others viewed them, their understanding of the social context, and by their own goals and motives. This resulted in involuntary responses to the stress of being stigmatised and contributed to low self-esteem, shame and guilt responses, and helped shape the 'self', which in this study was a condition influencing the central problem of *the threat of loss* and the basic psychosocial process of *safeguarding to limit loss*. Voluntary responses to the stigma-induced identity threat were the safeguarding processes employed to limit loss. These strategies were used in an attempt to regulate emotion and behaviour and create a better environment for themselves and their children. However, the interplay between the involuntary response to stigma-induced identity threat and the ways of coping with that threat influenced subjective interpretation of circumstances, thus creating the oscillating process between *struggling* and *taking back control*.

Throughout this study the analysis, conceptualisation and explanation of the phenomena of mothers who use illicit drugs revealed highly stigmatised individuals and stigmatised group identity. Consistent with theories on stigma, their stigmatised status contributed to the central problem of *the threat of loss* and to the basic psychosocial process of *safeguarding to limit loss*.

### **7.2.3 Theories of stress and coping**

Another theory that bears relevance to the present study is Stress and Coping (Lazarus, 1966). Since the 1960s there has been a plethora of research and literature on stress and coping in adaptation and health. Stress is a relational construct, or a consequence of the relationship between a person and the environment, that results when the perceived demands of a situation are assessed

as exceeding one's perceived resources to meet those demands (Lazarus, 1966; Major & O'Brien, 2005). Originally stress was considered a unidimensional concept but in later years Lazarus (1993) proposed that stress is a subset of emotion. This interpretation of stress better fits this current study as emotions are a much richer source of data to use in the interpretation of people's situations. The stress emotions of anger, anxiety, sadness, shame and guilt were prominent in this study and shaped the mothers interpretation of situations and their response to them and contributed to the researcher's analysis of the data and conceptualisation of the theory.

Central to stress and coping theory is the role of cognitive appraisal, a constantly occurring process of recognising and evaluating an encounter in terms of its implications (Lazarus & Folkman, 1984). At interview the mothers were able to articulate their appraisal of encounters which provided data to identify the shared central problem. Lazarus and Folkman (1984) identified *stress appraisal* to include harm; loss; threat, and challenge. For the mothers, some damage and loss had already occurred, whilst threat included harm and loss that was anticipated. The central problem of *the threat of loss* shared by the mothers thus fits the stress model. In response to the cognitive appraisal of their stress, further appraisal focussed on what they could do in response or how they would cope with a range of threats.

Coping is a complex dynamic process that "changes over time and [is] shaped by the adaptational context out of which it is generated" (Lazarus, 1993, p.234). Other interpretations of coping include: "dealing with adverse or stressful or difficult circumstances", and that coping contains "elements of modification or alteration" (Keil, 2004, p.660). As in Lazarus and Folkman's (1984) discussion, coping efforts vary to include problem-focused (Lazarus, 1993) strategies that modify the circumstances creating the harm, loss, threat, or challenge and emotion-focused (Lazarus, 1993) strategies that regulate one's response to the harm, loss, threat, or challenge. Within this study both foci were identified. For example, problem-focused strategies included changing priorities during pregnancy to limit loss of health to self and the fetus, and distancing self and children from harm through breaking free from abusive partners. Examples of emotion-focused strategies included altering perceptions through minimising judgment and positioning self in context. Coping is also influenced by resources available to use in response to threat and constraints that inhibit the application of those resources. This study

identified the influencing conditions and provided the contextual environment in which the stress was generated, maintained, and addressed. However, responses to and strategies employed in coping, whether in the manipulation of external stressors or in the modification of one's emotional responses to the stress, are generated internally and it was what the mothers did in response to stress that provided the understanding of their coping strategies.

Much research on stress and coping draws on standardized questionnaires to measure people's ways of coping and, indeed, there are a plethora of such tools (see for example, Ways of Coping Questionnaire (Folkman & Lazarus, 1988)). However, this inductive study, using grounded theory, did not employ interpretive criteria in advance but generated a theory about what was happening thus providing a subjective perspective of the mothers' reality, in context, of their stress and how they coped.

#### **7.2.4 Theories of self-protection**

The basic psychosocial process utilized in this current study has been labelled *safeguarding to limit loss*. This symbolizes a protective nature to the process mothers used to protect themselves and their children from the threat of multiple losses. When making comparison to other theories, Black's (2006) theory of *the thrust to wholeness* found that the driving force of humans was to "attain, maintain, or restore functional wholeness" (Black, 2006, p.193) through a process of self-protection. He defined the protective motive as: "The biopsychological thrust in human[s]...that requires social nurturance, is modified by experience, and induces biological mechanisms and self-directed actions to maintain, express, and enhance functional wholeness..." (Black, 2006, p.203).

In Black's (2006) model he identified the utilization of *homeostasis*, *defense*, *prevention*, *healing*, and *outreach* to achieve self-protection through maintaining and expressing integrity of body (physical) and self (psychological). Black referred to *body preservation* as the automatic biological processes of human functioning and to *self-conservation* as the voluntary actions of a person to promote maintenance of self. *Self-conservation* coincides closely with *safeguarding to limit loss* in this study. Black articulated similar strategies of maintaining identity; excuse making; affiliation; and restoration of self-assurance which were also used by the mothers in this current study. *Self-conservation* and *safeguarding to limit loss* were thus used to keep self and any extension of self functioning optimally.

This study demonstrates strategies employed by the mothers to maintain *self-homeostasis* which included the safeguarding of their infant through health promotion, nurturance, and preserving integrity. *Self-homeostasis* was also enhanced through social support; by redefining self in an effort to maintain a stable valuation of self; and by remodelling to create a preferred image for others. Black's (2006) *defense* of the body was also demonstrated within the current study through averting or counteracting injury. Mothers also limited exposure to threat by limited physical and emotional harm; distanced self and children from harm by breaking free and isolating; and controlled events to safeguard. Within the sub-processes the mothers demonstrated perceptual preparedness acquired through prior experience and were thus wary, cautious, and hypervigilant. They also modified their drug use; and defended self and children. Additionally, elements of preserving integrity such as concealing, excuse making, rationalising, and making comparisons all contributed to the defense of self. Indeed, even distorting one's reality through the use of psychoactive drugs, when they were unable to maintain control, was a component comparable to Black's *defense of self*.

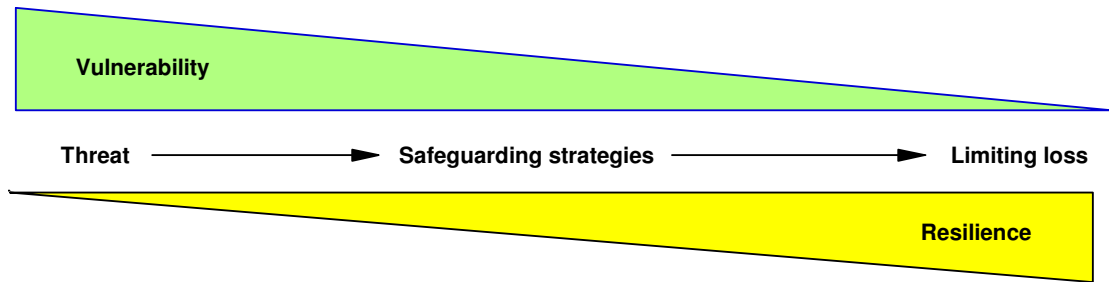
Black's (2006) process of *prevention* encompassed behaviours directed at future threats. Again, these processes were mirrored in the current study with safeguarding strategies such as the health promotion activities of self care; the teaching and guiding of children; increasing capacity of self to be better prepared for future exigencies; and pre-empting. In this current study the process was *safeguarding*, which was comparable to *self-conservation* against potential threats. The fourth element of Black's (2006) model was *healing*. Within the *self-conservation* aspect of protection, Black identified social support as a powerful mediator in the healing process and the mothers in this study, when being proactive and taking back control, carefully selected support to help them preserve their integrity. Finally Black identified *outreach* as an element of self-protection, and again, this concept is illustrated within this study where the mothers nurture their babies as an extension of self; proactively taking back control where successful attainment of what they are striving for enhances their capacity to attain even further success through creating "new potentials of competence" (Black, 2006) and increasing their resilience.

### 7.2.5 Theories of vulnerability and resilience

Mothers who participated in this study were identified as being extremely vulnerable. They were highly stigmatized and had low self-esteem, were socially disadvantaged, had limited support, and were dependent on psychoactive substances. In addition it was identified that the threat of multiple losses was problematic for these mothers and that despite their vulnerability these mothers were resilient. Indeed, the main antecedent to resilience, a dynamic developmental process (Luthar & Cicchetti, 2000), is adversity (Earvolina-Ramirez, 2007). In response to the *threat of loss* the mothers implemented a process of *safeguarding to limit loss*, with a range of outcomes.

From the data, vulnerability is defined as a biopsychosocial state of being without adequate emotional energy, skills, or resources to effectively safeguard against day-to-day threats and challenges, making mothers susceptible to physical and emotional harm, persuasion, and temptation. Resilience, on the other hand, was successful performance in the face of adversity, and developed as a consequence of repeated exposure to threats to which they had positively adapted, thus increasing their capacity. This concept is supported by others who have defined resilience as “the ability to bounce back, recover, or successfully adapt in the face of obstacles and adversity” (Zunz, Turner, & Norman, 1993, p.170). Miller and MacIntosh (1999, p.159) describe resilience as “positive adaptation despite negative environmental influences”; Gordon (1995, p.239) as the ability to “thrive, mature, and increase competence”; whilst Rutter (1987, p.316) suggests resilience is the “positive pole of individual differences in people’s response to stress and adversity”. Rutter (1987; 1993) and Shearer (2002) in their work on psychosocial resilience and protective mechanisms claim that vulnerability and resilience are opposite ends of the same continuum.

When comparison was made between this study and the work of Rutter (1987; 1993) and Shearer (2002) it was apparent that there was a difference in the interpretation of the relationship between vulnerability and resilience. When considering the adaptive trajectory that resulted from *safeguarding to limit loss* it is apparent that vulnerability and resilience have an inverse relationship (Figure 7.1).



**Figure 7.1: Adaptive trajectory and protective efficacy**

To explicate this notion, the mothers' vulnerability varied from high to low where one's ability to effectively implement strategies to safeguard (protective efficacy) was compromised when vulnerability was high and when vulnerability was low one's protective efficacy was enhanced. Thus, when one was most vulnerable they were least resilient, and when least vulnerable they were most resilient. This implies that the continua were separate, as depicted in Figure 7.1, and not as proposed by Rutter and Shearer as opposite ends of the same continuum. Shearer (2002, p.73) also described adaptation from the implementation of protective processes as a "continuum of consequences". However, in the context of this study, due to the oscillating nature of safeguarding strategies and the variation in outcomes, *a range of consequences*, better depicts what happened as some outcomes, despite them having some efficacy, fed back into maintaining their vulnerability and to the threat of loss, whilst others built resilience and limited loss.

Rutter (1987; 1993) also maintains that there are two separate critical features required for the development of resilience: firstly, one must be exposed to risk factors and secondly, the person must have protective factors available to them to balance against those risk factors. In this study, the mothers were repeatedly exposed to significant risk factors over extended periods which contributed to the embodiment of threat and increased vulnerability. Additionally, despite their adverse circumstances, they utilised protective factors such as their knowledge and experience gathered over time; support when it was available and trustworthy; their strong sense of mother identity; and their fear of being judged as 'bad mother'. These protective factors contributed to their motivation to safeguard self and their children in an effort to limit the potential for loss and gradually built resilience over time as success in one area led to increased capacity.

### **7.3 The state of play**

Until now, in Western Australia, the contextual nature of the complex lives of mothers who use illicit drugs has not been adequately understood and articulated. Interpretation and explanation of the complexities and extent of threat faced by this marginalised group revealed a variable but often highly judgmental, blaming and threatening culture with aggressive and, at times, punitive undertones. To counteract this culture of threat these mothers had to engage in safeguarding processes in an effort to lessen the pervasive threat and facilitate a tolerable existence whilst remaining vigilant and wary. This process necessitated the expenditure of time and energy that would have been better utilised in mothering activities, self care, and family orientated pursuits. With a greater understanding of the complex nature of the lives of mothers who use illicit drugs and the challenges they face, more effective interventions to constructively address the underlying issues as well as the on-going challenges will be more effective than attempting to change individual behaviours. Whilst those behaviours are considered to be deviant within the predominant, western, middleclass society and judged against societal norms it does not take into consideration the capabilities and circumstances of mothers who use illicit drugs. Without addressing the underlying factors that cause mothers to use illicit drugs and maintain them in a culture dominated by threat and loss they will remain disenfranchised and continue to be judged against “idealized notions of what a mother should be” (Richter & Bammer, 2000, p.412). These women, though vulnerable, are strong and capable and have learned unique ways to function in threatening environments. We should be focussing on their strengths and capabilities (Hulme, 1999) whilst we assist them to increase their capacity, become more competent, and simultaneously address underlying contextual constraints that impinge on their lives and at the same time strengthening supports available to them.

### **7.4 Limitations of this study**

This study was designed to explore the subjective experience of mothers in Western Australian who use illicit drugs. Western Australia is Australia’s largest state of 2,529,875 km<sup>2</sup>, which covers the western third of mainland Australia. The city of Perth, where this study was conducted, is often said to be the most remote major city on Earth (Wikipedia, 2005). The vastness of Western Australia creates a limitation to this and other research as access to regional, rural, and remote populations is restricted by the tyranny of distance. Therefore, mothers who use illicit drugs and give birth at regional, rural, or remote health care facilities within

Western Australia or live outside the metropolitan area may have different experiences.

Additionally, the mothers in this study delivered their babies at the only tertiary referral hospital within the state of Western Australia. This is a public facility and has the only dedicated antenatal chemical dependency clinic (ACDC) within the State and mothers in this study attended that clinic. However, women who chose to attend private health care facilities under the care of private obstetricians may have a different experience. Also, by attending the ACDC the substance using status of the mothers was established. In contrast, illicit-drug-use within childbearing women is often underreported or concealed and women who choose to conceal their substance using status may again have different experiences than those who have disclosed.

Another limitation of this study was that all participating mothers were over the age of 18 and were English speaking and adolescents and diverse ethnic groups were not represented within the cohort. Australia is an ethnically diverse country (Spooner & Hetherington, 2004) and it is well known that illicit-drug-use within some ethnic groups is high, for example, the Aboriginal and Torres Strait Islander population. However, it is purported that ethnic group differences in relation to drug use patterns is most likely due to socioeconomic factors rather than to ethnicity itself (Spooner & Hetherington, 2004). However, the experience of mothers whose second language is English and who use illicit drugs may have different experiences. Similarly the experience of adolescent mothers who use illicit drugs may differ from the experience of older mothers.

Finally, the sample size for this study was ultimately 14 mothers who use illicit drugs and six health professionals who regularly provided care for these mothers. Fourteen mothers do represent a relatively small sample size and data from additional mothers may have resulted in new perspectives. However, these 14 mothers collectively had 60 pregnancies and 35 live births, and two were pregnant at the time of interview. Sampling commenced with a purposive sample of five mothers followed by theoretical sampling of eight mothers and six health professionals. The data obtained was extremely rich and saturation was achieved and it is believed that the theory would be modifiable to incorporate new perspectives from any additional data.



Whilst every effort was taken to ensure the accuracy of the research by truthfully representing the experience of the study participants, and by using other data sources within the analysis, it cannot be claimed that the substantive theory has relevance to all mothers who use illicit drugs or fits their experience.

## **7.5 Implications for health and social policy**

In Western Australia the governance of substance use and misuse comes under the control of the Poisons Act (1964); the Poisons Regulations; and the Misuse of Drugs Act (1981). Australia's official approach to the management of illicit drugs in society is through the National Drug Strategy where the overarching goal is to minimise harm. The mothers in this study entered the health care system as established users of psychoactive drugs, consequently, the pertinent National Drug Strategy priority areas were: Reduction of drug use and related harm; and, improved access to quality treatment (MCDS, 2004).

### **7.5.1 Promoting health to minimise harm**

Raising awareness of the need to reduce drug use and related harms can be enhanced through health promotion strategies which are consistent with the ideology of health promotion espoused by the World Health Organisation (1986). If health promotion on illicit drugs use and related topics was undertaken not only on an individual basis but at a public health level, delivered through the popular press and free to air television, the opportunity to reach a wider audience would be achieved. Worthy topics could include: harm minimisation with safe injecting, avoidance of blood borne viruses, and safe keeping of drug paraphernalia; birth control; antenatal care; depression awareness; breastfeeding; and the promotion of services such as the DCD Best Beginnings. Promoting health in areas of identified need would also raise awareness, promote the message that treatment or management is available, and that engaging in health promoting activities increases capacity and wellbeing and reduces potential harm to the fetus/baby.

Opportunities to implement harm minimisation strategies with these mothers should also be taken during the antenatal, perinatal and postnatal periods as these are critical stages of development and transition with a window of opportunity to intervene. Early multidisciplinary intervention with the provision of good antenatal care provides the best opportunity to improve pregnancy and infant outcomes (Cairns, 2001). The antenatal regime should ideally focus on obstetric, nutritional, psychological, social, and drug and alcohol issues (Dean & McGuire, 2004), and

provide the opportunity to engage women in harm minimisation strategies such as pharmacotherapy for the management of opioid dependence.

### **7.5.2 Pharmacotherapies**

Whilst *MMT* is good for mothers during pregnancy and whilst parenting, as it helps stabilize their lives, their drug use, and limits their exposure to the sub-culture, accessing methadone on a daily basis is a substantial impediment to mothering. To have to travel, sometimes long distances or on public transport, to have a daily dose of methadone intrudes on valuable mothering time. Currently the policy governing takeaways in Western Australia allows three non-consecutive takeaways per week after 12 months of uneventful *MMT* (Drug and Alcohol Office, 2007). If mothers only commence their *MMT* early in their pregnancy they are effectively prohibited from takeaways for the duration of their pregnancy and into the early mothering experience; the very times that it is most difficult for them to comply with the restrictive regime. A less restrictive takeaway policy to limit the intrusion on their time and travel would ease their mothering burden somewhat. To only have to attend a pharmacist or central clinic every second day for methadone would substantially reduce the stress and inconvenience associated with *MMT* compliance. This would allow mothers more time to interact with their children and focus on mothering responsibilities.

*Buprenorphine* is currently not recommended in Australia for use during pregnancy and lactation, however, increasing numbers of pregnant and lactating mothers are choosing to remain on buprenorphine rather than transfer to methadone. Also, it has been observed that the *NAS* associated with buprenorphine is less severe than that related to methadone (Fischer et al., 2000; R. E. Johnson et al., 2003). Whilst the alternate day dosing of buprenorphine is more convenient for mothers than daily dosing with methadone, relaxation of policy to allow takeaways of buprenorphine would reduce some extraneous stressors contributing to parenting stress.

In Australia, oral *naltrexone* has been registered for use with the Australian Therapeutic Goods Administration since 1999 (Tucker & Ritter, 2000) and is used for abstinence-orientated treatment for opiate dependence and other disorders. An alternative method of *naltrexone* administration is through sustained-release implantable preparations. Prior to commencing *naltrexone* it is necessary for patients to be completely detoxified or risk severe withdrawal symptoms and overdose (Tedeschi, 2002; Tucker & Ritter, 2000). However, neither oral nor

sustained release naltrexone is recommended for use during pregnancy and lactation. Consideration of this abstinence-orientated treatment would provide more options for some patients.

*Psychostimulant* use is increasing in popularity in Western Australia and more pregnant psychostimulant users are presenting for care at the ACDC. Whilst there is no pharmacotherapy for psychostimulant users, interventions to reduce the perceived need to use, and to support mothers could be implemented. In this study, and also noted by others (Klee et al., 2002; Wright & Klee, 2000), mothers reported using speed to help them cope with their on-going challenges and to alter their reality when issues became overwhelming. Thus, parenting and other stressors are perceived by some amphetamine using mothers to precipitate psychostimulant use to help them cope.

If precipitating issues were addressed and strategies put into place to increase the capacity of mothers, through support systems and treatment, the need to use psychostimulants may be reduced. However, developing services to meet the needs of mothers who use illicit drugs, and their children, presents issues of funding, staffing, accessibility, and program development. For services to be successful, providers need to recognise the interrelationship between family responsibilities, the need for social interaction and stimulation, physical and psychological health needs, child care and early childhood development needs, and educational needs to increase mothers' capacity. Currently, services that are available do address separate components of the overall needs of mothers but few offer integrated services that address the holistic needs of mothers who use illicit drugs.

## **7.6 Implications for provision of and access to services**

Mothers with young families should be afforded greater flexibility to services whilst still remaining safe. Recognising the competing demands on mothers with babies and providing family friendly services would reduce additional stress on mothers, promote compliance with treatment, and encourage engagement in services. In Perth, Western Australia, the majority of services for mothers who use illicit drugs are located in the city centre within a radius of approximately 10 km. Whilst most of these services are accessible by public transport, the agencies are not in close proximity. Gaining access to these services whilst pregnant or with a baby and/or young children poses an impediment to utilising the services. For example, there is only one central dispensing clinic in the city and it is as far as 47 km from some of

the peripheral metropolitan suburbs in a northern, eastern or southern direction, making the journey to the city a 100 km round trip. Whilst a limited number of approved community pharmacists dispensing methadone and buprenorphine are an excellent addition to accessibility, they have a limited service and some mothers are reluctant to attend their local pharmacist for fear of being identified a user in their local community. To address these problems, better access could be attained if satellite clinics, offering similar services to the centrally located clinics, were established. Whilst this would be a long term strategy as funding, staffing, and education for health professionals would pose a problem, the investment would provide a more comprehensive service to meet the needs of this growing population.

Similar to the centrally located drug and alcohol service, obstetric, midwifery and allied health services specifically designed for chemically dependent mothers are only available at the centrally located tertiary referral hospital. The development of additional antenatal chemical dependency clinics for public patients in peripheral hospitals and the upgrading of some nursery facilities to accept babies with NAS would also provide a better service for this growing population of mothers.

Moreover, issues also exist with the community based program for pregnant or parenting substance users (PEPISU). This service not only has a drop-in centre where mothers can socialise and receive counselling, support, advocacy, and education but it also offers an outreach program. Again, the centre is located close to the city centre, making it difficult for mothers living in peripheral suburbs to attend. This service is a non-government organisation (NGO) and relies heavily on government funding to remain viable and thus has limited scope and places available. The opportunity to reach more mothers could be afforded if there was on-going funding and more centres offering similar services in peripheral suburbs.

## **7.7 Implications for the current model of care**

When awareness of issues affecting the provision of quality services is apparent, an opportunity to modify the status quo exists. Issues that could potentially be modified to provide a better environment in which to deliver services include: the negative stereotypical image of mothers who use illicit drugs; the negative image of existing services; the existing medley of follow-up services; the attitudes and practice of health professionals; and the unrealistic image of 'good mother'.

### **7.7.1 The negative stereotypical image**

Throughout this study the mothers demonstrated a diminished sense of self with low self-esteem, depression, and feelings of shame and guilt. These traits were, at times, impediments to their ability to have a strong sense of belonging or to take affirmative action to address challenges and make positive change. Additionally, one's sense of self was constantly being challenged when their respect was being threatened, their freedom was being destabilized, their health was under threat, their identity was nebulous, their integrity was contested, and they had lost trust in others. These mothers need support and encouragement to overcome barriers to their self-esteem and to their sense of belonging.

Whilst the predominant societal attitude towards mothers who use illicit drugs is one of censure, drug use does not preclude them from being good mothers. Many mothers who use illicit drugs are 'Mrs Suburbia' and face the same challenges as mainstream mothers. They too have to provide, nurture, educate, guide and support their children. However, these mothers do it with added challenges and often under intense scrutiny. Lack of skills and confidence and the unrealistic expectations of mothers contributed to fears of being 'bad mother' and of feeling overwhelmed by their burden. However, their attachment to their children and their identity as mother was strong, enduring and provided a window of opportunity to intervene and promote health and wellbeing. If the stereotypical image of mothers who use illicit drugs was softened and a more realistic understanding of the using mothers' lives was portrayed it would lessen the sense of not belonging and place these mothers within society along with other socially disadvantaged mothers who deserved respect and need help.

### **7.7.2 The negative image of existing services**

Comprehensive family assessment conducted at the time of engagement with pregnant users, and ongoing evaluation throughout pregnancy, can identify vulnerable families who can be referred to existing support systems. The Department of Community Services (DCD) in conjunction with the Department of Child Protection does offer Best Beginnings which is a home visiting program tailored to vulnerable families with new infants with a focus on enhancing child health and family wellbeing (DCD, 2008). The multidisciplinary Best Beginning team aims to address a range of issues. Unfortunately, the popular perception of DCD is not one of support and trust but is often viewed as a threat and that they will remove babies from their mother's care. Mothers are therefore reluctant to voluntarily utilise

the service. Therefore, effort should be undertaken to change the image of DCD and present the department as a helping organisation with a team of helpful professionals who aim to support and preserve families.

### **7.7.3 The existing medley of follow-up services**

Within the existing service medley some families have a stream of 'concerned' others entering their lives and placing them under added pressure to perform, which mainstream mothers do not have to tolerate. A mother should not be subjected to home visits from Community Child Health; Visiting Midwifery Services; Best Beginnings; and PEPISU all within the same week as was the case with one mother in this study. Over-servicing gives rise to conflicting information; intense scrutiny; added workload with preparation of the home for external inspection; and the erosion of time for the provision of care to the child and to other pursuits.

Support services should be coordinated to limit intrusion on families whilst still providing assistance, not be adding to their challenges. If coordinated and reciprocal services could be organised and adequate liaison between services/departments be achieved, one health professional could be assigned to each family thus improving the opportunity for engagement with the family, limiting overlap, reducing cost, developing continuity of care, whilst not overwhelming mothers. However, to achieve that goal a high degree of respect and liaison between professional groups would need to be coordinated and maintained to ensure the needs of the mother and her family were achieved.

As engagement with and trust in their dedicated health professional developed, strategies to support and protect the mother could be implemented; strengths identified; and progress applauded. Integrated care planning with realistic and achievable goals could be set and measured against the mothers capabilities and circumstances (S. Lewis, 2002), not against the "idealized notions of what a mother should be" (Richter & Bammer, 2000, p.412).

### **7.7.4 The attitude and practice of health professionals**

There has been limited research in Western Australia on mothers who use illicit drugs (see Bartu et al., 2006; Ludlow et al., 2004), with only one qualitative analysis of their subjective experience (Dowdell, Fenwick, Bartu, & Sharp, 2009). This current study has identified some areas of health professionals' attitudes and practice that indicates knowledge deficits and judgmental attitudes which are

detrimental to the mothers' experience and quality of care. Health professionals have a duty of care to provide a reasonable standard of skilled care and treatment and to avoid acts or omissions that may cause harm (Staunton & Chiarella, 2008). If health professionals' attitudes and practice cause distress or fear they are not meeting their professional obligation. However, it appears that many health professionals do not appreciate the significance and effect of their attitudes which are played out in body language, inappropriate comment, and avoidance. Additionally, some health professionals appear to not appreciate the impact of their knowledge deficit on the provision of care. Their attitudes and practice, at time, exacerbated the mothers' guilt, limited their trust, and diminishing their self-esteem, and wellbeing. When these mothers enter the health care system they are vulnerable and at risk. They are also guarded and wary of trusting health professionals and this influences the complex health professional-patient relationship.

However, health professionals who worked extensively with mothers who use illicit drugs, for example, ACDC and PEPISU staff had a better understanding of the realities faced by these mothers and the mothers' challenges, limitations, and capabilities. Those health professionals created a more supportive and encouraging environment and in return the mothers were more trusting and able to engage more effectively. However, those health professionals believed and observed some colleagues to not hold the same understanding of this group of mothers. They believed their colleagues judged mothers who use illicit drugs against idealistic expectations of 'good mothering' and against mainstream societal norms. These two multidisciplinary provider groups are exemplars of interdisciplinary cooperation and non-judgmental practice. Exploration of health professionals providing such care would help identify critical predictors of success that could be used as models for professional groups in other jurisdictions.

Caring for mothers who use illicit drugs and for their babies requires expanded and specialised knowledge. Education and training for health professionals on the complexity of care and the special needs of these mothers and their babies, is therefore essential to ensure they understand their client group and keep pace with current drug use trends and best practice. Education would also help health professionals understand the unique issues related to using and mothering; create a better understanding of the real issues these mothers face, such as the antecedents and maintenance of illicit-drug-use; the motivations and aspirations of mothers who

use illicit drugs; and addiction and the patterns and triggers of relapse and recovery. Additionally, greater knowledge should soften the stereotypical image of mothers who use illicit drugs by providing a better understanding of them as people who are 'more than just the drug'. Eliminating the 'master status' of drug-user; recognising a multifaceted person; adopting a 'no-blame' approach; applauding achievement; and showing compassion and trust would also enhance the health professional-patient relationship.

Professional credibility is also enhanced when the quality of care and the dissemination of information are consistent and based on best practice. Whilst there are at least, in Australia, national clinical guidelines and background papers for the management of drug use during pregnancy, birth and the early developmental years of the newborn (NSW Department of Health, 2006b); guidelines on the perinatal care of substance using mothers and their infants (Sharp et al., 2007b); and clinical guidelines within individual institutions, often practice is dominated by clinical experience and clinician preference. This adherence to clinician preference results in inconsistencies in practice and confusion for patients with suboptimal outcomes and diminished trust and credibility. The importance of adhering to best practice guidelines must be emphasised in the education of health professionals. Adherence to best practice guidelines should be mandatory and enforced within institutions to maintain a high standard of consistent care which is based on empirical evidence.

Whilst it can be identified that the attitudes and practice of health professionals plays a significant part in the health care experience of mothers who use illicit drugs; addressing the issues to a satisfactory level is somewhat more difficult. Although it is feasible to increase knowledge and awareness through education, experience, and exposure to the issues, there is no guarantee that the attitudes towards mothers who use illicit drugs will improve. However, competence to practice is an area where education and evaluation of practice can improve the prevailing situation.

#### **7.7.5 The unrealistic expectations of the 'ideal mother'**

Some commentators on mothers who use illicit drugs suggest that "the dilemma for all mothers, who are dependent drug users or not, is the discrepancy between the reality of their lives and idealized notions of what a mother should be" (Richter & Bammer, 2000, p.412). All of the mothers in this study were fearful of being judged to be 'bad mother'. These fears exerted additional pressure on their mothering work and evoked anxiety that they would be judged against the idealized 'good mother'



and found lacking and potentially 'have their baby taken off them'. Health professionals are in a unique position to provide support and encouragement to mothers who use illicit drugs by identifying the strengths of mothers and building on those positive aspects of parenting and allowing success in one area to support progress in other areas.

Services designed for mothers who use illicit drugs need to be based on models of support, encouragement, confidence building, and increasing capacity, not on punitive surveillance. Providing positive feedback at every opportunity and being non-judgmental are positive starting points. If health professionals believe what mothers say; give praise and encouragement; and never question their integrity, there is more opportunity for mothers to lift to meet those expectations than to play out the negative stereotype. These mothers are wary, conceal, are deceptive, tell lies and make excuses for a reason. If the reasons to employ those reactive responses are lessened, the necessity to enact them will also be lessened.

### **7.8 Implications for developing an extended model of care**

Because mothers who use illicit drugs are fearful of harming their babies, as a result of their drug use, and want to protect them from such harm, the opportunity for health professionals to engage these women during pregnancy and whilst mothering is unique. Every opportunity should be taken to capitalize on these unique opportunities of providing quality health care and interrupt or break the cycle of use and other negative influences on mothers' lives. However, to be effective those providing services must be credible, professional, non-judgmental, and educationally prepared.

The provision of an extended model of care and the preparation of health professionals to provide those cares should be achieved in tandem. Commencing with antenatal care, the model of care needs to extend through the perinatal and postnatal periods and continue into the early childhood years. A model of antenatal home visits; specialist antenatal care; extended hospital stay with focussed education; extended support and specialised education for the management of NAS; postnatal home visiting; and family centred one-stop services would provide a comprehensive model of care.

### **7.8.1 Antenatal home visits**

To encourage early engagement by mothers who use illicit drugs the initial antenatal visit could be conducted at home. Home visiting could moderate the imbalance of power and pre-empt reluctance to attend antenatal care. Care providers should be consistent to provide continuity and enhance the opportunity for building rapport and trust. During the initial home visit the opportunity to assess the physical environment, relationships, and the woman's interactions with other family members would be afforded. At this time the booking antenatal assessment with physical; psychological, and social parameters; drug use baseline for the mother and her partner; and risk assessment could be undertaken. Also at the first home visit, information on childbirth and parenting classes, the ACDC, the tertiary referral hospital, and other relevant community services should be provided and an opportunity given for the women to ask questions. This initial home visit should be followed up with routine antenatal care in an ACDC. Those with transport and financial issues should be provided with travel/taxi vouchers to enhance attendance.

### **7.8.2 Extended hospital stay with specialised education**

In the tertiary referral hospital, routine length of hospital stay for uncomplicated vaginal births is three days whilst routine postoperative stay following caesarean section is five days. If policy was relaxed on length of hospital stay mothers would feel less pressured and be afforded the opportunity to: rest and recover; stabilize opiate maintenance; establish feeding regimes; develop mothercrafting skills, and learn how to manage NAS and other issues.

Mothers have varying skills and levels of competence and health professionals should focus patient teaching to meet individual requirements. By assessing and applauding strengths and focusing education on areas of deficit, individualized care is provided. In this study, issues of concern for mothers were NAS, and the baby being separated from them and cared for in the NICU. When babies were transferred to NICU all of the mothers felt guilty and would have benefitted from support to help them cope with that experience. Similarly, the mothers were often discharged home with the baby still in NICU and again their guilt was exacerbated because they believe it was 'their fault' that the baby was withdrawing. At those times mothers need additional support and understanding and would have benefitted from: support to help them come to terms with their distress; greater involvement in the care of their baby in NICU; increasing their capacity through education on NAS and its management and trajectory; and tangible assistance like

taxi vouchers to allow them to visit, and crèche facilities to care for their other children whilst they provided care to the baby in NICU.

### **7.8.3 Postnatal home visiting intervention**

Postnatally these mothers are often discharged home to environments where there is little or no support, they lack confidence in their ability, they are fearful of being 'bad mother', and their baby is often unsettled and experiencing NAS. Extending the length of hospital stay and providing additional postnatal education whilst in hospital, would contribute to lessening some of those issues. However, on-going support through a home visiting intervention would provide a safety net for these vulnerable mothers and babies. Home visiting regimes by nurses trained in specific interventions have been very successful in supporting vulnerable families (Hupcey, 1998; Olds, Henderson, Tattlebaum, & Chamberlain, 1988; Olds et al., 2004) and these mothers could certainly benefit from additional support. However, care needs to be taken to avoid the medley of services which is currently being implemented.

### **7.8.4 Family centred one-stop services**

Mothers with babies and other dependent children are a unique client group and services should be tailored to meet their special needs. Easy access with dedicated non-judgmental staff would attract, engage, and retain the mothers, particularly if these services demonstrated professionalism and competence. To achieve this family centred supportive environment, issues of confidentiality; respect; behaviour within the centre; family unity; and child protection must be central to the philosophy of practice and focus on recognising and building on the strengths of mothers. Services should be sensitive to mothers' and children's requirements and be mindful of issues that could jeopardise attendance and participation, for example, illness, child care responsibilities, and transport.

Ideally, one-stop services distributed in areas of high social need and located on public transport routes should offer the range of services required to meet the physical, psychological, and social needs of this client group. Health care provision should include general practitioner and nursing/midwifery services; community child health nursing services; substance use counsellors; and psychological services. Social services to meet the need of the client group should include social workers; legal aide; financial planning; and occupational and vocational training. Health promotion activities should focus on issues pertinent to the health and wellbeing of the client group. The centre could also offer a safe place for socialisation with

coffee mornings; yoga; and polities for the mothers whilst children were catered for in crèche facilities. For the mother and baby, playgroup activities and early childhood education would provide mothers and children with opportunities for socialisation and learning. The one-stop centre would also be an ideal location for a charity run second-hand shop selling women's and children's clothing, books and toys.

## **7.9 Implications for research**

To address the limitations identified in this study, further research in the substantive area is warranted. As only urban metropolitan dwelling mothers who use illicit drugs shared their experiences for this study, it is suggested that further research be undertaken with regional, rural and remote mothers who use illicit drugs to gain an understanding of their experience within different circumstances. Additionally, further research with adolescent and ethnically diverse mothers who use illicit drugs should be undertaken to provide a more balanced perspective of the diversity of Western Australian mothers who use illicit drugs.

Research with mothers who use illicit drugs and have not engaged in antenatal care and patients under the care of private obstetricians should also be considered for investigation as those mothers may have a different experience. Similarly, the experiences of a diverse range of health professionals providing care for mothers who use illicit drugs should be explored to gain a comprehensive understanding of the attitudes, practices, challenges, and impediments to care provision for this marginalised group of mothers and their infants.

There are also implications for further research in relation to pharmacotherapies for mothers who use illicit drugs. To relax the takeaway policy and ease the burden of mothers accessing methadone on a daily basis, a trial of 'get one - take one' for mothers with babies and pre-school children could be conducted to ascertain the value, acceptability, and practical application of such an intervention. Allowing a 'get one - take one' policy would ease the mother's burden but still be relatively safe in relation to potential overdose and diversion. Additionally, there are other potential benefits of a relaxation of MMT policy, for example, those who could benefit from split dosing (see NSW Department of Health, 2006a, p.35) would only have to present once per day thus reducing their inconvenience, time and travel costs. Mothers would also not have to endure periods of 'being sick' every day prior to

getting their daily methadone and this could decrease risk of abuse to children from parenting stress, agitation and anger (Suchman & Luthar, 2001).

Currently there is limited empirical evidence on which to base recommending the use of buprenorphine during pregnancy and lactation. Whilst some research is being conducted in this area, further trials on buprenorphine in pregnancy and whilst lactating need to be conducted to gain a better understanding of the effects on the pregnancy, the fetus, the breastfed infant, and pain management during labour and post delivery. Further investigations into buprenorphine related withdrawal, intoxication or exposures in infants also need to be explored, identifying onset, duration, neurobehavioural, and physiologic signs. Buprenorphine levels in breast milk and the effects on babies until weaning and beyond also need to be conducted to gain a better understanding of the longer term effects of buprenorphine on infants.

For abstinence orientated treatment for opiate dependence, clinical trials of naltrexone implants during pregnancy and lactation would also provide additional evidence on the advantages and disadvantages of this treatment modality. As there is some experience with naltrexone implants in pregnancy in Western Australia (Hulse et al., 2003) there is opportunity to conduct those trials.

## **7.10 Concluding comments**

The substantive theory generated by this study contributes to a better understanding of the experiences of mothers in Western Australia who use illicit drugs. The study has been a journey of discovery as the search for understanding brought together diverse bodies of literature to create new knowledge. A melding of knowledge on mothering, drug-use, identity, trust, respect, stigma, shame, guilt, loss, protection, and resilience connected divergent concepts into an interconnected theory of the phenomenon. The theory of *safeguarding to limit loss* provides an interpretation of the processes employed by mothers to counteract the pervasive central problem of *the threat of loss*. The theory identified specific responses and strategies used whilst mothers attempted to manage the central issues impinging on their lives which necessitated them to safeguard themselves and their children. The knowledge gained from this study advances previous interpretations that mothers who use illicit drugs are a highly stigmatized, disadvantaged marginalised minority group. Whilst they remain vulnerable, marginalised and stigmatized new dimensions of resilience, motivation, strength, and 'good mother' have emerged.

The theory depicts an oscillating process characterised by reactive responses of *struggling* and proactive strategies of *taking back control* in response to threat. Those actions temporarily manage, modify, or negate immediate crises and persistent challenges. With knowledge of the influencing conditions that constrain these mothers, the conditions that support them, and successful strategies utilised by mothers as they took back control, interventions can be tailored to constructively support mothers in their efforts to promote health during pregnancy; provide nurturance and safe environments for their children and attain an identity of 'good mother'; and redefine themselves to preserve their integrity. Health and social policy makers and service providers need to be informed by the experiences of mothers who use illicit drugs and implement interventions to ease the burden on mothers with babies. By implementing programs and services that support and promote their efforts and meet their unique needs, improved outcomes for the mothers, their children and society will be achieved. Health professionals also need to be informed by the experiences of these mothers; ease the stereotypical image of them as deviant and untrustworthy; demonstrate respect, build rapport and trust; and work with them to support and encourage their efforts and increase their capacity.

Despite the extreme challenges faced by mothers who use illicit drugs, the goals, motivations, and aspirations demonstrated by the mothers in this study paralleled those of mainstream mothers. They worked hard attempting to achieve 'good mother' with limited support and multiple intrusions on their lives. They demonstrated a capacity for strength and resilience but were repeatedly exposed to threats that undermined their capacity to achieve their goals.

Whilst the theory developed in this study is restricted to the experiences of mothers in Western Australia who use illicit drugs, the experiences shared by the mothers and the safeguarding processes they employed to manage *the threat of loss* could potentially be more broadly applied to other socially disadvantaged groups. Further research to explore the experience of mothers who use illicit drugs from different socio-economic backgrounds, different ethnicities, and in diverse locations is warranted; so too is research to compare this theory to the experiences of other socially disadvantaged groups who are mothering under difficult circumstances.

In conclusion it is hoped that with a greater understanding of the complex nature of the lives of mothers who use illicit drugs more effective interventions to

constructively address the underlying issues, as well as on-going challenges, will be more effective than attempting to change individual behaviour. Individual behaviour is more likely to change when respect is afforded, freedom is achieved, better health is attained, children are secure, identity is defined, and they can trust those with whom they interact.

**The end**

## **Section 4**

### **References**

### **Appendices**



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### **Statement**

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## **APPENDICES**



## **APPENDIX 1: DEFINITION OF TERMS**

## Definition of terms

### **Licit drugs**

A *licit* drug is any drug that is legally available in a community, for example, alcohol, tobacco, over-the-counter medications and prescription medications that are prescribed by a qualified medical practitioner and used in accordance with the manufacturers and prescriber's directions.

### **Illicit drugs**

An *illicit* drug is defined as a drug whose production, sale or possession is prohibited (MCDS, 2004) and attracts legal sanctions when used without appropriate authorisation. Drugs such as marijuana, heroin, amphetamines and methamphetamines, ecstasy, and cocaine; volatile substances such as glue, solvents and petrol as inhalants; and prescription drugs obtained illegally or used contrary to the manufacturers and prescriber's directions (i.e. on-medical use) are considered illicit.

### **Polydrug use**

Polydrug use is defined as 'the use of more than one drug, simultaneously or at different times. The term 'polydrug user' is often used to distinguish a person with a varied pattern of drug use from someone who uses one kind of drug exclusively'. (MCDS, 2004; Peele, 1985)

### **Drug dependence**

Although drug dependence is commonly understood to be characterised by a person's heightened (tolerance) and habitual overpowering desire or need for a substance (craving); by the intense suffering that results from the discontinuation of its use (withdrawal); by impaired control over drug use with drugs dominating a user's life; and repeated drug use to suppress the symptoms of withdrawal (Peele, 1985), this definition is limited in its interpretation. Although these signs of addiction do occur, drug dependence also represents an habitual style of coping along a continuum of desire and behaviour that the individual is capable of modifying with changing psychological and life circumstances. This process involves a person's expectations, beliefs, values and self concept as well as the person's sense of alternative opportunities for gratification. Drug dependence is more than a

physiological response to drug use and is a powerful and complex process of human behaviour. (Dietze, Lanagan, & Thornton, 1998; B. F. Miller & Keane, 1987)

### **Tolerance**

Drug tolerance is a decrease or moderation in the response to a specific dose of a psychotropic drug. This phenomenon occurs as a result of repeated constant doses of a drug resulting in the need for higher doses to maintain the same physical or mental response. (Cohen, 2004)

### **Intoxication**

Intoxication occurs when the quantity of a substance or substances consumed exceeds the individual's tolerance and produces behavioral or physical abnormalities resulting in impairment of the person's mental and physical abilities (Novak, 1997). The level of intoxication relates to drug serum levels and can be potentially life threatening.

### **Withdrawal**

A psychologic and/or physical syndrome, with substance-specific signs and symptoms, caused by the abrupt cessation or marked reduction in the intake of a drug following prolonged regular use (1985, p.12). Peele (Amodeo, Lundgren, Chassler, & Witas, 2008) described withdrawal as a 'homeostatic readjustment to the removal of a substance that has had a notable impact on the body'.

### **Detoxification**

Detoxification is managed withdrawal from drugs of addiction. The process involves abstinence to clear the drug from the body, accompanied by social, environmental, and pharmacological support to address the physiological and psychological changes caused by ceasing the drug. (MCDS, 2004)

### **Harm minimisation**

Harm minimisation is a concept that refers to policies and programs aimed at reducing drug-related harm for individual users as well as for others in society. It focuses on improving health, social and economic outcomes and includes preventing anticipated harm, reducing actual harm, and creating a balance between demand reduction, supply reduction and harm reduction. (Commonwealth Department of Health Housing Local Government & Community Services, 1993; Western Sydney Area Health Service, 1996)

**Overdose**

An acute state that occurs when an individual has ingested a drug quantity higher than the recommended therapeutic dose and/or that exceeds his/her tolerance. Overdose can be accidental or intentional. The effects may be transient, lasting or fatal

**APPENDIX 2: DRUG PARENTS SHOULD LOSE KIDS:  
BISHOP**

# Drug parents should lose kids: Bishop

**RANIA GHANDOUR**

The trend to keep children with their biological parents at all costs could be tragic, according to the chairwoman of a Federal parliamentary committee on family and human services.

Drug-addicted parents should have their children removed if they could not clean up their act, Liberal backbencher Bronwyn Bishop said.

It was not in the children's best interests to stay with drug-addicted parents in spite of policy documents saying children should stay in contact with parents where possible.

At the committee's Perth public hearings on international adoptions this week, Ms Bishop said there was a lack of foster carers Australia-wide while many people wanted to adopt children. However, it was generally assumed that it was better to have the biological parents at all costs, and adoption was always second best.

"Everybody says it's in the best interests of the child but this seems like a mantra as distinct from a real policy," Ms Bishop said.

She held up a recent front-page report in an Eastern States newspaper headed *Pity Our Poor Drug Babies*.

The article told of a three-month-old baby who was left unattended in his pram while both parents suffered heroin overdoses in the next street.

The couple's decision to take the child on a drug run ended with him being removed from their care.

"If a biological parent can't get their act together in, say, two or three years, then they should be out of that child's life," Ms Bishop said.

"They can subsequently have information about them but the child should have the opportunity to be in a loving environment."

Ms Bishop said the Department for Community Development was almost aiding and abetting by not reporting drug-addicted parents to police.

DCD director east Leah Bonson said she could not speak for the police who make arrests in the case of parents with drugs. "That's their call," she said. "Our first concern is the safety of the baby."

DCD manager of adoption services Colin Keogh admitted there were huge risks in sending children back to biological parents with a drug problem, but making laws in these cases was difficult.

"You can't provide for those kind of clear distinctions in law and putting a time limit like six months or seven-and-a-half months is difficult," Mr Keogh said.

"You have to leave it to the people who are on the ground, who know the circumstances. You always go as far as you can to retain family ties."

## **APPENDIX 3: DEMOGRAPHIC QUESTIONNAIRE**

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## The early maternal experience of illicit drug using mothers: A Grounded theory study

### QUESTIONNAIRE

Thank you for agreeing to be part of this study.

This questionnaire asks you some background questions about yourself and includes some questions about your drug use.

Please read each question carefully and *colour in the appropriate circles **completely** using a dark pencil or write in the space provided.*

### ALL ANSWERS WILL BE STRICTLY CONFIDENTIAL

Thank you for your assistance.



**Firstly, some questions about yourself:**

Please colour in the appropriate circles **completely** using a dark pencil or write in the space provided.

1. What is your date of birth? \_\_\_/\_\_\_/\_\_\_

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2. What is your ethnic background?

Aboriginal

Asian

Caucasian

Other

(Please specify) \_\_\_\_\_

3. What was the last year at school that you completed?

For example: Year 10 : Year \_\_\_\_\_

or equivalent \_\_\_\_\_

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4. Since leaving school what further education have you completed?

None

Trade certificate or apprenticeship

Professional registration (non degree)

College Diploma or Degree eg TAFE

University Degree

Other type of education

(Please specify) \_\_\_\_\_

5. What is your marital status?

Married or defacto

Single

Please colour in the appropriate circle completely using a dark pencil or fill in the space provided

**6. What was your total family income before tax, last year?**

- Less than \$20,000
- \$20,000 - \$40,000
- more than \$40,000
- Family income unknown

If you don't know the total income before tax, what is the actual family 'take home' income per week: \$ \_\_\_\_\_

**The next section is about your drug use.**

**7. During your pregnancy, what was your usual pattern of drug use?**

	> 1/day	Daily	1-3/week	<1 /week	<1 /month
Heroin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other Opiates	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cannabis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Amphetamines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cocaine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Benzodiazapines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Barbiturates	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hallucinogens	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inhalants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Methadone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Naltrexone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**8. Did your use of drugs change because of your pregnancy?**

- Yes
- No

Please colour in the appropriate circle completely using a dark pencil or fill in the space provided

**9. If Yes to previous question, did your use of**

	Increase	Remain same	Decrease	Not applicable
Heroin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other Opiates	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cannabis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Amphetamines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cocaine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Benzodiazapines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Barbiturates	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hallucinogens	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inhalants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Methadone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Naltrexone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**10. If your drug use decreased, was this because of:**

- Possible adverse effects to baby
- Cost of drugs
- Pressure from partner
- Pressure from relatives/friends
- Other (please specify)

**Now some questions about this pregnancy.**

**11. What is your expected date of delivery?**

EDD \_\_\_\_\_

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<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**12. Was this pregnancy planned?**

- Yes
- No

## **APPENDIX 4: OBSTETRIC QUESTIONNAIRE**

**STUDY NUMBER**

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## **The early maternal experience of illicit-drug-using mothers: A grounded theory study**

### **Obstetric data**



**5. Prescribed medications in pregnancy**

	Yes	No
Antibiotics	<input type="radio"/>	<input type="radio"/>
Anti-hypertensives	<input type="radio"/>	<input type="radio"/>
Insulin	<input type="radio"/>	<input type="radio"/>
Antidepressants	<input type="radio"/>	<input type="radio"/>
Naltrexone	<input type="radio"/>	<input type="radio"/>
Methadone	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

(Please specify) \_\_\_\_\_

**Labour and delivery**

<b>6. Gestation</b>		<b>Weeks</b>	<b>Days</b>																	
0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**7. Onset of labour**

Spontaneous	<input type="radio"/>
Augmented	<input type="radio"/>
Induced	<input type="radio"/>
No labour	<input type="radio"/>

**8. Complications of labour/birth**

	Yes	No
Breech presentation	<input type="radio"/>	<input type="radio"/>
Other abnormal presentation	<input type="radio"/>	<input type="radio"/>
Cephalopelvic disproportion	<input type="radio"/>	<input type="radio"/>
Failure to progress other than CPD	<input type="radio"/>	<input type="radio"/>
Precipitate labour/birth	<input type="radio"/>	<input type="radio"/>
Pyrexia	<input type="radio"/>	<input type="radio"/>
Chorioamnionitis	<input type="radio"/>	<input type="radio"/>
Hypertension	<input type="radio"/>	<input type="radio"/>
Intrapartum haemorrhage	<input type="radio"/>	<input type="radio"/>
Fetal distress	<input type="radio"/>	<input type="radio"/>
Shoulder dystocia	<input type="radio"/>	<input type="radio"/>
Cord prolapse	<input type="radio"/>	<input type="radio"/>
Cord tight around neck	<input type="radio"/>	<input type="radio"/>
Other cord complications	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

(Please specify) \_\_\_\_\_

**9. Mode of delivery**

- |                                  |                       |
|----------------------------------|-----------------------|
| Spontaneous vaginal delivery     | <input type="radio"/> |
| Assisted vaginal delivery        | <input type="radio"/> |
| Breech vaginal delivery          | <input type="radio"/> |
| Caesarean section – elective     | <input type="radio"/> |
| Caesarean section – non-elective | <input type="radio"/> |

**10. Analgesia during labour/birth**

- |                        | Yes                   | No                    |
|------------------------|-----------------------|-----------------------|
| None                   | <input type="radio"/> | <input type="radio"/> |
| Nitrous oxide          | <input type="radio"/> | <input type="radio"/> |
| Intramuscular narcotic | <input type="radio"/> | <input type="radio"/> |
| Intravenous narcotic   | <input type="radio"/> | <input type="radio"/> |
| Pudendal block         | <input type="radio"/> | <input type="radio"/> |
| Epidural               | <input type="radio"/> | <input type="radio"/> |
| Spinal                 | <input type="radio"/> | <input type="radio"/> |
| General anaesthetic    | <input type="radio"/> | <input type="radio"/> |
| Other                  | <input type="radio"/> | <input type="radio"/> |

(Please specify) \_\_\_\_\_

**Postnatal****11. Postnatal analgesia**

- |                     | Yes                   | No                    |
|---------------------|-----------------------|-----------------------|
| None                | <input type="radio"/> | <input type="radio"/> |
| Panadol/panadiene   | <input type="radio"/> | <input type="radio"/> |
| Panadiene forte     | <input type="radio"/> | <input type="radio"/> |
| NSAIDs oral         | <input type="radio"/> | <input type="radio"/> |
| NSAIDs per rectum   | <input type="radio"/> | <input type="radio"/> |
| IMI Pethidine       | <input type="radio"/> | <input type="radio"/> |
| IMI Other narcotics | <input type="radio"/> | <input type="radio"/> |

(Please specify) \_\_\_\_\_

- |             |                       |                       |
|-------------|-----------------------|-----------------------|
| Epidural    | <input type="radio"/> | <input type="radio"/> |
| IV infusion | <input type="radio"/> | <input type="radio"/> |
| Other       | <input type="radio"/> | <input type="radio"/> |

(Please specify) \_\_\_\_\_

**12. Postnatal complications**

- |                                  | Yes                   | No                    |
|----------------------------------|-----------------------|-----------------------|
| Hypertension                     | <input type="radio"/> | <input type="radio"/> |
| Primary postpartum haemorrhage   | <input type="radio"/> | <input type="radio"/> |
| Secondary postpartum haemorrhage | <input type="radio"/> | <input type="radio"/> |
| Retained placenta                | <input type="radio"/> | <input type="radio"/> |
| Febrile requiring antibiotics    | <input type="radio"/> | <input type="radio"/> |
| Wound infection                  | <input type="radio"/> | <input type="radio"/> |
| Urinary tract infection          | <input type="radio"/> | <input type="radio"/> |
| Urinary retention                | <input type="radio"/> | <input type="radio"/> |
| Other                            | <input type="radio"/> | <input type="radio"/> |

(Please specify) \_\_\_\_\_



**13. Breastfeeding problems**

	Yes	No
Attachment problems	<input type="radio"/>	<input type="radio"/>
Nipple problems	<input type="radio"/>	<input type="radio"/>
Engorgement	<input type="radio"/>	<input type="radio"/>
Blocked ducts	<input type="radio"/>	<input type="radio"/>
Mastitis	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>
(Please specify)	_____	

**Neonatal**

**14. Date of birth?** \_\_/ \_\_/ \_\_

										Date
0	1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

**15. Birthweight**

Wt \_\_\_\_\_ gms

										Gms
0	1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

**16. Apgar Score**

										1 minute
0	1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

										5 minutes
0	1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

**17. Admitted to NICU/special care nursery?**

Not admitted	<input type="radio"/>
Level 2 nursery	<input type="radio"/>
Level 3 nursery	<input type="radio"/>
Other	<input type="radio"/>

(Please specify) \_\_\_\_\_

**18. If Yes to above question, number of days spent in NICU**

										Days in NICU
0	1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

**APPENDIX 5: FORMS OF DISCLOSURE AND INFORMED  
CONSENT**

## Form of Disclosure

### **Study title: The maternal experience of illicit-drug-using women: A grounded theory study**

My name is Jennie Sharp and I am enrolled in Doctoral Studies in the School of Nursing and Midwifery at Curtin University of Technology. The purpose of my research is to develop an understanding of the experience of mothers who use illicit drugs to see how they cope with their lives. The results of this research will provide information on mothers who are 'using' and build a foundation on which to develop appropriate services to meet the health care needs of other mothers with drug problems.

You are invited to participate in this research if you have been 'using' during your pregnancy and/or after your baby was born, or are on methadone or buprenorphine maintenance treatment. To collect the essential facts for the study it will be necessary for me to review your medical records to collect information on your socio-demographic background, obstetric, medical and psychological history, as well as information about the labour and birth, and about your baby. The main information for the study will be collected during a tape-recorded interview which will be conducted during the first two years of your child's life. The length of the interviews will be about 1 hour and will take place at King Edward Memorial Hospital, in your home or at a time and location suitable to you. Further interviews may be required at other times to clarify some details from the interview. It is hoped you will remain available for these extra interviews.

There are no risks associated with your involvement in this research. Your participation is voluntary, and if you decide not to be involved you may withdraw at any time without disadvantage. During interviews, you may choose not to answer some questions, ask for the tape-recorder to be turned off and request that your data be destroyed. In addition to interviews, the researcher will observe interactions between you and your baby, and with your other children. If your interview is at the hospital the researcher will also observe your interactions with health care providers. Your confidentiality will be maintained at all times and your name will not appear on the transcribed interviews or on any notes that the researcher may make during the

course of the research. Parts of the interviews may be used in the research report but you will not be identified in any way.

If you wish to ask any questions or discuss parts of the research I can be contacted at Curtin University of Technology on **9266 2204** or on **0404 867 895**. If you wish to speak to my supervisor; Associate Professor Anne Bartu can be contacted on **9370 0348** or **9266 2089**.

The Human Research Ethics Committee at Curtin University of Technology and the Institutional Ethics Committee of KEMH and Princess Margaret Hospital have approved the research proposal. The secretary of the Human Research Ethics Committee can be contacted on 9266 2784 should you wish to make a complaint on ethical grounds.

I would like to thank you for taking part in this study. The results will help develop a better understand of women who are using illicit drugs during their pregnancies and after their babies are born. Your participation is greatly appreciated.

## Participant's Statement and Consent Form

I, \_\_\_\_\_  
Given Name Surname

have read the information regarding research on the Maternal Experience of Illicit-drug-Using Women. I understand the nature and intent of the study. Any questions I have asked have been answered to my satisfaction, and I agree to participate. I have received a copy of the consent form and information sheet to keep for future reference and I know where to direct any further questions that I may have regarding the research.

Furthermore, I understand that:

- This research will be carried out in the manner conforming with the principles set out by the National Health & Medical Research Council as defined in the document: "National Statement on Ethical Conduct in Research Involving Humans (1999)".
- The information that I provide is confidential and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any party subject to legal requirements.
- My participation in this research is voluntary and if I choose to withdraw at any time this will not disadvantage me in any way.

I agree that parts of the interviews may be published provided my name is not used and I will not be identified in any way.

\_\_\_\_\_  
Participant's signature

\_\_\_\_\_  
Date

I, \_\_\_\_\_ have explained the study to the signatory who stated that she understood the purpose and process of this study.

\_\_\_\_\_  
Researcher's signature

\_\_\_\_\_  
Date

## Form of Disclosure (HP)

### **Study title: The maternal experience of illicit-drug-using women: A grounded theory study**

My name is Jennie Sharp and I am enrolled in Doctoral Studies in the School of Nursing and Midwifery at Curtin University of Technology. The purpose of my research is to develop an understanding of the maternal experience of women who are using illicit drugs to see how they cope with their lives. The results of this research will provide information on women who are 'using' and build a foundation on which to develop appropriate services to meet the health care needs of women with similar problems.

People who provide health care to illicit-drug-using women will influence their experience. Therefore, you are invited to participate in this research if you have, in the course of your duties, been caring for women who have been using illicit drugs or have been on drug treatment programs during their pregnancy and/or after the birth of their baby. The main information for the study will be collected by tape-recorded interviews. The length of the interviews will be about 1 hour and will take place at King Edward Memorial Hospital or at a time and location suitable to you. Further interviews may be required to clarify some details from the initial interview. It is hoped you will remain available for these extra interviews. In addition to interviews, the researcher will observe interactions between you and clients in the clinical care setting.

There are no risks associated with your involvement in this research. Your participation is voluntary, and if you decide not to be involved you may withdraw at any time without disadvantage. During interviews, you may choose not to answer some questions, ask for the tape-recorder to be turned off and request that your data be destroyed. Your confidentiality will be maintained at all times and your name will not appear on the transcribed interviews or on any notes that the researcher may make during the course of the research. Parts of the interviews may be used in the research report but you will not be identified in any way.

If you wish to ask any questions or discuss parts of the research I can be contacted at Curtin University of Technology on **9266 2204** or on **9474 1815**. If you wish to

Speak to my supervisor, Associate Professor Anne Bartu can be contacted on **9370 0348** or **9266 2089**.

The Human Research Ethics Committee at Curtin University of Technology and the Institutional Ethics Committee of KEMH and Princess Margaret Hospital have approved the research proposal. The secretary of the Human Research Ethics Committee can be contacted on 9266 2784 should you wish to make a complaint on ethical grounds.

I would like to thank you for taking part in this study. The results will help develop a better understanding of women who are 'using' or are on a treatment program during their pregnancies and after their babies are born. Your participation is greatly appreciated.

## Statement and Consent Form (HP)

I, \_\_\_\_\_  
Given Name Surname

have read the information regarding research on the Maternal Experience of Illicit-drug-Using Women. I understand the nature and intent of the study. Any questions I have asked have been answered to my satisfaction, and I agree to participate. I have received a copy of the consent form and information sheet to keep for future reference and I know where to direct any further questions that I may have regarding the research.

Furthermore, I understand that:

- This research will be carried out in the manner conforming with the principles set out by the National Health & Medical Research Council as defined in the document: "National Statement on Ethical Conduct in Research Involving Humans (1999)".
- The information that I provide is confidential and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any party, subject to legal requirements.
- My participation in this research is voluntary and if I choose to withdraw at any time this will not disadvantage me in any way.

I agree that parts of the interviews may be published provided my name is not used and I will not be identified in any way.

\_\_\_\_\_  
Participant's signature Date

I, \_\_\_\_\_ have explained the study to the signatory who stated that she understood the purpose and process of this study.

\_\_\_\_\_  
Researcher's signature Date



**APPENDIX 6: SAFEGUARDING TO LIMIT LOSS - TABLE**

## Safeguarding to limit loss

Sub-processes	Struggling Reactive	Taking back control Proactive
<b>Safeguarding during pregnancy</b>	<p><b>Struggling during pregnancy</b></p> <p><b>Decision making</b></p> <ul style="list-style-type: none"> <li>▪ Termination</li> </ul> <p><b>Finding a way</b></p> <ul style="list-style-type: none"> <li>▪ Seeking information</li> <li>▪ Making drug choices</li> <li>▪ Seeking referral</li> <li>▪ Getting checked out</li> </ul>	<p><b>Promoting health during pregnancy</b></p> <p><b>Changing priorities</b></p> <ul style="list-style-type: none"> <li>▪ Putting fetus first</li> <li>▪ Modifying drug use</li> </ul> <p><b>Self care</b></p> <ul style="list-style-type: none"> <li>▪ Improving diet</li> <li>▪ Resting</li> <li>▪ Seeking care</li> <li>▪ Adhering to Rx</li> </ul>
<b>Safeguarding as mother</b>	<p><b>Struggling to mother</b></p> <p><b>Trial &amp; error nurturing</b></p> <ul style="list-style-type: none"> <li>▪ Meeting basic needs</li> <li>▪ Struggling with care provision</li> <li>▪ [Over]protection               <ul style="list-style-type: none"> <li>○ Not trusting or relying on others</li> <li>○ Being hypervigilant</li> </ul> </li> <li>▪ Abandoning ideals &amp; lowering standards</li> <li>▪ Chemically enhanced mothering</li> </ul>	<p><b>Striving to be 'good mother'</b></p> <p><b>Nurturing</b></p> <ul style="list-style-type: none"> <li>▪ Putting children first</li> <li>▪ Provision of tender care &amp; protection</li> <li>▪ Stimulation, guidance, socialization</li> </ul> <p><b>Increasing capacity</b></p> <ul style="list-style-type: none"> <li>▪ Increasing knowledge &amp; skills</li> <li>▪ Being organised</li> </ul>
<b>Safeguarding to preserve integrity</b>	<p><b>Struggling to preserve integrity</b></p> <p><b>Limiting physical &amp; emotional harm</b></p> <ul style="list-style-type: none"> <li>▪ Safeguarding against abuse &amp; neglect</li> <li>▪ Minimising contact with drug-related activities &amp; environments</li> <li>▪ Defending</li> </ul> <p><b>Altering perceptions</b></p> <ul style="list-style-type: none"> <li>▪ Dissociating</li> <li>▪ Minimising judgment</li> <li>▪ Positioning self in context</li> </ul>	<p><b>Redefining to preserve integrity</b></p> <p><b>Creating a better environment</b></p> <ul style="list-style-type: none"> <li>▪ Breaking free from partner</li> <li>▪ Isolating self</li> </ul> <p><b>Controlling events</b></p> <ul style="list-style-type: none"> <li>▪ Pre-empting</li> <li>▪ Being assertive</li> </ul> <p><b>Accessing support systems</b></p> <ul style="list-style-type: none"> <li>▪ Working together</li> <li>▪ Activating support networks</li> </ul> <p><b>Remodelling self</b></p> <ul style="list-style-type: none"> <li>▪ Interacting differently</li> <li>▪ Modifying presentation</li> <li>▪ Reconciling boundaries</li> </ul>

## Definitions of concepts used in table

### Safeguarding

- ❖ Safeguarding involved actions taken by the mothers, deliberately or subconsciously, to lessen the potential for judgment and disapproval by self and others; for being abused, manipulated, overwhelmed and dependent; for damaging self and one's baby; for losing one's baby or having one's baby taken off them; for having a sense of not belonging; and for not trusting others or being trusted which resulted in multiple forms of loss such as loss of respect, loss of freedom, loss of health, loss of child, loss of identity, and loss of trust which were problematic for them.

### Sub-processes

- ❖ **Safeguarding during pregnancy** : involved struggling as one made decisions and found a way through multiple challenges, whilst simultaneously promoting health of self and the fetus
- ❖ **Safeguarding as mother**: encompassed the struggle of mothering with limited resources whilst endeavouring to attain 'good mother' status
- ❖ **Safeguarding to preserve integrity**: focussed on attempting to preserve integrity of self and children against physical and emotional harm whilst striving to redefine, or make different that which was, and create a better environment in which to live and raise their children

### Struggling during pregnancy

- ❖ Attempting to reduce the negative impact of drugs and lifestyle on their unborn babies

### Promoting health

- ❖ To promote health meant that mothers worked at improving their health and that of their unborn child and in doing so modified the nature and scope of threats and limited potential harms

### Trial and error

- ❖ A method of finding a satisfactory solution or means of doing something by experimenting with alternatives and eliminating failures

### Nurturing

- ❖ Putting children's needs before their own, providing tender care, love, protection, encouragement, stimulation and guidance, and being alert, available, and responsive

### **Increasing capacity**

- ❖ Gaining enduring knowledge and sustainable skills which strengthen ability, competence, and scope of expertise

### **Preserving integrity**

- ❖ **Integrity** is a human state of dignity and wholeness recognizing one's physical, psychological, social and spiritual aspects. Integrity implies that as an autonomous human being one is worthy of respect; entitled to self determination; and has the right to safeguard one's interests
- ❖ **Struggling to preserve integrity** included reactive responses to real or potential physical, verbal, and emotional assault in an effort to limit harm; and altering perceptions through strategies of dissociation; activities to minimize judgment through concealment, excuse making, and demonstrating acceptability; and positioning self in context to alter one's subjective interpretation of self
- ❖ **Redefining to preserve integrity** is making different that which was and includes *creating a better and more conducive* environment in which to live and raise their children; *controlling events* to achieve that which is best for one's family; *accessing support* systems to ease one's workload; and *remodeling self* on accepted societal norms thus causing self to be understood differently

