

**The lived experience of breastfeeding
methadone-treated mothers in early
motherhood**

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Abstract

Previously documented evidence suggests that motherhood is potentially an important time for change in drug-using behaviour. My research interest for this longitudinal phenomenological study stemmed from practice observations where methadone-treated women struggled to prove their trustworthiness as mothers. They consistently reported frustration in the face of continued professional suspicion of their identity as drug-users. The essence of the phenomenon is therefore described as an existential tension experienced by breastfeeding mothers in methadone maintenance treatment during the first 12 weeks of motherhood. The aim of this thesis is to reveal the previously hidden inter-subjective and social realms of their lived worlds.

Recruited via professional gatekeepers, four women were each interviewed four times over four months. Relational maps and drawings of their imagined non-ideal and ideal mothers facilitated conversation and enabled women to speak of their experiences in a non-threatening environment. Rich contextualised data were analysed to explore and interpret previously hidden meanings. The data indicated that, whilst in hospital, mothers experience internal emotional turbulence, from profound love for their babies to fear of being separated from them. In addition, within their external worlds they feel stereotyped as drug users and of risk to their babies. However, after discharge from hospital, mothers describe becoming good-enough and insightful mothers, to their own standards.

Insights from this study help to expand understanding of a previously little-known or understood group of drug-using women. Three of the five findings indicate the importance of breastfeeding. Firstly, due to powerful feelings of love, it provides a window of opportunity to change lives. Secondly, it acts as a non-verbal method of communication to publicise the care and nurturing of their infant. Thirdly, it helps mothers rationalise becoming good-enough mothers for themselves.

The remaining two findings highlight hitherto unexplored areas in the research literature. The needs of breastfeeding methadone-treated mothers are potentially overlooked where infant safeguarding is the sole focus of professional concern. This leads to poor and/or unsatisfactory practice that is suggestive of institutional abuse. Furthermore, women have insight into the functional role of methadone, stating an unwillingness to sacrifice a sense of well-being in order to satisfy the demands for abstinence from social services.

This study adds to the evidence base exploring and stressing the importance of supporting breastfeeding and providing empathetic care of vulnerable mothers. Health and social care professionals need to be aware of the effects of stigmatisation and actively incorporate this knowledge into their practice, educational programmes and advocacy services.

Keywords: Breastfeeding; methadone-treated mothers; love; stereotype; abuse; empathetic care; good-enough.

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List of attachments

With consent of the publishing journals, the following attachments are copies of two papers co-authored by my supervisors Professor Valerie Hall and Dr Kevin Lucas.

Attachment A

Jambert-Gray, R., Lucas, K. and Hall V. (2009a) Methadone-treated mothers: pregnancy and breastfeeding. *British Journal of Midwifery*. 17 (10) pp 654-657.

Attachment B

Jambert-Gray, R., Lucas, K. and Hall V. (2009b) The Mother of all issues. *Drink and Drug News*. September pp 14-15.

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Author's declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed: *R.A. Jambert-Gray*

Dated: 16 June 2014

Chapter 1: Introduction

1.1 Introduction to the problem and justification for the research

This thesis explores the subjective experiences of four breastfeeding mothers who are being treated with methadone for a heroin addiction. According to the *World Drug Report* (UNODC 2008) heroin is listed as the main illicit drug of choice in the United Kingdom (UK), with nearly two thirds of users (60.1%) seeking opiate replacement therapy treatment in 2006¹. Data published by the Home Office (2006) reports that of the 72,712 female heroin users in England, 90% (65,408) are of childbearing age. In response to an improvement in government funding, the numbers of women entering treatment in England increased by 60% in four years, from 35,527 in 2003-2004 to 56,936 in 2007-2008 (National Treatment Agency for Substance Abuse 2008, 2005). However, despite the fact that more drug-using mothers are entering treatment for an opiate addiction, research on this client group is rare with very little known about this population (Ettorre 2007). Thus, as more women of child-bearing age enter treatment for a heroin addiction, there is now a pressing need to understand the meaning of motherhood for methadone-treated women.

Addiction has been described as an ever-growing preoccupation with a substance; the powerless compulsion to consume any substance regardless of the familial, social, financial, psychological, physical and/or legal consequences (Radcliffe 2011, Robson 1999). Further assumptions about problematic drug-use are explored in Chapter 2. The craving for opiates is said to develop after regular and long-term use of drugs containing morphine and codeine extracts of the opium poppy or synthetic opioids. These drugs include heroin, prescribed or over-the-counter codeine painkillers (Robson 1999). Abrupt discontinuation of use causes physical distress: muscle aches and spasms; diarrhoea; cold flushes; tremors; sweating; chills; nausea; yawning and sleep

¹ Please refer to the glossary for further information on addiction, dependence, methadone, opioids/opiates and problematic drug-use.

problems (Ashton 2002). Although heroin withdrawal is not fatal to the user, opiates have medical/ physiological effects on the developing foetus and newly born babies. In some cases these result in intrauterine growth retardation, prematurity, low birth weight and neonatal [opiate] abstinence syndrome (NAS) (Hamdan 2009, Prentice 2007, Hall and Teijlingen 2006, Ashton 2002).

Describing such effects on the baby resulting from maternal drug-use can trigger emotional responses in the public and professional population that vilify and alienate the mother. Attitudes appear unchanged since the 1970s, when the derogatory term *pregnant addict* became synonymous with mothers who used heroin (Murphy and Rosenbaum, 1999). These judgments can persist even after a mother stops illicit drug-use and engages with methadone maintenance treatment (MMT).

All the mothers interviewed in this study were prescribed methadone, the standard treatment for an opiate addiction since the 1960s. Methadone now has a well-developed evidence base, drawing largely from quantitative, medical paradigms. Chapter 5 will present research in the early post-partum period to explore medical concerns for the health of the infant regarding the incidence and management of NAS, and whether the amount of methadone in breast milk is sufficient to ameliorate symptoms. Methadone has also been shown to have a stabilising effect on lifestyles and can help reduce drug-seeking and risk-taking behaviour when prescribed at an adequate dose (Dryden *et al.* 2009, Fraser *et al.* 2009, Murphy and Rosenbaum 1999). Where treatment and highly structured clinic schedules help put routine in women's lives, mothers learn to prioritise their own physical care needs and develop more positive relationships with their baby (Radcliffe 2009, Murphy and Rosenbaum 1999).

These conclusions would suggest the need for encouraging more mothers into treatment. However, as discussed below, observations made in my nursing practice appear not to be reflected in the literature. Anecdotally mothers relate stories of anger and frustration with professionals. They describe being treated with suspicion as drug-users and given conflicting advice as mothers. Therefore, in response to what I have heard from mothers, this thesis sets out to understand the lived experiences of

methadone-treated mothers in early motherhood and to develop knowledge of this little-known population.

1.2 Practice disturbance

This phenomenological study is practice-driven, prompted by impressions gained whilst nursing this particular client group. Whilst I recognise that heroin abuse can inflict terrible chaos on the lives of individuals and of those close to them, I am also aware that a majority cherish the hope that one day ‘things will be different’. For some, recovery from drugs does happen. When they become pregnant, a number of mothers continue to relate a narrative of hope. Driven by an innate drive to use motherhood as a positive motivator for change in drug-use and treatment, some will exploit this time as the vital pivotal moment in their lives. This thesis is deliberately focussed on a specifically identified, very small group of four mothers who were already experiencing this important transition from drug-user to mother. During their pregnancies they chose to engage in methadone treatment and said they had not used any illicit drugs. They continued to demonstrate this transition by engaging in breastfeeding.

However, despite the fact that motherhood is well-documented as a major motivator for change in drug-using behaviour (Fraser *et al.* 2009, Hepburn 2005, Ballard 2002, Murphy and Rosenbaum 1999, Ettore 1992), there is little research that aims to understand the processes of this change from the mother’s perspective. As this research is practice-driven, the following section goes on to outline the contact I have had with drug-using women. This précised account summarises the anecdotal stories related by the mothers at their frustration in the efforts they have to make to prove they are ‘good-enough’ mothers for their infants.

1.3 A perspective from practice

My interest in this area was initiated by a small-scale mixed methods audit in which I explored the service needs of female drug-users for a local substance misuse service (Jambert-Gray 1997). The findings are useful to this thesis on two accounts. Firstly,

60% of the 54 women interviewed described experiencing significant traumatic life experiences and using heroin as ‘my saviour’ or ‘the only friend I have’. Such findings influenced my assumptions about addiction and the role of opiates to regulate emotional pain, a perspective explored in Chapter 2. Secondly, 65% (35) of the women interviewed were either mothers already or pregnant for the first time. Ninety per cent of these women needed more information about the safety of taking or stopping methadone in pregnancy; none mentioned that they had breastfed or wanted to breastfeed. This finding indicated to me that, of women in treatment, a large majority were already mothers or mothers-to-be. In addition, nearly all indicated they were considering changing their behaviour, and were requesting reliable information on how to do this safely.

Since then, as a nurse specialist in addictions, I have spent many hours listening to mothers who use drugs. My role over the past 10 years has incorporated 30 minutes-1hour one-to-one contact with, on average, 8 women per week. In addition, for the past 6 years, I have facilitated a female service-user group, with a weekly attendance of between 3 and 6 participants. Having spent around 5,532 individual hours and 414 group hours listening to women, a majority of whom were mothers, this research stems from the impressions gained from these interactions.

Due to the precedence set within practice, the relationship to the women interviewed within this study comes from an empowering position, which respects them as experts of their lives. In other words, the design of the study reflects an advocacy approach that is interested in listening to and drawing out women’s voices to inform the research.

This standpoint is borne out of a specific advocacy-nursing role to which I aspire in practice. Nurses are described within the code of nursing conduct as advocates. The Nursing & Midwifery Council (2008: p.3) describes this as ‘helping [patients]...access relevant health and social care, information and support.’ In my practice, I aim to help women access their own innate behavioural, emotional and mental resources to promote recovery from drug abuse. This suggests a different nursing position from the one alluded to in the above Nursing & Midwifery Council statement which implies that help for patients comes from external sources. I concur with the observation made by

Gaylord and Grace (1995) that such an implication can appear to patronise or disempower some patients. An alternative empowering discourse is one which reflects an existential, relational position which is based on the principle of self-determination (Falk and Adeline 1995). In other words, where each mother is recognised as being the best expert on her own life, the nurse-advocate supports her to make informed decisions about her own well-being as the mother understands it (Vaartio 2008, Gaylord and Grace 1995). This position sits more comfortably with the approach I wish to apply to my nursing practice, inasmuch I believe each mother is an expert on her own life with her own right of self-determination.

From experience I have observed how this standpoint enhances the therapeutic relationship between me and my clients. I have noticed that approaching mothers as experts on their lives, coupled with attentive listening, encourages the sharing of information which is not always related to drug treatment. For instance, women have described concerns they have in relating and working with their social workers, who are largely depicted as being unfamiliar with drugs and methadone treatment. As mothers with drug-using histories, they demonstrate some awareness of professionals' health and social care statutory infant safeguarding duties. In certain incidences, they refer to stories in the media, especially concerning the tragic story of Baby Peter in 2007, and accept that children at risk need to be protected.

Stories about child abuse are horrific and disturbing. However, while a connection between parental drug-use and child abuse is often assumed, it cannot always be proven. For instance, whilst my clients mention the appalling case of Baby Peter, news reports do not describe his mother and her boyfriend as drug-users (Stubbley 2010). As explored in the following section, research into press coverage about drug-using parents highlights the judgemental tone of reporting. In the absence of more informed and sympathetic counterbalancing accounts, the link between drug-taking and child abuse becomes almost automatic. I suggest that as consumers of the media, the attitudes of health and social care professionals can also be negatively influenced by what they read. This may create a potential source of personal tension for carers faced with the

delicate balance between safeguarding the wellbeing of the infant and the maternal rights of the mother.

Coverage of drug-using parents in the British press

In 2010 the UK Drug Policy Commission (UKDPC) undertook a content analysis of newspaper reports investigating how drug-use and drug-users are represented in the British press. After cannabis (22.3%) and cocaine (20.4%), heroin receives the third highest press coverage (19.5%), with methadone ranking seventh on the list (2.8%). Thus in comparison to the domination of the three main illicit drugs, which command nearly two thirds of press interest, prescribed methadone is relatively underreported.

Of particular interest to this study is the tone of representation concerning the parent group of drug-users, including single mothers. They received the lowest share of press reporting (3.5%) after professionals, young people, celebrities, and offenders, members of the public, and non-professionals and the unemployed (UKDPC 2010). The data shows that the coverage of drug-using parents is mainly neutral (60%). However in terms of negative press, the amount of condemnatory remarks is almost as frequent as offenders (35.3% *cf.* 36.2%). This is largely because the contexts in which items are written contain news about court cases, where criminal acts are described and commented upon. Only 5% of reports are characterised as empathetic.

These findings are further underscored by the examination of the labels of ‘addict’ and ‘junkie’ parent, as reported by the UKDPC (2010). Connotations of these terms are explored in section 2.1. The most significant denigrated group of users were offenders, who received 27.3% of press coverage, with parents ranking a close second (23.6%). When reported in the press these two groups were more likely to be given the label ‘addict’ or ‘junkie’ than the other categorisations. Compared to the label ‘junkie’, the use of ‘addict’ is more frequent when used alone or with neutral adjectives (50% *cf.* 13%). However, where the tone of description is not neutral, the UKDPC suggest that drug-using parents are more likely to be described disparagingly, with 87% of negative press coverage using the term ‘junkie’. Neither term is used where the tone of description is positive, indicating that these words, especially ‘junkie’, are deliberately

chosen for their deprecating effect. This suggests that media depictions of drug-using parents can lack compassion.

In summary and for the purposes of this study, the UKDPC report (2010) indicates that there is nominal information about methadone in the media. In addition, despite the minimal amount of coverage about drug-using parents, and where the tone of representation is not neutral, disparaging reports about ‘junkie’, drug-using parents dominate. The lack of empathetic reporting further exposes readers to negative stereotypes. Because of the perception that they are poorly behaved and out of control (Hammersley and Reid 2001), drug-using parents *per se* appear to continue to struggle with entrenched stereotyped societal attitudes (section 2.1).

Thus, as consumers of the press, I suggest that health and social care professionals may be enculturated into treating drug-using parents with suspicion. In addition, in Western society childhood is privileged over adulthood as a state of vulnerability (section 3.2.2). Thus in the absence of the buttressing effect of education, *e.g.* concerning the safety of methadone in pregnancy and breastfeeding (Chapter 5), negative attitudes are at risk of becoming entrenched. Thus when faced with a MMT mother who wants to breastfeed, I suggest it is likely that professional accountability will be swayed towards protecting the neonate against the corrupting influence of the drug-using mother.

This suggests a vital tension in this subject of this study, *i.e.* the need to protect the vulnerable infant whilst at the same time balancing the maternal rights of the individual mother. It is a truism to state that all babies need nurturing, attentive care and protection. Social and healthcare professionals have statutory responsibilities and a duty of care to attend to concerns for safeguarding the health of babies (Home Office 2009), see section 3.4. However where the individuality of the mother is overlooked, and where all drug-using women are grouped as a homogeneous risk to their babies, maternal rights are at risk of being compromised. Whilst some will continue their drug-using behaviour which endangers their babies, there are others who will use motherhood as a major opportunity for change. Discerning which mother to trust is a major challenge for all health and social care professionals (section 10.4). However, the

four breastfeeding women interviewed in this study report a positive transition from drug-user to mother by choosing to engage in methadone treatment and stopping the use of heroin.

In order to assure the custody of their children, I have observed in my clinical practice the struggles some mothers describe in order to secure the favourable regard of professionals. Mothers narrate stories of being kept busy by being expected to attend appointments with social workers, drug teams, health visitors, psychiatric assessments, appearances at court and random home visits. As a result, those mothers who say that they are adhering to this rigorous regime will describe frequent visits and meetings as causing huge stress in their lives, especially when they live alone with their babies and children.

So, whilst voicing sympathy with the role, many mothers appear critical of their social workers and describe them as naive about certain important aspects of their lives. Professionals are judged by their surveillance and intrusion into the mothers' private lives. Women feel disparaged by an observed lack of knowledge that social workers have about their methadone treatment and the progress they have made in curtailing their illicit drug-use. Professionals are described as continuously demanding evidence of their responsibility for their babies in terms of the mothers' identities as drug-users, with enquiries into methadone treatment and urine test results as proof of the mothers' trustworthiness. The mothers also describe receiving conflicting advice in their nurturing role; for instance, whether or not to breastfeed whilst undergoing methadone treatment.

Thus, lack of professional insight into, and understanding of, this group of breastfeeding, methadone treated mothers underscores the need for more research, as outlined in the following section.

1.4 A perspective from the literature and published reports

Both theoretically and philosophically, this thesis is located within diverse literature into the specific use of heroin by women (*e.g.* Khantzian and Albanese 2008, Ettorre

2007, Dawe and Gerada 2005, Gerada and Dawe 2005, Murphy and Rosenbaum 1999, Byington 1997, Straussner 1997, Ettore 1992, Heather and Stallard 1989). Research into female drug-users is reported as rare (Ettore 2007, Murphy and Rosenbaum 1999, Pearson 1999). The sociologist Ettore (2007) noted that very little has changed in the thirty years since 1975 when Josseau Kalant described research into drug-using women as a 'non-field'. In the intervening years, two medical anthropologists, Murphy and Rosenbaum (1999), undertook a large qualitative study of 120 pregnant drug-users. This work was later described by Pearson (1999) as seminal. However, Ettore (2007) and Murphy and Rosenbaum (1999) focused their research interests exclusively on pregnant mothers. The lived experiences of breastfeeding methadone-treated mothers are relatively unexplored.

Aside from this, various non-governmental and governmental reports substantiate the subjective narratives of the mothers I spoke to in my practice. The personal accounts of being given confusing and misleading advice indicate that nothing much has changed since the London Health Observatory (2006) investigated women drugs users' experiences of maternity services in London. This report described the provision of interagency work for drug-users as 'lacking' and cited that only 29% of National Health Service (NHS) maternity units surveyed had formal contact with local substance misuse agencies. The report went on to identify problems and difficulties caused by differences in confidentiality arrangements and a lack of co-ordination between professionals. Furthermore, it describes mothers worrying about being stigmatised, fearing social service involvement and receiving conflicting advice within poorly-structured specialist maternity services.

In 2007, the government document *Maternity Matters* urged commissioners to identify barriers to maternity services experienced by substance-abusing mothers and to provide more flexible services (Department of Health 2007a). The report estimated that an extra 23 hours of outreach work was needed to maximise the opportunities for keeping mothers and babies together. This extra time was calculated as time spent working with substance misuse agencies, additional time for antenatal appointments, dealing with social issues, such as housing, and working with social services over child protection

concerns (Department of Health 2007b). However, two years on, the data collected from across the UK suggested that access to specialist maternity services was patchy, with just 40 drug and alcohol specialist midwives working closely with social workers and addiction services (Lakhani 2009).

Thus whilst the government urges change, the response across the country appears inconsistent. Whilst some areas were able to develop specialist maternity services others did not. This could suggest there is little interest in managing this group of mothers more proactively. Ettorre (2007) suggests that the paucity of research into women reflects how maternal rights are of little research interest, especially where mothers are continually and primarily identified as drug-users. This lack of interest is demonstrated by the patchy response of specialist maternity services across the UK. In the event, without more knowledge about this group of women, they risk continued marginalisation and exposure to others' preconceived ideas about drug-users, which impacts negatively on their identities as mothers and their relationships with their babies.

Thus, as more women of child-bearing age enter treatment for a heroin addiction, there is now a more pressing need to understand the meaning of motherhood for methadone-treated women. In response this thesis asks the research question:

What is the lived experience of being a methadone-treated mother who is breastfeeding her new-born baby?

The following section summarises the overall structure of this thesis, which explains how this research question is answered.

1.5 Organisation of the thesis

Chapter 2: Contextual issues: Addiction. This chapter introduces the concepts concerning addiction and methadone treatment contained in the research question. After discussing why the term 'drug-use/r' was chosen for this thesis, there follows a brief overview of two assumptions made about addiction from classical and anti-oppressive paradigms.

Chapter 3: Contextual issues: Motherhood. In a similar way to that in Chapter 2, this chapter looks at understandings of motherhood. It starts by introducing two major empirical studies which contribute to an empathetic awareness of what it means to be a drug-using mother. The chapter looks at the philosophical background to motherhood and the motivations for becoming a mother. It concludes by introducing the concept of the professional ego and constraints on professionals working within the statutory demands of infant safeguarding.

Chapter 4: Evolution of the research question and literature search strategy. This chapter sets out the evolution of the research question and an introduction to the literature search strategy used in this thesis. The various chronological dilemmas are reflected in the following three areas of investigation:

1. Is breastfeeding by a MMT mother safe for her baby?
2. What are the psycho-social benefits of breastfeeding for MMT mothers?
3. What is known from the literature about the perspective of the MMT breastfeeding mother?

With the finding that there are no English sources to date looking at the experiences of MMT breastfeeding mothers, the originality of this study is underscored.

Chapter 5: Evidence for the safety, and benefits, of breastfeeding. This chapter is written in response to the first two areas described in Chapter 4. It looks at the present evidence base investigating the safety concerns for the baby and benefits of breastfeeding for the mother. It concludes by observing that, within the biomedical literature, MMT mothers are encouraged to breastfeed their babies.

Chapter 6: Exploring mothers' perspectives within the literature. This chapter is guided by the third area of the search strategy. With an absence of the perspective of the MMT mother, this chapter explores in depth 11 studies that have explored

parenthood from the perspective of drug-using mothers/parents. The chapter reports on the observation that populations of hard-to-access drug-using mothers are likely to be of a similar class to professional carers; acting as gatekeepers to potential participants.

Chapter 7: Methodology. This chapter discusses the reasons for choosing lifeworld phenomenological theories as the ontological and epistemological point of departure for investigation into the research question. The essence of the phenomenon is defined as the existential tension experienced by MMT women as they strive to realize their new social identity as mothers in the early weeks of motherhood. The chapter traces, in a loosely chronological order, the steps through which this study evolved and developed, starting from the original research designs. Underlying philosophies and key concepts associated with Husserl, Heidegger and Merleau-Ponty are described in support of rationalising the choice of lifeworld for this study.

Chapter 8: Methods of data collection and ethical considerations. This chapter examines the methods and rationale for the choice of drawing as a reliable research tool for collecting data. The two drawing research tools are informed separately by the Relational Theory of Addiction and Personal Construct Psychological Theory. Reflections on the impact of drawing, and in particular, silence during the interview, are included at the end of this chapter.

Chapter 9: Data handling, analysis and presentation. This chapter examines the handling, analysis and presentation of the phenomenological data. Reflections on the process of data handling, from transcription to analysis, together with identifying steps based on Colaizzi's (1978) framework are incorporated as part of the data handling and analysis process. The major part of the chapter describes the organisation of the raw data under the headings of the emergent three categories: internal, emotional world of the MMT mother; external world of being 'the Other'; and becoming good-enough and insightful mothers for themselves.

Chapter 10: Discussion. This chapter discusses the mothers' subjective transition to motherhood. Superimposed onto the discussion in Chapter 10, are five major findings that contribute to the current body of knowledge:

1. Breastfeeding can provide a window of opportunity to change lives;
2. As a non-verbal method of communication, mothers demonstrate care and nurturing of their infant by breastfeeding;
3. The needs of breastfeeding methadone-treated mothers are potentially overlooked where infant safeguarding is the sole focus of professional concern. This leads to poor and/or unsatisfactory practice that is suggestive of institutional abuse;
4. By embracing, not rejecting, their drug-user identity, women rationalise becoming good-enough mothers for themselves;
5. Breastfeeding MMT mothers have insight into the functional role of methadone.

Chapter 11: Conclusions and Recommendations. This chapter is separated into three sections which reflect on the findings of the study, the process of undertaking a phenomenological study and knowledge exchange. The different methods of disseminating the study's findings are derived from the women during the course of being interviewed for this research project.

Chapter 2: Contextual issues concerning addiction

The previous chapter noted that in the absence of clear, well-researched understandings of the process of motherhood for methadone-treated, breastfeeding mothers, stereotyped attitudes will continue to flourish. Although anxiety for the well-being of the baby will continue to dominate concern for the welfare of the mother, this thesis is unique inasmuch as it situates the breastfeeding, methadone-treated mother at the centre of the research interest. It has been interesting to observe that, whilst discussing this study with other interested people, the mother-centric research position continues to prompt concern for the infant. Anecdotally, more questions are asked about the welfare of the baby fed with breast milk containing methadone, than about methadone-treated mothers.

Therefore, it could be argued that early motherhood is a time when drug-using women enter a contentious and multi-factorial arena, where parties vie over their differing knowledge and understanding of drug-use and motherhood with one another. In response to this complexity and to describe the framework for the study, this chapter, and the subsequent one, Chapter 3, identify and discuss contextual issues connected with addiction and motherhood respectively.

Chapter 2 begins by clarifying constructions associated with the concept of ‘drug-user’. Section 2.1 examines the sociological discourse which links words such as ‘addict’ or ‘junkie’ to illicit drug-use. Section 2.2 explores philosophical assumptions made about addiction; the hegemonic view which is based on biological explanations of chronic drug-use (section 2.2.1) and two alternative psychological approaches (self-medication and relational theories of addiction) which help pave the way for a deeper and social understanding of drug-use for methadone-treated breastfeeding mothers (section 2.2.2).

2.1 Constructions of drug-users

As discussed in Chapter 1, an advocacy position towards the women interviewed reflects an existential, relational belief that each mother is an expert in her own life with her own right of self-determination (Vaartio 2008, Falk and Adeline 1995, Gaylord and Grace 1995). This standpoint has influenced the terminology used to address the women within this thesis: as mothers with histories of heroin abuse they are simply referred to as ‘drug-users’. The advocacy research position taken to the women interviewed meant that the use of more derogatory and colloquial words, such as ‘junkie’ and ‘addict’ were construed as conveying harsh meanings of disrespect.

For breastfeeding mothers with histories of illicit heroin abuse, the unreflective employment of the pejorative term ‘junkie’ is particularly condemning. The other term, ‘addict’, is slightly more complex, as it is capable of being both deprecating and descriptive. When used offensively, the word ‘addict’ has similar connotations to ‘junkie’. However, as described later in section 2.2.1, this term could also be used inoffensively to describe somebody suffering from the ‘disease’ of addiction.

Such divisions reflect historic social constructions of problematic drug-use that have influenced social attitudes, potential empathy and understanding over the past century. Sociologists Radcliffe and Stevens (2008) explored the stigmatisation of drug-users and drug treatment by interviewing 53 problematic drug-users who had dropped out of treatment in the UK. This qualitative piece of work is helpful in its contribution to this thesis inasmuch as it describes, from the drug-user’s point of view, the stigmatising effect of being labelled a ‘junkie’. Radcliffe and Stevens noted that the term ‘junkie’ became common when legislation changed in the early 20th century. Before then, addiction to morphine via medical practice was socially acceptable. However, as legal prescriptions for morphine stopped, individuals became ‘junkmen’ or ‘junkies’, because they had to medicate their dependence through illicit opiate use. As a result, ‘junkies’ became associated with ‘spoiled identities’ and driven to live on the margins of society and drug-use became synonymous with poverty, homelessness, violence and crime (Radcliffe and Stevens 2008). As a seminal writer researching the sociology of

substance abuse, gender and ‘deviant bodies’ since the 1980s, Ettorre (2007) argues that as illicit drug-users continue to be morally reprimanded and culturally disciplined, this image persists in contemporary society.

Similarly ‘addicts’ can be depicted disparagingly as being criminal and socially deviant because of being dependent on *illegal drugs* that are accessed by criminal means. There is a sharp distinction between the descriptions of an addiction to illicit, as opposed to licit, substances, as observed by Gerada (2005), a general practitioner with a special interest in substance misuse. She notes that individuals with a dependence on *legal medication*, lawfully dispensed, for instance through GP prescriptions or bought ‘over the counter’, reject the notion of being ‘addicts’ even though they have a similar physiological dependence on opiates. However, as the following American report demonstrates, the population of pregnant women taking prescribed analgesia vastly outnumbers women using illicit heroin. As part of a nursing and psychology multidisciplinary academic team looking at the clinical management of methadone dependence during pregnancy, Wilbourne *et al.* (2001) report that, in the US in 2001, there were 1.4 million potential mothers using opioid-derived drugs: heroin, codeine-based analgesics and methadone. They cite the US National Pregnancy and Health Survey’s 1992 report as an illustration of the national prevalence of substance use during pregnancy. This indicates that a total of 357,500 women stated that they were using opioid derivatives at the time of gestation and through pregnancy. The vast majority (85%; n=305,200) were prescribed opiate analgesics, with a smaller number (14%; n=48,700) abusing opiate analgesics. Only 1% (3,600) were using heroin.

In effect, it could be argued from a sociological perspective that the number of people with a dependency on opiates is of less concern as an addiction problem than the effect that illicit drug-use has on society. In other words, addiction is culturally perceived as a social, rather than a personal, problem. Contrary to this belief, chartered health psychologists Hammersley and Reid (2002) argued that addiction should be considered normal behaviour in response to social causes. In their paper reviewing the nature and function of the myth of addiction, they claim that current discourses construe drug-use

as a compulsive, dangerous and dramatic condition caused by the biological effects of the drugs. As a result, drug-users continue to be depicted as at the root of social problems because they are driven to procure heroin by any available means, regardless of the immediate and long-term consequences often associated with poverty, violence and crime. Hammersley and Reid argue that the myth categorises drug-users as out of control and poorly behaved, because issues of control and good behaviour are stressed as a central concern of Western cultures. Writing in support of this, psychotherapist and writer Anne Shaef (1987) theorises that today's modern society is sick and addicted. She does so by drawing parallels with descriptions of addiction applied to individuals. She notes that today's society could be construed as addictive because it is self-centred and dishonest, constantly reacting to perceived crises whilst harbouring illusions of being in control. Her argument helps to further the understanding of Hammersley and Reid's (2002) conclusion that substance abuse should be perceived as a symptom of social problems rather than indicative of problems inflicted on society by 'out of control' drug-using individuals.

The above debates concerning the constructions of drug-users are based on several differing theories and understandings of addiction. At times, discussions of this complex subject feel convoluted. Since addiction is explained via various biomedical, genetic, psychological and sociological discourses, it is difficult to tease out, and appreciate, significant intricacies. This is especially true when seeking to understand the unique lived experiences of individuals.

In recognition of this difficulty, the remainder of this chapter makes reference to two particular paradigms, the biomedical and psychological, which are referred to in this thesis. They have been chosen specifically as helpful in the exploration of the lived experiences of mothers engaged in methadone maintenance treatment (MMT) and who want to breastfeed. The hegemonic and biochemical understanding of addiction is investigated in section 2.2.1. The disease model of addiction explains the need for abstinence because the image of the drug-user, 'under the influence' and out of control, conflicts with a social identity that demands disciplined behaviour (Hammersley and

Reid 2002). The section concludes by discussing confusion over the words ‘abstinence’ and ‘clean’.

2.2 Assumptions about addiction: philosophical considerations

2.2.1 Classical paradigm

Hegemonic and classical understandings of addiction stem from viewing drug-use as not only deviant, but also an ailment (Ettorre 2007). In the period up to the 1960s, addiction was predominantly treated as a disease (Bandura 1997), inasmuch as drugs, like toxins, can damage bodies and minds in predictable ways. In the last half of the 20th century, these views have become entrenched by technical and scientific research on brain physiology which advanced understanding of the biochemical processes of drug-use (Khantzian and Albanese 2008).

Heroin has been shown to influence the neurotransmitter mesolimbic dopaminergic and serotonergic pathways (Molintas 2006). These are the brain’s reward conduits in which are based pleasure (influenced by dopamine) and emotional memories (influenced by serotonin). Heroin causes a surge in dopamine and, consequently, a feeling of pleasure. In addition, the pleasure evoked when heroin is used for the first time is stored as an emotional memory. Thereafter, heroin is used in an effort to relive this good experience. The cycle of normal brain function involves the inhibition of neurons with the re-uptake of dopamine. Persistent and chronic use of heroin results in dampening down these responses and, over time, dopamine receptors become over-stimulated. In order to protect brain functions from the abnormal surge in dopamine, there is an alteration in normal neuron secretion. As a result, the drug-user becomes increasingly compelled to use more and more heroin in an effort to relive the pleasure. Ultimately, however, addiction results and, without heroin, the user experiences a persistent feeling of being unwell (Molintas 2006).

‘Brain-based’ explanations of addiction persist and are espoused by those who follow the 12-step Anonymous programmes, such as Alcoholics Anonymous (AA). AA describes addiction as a progressive, killer disease, which gets worse over time, and for

which there is no cure. They champion attending regular AA meetings, which are aimed at achieving and maintaining abstinence. With the claim that many thousands of people across the world have been saved from the misery of addiction, such programmes are described as being very successful (Alcoholics Anonymous 2008). However, in support of their theory that drug-users self-medicate emotional problems, psychiatrists Khantzian and Albanese (2008) are critical of the AA 'disease' model. They suggest that the notion of being diseased for the rest of the user's life engenders feelings of powerlessness in individuals who want to change their behaviour. This is further exacerbated when they exchange an addiction to drugs for an addiction to groups about drugs.

In addition, where solutions to drug addiction stress abstinence, Hammersley and Reid (2002) observe that they unhelpfully perpetuate, as they term it, the myth of addiction. This concept was originally devised by Davies (1992) who counters the disease model of addiction by stating that pharmacological changes in the brain do not explain drug-using behaviour in terms of reasoned and planned actions, for instance, as in the case of planning where and when to use drugs. Davies describes drug-users as people who take drugs simply because they want to, rather than being compelled by the pharmacology of the drug they use.

Drug-users were described by social structure theorist Merton (1968) as retreatist and deviant because they have given up the valued cultural goals of society and the institutionalised ends to achieve these goals. Psychologists Gurdin and Patterson (1987) elaborated on this idea by describing retreatists (drug-users) as being either passive or active. Firstly, portrayed as social failures, retreatists were claimed to use drugs because they were unable to achieve what is culturally and socially useful through legitimate and/or illegitimate means. Secondly, as social rebels, retreatists are described as using drugs to reject society's valued cultural goals. In this case, drug-taking makes sense in the users' own internal logic, whilst appearing illogical to the wider world. Such a position is echoed by the psychologist Falk (1983), who described dependence on substances as a symptom of behavioural troubles, rather than the result of personal

intrinsic effects, which are interpreted as behavioural problems. Thus the myth of addiction perpetuates the unhelpful image of an out-of-control drug-user. In an effort to rebalance conflicts within the discourse that social identity is about being disciplined and not addicted, abstinence becomes the focus of social restraint (Hammersley and Reid 2002).

Abstinent vs. ‘clean’

Thus with drug-use being synonymous with anti-social and undisciplined behaviour, the rights of drug-using mothers are recognised **only when** abstinence occurs. In effect, as Ettorre (2007) argues, the notion of motherhood becomes sacralised at the expense of the women. Radcliffe (2011) notes that the word ‘clean’ is used synonymously to convey the notion of being a normal mother. It is, therefore, important to understand what abstinence (‘clean’) means. On the one hand, abstinence could be interpreted as stressing that women abstain from all drugs, including methadone, whilst, on the other hand, it could mean being ‘clean’ from illicit substances. Continued misunderstanding over the definition of abstinence prolongs the struggle women experience in striving to prove themselves trustworthy mothers.

In her paper describing the morality of drug treatment in terms of demonstrating women’s capability to mother, Radcliffe (2011) suggested that, when drug-using women become pregnant, they have to manage their stigmatised, polluted and deviant ‘junkie’ personas. By aiming for and describing themselves as ‘clean’, mothers align themselves with normal, often idealised, discourses of motherhood. Only one of the women Radcliffe (2011) interviewed described herself as ‘clean’ in the way stipulated by professionals. She said when she was completely abstinent from illicit and prescribed drugs, this is what her social worker wanted. However ‘clean’, was also described as being abstinent from illicit drugs whilst undergoing drug treatment. Further extracts from conversations with other mothers in Radcliffe’s (2011) paper indicate that MMT offered the stability which helped them feel ‘normal’. They described changes in their lives, such that they were able to acquire goods that were previously sold for drugs, live in properly furnished flats, integrate into the community and be able to talk with their neighbours. Thus ‘clean’ parenthood, *i.e.*, motherhood and

family life, were largely associated with the regulated consumption of methadone. The journey towards motherhood was made easier for these women when they were able to present themselves as a family to the outside world (Radcliffe 2011). In other words, MMT women had a positive experience of motherhood when they were able to present themselves as moral actors by taking part in social life.

Even though treatment for substance abuse is known to improve stability in family and community life (United Nations International Drug Control Programme 2003), detoxification from methadone, as well as heroin, continues to be the ultimate goal. In this respect, the rights of mothers are recognised by some professionals only when they are abstinent from both illicit substances and prescribed medication. Alternatively, Radcliffe (2011) observes MMT mothers description of a different understanding of abstinence, where ‘clean’ means no use of ‘dirty’ illicit drugs. Concerned to maintain their health and repel cravings for illicit opiates in the interests of protecting their babies, they fully engage in methadone maintenance treatment.

In summary, section 2.2.1 has explored aspects of the biomedical explanation for addiction. Biological models are useful because they help explain the physical withdrawal symptoms women fear when they stop using opiates, as described in Chapter 1. However, the suggested reliance on the classical paradigm to explain drug-use in terms of a physical disease is considered unsatisfactory. Where drug-using mothers continue to receive methadone treatment, they will continue to be marginalised and stereotyped by those who perceive them as being out of control and criminal (Ettorre 2007). In addition, Khantzian and Albanese (2008) suggested that these biomedical models do not help explain how human emotions perpetuate drug-using behaviour.

The following section, 2.2.2, explores the rationale for alternative constructions of addiction which are less likely to describe methadone-treated mothers, in the words of Murphy and Rosenbaum (1999: p.1) as ‘failing in their reproductive role’. The two subsections describe the self-medication and relational theories of addiction in ways

that are concerned to ‘bear witness to the injustices that drug-users face...requiring attentive and ethical forms of listening’ (Ettorre 2007: p.11). In highlighting the importance of the protective, therapeutic role of methadone treatment, these theories are used within this thesis because they support a more compassionate and empathetic approach to addiction for breastfeeding MMT women.

2.2.2 Alternative constructions of addiction

Drug-users live in a world dominated by the consumerist market in which drugs are chosen for their psychotropic effects (Allamani 2007, Ettorre 2007). However, subjective narratives of use, describing individualised needs, risk conflicting with local policies of containment and control. McGlade *et al.* (2009) note that, in terms of child protection, maternal drug-use and child abuse increasingly have become linked. Drug-use is blamed predominantly for poor childcare, regardless of the poor socio-economic conditions. However, mothers engaged in methadone treatment and abstinent from illicit heroin might argue differently, against these generalised cultural condemnations, that drug-use *per se* causes childcare problems. In 2006, Banwell and Bammer conducted in-depth interviews with 70 mothers of children under five. Their study, described in greater detail in Chapter 6, explored the socio-cultural experiences of childrearing by women using illicit drugs. Banwell and Bammer concluded that all mothers, irrespective of drug-use, cited other factors such as poverty, poor diet, social isolation and being alone at home with young children as negatively impacting on childcare. Therefore, rather than reducing and generalising all childcare problems as due to illicit drug-use, Ettorre (2007) argues for a more holistic approach to drug-using women which explores and addresses their specific needs.

In addition to sociological discourses are the psychological arguments that help define drug-using women as belonging to a very vulnerable, complicated and disadvantaged group of mothers, with their own special needs. Many come from multi-generational drug-abusing families with very little potential for positive mothering role models (Jansson *et al.* 2004). Murphy and Rosenbaum (1999), in their study into pregnancy and drugs, noted that most of the 120 women interviewed described their childhoods as difficult. After being removed from families as children for their own safety from abuse

at home, the exposure to defilement in social care settings was another common research finding (Murphy and Rosenbaum 1999). Where women had experienced incest, rape, molestation or domestic violence, they said they felt their rights to control their bodies had been violated.

Such traumatic experiences can affect formed relationships. Feeling unsafe, women in early or late adolescence leave home environments early and suddenly and struggle to survive. They then face problems related to poverty, violent relationships, teenage pregnancy, interrupted education and working in low-waged, monotonous and menial employment (Murphy and Rosenbaum 1999). As a generalised social group, drug-using mothers are more likely to have left education early, be unemployed or unskilled, and be socially disadvantaged (Abel-Latif *et al.* 2006). Five times the number of younger women continue to use drugs in pregnancy than older pregnant women: 8% of women aged 15-25 years, compared to 1.6% of 26-44 year olds (Hamdan 2009).

Mason and Kreger (1998) described how some women treated their relationship with drugs as optimal. Traumatic childhood backgrounds and/or unstable intense personal adult relationships is cited as resulting in a lack of trust in human relationships. Women say they feel able to choose the drugs they need with the knowledge that they can depend on the drug's predictable psychotropic effect. These responses encapsulate more holistic approaches to understanding drug-using mothers and are contained within the self-medication and relational theories of addiction. Presented within the following two subsections, they are described by their respective authors, Khantzian and Albanese (2008) and Byington (1997), as not only giving voices to women, where previously they have been unheard, but also as raising cultural and social awareness to help explain women's chronic use of opiates.

Self-medication theory of addiction

As authors of the self-medication theory of addiction, Khantzian and Albanese (2008) explain that women choose to form relationships with drugs that help them to feel better. Drugs are described as:

Alleviating, removing or changing human psychological suffering...(with) a considerable degree in specificity in a person's choice of drugs (Khantzian and Albanese 2008: p.2).

As the drugs of choice, opiates are trusted to dampen emotions. Once introduced, women learn that heroin can calm and numb, 'soothing and smoothing', their emotional pain and distress. This is similar to the findings described in the audit in Chapter 1 and as subsequently observed in clients, whilst working as a specialist nurse practitioner. Khantzian and Albanese (2008) note opiate users are three times more likely than other drug-users to have a history of childhood abuse. An increase in opiate abuse is also linked to trauma, presented symptomatically as post-traumatic stress disorder (PTSD), and other similar conditions such as borderline personality disorders (BPD) (Khantzian and Albanese 2008, Mason and Kreger 1998).

Heroin has a powerful calming effect on intense emotional pain, which helps protect women from uncontrollable anger, not only towards others but also towards themselves; in the case of destructive impulses associated with suicidal behaviour, gestures or threats of self-mutilating behaviour (Mason and Kreger 1998). Khantzian and Albanese (2008) describe the mothers' dread of losing this protection and fear of becoming overwhelmed by unmanageable emotions. It is a terrifying prospect, especially during the time of becoming a mother of a tiny dependent baby. Khantzian and Albanese (2008) argue that a more compassionate response to mothers is prompted when opiate dependency is perceived as a maladaptive coping response to ameliorate emotional pain.

Relational theory of addiction

The relational theory is used within this thesis to complement the self-medication theory of addiction. The author, Byington (1997), argued that women, in the absence of trusting relationships with others, form close relationships with heroin because of the trusted effects it continues to bring. This theory, initially developed in the 1980s and founded on the work by Miller (1976), Chodorow (1978) and Gilligan (1982), is based

on the assumption that, in order to feel understood and valued, people need to feel a vital connection with a significant other. Relationships are important and give women a sense of self. Drawing on her background in psychology and social work, and with an academic interest in the problematic and traumatic relationships experienced by women, Byington (1997) applied a relational theory to female drug-users. Her descriptions of the two ways in which people connect with others are used to help forward an understanding of MMT mothers within this study. Whilst close relationships are described when people mutually care for each other and positively influence one another, functional relationships are orientated towards achieving a certain goal. At the core of the relational theory lies the argument that addiction is both the product of previously troubled relationships and the subsequent formation of functional relationships with the drugs that addicts use (Byington 1997).

Byington, together with Khantzian and Albanese (2008) and Murphy and Rosenbaum (1999), noted that opiate-dependent women will often describe traumatic histories related to the violation of their bodies. Consequently, Byington (1997) argues that drug-using women learn two important lessons regarding who they can and cannot trust. Firstly, they harbour a distrust of people because people they have trusted in the past have harmed them. This leads to the second lesson, and discovery, that they can always rely on opiates to ameliorate their emotional pain because these substances are perceived as emotionally 'safer' and predictable in their effects (Khantzian and Albanese 2008). Thus, whilst distrusting people, women form functional relationships with heroin and methadone for the predictable effects these drugs have on them.

Problems arise when these women become mothers and their drug-use might not be perceived or understood empathetically. The lack of a more compassionate response could be explained by the deficiency in exposure to this client group experienced by professionals working within maternity services. The population of MMT mothers is very small when compared to the wider population of non-drug-using mothers. As noted in the first chapter, 65,408 female heroin users in England were of childbearing age (Home Office 2006). In that same year The Information Centre for Health and

Social Care (2008) recorded 629,207 deliveries in NHS hospitals in the UK. Although unrealistic, even if all the female heroin users became pregnant in 2006, this would indicate an approximate statistic of 1 in 10 drug-using mothers delivering within a NHS hospital. However, this calculation of the number of mothers attending NHS hospitals might be considered over-inflated. According to local records kept by the specialist antenatal clinic, there were only 40 mothers using any substance, including alcohol, who delivered their babies at a large London NHS Hospital in 2008. According to BirthChoiceUK (2011), this London hospital has approximately 5,300 births/year. This computes as 0.75%, just 1 in 132 mothers with a substance abuse history delivering their babies at this particular hospital. In Nottingham, a case study of a centre of excellence, the number of deliveries from opiate-using mothers constitute just 0.37% of the total of babies delivered within the city (Appendix 1).

These statistics therefore suggest that, in many cases across the country, maternity and social service professionals may have little and/or regular contact with this group of mothers. Limited contact might undermine a curiosity and interest in knowing more about them and the functional relationship mothers have with methadone. Thus, without knowing about alternative constructions of addiction, professionals may well continue to refer to the hegemonic and classical disease theory, which stresses abstinence. As a result, this group of mothers continue to be perceived as pathological and suspect (Khantzian and Albanese 2008, Ettorre 2007, Byington 1997) because they continue to need and take their prescription of methadone, despite professional expectations that they must stop.

2.3 Summary

This chapter has reviewed two different concepts of addiction, based on the biomedical and psychological understandings. It has argued that the self-medication and relational theories, situated outside the classical paradigm of addiction, offer a more compassionate understanding of, and a different way of working with, methadone-treated mothers. The biological model helps to provide physiological explanations of

why there are changes in brain function in chronic heroin use and why drug-users fear the pain of opiate withdrawal and becoming sick. Even when concerns over infant safeguarding are raised, such a rationale offers a suggestion as to why mothers prefer to remain in MMT. They are prepared to face scepticism and reject abstinence from methadone for fear of becoming too emotionally and physically unwell to function as mothers. In instances where methadone-treated mothers continue to be perceived as 'diseased', feckless and irresponsible, this approach leaves little room for compassion. Alternative anti-oppressive explanations of the relationship that mothers have with methadone may provide a more proactive and less confrontational opportunity of working with them. The driver for that change is supporting women in their transition to motherhood, a role which is described in more detail in Chapter 3.

Chapter 3: Contextual issues concerning motherhood

The previous chapter noted that where drug-use is perceived as a disease, drug-using women are depicted as being antisocially out of control, and abstinence becomes recognised as a major benchmark by which maternal capability is measured. Therefore, even when engaged in methadone maintenance treatment (MMT) for an opiate dependency problem, women are at risk of being devalued in their worth as mothers.

Chapter 3 explores the effect of motherhood on the dual identity of MMT mothers. Section 3.1 briefly introduces two seminal works, authored by Murphy and Rosenbaum (1999) and Ettorre (2007). These largely focus on the experiences and life-world of pregnant drug-using mothers. Their findings and discussions offer this thesis a firm grounding from which to explore the experiences of breastfeeding MMT mothers. The rest of the chapter is split into three parts.

Section 3.2 is dedicated to examining the cultural meaning of motherhood. It starts by initially outlining the normative social construction of motherhood, in the context of 'non-drug-using' women (section 3.2.1). As drug-using mothers are culturally perceived as being deviant, the section goes on to describe how, from research so far, this point of view frustrates women who struggle to be recognised as mothers but continue to be treated with suspicion as drug-users (section 3.2.2). It concludes by briefly outlining the notion of choice for these mothers by drawing on some existentialist philosophical ideas (section 3.2.3).

Section 3.3 looks at the psychological impact of motherhood on the women. Reference to Bandura's (1997) theory of self-efficacy indicates that a positive transition to motherhood is affected by firmly held personal beliefs regarding the women's ability to mother (section 3.3.1). Kelly's (1991) personal construct psychology (PCP) is used to explain how mothers' internal construct systems are constantly being challenged and modified in response to becoming mothers (section 3.3.2). However in the absence of

empathetic care, and when exposed to the professional ego (Hart and Freeman 2005), drug-using mothers are at risk of feeling treated unfairly (section 3.4).

3.1 Seminal works on drug-using mothers

As noted previously in Chapter 1, sociologist authors Sheigla Murphy and Marsha Rosenbaum (1999), together with Elizabeth Ettorre (2007), stated that research on female drug-users is rare. Thus, these particular theorists are often cited within this chapter, and, more generally, throughout the thesis. Their respective publications have contributed to a greater and more empathetic understanding of what it means to be a drug-using mother.

American medical sociologists Murphy and Rosenbaum (1999) write about their 'Pregnancy and Drugs' study in *Pregnant Women on Drugs: Combating stereotypes and stigma*. Their book is explored more fully in section 6.1.1. They both have wide-ranging experience, researching areas of drug abuse since the 1970s. In the face of extensive literature based on maternal drug effects on the foetus, they describe their work as a response to a paucity of information about the mother herself. As they gathered information from the women's own perspectives, their book helps women voice their experiences. It contains a large amount of primary qualitative data on how it felt to be both a drug-user and mother. In addition, data are used to examine ways which result in drug-using mothers, culturally perceived as failing in their reproductive role, being placed in one of the most stigmatised groups in modern society.

With care and attention focussed on the baby at the time of delivery, drug-using mothers appear to risk being demoted in their role as primary carers. Murphy and Rosenbaum (1999) note that newly delivered mothers are in danger of becoming labelled as failures, at the very time when the transition to motherhood becomes manifest:

Even when women make substantial strides during pregnancy to reduce the risk of drug-use to their babies, they discovered at the time of delivery that their lived experiences failed to validate their worth as mothers. (p.104)

Thus, regardless of their efforts, the persistent perception of these women as drug-users appears to eclipse and negate pregnant mothers' attempts to demonstrate their willingness and capacity for change. As a result, the potentially positive emotional transition to motherhood is at risk of being jeopardised by others who judge them as being of little worth as mothers to their babies.

Murphy and Rosenbaum's (1999) overwhelming message is the need for women-centred treatment and healthcare, coupled with compassion and empathy, to help alleviate the problems faced by this group of women. Their research took place in America, where drug-taking during pregnancy has been interpreted historically as a criminal issue of child abuse (Dailard and Nash 2000). When interpreted this way, professionals are legally bound to initiate child protection or criminal justice proceedings. Although drug-using mothers are referred to social services in the UK, their drug-use is not legally interpreted as child abuse. However, the findings and discussions from Murphy and Rosenbaum's study are valid and relevant for use in this thesis as providing an important empirical foundation.

Elizabeth Ettorre is the second seminal writer whose work on the sociology of substance use, gender and embodiment are frequently cited within this study. As an American academic working in the UK, she has an extensive history of research and authorship extending back to 1992 with the publication of her first book on *Women and Substance Use*. Of interest to this thesis is *Revisioning Women and Drug-use: Gender, Power and the Body* (2007). She uses a feminist embodiment perspective to argue that female drug-use is viewed as a form of embodied deviance and linked to societal tasks of restraint and regulation of bodies, reproduction faculties and off-spring. Ettorre is able to produce new insights into the embodiment of deviancy as experienced by drug-using mothers. Thus whilst media-hyped stereotypes drug-using mothers as selfish and

unfeeling, reference to these two seminal works helps to bring added dimensions of both compassion and passion to this study.

3.2 Motherhood: dual identity

As the women interviewed in this study are both mothers and methadone-treated drug-users, this section explores the meaning of motherhood for women with these dual identities. They share common experiences with ‘normal’ mothers by being able to bear and breastfeed their babies. However, their continued dependence on methadone is a reminder of their opiate dependence and drug-using history, an aspect of their lives they do not share with other non-drug-using women.

3.2.1 Constructions of women and normative motherhood

Because of their biological ability to reproduce and nurture babies, when they become mothers women are described as realising their goal and fulfilling their predestined, teleological nature (Fearn 2001, Magee 2001). Normative social constructions of women are also culturally defined in terms of female reproductive functions, with motherhood described as the time when women achieve full adult status and demonstrate their feminine identity (Lewis 2002, Murphy and Rosenbaum 1999). Such constructions refer stereotypically to a normative meaning of a ‘good’ mother as a woman with natural maternal instincts, unconditional love and welcoming the demands of looking after her children (Lewis 2002).

However, there are concerns with teleological and sociological discourses which define women in terms of their reproductive functions. Ettorre (2007) notes that such arguments generalise and reduce women to a cultural value based on their somatic functioning. Murphy and Rosenbaum (1999) reason that, although women now have more prominent profiles within the labour market, they continue to be portrayed as being selfish or failed child-bearers when they do not conceive. They observe that for the women they interviewed, *not* being a mother was a situation to be explained. Thus, even for drug-using women living on the margins of society, motherhood is important. However in contrast to the normative construction of ‘good’ mothers, they are portrayed as being ‘bad’ and deviant.

3.2.2 Social construction of deviant motherhood

Derogatory adjectives such as bad, immoral, inferior, disgusting, diseased and out of order, are used colloquially to encapsulate abhorrence shown towards drug-using mothers and the associated deviance which challenges the normative construction of motherhood. Authors cite such words to underscore the marginalisation and alienation experienced by these women, whose bodies and offspring necessitate regulatory restrictions and control (*e.g.*: Radcliffe 2011, Radcliffe 2009, Ettorre 2007, Goode 2000, Murphy and Rosenbaum 1999). Ettorre (2007) argues that all women, regardless of whether they use drugs or not, are expected to behave and submit themselves in prescribed ways. When deferring to medical scrutiny they are expected to be docile. In the wake of professional advice given in the interests of optimising foetal health, pregnant mothers are expected to be active by responding and acting responsibly.

Implicit within these expectations of maternal behaviour, lies the discourse that social systems and regulating regimes construct and determine which sorts of bodies are 'reproductive'. Radcliffe (2011) writes that pregnant drug-using women are denigrated because they defy the cultural concept of what it is to be a 'good' mother. Mothers' use of illicit drugs, especially whilst pregnant, acts as the global reference for defining mothers as deviant, even though, as Keel (1999) argues, the construction of deviance is from a particular point of view which may be denied. Pregnant drug-users are situated outside the discourse of being healthily reproductive and castigated as being 'off the radar' because their drug-use 'marks bodies of individuals and determines their low social status' (Ettorre 2007: p.29). Goode (2000) interviewed 48 substance misusing women in her sociological study researching, what she describes as, 'hard-to-access' drug-using mothers. Her work is useful to this thesis because of the insights she gained about their lived experiences. She noted that deviant behaviour is concomitant with the use of illicit psychoactive substances and therefore incompatible with the social construction of normative motherhood. The use of illegal substances during pregnancy was also noted by Murphy and Rosenbaum (1999) as the cultural definition of the 'antithesis of responsible behaviour and good health' (p.1) because women were perceived as deliberately poisoning their wombs.

Such sentiments are reflected in the following statement by Ettorre (2007). Drug-using mothers are described as confronted, both internally and externally, with cultural notions of embodied deviance and values that define their ‘dirtied or polluted gendered body’ as:

a metaphor for failed femininity, emotionality, sexuality and a breakdown of self-risk management (p.18).

Therefore drug-using women’s inability to manage themselves is further blamed for their not fulfilling the ‘docile’ and ‘active’ roles normally expected of pregnant mothers. However where pregnant drug-using women are vilified as deviant, cultural stereotypes of drug-users have the potential to frustrate the women’s transition to ‘normative’ motherhood, as explained below.

Ettorre (2007) describes drug-using women as confronted by media hype that stereotypes their bodies, wombs and conceptual products as polluted and in need of control and regulation. Murphy and Rosenbaum (1999) note the exacerbation of social disgust fuelled by scientific research, which focuses largely on the effects of drug-use on the foetus and the effects of opiate withdrawal in the new-born. Ettorre (2007) writes that such disgust influences the portrayal of babies born to these mothers as being ghastly and defiled because of *in utero* exposure to drugs. Thus, not only are mothers exposed to regulatory physical and psychological control; their babies too become the objects of surveillance and supervision by health and social professionals.

As a result, drug-using mothers might experience a re-entrenchment of self-imposed emotions of badness, guilt and/or fear about the impact of their drug-use on the foetus, which discourages them from revealing themselves to professionals and seeking antenatal care. Murphy and Rosenbaum (1999) observe two major competing fears harboured by this group of mothers and, depending on which one is the greater, will affect attendance at specialist services. Firstly, women may seek professional advice to allay their anxiety concerning the unknown effects that their drug-use has on the foetus.

In opposition to this is a second fear in which women are reluctant to 'break cover' and seek professional help because they are scared their babies will be taken away by social services. Thus pregnant women struggle to conform with expected cultural roles regarding antenatal care. However after delivery, women comply with certain cultural expectations of motherhood. In her investigation into the identity of motherhood during the postpartum period, Radcliffe (2011) observes that women worked to present themselves as moral actors to ensure membership within the socially recognised social group of mothers.

However, where society continues to judge drug-using mothers as 'spoiled' and 'bad', they continue to be perceived as failing in their reproductive role and the antithesis of the well-behaved and healthy mother (Radcliffe 2011, Murphy and Rosenbaum 1999). Where the powerful cultural ideology of motherhood is not validated, Murphy and Rosenbaum (1999) describe women being faced with a 'destructive cycle of self- or mother-blame' (p.104). These descriptions are shared by Radcliffe (2011). She describes the task of convincing others of their capability to mother as a major struggle. As an embodiment of risk to the babies they bear, these mothers try to manage their status and moral sense of self by navigating a 'safe passage through a series of perceived risks, such as losing custody of their children, causing foetal damage or being severely stigmatised in public settings' (Ettorre 2007: p.104).

Where hegemonic societal attitudes criticise mothers for their lack of self-control for failing to protect the unborn foetus, Ettorre (2007) argues that such approaches are not always conducive to the welfare of the mother and baby. Murphy and Rosenbaum (1999) suggest that 'destructive cycles' are continually reproduced when fuelled by repeated references to their history of drug-use. These are further exacerbated when coupled with suspicious inferences that their illicit lifestyle are likely to persist in the future – unless the mothers can prove otherwise. Consequently, as this is impossible to demonstrate, drug-using mothers might never be fully trusted with their babies.

Thus, from a hegemonic cultural position, it appears unacceptable for some mothers to claim maternal rights where they continue their drug-using behaviour. As observed by Goode (2000), the normative construction of motherhood excludes the use of psychoactive substances. Her statement reflects the wider cultural concern for the baby, which is often at the expense of the mother, as discussed previously in Chapter 2. Contained within it is the implication that embodied experiences, and therefore drug-using women, are all the same. This study deliberately focuses on, and explores the lived experiences of, a group of women who, by opting to remain in MMT and breastfeed their infants, challenge this hegemonic discourse.

Therefore, by becoming mothers, women are faced with making choices about changing previous drug-using lifestyles. From an existentialist philosophical perspective, the drug-using mother can be described as adjusting from being preoccupied with immediate sensory gratification connected to drug-taking to experiencing moral responsibility – not only for their babies, but also for themselves. These ideas are explored in the following section.

3.2.3 Existential belief and choice

Underpinning the notion of choice lies existential beliefs that describe individuals making choices for themselves (Magee 2001, Gaarder 1996). The development of existentialist ideas evolved from the 17th century, originating initially from a rejection of Cartesian rationalism, in which the self is viewed as an uninvolved entity, passively observing the external world through the prism of mental understanding (Wrathall and Dreyfus 2006, Robinson and Groves 2004, Leonard 1989). These arguments were later developed by Kierkegaard, who criticised Hegel's notion of 'historicism', which depicted history as purposeful and evolutionary (Cohen 2006).

Kierkegaard contended that this notion obscured the effect that taking responsibility and making choices had on an individual's life (Gaarder 1996). Instead of searching for *The One Truth*, he argued for the importance of subjective truths that were personal and important to each individual, each referring to her own day to day existence and influenced by her thinking and the choices she makes. Kierkegaard stressed that human

beings have constantly to create their own natures or essences within a continual cycle of improvisation as there is no innate, *i.e.* no eternal, nature upon which to fall back. Existentialist philosophers would add that, as individuals are freed from having to refer to religious norms and values as moral compasses, they are personally responsible for the choices they make in their lives (Magee 2001). Kierkegaard reasoned that there are three different forms of life/stages, described as the aesthetic, ethical and religious (Gaarder 1996), of which the first two are of particular interest to this project.

The aesthetic stage of life is when people live for the moment, gratifying their senses to appease immediate desires or moods (Gaarder 1996). Thus, according to Kierkegaard's reasoning, whilst in the aesthetic stage, drug-using women can be described as living for the moment and satisfying their desires and moods. This reflects the earlier argument used by Khantzian and Albanese (2008) in which heroin is described as being used as a method of removing painful emotions which brings instantaneous pleasurable relief. However, on becoming breastfeeding mothers they face choices regarding the appropriateness of their drug-using behaviour.

For those who are successful in doing this, Kierkegaard described their moving to the ethical stage, a time characterised by seriousness and moral choice (Gaarder 1996). When MMT mothers seek and embrace change, with the responsibility and commitment this brings, they can be described as moving beyond self-appeasement to the higher ethical stage, which embraces a concern for their babies. Although their lives are lived differently from non-using 'normal' mothers, in essence, they are acting as 'normal' mothers and embracing motherhood by choosing to act in the best interests of their babies.

However, it is simplistic to suggest MMT breastfeeding women move from stage to stage with ease, independent of the world in which they live. The choices people make depend very much on how they perceive themselves and, as social actors, how they themselves are perceived by others (Sadala and Adorno 2002). Sartre, an existentialist philosopher, stresses the importance of existence over essence (Gaarder 1996). He

argues that people become like things when they describe themselves in a social role, adding that the self is not static. It can, therefore, be argued that drug-using mothers occupy two social roles, that of drug-user and mother. However, whilst they are experiencing the transition of starting to identify themselves as mothers, others, such as professionals, continue to relate to them as drug-users. Merleau-Ponty, an existentialist phenomenologist, described being-in-the-world as focussing on the study of the bodily experience of the world in perception (Sadala and Adorno 2002). He spoke of the body as the perceiving subject, as the self, the way individuals can be in the world, ‘ I do not have a body—but I am my body’ (p.286). The body is described as simultaneously perceiving and being perceived in the dialectic relationship between:

A person as a body and the world where it is located. The conditions of the world limit but do not determine a body; instead, people are in charge of determining themselves through their own choices (Sadala and Adorno 2002: p.286)

This quotation, therefore, suggests that, whilst mothers are limited by the world in which they live and by the people they are in contact with, they remain responsible for determining who they want to become when they decide to be breastfeeding mothers. Similarly, in a process known as *dialectics without synthesis*, Merleau-Ponty argues that individuals become involved in a ‘continuous search and transformation in which people are always moving forward, in a coming-into-being of possibilities’ (p.286). However, for MMT breastfeeding mothers, this dynamic and evolving transformation of their bodies and themselves is hugely influenced by how they are perceived and treated by others. This is the theme which is explored in greater detail in the following section.

3.3 Motherhood: motivation for personal change

Female bodies are described as acting as an ‘instrument for self-articulation for who we are and who we will grow to become’ (Ettorre 2007: p.27). For drug-using mothers, it is well documented that motherhood is a prime inspiring driver towards abstinence (Fraser *et al.* 2009, Ballard 2002, Murphy and Rosenbaum 1999, Byington 1997), with

pregnancy a powerful motivator for reflection, intensified in the final trimester (Hepburn 2005). Mothers often describe dramatic changes to their lives driven either by wanting to become pregnant, becoming pregnant, recent birth or feeling guilty about being a substance-abusing mother.

Becoming a mother is an intensely emotional time. Women's lives become embroiled in the transition to motherhood, seeking personal fulfilment and an alternate sense of self that is different from a purpose and meaning they had known previously (Barclay *et al.* 1997). In their qualitative, grounded theory study on non-drug-using women's experiences of early motherhood, Barclay *et al.* (1997) observed that mothers describe the transition towards motherhood as a distressing and evolving experience. They said they felt out of control because of the loss of a previous lifestyle and rewarding social roles. This is a similar theme to that observed by the psychologist Smith (1999). When investigating identity development during the transition to motherhood, he described the women's sense of self as being enhanced by withdrawing from the wider world into more intimate and closer circles with family and friends.

However, where mothers are perceived as having deviant bodies and defiled or 'spoiled' identities (Radcliffe 2009), this transition to motherhood, moving away from their previous drug-using lifestyle to becoming inward-looking and more enmeshed with their babies, is less welcomed and is treated with suspicion by others (Ettorre 2007). The transition is especially stressful when mothers face problems of self-confidence and esteem which may have initially led to, and been affected by, their drug-using career.

3.3.1 Transitions to motherhood

Drug-using women are described as having a sense of 'toxic shame', perceiving themselves as flawed and defective human beings (Mason and Kreger 1998). As their instincts may have been damaged by their history and trauma, a reference to Bandura's (1997) concept of self-efficacy helps to explain that, where women lack effective parenting models and have an insecure sense of self-efficacy, they may experience greater difficulties in approaching and adjusting to becoming mothers.

During his early days as an empirical psychologist in the 1960s, Bandura explored the development of personality. Initially, he proposed that children learnt aggression through observation and interaction with other people. This finding helped form the basis of his multi-faceted social cognitive theory, into which is incorporated the concept of self-efficacy. In an early paper, Bandura (1977) presented an integrative theoretical framework to explain and to predict psychological changes. He hypothesised that an individual's belief in her ability to succeed determines whether coping behaviour will be initiated, the amount of effort she will use to get what she wants and how long she will sustain this effort in the face of obstacles. In his later, seminal, book, *Self-Efficacy: The Exercise of Control*, Bandura (1997) examines his theory in more detail by looking at the various processes that affect human well-being and accomplishments. His Chapter 8 is dedicated to looking at issues concerned with drug abuse and methadone treatment. Written in 1997, some of the references to drug treatment at the time appear dated and biased towards male heroin users. However, his arguments on the role of self-efficacy, especially where they can be applied to methadone-treated mothers, are important for this thesis because of the motivation motherhood gives for change in behaviour.

Bandura (1997) cites four sources of self-efficacy: mastery experiences, social modelling, social persuasion and psychological responses. These are addressed here in reference to MMT breastfeeding mothers in the early days of motherhood. Firstly, where a strong sense of self-efficacy is strengthened by successfully performing a task, this is referred to as a mastery experience. In the case of the women interviewed for this study, success in being able to breastfeed is a strong factor in helping to boost their efficacy as mothers. Similarly, through social modelling, mothers might be inspired to believe they possess the capabilities to succeed when witnessing, and comparing themselves to, other mothers successfully breastfeeding and handling their babies. However, inspiration may be undermined when women compare themselves unfavourably, and see themselves as being different from non-drug-using mothers. Thirdly, self-doubt is defeated where mothers are able, through social persuasion, to

receive positive affirmation and verbal encouragement from others. This, obviously, can have an opposite effect where women do not receive such help. In that scenario, they are less likely to believe they have the capacity to succeed. This leads to the consideration of the last source of self-efficacy, that of psychological responses. The perception and interpretation of how mothers feel they are treated will colour their mood and sense of who they are. As also described by Jansson *et al.* (2004), Murphy and Rosenbaum (1999) and Ettore (1992) self-esteem effects how women judge themselves. When they believe they have poor self-worth, they are also more likely to expect failure.

Bandura (1997) describes a lack of self-esteem and a persistently unstable sense of who they are, as further exacerbated by society's imposed cultural stereotypes. As discussed earlier, drug-users are socially constructed as deviant through being involved with illegal activity (Ettore 2007, Hammersley and Reid 2002). As the mothers' treatment by society focuses on the drug-using stereotype rather than an individual woman's transitional experience, their self-esteem is further eroded. As a result, their efficacy as breastfeeding mothers is undermined, regardless of whether they are capable of feeding or not.

Thus, mothers experience tension and an internal struggle due to the contrast between their self-perception and how others perceive them. When faced with new social and material pressures related to their identity as drug-users, they might fail to experience an outpouring of maternal emotion which leads to widespread guilt and increased feelings of inadequacy (Lewis 2002). This can lead to a downward spiral. Whilst continuing to struggle, feeling overwhelmed and failures in their new maternal role, the mothers' confidence and feelings of self-worth become increasingly eroded by others' stereotyped attitudes (Lewis 2002). As described by Radcliffe (2009), mothers become further 'pathologised' by failing to live up to the cultural expectations of motherhood.

However, with reference to Bandura's (1997) theory, although poor self-esteem stems from many sources, mothers are able to draw on different corrective measures to help.

Such as engaging in drug treatment. Therefore, whilst MMT mothers struggle with turbulent emotions associated with the transitional period, they can also experience positive emotions which reinforce their beliefs as mothers and provide them with the hope of change.

Indicators of maternal success, which reinforce strongly-held beliefs in their capabilities as mothers, are described where women experience more emotional well-being, a close bonding with their baby and better adjustment to the parenting role after delivery (Bandura 1997). Here the emotional experience is positive. It reinforces her identity as a mother. Consequently women who experience positive emotions exert stronger-held beliefs in their capacity to fulfil cultural expectations of motherhood.

Conceptually, whilst emotions are essential to life, they are hard to define (Goleman 1996). In his book *Emotional Health*, psychiatrist Johnson (2002) describes emotions as instinctual and intuitive. They are all vital for life and influence human reactions to decisions, predicaments and tasks. Ettorre (2007) describes emotion, which, through a feeling of bodily change, puts the drug-using mother in touch with the world around her:

Affect regulation is significant in the healing process for female drug-users and an awareness of this type of affect regulation can enable them to deal with feelings of being dirty, afraid or worthless. Thus for female drug-users cultivating positive emotions and focusing on affect allows them to have access to a new sense of embodiment other than drug taking and to know more about the affective dimension of non-drug-using lifestyle (Ettorre 1992: p.130).

This is an important statement that sits at the very heart of this thesis. Emotions play a pivotal role in the healing process in which mothers can confront and deal with negative and internalised stereotypes. As a result they experience a ‘new sense of embodiment’ as opposed to ‘an embodiment of risk’, and, by implication, an upturn in self-esteem.

It might be deterministic to assume a connection between the strength of the drug-user's perceived self-regulative efficacy with the success of their efforts to stop and remain abstinent from drugs. However, as theorised by Bandura (1997), mothers report positive changes in the relationships they have with drugs and their drug-using lifestyle. This happens when they experience protective factors from supportive family and associates, as well as being involved in purposeful occupational activities around being a mother. As mothers define their role as being there for their children (Litzke 2008), they will work hard to present themselves as motivated and committed mothers by keeping to prescribing regimes and meeting with a multitude of agencies (Radcliffe 2009, Hart and Lockey 2002).

Thus, whilst some authors describe pregnancy or early motherhood as a motivation for abstinence from drugs (Fraser *et al.* 2009, Ballard 2002, Murphy and Rosenbaum 1999, Byington 1997), Radcliffe (2011) suggests that this is a time for other women, who are not ready for abstinence, to become engaged or re-engaged in drug treatment. During this developmental process, described by Ettore (2007) as a time of achieving 'maternal identity', motherhood is demonstrated as being the major turning point for a wide spectrum of drug-using women. They re-evaluate their drug-use and endeavour to overcome difficult odds to discover a new sense of self as mothers (Radcliffe 2011).

Thus, interfaced with sociological explanations of motherhood, are psychological descriptions of the individual internal processes experienced by women when they become mothers. The following section explores one particular cognitive psychological theory in this study, personal construct psychology (PCP). It is used to help explore women's renegotiation of their new identity as methadone-treated breastfeeding mothers. In addition to Kelly himself, the authors cited are personal construct psychologists.

3.3.2 Personal construct psychological theory

PCP is a theory of personality (Kelly 1991). Described as a constructivist system of psychology, PCP was developed by George Kelly and published in 1955 (Atherton 2011). Understood as a 'person-centred', 'cognitive' and 'humanistic' approach to

psychology, PCP focuses on the personal ways individuals use constructs to ‘construe’ (understand and interpret) their world (Atherton 2011, Ashworth 2003b).

Whilst working as a psychologist in the 1930s, Kelly noted that when his patients wanted to change themselves, they were helped little by the dominant behaviourist and psychoanalytic approaches of the time (Kenny 1984). Critical of the limitations and disabling aspects of both these approaches, Kelly developed an alternative understanding of the individual. PCP, as a psychological approach, rejects the imposition of theoretical concepts on subjects of interest and instead follows people's own "theories" of themselves (Kelly 1991), by exploring how people act in accordance with their own construction of the world (Ashworth 2003b). The term ‘construct’ was specifically chosen to reflect a duality (Atherton 2011). The word represents the view about the world that has been **constructed** through experience. It also indicates how the world is **construed** as it continues to be experienced.

Thus, within PCP, individuals are depicted as having active roles in making sense of their world and it highlights the axiom on which Kelly’s theory is based: that each and every person is a scientist of the self (Winter 2010). As informal scientists, individuals work in similar ways to empiricists by being involved in a continual process of forming, interpreting and making sense of the ‘data of the world’ (Winter 2010). As adults, personalities reflect a very developed complex model of reality in which they are able to be located (Atherton 2011). In a process described as *constructive alternativism*, the individual reappraises their own particular construction of the world to develop alternative construct systems in response to life events (Ashworth 2003b). The accuracy of constructed knowledge is tested in the performance the constructs suggest. Where there is congruence between results of these actions and predicted knowledge, these constructs are reinforced. Alternatively, constructs are modified when dissonance occurs between actions and what is predicted.

From his observations, Kelly suggests this process of constant internal reappraisal indicates personality is a fluid, not a fixed, entity (Kelly 1991). Because PCP is

concerned with exploring an individual's understanding of the personal world from their perspective, it is described as being phenomenological, rather than positivist (Atherton 2011). Also, by stating individual choice in modifying constructs, PCP incorporates some existentialist ideas as described in section 3.2.3. In building his theory, Kelly sets out eleven formal postulates and corollaries, which reflect some of these philosophical ideas. However, as argued by Atherton (2011), in essence, these are based on one *fundamental postulate* which states:

A person's processes are psychologically channelized by the way in which he anticipates events. (Kelly 1991: p.32).

Contained within this quote are specifically chosen words that Kelly deconstructs with great care (Kelly 1991: pp.33-34). By modifying his explanations in line with the purpose of this study, reference is made here to MMT breastfeeding mothers.

Kelly states that the primacy of concern is the individual person. Derived from this is an understanding that each mother interviewed is valued as an individual who responds to the world from within her own particular personal construct system. Kelly is very precise in stating 'A' in the above sentence. As noted by Atherton (2011), Kelly harboured disquiet concerning the 'rats, cats and stats' large-scale approaches to studying human behaviour, that psychology, as a new discipline, was focussing on at the time. Contrary to empirical researchers' endeavours to seek laws of human behaviour by generalising large groups of people or particular manifested behaviours, Kelly preferred to concentrate on the individual or small groups of people. In addition, with reference to Kelly's (1991) use of the word 'processes', lies the notion that each mother should not to be perceived as a static entity to be acted upon by outside forces. She should, instead, be understood as a dynamic actor and informal scientist who constantly assesses and reassesses her experiences in light of her core constructs - her deeply held beliefs and principles. This is described as channelized within a flexible 'network of pathways', which both facilitates and restricts her range of action.

At this point, Kelly's sentence changes direction from referring to an individual's historical personal constructs to an individual's disposition to perceive responses for future events. By stressing the word 'he' in his sentence, Kelly suggests ways in which each individual chooses to operate, 'rather than upon the way in which the operation might ideally be carried out' (p.34). Finally, by anticipating events, PCP is incorporating predictive and motivational features as, 'anticipation is both the push and pull of PCP'. Psychological processes are revealed when anticipating real events and tied to reality: 'It is the future which tantalises man, not the past. Always he reaches out to the future through the window of the present' (p.34).

In summary, PCP is used in this study to highlight the importance of each mother's constructed system that has evolved over her lifetime, culminating in an extended time of chronic heroin use, during which she continues to refer to her personal constructs to help interpret her reality. Becoming a mother presents her with a time of reflection that could contradict, amplify or modify her personal construction of motherhood. Such constructs are influenced by unhappy childhood memories of being mothered and/or traumatic recollections of bearing other babies who have been removed from her by Social Services. As noted above, motherhood is a momentous time in women's lives when some drug-using mothers change their drug-using habits. By choosing to breastfeed, women demonstrate their willingness to nurture their babies. Although this is tarnished by her continued use of methadone, which detracts from 'what should ideally be carried out', her actions still suggest an anticipation of being the kind of mother she would like to be like. In other words, mothers interviewed in this study could be described as engaging in the constant process of creating and recreating different images of themselves, structured within their own 'theories' of who they are becoming and anticipate they want to be.

Thus PCP helps to highlight an internal process in which mothers engage and understand their perception of the world. In making sense of the world for themselves, they, in turn, project their inner meaning of reality onto the outside world. However, they do not experience motherhood in isolation. The professionals they come into

contact with also have their own personal constructs of drug-using mothers which are in turn imposed onto the mothers. Professionals are also limited by policies and organisational structures. Thus, during the transition to motherhood, women are engaged in a process of continual redefinition of their identities (self-concepts), as mothers and drug-users, which, as the psychologist Bandura describes, is 'a composite view of oneself that is...formed through direct experience adopted from significant others' (Bandura 1997: p.10).

The following section goes on to explore the effects of this interaction in greater detail. When linked into a network of **empathetic** services, supportive professionals and personal relationships, women are helped in their personal endeavours, to demonstrate and prove their identity as mothers (Radcliffe 2011). However, where professionals hold entrenched negative views, mothers could experience feeling treated unfavourably.

3.4 Empathy, current maternity services, professional ego and safeguarding issues

Empathy and current maternity services

The stress on maternity services providing an empathetic approach to drug-using women is important. Ettore (2007) urgently implores services to:

be aware of the emotional, psychological, economic and social impacts of these issues and to try and actively engage all women drug-users in caring environments...[as] previous research suggests that drug-using women, particularly in treatment, respond favourably to an empathetic environment (Ettore 2007: pp.98 &105)

Situated within this quotation is the importance of caring empathetically for drug-using mothers who in turn, it is suggested, respond favourably.

Reference was made to women-centred care as indicative of best practice in the recently published NICE clinical guidelines (CG110), *Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors* (National Institute for Health and Clinical Excellence 2010). The document stressed that

Women should always be treated with kindness, respect and dignity. The views, beliefs and values of the woman in relation to her care and that of her baby should be sought and respected at all times. (p.6)

As one of four groups of complex pregnant women, substance misusers (alcohol and/or drugs) are included because of poorer pregnancy outcomes. Of particular interest to this study are barriers to attending services. According to the CG110, pregnant women do not access or maintain regular contact with antenatal maternity services because of their anxiety about the poor attitudes of healthcare staff, and the potential statutory role of social services. In addition, where they feel overwhelmed by the involvement of multiple agencies, the guidelines stress the importance of supportive and coordinated care during pregnancy.

A different version published by the National Collaborating Centre for Women's and Children's Health (NCC-WCH) (2010) contains details of the methods and evidence used to develop the NICE guidelines. Whilst stating that the establishment of specialist services is not the main drive for their publication (p.48), the NCC-WCH report that, following the implementation of structural changes, there is evidence of improved service outcomes. These include a reduction in pharmacological interventions, shorter hospital stays and fewer admissions to the NNU. Of interest to this study is the observation that the number of breastfed infants also increased, although there are no data to contextualise this statement. Four of the following structural changes reflect a more empathetic approach for drug-using mothers within current maternity services.

The first includes the development of the role of the specialist drug liaison midwife (DLM), who visits mothers at home when hospital appointments are missed. In some services, the DLM also co-ordinates care between the professional services and manages the clinical care of new-borns. Secondly, where health and social care professionals are educated and trained about addiction, there are noticeable improvements in staff attitudes and confidence when working with drug-using mothers. Thirdly, methadone exposed neonates are exempted from compulsory admission to the neonatal unit (NNU). Admissions are only indicated when there are signs of neonatal abstinence syndrome or other clinical reasons. Finally, the methadone prescribing regimen has been revised. Where the daily dose is increased rather than decreased, mothers are reported to engage earlier in antenatal care.

Following a survey undertaken by the Guideline Development Group (GDG), Appendix D of the NCC-WCH document contains descriptions of six exemplar specialist maternity services which incorporate such innovations into their programmes. These include Imperial College Healthcare NHS Trust (London), the PrePare Team (Edinburgh), the Jessop Wing (Sheffield), King's College Hospital (London), the Women's Alcohol and Drug Service (Nottinghamshire) and Manchester Specialist Midwifery Services. During the time of this study, I liaised directly with the consultant midwife from Manchester (see section 7.1) and with the specialist midwife in Nottingham (see Appendix 1).

This list is not exhaustive as there are other examples of good practice in this area. For instance, the two specialist units who actively supported this study by acting as gatekeepers are not included. In addition, no reference is made to the Aberdeen clinic, discussed in section 6.1.4, despite the continued profile of this specialist and integrated service in the literature. A study undertaken by Hall and Teijlingen (2006) was recently cited in two contemporary Australian studies. The first explores how a specialist clinic in Melbourne meets the needs of chemically dependent pregnant women (Morris *et al.* 2012). The second looks at midwives' experiences of working with pregnant illicit drug-using mothers (Miles *et al.* 2013).

In terms of service access for pregnant women in the UK who might want to use the internet to source a local specialist maternity service, a number of hospitals in the UK are shown following online internet searches. The NHS Choices website appears to restrict options by enforcing the drop-down term ‘maternity services’ alongside their geographical location. Specialist substance misuse services are not indicated. This emphasises the need for a comprehensive, concise and easily accessed online national directory.

A lack of online information is reflected in the paucity of literature about MMT breastfeeding mothers, as discussed in Chapter 4. Postnatal care was not specifically mentioned within the NICE (2010) and NCC-WCH (2010) guidelines, with the exception of the PrePare team in Edinburgh, who report extending service attention to the early postnatal phase. These omissions within national policy documents suggest that the provision of care for breastfeeding MMT mothers is relatively underdeveloped in comparison to services which cater for pregnant women.

However I have been able to access a one example in the literature which focuses on this group of mothers. In a rare publication, American paediatricians Demirci *et al.* (2014) describe their recent study exploring maternal perceptions surrounding breastfeeding decisions and the management of four post-partum breastfeeding MMT mothers. Using qualitative content analysis, the authors found that a lack of support from the healthcare community and misinformation represent significant, yet modifiable barriers to successful breastfeeding. Their recommendations are similar to those found within the NICE guidelines (2010). To increase the prevalence of breastfeeding the authors stress the importance of education for clinicians who care for methadone-exposed mothers and infants. Programmes should include a focus on improved communication, as well as learning about the benefits of breastfeeding for this population, and information on up-to-date contraindications (Demirci *et al.* 2014). Despite the above initiatives, programmes and interventions concerning MMT breastfeeding women continue to be limited. This suggests that on-going concerns

about stigmatisation, surveillance and the imputation of legal liability persist as barriers to attending maternity services. For women of low economic status the effects will be particularly detrimental (Ettorre 2007), and contrary to the exhortations of CG 100, some will carry on feeling excluded from sharing their ‘views, beliefs and values in relation to [their] care and that of [their babies]’ (p. 6).

The following section draws on the model of the ‘effect of the professional ego’, as designed by Hart and Freeman (2005), to help explain professional behaviour and attitudes around drug-using mothers.

Professional ego

Traditionally, from a psychological perspective, the word ‘ego’ forms part of Freud’s tripartite model of the mind: the compromise position between the ‘id’ and ‘superego’ (Cohen 2006). The ‘id’ describes the irrational, unconscious appetites and ‘superego’ the conscience, the moral faculty. The ‘ego’ is understood as the idealisation of oneself, stemming from the part of the mind that reacts to reality and is maintained by a sense of individuality and self-esteem. Such explanations help understanding of the term ‘professional ego’ as situated between the ‘professional id’, the seat of instinctive, and supposedly prejudicial, impulses and the ‘professional superego’, their professional conscience. Strategies are used to maintain and defend a sense of who they are.

Around the ‘professional ego’, positioned at the centre of their model, Hart and Freeman (2005) identify two broad aspects of the self, with a number of strategies for protection and development of the ego. In the first and explored further in section 10.4, labelling and stereotyping of out-groups and boundary maintenance help maintain professional self-preservation. Secondly, as part of their statutory role as ‘authoritative experts’, professionals continue to nourish and preserve their grandiose professional self, see below.

Safeguarding issues

Social and healthcare professionals have statutory responsibilities with concerns for safeguarding the health of the babies (Home Office 2009). However, when working with mothers with a drug history, or those engaged in methadone treatment, social workers are not only faced with directives that are designed to prioritise the wellbeing of the children but also they need to protect the rights of parents as vulnerable adults. This suggests a possible tension which can affect or impact negatively on the working relationship between mother and social worker.

In 2009 the Home Office published *Every Child Matters: Change for Children*, with reference to Section 11 (Children's Act 2004): this document urges the greater safeguarding and protection of children as a priority. Social workers are reminded of the: '... duty of specified public bodies and key individuals to carry out their functions having regard to the need to safeguard and promote the welfare of children' (Home Office 2009: p.2).

This report was the result of the earlier discussion Green Paper (Department of Education 2003) and written in response to Lord Laming's inquest into the tragic death of Victoria Climbié. It proposed a range of measures to reform and improve children's care. Children's life chances were discussed as being negatively shaped by certain socio-economic factors, including substance abuse and poor parenting. Subsequently, *Every Child Matters* (Home Office 2009) states the importance of involving families to develop working partnerships and develop confidence :

It is also important to develop a co-operative constructive working relationship with parents or caregivers so that they recognise that they are being respected and are being kept informed. Where there is respect and honesty in relating to parents they are likely to feel more confident about providing vital information about their child, themselves and their circumstances. (Home Office 2009: p.12)

This explicitly states the need to develop relationships in which parents are ‘respected and kept informed’. Implicit within this statement lies the argument that stresses the importance of a working relationship which contains mutual respect for all individuals’ opinions and truth. As stated earlier, existential theory depicts all individuals as defining their own versions of truth (Gaarder 1996). Based on this premise is the realisation that individuals need to communicate and share with others their perceptions of truth within a respectful and equal relationship.

Part of this relationship is dependent on understanding the vulnerability and complex needs of drug-using mothers. However with the primary focus of professional attention on the welfare of the infant and with drug-using mothers described as vulnerable (Department of Health 2007a, Goode 2000), potential safeguarding problems for both baby AND mother can arise. For example, problematic situations can develop where hospital policies direct the immediate admission of babies for monitoring of neonatal abstinence syndrome (NAS) into separate neonatal units (NNU). Although such policies appear to act out of a concern for the health of the infant, and are based on evidence that 60%-90% of all opiate exposed infants show signs of withdrawal (Abdel-Latif *et al.* 2006, Berghella *et al.* 2003), not all babies will require NNU intervention, as explored later in Chapter 5. Separating the baby from the mother is also contrary to evidence that mothers and babies should be kept together and advised to take to the breast as soon as possible to initiate lactation (Abrahams *et al.* 2007, Ballard 2002).

Separation from their babies implies that MMT maternal rights are threatened where policies homogenise all drug-using mothers and babies as ‘embodiments of risk’ and in need of medical intervention (Ettorre 2007). Mothers become secondary to the monitoring and treatment from healthcare professionals. In addition, where they face cultural stereotyped attitudes, there remains little room for developing ‘a co-operative constructive working relationship with parents’ (Home Office 2009: p.12). The Human Rights Act (1988) reminds all professionals with responsibility for the care of drug-using parents that:

Any adult at risk of abuse... should be able to access public organisations for appropriate interventions which enable them to live a life free from...abuse (Association of Directors of Social Services 2005: p.4)

The government document *No Secrets* (Department of Health and Home Office 2000) and subsequent paper *Safeguarding Adults* (Association of Directors of Social Services 2005) define institutional abuse in terms of 'isolated incidents of poor or unsatisfactory professional practice' (Department of Health and Home Office 2000: p.10). Particular concern is expressed where abuse is perpetrated by people in positions of power or authority who use these positions in ways that are detrimental to the health, safety, welfare and general well-being of a vulnerable person (Department of Health and Home Office 2000). Such concerns contravene professional codes of conduct. For instance, current discourse is unequivocal about upholding the dignity of the individuals. Nurses and midwives are required to treat mothers with respect and without discrimination:

Make the care of people your first concern...You must treat people as individuals and respect their dignity...You must not discriminate in any way against those in your care...You must treat people kindly and considerately (Nursing & Midwifery Council 2008: p.3)

Even so, House (2000) is disparaging of some professionals who act in ways that are self-serving. Similar to Hart and Freeman's (2005) 'effect of the professional ego' model, House is critical of the use of language and rituals that not only validates their actions but also have the effect of emphasising their positions of power. The methodological position taken in this study and the number of women interviewed precludes their experiences being defined as institutional abuse. However some of their reported experiences do have resonance with the Department of Health and Home Office (2000), which cites 'isolated incidents of poor or unsatisfactory practice' (p. 10).

3.5 Conclusion

Chapter 3 has examined the dual identity of MMT breastfeeding mothers, and how this influences the concept of motherhood from both a sociological and psychological perspective. Motherhood is recognised as a defining moment for drug-using women. By choosing to focus on becoming mothers and changing their drug-using behaviour, many MMT women embark on a tense journey, which is both personal and public. On the one hand, mothers become involved in an emotional internal world where success at becoming mothers, in the normative sense of the word, is dependent upon their own internal resources. An examination of how the individual's psychological personal constructs influence their response to the world is dependent upon the woman's ability to modify these constructs, which are in themselves dependent upon their history and experience with being mothered and previous mothering of earlier babies.

However, their journey is challenged by an external world, which can either support or challenge this transition and change in identity. Culturally construed as deviant, drug-using mothers face persistent suspicion and distrust from others. In addition, where professionals draw on their own personal constructs and respond to these women as being untrustworthy, mothers have to work very hard to challenge this perception successfully. Chapter 3 concludes by suggesting that, if this group of vulnerable mothers are not treated more favourably and with more empathy, they may be at risk of becoming abused by the institutions that should be protecting them.

Chapter 4 describes the evolution of the research question and details of the search strategy.

Chapter 4: Evolution of the research question and literature search strategy

Following on from the arguments on addiction and motherhood contained in Chapters 2 and 3, Chapter 4 first outlines the evolution of the research question for this study (section 4.1), before describing the iterative search strategy and compilation of a literature database (section 4.2). The ensuing discussion remarks on the preponderance of studies investigating the health concerns of the infant overshadowing the number of publications written about the experiences of the drug-using mothers. Chapters 5 and 6 detail the results of this search strategy as found in the literature.

4.1 Evolution of the research question

Over a period of seven years from when I started thinking about the research in 2005 to the time of writing up in 2012, the research question has been changed many times. Details and development of which, in relation to research design and methodology, are explored later in Chapter 7. The following list is used to demonstrate the changes made from the earliest to the present (emboldened) research question which reflect my reading over the time of this study. Constancy of research interest in breastfeeding opiate using mothers is maintained throughout:

- *Should opiate-using mothers breastfeed?*
- *Why do drug-using mothers not breastfeed?*
- *How do you maximise the potential for opiate using mothers to breastfeed?*
- *What maximises the potential for habitual opiate using mothers to breast-feed?*
- *What is the relationship between breastfeeding and drug-use for methadone-treated mothers?*
- **What is the lived experience of being a mother, dependent on methadone for an opiate addiction, choosing to breastfeed her new-born baby?**

During the course of this project, and often debated within supervision, is the experience of the struggle associated with the complexity of researching breastfeeding

mothers engaged in methadone maintenance treatment (MMT). As a work-related study, my role as a researcher in the early stages of the search strategy was shaped by embedded, practice concerns I had as a professional.

Thus the early search strategy included the exploration of literature that would help address questions of whether or not it is safe to breastfeed. A large amount of biomedical literature was uncovered. However, as demonstrated later and discussed in Chapter 5, the consensus of opinion contained within research-based sources generally conclude that breastfeeding by MMT mothers can be encouraged (*e.g.* Pritham *et al.* 2012, Hendrickson and McKeown 2012, Müller *et al.* 2011, Isemann *et al.* 2011, Jones *et al.* 2008, Jansson *et al.* 2007, Abdel-Latif *et al.* 2006). Worthy of note is the extent to which this literature now overshadows what is written about the mother. After searching the evidence base for some time, it became apparent that the large number of publications written in the interests of the infant eclipsed the paucity of literature about drug-using mothers. A major consequence of this concern for the neonate is defining the area of interest of MMT mothers. In the absence of an alternative perspective, *i.e.*, from the mother herself, this hegemonic biomedical view is sustained and reinforced. Once this imbalance was recognised, the idea of exploring the lived experiences of breastfeeding women was initiated, resulting in a change of direction in the project.

However handling of the infant-related information that had already had been gathered became the subject of discussion and debate within supervision. Arguments ranged between including and excluding these sources, depending on whether or not infant safety issues could be disregarded as an integral part of the study. It was agreed that the hegemonic concern for the well-being of the infant of a MMT mother should be acknowledged within the study. Therefore, a summary of findings of the biomedical literature is included within Chapter 5 and used to construct and demonstrate a carefully considered ethical foundation for the project in terms of infant safety.

In summary, the iterative sophistication of the current phenomenological mother-centred research question became influenced not only by what has been discovered

from the literature, and but also what was missing in terms of the lived experiences of breastfeeding MMT mothers. The absence of empirical sources highlights the unique nature of this study and ultimately shapes the wording and centrality of the breastfeeding MMT mother in the current research question.

4.2 Search strategy

Ultimately, the main objective of the research strategy was to determine what is known, as reported in the literature, about the lived experiences of breastfeeding by MMT mothers. This study is complex, as demonstrated by the arguments contained in the earlier chapters and outlined in the previous section. Listed in a specific, numerical order, which reflects various chronological dilemmas connected to the differing stages of the literature search strategy, are the following three areas of investigation:

- 1. Is breastfeeding by a MMT mother safe for her baby?**
- 2. What are the psycho-social benefits of breastfeeding for MMT mothers?**
- 3. What is known from the literature about the perspective of the MMT breastfeeding mother?**

Queries 1 and 2 were applied during early search strategies and act as ethical foundations to this thesis. The first investigates institutional concerns for the safety and application of breastfeeding for babies born to MMT mothers. The second normalises MMT mothers within the context of breastfeeding and is used to explore reasons why opiate-using mothers should be encouraged to feed. The final area is phenomenological and has direct relevance to the current research question.

This thesis is located within diverse literature on breastfeeding for methadone-treated mothers, including medical, psychology, sociology, midwifery, nursing and third sector (non-statutory) research. As a means of obtaining a deeper understanding of the problem and as a part of the evolution of the research question, the literature search strategy contained a number of approaches within an evolving and iterative process. After a structured literature review in the early stages, further information was sought

from other sources throughout the research study period and during writing up. The initial formal relevant literature was accessed using both manual searches and major electronic search engines, databases and on-line library catalogues. The years added in parentheses indicate the earliest date from when literature sources are included in the search engines:

- Allied and Complementary Medicine (AMED) (from 1985);
- British Nursing Index (BNI) (from 1994);
- Cumulative Index to Nursing and Allied Health Literature (CINAHL) (from 1982);
- DH DATA (from 1983);
- Excerpta Medica (EMBASE) (from 1974);
- Google Scholar;
- Kings Fund (from 1979);
- Medical Literature On-Line (MEDLINE) (from 1951);
- National Health Service (NHS) and Department of Health (DH);
- Psychology Literature (PsychINFO) (from 1806);
- PubMed Central (National Center for Biotechnology Information: NCBI);
- Academic online e-journals, reference journal libraries and PhD theses were accessed from the following libraries: The Universities of Brighton, Roehampton, London (St George's Medical School), Royal College of Nursing (RCN) and the British Library Electronic Theses Online Service (EThoS).

Search terms used within these searches included combinations of the following words:

- Breastfeed;
- Breast-feeding AND/OR lactation;
- Opiate AND/OR opioid;
- Heroin;
- Methadone;
- Methadone-maintenance;
- Opiate-addiction;

- Drug-abuse;
- Mother OR parent;
- Motherhood.

The searches were extended by the use of the ‘wild-card’ symbol \$ to capture references containing this word within the title or abstract, *e.g.*, breastfeed\$. In addition, the search was widened further within elicited journal articles by the use of descriptors to include words within the thesaurus tree and when ‘exploded’ with the symbol #, *e.g.*, breast-feeding. DE. and opiates#.

To guide the initial searches of the literature, as elicited from journal articles, areas 1 and 2 helped to examine aspects of breastfeeding, opiate use/addiction and methadone treatment. As Table 4.1 demonstrates, early searches did not reveal any results for combinations of the words associated with breastfeeding: methadone maintenance, opiate/opioid and heroin. It is also interesting to note from Table 4.1 that when the searches were widened from ‘breast-feeding.DE. AND opiates#.DE’ to include ‘OR opiate-addiction#.DE’ the number of references increased from 0 to 61. This finding suggests that breastfeeding and opiate use appear to be investigated only when set within the context of addiction.

Search terms	Number of References
breast-feeding.DE. AND methadone-maintenance.DE	0
breastfeed\$ AND opiate OR opioid	0
breast-feeding.DE. AND opiates#.W..DE	0
breastfeed\$ AND heroin	0
breast-feeding.DE AND drug addiction #.DE OR drug-abuse#.DE	6
breast-feeding.DE AND opiate#.W..DE. OR opiate-addiction#.DE	61
TOTAL	67

Table 4.1: Results of early search strategy

Mainly written by obstetricians and paediatricians, the literature on the effects of substance-use in pregnancy and in breast-milk generally has a narrow medical and pharmacological focus. Thus, the majority of contemporary research papers remain medically orientated and primarily concerned with the effects of methadone and managing opiate withdrawal in a neonate during pregnancy, at delivery and via breast-milk (*e.g.* Jansson *et al.* 2004, Berghella *et al.* 2003, Ballard 2002, Malpas and Darlow 1998, Kacew 1993).

As explored within Chapter 2, stereotyped understandings of what it means to be opiate dependent evoke responses which may, ultimately, stigmatise and label MMT women as criminal and socially deviant. Extrapolating from this in terms of research priorities is the underlying implication that these mothers are at risk from being prejudiced against and relegated in terms of importance to the infant. The imbalance in the early literature search strategy highlights the lack of research and is demonstrated by an absence of journal sources linking breastfeeding and mothers engaged in methadone drug treatment.

The search was further broadened to include other sources and was guided by the third research area. Thus, in addition to electronic journal searches, later references were hand-searched from published bibliographies and recommendations following presentations of work and through conversation with other interested parties. Specialist free journals, such as *Drink and Drug News*, which are not included within the above databases, were also searched for relevant articles. Other literature, such as reports, textbooks, dissertation abstracts and relevant fictional but informed books were included within the literature review. They act as a means of providing a more extensive understanding of particular topics, the development of philosophical ideas and government strategies relevant to the subject under investigation. The search was limited to English language reports. However, this was not necessarily exclusive. The search often incorporated some foreign language articles which contained abstracts that had been translated into English. In addition, and in the interests of keeping this study

as contemporary and well informed as possible, the National Center for Biotechnology Information (NCBI) was instructed to maintain an ongoing online literature search of the databases using search words as ‘drug-use’, ‘methadone’, ‘mother’, ‘motherhood’ and ‘breastfeeding’.

4.3 Literature database

The findings from these search strategies resulted in the compilation of an excel database. Spanning 27 years, 1985-2012, it lists 90 references and details of the author/s, date, title of publication, methodology, participants, conclusions and the researcher’s comments. To refine the specific contributions they make to the investigation of the current research question, they are categorised under nine major headings. Table 4.2 demonstrates these groupings. It shows that 47 references are ultimately included in the study as being relevant and the decision to exclude 43 references was made on the basis that the information they contain does not bear direct relevance to areas 1, 2 and 3. Appendix 2 contains details of the literature listed according to the relevance of these three questions.

Significance to thesis	TOTAL	Excluded	Included	Included				
				Area 1	Area 1&2	Area 2	Area 2&3	Area 3
Antenatal care	6	5	1	0	0	0	0	1
Breastfeeding	48	14	34	27	6	1	0	0
Drug addiction	6	6	0	0	0	0	0	0
Drug-users	12	6	6	0	0	0	0	6
Methadone	8	6	2	1	0	0	0	1
Mothers	4	1	3	0	0	0	0	3
Neonatal Abstinence Syndrome (NAS)	3	3	0	0	0	0	0	0
Pregnancy	2	2	0	0	0	0	0	0
Rooming-in	1	0	1	0	0	1	0	0
TOTAL	90	43	47	28	6	2	0	11

Table 4.2: Results of search strategy to the three areas

A brief quantitative exploration of the above data demonstrates graphically the preponderance of biomedical literature on the safety of breastfeeding for the neonate, when compared to the paucity of literature about the mothers. The calculation of the percentages reveal that over two thirds (n=34, 69%) of sources accessed for this thesis appear relevant to area 1 (with overlap area 2). As discussed in section 4.1, these sources help establish the ethicality of this study by exploring the safety of breastfeeding for MMT mothers. Of the remaining third of the database (n=13), weightings contribute to the second and third research areas and carry more relevance to the research question because they explore the mothers' perspectives and experience of breastfeeding and motherhood. With a bias weighted in favour of area 1, the uniqueness of this thesis is highlighted and underpinned by the examination of the four major operational terms contained within the research question and categorised within the database.

Three words, namely: 'mother', 'methadone' and 'addiction' are dominated by the term 'breastfeeding', which contains 34 references. In response to area 1, out of the 27 biomedical investigations into the safety of breastfeeding, 26 focus on the safety of the neonate (*e.g.* Hendrickson and McKeown 2012, Pritham *et al.* 2012, Bogen *et al.* 2011, Isemann *et al.* 2011, McQueen *et al.* 2011, Müller *et al.* 2011, Dryden *et al.* 2009, Jansson *et al.* 2008a, Jansson *et al.* 2007, Abdel-Latif *et al.* 2006, Begg *et al.* 2001, Kacew 1993). The final source (number 27) refers to a medical report written by Hepburn (2005), a specialist obstetrician from Glasgow. She notes that where an adequate dose of methadone helps maintain stability throughout pregnancy, breastfeeding is instrumental in keeping mother and baby together. In addition to these references are a further 6 sources which overlap with areas 1 and 2. They discuss the safety and benefits of breastfeeding (Backes *et al.* 2011, Jansson *et al.* 2004, Berghella *et al.* 2003, Phillip *et al.* 2003, Ballard 2002, Heinrichs *et al.* 2002, Lvoff *et al.* 2000). Of these, two papers are of particular interest to this thesis. One, from a medical perspective, comments on the incidental positive effects that breastfeeding appears to have on mothers (Ballard 2002). The second suggests that, despite the evidence base,

the power that clinicians have in ‘allowing’ mothers to feed, may be used negatively (Phillip *et al.*2003).

In the first paper, Ballard (2002), an American neonatologist, undertakes a clinical observation study on the management of the neonatal abstinence syndrome (NAS) with breast milk containing methadone. Aside from a clinical discussion on the positive treatment this has on alleviating symptoms of NAS, Ballard observed mothers deciding how to wean the baby from methadone when breastfeeding for longer than 2 months. This can either be done by reducing their own dose of methadone, or transferring the babies to formula feeding. She observed that most of the 10 mothers chose to decrease and stop methadone and continue feeding. Her conclusion, from a medical perspective, maintains clinical concern for the infant by recognising breastfeeding is a safe method for the amelioration of NAS. However, she also recognises the positive effect breastfeeding has on the mothers’ self-esteem.

In the second paper by Phillip *et al.* (2003), three medical doctors working within the Boston University Medical Breastfeeding Centre, review breastfeeding policies following a reappraisal of earlier recommendations by the American Academy of Pediatrics (AAP). Dating from 1983 to 2001, breastfeeding was only encouraged where the daily dosage of methadone was less than 20mgs. This restriction was overturned in the face of increasing evidence that emphasised the compatibility of methadone with breastfeeding. Even so, the authors observe that;

It is naïve...to expect that all health care providers will receive the recommendation enthusiastically. Breastfeeding is already an emotional topic about which clinicians are undereducated. To ‘allow’ or more appropriately, to encourage this particular population group to breastfeed will bring unique challenges (p.1480).

In light of the observation that encouragement to breastfeed might be lacking (Phillip *et al.* 2003), it is interesting to note nothing could be found within the literature database

about breastfeeding from the perspective of MMT mothers. This absence is further demonstrated when looking at references to the other three operational terms, where in comparison to 'breastfeeding', the amount of literature available appears minimal. Relevant literature for 'Mother' (n=3), 'Methadone' (n=2), and '(drug) addiction' (n=0) includes only five studies. Even when combined with the term 'drug-user' (n=6), this number only increases to 11. With relevance to area 3, these studies investigate the following issues:

- Constructions and narratives of mothering, managing the identities of drug-user and mother through discussions with substance-abusing mothers and pregnant women (Radcliffe 2011, 2009, Litzke 2008, Radcliffe and Stevens 2008, Banwell and Bammer 2006, Hall and Teijlingen 2006, Murphy and Rosenbaum 1999);
- Analysis of stereotypes of drug-using parents and the deviant embodiment of drug-using mothers (Fraser *et al.* 2009, Ettorre 2007, Goode 1999, Klee 1998).

In summary there are 34 references in the literature database compiled for this study which investigates concerns for an infant of a breastfeeding MMT mother. This finding indicates compatibility between the two. However there are no sources which look into the lived experience of the mother herself.

It is tautological to state that the bias towards biomedical studies results in an inequality of publication within the evidence base, an observation that was often debated within supervision. Although lying outside of the remit of a chapter on search strategy, it is important to recognise that this experiential area of research is overshadowed by the hegemonic political economy of research. For instance, prompted by continuing concerns for breastfeeding the neonate by a methadone-treated mother, Hendrickson and McKeown (2012), Backes *et al.* (2011) and Müller *et al.* (2011) note that, in recent years, the numbers of publications have increased as more MMT mothers are deciding to breastfeed. Using information taken from the database compiled for this study, Table 4.3 demonstrates nearly twice (from 17 to 30) as many publications over the past 7

years (2005-2012), as compared to the previous 11 years (1993-2004). The rise in publications is particularly noticeable within areas 1 and 3. However, with 8 papers published in recent years with relevance to area 3, and 20 responding to area 1, such numbers continue to demonstrate that the amount of biomedical research and literature continue to dominate the evidence base within this field of interest.

Research areas	1	1 & 2	2	3	TOTAL
1993 – 2004	8 (29%)	5 (83%)	1 (50%)	3 (27%)	17 (36%)
2005 – 2012	20 (71%)	1 (17%)	1 (50%)	8 (73%)	30 (64%)
TOTAL	28 (100%)	6 (100%)	2 (100%)	11 (100%)	47 (100%)

Table 4.3: Increase in publications since 2005

As a major source of data, biomedical studies describe various methods to measure methadone levels in the mother and baby, via breast milk and venous samples (*e.g.* Bogen *et al.* 2011, Jansson *et al.* 2008b, Jansson *et al.* 2008a, Jansson *et al.* 2007, Abdel-Latif *et al.* 2006, Begg *et al.* 2001, McCarthy and Posey 2000, Wojnar-Horton *et al.* 1997). Although some include dyads, the numbers involved are small. These range from 4 investigated by Jansson *et al.* (2008b) to 20, included within Bogen *et al.*'s (2011) more recent study.

This suggests that; whilst higher of numbers of publications imply the persistent hegemonic authority of biomedical research, the continued investigation into the safety of breastfeeding may be prompted by small numbers of participants recruited into these studies. As noted earlier in Chapter 2, and suggested by Phillip *et al.* (2003) above, the population of this client group is limited. Biomedical sample sizes are often associated with larger populations, which promote the 'generalizability' of the data. However, due to the small numbers of MMT breastfeeding mothers and babies, recruitment problems indicate potential dilemmas related to the understanding and use of data. Such was the argument used by Jansson *et al.* (2008c) in response to a letter by Liu and Nanan (2008). The authors make reference to the six-year retrospective study undertaken by Abdel-Latif *et al.* (2006) looking into the effects of breast milk on the severity and outcome of NAS. This seminal Australian study took place within a hospital for women and managed to recruit 190 drug-dependent mother/baby dyads. Even though the study is set within a specialist women's hospital, and with these numbers averaging out as access to 11 MMT breastfeeding mothers/year over the six-year duration of the study, the numbers of mothers they could access remained limited. Described by the authors as the first large scale study in this area, it was necessary to incorporate a longitudinal design to capture the small numbers of MMT breastfeeding mothers.

Thus, one method for overcoming this problem within biomedical paradigms is to conduct larger retrospective studies. One study undertaken by Lvoff *et al.* (2000), investigated 26,616 deliveries within a Russian hospital over a 12-year period. Such

studies are not possible when exploring the life experiences of mothers, and no retrospective studies with relevancy to area 3 were included within the database used for this thesis.

4.4 Summary

Chapter 4 has detailed the iterative search strategy over the course of this thesis, from 2005 to the time of writing up in 2012. Arising from the evolving process of searching the literature for information on the safety and benefits of breastfeeding, the final research question demonstrates the development of the enquiry into an experientially-focused study. This change is explored further in Chapter 7. Contents of the database devised for this study demonstrated the preponderance of biomedical research when compared to the paucity of literature from breastfeeding MMT mothers' perspectives. The absence of any literature in the area concerned with MMT mothers underscores not only the dominance of concern for the infant which continues to define this area of interest but also underscores the originality of this project. Findings within the literature unearthed for the purposes of the three search strategy areas are discussed in Chapters 5 and 6.

Chapter 5: Evidence for the safety, and benefits, of breastfeeding

As described in Chapter 4, identification of the final research question was the result of the exploration and thorough review of the literature. The responses to the three areas of the search strategy are used to frame and structure the following two chapters. Chapter 6 mirrors the phenomenological approach used in this thesis, and thoroughly explores the literature considered pertinent to area 3. Initially, however, Chapter 5 contextualises these findings by outlining the biomedical literature uncovered in response to areas 1 and 2. Acting as an evidence-based foundation, this provides an ethical framework for the safety and benefits of breastfeeding for a baby born to a mother in methadone maintenance treatment (MMT). However, as this literature is not central to the analysis of the research question, the amount of space given to these biomedical studies is restricted.

Emerging from the dominant biomedical literature from the past 20 years, and in contrast to the encouragement to breastfeed, is an implicit scepticism regarding the safety of breastfeeding for infants born to MMT mothers. In response to area 1, three major clinical concerns frame the ensuing discussion (section 5.1). Firstly, the presence of methadone in breast milk is generally noted as being safe when MMT mothers breastfeed (section 5.1.1). Secondly, concerns to correlate lower doses of methadone with the incidence of neonatal abstinence syndrome (NAS) are balanced against issues related to managing maternal health and limiting the craving for illicit heroin (section 5.1.2). Thirdly, breastfeeding helps ameliorate symptoms of NAS, with reduced hospital stays and costs (section 5.1.3).

Guided by area 2, section 5.2 explores the literature which discusses the physiological and psycho-social benefits of breastfeeding for mothers. As a case study, reference is made to a Russian hospital which introduced policies in accordance with the United Nations baby friendly hospital initiatives (BFHI). Section 5.3 concludes by suggesting there is sufficient evidence to indicate that breastfeeding should be actively supported

and encouraged as infants and mothers benefit from being together in the early days of life.

5.1 Safety concerns for the baby

Search Strategy Area 1: Is breastfeeding by a MMT mother safe for her baby?

This section addresses three major concerns for the infant which are raised by clinicians and researchers when facing a mother who is prescribed methadone and wishes to breastfeed:

1. Concerns about infant exposure to breast milk containing methadone;
2. Concerns that the withdrawal from methadone causes neonatal abstinence syndrome (NAS) that will need monitoring and treating;
3. Concerns as to the efficacy of breastfeeding in ameliorating NAS symptoms.

5.1.1 Exposure to methadone in breast milk

Generally speaking, all mothers are encouraged to breastfeed because of the advantageous physiological processes that help the development of the infant and potential wellbeing of the family. Where mothers are in receipt of any prescribed medication, reviews in the emergent literature have generally concluded that breastfeeding is not contraindicated. Such was the conclusion of a discussion paper by Kacew (1993) looking into the adverse effects of prescribed medication in breast milk on the nursing infant. Although this paper is now dated in terms of years, and methadone was not specifically mentioned, his statement that the advantages of breastfeeding outweigh the potential disadvantages remains constant throughout the ensuing debate.

In their discussion paper, aimed at informing professionals involved in the care of MMT mothers, Jansson *et al.* (2004) reviewed the arguments for and against breastfeeding and explored various issues of concern and the on-going debates between

care providers. Drawing from a list of 58 references, ranging from 1974 to 2003, they cited the recognition of the benefits to the general population of infants, inasmuch as breast milk helps promote positive long-lasting influences beyond the early babyhood stage. They note that whilst breast milk helps with early brain development, improvements in cognition and intellect continue to develop in early and middle childhood. In addition to providing passive immunity to infection and protecting against sudden infant death syndrome, Jansson *et al.* (2004) observe that breastfeeding also promotes interaction and bonding between the mother and child. They describe a strong physical and emotional attachment between mother and baby as a protective factor in helping to protect babies born to drug-using women which, in the long term, may help to break the cycle of multi-generational drug-abuse in families. This is an important argument. From research conducted for Turning Point (2006), a leading provider of substance misuse services in England and Wales, offspring of drug-using parents were noted to be more at risk from abuse, neglect and developing mental, emotional, behavioural and medical problems, than those born to homes with no substance misuse problems.

However, Hendrickson and McKeown (2012) observe that, as rates of breastfeeding by MMT mothers appear to be increasing, clinicians continue to express concern about the amount of methadone being transmitted to infants. After an extensive review of the literature to find out if common opioids, such as methadone, can cause breast milk contamination and risk exposing the neonate to opiate intoxication, Hendrickson and McKeown (2012), together with Müller *et al.* (2011) have been able to substantiate findings within earlier studies. For instance, with only a very small amount of methadone (2.2-2.8% daily dosage) being transmitted to breast milk (Abdel-Latif *et al.* 2006, Ballard 2002), breastfeeding by methadone-treated mothers is advised, regardless of the amount of methadone prescribed (*e.g.* Bogen *et al.* 2011, Glatstein *et al.* 2008, Jones *et al.* 2008, Winklbaaur *et al.* 2008, Anderson *et al.* 2003, Wilbourne *et al.* 2001, Geraghty *et al.* 1997). With the advantages of breastfeeding outweighing the risks of harming the new-born, recent studies by Hendrickson and McKeown (2012), together

with Müller *et al.* (2011), continue to corroborate previous evidence that breast milk containing methadone does not appear to compromise infant safety.

5.1.2 Correlation of methadone with the incidence of Neonatal Abstinence Syndrome

In two separate studies looking at the correlation between foetal exposure to methadone and the severity of NAS, Dashe *et al.* (2002) and Doberczak *et al.* (1993) observe that, with intensive medical and psychosocial support, many pregnant women successfully complete methadone detoxification, resulting in the decreased incidence and severity of neonatal withdrawal. For those mothers who continue to be treated with methadone in pregnancy, exposing the foetus to opioids may cause problems after delivery, with some new-borns exhibiting symptoms of opiate withdrawal (*e.g.* Dryden *et al.* 2009, O'Grady *et al.* 2009, Abdel-Latif *et al.* 2006, Ballard 2002, Malpas and Darlow 1998, Kacew 1993). Thus, whilst there remains a concern for the new-born, healthcare professionals might be tempted to reduce the methadone dosage during pregnancy to mitigate the occurrence of NAS.

However, the reduction of methadone during pregnancy might prove harmful to the foetus because of the risk of craving and use of illicit heroin. In a very early study which measured the plasma levels of nine pregnant MMT mothers, Pond *et al.* (1985) observed that, as methadone metabolism is enhanced during pregnancy, an increased dosage may be required during pregnancy to achieve methadone maintenance and prevent withdrawal and craving. This argument was later supported by Berghella *et al.* (2003) in a retrospective study of 100 case notes, investigating the correlation between lower NAS scores from babies born to mothers on higher doses of methadone. They noted that higher doses minimise the dangers to women and the growing foetus by removing cravings and drug hunger for additional illicit drugs along with the associated lifestyles, *e.g.*, criminal activity, prostitution, infections, such as HIV, Hep C, and sexually transmitted diseases, with increased morbidity and mortality rates. This finding is refuted by Kashiwagi *et al.* (2005). After a 5-year prospective study of 89 pregnant opiate addicts and their neonates, they are alone in the database created for

this thesis in advocating that methadone maintenance is inefficient in preventing pregnant women's exposure to additional illicit drug consumption.

However, the calculation of the optimal dose of methadone, which both maintains maternal health and minimises infant opiate withdrawal symptoms, appears to be still under debate within the literature. Symptoms of NAS are generally experienced in methadone exposed new-borns, although the dosage continues to be unclear. Jansson *et al.* (2004) note in their literature review that, despite the amount of methadone prescribed to mothers, NAS symptoms are observed in 60%-90% of all opiate exposed infants. Dashe *et al.* (2002) advise that there is no correlation between maternal methadone dosage and NAS, a finding later substantiated by Berghella *et al.* (2003). They concur with Jansson *et al.* (2004) in recognising that 70% infants experience withdrawal from methadone regardless of the maternal daily dosage. In addition, Berghella *et al.* argue that more mothers could benefit from effective methadone dosing in late pregnancy than reducing the dosage to offset neonatal harm. However, their conclusions are diametrically opposed to other studies. Findings that NAS scores do correlate with methadone dosage are supported by Abdel-Latif *et al.* (2006), described earlier in Chapter 4. They assess the results of breast milk on the severity and outcome of neonatal abstinence syndrome. They conclude that higher NAS scores were more common where mothers were treated with high doses of methadone. In a study that links arguments promoting breastfeeding to help ameliorate symptoms of NAS, Isemann *et al.* (2011) undertook a more recent retrospective review of the pharmacotherapy for opiate withdrawal in 128 babies. They concluded that the severity of NAS could be offset by reducing methadone to the lowest effective dose during pregnancy and encouraging breast milk feeds.

5.1.3 Breastfeeding as a treatment for NAS

Running parallel to the inconclusive arguments concerning a possible correlation between methadone dosage and NAS symptoms, the debate over the usefulness of breastfeeding in alleviating opiate withdrawal symptoms in the infant also remains

open ended. Discussions range from it not being useful to recognising the benefits of the physicality of breastfeeding in pacifying infants.

In the first instance, after comparing venous and breast milk levels of methadone in 8 dyads, Begg *et al.* (2001) conclude that the small amount of methadone in breast milk might not be sufficient to ameliorate NAS. However, an example in contrast to this is that Dryden *et al.* (2009) favour the positive impact of breastfeeding. After undertaking a 2-year retrospective study investigating any factors associated with the development of NAS, they conclude that a high methadone dosage does correlate with a higher incidence of NAS (nearly 46% of infants developed symptoms). In addition, they observe that symptoms are ameliorated when babies are breastfed for over 72 hours. Their findings add to the weight of evidence that breast milk containing methadone is linked to an amelioration of NAS symptoms (*e.g.* Hendrickson and McKeown 2012, Bogen *et al.* 2011, Müller *et al.* 2011, Glatstein *et al.* 2008, Liu and Nanan 2008, Jansson *et al.* 2008a, Jansson *et al.* 2008b, Jansson *et al.* 2007, Abdel-Latif *et al.* 2006, Jansson *et al.* 2004, Anderson *et al.* 2003, Begg *et al.* 2001, McCarthy and Posey 2000, Wojnar-Horton *et al.* 1997, Geraghty *et al.* 1997, Pons *et al.* 1994, Kacew 1993).

The influence of breastfeeding on the symptoms of NAS, whether or not this is due to the presence of methadone in breast milk and/or due to the physicality of feeding itself, were subjects of speculation within the letters written to the journal *Pediatrics* in 2008. The discussion was initiated by the publication of a study undertaken by Jansson *et al.* (2008a). Investigating methadone maintenance and breastfeeding in the neonatal period from a sample of eight MMT breastfeeding women and a matched group of formula-feeding women, they concluded that breastfed babies fared better than formula fed, even though the difference was not statistically significant. Jansson *et al.* (2008a) describe favouring feeding by MMT mothers because: ‘the intake of breast milk was associated with reduced NAS severity in infants’ (p.106). However, after reading their paper, Liu and Nanan (2008), questioned whether the benefits of breastfeeding could be associated with the physicality of feeding rather than the levels of methadone: ‘the

effects of breastfeeding are ... more related to the mother-child bonding and swaddling experience than to the components of breast milk' (p.869).

In reply Jansson *et al.* (2008c) conceded that the amelioration of NAS symptoms could also be dependent on physical contact, but that was difficult to investigate because of the small numbers of mothers involved. However, this is not demonstrated in the study undertaken by Abdel-Latif *et al.* (2006), cited by both Jansson *et al.* (2008a) and Liu and Nanan (2008). Out of a total of 190 pairs of drug-dependent mothers and infants, 85 babies were fed breast milk, either directly (n=58) or via gavage tube feeds (n=27). With the improvement of NAS symptoms noted in both sets of breastfed babies, Abdel-Latif *et al.* (2006) suggest that, even though the amounts of methadone in breast-milk are small, they are sufficient to ameliorate opiate withdrawal symptoms. Nonetheless, Liu and Nanan (2008), together with Jansson *et al.* (2008c) agree that breastfeeding has holistic benefits which help soothe agitated infants in opiate withdrawal. However, as these babies may thrash at the breast, clamp down on the nipple, cry a lot and not achieve the alert state required for successful nursing, Jansson *et al.* (2008c), together with the observations from neonatologist Ballard (2002), advise a breastfeeding mother receive specialist encouragement and support.

Further evidence also indicates that, despite clinical concerns for infants which necessitate monitoring and treatment, breastfed babies are being discharged earlier from hospital than those who are formula fed (Isemann *et al.* 2011, McQueen *et al.* 2011, Abdel-Latif *et al.* 2006, Ballard 2002). Abdel-Latif *et al.* (2006) note that, where infants received pharmacological treatment for NAS, their lengths of stay in hospital ranged from 10 to 20 days. The hospital stay was decreased to 6 to 10 days in breastfed babies, and there were fewer noted opiate withdrawal symptoms. In addition, findings from a retrospective UK study undertaken by Goel *et al.* (2011) suggest that an earlier discharge from hospital, facilitated by being able to diagnose NAS within five days, could help encourage more women to continue breastfeeding when they go home. However, only 26 (14%) of the original total of 186 mothers were breastfeeding on discharge. Written in 2011, Goel *et al.*'s calculation is five times less than the 73% of

MMT mothers reported to be breastfeeding when discharged home in New Zealand in 2003 (Phillip *et al.* 2003). The inference can be made that mothers with a history of substance abuse are not being actively encouraged to breastfeed in the UK, or that they lack the confidence and/or support to continue when they go home.

These data may reflect the recent UNICEF report that the UK has the lowest breastfeeding rates in Europe (United Nations Children's Fund 2012). Although this report was not available during the original search strategy, its subsequent publication is used here to underscore the poor feeding rates in the UK. The data refer to all mothers and not specifically to those in drug treatment. Whilst 81% of women were reported as initiating breastfeeding, over half of these mothers had stopped within six weeks. The report noted that 90% of women who had stopped described not wanting to but felt they needed to in the face of socio-cultural or clinical problems. In the interests of this thesis and of concern to drug-using women, extra encouragement to breastfeed is indicated as mothers appear less likely to want to feed unless they live in relatively affluent circumstances and with well-educated parents. In response to the UNICEF report, Health Minister Dr Dan Poulter pledged an extra 4,200 health visitors by 2015 to help support new mothers breastfeed (Smith 2012). As indicated in Chapter 6, such professionals will need specialist education to support more socially marginalised mothers, such as MMT mothers, in their efforts to feed.

Although the UNICEF report outlined the economic benefits of breastfeeding, these were stated in terms of longer term health outcomes for mother and infant, as outlined by Jansson *et al.* (2004). In terms of shorter hospital stays, breastfeeding by drug-using mothers is also being demonstrated as the cheaper option in terms of health economics (Pritham *et al.* 2012, Backes *et al.* 2011, Abdel-Latif *et al.* 2006, Ballard 2002). For instance, Backes *et al.* (2011) conducted a study into 121 mothers who received MMT whilst pregnant, with the objective of comparing the safety and efficacy of a traditional inpatient-only approach with a combined inpatient and outpatient methadone treatment programme. Out of a total of 139 neonates, 75 were treated longer in hospital (average 25 days). Of the 64 babies who were discharged early to the community, their hospital

stay was shorter, an average of 13 days. Breastfeeding was three times more common among infants treated in the community (24 vs. 8%). Even though this is an American study, Backes *et al.* (2011) were able to demonstrate the economic benefit of discharging babies earlier from hospital that could be applied to hospitals in the UK. With babies being discharged on average 12 days earlier, Backes *et al.* (2011) calculated that hospital costs were reduced by \$13,817 (approximately £8,500) for each baby when compared to traditional NAS inpatient treatment. Thus, with breastfed babies apparently going home earlier, this makes economic sense in terms of hospital treatment costs: breastfeeding appears to have wider-ranging benefits which go beyond mother and infant.

5.2 Benefits of breastfeeding for mother

Search Strategy Area 2: What are the physiological and psycho-social benefits of breastfeeding for mothers?

Breastfeeding mothers benefit emotionally from the physiological effects of lactation. With the suppression of the secretion of stress-responsive neurohormones and the short-term inhibition of cortisol reaction to mental stress, mothers experience a reduction in stress response (Jansson *et al.* 2004). As soon as women start breastfeeding, the hormone oxytocin is released to help in the let-down of milk and that contributes to the promotion of bonding between the mother and baby. Where breastfeeding mothers feel trusted, Wilkinson and Pickett (2010) suggest there might be a reciprocal reinforcing response in the secretion of oxytocin. This is particularly important for drug-using women. As discussed in Chapter 6, they are more likely to be treated with suspicion than trust. However, when trusted to breastfeed their infants, and with an increased secretion of oxytocin, they benefit from the many advantages associated with this hormone. For instance, the release of oxytocin was noted to: 'result in slight sleepiness, euphoria, raised pain threshold, and feelings of increased love for the infant' (Lvoff *et al.* 2000: p.476). Breastfeeding also helps to protect the mother from an overreaction to stressful stimuli (Heinrichs *et al.* 2002). They note that women

suffering from depression and mood disorders describe welcoming the positive psychological changes associated with breastfeeding.

To establish breastfeeding, baby-friendly hospital initiatives and 'rooming-in' arrangements keep mother and baby together from the time of delivery. With babies fed every 40-90 minutes (Lvoff *et al.* 2000), mothers receive hourly rises in oxytocin, resulting in continued feelings of warmth and love for the baby. This promotes bonding between mother and baby. Where babies are introduced to the breast in the first hours of life, researchers describe how mothers want to keep their infants within immediate reach. In the interests of MMT mothers, Abrahams *et al.* (2007) note that, in addition to promoting maternal attachment and a reduction in infant abandonment, rooming-in reduces the prevalence and severity of NAS. To explore the very positive impact that the United Nations' baby-friendly hospital initiatives (BFHI) has had on mothers, Lvoff *et al.* (2000) demonstrated that problems of infant abandonment are offset by such welfare reform programmes. They argue that keeping mother and baby together from the time of delivery helps in the development of mother and baby interaction.

Over a 12 year period from 1987 to 1998, Lvoff *et al.* (2000) explored the possible contributory factors to infant abandonment in a maternity hospital in St Petersburg described as serving a working class community. According to Russian law, a baby is considered abandoned when the mother signs a release form transferring care over to the state. Although separation from their baby is a major fear cited by drug-using mothers, the subject of infant abandonment as defined in terms of 'signed transfer' is not of primary interest to this study. However, of benefit to this research is the authors' observation that the first hours and days of being a mother is vital, a time when she is psychologically prepared to accept her infant as her own. When mothers are denied this time, the mother and baby dyad is affected. Such is the case of babies born to drug-using mothers. At birth, they may be removed into neonatal units for monitoring and the treatment of NAS (Abrahams *et al.* 2007). As a result, mothers who wish to breastfeed may experience bonding problems which, in some cases, could ultimately result in the surrender of the infant's care to the state.

The Russian study describes scenarios parallel to those experienced by drug-using mothers in hospitals in this country: in particular, babies being separated from mothers at birth, the primary supervision of infant care by nurses and other professionals and longer lengths of stay in hospital. Lvoff *et al.* (2000) note that from 1987 to 1992, Maternity Hospital 11 in St Petersburg followed the regulations as laid down by the Administration of Maternal and Infant Health. These regulations stipulated that, immediately after birth, babies had to be separated from their mothers so they could be 'stabilised' in a nursery for 8 hours. Mothers had no contact with them during this time. Afterwards, babies were taken to their mothers for supervised 30-minute bottle feeds, a process that was repeated six times a day. The results show that, during an average 8.8 day stay in hospital, babies and mothers were together for 13% of this time, and under the care of nurses in a nursery for the majority of their stay.

In 1992, Maternity Hospital 11 made changes to delivery room practices in which mothers delivered and stayed in private rooms instead of sharing with 6 to 8 other women. It also introduced BFHI. Even though, at the time, Russia was described as experiencing a period of economic decline during the transition to a market economy, the results of the study underline the effect that institutional policies have on mother-infant interaction. Out of a total of 15,802 babies born between 1987 and 1992, 79 had been abandoned: an average rate of 50/10,000 births. After the initiation of BFHI in 1992, 10,814 babies were born in the 6 year period up to and including 1998, and only 30 babies were abandoned: an average of 28/10,000 births. The type of first feeding changed from bottle to breastfeeding and the average length of stay reduced from 8.8 to 7.1 days. With a reduction of 44% in the numbers of babies signed over to state care, the results indicate a dramatic change in the lives of both mother and baby.

To emphasise their findings, Lvoff *et al.* (2000) compare their results to abandonment rates in another maternity hospital in St Petersburg which did not implement BFHI. Compared to a 44% decrease within Maternity Hospital 11, they note that over the same period of time, the rates of abandonment in the other hospital increased by 32%. They cite other studies which identify the importance of early contact with suckling and rooming-in. For instance, Buranasin (1991) explored the results of rooming-in

facilities when instituted in a Thai hospital and showed that mother-infant separation time was reduced from 6.3 to 3.1 hours and infant abandonment reduced from 33 to 1 infant/10,000 births. A similar finding was also demonstrated when BFHI was introduced in Costa Rica (Mata *et al.* 1988). Historically, in France, it has been demonstrated that, when mothers spend 8 days or more breastfeeding, they are less likely to give up their babies (Fuchs 1987).

5.3 Summary

The biomedical literature uncovered for this thesis demonstrates that although the amount of methadone being transmitted to the infant continues to cause debate amongst clinicians and scientists, publications appear to agree that, as the amount of methadone in the breast milk is low, feeding does not appear to put the infant at risk. Studies have also indicated that, when breastfeeding is considered holistically, the physicality and methadone content appear to ameliorate symptoms of NAS. In addition, Abdel-Latif *et al.* (2006) suggest that, as mothers need dedication and commitment in order to breastfeed successfully, they might constitute a self-selecting group of socially well-adjusted and, perhaps, more capable women. Such commitment is demonstrated whilst pregnant, inasmuch they are more likely to have comprehensive antenatal care, less likely to be poly-drug-users or noted as at-risk parents. In addition, as advocated by Ballard (2002) and Abrahams *et al.* (2007), to facilitate this process, mothers who prefer to breastfeed are more likely to succeed when putting their baby to the breast as soon as possible to initiate lactation, especially within rooming-in situations which keep them near to their baby.

Lvoff *et al.*'s (2000) study demonstrated positive results following the introduction of the United Nations' baby-friendly hospital initiatives. Although the numbers of deliveries dropped by nearly 5,000 over the 6 years following the introduction of the initiative, a phenomenon unexplained within their paper, the reduction of 44% in the abandonment rate appears to be dramatic and convincing. Such results can be interpreted favourably for MMT mothers. Breastfeeding within rooming-in arrangements promotes bonding between mother and baby. With the promotion of early

suckling, this impacts on institutional policies that advocate the removal of babies into separate units for monitoring and treatment of NAS. However, as demonstrated in Chapter 6, with drug-using mothers stereotyped as deviant, their treatment by professionals is compromised. With limited insight and understanding of this client group, mothers are treated with suspicion and distrust which undermines compassion and empathy.

Chapter 6: Exploring mothers' perspectives within the literature

Search Strategy Area 3: What is known from the literature about the perspective of the mother about her experience of motherhood?

6.1 Introduction

The search strategy in Chapter 4 did not identify any sources in publications written in English, which referred directly to the lived experiences of breastfeeding mothers undergoing methadone maintenance treatment (MMT). However as indicated in Chapter 3, where mothers appear in the literature, it is often within a framework of individualised psychopathology. Underpinning these discussions are the notions of the social construction of deviant motherhood. With biased public perception influencing the implementation of management strategies and policies aimed at helping drug-using mothers (*e.g.* McKeganey 2003, Bear and Tigges 1993), early motherhood experiences for these women are undermined by a lack of professional education about breastfeeding (*e.g.* Schanler *et al.* 1999, Freed *et al.* 1995).

Chapter 6 explores what has been researched in terms of drug-using women's experiences of motherhood. With findings in the literature generated from conversational interviews, the literature sources help identify the personal dilemmas faced by drug-using mothers. Aided by the use of direct quotations, they help shed light on mothers' experiences. As much of the literature refers to stereotyped treatment of drug-using mothers, section 6.1.1 briefly revisits the notion of the deviant embodiment of drug-using mothers (Ettorre 2007, Murphy and Rosenbaum 1999). Mentioned in previously in section 3.1, Murphy and Rosenbaum's (1999) study on 'Pregnancy and Drugs' is detailed in section 6.1.2, with recommendation for empathetic care included in section 6.1.3. Integrated treatment, as demonstrated by the Aberdeen clinic (Hall and Teijlingen 2006) highlights the positive influence of a service that is well-informed and mother-centred (section 6.1.4).

However, in the absence of such facilities mothers become stigmatised through association with traditional treatment centres who care for chaotic and problematic drug-users (Radcliffe and Stevens 2008) (section 6.1.5). The professional stigmatisation of drug-using parents is heavily based on the perceived risks they pose to their children (Klee 1998) (section 6.1.6). In addition to exploring the tension between perceived deviant and being a mother, Banwell and Bammer (2006) describe the complex ethical difficulty of researching the lived experience of drug-using mothers (section 6.1.7).

The final four sections explore how mothers try to manage their deviant identities, especially when supported by consistent, appropriate and non-intrusive social workers (Fraser *et al.* 2009). They work, not only within the social construction of motherhood and perception of the moral career of treatment (Radcliffe 2011, 2009), but also within the wider context of living within a patriarchal society (Goode 1999) in which mothers appear to assert their right to represent their own identities and to resist the public discourse on drug-using mothers (Litzke 2008).

6.1.1 Embodiment of risk and wayward wombs

As explored earlier in Chapter 3, drug-using mothers are associated with deviance that challenges the normative construction of motherhood. In a similar way to Ettorre's (2007) use of the phrase 'embodiment of risk' (p.95) to describe drug-using mothers, Murphy and Rosenbaum (1999) devise their own phraseology; 'wayward wombs'. Representing their feminist perspective, they deliberately describe choosing the word 'womb' because women continue to be defined by their reproductive functions. The adjective 'wayward' is used to imply that the women's drug-using behaviour sets them apart from normal social constructions, identities and roles associated with motherhood.

The polarity between the actualisation of their femininity, contrasted with their perceived deviancy, is situated at the core of what is found within literature about drug-

using mothers' lived experiences. Described here in Chapter 6 are some of the debates that encompass various struggles within these two perceived opposing identities.

6.1.2 A study of pregnant women on drugs

In their exploratory study, Murphy and Rosenbaum (1999) interpret information gathered from conversations with 120 drug-using mothers in the San Francisco Bay area. They do not state whether this is a deprived part of the city, favoured by drug-users. They specifically target women who used heroin and stimulants (cocaine, crack and methamphetamine), because these illicit drugs pose serious health risks to mother and child. With the study funded by the National Institute on Drug Abuse, the aim of the investigation was to inform: 'humane, pragmatic policies to reduce the harms associated with drug-use during pregnancy' (p.15).

From a research team described as six middle-class post-graduate women, the two principal investigators author a 184 page book to describe their in-depth study which took place over a ten-year period. This is divided into 6 chapters, with four directly related to the study's findings and discussion. Methodological and theoretical perspectives are explored in appendix 1. The goal of the study is described as gaining an understanding of social and social-psychological processes that characterise drug-use during pregnancy. Citing the words of John Lofland (1971), they aspired to understand life as their respondents saw it:

...This does not mean the one becomes an apologist for them, but rather that one faithfully depicts what goes on in their lives and what life is like for them, in such a way that one's audience is at least partially able to project themselves into the point of view of the people depicted... (Murphy and Rosenbaum 1999: p.160).

With Murphy portrayed as a student of later feminism (1986-90s), and Rosenbaum a product of 'blurred genres' and early feminism (1970-86), they describe referring to four closely-related theories that help focus on representing the participants in their own terms, namely; phenomenology, symbolic interactionism, postmodernism and

feminist theory. Of particular interest is their use of phenomenological theory which places the mother and her meaning-making process at the centre of the analysis. Furthermore, and discussed below with relevance to this study, feminist methods of data collection were used to reflect a 'more humane, interactive and equitable approach' (p.161). These were said to require reflexivity by the researchers, sensitivity to the relationship within the interview and the input of participants in data collection and analysis.

The 120 women recruited into the study were divided into three stages. In particular, the third group included 39 mothers who were no more than 6 months postpartum. From this list only 16 used heroin, and only one was reported as taking methadone. Moreover, women who said they had been engaged in drug treatment for more than five days were excluded from the study. Murphy and Rosenbaum rationalised this exclusion by restricting the study to women with re-established drug patterns because they wanted to explore why they had left treatment. Unfortunately, as the layout and index of the book does not facilitate access to quotations from specific women, I was unable to delve into the experiences of one specific postpartum MMT mother. As there is no reference to breastfeeding, it is impossible to know what happened to this woman in terms of feeding and caring for her baby.

Murphy and Rosenbaum describe using a combination of sampling and recruitment methods. Joint quota and chain-referral sampling were described as helping to locate and recruit subjects. They developed race and social class quotas for each of the three stages, although the descriptions for these are not made explicit and, as a descriptor, social class is not mentioned within the list of project participants. However, as recruitment of middle-class women was reported as being hampered by professional prejudice, this suggests an imbalance of social class representation in the study.

The stigma conferred on pregnant drug-users was blamed for discouraging some mothers from taking part. In terms of recruitment, this was demonstrated where the study was advertised by flyers posted up in public areas. Murphy and Rosenbaum found that recruitment of middle-class mothers was frustrated by gatekeepers, who refused to allow the project to operate in facilities aimed at serving these women. The

most successful method of recruitment was via chain-referral and limited the study to mothers who were known to one another. This suggests an important bias within this study, that the majority of the women recruited were described as from the 'underclass' (their term), *i.e.*, living at or below the poverty line. This is crucial in terms of understanding the researchers' definition of 'hard-to-find/access' groups of drug-using pregnant women. Without accessing and recruiting more affluent mothers into such studies, research into this area risks being affected by the perpetuation of the stereotyped cultural image of the drug-using mother as impoverished and in social need.

Data were collected via a mixture of quantitative and qualitative methods that took between 2 and 4 hours to complete. Women were interviewed in venues where they felt most comfortable and could speak as they wanted. Demographic data, consisting of short-answers and pre-coded questions helped glean background information about their family, work, education, criminal justice history, violence and drug-use history. Qualitative data were collected via a semi-structured interview with open-ended questions used to help elicit a considered description of the women's experiences. However, with the aim of eliciting a large amount of data, Murphy and Rosenbaum note limitations to the study in terms of being unable to conduct long private interviews in some of the women's living arrangements; for instance where they were living with other people. Presumably these problems were solved as their book reports findings from these interviews.

In terms of gathering scientific data that is both valid and reliable, Murphy and Rosenbaum describe problems establishing trust and rapport. Whilst gathering data to understand pregnancy and drug-use, they stated a sensitivity not to offend or exacerbate feelings of shame in their respondents; reminiscent of the concepts of toxic shame and low self-worth described by Mason and Kreger (1998) and Ettorre (1992) in section 3.3.1. With the women acting as the sole source of information, the researchers could not substantiate their stories by asking other people because of compromising confidentiality. They said they had to trust what they were being told.

In the interest of establishing a rapport, Murphy and Rosenbaum describe actively demonstrating respect by minimising status differences and stressing only the common ground between them, *i.e.* gender, and for some, being mothers. They describe using a conversational style to help make the interviewee feel safer. As a social experience reflecting feminist methods of data collection, they reported that the interview became an intimate conversation with a sympathetic listener, in which participants also become questioners. However, even with some women stating they had never talked so much about themselves before, the interviewers appeared cognisant of the differences between them and the notion of equality within the interview for their study appears elusive.

In an earlier paper on the ethics and politics of interviewing women, Finch (1984) describes the relationship between researcher and participants as the focus of much feminist discussion which stresses non-hierarchical relationships in the woman-to-woman interview relationship. In this respect, the research team for the 'Pregnancy and Drugs' study appear sensitive to there being little shared common ground, for instance, recognising they were six middle-class women interviewing mostly underclass women from diverse ethnicities and life experiences. In addition, perceived similarities between the identities of the researchers as 'professionals', such as social workers and hospital personnel, exacerbated difficulties in the drive to achieve true mutuality.

The interviewers appeared to be supported through the weekly research team meeting. For instance, they noted that where they were successful in gaining trust from the mothers, they were often told harrowing stories of violence and separation from children, where, on occasion, interviewers were asked for assistance. This was described as being difficult. The interviewers felt frustrated by feeling they were unable to do anything, except give information about specific services when asked. In addition the interviewers mentioned the personal trauma of bearing witness to disturbing and upsetting events and the frustration of knowing that, on the whole, women would return to their 'drug-, violence- and risk-inundated lives' (p.172).

Thus, researchers were faced with the reality of the women's worlds, which underscore and contrast greatly with the cultural construction of 'normal' motherhood. Murphy

and Rosenbaum note the pervasive and powerful images Americans have of mothers and fathers-to-be planning pregnancies, eating carefully and avoiding any unhealthy activities. Once born, this mother is assumed to care selflessly for her children and family. Although this is described as the 'myth of motherhood', it is a powerful image. Murphy and Rosenbaum say it is an image shared by drug-using women. However, for 'underclass' women, their realities are different. Constrained by inadequate emotional, social and material resources, unplanned pregnancies often blur the line between being children and being women. This is Murphy and Rosenbaum's description of the women they interviewed and, thus, excludes the experiences of more affluent pregnant, drug-using women they were unable to access.

As described earlier, Murphy and Rosenbaum describe using a feminist methodology that necessitated sensitivity to the relationship within the interview and input of participants in data collection and analysis. The above discussion describes how sensitive they were to the women they interviewed and welcomed women's efforts in making sense of their world which helped sharpen data analysis for the researchers. Apart from this, however, Murphy and Rosenbaum do not refer to any other participant input. The data were analysed using a grounded theory approach in which social, social-psychological and structural processes were allowed to emerge naturally. They describe this approach as being the most compatible method of combining data collection and analysis with the study's focus. They state they wanted to influence policy in favour of pregnant drug-users and to turn the tide of intolerance against these women which 'smacked more than a little of racism and elitism' (p.163).

In summary, and in semblance to this study, which explores the experiences of breastfeeding MMT mothers, Murphy and Rosenbaum undertook an exploratory study from the perspectives of pregnant drug-using women. Using anonymous pseudonyms, the mothers' quoted voices are rendered audible in their frequent appearance throughout the book. They describe how it feels to be a pregnant drug-using mother, often struggling against impossible obstacles concerned with income, race, violence and emotional difficulties. These primary qualitative data are used to examine the ways

that result in drug-using mothers, culturally perceived as failing in their reproductive role, being placed in one of the most stigmatised groups in modern society.

Even so, the comparison with this doctoral thesis is limited. For instance, unlike working as a lone PhD student, they describe being able to work within a skilled, knowledgeable, experienced and well-funded research team of six, which met weekly to discuss methodological and substantive issues. This method of working reflects a feminist non-hierarchical ethos, which seemed impossible to achieve within the research interview. The data are presented within four chapters out of six in the book, looking at life before pregnancy, the troubled trajectory of pregnancy, harm perception and reduction, birth and delivery. By doing so, Murphy and Rosenbaum honour their commitment to hear and record women's voices in ways that they hoped would influence policy, the implications of which were discussed in the final chapter.

The presentation of the women's quotes was described as the most divisive issue within the research team. The method examining how to do this was often challenged, especially the difference in the use of quotations, between researched and researcher. During this time, Rosenbaum interviewed each individual researcher on how they conducted their interviews. She was struck by how the colloquialisms and hesitations, similar to those in the speech of the mothers, were different in their relative written text, which, in the case of the interviewers, often appeared crafted and polished. She argued that ameliorating distinctions between interviewee and interviewer were not aided by their texts being treated differently. As a result, the book contains quotes that have been lightly edited to make their reading easier without detracting from the women's meanings. The following section explores Murphy and Rosenbaum's findings concerning the importance of delivering kind and empathetic professional care.

6.1.3 Empathetic care

Reflecting on cultural differences, when women refer to specific problems associated with the American health and social care systems, their voices within the Murphy and Rosenbaum study can sound foreign. Yet, when describing positive traits in health professionals, expressed kindness is the same in the UK as in the US. As an example,

Jocelyn, 26, an African American, HIV positive crack-user in the latter stages of pregnancy, and with previous experience of discriminatory health care, was able to describe her nurse practitioner as: 'extremely supportive'. She goes on to praise her doctor:

'I know she is worried about me. If it wasn't for her, I'd be dead right now. People just don't understand...Just a little bit of kindness can do a fucking lot. It really can.' (p.93)

Murphy and Rosenbaum argue that, when coupled with compassion and empathy, women-centred treatment and healthcare services can be well-suited to help alleviate problems faced by this group of women. They add that the most powerful harm reduction strategy might simply be tolerant and kind-hearted care. With an understanding of, and insight into, the lives of drug-users, the authors argue that mothers could receive information and intervention more appropriate to their individual care.

In another example, one mother appears to confront not only professional prejudice as a drug-using mother, but also racism when the doctor refers to how she and her mother 'looked'. Abigail, a 24-year-old Latina heroin user with a child under six months, describes the fight for her child between her social worker, who was supportive, and doctor, who tried to depict Abigail as a bad parent:

'...my social worker saw something else in me where she believed-she kind of in a way worked towards helping me keep my baby rather than it being taken away. But there was nothing that was gonna change the other doctor's mind at all. Whether I came up dirty or not, because the fact that the baby was on methadone, and the way I looked and my mother looked, she just-we weren't like-we were all wrong for this baby. This poor little baby was gonna have this horrible life. And she [the doctor] accused me of lying.' (p.124)

In this example Murphy and Rosenbaum describe the subjective arbitrariness of child custody. Where professionals work as mothers' advocates, they support efforts to keep

mother and baby together. However, by acting as advocates for the baby, they might work towards getting the child being removed from the ‘unfit’ mother. In Abigail’s case, because the final word lay with the social worker, she retained custody of her child despite the doctor’s objections.

In addition, contained within the book is a description about two dilemmas faced by pregnant mothers without previous service contact. They are described as divided into two groups: concealers or disclosers (referred to earlier in section 3.2.2). This division is dependent on whether women think professional intervention could help amend the effect of illicit drug-use on the foetus. Concealers perceive their drug-use as a personal issue. They distrust the system and express a lack of confidence that caregivers could help them achieve their goal of remaining with their baby. As a result, they remain outside the knowledge domain of professionals, do not enter antenatal care and go into labour without disclosing anything about their drug-use. Disclosers on the other hand, perceive service providers as being helpful to them. However, after revealing themselves, some mothers are critical of stigmatising and judgemental staff attitudes that impoverished their experience of the service. In response to this finding, the study explored in section 6.1.4 highlights the positive influence of a service that is well-informed and mother-centred.

6.1.4 Integrated services

In a more recent UK study, undertaken as a part of a MSc study in Health Services and Public Health Research, Hall and Teijlingen (2006) designed a study to determine an understanding of the little-known needs and views of prenatal services used by pregnant drug-using women. The authors noted a total absence of research into this area in Scotland. They conducted semi-structured interviews with 12 women, four of whom were pregnant, who had received prenatal care and drug services from the specialist Golden Square Special Clinic. Referred to as ‘The Aberdeen Clinic’, this community-based multidisciplinary facility (one-stop shop) offers a greater frequency of prenatal care than traditional antenatal care. The team is multidisciplinary and consists of an obstetrician, community midwife, community clinical nurse specialist in addiction from the local community drug and alcohol team, social worker and, for

counselling and social support, a drugs worker from a voluntary drugs service. The majority of pregnant women were being prescribed methadone for opiate dependency problems.

In a similar way, as described by Murphy and Rosenbaum (1999), Hall and Teijlingen conducted their interviews in two stages. The short questionnaire initially determined specific demographic and contextual information on drug-use and current pregnancy. The authors planned this stage as being useful in allowing a relationship to develop between the woman and interviewee. Although they were not explicit in explaining why they felt this strategy worked, they said these questions helped maximise the potential within the second part of the interview by allowing a relationship to develop between the 'researcher and interviewee' (p.3). Guided by an interview schedule, the semi-structured interview was designed to look at the mothers' experiences of their antenatal care, both within the specialist clinic and in hospital. This included the relationships they had with professionals and other staff. The taped interview was later transcribed, with key points categorised using content analysis. Although they described two researchers analysing the transcripts independently to ensure inter-rater reliability, Hall and Teijlingen did not say whether they did this between them, in their relationship as student and supervisor.

Along with citing the high level of prenatal support, mothers said they liked the multidisciplinary 'one-stop shop' arrangement of care. It seemed to produce better outcomes for both mother and child. In instances where some women were able to detoxify from drugs, they said being pregnant encouraged a renegotiation of their identity and the treatment they received helped reduce their guilt as drug-users. Pregnancy acted as a major impetus for change in their lives, with the women saying that pregnancy gave them a 'goal' in life they could aim for. As demonstrated in Table 6.1 below, the five most important aspects of care given by the clinic were found to be the non-judgemental attitude of staff, continuity of carers, a high level of support, reliable information and multi-agency integrated care.

Theme	Example
Attitude of staff	"They didn't make you feel like it was something to be ashamed of. They made you feel worth something that you were here, at least you are trying, you know..."
Continuity of carers	"... having the same people because they know you and you know them...you don't have to keep repeating yourself, telling your story over and over again."
High level of support	"I think it's important to drug-users to go more often. I mean, if you are going to relapse then there is somebody there to talk to."
Information	"They told you all about the drugs. I was quite far on and I didn't know that crack cocaine can kill the baby and I was a regular user. That's extremely important. They don't tell you that anywhere else"
Integrated care	"They all interlink with each other, you know...that was really, really handy...it saves you having to travel...it's all in one building, so it was really good."

Table 6.1: Themes related to care emerging from interviews

(Hall and Teijlingen 2006: p.5)

The table is included here because the women's quoted words express the minimal service expected of any specialist maternity service. With such a track record of high quality and empathetic prenatal care, the clinic offers a potential template for imitation by other services on how best to treat this vulnerable group of drug-using mothers. Where Hall and Teijlingen (2006) make no mention about any peri- or post-natal care, and specifically breastfeeding, I feel it is easy to assume that such a service would actively encourage mothers to breastfeed their babies.

In aiming to fill a gap in the knowledge about drug-using women who were becoming mothers, Hall and Teijlingen were also able to substantiate findings from previous studies. Women expressed sensitivity about their treatment from professionals when they felt judged because they used heroin. Not only were mothers specifically wary of social workers because of stigma, they also mentioned fearing midwives, especially where they have felt poorly treated in the past. However some mothers did add that, in certain circumstances, their contact with social workers was enhanced, when they felt helped and supported in practical problems, such as with housing. Women described feeling valued by drugs-workers because they felt their contact was more holistic and confidential than with other services. One woman was afraid of contact because the agency provided needles and she did not want this to act as a trigger for relapse back into drug-use.

The authors criticise the size of their study population and advocate larger and more representative samples of drug-using mothers for future studies. As the women they interviewed were attending a specialist clinic, the knowledge gained could be construed as being as being unrepresentative of mothers without this access. In the absence of such specialist and integrated services as the Aberdeen Clinic, mothers might experience a reluctance to attend traditional drug services because of their association with problematic drug-users. As observed by Radcliffe and Stevens (2008) below, the tarnished image of drug treatment agencies can bring about prejudice for service users and specialist professionals.

6.1.5 Traditional drug treatment services

Radcliffe's work is contemporary and seeks to address the gap in understanding motherhood from the perspective of the mother. As an Associate Researcher in Kent University School of Social Policy, Sociology and Social Research, Polly Radcliffe not only published articles on drug policy, identity, stigma and gender, but also has acted as principal investigator on an Economic and Social Research Council (ESRC)-funded study investigating substance misuse and pregnancy. This thesis refers to three of her papers. Explored first is a paper written in collaboration with fellow academic Professor Alex Stevens in 2008. Section 6.1.9 outlines the other two papers which investigate strategies mothers use to manage their drug-using identities (2009), and their 'moral career' (p. 984) when they become engaged in drug treatment (2011).

Funded by the Department of Health, Radcliffe and Stevens (2008) explored the management of stigmatised identities and noted that the image of treatment agencies can inadvertently discourage users to engage in therapy. Where the criminal justice systems direct prolific public offenders for drug treatment, the authors observe how services become associated with the most chaotic and problematic substance users. This has the result of excluding others not wishing to be associated with this group.

The 53 interviewees, 39 male and 14 female problem drug-users - defined where drug-use dominated time and space in their lives, were recruited from three different English Drug Action Teams. As Radcliffe and Stevens were interested in interviewing those that had dropped out of treatment within three months, the respondents were accessed via their old treatment service records. They also used snowball sampling from these participants to identify other potential respondents. They omit to describe the content and conduct of the interviews, difficulties in accessing respondents as well as obtaining informed consent. This suggests that their paper was less concerned with the mechanics of generating data than discussing the findings and how they could be applied to policy. This connection is made here with reference to the context in which this paper is situated. In four other papers cited as being co-authored by Stevens, all are related to

analysing UK drug policy, with two papers published by the Drug Policy Commission and Department of Health. This latter one is co-authored by Radcliffe in 2007.

Radcliffe and Stevens describe the data analysis stage as shaped by knowledge of the existing literature, together with emergent themes from previous research undertaken by the team and knowledge of the data. Details of the existing literature and previous research are not mentioned. Although there is no reference to the taping of the interviews, this information is implicit when they describe analysing interview transcripts using an adaptive coding approach. Ultimately, the paper describes four broad themes: the stigmatisation of the junkie, shame and the treatment service-‘That is not me’, stigma and the treatment regime and communities of users.

In their conclusion, Radcliffe and Stevens (2008) described their analysis as relevant to the delivery of drug-treatment services. Although not specifically related to the problems of drug-using mothers, their paper bears relevance to the choices drug-using mothers have to make. In particular, whilst targeting problematic drug-users, services are identified as discouraging those who are young and female. Thus, whilst Hall and Teijlingen (2006) cite the acclaim of mothers attending specialised combined antenatal and drug treatment services, conclusions by Radcliffe and Stevens (2008) suggest that, in the absence of such services, mothers face difficult dilemmas. On the one hand they may opt to stay away. On the other, if they decide to engage in treatment as offered, they face the risk of stigmatisation by other professionals, such as social workers. Through association with the stigmatised drug-user’s identity, they become discredited, as described by one male respondent as:

...thieving junkie scumbags...most members of society look down on...because most junkies are dirty, smelly...because that’s what it [heroin] does to you.
(Radcliffe and Stevens: p.1068).

Thus tarnished through association, MMT mothers risk becoming contaminated themselves. As explored by Klee (1998) in section 6.1.6 below, where health and social care professionals are deficient in training and understanding of the special needs of

this client group, they draw on stereotyped cultural portrayals of drug-users to inform their practice and refer to these stereotypes to bridge their gap in knowledge.

6.1.6 Stereotyped drug-using parents

The Director of the Centre for Social Research on Health and Substance Abuse at Manchester Metropolitan University, Hilary Klee (1998) writes about parenting in drug-using families, using data acquired 'serendipitously' from three studies she had been involved in during the 1990's. The numbers incorporated into these studies include: poly-drug misuse, total n=250, parents=78 (Klee *et al.* 1993-4); amphetamine use and treatment, total n=101, parents=43 (Klee *et al.* 1994-7); and illicit drug-use, pregnancy and early motherhood, total n=64 (Klee and Wright 1997). With data taken from other projects, Klee (1998) describes the total sample as being 240 parents. Transcriptions were analysed using thematic analysis. Guided by the four questions asked whilst analysing the data, the paper is categorised under four themes. Illustrated with quotations from parents, these are identified as being the nature and degree of parental attachment, an awareness of risk when drug taking, the efforts taken to protect the children and the likely outcome of the measures adopted.

Initially, Klee acknowledged the stereotype of the heroin user as dominated by inadequate diet, a lack of attention to hygiene, poor sleeping patterns and general self-neglect. She stated this depiction was not a dominant characteristic of the majority of parents interviewed. However, the following list of traits, used to describe drug-using parents, is most commonly identified by groups of professionals interviewed within her studies. They are used to rationalise concerns over the physical and emotional deprivation of children, even endangering life. She lists these traits as:

- selfish and uncaring;
- irresponsible;
- distracted;
- neglectful;
- intolerant;
- irritable and aggressive;

- no child-centred activity; and
- putting drugs before the child (p.439).

She recognises that these depictions are wholly negative and reflect professional ignorance and prejudice, as used to describe certain common characteristics attributed to the drug-using parent.

Thus whilst Klee acknowledges professional concern to protect children, she is critical that: ‘rational and sensible treatment of the subject’ (p.438), *i.e.*, child protection, is difficult when mothers are so negatively characterised. Their depiction becomes further entrenched by media frenzy and heightened public concern. She argues that the measures taken to maintain the welfare of children have proven to be less than effectual because disturbing reports of childcare events continue to be reported. Klee admits not all parents in her studies recognise when they needed professional help, either because of drug taking or negative influences of those around them. However, as parents generally expressed unease for the well-being of their children, Klee felt that services should respond to these concerns and work alongside parents. Effectively, this ‘joint working’ would maximise the safeguarding of the interests of the infant based on honesty and trust, as described in section 3.4.

However, where professionals continue to stereotype drug-using parents, the majority of Klee’s paper is dedicated to looking at the experiences of drug-using parents. There is no specific mention of methadone-treated mothers. In addition, many of the references allude to children and not to young babies. This limits the amount of information that can be applied to this study. Fathers were described as being involved in the care of children and provided strong support for the mother during pregnancy and afterwards. The stability of the parental relationship is important in benefiting the children, which was described as often being independent of drug-use. Parental characteristics which negatively impacted on the care of children were highlighted as being depressed, irritable and aggressive, both verbally and emotionally. These symptoms were commonly associated with withdrawing from drugs/medication and

helped by taking prescribed methadone. Klee notes that physical abuse was not reported by the parents, although accidents occurred when intoxicated. The strategies parents used to protect children include removing themselves from children, or removing children for a short break into the care of family or friends. Smoking cannabis is also used as a psychological detachment method, especially for lone mothers where they were unable physically to remove themselves. Benefits of drugs were stated in terms of giving energy for childcare and domestic chores. One opiate-using mother rationalised her use of drugs by stating heroin helped her to get through the day:

You just have a bit [of heroin] to help you get through the day and that's it...that's all I want, just to be OK so I don't be horrible, otherwise the kids would cop it then wouldn't they? (p.443)

Another MMT mother stated that methadone helped her function as a warm and loving mother, even though she acknowledged how wrong her explanation sounded:

When I wasn't on methadone, if I hadn't any gear then I was dead quick-tempered like. But as soon as I'd done my methadone, then I'd be fine within minutes and be dead lovable. I think that's wrong...but you just can't help it sometimes (p.443).

However there was some disquietude mentioned about rationalising the benefits of drug-use. One amphetamine-using mother recognised the loss of money to drug-use:

...No it doesn't make you a better mum, it [amphetamines] makes you worse I think. I think you're a good mum in the sense that like everybody else, you look after them an' everything, but you're still wondering-because, like all the money you're spending on it, you're thinking what you could have got for the kids an' that. (p.443).

In the discussion section, Klee writes that some of the parents' responses to their children were regretted. Guilt over poor insights into risk, and of the psychoactive damage of drugs, is explained as stemming from reduced sensitivity from the drugs themselves. In addition, she says parents often have disadvantaged and disrupted childhoods, with poor models upon which to base their own ideas of good parenting.

However, after recognising these difficulties, her discussion appears to become disconnected from earlier sections of the paper. For instance, she refers to formal systems of support as though referenced earlier in her paper by saying that some relationships with professionals were appreciated by mothers and much could be learned from these examples. However, none of these relationships were described or specific quotations used within the paper. This not only frustrates the potential of what these lessons are and mean, but also restricts the value her paper can contribute to this thesis.

It is difficult to tease out Klee's arguments, especially when she advocates how to encourage more parents to go to more family friendly services. In citing differences in parenting models, she outlines the divergence between two perceptions of what it is to be a safe and capable parent. In the first instance, with little insight into their behaviour, parents might perceive themselves as being of little or no risk to their children. However when measured against the perceptions of a professional/cultural group, they might be construed as being inept and dangerous. To develop services that encourage voluntary contact, Klee suggests that parents, motivated by a strong emotional attachment to their children, access prior 'user-friendly' information about services. By being able to compare their own model of parenting to what is expected, she argues that parental anxiety about the risks of disclosure would be alleviated. Although Klee does not embellish her ideas about what this would look like or how this would work to encourage all parents to attend, she argues that making voluntary contact with services will help establish progress that would be founded upon co-operation rather than compliance. However, her contentions appear to be countered by her own observations. In recognising that some parents have little understanding of the risks they pose to their children, they will be unlikely to involve themselves in the services. Oblivious to the

risks they pose and suspicious of treatment and social services, the parents who should be seeking help will continue to remain hidden even though they might be in greatest need in terms of infant safeguarding.

Even so, Klee's understanding of drug-using parents is useful to this thesis because she adds to the awareness of what it means to be a drug-using parent, in terms of the stressors of drug-use and realistic worries of not coping without the support of drugs or medication. In addition, her data suggests fertile ground in which professionals could grow cooperative services, aimed at working in the best interests of families. However, current difficulties experienced by both parents and services are perpetuated when such insights are ignored or overlooked, thereby fuelling persistent negative stereotypes and cultural images. Klee alludes to the danger of this by highlighting a lack of training in drug-use for non-specialist professionals, *i.e.*, those that do not work specifically within the drug field. She notes that poor education and insight have affected the quality of services provided for drug-users and compounded difficulties for inter-agency working. She recognises that whilst social workers have skills for assessing childcare, they feel deskilled when it comes to understanding drug-using parents. She describes them either ignoring the issue of drug-use completely or over-reacting to it.

Klee's paper could be criticised for being out of date. However 10 years on, more recent Government reports, such as the 2008-2018 Drug Strategy, would suggest that her arguments remain unaddressed (HM Government 2008). Whilst the report advocates more family-friendly treatment services and provision of parenting skills for drug-users, there is an implicit recognition that parents continue to be relatively excluded from the care of their children when compared to other mothers. Such directives echoes Klee's conclusion that services need to respond to the high emotional investment parents pour into their being recognised as capable and safe care givers. Where this energy could be used to motivate changes in the services, Klee argues that this is not happening because they fear exposing themselves to professionals who may lack specialist training and understanding.

To examine the enduring tension between being perceived as deviant and being a mother, the following section reviews an Australian paper by epidemiologists Banwell and Bammer (2006). Of particular interest to this study is their reference to the complex ethical difficulties associated with researching drug-using mothers.

6.1.7 Cultural concerns, surveillance and monitoring

Using in-depth interviews and the participant-observation of four groups of mothers, Banwell and Bammer (2006) explore the subjective socio-cultural experiences of childrearing by comparing women using illicit drugs with those who do not. Their paper is useful on two accounts. Firstly the authors acknowledge an ethical sensitivity about research in this area and, in response, design a study that helps to normalise mothers. In addition, the act of approaching and entering drug treatment is misconstrued. Whilst mothers argue that self-disclosure acts as a major indicator of maternal concern for the infant, services appear to respond punitively. However, even though pregnant women become objects of scrutiny and monitoring, a major deterrent to working co-operatively, as described by Klee (1998) above, mothers continue to be compelled to seek treatment for reassurance.

At the start of their paper, Banwell and Bammer (2006) acknowledge concerns that: 'drug research provides fertile ground for the display of epistemological and ontological differences associated with knowledge generation' (p.504) that cause contentions over depictions of the research 'subject'. With an increase of research into the life experiences of substance-abusing mothers, the authors note that investigations are fraught with complex ethical difficulties, issues concerning which are documented throughout this thesis:

Increasingly the voices of mothers who use heroin and other drugs are being recorded as researchers attempt to...understand the situated, everyday reality of their lives. But traversing such terrain is ethically complex and contestable (Banwell and Bammer 2006: p.505).

However despite these problems, Banwell and Bammer note the importance of alternative forms of research paradigms that seek to record the voices of mothers. They argue that accounts from marginalised populations of drug-users counterbalance findings from biomedical and behaviourist paradigms because: ‘epidemiological-driven characteristics of risk cannot accommodate the lived realities of intravenous drug-users...and other marginalised groups’ (p.504).

Banwell and Bammer’s intention to design a study highlighting the value of alternative research paradigms that better represent the voices of marginalised drug-using mothers is particularly useful to this thesis. They design a study to explore cultural concerns that construct drug-using mothers as risks to the welfare of their babies and young children. Citing work by anthropologist Arendell (1999), they note that even though many mothers do not live up to the ideal of mother as culturally constructed, not all are subjected to the same critical surveillance as mothers living on the fringes of society. These include not only drug-using mothers but also poor, single, lesbian and ethnic minority women. Referring to sociological work by Coxhead and Rhodes (2006), Banwell and Bammer argue that drugs users in Australia are not a homogenous population, *i.e.*, an easily knowable population, depicted by public health and other government policy as passive and unable to cope. With reference to Hunt and Barker (1999), they note that society takes on the role of judge, and reports of drug addicted babies are often cited as evidence of poor mothering.

In order to gauge a finer understanding of drug-using women who do not fit the hegemonic model of being good mothers, Banwell and Bammer planned a different approach situating them outside of condemning cultural discourse. They do so by broadening their focus away from concentration on the deviant, to investigating other shared practical concerns experienced by other mothers of different socio-economic statuses and life-styles. They designed a qualitative study in which they interviewed a total of 60 mothers with children aged up to 5, and divided them into four groups: illicit drug-users (n=22), those with low incomes (n=9), those with partners in the military and move home frequently (n=18) and women with medium and higher incomes (n=21). Recruitment strategies and problems were not described or discussed.

The interviews focussed on women's everyday experiences, such as perceptions of ideal and real parenting, stability, security, safety and parenting styles. The tapes were transcribed and subject to thematic and narrative analysis. The findings are useful in contextualising cultural perceptions of drug-using mothers as this helps to normalise their experiences.

All women, irrespective of whether or not they use drugs, are described as experiencing problems when living on a low income, being socially isolated and at home with young children. For instance, an explanatory emphasis on poverty, themed as 'financial insecurity', is often cited as the drug-using influence on the family. However, in their study, Banwell and Bammer are able to discern from the narratives that drug-using mothers are equal to other low-income families in terms of being passive victims of poverty. Both groups describe living in subsidised housing, in receipt of social benefits and struggling to meet utility and food bills. Due to their low income, these mothers describe restrictions to their children's diets, activities and opportunities for stimulation. This contrasts with middle and middle-income families descriptions of lives full of child-centred activities (such as swimming, gymnastics, sport or playgroups), which in the eyes of one mother, are fast becoming contemporary indicators of good mothering. Thus, mothers in low-income households say they feel marginalised as they do not have access to these activities, especially when they cannot afford a car to transport their children.

However, the authors note a cultural persistence in understanding drug-using mothers as the 'undeserving poor', with poverty-related problems perceived as self-inflicted. This perception is also supported within the data. Where most of the drug-using mothers interviewed had money problems, some regret was expressed about their drug expenses, as previously highlighted by Klee (1998) above. One woman lived with a partner who was a drug dealer and was able to get free heroin. She said the income from drug dealing provided more than the basic necessities of living. However, in the quote below, she described what happens when this precarious and illegal source of income dries up. It appears that what is given in times of plenty to the child to 'over-compensate' is taken away and sold when money is in short supply:

‘...we’d wake in the morning and have our drugs and we’d be fine. And there was more money around at that time too, there was more food in the house, [son] got toys, you know, you tend to over-compensate. But when things get really bad, all those wonderful things that you’ve bought for your child, if they’re sellable, you will, that’s the horrible reality of it. So the kid goes from one extreme to the other’ (Banwell and Bammer 2006: p.505).

Thus, whilst Banwell and Bammer’s study is useful to this thesis because it endeavours to tease out alternative stressors that impact on mothering, the authors are able to refer to specific experiences unique to drug-using mothers. Representation of themselves as good mothers and working constantly towards this morally-valued identity is the major over-arching theme expressed by all women in the four groups. To buttress their identities of being perceived as good mothers, they manage a myriad of personal, social and financial problems. To address drug problems, mothers approach and enter treatment. Whilst this may draw previously unwanted stigmatising attention to their drug identity, mothers argue that self-disclosure acts as a major indicator of maternal concern for the infant. In an earlier study, Richter and Bammer (2000) listed the hierarchy of strategies described by women. Whilst the cited optimal course of action is to stop using drugs, the second is to seek treatment with statutory and non-statutory support services in efforts to prove their worth as mothers.

However, Banwell and Bammer (2006) note that services do not appear to respond positively. Agencies are more likely to adopt monitoring and surveillance strategies in the interests of infant welfare that appear punitive. These echo reflections by Klee (1998) above, when she describes retaliatory responses potentially eroding the high emotional investment mothers use to demonstrate their capability to mother. However, as acknowledged by academics Murphy and Rosenbaum (1999) with Radcliffe (2011), even though negative reactions to women aggravate their experiences of the services, mothers will continue to seek treatment for personal reassurance and evidence of maternal capability. By doing so, as described below in section 6.1.8, Radcliffe (2011,

2009) argues that women try to manage their drug-user identity within the moral career of treatment.

6.1.8 Managing identities & moral career of drug treatment

Within her earlier paper, Radcliffe (2009) reported on thematic findings from a preliminary qualitative study on substance misuse and pregnancy. To explore strategies used for managing identities, she interviewed 17 pregnant substance-misusing pregnant women and new mothers with children under one year old and noted that contemporary society defines their identity as linked to their practices and patterns of consumption. Radcliffe (2009) observes that, with a dual identity of mother and drug-user, as their pattern of consumption is considered 'flawed', society questions their capacity to care. She argues that they have to *make* themselves into mothers by engaging extensively with the discourse of motherhood and presenting themselves in particular ways to health and welfare services.

The account of her methodology is very sparse. Aside from explaining that the women she interviewed were within an ESRC funded study, she does not describe any of the interviews or how the data were analysed, all of which makes this paper appear superficial. However, her discussion of women's strategies for managing their drug-using identities from their perspective is useful in helping to set the scene for this thesis. This finding is explored further in the third of her papers.

Radcliffe (2011) describes 12 of the 24 interviews she had with mothers for the ESRC-funded study on substance misuse and pregnancy. Writing on gendered identity and motherhood from accounts of pregnant and postpartum women, she again describes how women use discursive strategies to present themselves as plausible mothers. In contrast to her two previous papers, Radcliffe used great detail to describe the amount of time and effort she took to recruit and interview women from 2008 to 2009. The mothers she interviewed were identified as problematic substance users, who were either pregnant or had given birth within the past two years. All had current or previous contact with drug treatment services. Only two mothers had not been opiate users. The different methods of recruitment across three hospital Trusts highlighted not only

differences in maternity care across a small area in the south of England, but also women's sensitivity to the identity of being a pregnant drug-user.

In the first Trust, and reminiscent of Murphy and Rosenbaum's (1999) study, women were selected by a specialist midwife who acted as gatekeeper by deciding on each mother's suitability for inclusion into the study. In the second Trust, the specialist clinic was run in partnership with the local substance misuse and health services as part of the antenatal clinic in the general hospital. Radcliffe made herself and her research known by attending several multidisciplinary meetings and from this she was invited to introduce herself directly to the women attending the specialist clinic. In the third instance, she tried to access women in a more geographically diverse location. Recruitment took place via drug workers in drug treatment agencies, places in which she had previously carried out research. She also placed advertisements in local newspapers and via flyers in drug treatment centre waiting rooms. Radcliffe described the lack of success of these methods, as none were recruited this way. She also noted the failure of snowballing, a technique described previously as being used successfully to recruit problematic drug-users of both genders (Radcliffe and Stevens 2008). In her later paper, Radcliffe (2009) wrote that a failure to recruit via the snowballing method reflected women's sensitivity about their drug-user identity.

Radcliffe does not identify bias within her study. Whilst recognizing the importance of personal endorsement by trusted professionals, she did not explore as a methodological problem the different recruitment strategies across the Trusts, for instance, when the specialist midwife acted as gatekeeper, and thereby filter, to mothers whose antenatal treatment she felt would be jeopardized by their taking part. Radcliffe does not describe what was meant by this or appear to consider which mothers were missed as a result of the midwife's censorship and how this affected the data.

The issue of gatekeeping is important as censoring of potential respondents maintains cultural stereotypes of drug-using mothers as socially deprived. This problem was discussed in a paper by Goode (2000). She reviewed methodological problems of recruitment access for her PhD study undertaken in 1999 in the West Midlands area. Described below in section 6.1.9., Goode noticed that drug workers were key in acting

as gatekeepers in assisting, locating and recruiting volunteers for interview. She was finally granted access to 13 out of 16 drug agencies after spending time publicising the project and negotiating access. However, to gain consent to access respondents, Goode described taking time to explain the study to the gatekeeping organisations, with the result that all but one were willing to facilitate access. With respect to the influence of gatekeepers on contacting women, she describes facing two major barriers.

Firstly, they were unfamiliar with, and suspicious of, the qualitative research paradigm that necessitated greater rapport and empathy with women than other traditional, more objective, medical models of inquiry. Goode said she was advised not to enter into any counselling relationship with the women interviewed. Describing herself as a qualified occupational therapist trained in counselling techniques, she says she listened quietly and empathetically to women, especially when distressed, in the interviews. She said this lay at the heart of good researching, as well as good counselling skills. Secondly, she expressed great concern when advised about a major condition of access to clients. She was informed that for consent to be given, she had to declare explicitly her duty to report any suspected cases of child abuse to respondents before she started interviewing. As Goode was exploring difficulties in parenting, this stipulation regarding access worried her. Although she does not describe whether or not she complied with this condition, she says that in the event no specific cases of reportable child abuse were encountered. Thus, as conditions laid down by gatekeepers lead at times to a problematic relationship with clients, Goode questions whether the nature of the drug-worker/client relationship and the drug-worker's status as gatekeeper contributed to the research inaccessibility of this vulnerable population. Such aspects are not explored by Radcliffe (2011) in her paper.

Radcliffe (2011) describes the conduct of the semi-structured interview which gathered information on; childhood, drug-using/treatment career, attitude to pregnancy and motherhood, previous pregnancies, family life and experience of maternity services. Interviews took place in a variety of settings; their homes, detoxification units, mother and baby assessment centres. She presents extracts from 12 interviews to demonstrate the range of narrative strategies women used. These were categorized under headings

of careers of drug treatment – narratives of change and work of recovering; normative families; deficit models and addiction.

What makes Radcliffe's (2011) article useful to this thesis is the use of women's voices to give an insight into how they work to present themselves as plausible mothers, discussions of which were alluded to in sections 2.2.1 and 3.2. Although she does not mention any detail about her theoretical methodological position, she describes their endeavours to locate themselves in relation to a moral career of drug treatment and motherhood, by referring to sociologist Erving Goffman's discourse on the presentation of the self in everyday life (Goffman 1959-1971) and 'moral career' (Goffman 1961A/2).

In the former Radcliffe asserts the importance of the:

...ability to present oneself as a moral actor [as] crucial in one's ability to play a part in social life and to ensure membership of social groups (Radcliffe 2011: p.985).

The need to present oneself in the best possible light is very pertinent for drug-using mothers, and Radcliffe describes them working to control or guide the impression that others might make of them. Having a stigmatised drug-using identity influences how women are able to manage these impressions, because they fear being unable to meet professionals' standards and expectations of being capable mothers. Where women were able to present themselves as moral actors and take part in social life, they described having a positive experience of motherhood (Radcliffe 2011).

In consideration of the second of Goffman's discourse on 'moral career', Radcliffe discusses the fluidity associated with this term. She states her dislike of the idea of the 'repair of spoiled identity' (p.984) as not representing the processes involved in moving out of drug-use and maintaining recovery. For this reason, she prefers Goffman's definition as referring to 'any social strand of any person's course through life' (p.985). However, she does not describe what she means by this and does not go on to describe

the concept of two-sidedness that is also associated with Goffman's 'moral career'. On one side is the private internal world in which resides images of self and felt identity. As women transition from being drug-users to mothers, this image of self and felt identity becomes more fluid. This reflects Kelly's (1991) personal construct psychology theory that people follow their own theories of themselves, by acting in accordance with their own construction of the world (section 3.3.2).

In addition, as drug-using mothers, the personal becomes exposed to the external world's construction of who they are. With reference to Goffman, this is encapsulated within the second side and contains the public face of the individual and their style of life as part of a 'publicly accessible institutional complex' (Goffman 1961A/2: p.119). Lying within this concept is the notion that each person's moral career, and behind this, their sense of self, occurs within the confines of an institutional system. In the case of pregnant MMT mothers, this occurs within a complex set of professional relationships. Whilst privately engaged in the transition of an identity change, they become enmeshed within an institutional world where their drug life-style becomes the major point of reference and potential excuse for stigmatisation. In this respect, Radcliffe's paper appears to be unbalanced, a criticism she acknowledges herself. Whilst making mention of their moral career, she describes limiting her discussion on the 'front stage' and not the 'back stage', as described by Goffman's dramaturgy.

Section 6.1.9 helps provide a cultural context to this 'back stage'. Goode (1999) argues that it is the dominance of patriarchy within society that provides the major reason for all mothers' struggles, not just those that use drugs.

6.1.9 Patriarchy and hidden accounts

As a sociology PhD student, Goode (1999) contended that maternal struggles are set within the context of a patriarchal society. She suggested that the fundamental root of all oppressive conditions lie in the institutionalised inequity of power in female-male relations. She describes this as: 'patriarchy, compulsory heterosexuality, the battle of the sexes, sexual politics or similar terms conveying an understanding of gender-based power structures' (p.19). In addition, she states that gendered power inequality does not

only express itself grossly, but also in subtle and diffuse forms, such as the structuring of language and differential credibility accorded to the gender of speakers.

As all mothers in this country live under such hegemony, Goode maintains that all are the same in harbouring a sense of powerless responsibility for the well-being of their children. Another participatory study supports this finding and indicates that 'normal' mothers feel unheard when in contact with maternity services. Salmon (1999) uses an unstructured format to interview six further-educated women about their experiences of childbirth. In relation to gender and within the doctor-patient relationship, the mothers say they were not listened to. With a lack of available information and advice, Salmon advises that listening to women is key to improving interpersonal skills.

However, in an unexplained move away from citing the predicament of all mothers, Goode (1999) expresses specific concern for the growing numbers of homes with a drug-using parent. Because mothers fear contact with the services, Goode speculates they are less likely to seek help for a drug problem than their male counterparts. Therefore, Goode describes using a feminist approach to understand mothers' experiences; gaining an understanding of female substance abuse within the social context within which drug-use takes place. Although not explored within this chapter, Goode identifies five central culturally-determined elements which shape the women's use of drugs, namely: the need to conform to normative notions of femininity; a gendered experience of role strain, as workers, housewives and carers; cultural notions of being psychologically weaker than, and therefore more dependent on, men; experience of psychological trauma, violence and abuse, where distress is internalised and drugs used as a coping strategy and within a postmodern context, a reduction in stigma regarding female recreational use of substances. Goode is explicit in stating a disinterest in any direct cause-and-effect relationship between women's substance abuse and patriarchy or heterosexuality. Of the 48 drug-using mothers interviewed, 17 were described as using opiates. There is no differentiation made between those taking illicit heroin or engaged in methadone treatment. Methadone is rarely mentioned in her document. Breastfeeding, too, is not specifically identified.

Goode's approach appears to counter Banwell and Bammer's (2006) methodology in their quest to 'normalise' mothers through an investigation of shared stressors. Conversely, she seems to focus on the experiences of drug-using women as social indicators of wider patriarchal hegemony. Specifically, she is interested in women's 'hidden accounts' of experiences of oppression. She was drawn to this notion after observing a constant struggle when trying to reveal the discourse of women's lived experiences because that is 'continuously subverted and submerged again within the dominant masculinist discourse' (p.21). To this end, she designs a study which she says gives voice to previously unspoken voices of women and helps disempowered women articulate 'hidden accounts' of their lives (p. 23).

Goode (1999) describes three levels of explanation as used by women when giving an account of themselves:

1. Mundane level: the presentation of a bland, even banal, image of self.
2. Private level: the account of the self that is shared with friends, family, and trusted colleagues. Women feel more vulnerable here than previously, but are able to retain many elements of impression management in order to present a good 'face'.
3. Hidden account: the account of the self that she claims is alexithymic, almost without words and largely expressed in 'hints, pauses, silences, and dreams' (p.23).

At this 'hidden account' level, Goode suggests that any experiences, divulged through speech, are largely unrecognised by the dominant masculinist discourse. Using Goode's own arguments about feminist perceptions of motherhood, she reasons that when women try to explain their experience of motherhood in terms of individualised personal troubles, their explanations become trivialised by patriarchal hegemony. In addition, on trying to align themselves to accepted social constructions of normative motherhood which ascribe notions of mothering related to self-sacrifice and love, drug-

using women describe experiencing senses of failure and guilt because they perceive themselves failing to measure-up to this ideal. Framed in this way, it is easy to understand the susceptibility to taking drugs in order to self-medicate emotional pain and confusion. Thus, it was ‘hidden accounts’, these aspects of social reality least spoken of and least amenable to research, that Goode wanted to investigate.

She uses a three-part tape-recorded, semi-structured interview format. To analyse her data, Goode describes using a grounded-theory approach, with a selection of themes guided by the existing literature, interests and concerns of the participants and continued contact with the women and others in the field after interview. She identifies four major themes and sub-themes corresponding to her research interests, as listed above. They help bridge the gap in knowledge of the struggles experienced by drug-using mothers in their efforts to maintain their family-lives. Women are described as ‘taking and losing control’ (p. 136) in the face of disruptive forces. Whilst holding on to traditional views of motherhood, as drug-users, they are portrayed as ‘reluctant non-conformists’ to this ideal (p. 216).

Women interviewed in Goode’s study describe caring for their children and protecting them against their drug-use. Reflections made by one young opiate-using mother of three children, living with an opiate-using partner, help to describe the harrowing reality of caring for children when under the influence of drugs:

It makes you lazy as well. You just want to sit there, you can't be bothered to do this, that and the other. I can't be doing with that. And the kids do suffer. Well, if you've spent all the money, come dinner-time you've got to make a dinner out of what? Nothing. And that's not fair. And clothes-wise, and going out, that's not fair either. You know, because you haven't got the money to buy them the clothes they need (p. 204).

However, this image is in danger of perpetuating the stereotyped image of the drug-using mother as out of control. Whilst wanting to research the daily lives of substance-

abusing women across a broad spectrum of disciplines, Goode's broad remit appears to result in a stereotypical portrayal and the loss of individuality. This implies her findings correspond to hegemonic images that appear to defeat her own objective of revealing women's 'hidden accounts'. With a lack of discussion of methadone and breastfeeding in her document, Goode's investigation into drug-using mothers' experiences appears to entrench, as she describes, their status as 'junkies'. She recounts problems with poverty, domestic violence, housing instability, separation from children and crime, including prostitution. She sets out the functions of substances in their lives as providing, for example, pleasure, everyday mood management, dealing with difficulties in life and managing adult relationship problems.

This might not always be the case, especially when women seek help with their drug problem and, whilst pregnant, become engaged in methadone treatment and state a desire to breastfeed. In her thesis, Goode suggests that even though these mothers are conceptualised as being problematic, their failure to cope and protect their children is more symptomatic of the high expectations made of all mothers. She recognises that all mothers, regardless of whether or not they use drugs, are judged by their ability to control themselves in the interests of their children and argues that this is a previously undiscovered element contained within cultural understandings of motherhood.

Goode argued that her study appears to be the first to tie together findings from many disparate, but highly relevant, elements that begin the task of building a coherent theoretical account of addiction. She refers to a lack of consensus within addiction studies, citing Shaffer and Burglass's (1981) description of being in a 'pre-paradigm' state, *i.e.*, with no leading theory. She describes three consequences of this situation. Firstly, as there is little cross-referencing between different bodies of literature dealing with various aspects of addiction, the nature of research in this area is fragmented. Secondly, she refers to key studies by Rosenbaum (1981) and Taylor (1993), often referenced in the literature but with little evidence that their findings were analysed or theoretically advanced. With the lack of critical and detailed analysis of early research work, Goode notes the lack of impact these findings have had on theory or practice.

This led to her third point that sociological studies, in particular, have made little impact on clinical treatment. She suggests greater theoretical agreement on the definition and, therefore, treatment of substance-use problems would allow research and clinical practice to collaborate more closely and effectively.

As noted in Chapter 2, the state of addiction studies can continue to be described as pre-paradigmatic, although there appears to be some shift from the fragmented state described by Goode. For instance, this PhD study could be described as referencing a different body of literature by referring to biomedical research that considers the safety of breastfeeding babies born to MMT mothers. In addition, it refers to developmental and psychological theories of addiction which complement one another, *i.e.*, Byington's (1997) relational theory and Khantzian and Albanese's (2008) self-medication theory of addiction. This chapter cites studies from a wide range of disciplines, *e.g.*, medical sociology, psychology, public health, sociology, ethnography, social services, marriage and family therapy.

As a final contribution to the thesis, contained in her discussion of qualitative data analysis, Goode notes problems related to issues of reliability and the validity of analysis in terms of being repeatable and the possibility of generating the same theory from the data. She goes on to refer to three studies by way of illustration of how little is understood about how data are analysed. In a study of women drug-users, Taylor (1993) is referred to as discussing her methodology in detail, but not how she analysed her data. When writing about the experiences of crack-using women Inciardi *et al.* (1993) are mentioned because they discuss the ethics and dangers of researching on location, but omit how data are analysed. Only one author, Rosenbaum (1981) is cited as analysing data, using 'a pure form of grounded theory' (p.55), with the extensive use of coding and memo-ing each transcript and theoretical sampling to address emerging issues.

However Goode does not follow Rosenbaum's example by demonstrating her own data analysis. Instead she states her confidence in her own work because she says she is able

to work backwards from the generated theory to the original data. She acknowledges that other researchers would interpret the data differently according to their own individual nuances. As a result, she admits that, whilst the same data could, perhaps, identify similar basic themes, these might be presented as different theories. Without demonstrating what she did, whilst at the same time arguing for a greater understanding of qualitative data analysis procedures, Goode's work ultimately reflects Taylor's (1993) and Inciardi's (1993) omissions.

The following section describes a small-scale research project undertaken in the Midlands. Of interest to this study is the authorship. Written by social workers and published in a social work journal, the study discusses the impact of social services in the lives of drug-using families.

6.1.10 Drug-using families and social workers

Fraser *et al.* (2009) explore the impact of parental substance use on families and interview a self-selecting group of 25 parents (both male and female), 12 of whom were on methadone prescriptions. Writing in the *British Journal of Social Work*, the research team, including one director of Social Services, was commissioned by the Mid-Shire County Council to explore the views and experiences of families affected by substance abuse. This followed the discovery by an earlier audit, conducted in 2002, within one of the largest mixed urban and rural conurbations in the UK, that substance misuse was a major factor in 75% of families involved in care proceedings. The literature review cited work by Street *et al.* (2004) which suggested maternal drug-use is not always synonymous with poor parenting. Even so, the authors, mentioning work undertaken by Taylor and Kroll (2004), noted a lack of knowledge about substance misuse amongst professionals involved in child care. When considering the needs of children and babies, they described the concern that poorly informed professionals might have a negative impact on how drug-using parents are treated.

Headed by an independent research consultant, the project described the rigorous process of preparation to gain trust in the project by social workers and families. As a sensitive piece of research, it not only required the consent of children and adults, but

might also impact on parent-child relationships. The authors devised a study which involved children and their substance misusing parents, recruited via social workers who assessed their appropriateness to participate. Of twenty-five families targeted for interview, 18 were ultimately recruited. Twelve families were not invited to take part either because substance work with social workers was very recent or problems the families encountered were too complex. None of the eight children interviewed were younger than 4. From the self-selecting group of 25 parents (both male and female), 12 were receiving methadone prescriptions. The children were interviewed using a 'draw and write' technique, enabling them to discuss sensitive topics in a non-threatening way (p. 850). Parents were interviewed within a semi-structured structure, which gave them the freedom to elaborate on relevant issues concerned with the impact of drug-use on family life. All were taped and transcribed.

Fraser *et al.* (2009) describe analysing the data from a phenomenological perspective because they wanted to understand the participants' points of view and experiences. After identifying themes that emerged from the data, the researchers discussed these with relevance to key areas of interest as identified by the commissioning agency. Of the 8 children, all bar the youngest were aware of parental drug problems. Social workers who were consistent in their care were valued as important people in their lives. Children were critical of social workers who failed to deliver what they promised.

The study revealed that the majority of parents experienced mental health problems, in particular depression. Parents cited the need for support, recognised the legitimacy of social worker concerns and appreciated help from a myriad of agencies including drug and alcohol services. Co-authored by a social worker, of particular interest to this thesis is the discussion of the impact of social services in the lives of families, as all parents had significant experience of social service involvement, with threats of their children being removed. Parents acknowledged the legitimacy of social worker involvement for the sake of the children and welcomed their support. But, in some cases, parents felt undermined when facing prejudicial professional attitudes. There were observations that social workers lacked specialist knowledge about drug-use. Parents spoke of the

need for professionals to attend training programmes in drug awareness, to enhance their insight into the impact of use on mood and problems related to withdrawal.

Money spent on drugs often wrecked family finances and impacted on their ability to parent. However, driven by wanting to improve their relationship with their children and resuming parental responsibility when separated, they were motivated to seek treatment. The authors discovered that most of the adults had recognised their need for help and, motivated by wanting to look after their children properly, had obtained treatment for their problems. For those using heroin, parents described access to methadone treatment as a stabilising influence on their lives, which, ultimately, helped them care for their children. This suggests that being engaged in methadone treatment gives some parents a sense of control. Parents state clearly that taking heroin is undesirable because of the resultant loss of control and stability in their lives. Therefore, as an empowering force in the mothers' lives, prescribed methadone not only helps maintain their sense of control, it also enables them to acquire household and domestic goods previously sold for drugs (Radcliffe 2011).

The study did not describe the inclusion of mothers of particular interest to this study. During the recruitment phase, social workers were consulted about the suitability of families they worked with. As the authors did not describe the severity of the difficulties that excluded participants, it is impossible to know whether these included pregnant or new mothers, especially those wanting to breastfeed. By acting as gatekeepers, as previously examined via the work of Goode (2000), it could be argued that access was restricted only to those families where social workers were happy to be interviewed and did not fear vociferous criticism of their work. Because pregnant and new parents were not identified within the paper, there are no new insights gained into the impact of engagement with social services during pregnancy and early motherhood.

Thus, with reference to Fraser *et al.*'s (2009) study, the stabilising effect of methadone treatment is highlighted. Motivated by continued parental control and working closely with well-informed and consistent social workers, mothers can define safely their own constructions of motherhood, which represent their dual identities as drug-users and

mothers. Such conclusions are incorporated into a study undertaken as part of the second PhD research project and final reference uncovered for this research.

6.1.11 Mothers: resistance & acceptance of the public discourse

An American marriage and family therapist, Litzke (2008) wrote about constructions of motherhood from six group discussions she had with seven mothers, who were undergoing treatment for drug abuse and dependency in a specialist residential treatment centre. By conducting research into women's issues from a liberal feminist perspective, she aimed to select discourses which 'privilege' their voices and provide deeper insights into what it means to be a drug-using mother in residential drug treatment. The two aims of her research were focused on looking at how women feel about themselves and how they may have internalised society's view of what constitutes 'bad mothers'.

Data for her study emerged from six group sessions with the women, as part of a larger research project conducted by a team of researchers in 2002-3, examining the attachment of mothers to their children while undergoing drug treatment. As a member of that team and listening to tape recordings of the group sessions, Litzke became curious *how* the mothers were discussing motherhood, their own mothers and mothering their own children. She noted her own bias with the revelation that more is expected in terms of conduct by drug-using mothers than by fathers. As single parents, they bear the burden of blame and shame when something goes wrong. Two years later, Litzke used data from the original study to investigate how the women in a recovery facility construct the reality of motherhood in the context of their marginalisation and oppression.

Even though the data had been collected originally for a different study, Litzke appears to have been able to access tapes, which she transcribed two years later. In effect, her data was serendipitous, similar to that described by Klee (1998). However, she does not mention contacting the mothers again, or seeking additional ethical consent for the data to be used again, be it for a similar, but differently-focussed study. Litzke does not

appear to reflect on whether this action is congruent with being a feminist researcher, as she herself describes the relationship between the subject and object of the study as visible and, therefore, by implication, held accountable to the women interviewed.

Out of four main currents of feminism stemming from the second wave of the 'Women's Liberation Movement' in the late 1960's, Litzke describes using liberal feminist theory to underpin her thesis. This has deep roots within American culture in terms of democracy, concerned with political and economic equality. Within the context of capitalism, full access for all to privileges previously enjoyed only by the wealthy and powerful (*i.e.*, 'white, heterosexual able bodied men of European descent', p.12). She cites the work of Olesen (2000) in terms of the growing complexity of feminist research and writes that she is interested in producing research that is not only *about* women but *for* women. She omits to include Olesen's (2005) later edition which evaluated the shift in feminist thought from political agendas that are concerned with understanding and alleviating women's oppression to 'descriptions of mothers' lives or arcane epistemological questions' (p.261).

Under the guise of liberal feminism arguing for equality with men, Litzke notes that the right *to be* women, especially in recognition of the specific needs of mothers, is part of being a woman that is negated. She does not say why or how she came to that conclusion. It is interesting to note that even though this is not discussed within the main thesis document, she states clearly why she uses feminist theory within the abstract:

Feminist theory provides the foundational premise that mothers in treatment for drug and alcohol abuse have the right to represent and constitute their own identities in a society which has historically demonized and criminalized them merely for being mothers (p.viii)

Using discourse analysis, she analysed and coded her transcriptions of the tapes to identify four main themes. Under the first, 'Identity', Litzke reports that mothers within the group overwhelmingly agreed that 'being there' was a minimum requirement for good mothering practice. The second concerned the connection the mothers had with

their children, who were either with them or staying with family or in foster care. Litzke notes that they talked differently about both, feeling closer to the children who were with them than the others who were not.

Of particular interest to this study is her third and fourth finding. The heading 'Resisting or Challenging' resulted from Litzke's focus on what mothers said they did in a society, in which mothers who use and abuse drugs are viewed as deviant. She describes the mothers often resisting this characterisation of themselves as neglecting their maternal responsibilities. However, having said that, under the fourth heading 'Accepting' Litzke noted there were times when mothers agreed with the notion that drug-using and being a mother were incompatible, and accepted that children should be removed from their care.

Thus, Litzke appears to have met the aim of her research, which was to look at how women feel about themselves and how they may have internalised society's view of what constitutes 'bad mothers'. Of interest to this study are her findings that mothers want to be there for their children and that being separated from them may negatively affect the bonding they have with them. In addition, even though culturally portrayed as deviant mothers, mothers defended their right to represent their own identities and also were relieved to accept help when drug-use is out of control. This latter finding may not be relevant to the breastfeeding mothers interviewed in this PhD study, but it does indicate women, such as those interviewed in previous studies, welcome a working relationship with social services, where help and support appears consistent, appropriate and non-intrusive (Radcliffe and Stevens 2008, Hall and Teijlingen 2006, Murphy and Rosenbaum 1999).

6.2 Summary

The qualitative studies explored within Chapter 6 have discussed aspects of the 'ethically complex and contestable terrain' (Banwell and Bammer 2006) associated with drug-using mothers and set within a public discourse that refers to the duality as 'embodiments of risk' (Ettorre 2007) and 'wayward wombs' (Murphy and Rosenbaum 1999). Some of the studies describe the destructive influence illicit drug-use has on

parenting ability. For instance Klee (1998) identifies parents' behaviour being affected by drug-use and withdrawal, when they can become irritable and depressed: a mental health problem identified in a majority of parents interviewed by Fraser *et al.* (2009). Illicit drug-use dominates the home and diverts money away from buying food, clothes and paying bills (Banwell and Bammer 2006, Goode 1999). Thus, set within an arena of vying perceptions, this image creates conflict between the mother and professional. Split into opposing sides, the situation can become unequally divided between professionals, holding statutory powers around issues of infant safeguarding, and drug-using mothers, emboldened by becoming mothers but disempowered by their history. However, not all drug-using mothers are the same. They do not belong to a homogenous population, *i.e.*, an easily knowable population, depicted by public health and other government policies as passive and unable to cope. Professionals need to differentiate between mothers who are able to engage in treatment with those who are not.

Murphy and Rosenbaum (1999) describe pregnant mothers as divided into concealers and disclosers, based on whether or not they trust the help offered by professional services. This useful division helps frame this summary. Firstly, for the purpose of this study, the group of concealers are not pertinent because they perceive their drug-use as a personal issue and remain outside the knowledge domain of professionals. Thus, it might be expected that as some mothers have little understanding of the risks they pose to their children, they are unlikely to involve themselves in services. Whilst suspicious of treatment and social services, these parents will continue to remain hidden and oblivious to the potential risks they pose to their infants. This limits their use to this study, which has a specific interest in the experiences of breastfeeding mothers engaged in methadone treatment. Alternatively, as 'disclosers' have a high service profile, much can be learned about the cost of making themselves known to professionals. Based on findings within the literature this cost can be experienced as either 'welcomed' or 'punitive'.

Welcomed care was described as being kind, women-centred and empathetic (Murphy and Rosenbaum 1999). Women like integrated maternity arrangements because of the

consistent, appropriate and non-intrusive continuity of care and linking of services. They trust midwives and social workers where they have felt helped and supported in the past, especially with practical problems such as housing (Fraser *et al.* 2009, Hall and Teijlingen 2006). However, evidence from the literature would suggest that when professionals refer to damning descriptions of mothers contained within cultural constructions of 'normal' motherhood, mothers experience 'punitive' treatment (Radcliffe and Stevens 2008, Banwell and Bammer 2006).

When making the decision to 'reveal' themselves to services, any control and high emotional investment pregnant mothers might have experienced beforehand is leached away from them through judgemental treatment (Klee 1998). Mothers become objects of surveillance and control by maternity services that are suspicious of their ability to care (Banwell and Bammer 2006). Although engaged in methadone treatment, part of this suspicion hinges on the perception of the stabilising role of methadone. Tension results where this insight is deficient, for example, by social workers who lack specialist training (Klee 1998). Even though prescribed by a doctor, the role of methadone can be construed by some professionals as continued evidence that they remain irresponsible drug takers. Fraser *et al.* (2009) and Radcliffe (2011) note that methadone acts as an important normalising influence which helps keep mothers 'clean' from heroin. However, where professionals stress the importance of being 'clean' they refer to the cultural construction of the 'normal', non-drug-using mother (Radcliffe 2011, 2009). Within this lies the implication that 'normal' means abstinence, not only from illicit substances but also methadone.

However, in opposition to this characterisation and lying as central to the findings of Radcliffe (2011, 2009), Litzke (2008) and Fraser *et al.* (2009) are notions of the moral sense of self and self-actualisation of drug-using parents and their stated right to represent their own identities as mothers with their own perceptions of drug treatment. Litzke's (2008) observation that mothers both accept and resist society's perceptions that they are 'embodiments of risk', appears to suggest that mothers balance and embrace the duality of being both mother and drug-user.

Although the existing literature has provided a crucial foundation upon which further research can be based, it also highlighted the following issues.

The question of ‘hard to access’ populations of drug-using mothers

The issue of gatekeeping was raised in four studies (Radcliffe 2011, Fraser *et al.* 2009, Goode 2000, Murphy and Rosenbaum 1999) and indirectly suggests an alternative, and little understood, notion of ‘hard to access’ research population. Contrary to the hegemonic understanding of a ‘drug-using mother’, through frustrated omission, these studies identify that being ‘hard to access’ are not necessarily the ‘concealers’ or ‘underclass’, but mothers who are relatively more affluent. This is especially evident where professional gatekeepers refused permission to access middle class women, either in advertising the study in facilities serving these women or through censorship in the selection of possible respondents. In other words, professionals, as members of the middle class in society, appear to reflect societal prejudices of the deviant drug-using mother. As a result, when recruitment is dependent on professional control and gatekeeping, the ‘hard to access’ can be alternatively defined as drug-using mothers from the middle class.

Lack of information about breastfeeding MMT mothers

Literature uncovered in the search strategy did not make any specific reference to women who want to nurture and feed their own babies. In the absence of any literature on the experiences of breastfeeding mothers, this is especially important. Whilst Murphy and Rosenbaum (1999) state that society’s most spiteful condemnation might be reserved for pregnant women, breastfeeding mothers run the risk of being treated with disgust because they appear to feed babies breast milk contaminated (poisoned) with methadone. As described by Abdel-Latif *et al.* (2006) and discussed in Chapter 5, with successful breastfeeding requiring dedication and commitment, these women may constitute a self-selecting group of socially well-adjusted and possibly more capable women. This aspect of being a drug-using mother is not explored in the literature.

The variety of theoretical choice when exploring women's experiences

Of the ten studies explored in this chapter, the following methodological perspectives and methods of data analysis in Table 6.2, were cited as all being relevant to exploring the experiences of mothers from their own perspectives:

Methodological framework	Data analysis
<i>Phenomenology</i> Murphy & Rosenbaum (1999)	<i>Grounded theory</i> Goode (1999) Murphy & Rosenbaum (1999)
<i>Symbolic Interactionism</i> Murphy & Rosenbaum (1999)	<i>Content analysis</i> Hall & Teijlingen (2006)
<i>Postmodernism</i> Murphy & Rosenbaum (1999)	<i>Thematic analysis</i> Banwell & Bammer (2006) Klee (1998)
<i>Feminist theory</i> Litzke (2008) Murphy & Rosenbaum (1999) Goode (1999)	<i>Narrative analysis</i> Banwell & Bammer (2006)
<i>Not mentioned</i> Radcliffe (2011) Radcliffe & Stevens (2008) Hall & Teijlingen (2006) Klee (1998) Banwell & Bammer (2006) describe using an 'alternative research paradigm'	<i>Discourse analysis</i> Litzke (2008)
	<i>Phenomenological analysis</i> Fraser <i>et al.</i> (2009)
	<i>Not mentioned</i> Radcliffe (2011) & (2009) Radcliffe & Stevens (2008)

Table 6.2: Methodological frameworks & methods of data analysis

Even though the studies incorporate different underlying methodological frameworks, methods of data collection, other than those done serendipitously (Litzke 2008, Klee 1998), they share commonalities inasmuch as the interviews incorporate a semi-structured questionnaire. This was the sole research tool for authors Fraser (2009), Banwell and Bammer (2006) and Goode (1999). However Radcliffe (2011), Hall and Teijlingen (2006), together with Murphy and Rosenbaum (1999), describe using mixed methods. The initial short questionnaire helps to determine specific demographic and contextual information. This part of the interview is welcomed in the studies by allowing a relationship to develop between ‘researcher and interviewee’ (p. 3). As a result, the second part, using the semi-structured questionnaire, is described as more relaxed and conversational, thereby appearing congruent to feminist research aspirations to reflect a more equitable approach to respondents. Fraser *et al.* (2009) also mention using a ‘draw and write’ technique for children so they could talk about sensitive subjects in a non-threatening way (p. 850). In addition, it is interesting to note that all interviews were taped and transcribed, and later described as being coded and themed.

As a phenomenological study, this thesis is committed to exploring the lived experiences of methadone-treated breast-feeding mothers. The use of phenomenology reflects Murphy and Rosenbaum’s (1999) inclination to place the mother and her meaning-making process at the centre of the analysis. Similar sentiments are expressed by Fraser *et al.* (2009) who wanted to understand the women’s point of view and experiences. The underlying philosophical foundation of this study is explored within the Chapter 7.

Chapter 7: Methodology

Whilst eleven studies, uncovered for this thesis and explored in Chapter 6, describe various experiences of drug-using mothers, there are none that explore early motherhood from the perspective of breastfeeding mothers in methadone maintenance treatment (MMT). Chapter 7 initially outlines the iterative process involved in choosing a suitable starting point for this under-researched area (section 7.1). Phenomenology was eventually identified as the most suitable theoretical framework to explore and interpret the lived experience of breastfeeding MMT mothers. Section 7.2 looks at the overarching concept of phenomenology and associated schools. The relevance of lifeworld theory as the ontological and epistemological point of departure for this study is shown in section 7.3, with its practical application explored in section 7.4. Concerns about the compatibility between existentialism and phenomenology are outlined in section 7.5.

Identification of a disturbance as a research problem for this thesis was founded on three inter-related observations, reported in Chapters 1, 5 and 6. Firstly, this is a practice-driven thesis which stems from remarks made by drug-using women, during consultation with me, who referred to motherhood as their motivation for change from a drug-using lifestyle. Secondly, research on female drug-users continues to be reported as rare (Ettorre 2007, Murphy and Rosenbaum 1999, Pearson 1999). Finally, alongside the dearth of studies reported in the literature, the lived experiences of methadone-treated mothers who breastfeed remain relatively unexplored. With Brookes (1976) contending that disturbances become more explicit through a process of exploration, discussion and rationalisation, section 7.1 describes the iterative route undertaken for the purposes of this study.

7.1 Iterative development of the research question

I introduce this section by describing a client CJ. As a drug-using woman, she was motivated to change her lifestyle because she wanted to become pregnant. Although not a participant in this study, she serves to not only encapsulate the essence of this

practice-driven thesis but also to demonstrate the motivation for the wording of the first of the research questions. At the time of our meeting, CJ was 42 and had spent the past 30 years of her life using a vast range of illicit drugs (Appendix 3). Even though she had children, she was separated from them because she chose to continue her chaotic drug-using lifestyle. When we met, she described being happily married and wanting to have a family. To do this she said she wanted to address her drug-use to keep her baby. She also wanted to breastfeed. CJ managed to attain abstinence from all substances after a year.

I describe the life of CJ because she exemplifies the complexity drug-using women present to professionals. Although set within an unknowable future, as her nurse, I was cautious about her ability to cope with the stress of being responsible for a dependent baby without using drugs. For reasons described in Chapter 2, this suggests I was reacting to her as an ‘embodiment of risk’ (Ettorre 2007). This means that, regardless of CJ’s hard work to change her behaviour, the persistent perception of her as a chaotic drug-user was eclipsing her efforts as presented to me. The first of the research questions reflects this scepticism. Written in the early weeks of being a doctoral student, I recognise the echoes of a prejudicial position to opiate-using mothers similar to those reported in the literature:

Should opiate-using mothers breastfeed?

As a part of my reading, I engaged in the construction of a database of literature that was preponderantly in favour of breastfeeding, especially by MMT mothers. During this time I met with a much experienced consultant specialist midwife. The specialist knowledge she had accumulated from working with drug-using women over a long period of time triangulated with what I read for this thesis. She reiterated the existence of a large evidence base on the safety of breastfeeding and added there were no national guidelines supporting mothers who wanted to breastfeed. She also identified the need amongst professionals for awareness-raising and for an understanding of drug-using women’s lives. I was impressed by these suggestions, as my reading to date had

not yet revealed these insights. Therefore, in addition to the finding that the majority of the evidence base advocates breastfeeding by drug-using women, the research question was changed to incorporate the discourse contained within our conversation to ask what prevents this from happening:

Why do female drug-using mothers not breastfeed?

However this very broad research question lacks direction to explore the multitudinous reasons why mothers do not feed. As the mechanisms for successful uptake of breastfeeding are unknown, it was reframed to reflect a more practice-based application. Therefore whilst continuing to look positively at a group of opiate-using breastfeeding women, the question was changed to include the exploration of how to increase the opportunities for feeding:

How do you maximise the potential for opiate-using mothers to breastfeed?

This question reflects an underlying ontological belief that there exist independent structures or mechanisms that are powerful enough to increase breastfeeding by opiate-using mothers. Epistemologically, knowledge is constructed with reference to the examination of how these mechanisms promote the successful uptake of breast-feeding. To this end, Realistic Evaluation (RE) was initially considered an appropriate underlying methodological framework as illuminatory of both ontological and epistemological explanations.

7.1.1 Consideration of Realistic Evaluation

RE is a term drawn from Pawson and Tilley's work (2004). Both are sociologists involved in academic research in various aspects of social policy. As the name suggests, RE is an approach grounded in realism, a school of philosophy that believes both the material and the social worlds are 'real' and exist independently of observers. As these worlds can influence changes around them, Pawson and Tilley believe it is possible to work towards a closer understanding of what causes change.

Within RE, outcomes of programmes involve the understanding of both context and mechanism. The contexts in which programmes operate make a difference to the outcomes they achieve. Pawson and Tilley (2004) argue that all social programmes are stratified, with interplay between them resulting in inherent disagreements and power play. In the case of drug-using breastfeeding MMT mothers, they might be described as being subject to organisational structure, programme staffing and statutory constraints. Whilst some might be restrained from breastfeeding, programmes ‘work’ when they enable women to make independent choices about how they want to feed their babies. A woman can be described as making choices based on individual reasoning and influenced by her values, beliefs and attitudes. Choices are either enhanced or restricted by her ability to access relevant and available resources, such as professional advice and support. Within RE, this combination of ‘reasoning and resources’ is what enables the programme to ‘work’. It is known as a programme ‘mechanism’.

Thus, where some factors in this context might enable particular mechanisms to be triggered, *i.e.*, success at breastfeeding, other aspects of the context can prevent this mechanism. One of the tasks of RE in approaching the above question of how to maximise the potential for breastfeeding in opiate-using mothers involves learning about what works for MMT mothers, and of the context and mechanisms that trigger these outcomes. Therefore, realistic evaluation of post-natal services should necessitate a sociological understanding of these dynamics, including the deconstruction of the social structures of postnatal maternity units to reveal the resources and choices available to staff and mothers.

However, decisions of where to situate my research interest were challenged by my reading of previous studies (Chapter 6) as authentic voices of MMT breastfeeding mothers were missing. As a methodological issue, this prompted a change in direction from one concerned with the influence of social structures and processes to one which explored the subjective and individualised experiences of mothers themselves.

Ultimately, it was learning about the ‘Parley Principle’ that prompted a reconsideration of how to approach the problem. The ‘parley principle’ of RE, as described by Pawson and Tilley’s (2004) theory-driven model, incorporates the expertise of the respondent within a ‘division of labour’. Working hard at a research question comes not only from the scrutiny of quantitative or qualitative data but also from the utilisation of joint expertise, the inter-linking of both ‘scholarship’ and ‘savvy’, *i.e.*, with both researcher and respondent working together. It was the prospect of joint working in a research partnership that turned me to consider Participatory Action Research, before finally deciding to settle on phenomenology as the methodological framework for this study.

7.1.2 Consideration of Participatory Action Research

With user involvement described as being best practice in research (Hart *et al.* 2005), an alternative Participatory Action Research methodology based on involving the expertise and knowledge of service users was considered. The aim was to involve opiate-using mothers who have breastfed as co-researchers and research assistants. This emancipatory method appeared to sit comfortably with a feminist epistemology, and congruent with my advocacy role, discussed in Chapter 1.

Feminist epistemologies in the early days related to making women visible (Oakley 1992, 1979) and worked within politicised agendas of oppression and gender politics (Ardovini-Brooker 2000). Since Oakley’s time there have been further developments that have questioned the universality of the difference in women’s position in society. Gender is no longer seen as a theoretical variable floating separately from other axes of oppression and subject to a unique analysis (Ardovini-Brooker 2000). Within today’s world of feminist epistemologies lies the recognition that women do not form a single, homogenous social set of agents, but exist within a multiplicity of social relations and voices (Ardovini-Brooker 2000, Mouffe 1999). Once the idea of a common identity has been discarded this liberates the notion of MMT mothers as individuals in their own right. Research can help reveal their previously unhidden and largely unrecognised identities. This is emancipatory because the research gaze can then shift from approaching the participants as socially disadvantaged deviant drug-users to the individual meanings mothers have about themselves and their experiences.

However, a Participatory Action Research methodology appeared expensive in terms of resources, recruiting and managing the expectations of co-researchers. Time was also a factor when entering cycles of new dialogues stimulated by the emergence of new ideas. The other major challenge was the management of the research: as I was employed full-time, that meant leaving my co-researchers to oversee parts of the research process on their own. As a lone and a relatively inexperienced researcher, I therefore concluded that it would be difficult to supervise within a doctoral study, and this method was more suited to a post-doctoral study with the necessary money and time invested in a particular methodology.

7.1.3 The research question

As I read more widely around this subject area, I noted, in a study by neonatologist Jeanne Ballard (2002), that breastfeeding appeared to be able to motivate changes in drug-using lifestyles as mothers weaned themselves off methadone rather than wean their babies off the breast. Therefore the research question changed to become:

What is the relationship between breastfeeding and drug-use for methadone-treated mothers?

However that question suggests a causal link between breastfeeding and drug-use for MMT mothers. I recognised that this question lay *a posteriori* to my research interest. I therefore returned to the exploration of breastfeeding, with the question:

What is the impact of breastfeeding on the identities of mothers treated with methadone for an opiate addiction?

At that time, I was introduced to Interpretative Phenomenological Analysis (IPA). Within IPA, empathetic hermeneutics firstly endeavour to understand the mother's world from her point of view, whilst questioning hermeneutics try to make sense of her making sense (Smith 2003b). Hermeneutics is understood as aiming to achieve an understanding of text through interpretation. Meaning is created from the following

interpretation usually via the identification of themes and patterns in the text (Converse 2012, Dowling and Cooney 2012, Holloway and Wheeler 2010). By exploring the double hermeneutics of mothers' experiences, I therefore felt an IPA study would help facilitate the investigation of the impact of breastfeeding on the identities of MMT mothers.

However, when later analysing the collected data, I felt a further shift when advised to consider how new mothers engaged in methadone treatment and breastfeeding *felt* about their experience. This appeared to lie at the heart and essence of all the other research questions I had been exploring. Although continuing to hold a phenomenological theoretical position, the question was finally changed to reflect an interest in the women's lifeworld, which ultimately helped guide the data analysis:

What is the lived experience of being a methadone-treated mother who is breastfeeding her new-born baby?

As described below in section 7.2, phenomenology is acquainted with such words as 'essence', used to portray the universality of an experience to a specific group of individuals and revealed as a phenomenon (Norlyk and Harder 2010). Such a definition helps to identify this study as being phenomenological. It is an in-depth study looking at the phenomenon, the lifeworld-shared experience, of a specific group of MMT breastfeeding women in the early weeks of motherhood. Dahlberg *et al.* (2009) describe a lifeworld philosophical approach as framing the exploration of the phenomenon and draws on an existential view of being human in which people take responsibility for their own actions. Lifeworld theory is described as the ontological and epistemological point of departure for this thesis and is one variation of many phenomenological empirical approaches, an outline of which is shown in Table 7.1 below.

Schools of Phenomenology	Examples of primary sources	Underlying philosophical assumptions	Keywords
1 Eidetic or Descriptive	Husserl	Content of consciousness: interest to reveal the essence of the phenomenon.	Intentionality Bracketing/ <i>epoché</i> / reduction. Lifeworld
2 Interpretive	<p>Heidegger (1993) Benner (1994b) Diekelmann <i>et al.</i> (1989)</p> <p>Hermeneutics: Ricoeur (1970) Gadamer (1975) Fleming <i>et al.</i> (2003)</p> <p>Existential: Merleau-Ponty (1962)</p>	<p>Interested in 'being', and endeavouring to understand phenomenon in relation to the researcher.</p> <p>Highlight researcher's role and horizons of interpretation. Theory of interpretation of meaning.</p> <p>Being-in-the-world focussed on study of bodily experience of the world in perception.</p>	<p>Dasein/ Being-in-the world.</p> <p>Hermeneutics</p> <p>Essence</p>

Schools of Phenomenology	Examples of primary sources	Underlying philosophical assumptions	Keywords
3 Dutch (Utrecht)	Van Manen (1990), Smith <i>et al.</i> (2009)	Descriptive and interpretative. Phenomenology as a practical & reflective method, not as a professional philosophy.	Scientific vs. Philosophical Phenomenology Lived experience
4 Duquesne	Van Kaam (1959) Colaizzi (1978) Polkinghorne (1988) Giorgi (2011, 1994) Moustakas (1994)	Descriptive empirical phenomenology, inspired by Husserl. Heuristic (empirical) approach adopted by Moustakas.	Phenomenological psychology Essential structures or essences of phenomena as they appear in consciousness
5 Reflective Lifeworld Approach	Dahlberg <i>et al.</i> (2001, 2009) Todres <i>et al.</i> (2007) Ashworth (2003a)	A variation on a phenomenological method: focus on world seeks to elucidate essential structures. Embodied enquiries.	Lifeworld

Table 7.1: Five major schools of phenomenology

(Dowling and Cooney 2012, Finlay 2008)

7.2 Phenomenology

According to Holloway and Wheeler (2010), the word ‘phenomenology’ derives from the Greek word *phainomenon* which means ‘that which appears’. From a philosophical perspective, Converse (2012) writes that the concept of phenomena describes things that take place in the mind rather than realities that can be observed. In Norlyk and Harder’s (2010) systematic review of 32 phenomenological nursing studies, the word ‘experience’ is often used by researchers to describe their work as phenomenological, although they add that the meaning of experience is not often clarified within the papers. In addition, they mention some studies are described as phenomenological because of relating in some way to a phenomenon: ‘in-depth studies of a specific phenomenon, group or individuals or of perceptions of social phenomena’ (p.423). Essence too is described as being ‘universal in the experience...related to a specific group’ (p.423). With reference to Husserl, and writing as an academic consultant on phenomenology, Finlay (2008) noted that a phenomenon exists only when there is a subject who experiences the phenomenon, or where the essence of the phenomenon is revealed. In Chapter 6, phenomenology was described via two studies. Both studies appeared to reflect the basic underlying notion that phenomenology is used to describe phenomena as they are lived and experienced by individuals. Firstly, it helped place the mother and her meaning-making process at the centre of the analysis (Murphy and Rosenbaum 1999). Secondly, it helped in data analysis because the researchers wanted to understand the participants’ points of view and experiences (Fraser *et al.* 2009), a process that has been adopted within this study.

As an academic and a nurse, with publications on different phenomenological perspectives (2008, 2007, 2004), Dowling, together with Cooney (2012), describes phenomenological research as being well suited to nurse and midwife researchers. They suggest that it is used to focus on understanding the reality of patients’ experiences as they engage with the phenomenon. This viewpoint is shared by Leonard (1989), Sadala and Adorno (2002) in their identification of the usefulness of the methodology where the research question stresses wanting to know and understanding clients’ experience

from their standpoint as clients. However, the complexity of writing about and understanding phenomenology is currently being reported as problematic for nurse researchers (*e.g.* Dowling and Cooney 2012, Norlyk and Harder 2010). This complexity appears to be exacerbated by the different ways in which phenomenology is interpreted by authors, either as a philosophy, research method or an umbrella term (Converse 2012, Dowling and Cooney 2012, Holloway and Wheeler 2010, Finlay 2008). In this regard, Norlyk and Harder (2010) observe that phenomenological nursing research appears to be at an early evolutionary phase and criticised for the omission of an explication of philosophical assumptions, especially concerning the differing meanings given by Husserl and Heidegger.

Acting as the basis for their review, Norlyk and Harder (2010) speculate about progress and development that has been made by researchers since Crotty (1996) and Paley (1997) criticised nurses for disregarding fundamental philosophical principles and misunderstanding key concepts. For instance, working as a principal research fellow, John Paley (1997) was critical of the second-hand manner in which phenomenological research had been imported into nursing and attested this was due to the differing sources and of several 'tiers' built up in the literature. However, it appears not much has changed since his publication. Norlyk and Harder (2010) report that considerable variations, apparent inconsistencies and omissions continue to persist to the present day. This suggests a pragmatic schism between some academics who stress the importance of including descriptions of phenomenology as an underlying philosophy and nurse researchers who are practically applying it as a methodology within research, as demonstrated within this study.

This suggestion is similar to an explanation made by Dowling and Cooney (2012). With nurses trying to make sense of the different ways these philosophies are described within the literature, the authors claim that confusion is understandable as there appear to be different interpretations of the meanings of underlying philosophies. As a way of circumventing this, they claim that nurse researchers are omitting background philosophical explanations to concentrate instead on the lived experience of the

phenomenon. In this way, Dowling and Cooney (2012) propose that criticisms regarding philosophical frameworks are becoming less frequent because references, especially to Husserl and Heidegger, are being excluded. Fleming *et al.* (2003) offer an alternative suggestion when they describe the problem as appearing to stem from a lack of a clearly defined or described phenomenological research method. Instead of blaming the researchers themselves, Sadala and Adorno (2002), conclude the problem can be traced back to the original phenomenological philosophers. Describing them as more concerned with developing philosophies than developing method, they left today's nurse researchers gleaning what they can. This observation was borne out in the literature search for this thesis. Although described as phenomenological, the two studies mentioned above did not refer to a specific school or tradition of phenomenology but instead referred to its practical application in relation to their research interest.

In response to critics such as Paley who prefer the use of original sources, I defer to an argument made by Lawrence (2009). As a PhD student, she initially made the decision to read Merleau-Ponty's original treatise. However, she said she found his thoughts inaccessible due to his very confusing writing style, and added that Merleau-Ponty himself described struggling to understand what he had written. Lawrence (2009) therefore concluded she would not read his early texts. To apply his philosophy she referred to other writers who interpreted his work. Within this thesis, references are made to Husserl, Heidegger and Merleau-Ponty as a way of background information. The explanations are not presented as definitive. They are used here to describe how I have come to understand these philosophies from texts written by authors who are able to convey understanding and insight, and how these have influenced the study.

7.2.1 Philosophical underpinnings

Husserl is quoted as founding phenomenology as a 'discernible movement' by philosophers, (Wrathall and Dreyfus 2006). Husserl's interest in the *content* of consciousness and intentionality, *i.e.* object directedness, is also described. This notion is concerned to decipher: 'what we experience when we experience' by focussing on

the analysis of things as they appear in the conscious as the 'primacy of intention'. Any act of mind is directed towards an object, for instance, if someone wants, they want *something*. As a member of the Duquesne School of Phenomenological Psychology inspired by Husserl, Moustakas (1994) describes anything that appears in consciousness as a phenomenon. For instance, the phenomenon within this thesis could be described as anything that appears in the consciousness of the MMT breastfeeding mother that might determine her choice of action.

Heidegger was Husserl's student and he was interested in extending earlier existential traditions. He rejected a focus on the conscious by asking more about Being, and what it meant to be (Wrathall and Dreyfus 2006). Dowling and Cooney (2012) identify Heidegger's fundamental ontological concern with Being as an existential analysis of the 'existence' of man. Heidegger contended that *Dasein* (there-being) was not the same as being conscious and that the human being, already involved in meaningful projects with others and things, exists as the projection of possibilities which open up as a world (Robinson and Groves 2004, Friedman 1964). In this sense, the human being is not 'in the world' in the same way as a sardine is in a tin, but rather in the sense that one is 'in love' or 'in a relationship'. Thus, *Dasein* is understood as subject and object inseparably linked, with the self and world belonging together in one being (Mulhall 2005, Moustakas 1994). In this way, and with reference to Heideggerian thinking, breastfeeding MMT women can be described as subjects projecting meaning onto their life experience (object) during the early time of motherhood.

For me, the interconnection between subjective experience and an objective world (Mulhall 2005, Moustakas 1994) is graphically demonstrated in the following quotation from Gabriel Garcia Marquez's book: *One Hundred Years of Solitude* (1970, p.12):

...the Gypsies returned...they placed a...woman at one end of the village and set up the telescope at the entrance to the tent....People could look into the telescope and see the...woman an arm's length away. (Munhall 1994: p.5)

The story describes how the viewer had initially stated ‘science had eliminated distance’ (p.5). However, in reality, the distance of the viewer to the object remained the same. The experienced reality was an expression of consciousness, the viewer’s perspective of the world. This demonstrates that phenomenology is not concerned with the ‘truth’ of the situation, but is interested in the viewer’s perception of their reality, *i.e.*, not how it is thought but how it is lived. Phenomenology does not seek to answer the question ‘which one is true?’ because this infers that one has more ‘truth’ than the other. As described by sociologist and academic Ardovini-Brooker (2000), phenomenology as a research method is sceptical of truth, which is sometimes described as an illusion. Thus, the above illustration is useful inasmuch as it able to juxtapose both perceptions as being believable and ever changing.

Although this acts as one writer’s example to help demonstrate Heidegger’s *Dasein*, according to Copleston (1965), writing in his *History of Philosophy*, Heidegger was unable to describe exactly what this is. This suggests *Dasein* might be understood differently today to that originally conceived by Heidegger himself. This has implications for the way phenomenology has been interpreted, as, for instance, with the issue of bracketing which is traditionally associated with Husserl, as explored below.

7.2.2 Phenomenological attitude: bracketing and reflexivity

Husserl’s epistemology aims to reveal and understand the essence of a phenomenon which is described as being obtained independently from the researcher through bracketing (Dowling and Cooney 2012). However, the researcher faces difficulties in ‘how’ to do this. Depending on which tradition guides the research, maintaining a phenomenological attitude is attained through open mindedness, using bracketing or reflexivity (Norlyk and Harder 2010, Finlay 2008).

As a mathematician, Husserl suggested that the only way to go about knowing the essence of the phenomenon was through a series of reductions, as used in natural science research (Finlay 2008). *Époché* is a term associated with natural science where the researcher abstains from previous theories, explanations, scientific

conceptualisation and knowledge, *i.e.*, the suspension or bracketing all notions of truth or reality (Robinson and Groves 2004).

Norlyk and Harder (2010) note that many authors use the terms bracketing, *epoché* and reduction synonymously, which reveals not only a lack of understanding of how the idea was used originally but also how to use it in practice. In their article looking at research approaches to phenomenology, Dowling and Cooney (2012) describe the act of bracketing by the researcher to narrow personal attention in order to identify the rational principles underlying the phenomenon of concern. Finlay (2008) talks of ‘disciplined naiveté’, ‘disinterested attentiveness’ and or a process of retaining an ‘empathetic wonderment in face of world’, anything which would cloud descriptions of the phenomenon itself (p.6 in *Debating Phenomenological Research Methods*). Using an alternative term, as suggested in an article by Dahlberg *et al.* (2008), and in their study of patients with spinal injury within assisted feeding regimes, Martinsen *et al.* (2009) described ‘bridling’ prior knowledge and assumptions about the phenomenon in their data analysis. With the goal of clarifying the phenomenon’s essence, bridling helped aid the transformation of a concrete lived experience to an abstract level of description.

Bracketing, or other terms associated with it, continue to define the difference between Husserlian and Heideggerian research with all the specific philosophical assumptions upon which such a study is based (Norlyk and Harder 2010). Finlay (2008) observes that some phenomenologists, particularly from within hermeneutic traditions, deny it is possible, or even desirable, to bracket researchers’ experiences and understandings. Within research stemming from a Heideggerian interpretative or hermeneutic tradition, the term *reflexivity* is used where the researcher reflects on and critically examines their location within the study (Holloway and Wheeler 2010). Thus, as observed by Brocki and Wearden (2006), research is bounded by the participants’ ability to express their thoughts and experiences and the researcher’s ability to reflect and analyse the data collected.

In the same way, I do not want to bracket the expertise and insights gained from working with drug-using women and the literature search detailed in Chapters 5 and 6. I want to be able to use this *a priori* knowledge within the research process. However, as advised by Norlyk and Harder (2010), I describe how I have endeavoured to maintain an open mind throughout the research process in this document. This has been demonstrated thus far in detailing my advocacy position within Chapter 1 and describing the iterative process in the development of the research question earlier in Chapter 7.

7.2.3 Uncovering the hidden

This investigation is concerned to uncover the meanings MMT women ascribe to their everyday lived experiences as breastfeeding mothers. In other words, the results of this phenomenological study help to reveal various subjective truths that previously had lain hidden. Finlay (2008) writes about the notion of ‘lived experience’ and notes that phenomenology is often misrepresented as being about an individual’s subjective experience as accessed through introspection. In this respect, introspection, *i.e.*, a process of self-examination, is not to be confused with the understanding that phenomenology helps to reveal that which is hidden, as demonstrated by Munhall (1994).

Interested in the lived world of human beings as a nurse and psychotherapist, Munhall uses Heidegger’s (1927) metaphor of physical pain to demonstrate the location and exposure of what lies hidden. There are certain occurrences in the body that show themselves as indicators of something that lies hidden and needs revealing. Pain is an example of such an occurrence. As a symptom and indication of something wrong, the subject suffers pain. Located as lying deeply hidden within the body, the affected part waits to be discovered, usually via testing. Similarly, through conducting a phenomenological study, ‘something that was not known before will be revealed: ...through the understanding of individual perception-come upon the misunderstood’ (Munhall 1994: p.25) and come ‘...to know that which is most essential to being’ (Van Manen 1990: p.5).

Describing phenomenology as a philosophy, Munhall (1994) advises students to become immersed in their work, almost in a 'Zen' way. By being open to others' experiences, with a deeper understanding stemming from an increased awareness of these experiences, they are able to go beyond the obvious to reveal the hidden:

Phenomenology focuses on meaning not behaviour/experience and by doing so can offer more useful ways of doing. (Munhall 1994: p.33)

Thus, based upon the subjects' descriptions of their experiences, phenomenological analysis seeks to uncover the meaning of humanly-experienced phenomena (Dahlberg *et al.* 2001). As a methodological approach, Munhall (1994) writes that phenomenology promotes the understanding of ordinary experiences within the context of daily lives. Therefore, insights help offer the potential and opportunity for a fresh working perspective with MMT breastfeeding mothers which contrasts with 'the dehumanisation of technology, vacant morality and arbitrary norms' (Munhall 1994: p.45).

7.3 The relevance of lifeworld theory to this study.

Building on the above phenomenological position, this thesis uses a lifeworld theory to explore the phenomenon of what it feels like to be a breastfeeding methadone-treated woman in the early weeks of motherhood. Lifeworld as an underlying theoretical framework is described as being utilized within nursing research to make sense of hidden meanings within people's daily lives (Dowling and Cooney 2012). For instance, Friberg *et al.* (2007) use this approach to explore pedagogical encounters between nurses and patients in a medical ward, described as a context of a world in which nurses and patients meet and live daily lives. Writing about patient-led healthcare, Todres *et al.* (2007) note that lifeworld perspective is crucial in humanizing healthcare:

Any description of the significance of the lifeworld is a description of the meaningful relationships in a world that is lived, thus indicating ‘more’ of those relationships (p.56).

This quotation appears to contain both Husserlian ideas and Heideggerian ontology. With reference to this thesis, the former reflects an idea of describing the content of consciousness and intentionality as appearing from the significant liaisons mothers construct in the early weeks of motherhood. The latter can be said to regard the revelation and laying bare, *i.e.*, ‘more’, within these meaningful relationships. In addition to the above Husserlian and Heideggerian philosophies, Dahlberg *et al.* (2009) add Merleau-Ponty’s existentialist ideas to complete the composite that is lifeworld theory. Human beings are described as exercising existential freedom that makes choices and agency meaningful within certain limits. With the notion of women as existential human beings, the mothers in this study can be portrayed as exercising choice in their self-determination and coming-into-being.

We are beings that can transcend our determined circumstances in some sense... reveal a view of being human that is always in process, and ‘not finished’ (Dahlberg *et al* (2009): p.267)

This is an empathetic view and one that can be applied to a mother with a drug-using history. Even though there is little research on understanding the processes of this change from the mother’s perspective, this statement welcomes the notion as reported within the literature (Fraser *et al.* 2009, Hepburn 2005, Ballard 2002, Murphy and Rosenbaum 1999, Ettore 1992).

For reasons described in section 3.2.1, normative social constructions of motherhood are described as motivators for change. However this is a complex process. Whilst mothers choose to ‘transcend...determined circumstances’ as drug-users they are limited by conditions they face within their worlds. Contained within Merleau-Ponty’s

concept of being-in-the-world, the bodily experience of the world in perception, is the view of the body and world lying in a 'dialectic relationship':

...a person as a body and the world where it is located. The conditions of the world limit but do not determine a body; instead, people are in charge of determining themselves through their own choices (Sadala and Adorno 2002: p.286)

As bodily entities, individuals become involved in a 'continuous search and transformation in which [they] are always moving forward, in a coming-into-being of possibilities' (p.286). For women, this notion is utilised by Ettore (2007) when she depicts the female reproductive body as an 'instrument for self-articulation for who we are and who we will grow to become' (p.27). Both these quotations are evocative of the fluidity of identity: a central component of personal construct psychology (PCP) theory. As outlined in section 3.3.2, PCP describes the process of constant internal reappraisal as being fluid and not fixed (Kelly 1991). Such arguments about self-determination can be applied to MMT breastfeeding mothers. It is suggested that, in early motherhood, their nurturing bodies act as conduits of self-expression in the process of choosing and coming-into-being as mothers. This is described as a fluid and continuous process of creating and recreating different images, in which personalities are not fixed. In other words, these different images are structured within their own "theories" of who they are becoming, which may incorporate both identities, either drug-user or mother, or even both.

However, this notion of self-determination is limited by the world in which they are located. This is especially relevant for this study where choices MMT breastfeeding women make about who they want to become are restricted by others' perception of them. As 'embodiments of risk', Ettore (2007) describes mothers facing a suspicious objective world that continues to stereotype them as drug-users. With a restriction of personal freedom described by Heidegger (1993) as 'situated freedom', this concept is further expanded by lifeworld phenomenologists Dahlberg *et al.* (2009). They warn

that human beings are not totally free due to the tension between the dimensions of human vulnerability and choice:

Both the vulnerabilities of being human and the possible freedoms of being human are acknowledged as fundamental dimensions that are in creative tension with one another (Dahlberg *et al.* 2009: p.267).

This view is supported within the literature discussed in Chapter 6. For instance, studies by Klee (1998) and Radcliffe (2011) describe stereotyping of drug-using parents and how women try to manage their identities as plausible mothers when facing suspicious professionals.

In other words, within their situated freedom, a creative tension is created when MMT mothers strive to realize a new social identity as mothers. This transition is limited by conditions within their lifeworld that refer primarily to their vulnerability as drug-users. For the purpose of this thesis, the essence of the phenomenon is understood as the experience of these two perceived opposing social roles, mother and drug-user, as inferred within the fundamental phenomenological research question:

What is the lived experience of being a methadone-treated mother who is breastfeeding her new-born baby?

Lifeworld underlying philosophies provide the relevant ontological and epistemological theoretical framework for understanding this phenomenon. The wording of the question implies belief in the existence in a deep, previously hidden, understanding of the lived experience of breastfeeding MMT women at a time of existential upheaval. This extends further than mothers' descriptions of their immediately perceived and constructed lifeworld, couched in terms of significant relationships with babies, methadone, family and professionals. Knowledge for this study is constructed from intuited interpretations of these data that go beyond the obvious to reveal hidden meanings of their lived experience as MMT breastfeeding mothers.

7.4 The practical application of lifeworld theory

Whilst Dowling and Cooney (2012) stress there is no single way of conducting such a study, phenomenological research is criticized for a lack of a clearly defined or described phenomenological research methods. In this regard, Ashworth (2003) and Todres *et al.* (2007) are referred to below as they help demonstrate the practicality of lifeworld theory as applied within this thesis.

In his paper on the contingencies (possibilities) of lifeworld, Ashworth (2003a) refers to Merleau-Ponty's *Phenomenology of Perception*. He quotes seven meanings of lifeworld: selfhood, sociality, embodiment, temporality, spatiality, project and discourse and adds that each of the seven fragments listed can be investigated through separate phenomenological studies. They are cited here because they help illustrate the multi-faceted nature of lifeworld. Similarly listed, but with no reference to either Ashworth or Merleau-Ponty, Todres *et al.* (2007) identify five interlinked categories/parameters which are used to look at the 'what' of the relationship. These include embodiment, temporality and spatiality as listed above. Although selfhood, sociality, project and discourse are excluded, Todres *et al.* (2007) add intersubjectivity, mood or emotional attunement. After a comparison of both aspects, I constructed an amended list and questions to help frame possible various meanings given by MMT breastfeeding women in the early weeks of their lives as mothers:

1. **Temporality:** Refers to the continuities and discontinuities of time as humanly experienced.
 - As part of a moment of human experience within her story, what does a MMT woman feel whilst becoming a breastfeeding mother?
2. **Spatiality & Project:** Refers to a world of places and things that have meaning to living, in terms of spatial (three-dimensional) distance or closeness.
 - Which meanings are described by MMT breastfeeding mothers related to their ability to carry out activities they are committed to, and to which

they regard as central to their lives within changing worlds, from being in and out of hospital, separated from and being with significant others?

3. **Intersubjectivity, Selfhood & Sociality:** Intersubjectivity is key to describing relationships intrinsic to lifeworld and refers to how we are in the world with others and existence with others in an understanding way.

- For breastfeeding MMT mothers, which are described as kind/unkind experiences? (Which kinds of dialogue, interaction did mothers describe having with others?)

4. **Embodiment:** Refers to the concrete 'here' of ourselves, the lived body in meaningful ways in relation to the world and others. Bodies can be partially constituted as a commodity.

- What are the descriptions that a MMT mother has of her body in how it lives and functions meaningfully, including a perception of being 'disabled' by a drug-using history?

5. **Mood or emotional attunement & Discourse:** Lived experience is coloured by mood. Mood 'sniffs out' the situation and gathered experience in immediate, bodily felt ways.

- Which various emotions are described by breastfeeding MMT as they experience becoming mothers?

As described by Ashworth (2003a), each of these are sufficient in themselves as separate phenomenological studies. However, in the interest of this study, they help to highlight the myriad of experiences in early motherhood, which could help illuminate findings within the data.

7.5 Existential-phenomenology

There are concerns regarding the use of an existential-phenomenological approach where the ultimate aim of the data analysis is to construct an overarching interpretation of a general phenomenon from individually described experiences. For this reason, some academics remain unconvinced of the compatibility between existentialism and phenomenology. For instance, Moore (1967) describes the relationship as an ‘unholy alliance’. In addition, phenomenology is described as being unfit for existentialist investigation because it necessitates having to ignore individual existence in its search for a general and universal structure (Wrathall and Dreyfus 2006). However, they admit that a merging of existential-phenomenological philosophical traditions can be successful. As an example, Sadala and Adorno’s (2002) paper on ‘Phenomenology as a method to investigate the experience lived’, contains a discussion of the apparent discord between a focus on the individual existence and working with a number of subjects to arrive at a general structure of the phenomenon. The authors interviewed 11 nursing students, working on an isolation ward, to explore the meaning of this work from their perspective. When individuals were asked for descriptions of a certain phenomenon, each gave a description from their own standpoint. These differing viewpoints cross over each other in intersubjectivity, resulting in common meanings that provide further understanding of the phenomena. When the researcher joins in the process by interpreting the data, the phenomenon is understood from that perspective. This is described as being from another field or horizon belonging to scientific knowledge. Finally, the accumulated data are used to reach a specific field of generalities which belongs to the general structure of the phenomenon under investigation (Sadala and Adorno 2002).

Such arguments used by Sadala and Adorno to defend how they interpreted their data bears relevance to this study. Even though interviewing four women might produce four different viewpoints, their data is used to gain a common meaning of the essence of becoming a breastfeeding mother within a commonly constructed lifeworld.

7.6 Conclusion

Chapter 7 has discussed the underlying phenomenological philosophies and key concepts associated with Husserl, Heidegger and Merleau-Ponty. After the identification of disturbance as a research problem for this thesis, the ensuing iterative process helped identify and refine the fundamental research question for this thesis. This procedure highlighted the innovative nature of this study as no research referred to in this thesis explored and interpreted the lived experience/the lifeworld of breastfeeding MMT mothers.

The research question reflects a phenomenological standpoint, with lifeworld theory chosen as the ontological and epistemological point of departure. Reference is made to the five lifeworld categories: temporality, spatiality, inter-subjectivity, embodiment and emotional attunement as rooted in the early work of Merleau-Ponty and developed by contemporary lifeworld empiricists. Although sufficient in themselves as separate phenomenological studies, they help illuminate the myriad of experiences in early motherhood.

Chapter 8 describes details of data collection methods and ethical considerations employed in this study.

Chapter 8: Ethical considerations and methods of data collection

8.1 Introduction and ethical considerations

As discussed previously in Chapter 7, the essence of the phenomenon is described as an existential tension experienced by breastfeeding MMT women, as both mother and drug-user, in the early weeks of motherhood. The aim of this thesis is to explore and interpret an inter-subjective meaning of the essence, previously hidden within their commonly constructed lifeworlds.

Ethics approval for this study was gained, with a few minor changes, from The University of Brighton Faculty Research Ethics and Governance Committee (FREGC) and the London-Surrey Borders Research Ethics Committee (Appendix 4). This approval was incorporated into the application to the Research & Development committees St George's Healthcare NHS Trust and Brighton and Sussex University Hospital NHS Trust. A later application was made to these committees for consideration of an amendment concerning the hiring of transcribers.

The guidance cited in the NHS Research Governance Framework (Department of Health 2005) regarding three ethical concerns; informed consent, absence of coercion and sampling issues are addressed in Chapter 8. To contextualise the responses, section 8.2 first introduces the reader to the study design. Each of the three ethical concerns is then addressed separately. Section 8.3 looks at how women were recruited into the study with their informed consent. Secondly, as these were a vulnerable group of mothers, section 8.4 explores the issue of sensitive research. It demonstrates the lack of coercion and considerations of researcher vulnerability. Section 8.5 outlines the sampling strategy, inclusion and exclusion criteria with sample size. An overview of all the methods of data collection is found in section 8.6.

8.2 Study design: Longitudinal and prospective cohort study

To reveal the essence of the phenomenon under investigation, a longitudinal and prospective cohort study was designed to gather rich and broad data from late pregnancy to the first three months of motherhood. A cohort of four women all demonstrated their readiness for change by engaging in methadone maintenance treatment (MMT) and choosing to breastfeed their babies. Table 8.1 lists the four interviews corresponding to four significant points in the mothers' lives. Particular reference is made to Abdel-Latif *et al.*'s (2006) study in which the inclusion criterion for mothers into the breastfeeding group is delineated. Being so clearly stated and appropriate, this definition is used in this thesis. Similarly Ballard's (2002) observation of when mothers usually consider weaning from breast-milk acts to mark a suitable time for the second and third interview. During this time, with decrease in plasma volume, the daily dose of methadone is reviewed and usually reduced to pre-pregnancy levels (Abdel-Latif *et al.* 2006).

Name of interview	Time when occurred	Reason why the time period was chosen (with reference to relevant literature)
Baseline (T0)	36 weeks pregnant	Discussion with midwives on mothers' feeding plans.
First (T1)	5 days postpartum	Entered into study if breastfeeding or supplementing with two or less formula feeds a day (Abdel-Latif <i>et al.</i> , 2006).
Second (T2)	6 weeks postpartum	Time to consider weaning off breastfeeding or methadone (Ballard 2002) as methadone dose reviewed (Abdel-Latif <i>et al.</i> 2006).
Third (T3)	3 months postpartum	Some mothers may consider weaning to more solid foods.

Table 8.1: Significance of the timing for the four interviews

8.3 Referral and recruitment to the study

Referral and recruitment of suitable mothers for the study required professional informants. In this respect my experience was similar to that described by Goode (2000). I concentrated on developing good relationships with gatekeepers because I observed that contact with mothers for research purposes was more successful when introduced beforehand. However in the beginning there were no mothers who met the inclusion criteria, despite the initial plan to recruit from the Inner London hospital, via the specialist antenatal clinic and specialist midwife whom I had known previously in a work capacity. After gaining further research governance approval, recruitment of two mothers attending a specialist antenatal clinic in the hospital located outside London was achieved. The third and fourth mothers were later recruited from the Inner London hospital, the former via a colleague in the drug services and the latter with help from the specialist midwife.

At each stage of the study, I ensured the women gave their informed consent. At the beginning of our contact, I sent a letter of introduction to each pregnant woman with a copy of the participant information sheet (Appendix 5). I met them in the antenatal clinic to discuss the purpose of the project, the interview and research tools. We arranged a time for the first interview and, after clarifying the implications of participation, the mothers signed the consent form (Appendix 6). After each interview, I requested additional verbal and written consent to contact them again at an agreed and suitable time and venue for our next meeting (Appendix 7). About two weeks before this time, I wrote a letter, followed up with a phone call, asking if they wanted to continue in the study. None of the women declined their consent or wanted to withdraw.

Blaxter (1999) states that a research relationship requires participant informed and voluntary consent to ensure they have freedom of choice and the capacity to understand and agree to take part. In addition, she describes this as a process for involving

participants in the project, which is not to be perceived as a 'one off' event. This method is reflected in the care I exercised not only to ensure recruitment into the study but also retain interest for follow-up interviews. However, access was complicated when women changed their home address and did not inform me. Contact was further complicated by being unable to phone the mothers as either they did not answer or lost my phone number. A further major problem, associated with living on low state-benefit income, was either having very little or no phone credit. I therefore did not leave any messages on their mobile answer machines. The most successful contact during the project was via text messaging.

My continued efforts to make contact proved successful in retaining women in the study. According to de Vaus (2006), collecting longitudinal data is reported as being problematic especially where sample sizes are small. The quality of data can be affected when participants drop out of the study and data are not collected from a second or subsequent occasion. However, contrary to initial concerns that the dropout rate would be high, the mothers continued to take part once recruited. There was only one missed contact. The first interview with Anna, my first participant, was aborted due to my train journey being cancelled en route. A further appointment was scheduled the following week, but could not take place as her baby was born at the weekend. I managed to collect her baseline data during the time of the second interview.

8.4 Researching vulnerable women

This study deliberately focused on a very small group of women who demonstrated readiness for change. However, as part of the larger group of vulnerable drug-using mothers, there were additional ethical considerations. Women's participation in the study may cause distress and possible complications in their lives and treatment when they fear their responses will result in their being judged or used against them. As revealed in the literature, some professionals can stereotype drug-using parents (Klee 1998), and adopt punitive surveillance and monitoring strategies (Banwell and Bammer 2006). Therefore when mothers are able to refer back to previous poor interactions with health professionals, their concerns regarding contact with professionals may appear well-founded. So they did not feel coerced into divulging private information against their will, their contribution to creating new knowledge involved careful consideration and the negotiation of specific ethical concerns and issues.

Research topics which can be perceived as intimate, discreditable or incriminating are defined by Lee (1995) as sensitive. Thus, mothers involved in this study might sense that the questions are personal, shameful and/or contravening their right to privacy. Section 8.4 initially examines two potential threats due to the possibly intrusive nature of the questions and matters of confidentiality. Finally, careful choice of venue is discussed as being conducive to helping the mothers feel at 'home'.

Decision to exclude questions on drug-using history

For reasons described in Chapter 6, Murphy and Rosenbaum (1999) argued they used feminist methods to enhance the interview experience because this standpoint offered a more open and interactive approach to the women interviewed. Due to the similarity of their study to this thesis, I have employed comparable methods to reflect a respectful and fair approach to our relationship, discussed later in section 8.6.

However, contrary to Murphy and Rosenbaum's (1999) approach where they asked women about drug-use history, I decided to exclude such questions from this study for two reasons. Firstly as premised on Khantzian and Albanese's (2008) theory of addiction (section 2.2.2), opiate-using women are depicted as self-medicating emotional pain with heroin. Therefore, the decision to omit sensitive questions enhanced a more open approach to the mothers by protecting them against unnecessarily triggered painful memories. Secondly, I considered questions about previous drug-use history as unnecessarily intrusive for this phenomenological study. Such questions might seem to conflict with the reason why I was interviewing them, namely to hear what they had to say about their current lived experiences as breastfeeding MMT mothers. Therefore guided by the wording of the research question, I felt it was sufficient to know they were engaged in methadone treatment.

Protection of confidentiality

Lee (1995) argues that care is needed when considering vulnerable participant's fear of incrimination. In terms of this study, women might feel criticised or judged for something they share or describe. Thus, in the event that the women should disclose any criminal or dangerous activity, I consulted the Nurses and Midwives Code of Conduct (Nursing & Midwifery Council 2008), where section 5 refers to the protection of confidential information. It states that any information, given with informed consent, should be treated as private and used only for the purposes for which it is given, in this case, for research purposes. There was an added proviso: the women were informed that should they reveal that they or another person needed protecting from significant harm, this information would be disclosed, with their consent, outside of the interview. In this respect I was acting in the same way to the professional gatekeepers who advised Goode (2000) to report any suspected cases of abuse (section 6.1.8). This proviso was necessary to reaffirm the ethical basis of this study in terms of the babies' safety. As that experienced by Goode, I did not meet this situation any time in the study.

Importance of venue

After noting the sensitivity of interviewing MMT breastfeeding mothers, I also acknowledge they might harbour anxieties about being interviewed. From the literature I noted that the choice of venue was conducive to the mother feeling 'at home' with the interview. For instance, Murphy and Rosenbaum (1999) described interviewing women in venues where they felt most comfortable, which was often in their homes.

From a feminist perspective, interviewing is described as a 'conversation with a purpose' (Holloway 1997: p.94). Oakley (1992) described this as a social way of collecting data, but it was dependent upon the relationship between both parties. According to Finch (1984), interviewing at home helps contribute to a more relaxed atmosphere because the researcher is invited in as a guest. Presumably, this empowers the interviewee as they can ask the interviewer to leave their home at any time during the process when it starts to feel inquisitorial. In addition, Finch recognised that women appear to respond freely to a friendly, empathetic, female interviewer, especially when at home.

Of the 15 interviews, five took place in the women's homes. Each took about an hour to complete. One of those meetings took place in a café, due to a sudden change of domestic arrangements. To maintain the privacy of the interview, we sat apart from the other customers. Another took place in a relative's home, where the mother had been placed by social services for a residential parenting assessment. We sat on a double bed she shared with her aunt. Meetings that took place in clinical or supervised venues were interrupted by staff. I conjecture they were either suspicious of me or worried about our meeting privately. Such an observation is similar to the one identified by Goode (2000). For reasons described in section 6.1.8, professionals can be suspicious of a qualitative research paradigm that necessitates a greater rapport and empathy with women via lengthy conversation.

The women said they enjoyed being interviewed, with time to talk about their experiences. They also stated how useful and therapeutic the interview was for them.

After her second interview, Doris described the interview as particularly cathartic and empowering and texted me the next day to say ‘thank you’ for how much the interview had helped her take stock of her situation. Her comments reminded me of previous work with women:

‘It’s lovely talking to you, Sarah, it really is, it’s so therapeutic’ (Goode 2000: p6).

‘I’ve really enjoyed having someone to talk to’ (Oakley 1992: p14).

‘It’s great having someone to talk to’ (Finch 1984: p74).

These similar responses suggest women not only value the opportunity of having somebody to talk but also indicate such occasions for sharing might be missing in their lives.

Table 8.2 below lists the venues of each interview. In the interests of participant confidentiality the names used in this thesis are pseudonyms and listed according to when women are recruited into the study, *i.e.*, participants 1, 2, 3 and 4 are named Anna, Beth, Chloe and Doris respectively.

	T0 Baseline data whilst mother is still pregnant	T1 5 days following delivery	T2 6 weeks following delivery	T3 12 weeks following delivery
1 Anna Recruited outside London	Aborted. Train journey terminated en route to interview.	Postnatal ward: Single bedroom. Interrupted by staff	Mother's home: Living room with new baby. Partner and older child were absent.	Tesco café: Planned to meet mother's home, changed at last minute due to change in circumstances.
2 Beth Recruited in London	In-patient detoxification ward in mental health hospital: Office. Interrupted by staff	Neonatal ward: Private side room used by parents Interrupted by staff	Parenting assessment unit outside London: Living room. Interrupted by another resident and member of staff	Parenting assessment unit outside London: Small interview room. Interrupted by staff

<p>3 Chloe Recruited in London</p>	<p>Specialist drugs and alcohol antenatal clinic: Consultation room.</p> <p>Partner present</p>	<p>Postnatal ward: Stock room.</p> <p>Interrupted by staff</p>	<p>Special care baby unit: Private side room used by parents</p> <p>Interrupted by staff</p>	<p>Relative's home: Main bedroom sitting on double bed.</p>
<p>4 Doris Recruited outside of London</p>	<p>Specialist drugs and alcohol antenatal clinic: Consultation room.</p> <p>Interrupted by staff and fire alarm</p>	<p>Postnatal ward: conference room.</p> <p>Interrupted by staff</p>	<p>Participant's home.</p> <p>Partner left after I arrived. Absent during interview.</p>	<p>Participant's home.</p> <p>Partner absent.</p>

Table 8.2: Venues of interviews

Researcher vulnerability

Finally, as I met mothers alone in their homes, I had to consider issues related to researcher vulnerability. Outside the hospital, it was not possible to meet in a more public place, such as the GP's surgery or drug clinic. The baseline interview assessed possible risks for interviewing in their homes (Appendix 8). I adhered to my employer's Health and Safety Policy for Safe Working in the Community. Where possible, I assessed the risks before entering the premises and placed myself ready for an easy exit. I carried a mobile phone at all times. Friends and family were informed of where I was going, when I was entering the premises and when I left. I had a Criminal Records Bureau (CRB) enhanced status check for contact with the babies.

Time spent collecting data was largely experienced as an exciting and satisfying part of the research process. However there are also times of loneliness, for instance, when I felt overwhelmed in my first ever interview with Anna on the postnatal ward (see section 9.4 for details of individual case summaries). The interview was dominated by the events of the previous night as her baby had fallen off the bed whilst she was breastfeeding. She described being upset and stressed, but also angry when a midwife said that 'her medication', *i.e.*, methadone, was making her drowsy, even though she had been taking the same dose for many years. During the interview, she left to take her baby for a skull x-ray and instructed me to wait as she wanted to continue. On her return, the process felt rushed and we were often interrupted. However Anna persisted in saying she wanted to continue. Just before completion, the interview was finally terminated when two doctors said her baby had a fractured skull. I waited an hour to say good-bye and thank you. Even though she was distressed by finding her baby had been injured, and this was compounded by anxiety that social services were going to be involved, she said she wanted to continue with the research. Afterwards I felt shaken. A later conversation with my supervisor helped me to debrief and recover. Given the circumstances as they happened, we both reflected on the event as an example of being a lone researcher.

8.5 Sampling Issues

Sampling strategy

As I was exploring a closely defined group which would provide sufficient perspectives of a given context, the sampling techniques I used is described as purposive (Brocki and Wearden 2006, Smith 2003a, Gehart *et al.* 2001). Purposive sampling provided a comparative cohort of four pregnant mothers which was criterion-based and met with the following exclusion and inclusion criteria (Gehart *et al.* 2001, Lincoln and Guba 1989). These are normal considerations but particularly important in this study.

Inclusion and exclusion criteria

MMT mothers wanting to breastfeed: For reasons described in Chapter 5, methadone-treated breastfeeding mothers were considered for this project because of the supporting evidence base for methadone developed over 30 years, incorporating particular research on the safety of methadone in pregnancy and breastfeeding. All mothers were engaged in treatment for an opiate addiction with methadone. In the absence of medical concern for mother and/or baby, no mothers were excluded based on these criteria.

MMT mothers attending a specialist antenatal clinic at an Inner London or a hospital outside London: As described in studies explored in Chapter 6, by engaging in these specialist maternity services, often following referrals from their prescribing services, the mothers interviewed for this study were demonstrating their intention to change and capability to mother. The hospitals were selected purely for convenience and accessibility. None of the mothers were excluded because of the risk posed to the baby because the mothers were not HIV/AIDs positive or involved in poly-substance misuse.

MMT mothers' ability to understand, read and write English: Although this suggests a cultural bias, I did not wish to exclude mothers whose first language is not English. This criterion is a reflection of the practical limitations of the study: working as a lone English-speaking researcher without the services of a translator.

Sample size

The intention was to recruit five participants; however, four were eventually recruited into the study. The numbers were restricted by the narrow inclusion criteria from an already very small population of substance-abusing mothers. For instance, there were only 40 mothers using any substance, including alcohol, who delivered their babies at the Inner London hospital in 2008. For this reason I extended the study from one to two centres in an effort to raise the chance of being able to recruit more women. However, given the longitudinal nature of the study and the intensive interviews, four participants were judged sufficient to provide the richness of data needed to meet the project's purpose and methodology.

8.6 Overview of data collection methods

In Chapter 7.1.3, Interpretative Phenomenological Analysis (IPA) was described as being influential at the time of data collection. The interview consisted of two parts within a mixed methods approach: the smaller structured questionnaire and the semi-structured interview. This format is particularly favoured as 'the exemplary method for IPA', with an interactive, as opposed to non-interactive, researcher role (Brocki and Wearden 2006: p.90, Gehart *et al.* 2001). In addition, Jonathan Smith (2003a), a notable IPA researcher and writer, advises the use of a schedule to guide the interview. He says that writing beforehand helps plan and guide the overall area and broad aims of the interview, as well as the sequence.

For this study, a schedule was devised and helped maintain the focus of the interview on the research question (Appendix 9). Topics were listed and funnelled, with the most sensitive (most personal) placed after the least sensitive questions. The interview was then laid out in six pre-planned sections:

- Section 1: Contact details collected at the first interview
- Section 2: Baseline information collected at the first interview (Appendix 8)
- Section 3: Update of circumstances, subsequent interviews (Appendix 10)
- Section 4: Relational map drawing and index (Appendices 11 and 12)

- Section 5: Questions for, and drawings, of the non/ideal mothers (Appendices 13 and 14)
- Section 6: After the interview/ consent to continue (Appendix 7)

Structured questionnaire

The structured questionnaire format of the baseline and update interviews was used to engage and relax the mother. The questions were designed to be non-intrusive and easy to answer before proceeding to the relational map and finishing with the drawings of the non/ideal imaginary mothers.

The baseline interviews were designed to collect data to provide a profile of the mothers over the time of the study. Data consisted of simple demographic information: age, social circumstances, employment status, education and housing. Women were asked about when they discovered their pregnancy and their engagement with antenatal care. They were also asked about their feeding plans and current methadone treatment history. Subsequent interviews did not repeat this information but concentrated on asking about their status, if they were still breastfeeding and any changes in their circumstances since the last interview.

Questions were based on assumptions and information about breastfeeding mothers, and stemmed from the conclusions and discussions of the 2005 breastfeeding survey (Information Centre for Health and Social Care 2007) and previous research by Abdel-Latif *et al.* (2006), as described in Chapter 5. These were used for comparison with the sample of women interviewed.

The nationwide survey of infant feeding undertaken by the Information Centre for Health and Social Care (2007) described the highest prevalence of breastfeeding amongst mothers with higher levels of education, aged over 30, first-time mothers and those working in the managerial and professional occupations. These findings were not reflected in the biographical backgrounds of this group of mothers interviewed in this

study. However as these mothers were stable, engaged in treatment and, apart from cannabis, did not use illicit drugs they are similar to discoveries made by Abdel-Latif *et al.* (2006). They said that mothers who formula rather than breast-fed their babies were more likely to lead more chaotic lives and continue to use illicit substances in addition to their methadone prescription.

Overview description of participants using baseline data

Demographics: All women were white British with an average age of 25 years, ranged from 19 to 32. Only Beth and Chloe described themselves as unemployed. Anna said she was a housewife, whilst Doris was fully employed in security and events management.

Education: The mean age of leaving school was 15.5 years, ranged from 14 to 17. Only Chloe left school before taking any exams. All the others had 3-13 GCSEs. Doris had started an A level course but left early to help her father. Anna left school at 17 with 4 GCSEs even though she said she hardly attended, indicating her achievement level might have been different if she went to school regularly.

Accommodation: All were living in rented accommodation. Although no one described problems with housing, Beth described that she had no furniture in the flat as it had been sold for drugs. She was interviewed at a parenting assessment unit where she had been placed by social services immediately following her discharge from hospital. Similarly, even though Chloe did not cite any housing problems, she did not return home to her partner on discharge. To assess her parenting capabilities, she was placed in a relative's house in another part of London.

Current pregnancy: Beth and Doris were first-time mothers. Anna discovered she was pregnant at 6 weeks. Beth and Chloe made the discovery at 3 months, whilst Doris was unaware of her pregnancy for nearly 6 months. However, once their pregnancies were confirmed, all engaged within the specialist antenatal services and kept regular

fortnightly appointments. Reasons for breastfeeding were all cited as benefiting their babies.

Other children: Anna lived with her 10-year old son. Chloe's 4-year old daughter was fostered by her parents, who lived separately. Both women had attempted breastfeeding previously. Anna managed to feed for 3 months but had to stop because her son was losing weight. Chloe (then aged 16) tried to feed, but said her daughter was too hungry.

Family and support: All cited their partners and family as their main support. Chloe also mentioned social services.

Methadone treatment: Except for Anna who had been receiving a prescription for about 13 years, all the women had started engaging in methadone treatment whilst pregnant which led to them being referred to social services. This suggests that they had discovered their pregnancies whilst using illicit drugs and starting methadone treatment brought them to the attention of social services.

Other medication or drugs: None of the women were receiving prescribed medication, including antidepressants. None reported taking non-prescribed drugs except Doris, who said that she continued to smoke cannabis occasionally to help her sleep.

Semi-structured interview

Whilst planning the structure of the interview, I reflected on Holloway's (1997) observation that the choice of interview design is dependent on how it is possible to gain the participants' perspectives of their experience. To this end, unstructured interviews give participants the time and space to describe their accounts of events. I considered using narrative analysis, which necessitates the use of an unstructured interview format. Holloway (1997) says that broad and open-ended questions promote the exploration of the lives and experiences of the participants, which ultimately are presented as case studies, either individually or within a cohort. Each 'case' is described where participants are similar and separate enough to involve them as

comparable instances of the same general phenomenon (Ragin and Becker 1992). This is a relevant comparative portrayal for the cohort of breastfeeding MMT mothers interviewed for this study.

However, having acknowledged the similarity of a narrative, when compared to phenomenological analysis, unstructured interviewing was rejected for use in this thesis. This decision was made on the basis that, instead of requiring a broad view of their experiences as mothers narrate them, this study is intent on exploring the essence of the phenomenon of early motherhood for breastfeeding MMT mothers. So, although the mother's narratives are relevant inasmuch as they reflect their experience, paradoxically their stories might not be relevant enough and risk omitting the very phenomenon that is under investigation, *i.e.*, the existential tension experienced by this specific group of mothers as they strive to realize their new social identity.

For instance I observed the structured questionnaire appeared to offer the women opportunities to describe the context of their experiences more in keeping with an unstructured format (Appendix 10). The first question used in the second and subsequent interviews asks about their welfare. The opening question, 'How are you?' prompted conversation that provided data on the broad context of their lives. Initially, I was concerned that the interview should have been designed differently to include the use of an unstructured questionnaire. However, as they spoke on a myriad of problems, including with the social benefits system, I felt that my choice of methods was vindicated because they focussed on collecting data that was relevant to the research question.

Therefore, due to the specificity of the phenomenon, a semi-structured interview format was used, with drawing, specifically of the relational map and non/ideal imaginary mothers, as a research method.

Drawing as a research method

In his work on Mind Maps, Tony Buzan (2000) explains that drawing helps utilise the way the world is interpreted because description (creative thinking) is not constrained by linear forms. In her use of drawing to explore the understanding of illness, Guillemin (2004) describes drawings as a rich and insightful research tool. She observed people make sense of their world through what they drew. The act of drawing requires knowledge production as a visual creation, but lies beyond the boundaries of speech. In this respect, Buzan (2000) describes speech as a complex process of sorting and selecting. Listening is portrayed as an act of receiving the context of words that surrounds them and, into which, unbeknown to the speaker, the listener projects their own interpretations and associations concerning what is being said. Therefore, for use in this thesis, drawing helped to contextualise the conversation and clarify both parties' interpretation of the subject under investigation.

Described in Chapter 6.1.10, Fraser *et al.* (2009) use drawing in their study when interviewing children. Although the parents were interviewed via semi-structured questionnaires, the children used a 'draw and write' technique enabling them to discuss sensitive topics in a non-threatening way. Similarly, drawing as a research tool has particular relevance for this study as it allowed mothers to express themselves in a manner that is meaningful, regardless of educational achievement and potential problems with literacy. In terms of doing sensitive research (section 8.4), this cohort of drug-using vulnerable mothers may be depicted as harbouring fears of being discredited or incriminated by their responses. In addition, female drug-users are often described as suffering from poor esteem (*e.g.* Murphy and Rosenbaum 1999). These portrayals suggest that a direct face-to-face questioning technique, when perceived as threatening, may restrict conversation. Therefore, in the interest of this thesis, the choice of research tool was premised on the need to address the issue of putting the women at ease within the interview.

Even in interviews where women do not use drugs, the relationship between researcher and participants is the focus of much feminist discussion. Writing about the ethics and

politics of interviewing women, Finch (1984) notes the preference for qualitative techniques and non-hierarchy in the woman-to-woman interview relationship. As a social experience, the interview is described as an intimate conversation with a sympathetic listener and within which the participants too become questioners. Observing this two-way process as part of natural human interaction, Oakley (1992, 1979) says that women interviewing women is a contradiction in terms. As a sensitive medium for promoting a non-hierarchical and non-threatening research relationship, drawing as a research method encourages conversation, whilst omitting direct questions, which might be interpreted as daunting.

The notion of using more indirect methods of conversation stemmed from my work as a nurse. Used as a psychological tool, I noticed the impact that drawing had on clients through a palpable shift in conversation. They described an increase in understanding, with new insights, which, before using drawing, would have remained hidden. In addition when meeting later on, clients have told me they have remembered their drawings and the meanings that were triggered. They said they had reflected what these meant for them, both alone and with their partners.

However drawings can pose problems related to issues such as increased sensitivity and resistance. Writing on the use of diagrams and relational maps, Copeland and Agosto (2012) observed that, as participants draw, they become more aware of their thoughts, opinions and emotions. In addition they describe some respondents becoming uncomfortable when asked to create increasingly comprehensive drawings. It is suggested that, in this scenario, the added details prompt previously hidden and uncomfortable insights and feelings. Within this study, although the women were involved in drawing, the pictures and their descriptions were imaginary images which were not profoundly itemised. A further way this study reduced the potential risk of drawing is to discuss the procedure before women give consent to enter, and continue with, the study. When initially describing the study before gaining consent, Guillemin (2004) discussed drawings with her participants as the method she used for data collection. However, even though drawing was described in the participant information

sheet, she says she was surprised by the participants' reactions at being asked to draw in the interview, with exclamations of 'I can't draw!' Although they needed a few minutes to reflect, they all appeared to continue drawing. In a similar way, women interviewed in this study were told beforehand about drawing as a research tool, details of which were included on the printed information sheet sent with my initial letter of introduction. All gave their consent and none declined to draw.

Finally in their investigation of draw and write techniques used for research with children, Backett-Milburn and McKie (1999) expressed concern about bias within drawing. They cited three examples: children deciding to draw what they find easy to depict, the influence of recent lessons or experiences and the children's desire to please the researcher. All three can be addressed favourably within this study. As the drawings were directed by a simple set of questions, the women did not have to find something difficult to illustrate. Similarly, as the interviews took place regularly during a period of intense existential tension, what they drew was expected to be influenced by recent experiences. In this respect, it does not matter if what was drawn was true or pleasing to me. The drawings are not used as images of absolute truth, but explore the context, via conversation, of the particular settings and times of the interviews in which they are drawn.

Therefore, in terms of interviewing MMT breastfeeding mothers, drawing is considered the optimal research tool because it is:

- Non-threatening, easily explained and understood;
- Able to encourage constructive reflection and conversation;
- Interesting, so that mothers would feel as if they had learned/gained something from the interview, and wanted to return.

However, before describing the tools chosen for use by this study, the next section outlines the process of how they were refined and developed.

Pilot study

The aim of using an early pilot study was to refine and develop two tools, previously used in clinical psychology, for research use, *viz.* the relational map and drawings of the non-ideal/ideal mothers. As described in Chapters 2 and 3, they are informed respectively by relational and personal construct psychology theories. However, due to the unfamiliarity of their use as research tools, and before using them to collect data, I undertook a month's trial on four university colleagues (Appendix 15). There were two main objectives to this process:

- To explore the acceptability of the tools for research and whether they were capable of gathering the data needed;
- To familiarise myself with the tools, interview style and use of an audio tape before interviewing participants.

The interviews took about an hour to complete. Although the methods were extremely simple, all the interviewees were very positive about the kind of data that would be elicited, which was described as enormous and very rich. They all felt the drawings would help answer the research question. In addition, after changing a few details, such as adding 'feeding her baby' to the drawings and offering a time within the interview for a break if needed, I felt the tools could be used for participants in this study. I also addressed recording problems by using a digital recording device that did not stop half way through the interview. Whilst refining the baseline questionnaire, I also trialled later interviews via a colleague who pretended she had a 6-week old baby. This highlighted logistical problems of contact. As a result, I set out a clear plan at the first meeting of how to contact the mother at the time of delivery. In addition, I not only listed her expected date of delivery (EDD) but also suitable contact phone numbers. As it turned out, I was able to get in touch with all the mothers via their mobile telephones, even when in hospital.

The following sections describe the drawings as data collection tools. The conversation that was facilitated during this process was later transcribed as text and analysed.

Relational Map

Within this study, the map is used as a tool to promote discussion, with mothers encouraged to consider the meaning drawn into the maps. Described in section 2.2.2 Relational Theory (Byington 1997) outlined the importance of relationships which give women a sense of self. She noted that for drug-using women, the one important functional relationship in their lives was with the drugs they used because they feared becoming unwell when they did not have them. This tool is used to help explore the women's relationships that are intrinsic to their life world, for instance with their baby, family, professionals and methadone.

This map comprises one blank piece of paper, photocopied with ME written in a circle at the centre of the page, laid out in 'landscape' fashion (Appendices 11 and 12). After identifying and listing significant relationships at the time of interview, the mother draws these onto the map using varying lengths of line. Those identified as being very close are drawn with the shortest lines. Afterwards they draw in the position of methadone: where it is at the time of the interview and where they would like to see it at the time of the next appointment.

The women were encouraged to reflect on, and discuss, the relationships drawn on the maps. For instance, where methadone was given the shortest line, mothers were asked to reflect on the kind of relationship they have with it. This process added to the credibility of the data as enhancing the input of the women interviewed. They were given time and encouragement to reflect on what they might want to add or detract from the conversation.

Drawing the non-ideal/ideal mother

Personal Construct Psychological Theory is described in section 3.3.2. It underpins Heather Moran's drawing of ideal self (Moran 2001). This tool was originally devised for use by children's and adolescents' mental health services (CAMHS), but has never been evaluated as a research tool. The drawings are used to explore the meanings as they move from the experience of being pregnant MMT women to becoming

breastfeeding MMT mothers. As they draw and imagine mothers, they are invited to construct what constitutes an ideal/non-ideal mother which may or may not reflect the social construction of motherhood.

On discussion with Moran, she advised the use of very little equipment: just 3 pieces of A4 paper and a pencil. Two imaginary mothers are drawn on two separate sheets of paper in portrait fashion. At the end, the third piece of paper, laid 'landscape' is placed between them, the function of which is discussed below (Appendix 13).

The words used are very exact. On the first sheet is written '**The kind of mother, feeding her baby, I would not like to be like**'. On the second is written '**The kind of mother, feeding her baby, I would like to be like**'. The words were clearly specified, based on experience Moran had had using similar phraseology with adolescents, in the context of their lives. The word 'like' is used to invite exploration of an imagined mother the interviewee resembles or is dissimilar to. The sense of meaning changes if words such as 'plan' or 'want' are used. These words suggest a dynamic process of scheming or desire within themselves either to become the mothers they have imagined, or change from the mother they imagine they do not want to be like. The slight change in wording appears to change the ethos of the drawing from comparison with their own construction of an ideal/non-ideal mother to what parts of them they identify as needing to change to become that mother. As a research tool, the former was better suited to generating discussion and data for this thesis.

Taking each drawing in turn, starting with '**The kind of mother, feeding her baby, I would not like to be like**', it was stated constantly throughout the interview that the mothers they drew were not real people, but imaginary ones. The women drew a picture in the centre of the page and wrote down their responses to the questions which were asked in a specific order. Eight predetermined questions helped to describe the imaginary mothers in great detail (Appendix 14). This gave each participant time to describe their paper-based mothers and also reflect on their own constructs. Each question was completed in a strict sequence before moving on to the next one. The

process was also completed for the **‘The kind of mother, feeding her baby, I would like to be like’**.

As Moran usually works with children, her questions were directed towards a child’s life and included going to school and birthday presents. I amended this list to reflect a more adult world, but included original questions. The final list asks for a general description of the mother, her handbag and contents, preferred birthday present, her relationship with her family and friends, her greatest fear, history and future.

The final stage involved the mothers situating themselves on a line of self-construct. A third piece of paper, on which was drawn a horizontal line, with the centre marked as a convenient reference point, was laid between the two imagined extremes: non-ideal mother to the left with the ideal mother on the right. The participants rated themselves along this line. Predetermined questions helped the mothers to evaluate where they positioned themselves at the time of the interview, in the short- and long-terms, with three ideas of how to arrive at their goals. Finally, on finishing the drawings, the mothers were asked for any further comments. They returned to the relational map to imagine the future position of methadone, whilst discussing their reasons why.

At this stage, the interview opened up into general discussion. At the end of every interview, the women were given time to ask questions and say how they might have been affected by the interview, and whether any of the questions were particularly upsetting and how it felt to be interviewed. They were also asked about the use of the research in terms of the publicity of the findings. Included within this section, I asked for reflections on the drawings, whether they liked them, or found them useful and whether the interview could have elicited similar responses in a different format.

Reflections on the drawings as methods of data collection

Situated within the second part of the semi-structured interview, the drawings helped structure the women’s responses to breastfeeding and their methadone treatment. During the time they were concentrating on drawing their imaginary mothers, I

observed an additional unforeseen benefit, that of silence. Whilst drawing, they would comment on how they could not draw or had not done so since school or hummed whilst they drew. A lot of time was spent trying to get the drawing 'right', which included some use of the eraser. In her paper examining drawing as a flexible method to gain a greater understanding of an object, Lyons (2012) became interested in the phenomenon of silent concentration. Silence happened when the participants focused on the drawings, as they engaged in the activity and gained knowledge from them. Being so absorbed in the experience, at times the silence was intense and continued for a long time. To test this phenomenon, Lyons instructed the participants to talk whilst they drew. When the participants rejected this notion because it was unnecessarily intrusive, Lyons concluded that silence is a necessary part of the concentration needed to engage in the activity of drawing. She noted that, as drawing deserves the subject's undivided attention, talking is misplaced as demonstrating disrespect and a break in concentration.

I interpreted the women's silence as a measure of how comfortable the women felt and how interested they were in their own drawings. I also noted the length of time it took to draw a satisfactory imaginary mother. However, where Lyons (2012) was able to accept this as part of her research process, I was concerned about the time it was taking to draw and questioned the appropriateness of the drawings during the interview.

Firstly, I wondered whether the procedure of describing the mothers was too long and tedious, as the request for descriptions of their imagined mothers seemed inappropriate to the interview setting. I was particularly worried when mothers looked tired or when they described being in difficult and stressful situations. For example Anna continued drawing even though she had to take her baby to have an x-ray in our first meeting. Doris also continued drawing during the second interview, even after describing feeling really angry as her baby had recently been taken to the NNU. During such times, I noticed I wanted to hurry through the descriptions. However, as none of the women declined to draw or stated they felt unable to do so, I wondered whether this was due to the perceived unequal power relationship within the interview. Limitations of my role

as interviewer are explored later in section 11.3. However, as the drawings were repeated over the four interviews, they said they could predict what they were to draw next.

Even so their involvement in the drawings despite the stressful juxtaposition within the context of their lives, raised an added concern that the drawings were an impractical tool where mothers often had their babies with them in the interviews. In the absence of a table to draw on, mothers had to resort to leaning on books balanced on their knees. Sometimes they did this with a restless baby in their arms. They said they did not want to stop when I questioned them, stating they were happy to continue with the interview. On occasion I offered to hold their babies whilst they drew. So, although I experienced anxieties over the appropriateness of drawing for mothers with small babies, these appeared to be unfounded when reporting the experiences of the mothers interviewed.

8.7 Conclusion

Where recruitment was restricted by a limited population of breastfeeding MMT mothers, once enlisted, work was needed to ensure their continued consent to be interviewed within this study. Therefore, the overarching theme in Chapter 8 is the importance of the interview experience for the women recruited. It should be the least intimidating and most interesting experience possible. This affected not only the choice of venue and methods, with the persistence of access as a retention method, but also the careful choice of research tools. This was demonstrated in the choice of drawing as a medium for encouraging conversation and which enabled the researchers to discuss sensitive topics in a non-threatening way. The drawings for this study were based on two simple psychological tools that appeared to engross the women. Silence in an interview was interpreted as a mark of being comfortable. In addition, as all the interviews for the women were completed, this was interpreted as expressing their continued interest in the study.

The data collected within a conversation during this time is discussed in Chapter 9. After describing how the data are analysed, the chapter looks at previously hidden meanings mothers have of their lifeworld in relation to the research question.

Chapter 9: Data handling, analysis and presentation

Chapter 9 examines the handling, analysis and presentation of data from a cohort of four breastfeeding methadone-treated mothers. Section 9.1 describes preparation of the data, including how the taped conversations were transcribed. Section 9.2 outlines the background process of doing phenomenological data analysis and includes Colaizzi's five stages of examination (1978). Demonstration of how these are applied to this study is shown in section 9.3. Section 9.4 introduces the mothers' individual summaries and common aspects of their constructed lifeworlds. According to Benner (1994a), within the context of a phenomenological study, data are used to hear and understand the voice of the participants. Thus section 9.5 presents the data to give greater access to an understanding of the text in ways that illuminate previously unknown or unseen aspects of their experiences. Three categories that emerged from the data, namely; the mothers' internal emotional world, their external world of being treated as 'the Other' and their resolved tension on leaving hospital, are displayed in this section.

9.1 Data handling

All interviews were recorded and transcribed by a professional service to produce 427 single spaced pages of transcription for 16 interview hours, as shown in Table 9.1.

		Interview 1 (Baseline)	Interview 2	Interview 3	Interview 4	Total
Anna Delivered son: EDD - 15 days.	<i>Interview</i>	Aborted	October 2008	December 2008	January 2009	
	<i>Duration</i>		1hr 30mins (in 2 parts)	1hr	45mins	3hrs 15mins
	<i>Pages of transcription</i>		36 pages	26 pages	Tape failed to record-too much noise in café	62 pages
Beth Delivered daughter : EDD + 9 days.	<i>Interview</i>	January 2009	February 2009	April 2009	May 2009	
	<i>Duration</i>	40mins	43mins	1hr 16mins	1hr 13mins	3hrs 52mins
	<i>Pages of transcription</i>	Discovery tape did not record after interview	17 pages	35 pages	32 pages	84 pages
Chloe Delivered daughter: EDD + 1 day.	<i>Interview</i>	June 2009	August 2009	September 2009	October 2009	
	<i>Duration</i>	50mins	1hr 7mins	1hr 20mins	1hr 10mins	4hrs 25mins
	<i>Pages of transcription</i>	26 pages	39 pages	51 pages	32 pages	153 pages
Doris Delivered daughter: EDD.	<i>Interview</i>	September 2009	October 2009	November 2009	January 2010	
	<i>Duration</i>	56mins	1hr 20mins	1hr 20mins	1hr	4hrs 36mins
	<i>Pages of transcription</i>	27 pages	35 pages	35 pages	31 pages	128 pages

Table 9.1: Interviews: dates, duration and amount of transcribed data.

In total: 15 interviews, comprising 16hrs 08mins, transcribed across 427 single space pages.

I tried to transcribe the tapes myself but experienced problems, trying firstly to hear and secondly write down the words, of two very quietly spoken and relatively inarticulate women. Initially I was hesitant to hire people to do this for me because of arguments which stress the importance of becoming familiar with the taped conversations. For instance Tilley (2003) argues that portioning out to a third party risks the researchers' lack of involvement with the data, with the implication this could negatively impact on the shaping of the final text. In an earlier paper, Lapadat and Lindsay (1999) preferred listening and re-listening to the taped conversations. In a process described as 'methodical re-listening', they advocate becoming submersed in the data to facilitate the close attention and associated interpretative thinking needed to help make sense of them.

Thus, whilst facing logistical problems of transcribing the tapes and being aware of the need to be immersed in the tapes and texts as advocated by these authors, I took a pragmatic middle road. Where normally they would hand them to their proof-readers for final correction, the transcribers were instructed to give me their draft copies. Engaging in the process at this level offered the opportunity to return to, and immerse myself in, the data by re-listening to the audiotapes and correcting the text where I felt it had been presented differently.

Based on the methodological approach needed for this study, the transcribers were instructed to use an approach similar to that contained in the discourse of de-naturalism. An alternative style is naturalism, used largely within conversational analysis. This stresses the importance of describing all utterances in great detail and includes all pronunciation, slang and non-verbal utterances (Oliver *et al.* 2005). De-naturalism, on the other hand, is a method used where the specifics of communication are not as important as the informational content. It attempts a verbatim depiction of speech but the accuracy lies within the substance of the interview, its meaning and perceptions created and shared during the time the participant and researcher are together. Oliver *et al.* (2005) use critical discourse analysis and grounded theory as

examples in which the aim is to get an *emic* point of view: an insider meaning attached to the phenomena under investigation. For pragmatic reasons, the transcribers were instructed to present the data using a hybrid of the de-naturalised approach.

Data recorded this way was consistent with the methodological approach used in this study. The transcribers were instructed to insert non-verbal utterances where these might add greater understanding of meaning within the verbal context. Thus, whilst sighs were included, repeated utterances such as ‘you know’ were excluded. Once this stage was completed, the transcriptions were handed to me. I became familiar with the individual women’s voices and nuances by correcting the texts and re-listening to the tapes. To get even closer to the data, the transcriptions were entered, together with field notes written at the time of interview, onto Atlas.ti, a Computer Assisted Qualitative Data Analysis package (CAQDAS). As Atlas.ti is interactive, I was able to explore, search and interrogate, facilitated by the package’s ability to multi-code and retrieve codes flexibly. Extra levels of abstraction were further recorded via memo-ing, commentating and annotating the data.

Abstraction is a part of the phenomenological analysis process that is difficult to understand due to the intuitive way of handling the data. In this respect, phenomenology is explained as being both an ontology and method, as described below in section 9.2.

9.2 Phenomenological data analysis

According to Benner (1994a), phenomenology can be viewed as an ontology because of the intuitive element of analysis. Reflecting a philosophical approach, Munhall (1994) advises students to become immersed in the data in a way that opens them up to others’ experiences. This is reminiscent of the term ‘intuit’. Although described by Lemon and Taylor (1998) as difficult to execute, they state this as getting to know the human knowledge of things, *i.e.*, the subjective experience.

Alternatively, the use of phenomenology as a method is considered complex because, as data is interpreted via intuition, this process is difficult to define or describe (see section 7.2). There is a dearth of information in the literature about strategies for analysing data. For instance, whilst the two phenomenological studies, examined in Chapter 6 (Fraser *et al.* 2009, Murphy and Rosenbaum 1999) discuss deriving themes or categories from the data, there is a lack of description of how they managed the abstraction process. However, Lemon and Taylor (1998) give a thorough account of how they analysed their data using Colaizzi's (1978) five stages of examination. Their recording of how they use this structure in practice provides an insight into how I analysed the data for this thesis.

With examples from this thesis used to demonstrate the data analysis process, section 9.3 makes reference to Colaizzi's (1978) framework as mentioned by Lemon and Taylor (1998) and Haase (1987):

1. Gain familiarity by reading and re-reading transcripts;
2. Extract statements that describe the phenomena for analysis;
3. Formulate meaning through reflection of the highlighted statements for each transcript;
4. Group into themes of related meaning;
5. Formulate themes into description of the phenomena.

Ultimately, the data are considered within an iterative process which also incorporates Miles and Huberman's (1994) simple four-part structure: individual case synopsis; illustrated narrative across the cases; general condensation and general psychological structure (pp.86-87). Short individual case summaries of each mother's lifeworld, over the time of their involvement in the study, are described in section 9.4.

However, before moving onto examining the analysis of the data, I acknowledge that another researcher, given the same set of data, might come to a different conclusion to mine. In an observation similar to that described by Lemon and Taylor (1998) there is

no single ultimate, or correct, interpretation of another reality that lies outside the mothers' descriptions of their lifeworld experiences in this interpretative study. Another researcher would bring their own situated standpoints making them more or less sensitive to the nuances of the data, just as it has done for me. I have been influenced as indicated by observations made in my practice and arguments contained in Chapters 2 and 3. Although I worked alone, the following stages of analysis were clarified and discussed throughout with my supervisors.

9.3 Stages of data analysis

The data from the interviews are analysed in line with Colaizzi's five stages of examination (section 9.2). I first gained familiarity with the texts by reading and re-reading the transcripts. During this time, I listened to tapes alongside the transcripts which added familiarisation with the voice and idioms of each individual mother to intuit deeper understanding. As noted by Lemon and Taylor (1998), there are no rules about how often this needs to be done; but, as an inductive process, it should be long enough for potential meanings to emerge from the transcripts. In addition to field notes and memos, at the end of this stage, I was able to write up a vignette of each mother and my initial impressions of their story. This describes the horizon and personal experience of each mother and their individual case synopses.

With reference to Colaizzi's second stage, meaningful statements that described the phenomena for analysis were identified. The 15 interviews generated 316 significant statements. I went through each mother's transcript individually to retain the freshness of their story and to recall what they said. Certain statements were highlighted within this context. Colaizzi's third stage is concerned to restate these significant statements into formulated meanings or codes. Part of this process involved restating the more general form of language as used by the women in more objective scientific language. I continued to revisit the transcripts and tape recordings to contextualise the statements. Additional non-linguistic cues such as sighing helped clarify the meaning.

Reading Hayakawa's (2010) ladder of abstraction increased the understanding of the intuitive process. As a working illustration, Hayakawa describes the abstraction process from an initial perception of an object (*e.g.*, a cow) to the highest level as part of the wealth of the farm. Similarly, being interested in a more abstracted existential experience, I was able to move away from the individual subjectivity of the women's narratives. By identifying how the women were feeling in each statement, I was able to reveal the experience of the phenomenon through their eyes. This was aided by the memos, comments and notes I had written. After this process, I identified 37 formulated meanings (codes), with some having multiple significances. These codes, together with their significant statements, are alphabetically listed within a library of quotations. Such organized data helped access the most relevant statements needed to answer the research question.

The fourth stage involved grouping these codes into three themes of related formulated meaning (categories) by restudying the significant statements and restatements. To ensure the internal validation of themes, I continued to refer back to the original transcripts and tape recordings to judge their adequacy.

Table 9.2 uses three exemplar statements to demonstrate the development through Colaizzi's second, third and fourth stages of examination as described in this section. A more detailed progression is presented in Appendix 16. This shows the addition of two evolutionary stages of abstraction situated between Colaizzi's third and fourth stage. The first column on the right of the table gives examples of associated exemplar statements which are taken from the 316 generated at the second stage in Colaizzi's framework. Next to this are the 37 formulated meanings produced at the third stage of analysis. Some are repeated because they have more than one significance. The next two columns demonstrate the detailed process of abstraction which moves upwards through 22 themes to seven theme clusters. Arising from these in the column on the far left are the three separate themes of related formulated meaning (categories) as defined at Colaizzi's fourth stage and explored in section 9.5.

<p align="center">Exemplar statements Second stage</p>	<p align="center">Formulated meanings Third stage</p>	<p align="center">Themes of related meaning (Categories) Fourth stage</p>
<p>‘For some reason you feel different...when you’re bottle-feeding...you still love your child. But when you’re breastfeeding it’s the closeness, the way they sleep and it’s more comfortable and you can feel it. You are comfortable...It makes you realise that you are [a mother]’ (Beth: Interview 3).</p>	<p>Experience of breastfeeding: Whilst bonding with their babies, women were realising how breastfeeding was making them feel in terms of becoming a mother.</p>	<p>The mothers’ internal emotional world: Women describe the emotional changes experienced whilst becoming mothers.</p>
<p>‘We were definitely getting a lot of attitude and I mean we felt we were being quite defensive, but...it sort of, I think it was rightly so. I mean when we first went up on the upstairs ward [Neo-Natal Unit] the nurses were being really sort of quite...quite rude to us.’ (Doris: Interview 3).</p>	<p>Being judged: Women were sensitive to becoming defensive when they feel unfairly judged by professionals.</p>	<p>External world of being ‘the Other’: Mothers describe facing the judgemental reactions of professionals who continue to perceive them as drug-users and different from other non-drug-using mothers.</p>
<p>‘It’s [methadone] very important right now in my life. Keeps me stable...to do the things that I need to do on a daily basis, help my child,...do all the things for my children, and at the same time...I can talk to all these meetings. If I don’t have it I won’t have the strength’ (Chloe: Interview 3).</p>	<p>Relationship with methadone: Whilst embracing a dual identity of being mother and drug-user, women were feeling and recognising the important functional role of methadone within their lives.</p>	<p>Tension between internal changes and external world as experienced by mothers: Mothers describe coming to terms with their dual identity, as a drug-user whilst and functioning as a mother.</p>

Table 9.2: Three stages of data analysis, with reference to Colaizzi (1978)

Colaizzi's fifth stage involves moving away from the primary data. This involves a narrative integration—an elaboration and combination—of the themes. With added insight into the structures of lived experience, data are fashioned into an exhaustive description of the phenomenon under investigation. This description is contained in the discussion in Chapter 10.

9.3.1 Colaizzi's sixth and seventh stages

Although reference is made above to Colaizzi's (1978) five stages for data analysis, there are a further two processional steps. These relate to the identification of the fundamental structure of the phenomenon (sixth stage) and returning to the participants at a later date for validation of findings (seventh stage) (Holloway and Wheeler 2010, Sanders 2003). In this study the overlap between stages five and six is incorporated into Chapter 10. Underlying essential structures, identified by superimposing five major findings onto the discussion, are incorporated into an exhaustive description of the phenomenon under investigation. Also, for the purposes of this study, although respondent validation is often incorporated to ensure that the phenomenon represents the women's experience, stage seven of Colaizzi's model was eventually eliminated for the following two reasons.

Firstly, whilst writing up the research proposal, I was interested in receiving feedback from mothers on the research design. For this purpose, I identified two older mothers in my women's support group who often spoke at length about their difficulties. They said they would read the proposal and offer feedback. However, outside the group, I experienced difficulty in getting their comments. One woman told me she did not have time to read the proposal and the other kept saying she was 'getting around to it'. The second reason concerns the accessibility of the mothers interviewed for the thesis (section 8.3). Only two mothers seemed comfortable writing. One declined to write because she said she had literacy problems. Therefore, I thought that if I sent them a copy of my findings, I would probably not receive a reply.

Thus, instead of seeking respondent validation after the interviews, I chose to invite their reflections and clarifications during the time we were together during the time of the interviews. This is similar to a strategy suggested by Blaxter (1999) in her consideration of ethical issues in healthcare research. I noted the two-way conversational process ensured that women were able to validate the interpretations of their maps and drawings as a reasonable representation of their views. In the event, this added to the subtlety of the data; for instance, it revealed the previously hidden functional role of methadone. The mothers only became aware of the relationship they had with methadone when I asked for clarification at the time when they were engaged in their own personal meaning-making process.

Another example taken from my reflective diary demonstrates how the use of probing questions at the end of the interview helped to clarify the difference breastfeeding made in the mothers' lives. Described later in section 9.5.1, Beth doubted bonding with her baby if she had bottle fed. She instead predicted reverting back to her old drug-using behaviour. She concluded that as she was abstinent and no longer craving drugs, breastfeeding had altered the course of her life. Such reflections ultimately helped to validate the data analysis about the emotional benefits of breastfeeding.

In the following section I refer to specific extracts taken from my diary and memo to demonstrate the part it played in data analysis. At the time I was looking at Chloe's second interview, taken at the time she was on the postnatal ward. The discipline of writing in reflective journals and memos is described by Clarke (2009) as helpful in establishing transparency during the research process. As noted below, writing helped to challenge my ideas about professional prejudice during the time I was engaged in the process of identifying and codifying meaningful statements from the tapes and transcriptions.

9.3.2 Diary extracts to demonstrate researcher reflexivity

The extracts show that over the course of four days, I was working at Colaizzi's second and third stages. From listening to the tapes and re-reading the transcriptions, I

intuitively reflected on how Chloe is portrayed as lonely and isolated by her narrative within the data, and wondered about her unfair and stereotyped treatment by the professionals she meets. Whilst referring to two exemplar statements, (sections 9.5.2 and 10.4), I commented on the professionals' anxiety about Chloe. I was curious to know more about this interaction, in terms of their lack of trust and suspicions. I recognised that my questions lay outside the remit of this study and indicated this as a gap in this research project.

Reflective diary

- Days 1 and 2: Identifying and marking in meaningful statements in the text on Atlas.ti. Work through the transcriptions and identify possible initial codes via memoing.
- Days 3 and 4: Writing in the codes and comments. Through re-listening and re-reading I was becoming increasingly more familiar with the nuances contained within the text. This prompted thinking more about Chloe's experience of becoming a mother in the face of suspicious staff and the continued 'will she, won't she use' debate about drug use.

Memo: My intuited feelings regarding the manner of Chloe's narrative portrays her as a lonely, isolated and mistrusted mother on the postnatal ward. She describes offering urine samples for drug testing whenever she leaves the ward. She says she is motivated not to use or want illicit drugs because she experiences being a mother by having her daughter next to her on the hospital ward. However she sounds frustrated when describing the lack of acknowledgement of her continued abstinence from drugs. She repeatedly lays claims to the accusations she will relapse. Either professionals are stereotyping her, revealed in their attitudes towards her, though if I had access to the professionals' own accounts they might disagree with Chloe's version of events. Even so, her story strongly suggests that nobody is listening to her, and that she is distrusted, as demonstrated in this statement:

‘One of the night staff follows me into the toilet when I was washing my face and brushing my teeth and going to the toilet, and literally when I flushed the chain she knocked at the door and started searching the room, and the first thing that was out of her mouth, “what have I been smoking in here?”...It’s like accusing us of bringing drugs in the toilet’ (Chloe: Interview 2).

Members of staff appear very anxious about the possibility of Chloe using drugs in hospital. Where did this anxiety come from? Chloe's previous history? Their lack of knowledge and experience of working with drug-using MMT mothers? The pressure to comply with a care plan, which monitors for illicit drug taking? Lack of understanding or compassion? Other reasons? It seems that there are enough available midwives to follow Chloe around the ward, but too few when she asks for help with breastfeeding:

‘I don’t usually bother asking for anything [help with breastfeeding] because... there’s not enough staff, as they keep saying, so there’s hardly anyone to anything’. (Chloe: Interview 2).

I feel frustrated at not being able to answer these questions because they lie outside the remit of this study. This indicates to me the need for further research, in which both mother and staff can be interviewed over the same period of time.

During data analysis, ‘being judged’ was a formulated meaning with the largest number of statements. In the following section I describe supervisory guidance arising from a reported discrepancy between the mothers’ needs and their self-reporting of judgemental professional attitudes (section 9.5.2).

9.3.3 Validation of data analysis in supervision

One of the themes of the discussion was the effect on professionals of being socialised to have certain views which are teleological in origin and have a cultural (middle class) overlay. This included the notion that breastfeeding is an activity undertaken by normal

non-drug-using mothers. By implication MMT mothers are excluded because methadone in the breast milk has a polluting effect on their babies. However, this approach to the study was considered too polarised. Concerns were expressed around the narrowly biased analyses, with findings at risk of being presented as interpretations of truth rather than 'reported stereotypical attitudes'. Stereotyped attitudes were blamed as being caused by high work load, inadequate staffing levels, poor morale and young age of midwives/social workers. Discussion about 'boundary maintenance' (section 10.4), and specifically Menzies Lyth's (1960) research into attitudes of student nurses and Hart and Freeman's (2005) model of the professional ego resulted from these conversations. We acknowledged additional difficulties working with, and navigating around, challenging patients, especially when balancing statutory infant safeguarding responsibilities. Finally, enmeshed within this complex relationship, are the PMs' own perceptions of professionals.

A major contribution of supervision at this point was acknowledging my position to the study from an advocacy persona standpoint (see section 10.1). In terms of corroborating the analysis, I was advised by my supervisors to consider what had surprised me in the data and what I thought were important contributions to knowledge. I was able to identify the following six in the early stages of data analysis. These eventually contributed to final five major findings and discussion in Chapter 10.

Firstly, as discussed in section 1.3, I acknowledged my approach to the mothers from an advocacy standpoint which enabled them to be experts of their own lives. This lay harmoniously with my choice of methodology inasmuch as phenomenology is not concerned with the 'truth' of the situation, but is interested in the mother's perception of their reality. Secondly, there was recognition of a cathartic influence on women telling their stories and a probable factor in retaining the women in the study. Thirdly, the data indicated a mutual concern for the safety of baby from both mother and professional. This connects to the fourth observation, that breastfeeding is a language used by mothers to communicate their nurturing capability, which might not always be understood by professionals. Fifthly, mothers' reports of alleged, isolated incidences of

'poor or unsatisfactory practice' (p.10) resonate with the Department of Health and Home Office's (2000) definition of institutional abuse. Finally, there is the finding of women's previously hidden functional relationship with methadone. I recognised my mistaken assumption that an outside reader had a similar amount of knowledge and insight into methadone as I had.

9.4 Presentation of individual case summaries

The contexts of the women's lifeworlds are boundaried by what was happening to the women in their late pregnancy and the three months following delivery.

ANNA

As she was already raising her 10-year old son, Anna constructed her lifeworld through the dominant discourse of being a mother. She described receiving excellent antenatal advice but felt judged by a midwife after an incident soon after her baby was born. Throughout the interviews, she continued to feel angry. In the 10 postnatal days she had to remain in hospital, Anna felt alone and separated from her older son.

Breastfeeding helped her bond with her baby and contributed to feeling more self-assured and content. Although Anna did not make a connection between breastfeeding and weaning, she was considering reducing and stopping methadone over the next year, but feared being tempted back to street drugs. Anna's early journey describes the tension between her internal emotional world and how a single thoughtless comment by a midwife, which referred to her drug-user identity, could continue to anger her three months after the event. In addition to her baby, Anna identified five family members who were significant in her life at the time of the study.

BETH

Beth's lifeworld was constructed as a first-time mother, who described a powerful and positive response to breastfeeding. As soon as she started feeding three days following delivery, she became aware of becoming a mother. Before that time, she described

having no feelings for her baby. Beth described her profound emotional response as the key that opened the door to changing her life.

She immediately fell in love with her baby, who is described as the most important person in her life. Reflecting on how she was before this experience, she said she was shocked by her response. As soon as she was discharged from hospital, she rejected methadone and put herself through a very rapid and painful detoxification. She said breastfeeding was protecting her from resorting back to using drugs again. By contrast, if she had bottle-fed, Beth reflected that she would have abandoned her baby and returned to illicit drug-use.

Beth's early journey describes the tension between her internal emotional and external behavioural changes and relationships with others around her, who were slower to realise her transformation from drug-user to mother. Whilst experiencing a different identity as a mother, she continued to be perceived as a drug-user. She vented her frustration that one of the managers at the parenting assessment unit expressed doubt when she reported how differently she felt. Beth was irritated by her perception that every drug-using mother was classified as being the same.

CHLOE

For Chloe, an important theme in her lifeworld construction was that of being a mother already, although she said she did not have any parental responsibility for her 4-year old daughter. Whilst pregnant, Chloe was aware of becoming a mother and that she wanted to breastfeed. After the birth of her daughter, she tried to breastfeed, but had to stop when she did not receive the support she wanted. However, she continued to align herself with her imagined ideal mother who breastfed, surrounded by her partner, children and family. Chloe's early journey describes the tension between both her real and imagined worlds.

Implicit within Chloe's situation lay the stress of creating a new identity as a mother and her identity as an illicit drug-user. Chloe described her struggle to be a mother to

her baby. Breastfeeding was very important as demonstrating care, nurture, love for and bonding with her baby. Although Chloe appeared to try very hard to do this for herself, she says her efforts were in vain because professionals did not help and support her as a new mother experiencing feeding difficulties. She said that her wish to breastfeed was initially dismissed until it was later ignored completely. By continued references to being a drug-user, she describes feeling increasingly disempowered as a mother. According to Chloe, the professionals she was in contact with appeared to have little understanding of the functional role of methadone. She says they continued to criticise her persistent use of methadone and history of drug-use.

Chloe was influenced by the relationships with people and institutions she describes within the four interviews. In addition to her baby, Chloe identified two family members, a social worker and hospital staff (postnatal ward and NNU) who were significant in her life at the time of the study. There is a sample of Chloe's drawings in Appendix 17. Her relational map at second (T1) and fourth (T3) interviews show how she continues to stress the importance of methadone. Her line of self-construct indicates the marked difference between Chloe's perception of the relatively low confidence her social worker has in her as a breastfeeding mother compared to how she feels about herself (marked NOW).

DORIS

Doris perceived her world as a new mother. Whilst recognising her ignorance of this role, she said she was able to respond instinctively to her baby when breastfeeding. She described receiving excellent antenatal advice. However, after delivery, she felt judged by professionals, who were depicted as using personal opinions to inform clinical decisions, and omitting to give her the support and help she required. She was especially distressed at the sudden removal of her baby to NNU to monitor for neonatal abstinence syndrome. This affected her early experience as a mother. However, she was supported by her own mother, a specialist midwife, and her partner.

Doris' experience describes the tension between her concern for her baby's well-being, whilst being perceived as a drug-user. This left her feeling both stigmatised and marginalised. As one of the most articulate of the four mothers interviewed, she often reflected on her hospital stay and expressed confusion and anger about what happened to her in hospital, which she related directly to her being identified as a drug-user.

Although important to her, breastfeeding did not contribute to her defining herself as a mother. Doris was able to feed, enjoyed doing so, the result of which she added, resulted in a happy and settled baby. Doris' early journey describes the tension between her internal emotional and external worlds and relationships with others around her. In addition to her baby, Doris identified five family members, nine best friends and her dog as significant in her life at the time of the study.

9.5 Common aspects of the women's constructed lifeworlds

As previously demonstrated in Table 9.2 and Appendix 16, the following three categories emerged from the significant statements, restatements and formulated meanings:

- The mother's internal, emotional world;
- The external world of being 'the Other';
- Tension between internal changes and external world as experienced by mothers.

The implications of these three themes are discussed in the following sections. The first category describes how the mothers experienced the early transition from pregnancy to becoming a mother, from falling in love with their babies to feeling scared of losing them (section 9.5.1). Secondly, during their extended stay in hospital, whilst their babies were being monitored for opiate withdrawal and their suitability as mothers was being considered, they described how they experienced being 'the Other' (section 9.5.2). Thirdly, on their discharge from hospital, and for Beth during her extended time within a parenting assessment unit, they were able to reflect on how they were

becoming ‘good-enough’ mothers for themselves and displaying insight regarding the role of methadone (section 9.5.3).

The data are displayed using the convention that parts of the quotation which are not considered relevant are indicated missing by the use of an ellipsis (...).

9.5.1 Internal, emotional world of the MMT breastfeeding mother

As a result of breastfeeding, and stemming from a profound experience of love and fear, the post-delivery period is described as the time of major behavioural and emotional change. To explore the positive and negative emotional transitions, this category is divided into the two theme clusters.

Positive emotional transition

Although these data describe the common lifeworld experiences of a cohort of women, not all their experiences were similar. Because of her expression of the sheer volume of love as having life-changing powers, Beth is referred to extensively within this section. Her narrative details the emotional benefits of breastfeeding. Regardless of whether women have a similar chaotic drug using background, her experience is one that could be shared by other breastfeeding mothers.

Beth said she fell in love with her baby as the result of being able to breastfeed. In this quotation, she reflected on how she felt before she started to feed. Her daughter was born on a Friday and immediately transferred to the NNU for monitoring of opiate withdrawal symptoms. She said she did not pick her baby up during this time.

‘You just go there [NNU] and look at her and think this baby’s screaming like all the other babies. I didn’t think she was mine I just didn’t feel...I just looked at her. It was strange you [baby] come out of me and I don’t feel that love...’
(Beth: interview 4).

When Beth started to breastfeed on the following Monday, she describes crying because she felt she had not cared for her baby before that time.

‘I went to see her and actually tried to breastfeed her and when I did AW! [loud sigh]...I actually cried that day...Felt guilty cos I didn’t go down and see her for so long, how could I not care?’ (Beth: interview 4).

As described in Chapter 5.2, mothers are encouraged to breastfeed to bond with their babies. In this statement, Beth described this feeling, in which the identity of being a mother is realised.

‘...when you’re breast feeding it’s the closeness, the way they sleep and it’s more comfortable and you can feel it. You are comfortable It makes you realise that you are (a mother)’ (Beth: Interview 3).

Reflecting on the changes in her life as a result of breastfeeding, Beth appeared overwhelmed by her experience. In this quotation, love is described as a strong and unstoppable emotion, with the power to change her from a selfish, unloving person to one completely besotted with her baby.

‘I’ve lived by being selfish my whole life. This is the first time I have ever loved someone else...I’ve never loved anyone else, let alone myself. So to love A [baby], it’s the first time I’m ever loving truly. You know to even recognise what love is, that’s what she gave me cos I didn’t know the meaning. Strong, strong feeling, you can’t ignore it, you can’t switch it off...So that’s what I got from it [breastfeeding].’ (Beth: Interview 3).

In a later interview, Beth reflected on whether she would have felt the same about her daughter if she had bottle-fed. Referring again to the lack of feeling for her daughter in the immediate postnatal period, she assumed that she would have continued this way if she had not breastfed. She describes stopping methadone because she believed she

would not have cared for her baby, predicting she would return to her previous drug-using lifestyle.

‘I think I’d have felt differently...I don’t even think I would have stayed...I think I might have given up on her...Cos I remember when I first had her, she didn’t feel like she was mine I was scared to hold her, just having nothing to do with her. She was crying. I still didn’t feel nothing for her, no way about it, just thought ‘get away’. I didn’t go and see her, I wasn’t bothered whether she ate or not, ...so if I didn’t [breastfeed] maybe that feeling would have gone further I wouldn’t have gone to rehab, I would have gone back to my life...I would have come off methadone...because I wouldn’t be [*i.e.*, bottle feeding], I’d be using [drugs]...I wouldn’t care’ (Beth: Interview 4).

In this quotation, Beth demonstrates that instead of returning to a drug-using lifestyle, she is now able to consider having a family of her own.

‘The picture I’ve drawn is really myself...like I want to have my own family, and to do that I can’t do it on drugs...I’m a whole different person on drugs...I wouldn’t even love my baby if I was on drugs’ (Beth: interview 3).

However, whilst these changes are welcomed, they are experienced as dramatic and ‘freaky’. Living in a parenting assessment unit, Beth described being faced with other residents, also substance-users, goading her to fight. Whilst acknowledging she would have retaliated previously as a drug-user, she decided her reactions have changed as thoughts of her baby helped stop her from becoming involved. With the added shock that she was thinking of her baby before herself, she says she did not recognise herself for a couple of days:

‘[Breastfeeding] has changed me a lot, to people, my reactions, my lifestyle. Sometimes I don’t even recognise myself...You know I’ve been confronted with conflicts where people are just in my face - screaming. In the past I would

have reacted...I just want to go back upstairs and got to stay calm and make sure she's [baby] alright...And I was scared...I've never actually put anybody first...And the fact that she [her baby] just came into my mind - that freaked me out. I was shaking for a bit and I spoke to somebody and told them like my reaction freaked me out...I just felt like I didn't know myself for a bit. I went through a couple of days of not knowing how I felt' (Beth: Interview 4).

Beth's response to becoming a breastfeeding mother is particularly dramatic because of her articulation of the experience whilst living in an atmosphere of highly expressed emotion. In the following quotation, Doris described an underlying anxiety that circumstances could change for the worse. As a breastfeeding mother and using techniques learnt whilst being pregnant, she discovered she is able to respond to these concerns with equanimity:

'I'm also aware that even now...something could go wrong...I think one of the very important things I've learnt is...not to get stressed out [with] things that normally would stress me out, and I mean not even would make me take drugs or anything, but that I'd just be upset about and get in a state about. When I've been pregnant I've just been like [exhales slowly] and not been upset about them. That's really shocked me, how much just having your attitude about something can...can sort of help everything really' (Doris: Interview 2).

Negative emotional transition

Whilst experiencing the positive transition to motherhood via breastfeeding, the mothers' experiences are tempered by an awareness they are recovering heroin addicts. Negative emotional transition is experienced through being anxious, scared and powerless in relation to the influence of their drug-user identity in the early days of their care. As breastfeeding mothers, the women outlined their confusion, the result of a lack of available information for mothers and professionals alike. In the absence of the correct level of empathy and support, mothers risk becoming isolated and marginalised

from the care of their babies. As described in the previous section, this results in the constant awareness of others' perceptions:

'I'm always aware of what other people think...I'm a heroin addict. I'm a recovering heroin addict, but I'm still going to be a heroin addict always' (Anna: Interview 2).

Despite feeling capable of mothering, women described feeling worried, paranoid and scared because of being depicted as 'bad mothers':

'I've got the worry of myself, because everyone thinks that you must be some really bad drug-user or something who's not capable of what I'm capable of' (Anna: Interview 2).

This suggests that mothers' self-confidence becomes eroded. For instance, in the following quotation, despite responding to the many interruptions from other people in the interview, Anna expressed concern that her absence would be interpreted as neglect:

'I'm paranoid now. They'll think I'm neglecting my baby by being here' [taking part in the interview] (Anna: Interview 2).

As mothers with drug-using histories, anxieties were compounded by thoughts their methadone treatment had affected their babies *in utero*. Just after birth, their sense of concern was heightened, interpreting everything their baby did as related to opiate withdrawal:

'I've been waiting. Every little sneeze, every little cough I've been jumping up saying does he feel hot? Is he this? Is he that? So I'm more stressed out than most people anyway' (Anna: Interview 2).

And later Anna reflected that at the time, she was:

... 'worried about everything. Does he sleep too much? Is it this? Like no, he'll wake when he wants to. It really ruined the beginning of it for me. Really did, I can't tell you how much it did' (Anna: Interview 3).

Even though social services were not involved in her care, Anna described feeling scared of them. The following statement described other drug-using mothers she had known and seen on the hospital ward, who continued to use illicit drugs in addition to (*on top of*) their methadone prescription. Although she denied this drug-use herself, she still cited her fear of the power of social services to take away her baby:

'I thought well why aren't they [other drug-using mothers] taking their babies home [from hospital]? Because they were still using [illicit drugs] on top of it [methadone]. I wasn't you know, but that was another scary thing...They were telling me they [their babies] just got taken off them at the drop of a hat, like that. And that's what I thought was going to happen to me' (Anna: Interview 2).

As alluded to by Anna above, women interviewed in this study were aware that they can be stereotyped and treated as bad mothers. The awareness of this typecasting can influence how they react to professionals. In this statement, Doris reflects on her immediate postnatal experience. After describing poor professional attitudes, she says she tolerated them because she was scared not to, implying she did not want to appear confrontational:

'That was sort of quite horrible and I just felt when I saw you I felt that we'd taken a lot of sort of flak and attitude and we'd really just taken it because we were scared not to take it' (Doris: Interview 3).

In an effort to prove their capability to mother, they expressed powerlessness over plans that stated that they had to attend frequent meetings with different professionals.

As illustrated below, Doris talked about trying to establish breastfeeding and attend daily meetings, which she said were contrary to medical advice:

‘I was breastfeeding on demand...at the time I was really trying to increase my milk and...(that was another thing that Dr L (paediatrician) was quite angry about) they were wanting me to go up [to the centre], it was working out that I had an appointment nearly every day and having to go out nearly every day to something or other’ (Doris: Interview 4).

Whilst Chloe’s baby (aged 6 weeks) was in the NNU, Chloe cited being informed that they were to be discharged into the care of her aunt. This resulted in her becoming very busy. Aside from visiting her daughter in hospital, where she was interviewed, she continued to attend different meetings with a wide range of professionals. In addition, she had to make preparations for living in a different part of London, geographically distant from the home she shared with her partner:

‘I went to court on Friday...I have my drug team meeting once a week; and then I’ve got social workers’ meetings; I’ve got solicitors’ meetings; [and] I’m trying to get all my stuff up to my auntie’s house’ (Chloe: Interview 3).

Summary of internal, emotional world

The internal emotional world of MMT breastfeeding mothers is dominated by the overlap of their dual identity. Breastfeeding has been demonstrated unpredictably to change the lives of drug-using women. Women are left feeling scared when this is a sudden and dramatic event. However, women also feel scared about the welfare and custody of their babies, which leaves them exposed to poor professional practice and attitudes. They are kept busy attending a myriad of meetings in ways that are not advised by professionals in the cases of other non-drug-using mothers.

9.5.2 External world of being ‘the Other’

This second category explores the difference that mothers experience in the immediate post-delivery period whilst in contact with health and social care professionals. The mothers interviewed for this study remained on the ward for up to 10 days, much longer than their non-drug using counterparts. As breastfeeding mothers, the women described being stereotyped, which left them feeling different from other mothers, and are portrayed here as ‘the Other’:

‘Definitely being treated differently by some of the staff to how they treat other ladies on the ward’ (Doris: Interview 2).

As divided by the three theme clusters, section 9.5.2 explores the mothers’ experiences.

What it is like to be ‘the Other’

The women experienced being stereotyped as drug-users, and, as a minority group, being treated differently. Although breastfeeding, the women described how this left them feeling distrusted and disempowered.

All women described being judged. This was the main reason that tainted their experience of hospitals as mothers:

‘I think really, that’s been the most disappointing thing about being in here has been other people’s attitudes’ (Doris: Interview 2).

All describe the frustration of being lumped together under the label of ‘drug-user’ and not treated as individuals in their own right.

‘I think it’s just because they label me. I honestly think it’s because of what they think I might be going off to take drugs or something. It’s just ridiculous. I take enough fucking drug tests to know, prove, that I’m not taking drugs. I don’t need the hospital to, you know, to judge me’ (Chloe: Interview 3).

'It's absolute rubbish. There are some people who are like that [as stereotypical image of drug-user]...I'm not one of them' (Anna: Interview 2).

In this respect, mothers, such as Beth, felt portrayed as a homogenous group of drug-users who were incapable of change:

'They [staff members] put all drug-users in the same boat, when we all feel different and react different to things. We're all human beings at the end of the day, we might have done the same things but we're not all going to do the same thing again...I just don't understand why they put us in the same boat' (Beth: Interview 3).

In the following quotation, Beth reflected on her experience as a resident of a parenting assessment unit, with the specialist staff group used to working with drug-using parents. After a meeting with the manager, Beth described her frustration and resignation due to his failure to recognise the changes she experienced as a breastfeeding mother:

'I was telling the manager I could be that one out of the hundred that's not going to relapse or that's not going to react to the same things they [other residents] react to. He said we're not going to take that risk and there's no such thing as that one out of a hundred. So we're all the same basically...There cannot be one out of a hundred' (Beth: Interview 3).

Hesitation in perceiving Beth as the 'one out of a hundred' could be ascribed to the lack of experience professionals have with MMT mothers who want to breastfeed. Doris suggested that, as they are small in number, they constitute an unusual group of women:

'The woman I see at [name of substance misuse service] has got 35 other people doing [a parents of children at risk] course...I'm the only person breastfeeding. There's about 15 babies under three months old there at the moment, and not everyone there is on methadone, but...quite a few of them are. And I know from talking to [the specialist midwife] and my mum and other people about it as well that...it doesn't happen very often' (Doris: Interview 4).

The implications of being in a minority group are that professionals have very little understanding of the women's transitional experiences to motherhood. In the absence of empathy, as demonstrated below, mothers face reactionary and judgemental attitudes. In terms of infant safeguarding, and regardless of her subsequent engagement in treatment, Doris says that whilst pregnant, she was stereotyped as a harmful drug-user by an inexperienced health visitor.

'I think we're the first people she's [health visitor] ever seen that have got drug issues. She's very unaware of all of them. When we had the initial case conference meeting, she said that she believed neglect had already occurred...and that we'd already damaged the baby. This is before I'd had the baby' (Doris: Interview 3).

Although the mothers appeared distressed by such criticisms, they themselves referred to the same cultural stereotypes when differentiating themselves as a rare group of mothers. In this statement, Doris suggested that the health and social care providers seemed to be confused because she did not fit the formulaic image of a drug user:

'I think all of the professionals that we've dealt with, we've actually ended up being...difficult for them because we don't fit in any boxes and that's what they found very difficult with me and [partner]. It would've been a lot easier for them if I was a single mother that didn't have a job and had always been on benefit' (Doris: Interview 4).

As an unemployed single breastfeeding mother, Anna rejected the notion of being stereotyped simply because she was a drug-user. By doing so, she appeared to state all drug-using mothers should be respected as individuals, to the exclusion of stereotypical perceptions:

‘I mean the stereotypical stuff is just all rubbish’ (Anna: Interview 3).

The mothers’ relationships with the professionals were reportedly undermined by negative, punitive and uncaring attitudes founded on distrust, disbelief and inflexibility. For instance, the women noticed differences in professionals’ body language and communication when compared to their treatment of other parents. In the following description, Chloe reflected on how the neonatal nurses, looking after her baby, F, interacted differently with other parents:

‘...this woman who’s looking after F...and the...child next to me, and the way she was with them, she was always laughing, you know, talking nice to the baby and that. Well, when she come to us she would talk to the baby nice, but she would not even like smile or talk nicely or anything like that’ (Chloe: Interview 3).

Chloe continued by citing differences in the reaction of neonatal nurses to her absences, in contrast to when other parents left the NNU. Whilst demonstrating their criticism of her absenteeism from the ward, the nurses also appeared uninformed as to where, and why, she was not there:

‘I mean it’s like every other person, they can spend, what, like even five minutes a day with the baby and they don’t say nothing. If I leave the room for my lunch or to go and pack my stuff for Auntie J or go for a meeting, they don’t like it’ (Chloe: Interview 3).

Whilst on the postnatal ward, the mothers observed that their family and friends were also treated differently to other mothers' visitors. In the following quotation, Doris described what happens at visiting time. She noted that, whilst other visitors were not quizzed by the staff, her friend appeared to be interrogated at the desk for five minutes:

'I've seen everyone else would get buzzed in [to the ward] and they wouldn't ask them who they were coming to see or anything, you know, they'd just buzz them in and people would get on with it. Staff are too busy to ask who you've come to see. But when our friend came up he got really quizzed about who he was coming to see and what was my surname, and all of this sort of stuff...they kept him at the desk for about five minutes' (Doris: Interview 3).

What it feels like to be treated as 'the Other'

Belonging to a minority of the 'Other', the mothers said they felt unimportant, distrusted, isolated and disempowered in their exposure to poor professional attitudes, in which they perceived professionals hiding behind their statutory roles.

The staff were reported as being too busy to offer continued instruction and encouragement for breastfeeding, a common problem presumably experienced by any breastfeeding mother on a busy postnatal ward. However MMT mothers described a lack of communication about monitoring for neonatal abstinence syndrome, which left them feeling unimportant as mothers in the care of their baby. For instance, Doris described being unaware that her baby was being monitored, as nobody had spoken to her:

'It would just've been nice if that had been explained to us...I just wasn't aware that they were doing anything [monitoring for opiate withdrawal]' (Doris: Interview 2).

Doris was able to breastfeed and enjoyed having her daughter with her on the postnatal ward. However, her distress at the lack of communication was further exacerbated

when her baby was suddenly removed and taken upstairs to the NNU at five days post-delivery. Doris described her incomprehension, as nobody appears to have explained what the score indicated:

‘We really hadn’t realised why [baby] had gone upstairs [to NNU] because someone just said to us, ‘Oh, she’s hit 10 on her scores and she needs to go upstairs’. We didn’t know what she was being scored for. We didn’t understand. It had never been explained to us’... (Doris: Interview 3).

When she tried to find out more detail, she stated her confusion over what was reasoned as a medical explanation, as opposed to being given as personal opinion:

‘We kept getting, being given people’s personal opinions like it was medical fact, and then someone else would give their opinion and it would be completely different’ (Doris: Interview 3).

As mothers experience the transition to motherhood, professionals are portrayed as suspicious because they continue to harbour a distrust of mothers whom they suspect will return to taking illicit drugs. In the early postnatal period, Chloe described the behaviour of one of the midwives and her accusation of illicit drug abuse:

‘One of the night staff follows me into the toilet when I was washing my face and brushing my teeth and going to the toilet, and literally when I flushed the chain she knocked at the door and started searching the room, and the first thing that was out of her mouth, ‘what have I been smoking in here?’...It’s like accusing us of bringing drugs in the toilet’ (Chloe: Interview 2).

Women seem to be disempowered and isolated when depicted as ‘easy targets’ of blame and professional bad attitudes. This is apparent when they appear to be excluded from decisions made about their care. Whilst her baby remained in hospital, Chloe endeavoured to explain her version of events about her care plan as decreed by a court

of law. Whilst revealing the poor extent of her understanding of the process, there is no reference to any advocate working on her behalf:

‘I think what they [social workers] said in court to me, my understanding of what they said in court, they’re gonna do a psychiatric test straightaway...because they want to see if I am taking drugs, why I did take drugs and all of that crap. But basically they want to see if I can look after the baby and there’s a good chance that I’m going to go back to drugs, before they put us in a baby, mother, a baby unit’ (Chloe: Interview 3).

As a result of this decision, Chloe is put into the care of her aunt in cramped living arrangements. We sat on the double bed they both shared together, as the only private venue for the final interview. Chloe explained how she understood why she had to remain at the house. Her description demonstrated the powerlessness she felt because social workers continued to remain suspicious of her. Therefore, in addition to any mention of a person supporting her, there was an omission in future plans regarding a parenting assessment unit, as referred to previously, or a likely time when she could hope to return home to her partner and the father of her baby:

...’because they [social workers] don’t think that I’m fit enough right now to look after her, so they needed someone to observe me 24 hours so I don’t do nothing wrong’ (Chloe: Interview 4).

Chloe suggested that not only were professionals expecting failure, they also appeared to hope for relapse as a vindication of their treatment of her:

‘They [professionals] think I will go straight back onto drugs...You hear the way they’re talking you just know that’s what they’re thinking. And that’s what they’re hoping as well’ (Chloe: Interview 4).

Doris also reflected on the suspicious treatment she received whilst in hospital. She described the problems she experienced trying to get a urine sample from her new-born son. Her lack of success was described as deliberate non-compliance with the treatment. Contained within her statement is an implication that, as she was unable to provide a sample from her baby, she is guilty of drug-use:

‘And I got treated very much like it was my fault...How I felt it was, was that they were thinking that I didn’t want them to get this urine sample [from her baby son] for some reason or another’ (Doris: Interview 3).

As a result, the experience of this negativity and rudeness from professionals resulted in leaving Doris feeling defensive about being unfairly judged by professionals:

‘We were definitely getting a lot of attitude and I mean we felt we were being quite defensive, but...it sort of, I think it was rightly so. I mean when we first went up on the upstairs ward [NNU] the nurses were being really sort of quite...quite rude to us’ (Doris: Interview 3).

Poor professional attitudes were experienced as a lack of understanding of and empathy for the special needs of this group of mothers. In this quotation, Beth described how the specialist staff at the parenting assessment unit, who should have demonstrated greater empathy for her situation, appeared not to recognise her profound transitional experience. So, instead of receiving encouragement from the staff, she described being met with negativity, which appeared to border on disinterest:

‘And they don’t...even encourage and say you’re know doing well or improving...They’re always negative...It’s like ‘Oh that’s only the beginning there’s more to do’’ (Beth: Interview 3).

At five days post-delivery, Doris described her experience on the postnatal ward. She was depicted as anxious to receive her methadone, as prescribed daily at midday. This

was demonstrated in the care she took to remind staff members. However, methadone appears to have been withheld on a regular basis, despite her reminders and the distress it caused her. Therefore, their continued tardiness indicates how Doris felt the victim of a poor level of clinical care that, on reflection, might be construed as punitive:

‘I was having to ask for my medication about four or five times, it was, for my methadone, it was, it had been late every day. It’s been said on my notes that I had to have it by midday. Every day I’d mention it about 10 o’clock and...then I’d mention it again at midday and again at half 12 and 1, and sometimes it would be 3 o’clock by the time I got it.’ (Doris: Interview 2).

The impact of being ‘the Other’

In this section, mothers described the negative impact when penalised for being ‘the Other’. They described feeling the victims of circumstance when kept longer on the ward than other mothers. This left them feeling powerless, defeated and alone. In contrast, they welcomed feeling positive when other people valued them as mothers and were knowledgeable about their medical requirements.

As mothers with drug-using histories, they were kept on the postnatal wards to allow for the monitoring of neonatal abstinence syndrome. Due to the enforced stay in hospital, the mothers felt alone and isolated from their families, with whom they felt they could cope better. Thus, whilst the professionals focussed on the baby, the mothers appear to have become neglected. Anna described being jealous of other mothers who were able to go home earlier as she wanted to be reunited with her 10-year old son:

‘I’ve seen people just come in here just to have a baby... I’ve seen people after two hours go home and I’m really jealous because I just want to go home...I know I’ll cope better at home because I’ve got my son at home’ (Anna: Interview 2).

As they were kept on the ward for a prolonged period, the mothers wondered whether they became victims of circumstances, embroiled in problems associated with inadequate staffing and busyness:

‘I do feel a lot of this really is just victim of circumstance and victim of what is going on up at the hospital at the moment, and just how busy they were and...how few staff they have up there’ (Doris: Interview 3).

The busyness of the ward staff impacted upon the time they spent introducing themselves to the mothers. In this quotation, Doris lamented her confusion over the identities of people because they did not wear name badges, and so she mistook a nursery nurse for a doctor because she treated Doris differently from the other staff members:

‘I think one of the things I was most angry about... no one introduced themselves ever and no one ever had name badges on...there was one of the nursery nurses who was actually really nice...and I presumed she was a doctor just because she was so different and treated us so differently to how all the other ones did...so I just presumed she was a doctor. And for a whole week I presumed that...but that’s just really wrong...because none of them wore name badges and no one ever introduced themselves...a few of them did and it was only that a few of them did that made me realise that the others hadn’t...’ (Doris: Interview 3).

The lack of communication about their identity was one aspect of poor communication that, as long-term patients, mothers were able to observe. On occasion, this resulted in their feeling penalised. For instance, Doris said nobody told her that she was expected to sign in and out every time she left the ward. As a result her post-birth assessment was critical of her frequent unrecorded disappearances:

‘...on the very last day I was there...I’d been outside to make a phone call...I came back upstairs and I went to the desk to ask something, and she said, ‘Oh, have you come to sign back in?’ And I said, ‘What do you mean, ‘sign back in’?’ She said, ‘You’re supposed to sign back in and out every time you leave the ward’. No one had told me that and...and then on my post-birth assessment from the hospital one of the things that was written quite negatively was that I disappeared off the ward frequently and never told anyone where I was going and never signed in and out’ (Doris: Interview 3).

This lack of communication further penalised Doris after her discharge from hospital. Although nobody had informed her, she said she was reprimanded for not attending meetings:

‘It actually turned out that I’d been...signed up for [a parents of children at risk organisation] without realising it and suddenly was getting in trouble for not going to meetings and stuff or cancelling meetings’ (Doris: Interview 4).

In her narrative, Doris cites other examples where she was misjudged because of poor professional record keeping. In one example, she said her maternity notes inaccurately recorded she was living in a semi-derelict building, which were considered unsuitable for a baby. After correcting this error, Doris describes a ‘palpable change in the nurses’ attitude to us’. A further error of judgment resulted in Doris being shocked to learn from one of the paediatric doctors that her baby would remain in hospital for a long period of time after her discharge. Professionals who make such off-hand remarks seem unable to comprehend the anxious bewilderment they cause:

‘I’d asked one of the paediatric doctors how, this was on the Sunday and we [mother and baby] got out on the Monday, I said, ‘How long do you think [baby’s] going to be in hospital?’ and she said, ‘Oh, [baby’s] going to need to be in here for at least a couple of months but they won’t let you stay that long’...And we were just like, ‘WHAT (shock)?’ and I was like, ‘What?’ and

she was like, 'Well, that's how long she'll need to be on medication'' (Doris: Interview 3).

Such examples of poor communication and record-keeping, resulted in the mothers feeling powerless. Desirous of being involved in the care of their babies on the NNU, the mothers described having a passive role in the presence of professional care. In this example, Chloe described her impotent frustration. It appears that when she had tried to retrieve some maternal control in the shape of choosing a barrier cream, she was ignored by professionals:

'I was screaming blue murder...I told them, 'No, can you not put this on her please because, look, it's bleeding now...I know it's the cream. She has very sensitive skin like me'. It cleared up again, and yet again they put that same cream on'.(Chloe: Interview 3).

Chloe's experience illustrates the vulnerability of mothers at the hands of professionals. In this quotation, she described how visiting plans for her partner were allegedly made without their being involved:

'They [social workers] made a...visiting plan [for her partner to come to her relatives house]...they'd done it when we was in a room but they didn't really ask, they just said well this is going to happen, this is going to happen on this day...just made that decision by themselves' (Chloe: Interview 4).

Where mothers encountered continued professional obstruction and a lack of support, they experienced defeat in meeting their own preconceived ideas of being a mother. In this example, Chloe described struggling to express breast milk for six weeks before she finally gave up. She felt she had done all she could, but in the absence of support and help she was defeated:

'Breastfeeding - it didn't really work out because I just couldn't produce, my boobs just wouldn't get stimulated, so I stopped [**chuckles**]...it just was not coming really. It was just slowly stopping itself. [I feel] disappointed because I wanted to do it but...well, you can do nothing now, can you [**nervous chuckle**]?' You know, I tried everything I could' (Chloe: Interview 4).

In an earlier interview she was able to reflect on the difference that meeting one kindly and empathetic nurse could have had on her being able to feed:

'It's only like been like the past two weeks now...I checked if the milk was still coming and it was literally coming by a tiny bit...I said, 'It's still coming by a tiny bit, is that alright, and I would like to express?' And the woman said, 'No, that's fine,' and she gave it [breast pump] to me straight away. And I'm just thinking, 'If this woman just gave it to me four weeks ago...'' (Chloe: Interview 3).

Contained within Chloe's lifeworld is the image of a mother standing alone against the system. In the following quotation, as Chloe struggled to prove changes to her identity which were not acknowledged by professionals, she had a strong sense of feeling isolated. She seemed continually to be discouraged as services appeared to wait for a time when she weakened and relapsed back into illicit drug-taking. However Chloe countered this by describing how she valued the progress she has made and by continuing to persevere to become the mother she wanted to be for her baby. Such a stated belief in this positive aspect of her personality is an indication of her becoming empowered in the transition to motherhood:

'I know for a fact that if I was going to go back on drugs I would have done it at the first moment when you tried to take my children. I know who I am and I know what I'm like and I know for a fact I either stick with it or run away. And if I run away I do that at the first moment, I don't stay...stick by for like six weeks just to give up...I'm sorry but I don't do that...but they say, 'But you can

never say never'. Yes, I can say 'never' actually. I know who I am.' (Chloe: Interview 3).

Chloe's experience demonstrates how, despite her struggles and their outcome, she experienced an internal transformation. For all mothers interviewed for this study, in the face of the negativity as described above, there were only a few individual professionals who related to them as mothers. However, their small acts of kindness were not only remembered, but also made a difference to their early experiences as mothers. It appears that those without statutory powers, such as student midwives and cleaners, have a vital role in being able to demonstrate compassion and empathy and this is valued and welcomed by the mothers interviewed in this study. In the following quotation, Doris described how she remembers the kindness of one student midwife:

'I think the person who helped me most was...a student midwife who was there one night and who came and sat with me in the feeding room and just really encouraged me and really sort of calmed me down. It was a night I was really stressed and she was really, really lovely' (Doris: Interview 3).

After the removal of her baby to the NNU, Doris remembered how the cleaning staff responded to her as a mother:

'I've felt more supported by the cleaning staff...just in terms of them smiling and being nice and noticing that my baby wasn't still with me, asking if she was alright and stuff like that' (Doris: Interview 2).

Whilst being cognisant of the effects methadone might have on her baby, Anna described how she was anxious for her son. She remembers how two midwives appeared to mother her by their reassurance and encouragement to go back to bed:

‘Especially a couple of the midwives. Really, really nice. And when I’ve been worried they’ve been like ‘Anna, there’s nothing wrong with him, he’s beautiful, go to bed’ (Anna: Interview 2).

In addition to being supported by her partner, Doris appears to have received support from her daughter’s paediatrician who is described as going beyond the call of duty by writing to social services to ask why Doris and her partner had to attend parenting classes:

‘What’s been great is her paediatrician, Dr L, has been brilliant and actually wrote a letter to social services without us knowing, saying that him and his wife hadn’t had to go parenting classes when they’d had a baby so he had no idea at all why we had to, and just because we had substance misuse problem didn’t automatically mean that we couldn’t parent’ (Doris: Interview 4).

Where professionals are willing to acknowledge their lack of knowledge in this area and work with the mothers and learn from them, this provides a wonderful opportunity to build a positive working relationship between both parties, based on honesty and trust:

‘I just think there’s a lot of misinformation and rumours and...that sort of stuff out there and once you get to talk to professionals and stuff, that does clear a lot of things up and...and you actually realise that a lot of what you thought was truth wasn’t truth’ (Doris: Interview 1).

Where previously Doris’ health visitor accused her of harming her baby whilst pregnant (9.5.2), she was later able to admit her ignorance about drug-use. As a result, Doris was able to share her knowledge, which appears to have strengthened their relationship:

‘[The Health Visitor] has since admitted she didn’t have a clue what she was talking about, and I think she’s actually learnt quite a lot off us and I think she’s actually been surprised what she’s learnt off us’ (Doris: Interview 3).

Summary of the external world of being ‘the Other’

The external world of being ‘the Other’ is described as being stereotyped and misunderstood as a minority group, where women are treated differently to other mothers. They report feeling unimportant in the care of their babies. As professionals remain suspicious, women are portrayed as feeling isolated and distrusted. Women appear to use breastfeeding as a language to communicate that they are capable and loving mothers. Resident on postnatal wards for long periods of time, they seem to be forgotten in the busyness of the wards, which impacts on the times when methadone is dispensed and for signing in and out of the ward. However, instead of apologising, mothers seem punished by a system of care that appears eager to report, control and manipulate. Viewed positively, mothers respond warmly to kindness from other people who seem to respect their being mothers and not drug-users. As expert patients, mothers welcome sharing their expertise with professionals who are able to concede their lack of knowledge.

9.5.3 Tension between internal changes and external worlds

Emerging from the data, the third category describes how women feel once back at home and able to reflect on their transitional experience into motherhood. It is a category that reveals self-awareness of their dual identity, moving from drug-user to breastfeeding methadone-treated mother. This section is divided into the two theme clusters; becoming good-enough and insightful mothers for themselves.

Becoming the good-enough mother

As a cohort of mothers, they not only describe feeling stereotyped by other people as being different from other non-drug-using mothers, they also acknowledge their own drug-user identity. As stated by Anna:

'I'm a heroin addict. I'm a recovering heroin addict, but I'm still going to be a heroin addict always' (Anna: Interview 2).

However, this statement is greater than a confession of a commonly-perceived identity. What the women describe in the data is an existential shift in which they relate dramatic changes in their behaviour and attitudes as a direct result of breastfeeding.

Being a drug-user appears to act as an orientation point of reference for changes in their lives. As breastfeeding mothers, the women refer to how they would have behaved previously in order to reflect on how different they have become. In this statement, Beth described the enjoyment she has from her baby and noted how she feels different from other residents, even though they all have similar drug-using backgrounds. Whilst they are portrayed as craving drugs, Beth does not feel the same:

'Just the smiles she [baby] gives me...I never thought I could do it but I've done it. When it comes to not taking drugs and not actually getting the cravings as bad as when I see people in here [parenting assessment unit], they go mad and they think about [drugs] all the time. I don't...I'm never stressed about being stoned or using' (Beth: Interview 4).

In the following statement, Doris appears to be reflecting on an internal dialogue, which describes profound internal and permanent changes. She initially declared a continued attraction to heroin. However, because life is now experienced differently, Doris seemed to have a sudden insight that, even if her baby or partner did not exist, she would not go back to her old habits:

'What I said to [partner] is that, yes...heroin's nice, I totally understand that...but the only time I'd want, the only way I'd want to use it, was if I was in a little room all on my own, not with [baby] but not even with [partner]. But if [baby] didn't exist, and not even if [partner] didn't exist because...even then I

could think of sort of 67 things I'd rather do, and I literally would rather do the washing up or clean the kitchen or do something that I never have time to do, like wipe down the woodwork or something, which, might sound silly, or really I'd rather take the dog for a walk. But that really genuinely is how I feel. I'm just not bothered about it [heroin] at all' (Doris: Interview 4).

Whilst becoming good-enough mothers for themselves, they move from being drug-users with little self-esteem to mothers with positive self-awareness. Women describe improvements in self-confidence and self-worth in which they recognise the fundamental role they have within their families. As stated here, Anna is discovering that being able to acknowledge her drug-using identity gives her a sense of:

'Self-confidence...believing...and self-worth really. That's important because I used to hate myself. I thought no one else could possibly like me, I didn't even like me...I've spent so many years trying to be different from who I am, and now I'm starting to say well, this is who I am' (Anna: Interview 3).

Anna's comment that she no longer hates herself is significant. Such a reflection and insight became apparent during the interview when women discerned previously hidden changes. Whilst reflecting on her relationship map in this statement, Anna is able to recognise and acknowledge the important pivotal role she has within her family:

'Who are important people in my life at the moment? (talking to self) that's my baby boy, partner, older son,...Me actually, because I've got to look after them, and it's really important. And I never used to give a shit about myself and I'm starting to care' (Anna: Interview 2).

Sometimes this comprehension was not immediate but occurred after the interview had ended. In the following quotation, Doris alluded to our second meeting, which occurred during the time her baby was removed into the NNU. She described the conversation as

'cathartic' because she gained insight into how 'wrongly' they were being treated in hospital:

'I know especially in the hospital it really did help me talking to you. It was very, very cathartic and just helped me to get everything in sort of order in my head... It just sort of made me think actually, I know I'm being ridiculous now by not making a fuss about these things. We have been treated wrongly and it's not right and I'm not having it anymore' (Doris: Interview 3).

In a text message the following day, Doris described using the energy from her anger to seek out immediate medical support and have her baby returned to the postnatal ward:

...'to say thanks for coming down yesterday...made me get angry about lot of things to do with way we been treated. 5 minutes after you left Dr A...turned up... Got furious that she [baby] had been pressurised into formula feeding and upshot of all is baby back with me on ward, in cot next to me being looked after by her mum and dad and is back on the breast' (Doris: Text day after Interview 2).

However, although Doris was able to successfully appeal to one influential healthcare professional who agreed with her, other assertive mothers described facing external control and confrontation with professionals who continued to be described as judgemental and sceptical of change. In her statement, Beth described how the staff members of the parenting unit continue to relate to her as they do to other residents, who persist using 'old behaviours' associated with drug-taking. As a changed woman, she confronted them about their behaviour. This resulted in Beth being punished by the staff for having a bad attitude. Therefore, in an act of self-preservation, she described becoming more private and used writing as an emotional outlet:

'They [the staff] want you to be the thing, you're in rehab so be the thing. When you stop drugs, you need to also stop the old behaviours. There's no point

stopping the drugs and still carrying on old behaviours, which I find with most of the women here...Stealing, lying, deceiving...bullying. And I've confronted a lot of that which I've been on contract because of my attitude is bad. And really and truly I was just standing up for myself. It's funny. So what I do now is write down what I don't think is right' (Beth: Interview 3).

Becoming the insightful mother

Doris and Beth demonstrate that, when living within situations with little respect and understanding, breastfeeding MMT mothers have very little control. In this statement Doris alluded to a knowledge gap between the women, who conceded an identity as drug-user, and cultural fabrication about people who use drugs:

'I think there's a lot of myths and...misinformation on the whole drug scene'
(Doris: Interview 1).

Where contact with drug-users and knowledge are minimal, Doris not only accepted that myths can fuel biased perceptions but also admitted that professional ignorance is plausible:

'Especially if you've never been in the situation or you've never known other people...of course that [myth] is what you're going to think...if you've got no personal experience or knowledge or don't know other people that have [used drugs], then that is what you're going to think and that's fair enough' (Doris: Interview 1).

Therefore, in this phenomenological study, the women interviewed are experts on their lives and provide data that bridges this gap in knowledge about MMT mothers who breastfeed. More specifically, during conversations around the time of drawing the relational map, data revealed a previously hidden and little-understood functional role of methadone. As mothers were unaware of the importance of methadone before this

time, they described their distress when drawing it with shorter lines than their babies, or with no line at all:

‘That just came totally without even thinking about it. [Drew methadone within the central circle of the map] I feel like surrounded by this [methadone]. I am aren’t I? It’s in me’ (Anna: Interview 2).

During the interviews, the mothers reflected on this as a functional position, a ‘head and heart’ issue:

‘I felt almost like the heart and head sort of thing... But, yeah...I don’t feel that it’s [methadone] a big deal in my life at all but then, on the other hand if it wasn’t there it would be [a big deal], so it must be’ (Doris: Interview 3).

The mothers discussed what this meant in terms of enabling them to function in their role as mothers. Chloe associated methadone with keeping her well and giving her strength. Methadone’s stabilising role helped her attend meetings and deal with other demands in her life:

‘It’s [methadone] very important right now in my life. Keeps me stable so I reckon that used to do the things that I need to do on a daily basis, help my child, you know, do all the things for my children, and at the same time, you know, so I can talk to all these meetings. If I don’t have it I won’t have the strength’ (Chloe: Interview 3).

Conversely stopping and detoxifying from methadone is identified with becoming unwell, which, according to Anna, would undermine her ability to mother:

‘The only thing I would say is because I’m on it [methadone]. At the moment I’ve got to take it because otherwise I’ll start to withdraw from it and I won’t be able to cope with anything then, I know I wouldn’t because it’s awful. I’m

scared of not getting off it. I've done it before, I came all the way down to 5 [millilitres] years ago, but the last time I came off it, years ago, I ended up using [heroin] again, I'm not sure why. I wasn't in the same place I am now though' (Anna: Interview 3).

Beth was the only woman, out of the four interviewed, who stopped taking methadone during the time of the study. She decided that her experience of love was compromised by methadone. Following her transfer to the parenting assessment unit, Beth suddenly stopped taking it:

'Just wanted to detox as soon as possible...Cos I knew the methadone was in control of my feelings...the way I was functioning, so I wanted to know how I really felt' (Beth: Interview 3).

The following three quotations graphically illustrate the misery Beth experienced as the result of methadone withdrawal. On the fifth day after stopping, Beth described the symptoms as:

'Shock, big shock, all my emotions, I was irritable, I was shaking, I couldn't stand still, I couldn't sleep or do nothing' (Beth: Interview 3).

As she was not coping, her baby was put into the care of a foster mother for five days. At the time, Beth said she was ready to leave the unit and give her baby over to her estranged partner:

'There was even one point that I was gonna leave and let her dad have her... because I just didn't feel the bond anymore...I was scared to have her back and not love her' (Beth: Interview 3).

As a result, Beth described being fearful about being distant from her baby and not feeling like a mother.

When I didn't breastfeed that's the time I felt distant, I didn't know what to do, I didn't feel like a mother...I was scared to get her back...I don't know why. That's was really strange cos as soon as she came back it all come back to me, all the feelings, but when she wasn't there it was like for some reason I didn't feel like a mum (Beth: Interview 3).

Although she was ill-advised to stop suddenly, Beth's narrative supports other mothers fears that, without methadone, they lose their ability to mother. In this respect, they are the experts on the functional role of methadone. However, in contrast to this, and emerging from the data, is a lack of professional understanding. In the absence of such information, professional perceptions continue to be distorted by the assumption that methadone is evidence of a continued identity as a drug-user and synonymous with being a bad mother. These suppositions were refuted by Chloe:

'I think just because you're on methadone it don't mean that you are a bad person...just because someone's on methadone doesn't necessarily mean they don't know what they're doing and don't know how to take care of their baby, everybody assumes they will go back on the drugs' (Chloe: Interview 2).

Therefore, the women's recognition of the importance of methadone was fundamental to becoming good-enough and insightful mothers for themselves. In this, the women were prepared to defy social workers' expectations that they stop:

'I know my social worker is quite keen on me to cut down but I keep saying to her right now I'm quite comfortable in that I don't want to take no chances of going back onto it [heroin]...I'm not disputing that I have to cut down some day and stop someday, I really want to stop someday, but not at this precise moment...So even though I'm comfortable I am not prepared to take the risk. I'm sorry but I'm prepared to stay on the same amount than to go back onto drugs' (Chloe: Interview 3).

Therefore, women state an expertise about themselves as drug-users, with insights into the role of methadone that lie outside the knowledge domain of professionals. However, as experts, they welcome healthier working relationships in situations where professionals are able to acknowledge their gap in information:

‘The social worker sort of wanted to know how it [methadone] worked and once I’d talked him through that was fine’ (Doris: Interview 4).

Summary of the tension between internal changes & external worlds

The tension between their internal changes and external world is depicted as empowering, as mothers move to becoming good-enough and insightful mothers for themselves. Findings reveal that, where mothers face stereotyped and judgemental perceptions, women demonstrate an awareness and acceptance of their identity as drug-users. However, their experiences as breastfeeding mothers appeared so profound as to be described as irreversible. With an increase in self-esteem, mothers assert themselves in the face of authority, and devise private methods of self-expression on the occasions they continue to be derided. Becoming insightful mothers is interpreted in this thesis as discovering the functional role of methadone in keeping them well. Despite professional exhortations to stop, mothers are portrayed as experts. Where professionals are able to acknowledge the mothers’ specialist know-how, women describe an improved working relationship, based on greater understanding and improved mutual respect.

9.6 Conclusion

Chapter 9 has analysed data collected for this study using phenomenological methods. Three separate categories, deriving from seven theme clusters, emerged from the data in response to the research aim of this phenomenological study - to reveal previously hidden realms of being within the inter-subjective and social realms of four breastfeeding MMT mothers in early motherhood. By helping to frame the myriad and multifaced nature of the women’s experiences, lifeworld theory was chosen for its

practical application to this study for reasons discussed in section 7.4. Therefore in preparation for the discussion in Chapter 10, the structures of their commonly constructed lifeworld are outlined below by drawing on the parameters; temporality, mood attunement, intersubjectivity and project.

As a part of a moment of human experience, the women interviewed in this study describe the emotions associated with their lived experience of becoming breastfeeding mothers within the first twelve weeks of motherhood. The fluctuation between the duality of their identity, from drug-user to mother, exposes a wide range of positive and negative feelings. They refer to being in love and besotted with their babies. At the same time, they are scared because they feel so changed from how they used to be as drug-users. A dearth of information about breastfeeding for MMT mothers results in maternal confusion and anxiety.

In addition, with intersubjectivity being the key to describing relationships intrinsic to their lifeworld, the mothers talk about the kind of dialogues and interactions they have with other people, especially in hospital. When approached as mothers, women say they were able to respond to an individual's spontaneous and empathetic kindness. However, although the data shows that both mother and professional are concerned for the wellbeing of the infant, when approached as drug-users women are represented as 'the Other'. Marginalised within this minority group, and with focus on the statutory duties of infant safeguarding, mothers depict the relationship they have with professionals as abusive. To monitor their continued abstinence from drugs by attending a myriad of professional meetings, they articulate being absent from their new-born infants. This is contrary to the advice that breastfeeding mothers stay with their babies to encourage early suckling and bonding (section 5.2). On return to the hospital wards women voice facing additional exposure to prejudice when professionals complained about their non-attendance.

Finally, with reference to a world of places and things that have meaning to living, mothers describe their ability to carry out maternal activities in regard being to being at

home and able to function with the help of methadone. Once home and distanced from direct professional surveillance, women express becoming good-enough mothers for themselves. Finally, the mothers reveal a vital functional relationship with methadone which stops them from becoming sick and enables them to fulfil their role as primary nurturers of their babies.

As the fifth stage of data analysis, one that involves moving away from the primary data, Chapter 10 discusses five major findings which have been intuited from these structures to give an exhaustive description of the phenomenon under investigation.

Chapter 10: Discussion

10.1 Introduction

Chapter 10 discusses the experiences of four breastfeeding mothers engaged in methadone maintenance treatment (MMT). They are referred to in this discussion chapter as Participant Mother(s) and abbreviated in the text to PM or PMs. Although this may come across as cumbersome for the readers, alternative terms were either considered too gender neutral (*e.g.* participants, respondents) or rejected for not acknowledging the women's status as mothers. The word 'professional' is used as a generic term to incorporate both health and social care staff members who were in contact with the PMs; midwives, nurses, social workers, doctors, nursery nurses and health visitors.

As discussed previously in section 9.3.3, a major insight regarding the process and outcomes of this study stemmed from recognising the origins of my advocacy standpoint (section 1.3) and the reactions to the mothers' reported treatment from professionals. I connected these with experiences from my practice as I recalled often feeling angry hearing my clients describe receiving compromised care from professionals who were characterised as prejudiced. In supervision, I was able to acknowledge that vicarious trauma (see section 11.3) had influenced my research interest and that I was not a neutral researcher inasmuch as I was sympathetic of the women interviewed. This position permeated the study, not only in my role as a researcher, but also in how I structured the research question, my choice of methodology and methods and ultimately how the data were analysed and discussed.

However, this fury needed unpicking in the early days as it was affecting the framing of data analysis. Once recognised, the anger had to be controlled. I discovered that writing diaries, followed by discussion in supervision, ultimately helped to manage these early angry rants and increase self-awareness, especially during the data analysis and discussion stages.

Chapter 10 explores concepts as they emerged from the data, which reflect the enormous changes that drug-using women experience in the first three months of becoming breastfeeding mothers. With the fulfilment of women's teleological nature, cited as the bearing of children (Fearn 2001, Magee 2001), section 10.2 initially explores some shared commonalities and differences in experiences within the duality of being mother and drug-user. To help facilitate an understanding of the turmoil experienced by the PMs, reference is made to the three categories identified in Chapter 9. Using mainly psychological perspectives, section 10.3 investigates the emotional internal world of becoming a mother. The perception of being treated as 'the Other' within their external world is explored in section 10.4, and draws on the previously sociologically defined concept of professional ego (section 3.4). Section 10.5 discusses the tension PMs experience between their internal and external world, in which they describe increased self-awareness and self-efficacy. Incorporated into the discussion are suggestions of where these newly discovered insights might help inform and enhance other mothers' transition to motherhood.

Superimposed onto the discussion in Chapter 10, are the following five major findings. These are identified as contributors to knowledge about MMT breastfeeding mothers during the first few weeks of motherhood:

1. Due to profound and powerful feelings of love, breastfeeding appears to provide a window of opportunity to change lives (section 10.3).
2. As a non-verbal method of communication, mothers publicise care and nurturing of their infant by breastfeeding. Where professionals appear unresponsive to this reasoning, women are busy, and, on occasion, separated from their new-born babies, attending numerous multi-agency appointments to prove their worth as mothers (section 10.3).

3. Breastfeeding MMT women appear to be vulnerable and at risk of feeling discriminated against because of their exposure to professionals' prejudicial and stereotyped treatment. (section 10.4).
4. By embracing, not rejecting, their drug-user identity, women rationalise becoming good-enough mothers for themselves (section 10.5).
5. Breastfeeding MMT mothers have insight into the functional role of methadone, stating an unwillingness to sacrifice a sense of wellbeing in order to satisfy the demands for abstinence from social services (section 10.5).

10.2 Duality: being a 'normal' mother and drug-user

With membership of two socially recognised groups emerging clearly from the data, the duality of their identity acts as the standpoint for understanding these women. As breastfeeding mothers, they belong to a widely-recognised and socially accepted group of normative mothers. They gain acceptance into this group by demonstrating their predestined, teleological nature, described by Lewis (2002) as responding to their natural maternal instincts and demonstrating unconditional love. Lewis (2002), together with Murphy and Rosenbaum (1999), regard this as a time when, by fulfilling and demonstrating their feminine identity, women achieve full adult status. Whilst this depiction might stereotype a persistent image of the 'perfect normal mother,' the comparison is useful because these mothers are simultaneously members of a less socially acceptable social group of drug-users. As discussed in Chapter 3.2.2, drug-using mothers are defined as deviant because of their involvement with illicit drug-use and social contact with other illicit drug-users.

In this study, becoming a mother is described as a pivotal life-changing event, where major changes appear to be triggered by innate responses to motherhood. Such a finding concurs with other authors who cite motherhood as a major motivator for change in drug-using behaviour (Fraser *et al.* 2009, Hepburn 2005, Ballard 2002, Murphy and Rosenbaum 1999, Ettore 1992).

PMs demonstrate similarities in experience with those reported by non-drug-using mothers. For instance, they describe experiencing enormous emotional changes in their early transition to motherhood. In a study of (normal) women's experience of early motherhood, Barclay *et al.* (1997) note that this is described as a distressing although evolving experience, due to the losses associated with previous lifestyles. In his study examining identity development during the transition to motherhood, Smith (1999) observes that mothers report that the sense of loss is ameliorated by their growing awareness of a sense of self. This is enhanced by social contact with their significant others, notably their families. Similarly, PMs in this study describe a heightened sense of self through connecting and developing close relationships with partners, family and close friends. In particular, Chloe and Doris describe becoming reconciled with their previously estranged mothers, who acted as vital sources of support. They said that they felt cared for, understood and valued at a time of isolation and loneliness in hospital. Where they felt central to the needs of their family, they were also characterised as 'normal' (*i.e.*, non-drug-using) mothers.

Nonetheless, this similarity soon evaporated when they described being reminded of their 'otherness'. In the transition from their old identities as drug-users to their new ones as mothers, their emotional turbulence appears accentuated by insensitive attitudes and prejudicial treatment, especially from the professionals they met in hospital. Their self-reported experiences cannot be generalised as institutional abuse; however, the findings indicate the following two areas where they describe feeling particularly defenceless and discriminated against. These resonate with the Department of Health and Home Office's (2000) definition of institutional abuse as 'isolated incidents of poor or unsatisfactory practice' (p. 10), explored later under the heading 'Authoritative Experts', section 10.4.

Firstly, PMs described feeling blamed and that professional treatment was perceived as punitive because they did not reflect normative constructions of motherhood, as explored in Chapter 3. This finding is also reminiscent of the argument in Chapter 2

that associates drugs-users with a homogenous group of 'junkies' who live on the margins of society (Radcliffe and Stevens 2008). The physician Sohr (1996) described health professionals' attitudes towards the 'Good and Bad Patient' and negative illnesses, which includes those who are manipulative, such as drug-users. He observed how this group of patients make health practitioners feel anger, sadness, frustration, avoidance, hopelessness and depression. Thus, MMT breastfeeding mothers are at risk of feeling vulnerable when exposed to some professionals who express little interest in, or knowledge of, them.

Little specialist knowledge often left PMs feeling bewildered. One major area in which they felt confused concerned the inconsistent advice they received about breastfeeding. For instance, Chloe says that, whilst acknowledging her desire to breastfeed, her social worker advised her to bottle feed as soon as her daughter was born. Despite this conflicting advice, Chloe continued to try. Notwithstanding her patience and persistence, she was the only mother out of the four interviewed who struggled to breastfeed. In the final interview, she says her participation in the study had encouraged her to keep trying. Thus suggestions for her perseverance are explored in section 11.3 as part of the examination of my role and influence as researcher.

Secondly, despite efforts to prove their trustworthiness, PMs described feeling powerless when exposed to professionals' stereotyped and prejudicial treatment. Reactions to PMs become premised on a public discourse in which they have been referred to as 'embodiments of risk' (Ettorre 2007) and 'wayward wombs' (Murphy and Rosenbaum 1999). During pregnancy, PMs said they were the focus of professional attention and described making substantial changes to their lives by engaging in regular antenatal care and drug treatment programmes: a finding similar to that made by Radcliffe (2011, 2009). After delivery, and with professional attention shifted onto their babies, PMs felt marginalised and impotent. According to Goffman (1963), drug addiction is an example of deviation in personal traits by which reactions of others have the power to spoil any claim the individual may make to having a normal identity. Thus any claims pregnant women make to validate their worth as

mothers appear inconsequential after delivery. This is a finding which demonstrates that attitudes have remained relatively unchanged since Murphy and Rosenbaum's (1999) study (section 6.1.2).

Therefore, in summary, PMs appeared to experience enormous emotional changes in their lives associated with becoming mothers. However, they were vulnerable when perceived primarily, and approached, as drug-users. They describe struggling to make sense of their changing identity in the face of punitive, stereotyped and prejudicial professional treatment. In addition, they also appear engaged in a personal struggle with emotions that they fear will overwhelm them.

The surge in emotions is not only the consequence of the enormous hormonal upheaval associated with motherhood, but also of their exposure to feelings they have previously managed to keep under control through drug-use. Outlined in section 2.2, the self-medication theory of addiction hypothesises that heroin helps numb emotions (Khantzian and Albanese 2008). Therefore, abstinence, or a reduction in methadone dosage, exposes the user to feelings they have not experienced for a long time. With the added demands and responsibilities associated with childcare, mothers fear becoming emotionally vulnerable – a vital finding outlined in the studies described in Chapter 6, undertaken by Fraser *et al.* (2009) and Klee (1998). This internal, emotional world is explored further in section 10.3.

10.3 The Participant Mothers' internal, emotional world

In writing about emotional intelligence, Goleman (1996) describes emotions as numerous; with hundreds of feelings, emotional blends, variations and mutations. Conceptually, they are hard to define. Distinguished from intellectual reasoning or knowledge, emotions are described as instinctual and intuitive, which are vital to life and influence human reactions to decisions, predicaments and tasks (Johnson 2002). The word 'emotion' stems from the Latin verb *motere* meaning *to move*. With the additional prefix 'e', the word itself means *to move out of*. This implies that each emotion contains a tendency for action (Goleman 1996). As emotions promote the flow

of thoughts through our minds, these thoughts in turn promote impulses to act (Johnson 2002).

For the PMs, the turbulence of their emotions caused great internal conflict. In the first part of this section and presented as the first major finding, love is described as so profound an emotion that it literally changed one mother's life. The second part incorporates descriptions of PMs' fears of being identified as 'bad' mothers and punished by being separated from their babies.

Feeling love as breastfeeding mothers

All the PMs spoke about demonstrating and feeling love for their babies. However, only one out of the four mothers interviewed describes the details of this massive and profound shift in their lives, see section 9.5.1. Beth's experience was the only one that reflected parallels with decisions taken by breastfeeding mothers recruited into Ballard's (2002) study, in which methadone was stopped in favour of continuing to breastfeed. As this is a phenomenological study, I do not suggest that Beth's experiences are generalisable to all MMT breastfeeding mothers. Although the three other women were also exposed to the oxytocin effect, described in section 5.2, Beth's unique experiences are described here because she astonished me as a researcher.

Described as a profound and life-changing event, Beth's responses to breastfeeding were totally unpredictable. Her account of the dramatic changes that breastfeeding made in her life is vivid and detailed. Whilst reflecting on her experience in the final interview, Beth was able to connect the direct relationship between breastfeeding and love. Her descriptions of this experience are summarised below.

In the immediate postnatal period, during the time she was expressing breast milk, Beth described feeling ambivalent and alienated towards her baby. However, she stated that she instantaneously fell in love with her baby on the commencement of breastfeeding. She said this was a totally new feeling for her, as she had never loved anybody else in her adult life, including herself. Over the course of the three postnatal interviews, Beth

stated that she was shocked when she reflected on the changes that breastfeeding had triggered within her and felt scared because her instincts had changed. As a drug-user, she reported that she would have been involved in fights when others pressed her to retaliate. On becoming a caring, loving and insightful mother, abstinent from all drugs and prescribed medication, she faced an incident where she was taunted to fight. She decided to leave the situation because she said her first reaction was to think of, and want to be with, her baby.

Beth is depicted in the data as moving away from being a chaotic and restless drug-user to becoming an assertive young woman. Always softly spoken, her demeanour changed over the course of the four interviews. With responses kept to a minimum, her first interview was very short. However, by end of our contact, her confidence and self-esteem had increased dramatically and she was able to spend more time reflecting on her experiences. During this time, she already was taking positive personal decisions. With her focus entirely on her baby, Beth stopped taking methadone because she did not want anything numbing her experience of her love for her child. When unable to speak to others and to nurture her perceived personal growth, she recorded her reflections in a private diary. In other words, the explosion of love propelled Beth into becoming a responsible mother and a thoughtful and reflective young woman.

However, nobody, including Beth herself, could have forecast her reaction and the profound impact that breastfeeding had on her life and the life of her baby. At the time of her first contact with her GP, Beth said she led a chaotic poly-drug-using lifestyle, in which there appeared no hope for change. She started using heroin as an antidepressant and her flat was devoid of furniture, as she had sold it all for drugs and alcohol. Once breastfeeding, Beth started to give personal meaning to her life through the connection with her baby. This reaction is hypothesised by Kelly (1991) in section 3.3.2. In a world now personally constructed by her positive experience of breastfeeding, Beth started to construe it, and herself, differently. As her maternal relationship with her baby proved stronger, the dependence on methadone became inconsequential, as predicted by Byington's (1997) relational theory of addiction (Section 2.2.2).

This underscores the first major finding of this study. Whilst promoting long-term wellbeing and health to both mother and baby, breastfeeding provides an additional window of opportunity to change lives. As a confirmation of her experience, Beth predicted that, if she had not breastfed, she would have returned to her previous life as an illicit drug-user, even if this meant abandoning her baby. Although Beth was the only mother to detail her experience, all the PMs demonstrated loving attachments to their babies. However, by way of contrast, and underlying the early transition to motherhood, was a fear that, as drug-using mothers, they would not be considered ‘good-enough’ carers for their babies, as described below.

Feeling fear as drug-using mothers

Contrary to Barclay *et al.*'s (1997) findings that ‘normal’ mothers were prepared to stand up against the decisions that others were making about their babies, all the PMs stated they felt anxious and afraid of being assertive because they did not want to be perceived as aggressive. They cite toleration of professionals’ stereotypical attitudes because they were scared of the potential consequences. For instance, Doris said she did not argue against the decision to remove her baby to NNU, because she was fearful of being perceived as a difficult and ‘bad’ mother.

An additional fear highlighted in this study was the professional stereotyping of babies. From a notion described by Ettore as a by-product of the embodiment of risk (2007), babies of the PMs also appear to become ‘contaminated’ by the drug-use. This is demonstrated when Chloe’s baby is transferred to the NNU. Citing breastfeeding as the optimal nourishment for her child, Chloe is eager to feed. After claiming to have her request to express milk rejected, Chloe voices frustration at handing her daughter over to carers, whom she suspects will not place her daughter’s interests as high as she does. I, therefore, suggest that, as Chloe is perceived as a ‘bad’ drug-using mother, she is articulating her fear that her baby will be handled in the same way, *i.e.*, undeserving of ‘good’ care.

Goleman (1996) conceptualises 'fear' as an umbrella term, incorporating anxiety, confusion and vulnerability. He adds that people start to feel edgy and ultra-alert as a direct consequence of emotional centres being flooded by negative fearful emotions. Findings from this study suggest that both PMs and professionals express similar anxieties for the wellbeing of the infant. However, instead of feeling reassured by the services they approach for help, PMs say they become increasingly anxious when they discover, that instead of validating their efforts to prove their capability to mother, professionals turn them into objects of monitoring and surveillance.

Despite this, all the PMs cite a willingness to work with social services and compliance in meeting professional demands because they are fearful of being separated from their babies. The second major finding of the study suggests that breastfeeding acts as a conduit through which PMs try to publicise their care and nurturing of their infant. As a non-verbal method of communication, the data reveals that professionals do not recognise the meaning behind the PMs behaviour. Instead, they expect PMs to attend numerous multi-agency appointments to talk about, and plan, care. This has the effect of temporarily separating them from their babies. PMs then risk exposure to criticism and anger when they return to the wards. Insinuations of being feckless were made by staff who appeared to blame PMs for their absence from their new-born babies. This is similar to a finding documented by Fraser *et al.* (2007) in a study of neonatal nurses' attitudes towards drug-using parents. Staff expressed ignorance of the meetings parents had to attend and said, if they had known, they would not have felt so judgemental.

Where they are treated differently from other mothers, they describe being 'the Other', an identity explored in section 10.4. Whilst acknowledging that professionals are working under the constraints of the present-day NHS, with low staffing numbers, resulting in people being excessively busy, they are depicted in the data as lacking experience when working with breastfeeding MMT mothers.

10.4 The external world of being ‘the Other’

As highlighted in Chapter 4, this thesis set out to address the paucity of research from the perspective of drug-using mothers. The criteria for recruitment into the study were deliberately precise in order to exclude those women who would obviously fit the stereotype of ‘junkie’ (section 2.1). The PMs were chosen because their lifestyles reflected stability and an eagerness to become mothers. As MMT breastfeeding mothers were the only participants, I accept this exposes the study to criticisms of being unbalanced. However, even though no-one professional was interviewed, confidence in the findings of this study stems from the richness and quality of the data collected.

Section 10.4 explores the link between the actions of service providers and the potential negative effects on the health of their clients. As noted in section 2.2.2, because of the small population size of drug-using mothers when compared to other ‘normal’ mothers, it is suggested that professionals in hospitals are restricted by their lack of contact and knowledge. Findings from this study indicate that, because PMs lie outside the familiarity of the professionals’ own cultural frame of reference, they are treated with hostility.

‘Being Judged’ was the major theme that emerged from the data, and all PMs describe how they felt labelled and stigmatised as ‘the Other’. With an overwhelming emphasis on children and babies, the data describes professional reactions to a reality they think they see, *i.e.*, one in which the view of the Mother as the nurturer is skewed by the perception of her as a drug-user. As observed by Klee (1998), such a perception rationalises the reactions of professionals. These distort the treatment of the PMs because the baby is identified as being at risk. They describe staying on the post-natal ward for a further week after the departure of ‘normal’ mothers. In addition, they are depicted as secondary carers when professionals do not talk with them. For instance, Doris recounted her horror and confusion on watching her baby being transferred to the NNU at five days post-delivery. She said she felt angry and upset after being told that

the midwives had been covertly monitoring her baby for opiate withdrawal symptoms without informing her of what they were doing.

The following discussion is framed by three strategies as contained within Hart and Freeman's (2005) 'effect of the professional ego' model outlined in section 3.4. By stereotyping the PMs as the out-group and through boundary maintenance, the authors argue professionals are able to maintain a sense of self-preservation. In addition, by acting as 'authoritative experts', Hart and Freeman describe professionals nourishing and preserving their grandiose professional self as part of their statutory role. Through an examination of psychosocial, psychodynamic and cultural elements, the model helps to explain why equal access to health care for MMT breastfeeding mothers is impeded.

Stereotyped and labelled as the out-group

All the PMs said they felt treated as members belonging to one homogeneous entity of feckless drug-users (section 2.1). PMs report that care was often distilled down to personal and stereotyped opinion rather than being informed from research and professional education. These commonly held beliefs are based on images, or caricatures, that remain entrenched regardless of evidence to the contrary:

A caricature which exaggerates the negative features of a group and assumes they are possessed by all the members of the group...furthermore it is usually based on prejudice rather than fact and is difficult to change in the light of contrary evidence (van de Lagemaat 2005: p.66).

When writing about the nature of prejudice, Allport (1954) argues that hostility can be benign, used to describe, and possibly even excuse, in-group action towards the out-group. Allport designates protective boundaries drawn around commonly-held values that maintain the holder's sense of security. Thus whilst depicting 'the Other' as alien, he contends that this is due to unfamiliarity on the part of the in-group and does not necessarily mean the feeling is negative.

However, the emergent data from this study suggests that PMs appear to be treated with more hostility than suggested by Allport. With a division between the groups accentuated by an inequality in power, PMs are portrayed as being marginalised, alone and vulnerable. Over the time of the study, PMs describe experiencing suspicious, distrustful, obstructive and uncaring treatment, with relationships marred by distrust in which all PMs feel judged. Their identity as drug-users was underscored publicly each time they were dispensed methadone. As a controlled drug, two nurses would supervise consumption of the green liquid in front of other mothers. This breached their right to confidentiality. Doris said she overheard a phone conversation by another mother in which she was referred to as 'methadone mother'. In addition, poor professional attitudes spilled over to the prejudicial treatment of their family and friends.

Staff members of a specialist assessment unit working specifically with substance-misusing parents also demonstrated such attitudes. When Beth describes sharing with the manager how she felt changed since becoming a breastfeeding mother, she describes being met with cynicism and disbelief. Thus, regardless of Beth's claims to the contrary, his attitude demonstrates entrenched beliefs about the unchangeable and negative characteristics of 'the Other' drug-using parent group.

Such poor attitudes leave PMs feeling oppressed and humiliated. This is unacceptable practice. Recognised by the Department of Health (2007a) as belonging to a socially disadvantaged and vulnerable group of mothers, *Maternity Matters* urges they be treated with more compassion. However, as discussed throughout this chapter, their experience of prejudice and social exclusion as members of a minority group underscores Hart *et al.*'s (2003) argument that the lack of an inequalities imagination results in harmful and discriminatory practices.

For instance, Hoskins *et al.* (2005) argue that negative reactions to illicit drug-users affects perceptions of workload demands associated with treating this group of patients. Perceived as burdensome in terms of time and resources, 46% of respondents in an inner city Accident and Emergency department over-estimated the number of attendances of patients. A major factor affecting management of this group of patients

appeared to stem from anxiety of being manipulated by patients seeking prescription drugs. Staff commented on poor patient behaviour, described as aggressive and rude. However according to the data collected, and published separately, Binks *et al.* (2005) report that of the 290 lifetime drug-user respondents, 258 (89%) had presented with either indirect or unrelated reasons to drug-use. The most common complaint was assault/head injury. All the staff members acknowledged the need for education and training around drugs for more effective management of this group of patients (Hoskins *et al.* 2005).

Such reflections are incorporated within Hart *et al.*'s (2003) Inequalities Imagination Model. Designed to improve practice by promoting basic human rights and dignity at the grass-roots level, the model is developed to work in three ways, by helping: practitioners reflect on current practice, increase in understanding and awareness of how they interact with clients and, finally, to prepare others to do the same.

However, despite such narratives within the literature, professionals working with the PMs continue to demonstrate a lack of compassion and insight. Behaviour towards PMs portrayed more of a sense of in-group bias resulting in out-group distaste, leaving little room for empathy and understanding for those who are not part of their group. This reflects Brewer's (1999) description of 'in-group love' or 'out-group hate' and evokes a commonly held dictionary understanding of 'hostility' in terms of conflict between opposing forces (Concise Oxford English Dictionary 2004).

Therefore, following on from Allport's (1954) argument regarding in-group identity and Brewer's (1999) notion of out-group hate, stereotyping highlights the contrast and division between both groups. Through commonly shared and held beliefs, members of one group exclude, and prevent, others from joining others. For instance, even though the majority of professional staff were of similar child-bearing age and more likely to have or have had children, PMs did not report talking about life experiences they might have had in common with one another. Instead, they described their struggles, and subsequent frustration to 'validate their worth as mothers' (Murphy and Rosenbaum 1999: p.104).

As PMs portrayed themselves as isolated and demoralised, it seems logical to suggest that the PM's own internalised devalued differences, and sense of who they were becoming as mothers, were corroded by the treatment they received at the hands of professional health and social care givers. PMs stated they did not need another person to remind them of what they are in terms of being drug-users. They said they were constantly aware of their illicit opiate use whilst holding, or looking at, their babies.

Even so, there are a few incidences where PMs described feeling they were treated well. Some people were able to relate to the PM on a human level. In these isolated incidences, PMs said they were treated with compassion. For instance, a student midwife took time out of a busy night shift to sit with Anna and help her breastfeed. Doris remembers the cleaners on the ward with fondness because they spoke kindly with her as a mother. Small acts of kindness were not only remembered but also made a difference to their early experience as mothers:

One tolerant health professional can heal more than just an ailing body...the most powerful harm-reduction strategy may be tolerant and compassionate care by practitioners with an understanding of drug-users and their related life-style issues (Murphy and Rosenbaum 1999: p.93)

In addition, PMs commented that professionals were, like themselves, victims of circumstance. For instance, PMs cited poor staffing levels, which prevented attendance to requests for help with breastfeeding; a finding which, presumably, was also experienced by other 'normal' mothers on the postnatal wards. However, with the PM's stay on the ward extended to ten days for monitoring purposes, they were able to witness the constraints under which staff were working, and the measures they used to protect themselves. The next section discusses the formation of protective professional boundaries, devised to help maintain emotional distance and the impact this had on the PMs. Boundary maintenance

In her seminal study, Menzies Lyth (1960) observed high sickness rates and frequent job changes in response to the tension and distress associated with the normal course of nursing duties. Nurses were reported as harbouring fears of the patients and the

illnesses. Intimate contact with patients and relatives was described as psychologically stressful and disgusting. Drawing on this work, and whilst developing their model of the professional ego, Hart and Freeman (2005) observed that professionals draw and maintain personal boundaries when they want to protect themselves from feeling overwhelmed. They do this by becoming *task orientated*, which emphasises getting the 'job done'.

However, whilst boundary maintenance protects nurses, the distance created can cause problems for patients. For instance, a simple oversight of, and the anonymity associated with, not wearing a name badge left Doris feeling disorientated. She says she once asked another member of staff about somebody she thought was a doctor because she was particularly caring when her baby was on the NNU. She was told 'the doctor' was a nursery nurse. Such oversights might appear trivial but, when set in the context of being treated as 'the Other', only added to her feeling confused, vulnerable and alone.

From working with this client group, I understand that issues connected with drug-using mothers can be difficult and complex (*e.g.* Ettorre 2007, Hall and Teijlingen 2006, Goode 1999, Klee 1998). As a nurse, I appreciate that an already-taxing occupation becomes even more stressful when trying to balance the needs of drug-using mothers and their babies. This tension must be especially onerous where professionals lack consistent opportunities to work with, and therefore gain greater understanding of, these mothers. With the number of deliveries from opiate-using mothers constituting less than one percent of the total of babies delivered (section 2.2.2.), the diverse nature of these women will continue to pose huge and subtle challenges for health and social care staff. As previously stated in this thesis (*e.g.* sections 2.1, 3.4, 6.1 and 9.5.2), drug-using mothers respond to empathetic care, and when approached individually.

By way of illustration and to help to position the women interviewed in this study, I draw on the example of the line of self-construct. In the interviews, the women always positioned themselves close to the drawings of their imagined ideal mothers. By using a similar line of risks that drug-using mothers pose to their babies, and in keeping with

my advocacy position, I locate MMT breastfeeding mothers distally and away from the feckless and chaotic drug-using mother who continues to use substances. Whilst envisioning them more proximal to the 'normal' non-drug-using mother, I acknowledge the difficulty in knowing precisely where these women might lay.

This struggle is demonstrated in the following quotation taken from a paper outlining an Australian survey of experienced specialist midwives who work with illicit drug-using mothers. Even though they are portrayed as empathetic practitioners, they grapple with accepting the trustworthiness of women who attend antenatal care:

The midwives felt that acceptance is required of the woman as an individual, a separate person, with a belief that she is trying to do the right thing by attending antenatal clinic and is fundamentally trustworthy. The participants found this was not simple to achieve and in order to come close requires them to have genuine, honest, real or congruent understanding about themselves. (Miles *et al.* 2013: p.3)

The midwives are candid in recognising that reflexivity helped to soften their beliefs and attitudes towards drug-using mothers. This led to a greater understanding of the challenges the women faced, with admiration of their strength and resilience in the face of their difficulties. In the early stages of this study, I acted on my concerns to establish the safety of methadone for breastfed babies by undertaking a literature search (see section 5.1). Based on findings derived from additional research (e.g. Radcliffe 2011, Fraser *et al.* 2009 & Litzke 2008), and from my two published papers (Jambert-Gray *et al.* 2009a & 2009b), I felt confident in suggesting that engagement in methadone treatment and abstinence from heroin are early and positive indications of the transition from drug-user to mother.

However the data from this study have shown that despite the shift in the women's behaviour some professionals continue to react with personal feelings of distrust and suspicion. As suggested in sections 1.3 and 2.1, derogatory media coverage of drug-using parents may continue to negatively impact on responses to MMT mothers. Without self-reflection on the part of social and healthcare professionals, as shown in

the quotation above, women like those interviewed for this study are at risk of facing compromised treatment.

Writing on the inequalities of health-care provision, Hart and Lockey (2002) identify problems with managers who lack adequate strategic vision to support practitioners in targeting resources to disadvantaged mothers. *Maternity Matters* (Department of Health 2007a) urges a two per cent increase in the rate of breastfeeding for all women. Despite Government recommendations and a substantial evidence-base in favour of breastfeeding (section 5.1), the emergent data in this study suggests that PMs continue to feel informed by professionals' personal and biased opinions. The work of preserving boundaries, with mechanisms designed to monitor the PMs as drug-users, appear to continue unabated.

For instance, PMs describe examples where they feel excessively monitored. In the early days following the birth of her baby, Chloe claims that, whilst she was flushing the toilet, a midwife came into the bathroom to accuse her of taking drugs. Her narrative implies the midwife had time to stand outside the door, presumably trying to listen to what Chloe was doing. As commented in Illich (1997), episodes of excessive surveillance and intervention can compromise the individual dignity of the person under scrutiny. The surveillance culture on the ward becomes increasingly more evident when contrasted with other less suspicious activities. Chloe said she constantly asked for help to breastfeed, only to be told the midwives were too busy. In other words, while midwives appeared too busy to help her efforts to breastfeed, they were described as being able to stand waiting outside a bathroom door when illicit drug-taking was suspected.

Conversely, and enmeshed within this complex relationship, lie the PMs' own perceptions of professionals. Menzies Lyth (1960) writes that patients respond to nurses in ways that are negative. In her study, patients appear to resent their dependence on nurses and grudgingly accept the discipline imposed by hospitals. In response to their envy of the nurse's health and skills, patients were reported as

demanding, possessive and jealous. Although jealousy or envy of the independence and skills of professionals was not stated explicitly in this study, PMs acknowledged their fear of professionals. To preserve contact with their babies, they subordinated themselves to complex social care plans. This may account for some of their criticism of professionals.

As part of their statutory role, professionals became ‘authoritative experts’, the third strategy in Hart and Freeman’s (2005) model of the professional ego. The following section describes the pursuit of duty of care to the infant and the impact this has on the safeguarding needs of the PMs.

Authoritative experts: Safeguarding infants vs. safeguarding adults

PMs described facing a large and amorphous group of social workers, midwives, nurses and doctors. Brewer (1999) suggests that, in the presence of a common goal, loosely knit groups rally round as a united, cohesive group. In this study, all professionals appeared to share an underlying fear (and ignorance) that PMs’ lives were out of control and dominated by illicit drug-use. Therefore, the major rallying cry concerned their statutory role in safeguarding the wellbeing of infants (Home Office 2009): see section 3.4.

At this juncture, I propose the third major, and controversial, finding of this study. Whilst in hospital, PMs appear to be at risk of being exposed to ‘isolated incidents of poor or unsatisfactory professional practice’ (Department of Health and Home Office 2000: p.10). It is difficult to state the extent of this experience in terms of ‘significant harm’; however, it is clear that PMs felt abused when in contact with professionals. PMs are portrayed as defenceless against a powerful system, which concentrates entirely on safeguarding infants.

PMs described excessive surveillance and control which left them feeling increasingly marginalised, infantilised and redundant. They cited stories of their babies being covertly scored for symptoms of NAS. They said they felt helpless when their babies

were stressed in order to gauge, as a symptom of opiate withdrawal, whether the cry was high-pitched. In addition, they described their struggles trying to bond and establish breastfeeding where hospital policy dictates the infant's admission to the NNU for monitoring and the treatment of opiate withdrawal. In the units, PMs were left feeling superfluous when nurses became their babies' professional carers. After transfer to the NNU, Doris said she felt pressurised to stop breastfeeding because staff told her bottle feeding was easier for her five-day-old baby. It therefore appears that PMs felt angry and frustrated by a system that appeared to work against them at the very time they were trying to convince professionals that they did not pose a risk to their babies.

As a result, there were lost opportunities for developing co-operative constructive working relationships, as advised by The Home Office (2009). In *Every Child Matters*, liaisons between parents and professions are notable protective elements against such disadvantaging factors as substance abuse and poor parenting. However, ground is lost when professionals continue to leave PMs feeling disempowered. The depiction of poor and unsatisfactory practice in the data is contrary to the stated protection of mothers, who should be able to access public organisations without fear of abuse (Association of Directors of Social Services 2005). Government documents cite particular concern in cases where abuse is perpetrated by people in positions of power or authority, and who use these positions to the detriment of the health, safety, welfare and general well-being of a vulnerable person. According to House (2000), when professionals act in ways that are self-serving, *i.e.*, seen to be fulfilling their statutory duties, they use language and rituals which not only reinforce the validation of their actions but which also have the effect of buttressing their positions of power. In this study, instead of constructive interventions for improved working relationships, PMs' experiences imply that, whilst professionals protect their positions of power, their own human rights are violated. In other words, whilst in hospital, PMs describe feeling discriminated against.

In the previous sentence, I originally described the PMs as 'victims of institutional abuse'. However I recognise that the term may evoke associations with systemic maltreatment of vulnerable individuals across the whole of the NHS and social services. Such an understanding is not intended as the findings are not generalisable. I

interviewed just four women and used a methodology which relied on their unsubstantiated and self-reported experiences, which, as data were subject to my own interpretation. For these reasons I have not employed the term explicitly within this thesis.

Even so, I feel that the definition used in the government document *No Secrets* (Department of Health and Home Office 2000) and subsequent paper *Safeguarding Adults* (Association of Directors of Social Services 2005) is appropriate to this thesis (section 3.4). ‘Isolated incidents of poor or unsatisfactory professional practice’ (Department of Health and Home Office 2000: p.10) seem relevant to framing the women’s reports of discrimination from professionals.

Because some of their experiences do have resonance with this definition, I instead describe the four MMT breastfeeding mothers’ experiences as instances of poor and/or unsatisfactory practice where they might feel discriminated against through unfair and/or unfavourable treatment.

On discharge home, the following section suggests that PMs continue to focus on areas of their lives that were important to them, *i.e.* their babies and family. This final section stems from discussions with PMs post-discharge. They describe reactions to their becoming good-enough mothers for themselves. Their internal changes suggest a strong identification with being mothers. In a document written for social workers, Mounteney and Shapiro (1997) depict drug-using mothers as at risk of damaging their babies through child neglect. Contrary to this illustration, the PMs are described as insightful, culturally belonging to their own virtual ‘in-group’ with their own defined identity and construction as breastfeeding and methadone-treated mothers.

10.5 Tension between internal changes and external world

The findings for this study suggest that the PMs’ early stage of maternal psychophysiological preparedness for becoming a good-enough mother was disturbed whilst being monitored in hospital. However, once discharged, there were noticeable changes

in how they described themselves. Whilst continuing their journey into motherhood, they all demonstrated personal resilience in the perpetuation of their identities as breastfeeding mothers.

Becoming the good-enough mother

The fourth major finding in this study shows that when mothers are able to settle into motherhood, they enter a process in which they learn to accept themselves as ‘good-enough’. This differs from the concept of the ‘social construction of *deviant* motherhood’ as used by Goode (2000) to describe the drug-using mothers she interviewed (section 3.2). With motherhood described as incompatible with psychoactive substances, including methadone, Goode argues that the word ‘deviant’ demonstrates departure from culturally-defined prescriptions of who mothers are, and how they should behave. However, the findings of this thesis suggest this is not always so. The PMs demonstrate there can be a compromise between the oppositional and dialectical positions where they can be both nurturing (breastfeeding) and deviant (methadone-treated). Thus the concept of the social construction of *deviant* motherhood is replaced by *good-enough* motherhood. This reflects how PMs behave more in congruence with culturally-expected rules of maternal conduct.

This concept is associated with Winnicott’s work (1953) and identifies a good-enough mother as one who adapts to the needs of her baby. The early stages of motherhood are particularly important as the time when a new mother learns to identify closely and intuitively with her baby. Being good-enough stresses the importance of responding immediately and appropriately to the infant’s physical and emotional needs (Winnicott 1956). This response is especially pronounced through breastfeeding, where close contact with the mother induces a sense of security and comfort. Psychotherapist Johns (2011) adds that being physically close and available through breastfeeding allows the mother to respond immediately and her prompt response protects her baby from unnecessary distress and anxiety.

Further data, collected at three months, indicates that, once home with their families and away from direct surveillance and controls, PMs demonstrate a strong innate maternal capacity to reconnect with their babies. They define and align themselves within the social construction of normative motherhood and describe busying themselves with maternal and domestic duties. In a finding that mirrors Kelly's (1991) hypothesis of personal construct psychology (section 3.3.2), on their return home, PMs become more deeply involved in their identity renegotiation because they are removed from, and therefore less concerned with, professionals. With a reduction in professional intrusion, the ebb and flow from internal and external lifeworlds were not so dramatically experienced as before.

In addition, during this process, PMs said that their experience of breastfeeding improved their sense of internalised devalued differences. They recognised how little they had valued themselves before becoming mothers: PMs either described failures in their efforts to change from being drug-users (Anna and Chloe), or continuing to use drugs because there was no need to change (Beth and Doris). As mothers, they started to regard themselves as important because of the central role they occupied with their babies. They discovered they were able to be more assertive, recognising they had the right to feel angry about how they had been treated by professionals.

Thus, after leaving hospital, the data suggests the PMs entered into a process in which they experienced and entrenched increases in self-esteem and maternal self-efficacy. Their responses demonstrate, that as their perceived self-regulative efficacy became stronger, their efforts to become good-enough mothers for themselves were more successful, a development hypothesised by Bandura's (1997) theory of self-efficacy (section 3.3.1). By accepting positive aspects of their personalities, they remarked they were feeling more optimistic.

The final part of this discussion reports how PMs continued to reflect on their transition and started to depict themselves as 'expert patients'. They reflected on the hitherto unforeseen functional role of methadone, as discussed below.

Becoming insightful mothers

Becoming insightful was a concept that emerged from observations in the final interviews. At this time, the PMs were feeling more settled at home and able to reflect on their reactions to how they had been treated when in hospital. They were also able to consider aspects of their experiences that had not been obvious previously. Goleman (1996) describes such thoughtful reflection as a time of self-awareness, when attention can be given to previously experienced, but unexplored, feelings. For instance, Doris was able to recognise that professionals lacked experience and contact with MMT breastfeeding mothers. After acknowledging that professionals were probably responding to myth and misinformation about drug-users (section 2.1), she was able to say she felt more forgiving of some their stereotyped and prejudiced attitudes.

PMs also described feeling uncomfortable and shocked by the graphic depiction of methadone and their babies on their rational maps. As methadone was persistently drawn closer to them than their babies, they were distressed that this demonstrated the most significant relationship in their lives. It was the part of the interview they most frequently discussed afterwards with their partners, because they reasoned their babies, not methadone, should be drawn nearest to them.

The misunderstood role of methadone is the fifth major finding of this study. The PMs instinctively knew they needed methadone as their major source of strength and were terrified by jeopardising their ability to mother without it. The data derived from conversations about the drawings reveal the PMs impulsively and emotionally drew in methadone's position. During the final interview, they reflected on why it was sited that way. They identified this tension as a 'head and heart' issue, similar to the emotional/rational dichotomy described by Goleman (1996). As an example, Chloe stated methadone was fundamental to stability in her life. She mentioned her concern that, without it, she would start to feel unwell and unable to cope with the stresses of motherhood. However, by remaining on her prescription, she was prepared to confront the very social workers she feared and who demanded abstinence from it. In a reaction that appears punitive, she became increasingly monitored and controlled by social

service interventions. Thus, methadone became the tense interface between the PMs' desperation to continue functioning and professionals' ignorance that it was evidence of their unreliability as drug-users.

Where the PMs are able to share these insights, this finding indicates the potential to develop more positive partnerships between the two parties. For instance, when asked by her social worker about methadone, Doris not only enjoyed sharing her expertise but also was able to recount an improvement in their relationship. The significance of the simple, well-placed question, along with a willingness to listen to the answer, was remembered with gratitude in the interview.

10.6 Summary

By drawing on previous publications and research, outlined in Chapters 2, 3 and 6, Chapter 10 has explored the three categories identified from the data, *i.e.*, the PMs' internal emotional world, their perception as 'the Other' and finally their becoming good-enough and insightful-enough mothers for themselves. Using their dual identity as 'normal' mothers and drug-users as the standpoint for understanding these women, these themes have been used to highlight and frame five major findings.

In the early days of motherhood, breastfeeding MMT PMs' internal worlds are buffeted by the emotions of love and fear. In the first major finding of this study, all the women described being in love with their babies. However, Beth's experience is particularly poignant because her reflections graphically illustrate the significance of the connection between love and breastfeeding that helps provide that vital window of opportunity for change. Before pregnancy, she was depicted as an inexperienced and isolated girl who used heroin as an antidepressant. After breastfeeding, she is portrayed as a thoughtful and abstinent young woman.

Whilst undergoing this process of positive transformation, the PMs described their fear of professionals who have the power to separate them from their babies. In the second major finding of this study, the PMs endeavoured to publicise their care and nurturing

of their infants by breastfeeding. However, these efforts appeared to go unrecognised by professionals, who demanded the PMs attended numerous multi-agency appointments to prove their trustworthiness. Ironically, on these occasions, the PMs are separated from their babies. In addition, on their return to the wards, they were exposed to further criticism by staff members who, suspecting the worst, did not know why they were absent and where they had been.

During their extended time in hospital, PMs were described as ‘the Other’. Demonised as ‘junkies’ (Radcliffe and Stevens 2008), stereotyped as ‘embodiments of risk’ (Ettorre 2007), with ‘wayward wombs’ (Murphy and Rosenbaum 1999), they were exposed to the harmful external world of health and social care workers who demonstrated a lack of inequalities imagination (Hart *et al.* 2003). They were defined as a group of vulnerable mothers. The third major finding of this study shows that, where professionals’ attention is diverted solely to safeguarding the infant, breastfeeding MMT women appear to suffer from unintentionally prejudicial treatment which risks making them victims of discrimination.

However, once at home and away from direct monitoring and a judgemental professional gaze, the PMs were able to reflect on their identity as methadone-treated, breastfeeding mothers. In the fourth major finding, Winnicott’s (1953) concept of the ‘good-enough’ mother is used to demonstrate how they embraced their drug-user identity. The fifth and final finding reveals how breastfeeding MMT PMs have insights into the functional role of methadone. They state an unwillingness to sacrifice a sense of wellbeing in order to satisfy the demands for abstinence from social services.

Their specialist knowledge of the functional role of methadone offers the potential for PMs to act as ‘expert patients’. *i.e.*, they have a greater ‘lived’ understanding than professionals, as described in the document *Expert Patients Programme* (2011). This promises an opening for a more open and respectful dialogue between mothers and professionals, with optimism for an increase in constructive working relationships.

In conclusion to this thesis, Chapter 11 is used to reflect on how these findings can be developed in the interests of future mothers. The discussion first explores the process of doing the thesis, with implications for further research. Thereafter, ideas are explored about how to disseminate the findings in democratic ways that will help reduce the power imbalance between the mother and the services she accesses. Methods such as co-presenting lectures and encouraging mothers to work as advocates are suggested as possible avenues which will help support future breastfeeding MMT mothers.

Chapter 11: Conclusion

11.1 Introduction

This phenomenological study adds to the previously documented evidence that motherhood is a potentially important time for change in drug-using behaviour (Fraser *et al.* 2009, Hepburn 2005, Ballard 2002, Murphy and Rosenbaum 1999, Ettore 1992). As introduced in Chapter 1, the impetus for my research stemmed from the observation of a practice disturbance in which substance-misusing women consistently reported frustration when struggling to prove their trustworthiness as mothers to sceptical professionals. With the essence of the phenomenon described as an existential tension experienced by breastfeeding mothers in methadone maintenance treatment (MMT), the aim of this thesis is to reveal the previously hidden inter-subjective and social realms of their lived worlds. The research question places the mother at the centre of her meaning-making process:

What is the lived experience of being a methadone-treated mother who is breastfeeding her new-born baby?

Outcomes from this study show that the aim has been achieved and insights help further understanding of a previously little-known or understood group of drug-using women. Three of the five findings indicate that breastfeeding provides 1, a window of opportunity through which four MMT women felt they could 2, communicate their nurturing capability and 3, become good-enough mothers. The remaining two findings highlight hitherto unexplored areas in the research literature; namely, the concepts of feeling victimised by reported poor and/or unsatisfactory professional practice, and the functional role of methadone. This thesis stresses the importance of supporting breastfeeding and providing empathetic care for vulnerable mothers. To do this effectively, health and social care professionals need to be aware of the negative effects of stigmatisation and actively incorporate this knowledge into their practice.

The following section 11.2 contains the first four findings of this study. Reference is first made to breastfeeding and demonstrates that little has changed in the application of research. Secondly, the novel finding that the needs of breastfeeding methadone-treated mothers are potentially overlooked where infant safeguarding is the sole focus of professional concern, leads to poor and/or unsatisfactory practice that is suggestive of institutional abuse. The section concludes by proposing the need for a radical change in professional attitudes. The functional role of methadone is incorporated into the discussion in section 11.3.

11.2 Reflections on the findings

This study has indicated that the four mothers, moulded by their own experiences and prejudicial treatment, strive to match cultural and normative constructions about motherhood. With reference to Kelly's (1991) Personal Construct Psychology (section 3.3.2), I posit the experience of breastfeeding challenged their internal construct systems and created a window of opportunity for change in drug-using behaviour. After three months, the mothers acknowledged this change when they described themselves as good-enough mothers. Included in this definition is an embrace of their drug-user identity.

However, the mothers' conversations indicate there has been little change in terms of the practical application of current breastfeeding research and advice. For instance, professional support of mothers to breastfeed helps to promote bonding between mother and baby. In section 5.2, oxytocin release was linked with the promotion of bonding and maternal wellbeing (*e.g.* Jansson *et al.* 2004, Heinrichs *et al.* 2002). Lvoff *et al.* (2000) report that special United Nations' baby-friendly hospital rooming-in initiatives are effective in keeping breastfeeding mother and baby together. The UK's largest charity for parents, the National Childbirth Trust (NCT) (2013), offers practical advice about breastfeeding to new mothers. Whilst acknowledging maternal tiredness in the early weeks following delivery, the charity advises mothers to reduce all activity that is not concerned with looking after their new-born baby. On the premise that a hungry baby fed on demand is a happy baby, mothers are advised their babies should

set the pace of breastfeeding in the early weeks. As the production of breast milk is prompted by responses to their babies, mothers are informed that a reduced number of breastfeeds results in a decreased supply.

Even so, it is clear that such advice was not proposed for MMT mothers in this study as they were often separated from their new-born babies. They report attending myriad meetings to discuss their capability to mother, with babies removed to neonatal units for monitoring of opiate withdrawal symptoms. Whilst insisting on protocol that absents mothers from baby, professionals potentially risk damaging the vital bonding process which is dependent on rest and demand feeding. Thus despite professional codes of conduct instructing nurses and midwives to treat 'people as individuals and respect their dignity' (Nursing & Midwifery Council 2008: p3), women continue to narrate stories of poor treatment.

It is disappointing that the findings of this study appear to repeat other similar and comprehensively documented research reports of health inequalities (see Chapter 6). For instance, Banwell and Bammer (2006) observe that mothers are condemned by services because of their drug-use. Authors Hart *et al.* (2003) are critical of nebulous and politically correct current models of care which, in the presence of discrimination and oppression, fall short of meeting the needs of the individual. Therefore, as an extensive evidence base about the stigmatising and oppressive professional practices already exists, many readers might interpret the findings of this study as having little extra value - except to support the current evidence base.

Even so, it is tautological to state that exposure to professional, prejudicial attitudes were harmful for the women. This could limit this study's contribution to current knowledge. An innovative and controversial finding of this study is the recognition that, where infant safeguarding is the sole focus of professional concern, the needs of breastfeeding methadone-treated mothers are potentially overlooked. This may result in poor and/or unsatisfactory practice, reminiscent of institutional abuse.

As a senior lecturer in medical ethics and law, Sokol (2013) writes of the clinician's need to

balance their obligation to benefit the patient (the principle of beneficence) against their obligation not to cause harm (the principle of non-maleficence) (p.23).

This statement raises an interesting issue regarding care of the mother-baby dyad: who, if not both, is 'the patient'? During pregnancy the mother is the focus of health and social care concern. After delivery, the data collected for this study portrays her as alone and devalued as the 'Other'. An implied shift in professional focus suggests the baby has become 'the patient'. Where health and social professionals perceive drug-using women as embodiments of risk, they act to benefit babies by protecting them from mothers via statutory infant safeguarding procedures.

To shield mothers, I therefore propose the parallel construction of maternal protective care plans under adult safeguarding legislation. These will help mitigate the harm caused by public organisations and reflect the statutory advice that MMT breastfeeding women be enabled to access services free from abuse (Association of Directors of Social Services 2005).

The overall message from the data urges health and social care professionals to be aware of the complexity inherent in the dual identity of mothers. Thus, to take this thesis forward, I feel that broader debates of common decency, promoting a more honest, reflective and compassionate commitment to care, should be prioritised on today's healthcare agenda. Familiarity with the research, and actively incorporating this knowledge into practice, will help support services and communities to work more positively with MMT breastfeeding mothers – as explored later in section 11.4. A

seismic change in professional attitudes requires an informed leap of faith which can only herald improved, informed and empathetic care.

The following section 11.3 reflects on the process of undertaking this study with reference to how the functional role of methadone was revealed through the use of the relational map as a reflective research tool.

11.3 Reflections on the process of undertaking a phenomenological study

Methodology

In terms of methodology, and as described in Chapter 7, the lifeworld phenomenological pathway for this study provided a practical, methodological guide for collecting and analysing interview data. With reference to the lifeworld category ‘temporality’, exploring a tiny, but highly influential, moment in a life of multifaceted and varied human experience, the timing of the investigation proved invaluable. Within the context of the four discrete interviews and via her drawings, each of the four women were invited to reflect on early motherhood experiences, whilst in hospital and at home. There were initial concerns that recruiting four women was insufficient to gain an understanding of their lifeworlds and efforts were made to recruit more mothers (section 8.5). After due consideration, this number was judged sufficient to provide the richness of data needed to meet the project’s purpose and methodology within the context of a longitudinal study. Four intensive interviews generated 427 pages of single spaced transcription (Table 9.1).

I think the research tools proved particularly appropriate for this purpose (section 8.6). Although they are primarily used as therapeutic psychological instruments, to my knowledge this is the first time they have been used for research purposes. Whilst both helped generate conversation relevant to the research question, I feel the relational map in particular was simple to use and remember. As described in section 10.5, this reflective tool proved invaluable in understanding the hitherto little understood

functional role of methadone. Mothers said they continued to think about what they had drawn afterwards and used these reflections to add to the data in later interviews.

However, it is important to state that as a phenomenological study, I do not claim to offer generalisable predictions that all drug-using mothers will have similar experiences to those who participated in this study. With reference to Miles and Huberman (1994), the major benefit of this phenomenological study is the investigation of the mothers' human experiences within a cultural context in which findings are not generalised. However, although the focus is on the individual, particular and subjective, phenomena are observed and evaluated in order to facilitate the emergence of theories grounded in data (Holloway 1997, Lincoln and Guba 1989). The women's differing viewpoints collected for this project are used to gain a common meaning of the essence of becoming a breastfeeding mother within a commonly constructed lifeworld. These cross over each other in intersubjectivity and triangulate with findings from the literature.

Questions of validity and reliability

Questions of validity and reliability are discussed at varying lengths within the literature, in which methodological problems refer to the need for transparency of results and reflexivity within the interpretative stage (Reid *et al.* 2005). However, the aim of validity is:

not to prescribe to the singular true account but to ensure credibility of the final account (Brocki and Wearden 2006: p.98).

In terms of ensuring credibility, member checking is a method described by authors such as McBrien (2008) and Shaw (2001), in which participants review the researcher's interpretation of their words, usually during the data analysis stage. This is done to ensure consistency between the participants' views and the researcher's representation of them. Section 9.3.1 details the two reasons why the notion of member checking at a later date was eventually eliminated in this thesis.

Strengths of a longitudinal design

For the reader, the research design of meeting the same mother regularly over a period of four months might appear excessive. However I think four interviews were apposite because they not only helped to generate sufficient data; each meeting also established rapport. During the course of the study, I noted that with continued and regular contact, women appear to use the interview and six-week interval to reflect on their experiences and feelings. This insight came as the direct result of listening to their taped voices. I became aware of how our first meeting sounded more formal when compared to the later interviews. On reflection, I suggest they responded to my role as researcher in two specific ways.

Firstly, over the period of being involved with the study, I became a source of information. At the first interview, the pregnant women often asked questions about the safety of breastfeeding whilst being prescribed methadone. Here my experience as a researcher reflects the observations made by Oakley (1979) when her respondents asked many questions, mostly for information which could have been provided by professionals (Oakley 1992). In addition, over subsequent interviews, the questions became predictable. Women appeared to be interested in the project by anticipating the interview and using the six weeks in between as time for reflection.

This leads on to their second response and, as previously observed by Holloway (1997) and Oakley (1992), shows that the interviews were perceived as a social way of collecting data. Telling their stories had a cathartic influence on their continued engagement and participation because they appeared to have valued and benefited personally from taking part in the study. For example, Doris sent me a text message the day after an interview. She said how much she valued speaking to me because the interview had helped her reflect on how she had been treated. She added she was looking forward to meeting again in six weeks.

I suggest the three six-weekly postnatal contacts gave women time and opportunity for reflection as their experience was still relatively recent. If the number of contacts were

reduced to meeting five days and three months post-delivery, I conjecture that the extended interval time might affect their reflections and recall of early experiences. If the contacts were at five days and six weeks, the interval time might prove too short a time for reflection on becoming good-enough mothers. Therefore with the study delineated by the first 12 weeks of motherhood, three postnatal interviews proved invaluable in providing a richness of data which revealed the deep sense of the mothers' emotional turbulence.

However, if this project were to be repeated, I would not only keep the same number and time of contacts, but would also add an additional meeting because I am interested in meeting the mothers at a later date. During the process of collecting and analysing the data I often wondered about the long-term experience of breastfeeding, especially in terms of their methadone treatment and relationship with their children. As this lies outside the parameters of this study, I suggest future studies might incorporate a later time to examine whether or not the experiences breastfeeding MMT women revealed in this study have become entrenched over a longer period of time.

Concerns about managing *a priori* knowledge

As this study is based on previous clinical experience, I exposed *a priori* knowledge by constantly re-evaluating my role and position as a researcher. Although this is not 'bracketing' of preformed views in the strict Husserlian tradition, I nevertheless endeavoured to maintain a researcher's sensitivity to the world as described by the women. Even though I was mindful that my intuitions as a clinician should not cloud my role as a researcher, my experience is similar to that outlined by Munhall (1994). She describes unconscious processes at work and how having an added awareness of the world helps to understand things that are hidden. Awareness of my researcher role, of how I asked questions and responded to the women's conversation, was promoted by keeping and using reflective journals, and listening carefully to the tapes. Throughout the period of the research project, and especially during the data collection process, I kept reflective diaries. Clarke (2009) describes this as a method of helping to establish

transparency by setting up an audit trail of personal reflections which may have affected the interviews.

I identify the following two examples to demonstrate the unconscious and hidden nature of *a priori* knowledge revealed in this study. In the first I outline my vicarious trauma over the women's stories of their treatment. In the second I question the effect I might have had on Chloe. I conjecture that as she was influenced by previously held perceptions of powerful professionals, I responded to her accordingly.

It is interesting to note that all the mothers described how they 'felt judged' by some of their caregivers (sections 9.5.2 and 10.4). Listening to their experiences raised personal issues of vicarious trauma stemming from my clinical practice. For instance, when going to hospital, clients will sometimes relate stories of a noticeable change in attitude when a professional learns that their patient has a history of drug-use. Furthermore, mothers told me similar stories about receiving a perceived lower standard of care, with poor understanding and empathy towards their needs, compared to other mothers. Thus, in terms of my role as a researcher, self-awareness through reflexivity and self-monitoring ultimately helped guard my interpretations from becoming personal and going beyond what the mothers said.

I discovered that writing diaries, followed up by discussion in supervision, ultimately helped to manage my vicarious trauma, because early chapters were often very angry rants. In addition, another strategy I employed to minimise my own bias and ensure that my interpretations remained grounded in the participants' accounts was the use of verbatim extracts as examples (section 9.3). In the early stages of data analysis, I used the women's own words as headings. Thus, as an example, the heading 'Being Judged' was used to collate all relevant statements.

Nonetheless, whilst this study is designed to focus specifically on the mothers, their uncorroborated stories highlight a need to interview both mothers and professionals to gain a deeper understanding of their interactions. I am aware that, whilst recording the

mothers' perceptions of their truth in terms of their treatment, professional views were omitted. Perceived imbalances in perspectives within this study are demonstrated in my diary extracts, discussed in section 9.3.2. During data analysis I highlight questions of concern about the lack of involvement from social and health care professionals as respondents in the study. I suggest that this omission can be rectified in a future project. Interviewing professionals about their views and experiences, concurrently and in parallel with mothers, would help to address any perceived imbalances in perspectives.

I suggest that this be achieved by the continued use of phenomenology. The research might be designed to reveal hidden essential characteristics or 'essences' of phenomena, and in a way which will encourage professionals to describe their experiences in an 'uncontaminated' fashion. Although interviews within a phenomenological framework usually take the form of one interviewer and one respondent, the problem for the proposed parallel project would be the identification of which individual staff member to interview, as there will be more than one. As a solution to this problem, I suggest employing a focus group consisting of professionals who work with a breastfeeding MMT mother, and taken around the time of her interview.

Because phenomenology normally explores an individual's experience, Bradbury-Jones *et al.* (2009) investigate the perception that this methodology is incompatible with focus groups. In their study of the empowerment of student nurses, the authors concluded that both are compatible. The small groups of five students not only helped to stimulate discussion, but also opened new perspectives that previously lay hidden. In terms of respondent validation, the group was also able to cross-check and clarify understanding. In a similar way, I suggest small focus groups of social and health care professionals with the aim of exploring the meaning of caring for a breastfeeding MMT mother.

In the second of the examples, I became concerned about the influence that I, or the study, had on Chloe. My concerns for her were raised after the interviews and when listening to the tapes during the period of data analysis. In the final interview, she

acknowledged her participation had encouraged her to keep trying to breastfeed. From an ethical perspective, I am retrospectively anxious for her wellbeing as a participant and suggest two possibilities for her continuation. In the first I appear to look after Chloe. In the second she seems to be looking after me.

Firstly, Chloe was one of the mothers who initially asked me for advice about breastfeeding. Her continued participation indicates a gap in her care which should have been provided by other professionals (Oakley 1992). In the assumed absence of any other support, I helped by giving her the information she needed and demonstrated an interest in her as a breastfeeding mother by our meeting on regular and pre-arranged occasions. Thus, I propose that she continued with the study because she felt I looked after her.

However, leading on from this, I am concerned that Chloe continued for a second but more disconcerting reason; and one that is based on reports in the literature that drug-using women have poor self-worth and are more likely to expect failure (Jansson *et al.* 2004, Murphy and Rosenbaum 1999, Ettorre 1992). I wonder whether Chloe thought of withdrawing from the study when she struggled with her failure at not being able to breastfeed. Because I had helped her previously with her queries on breastfeeding, I conjecture she perceived me as a powerful and knowledgeable university student and so did not want to risk upsetting or displeasing me. The power imbalance between us may have resulted in Chloe's persistent, although fruitless, efforts to express breast-milk over an extended period of time.

These observations of Chloe disturb me because, as part of my ethical duty, I always ensured that I asked for the women's consent to continue at every stage of the process. However, where Chloe was unable to articulate what she felt about her participation, Anna was more explicit. She expressed genuine surprise at my attentiveness to her and was intrigued that I, as a university researcher, had made a special journey down from London just to interview her. Whilst Anna's reflection appears to comment on the power imbalance in the interview, she is able to value the contribution she makes to the

project. Her candidness demonstrates, although she felt a power gap between us, my being there and showing a continued interest in her story made her feel valued, and she continued to participate in the study.

periences of an unequal power imbalance within the interview prove to be unpredictably subjective. Regardless of my efforts to minimise the differential within the interview, I suggest that women's responses to the interview will continue to be influenced by their own *a priori* knowledge of, and familiarity with, a hierarchical service model. I appeared to respond accordingly as a professional and assumed the women would withdraw if they wanted.

My experience demonstrates that undertaking research about drug-using mothers is ethically complex, which supports observations made by Banwell and Bammer (2006). Murphy and Rosenbaum (1999) add that, regardless of the efforts at minimising status differences, the women in their study continued to perceive the interviewers as powerful 'professionals'. The notion of a non-hierarchical relationship in woman-to-woman interviews, as espoused by Finch (1984) therefore seems unrealistic when interviewing this group of women. Both Chloe and Anna demonstrate there will always be discrepancies, the extent to which seems impossible to foretell.

Implications for further research

As the mothers interviewed in this study were critical of their treatment, I conclude that the two sites in and outside London did not work proactively with MMT breastfeeding mothers and thus advocate replicating this study. With the aim of extending understanding of the mothers' life-experiences and perceptions of empathetic care, later projects could recruit from various centres of excellence where breastfeeding is actively encouraged for methadone-treated women. The literature contains examples of such places; for instance the Aberdeen Clinic facility (Hall and Teijlingen 2006), described in Chapter 6. Other inspirational developments include those hospitals listed in section 3.4. I predict the number of women recruited from each site will be similar

to that in this study because the population of opiate-using mothers remains small (section 2.2.2).

In addition, I am aware I rejected adopting a critical realism framework in favour of a phenomenological approach because of the lack of studies using authentic voices of MMT breastfeeding mothers (section 7.1). McEvoy and Richards (2006) describe critical theory as helping to explain how personal meaning and actions are influenced by a person's social environment. As the literature search influenced my research interest, the trajectory of this study changed from one concerned with understanding institutional structures in which MMT mothers are situated to one exploring the experiences of mothers themselves.

However, Porter (2002) argues that the tendency to focus on subjective individualised interpretations of experiences comes at the cost of examining how social structures and processes have influenced these interpretations. As all of the women interviewed were critical of their treatment in hospital and relied on support from their families, a broader and more systemic approach to research in this area is indicated to link subjective individual understanding with structural positions in which drug-using mothers are placed. A stakeholder analysis of resources and choices available to professionals, mothers and families would help provide a context for women's lived experiences, both within maternity services and their own families.

The final section 11.4 explores different ideas for disseminating the study's findings. These are derived from the women during the course of being interviewed for this research project.

11.4 Knowledge exchange

Ultimately, with increased knowledge about the early motherhood experience for MMT breastfeeding mothers, I would like to see practitioners becoming more informed in their practice. All the women in this study expressed an interest in the research and stressed that they did not want others to have the same struggles. The women's

reflections suggest that knowledge generated by previous research about breastfeeding has not been translated into practice by providers and policymakers even though it is shown to be beneficial (Chapter 5). In addition, Davies (2000) argues that, whilst randomised controlled trials are often the ‘gold standard’ contributors to evidence-based practice, qualitative approaches can inform policy and practice by going ‘beyond, behind and below the surface level of experimental and statistical evidence’ (p. 308). In terms of dissemination of evidence, the primary method according to Nutley *et al.* (2007) is presentation of the findings in a format that is tailored to the target audience.

The target audience for this study can be both professionals and MMT breastfeeding mothers. For instance, the women suggested I write this dissertation as a book, written for health and social care professionals. I note that Ettorre (1992) reverses this target audience. She describes her book, *Revisioning Women and Drug Use*, as valuable reading for female drug-users, because she feels:

...passionately about women who use drugs [*and she wants*] this book to speak to them and their needs (Ettorre 2007: p.1).

As her book is at times written in dense academic language, many women might find it difficult to read and understand. This statement is based on an observation made by Murphy and Rosenbaum (1999) that female drug-users often experience interruptions in their education. Roberts (1984), a feminist writer, argues that research should be accessed by a wider audience than academia, with sensitivity about how this is done. Finch (1984) expounds this proposition further by adding that the end product of the research, the way it is packaged, marketed and disseminated, reflects the respect the interviewer has for the women who participated in it. Oakley (1992) suggests that the researcher is morally bound, emotionally and intellectually, to promote women’s interests to a wider social world.

As these approaches underscore my own advocated position outlined in Chapter 1, I plan to disseminate the findings to reflect my respect for the women who participated in this study. With hope of inspiring changes in practice, the following suggestions stress the forging of sound working partnerships between mothers, professionals and advocacy drug-user groups. In addition to publishing from this thesis in various easily-accessed formats (*e.g.*, books, journals, pamphlets and magazines) when presenting the findings and other thesis-related subjects at conferences and on educational programmes, I propose that mothers should be involved both as members of a shared audience and as co-presenters.

Co-presenting within educational programmes

Nutley *et al.*(2007) advocate reliance on experts and peers to help to disseminate evidence, with face-to-face contact as the most trustworthy means for the exchange of knowledge. I therefore propose professionals meet to listen and learn from women who have had prior experience of services. Because mothers understand their lives better than professionals, they would assume the influential role of ‘expert patients’, as described in the government leaflet *Expert Patients Programme* (2011). Although this might be easier said than done, I am confident that co-presentations will help to reduce polarisation as mothers share their expertise and inside knowledge as drug-users, the ultimate aim of which is to promote understanding and empathy for each other’s perspectives, realities and worlds.

As an idea discussed and agreed with the mothers interviewed, it appeared simple. However, in practice, it has proved more difficult. For instance, when I was invited to present my findings to a conference of neonatal nurses, I e-mailed Doris to ask if she would like to present with me. She had stated she would welcome the opportunity to talk about her experiences. As she accessed her e-mails on an infrequent basis, I received a reply a few weeks after the presentation.

Since then, I have been able to take an initial and exploratory tiny step into the field of service-user collaboration. This year I co-presented two afternoon sessions with two

breastfeeding mothers (not involved in the study) to a group of MSc students about maternal substance misuse. As evidenced through discussion, the women's presence prompted an increase in awareness and empathy for drug-using mothers. Due to the enthusiastic student feedback, we have been invited to repeat the session with a group of undergraduate midwives in 2014. In addition, the midwife course director is applying for funding from a local university to make a video about these women's experiences for a wider student audience. Admittedly two one-off sessions and the proposition of making a video with two willing mothers are clearly only partial solutions to a wider exchange of knowledge problem. But it does indicate the impact that immediate contact has when both parties can share their experiences and insights, especially concerning issues around methadone and breastfeeding.

I also propose that education programmes for midwives, nurses, doctors and social workers should include various discourses around addiction, similar to those contained in Chapters 2 and 3. In response to suggestions from the women interviewed, the study's findings should also be made available to future mothers. Whilst pregnant, they received conflicting advice from professionals and assumed they would not be able to feed because they were being prescribed methadone. They thought an attractive pamphlet about the safety of breastfeeding would help other mothers in treatment and suggested their distribution at GP surgeries, drug treatment and antenatal clinics.

There are a few organisations dedicated to supporting breastfeeding in this country, for instance the NCT, mentioned earlier, and the Breastfeeding Network (BfN), both of which run telephone help lines and local groups. However, dedicated information for MMT women is lacking and both organisations appear to offer support primarily for non-drug using mothers. The BfN describes training to support breastfeeding mothers in their communities via a peer support course. I would like to think it would be possible to approach the BfN with the suggestion of setting up training for communities of MMT mothers. In addition, where projects such as Oasis in Brighton are dedicated to working with drug-using mothers with social service involvement, there does not appear to be a supportive service specifically for breastfeeding women. This indicates

potential for developing services for breastfeeding MMT mothers. Suggestions may involve working alongside already established organisations, with user-friendly websites and blogs for mothers with internet access.

Finally, one further aspect of education would aim to keep students up-to-date with political developments. For instance, in the most recent Drug Strategy (2010), it is reported that recovery from drug dependency is aided by putting power and accountability in the hands of local communities. The coalition government-inspired initiative has said it is making money available for projects. These could include the following ideas for the development of specialist women's and advocacy services.

Developing specialist women's services

The participant mothers describe being treated primarily as drug-users during pregnancy. They were critical of their contact with antenatal services, which emphasise the predominance of urine testing for illicit drug use. They intimated that they missed out on information given to other 'normal' mothers, such as antenatal classes, instruction on breastfeeding and parent-craft classes. Thus services, as advocated by Klee (1998), should jealously promote the care and protection of the vulnerable individual woman against the feckless cultural stereotype of the drug-using parent.

By using baby friendly hospital initiatives similar to those discussed in section 5.2, care pathways would ensure that mothers and babies are kept together from the time of delivery. I propose extending the development of previously successful, inspiring and empathetic integrated services in a community-based multidisciplinary facility, similar to that described by Hall and Teijlingen (2006) in section 6.1.4. I suggest replacing the community midwife with a specialist midwife so that the services could incorporate an extended motherhood care one-stop-shop pathway, combining services for pregnancy, delivery, breastfeeding and early motherhood. Thus pregnant women and new mothers who are not in favour of traditional drug services (Radcliffe and Stevens 2008) can receive treatment within this arrangement. I also advocate the addition of a neonatologist onto the team. Pregnant women would be able to ask questions about and

then seek ways of minimising the effects, symptoms and potential treatment of babies exposed to illicit drugs in *utero*. Social services would be incorporated into this structure to decrease further the stigmatisation of the surveillance and monitoring of mothers by promoting familiarity with the individual woman (Banwell and Bammer 2006). Finally, women should be able to find out about local specialist maternity services via a comprehensive, concise and easily accessed online national directory.

Developing advocacy services

In the face of direct questioning from health and social care professionals, women said they lacked the confidence to defend themselves and remember what is being, and has been, said. Women also state they were afraid to be assertive because professionals might think they were being aggressive. Such concerns are further complicated by mothers feeling overwhelmed and vulnerable when meeting articulate and powerful professionals from middle-class backgrounds. As mentioned earlier, I do not claim to make generalisable predictions about all mothers from the findings of this phenomenological study. However when triangulating findings from this study with my own practice observations (Chapter 1) and discussions in the literature (Chapter 6), it seems plausible to expect that drug-using mothers will continue to report feeling vulnerable.

Therefore, to reduce the vulnerability of mothers, and to act as an advocate, I suggest specially trained peer support from experienced mothers as ‘buddies’. This might be similar to the BfN model above or another specially assigned individual from the wider community of self-help groups and agencies for drug-using families. Advocates would help boost a mother’s lack of self-confidence and offer counsel on the best means of representation in meetings, both formal and informal. By listening carefully and writing things down, they would ensure women understand the questions within the context of the conversations. A more confident response from women would impact positively on how their capability to mother is perceived. With an increased sensitivity to this communication and social gap, professionals could also offer to meet in less formal and anxiety-provoking situations.

Finally, as described earlier, all mothers report being judged for being drug-users. During their stay and after discharge, they continued to describe feeling angry and distressed. Although advised by other more empathetic professionals to report these incidents to the Patient Advocacy Liaison Service (PALS), they stated that ‘they would do something about it’ when they got home, as they felt too tired and anxious whilst in hospital. However, after discharge they said they had become too busy to complain. As a result, the complaints were dropped.

Whilst the presence of PALS within hospitals confirms that institutions are aware of their accountability to protect vulnerable patients, these findings suggest that mothers did not access this service because it was not readily available at a time when they needed it. I propose that PALS should develop a wider outreach scheme for access by all patients to representatives visiting wards, including NNUUs. This would normalise their contact and greatly reduce the stigmatisation and fear of drug-using mothers when reporting their experiences. Promoting contact with such agencies would also help ensure mothers have a right of reply at the time when they feel they have been abused.

11.5 Concluding remarks

Aside from the demands of writing this PhD as an academic document, I note that writing itself has been a method of phenomenology. The empirical phenomenologist Van Manen (1990) describes:

Language is a central concern in phenomenological research because responsive-reflective writing is the very activity of doing phenomenology. Writing and rewriting is the thing. Phenomenologists have commented on the reflexive character of writing. Writing is a reflexive activity that involves the totality of our physical and mental being. (p132)

Integral to understanding this process is the consideration of phenomenology as a philosophy. To this end Munhall (1994) advises researchers to become immersed in

their work and open to another's experience in a 'Zen' way. The essence of Zen is described as favouring a direct understanding of life without being misled by logical thought or language (BBC 2013, Wikipedia 2013).

Thus by intuitively opening out and entering into the iterative process of writing and rewriting, I gained a deeper understanding of the data. This took me beyond my initial data analysis, described in Chapter 9, to the revelation of the five findings in Chapter 10. However due to the limits set by the time span of this doctorate, this process had to come to an end. I am confident this document reflects the stage at which I was able to gain maximum insight needed to answer the research question. However, I acknowledge that as this process is ongoing, the data may continue to hold other meanings that lie outside of my own discoveries.

Glossary

Addiction

Addiction can be defined as an ever-growing preoccupation which interferes with other priorities in life to do with the family, work and leisure pursuits. There is a compulsion, feeling driven to do something one would not normally prefer to do. Daily routines become focussed on a ready supply. Consumption of the substance pays less heed to what is appropriate in time or place, with less concern for consequences. As tolerance develops consumption may increase. See definitions of dependence from DSM-IV and ICD-10.

Dependence

Notes on the DSM-IV and ICD-10:

These are the two most commonly used medical model standards for categorizing forms of psychological distress in the psychiatric profession. They are used to provide some measure of consistency when mental health professionals are making formal diagnoses of psychological disorders. The diagnostic criteria are then more easily understood by another person. Substance dependence is listed as one.

The most widely used, especially in the US, is the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (1994) (DSM-IV) and updated version of the previous III. The second, International Statistical Classification of Diseases and Related Health Problems (ICD-10: 10th revision) is more widely used in Europe.

Criteria for Opioid Dependence as defined by DSM-IV

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by 3 (or more) of the following occurring at any time in the same 12-month period:

1. **Tolerance** as defined by either of the following:

- Need for markedly increased amounts of the substance to achieve intoxication or the desired effect
 - Markedly diminished effect with continued use of the same amount of substance.
2. **Withdrawal**, following cessation of use or administration of an opioid antagonist, which includes 3 of the following, developing within minutes or days:
- Dysphoric mood (generalised feeling of distress)
 - Nausea or vomiting
 - Muscle aches
 - Lacrimation or rhinorrhoea (tears or runny nose)
 - Pupillary dilation, piloerection (goose bumps) or sweating
 - Diarrhoea
 - Yawning
 - Fever
 - Insomnia
- Where these symptoms cause clinically significant distress or impairment in social, occupation or other important areas of functioning.
 - These symptoms are not due to another medical condition or mental disorder.
 - Or administration of the same (or a closely related) substances is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period that was intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects.

6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Criteria for Dependence Syndrome as defined by the ICD-10

‘A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug-use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state’ (National Institute for Health and Clinical Excellence 2007).

Methadone

Methadone is a synthetic opioid receptor agonist with pharmacological activity similar to that of opiates (National Institute for Health and Clinical Excellence 2007). It is used in the treatment of heroin (and other opioids) addiction as it prevents withdrawal symptoms. It does not reward the user with a ‘high’ associated with heroin and opioid analgesics (Robson 1999).

Methadone is used for people who are opioid dependent, in either long-term maintenance, detoxification or abstinence programmes. Programmes are designed to meet the government’s ‘Drug Strategy’ aims to reduce harm caused by illicit drugs by engaging people in drug treatment. In 2004 there were 1,954,700 people, aged 15 – 64, were receiving methadone treatment, at a cost of £17 million (National Institute for Health and Clinical Excellence 2007). As numbers of women in treatment, measured in a ratio to men is usually 1:2, I calculate 651,566 of these were women. Methadone is largely prescribed by drug treatment services but also by GP’s and other primary care services.

Results from meta-analyses on methadone maintenance therapy indicates that a fixed dose has superior levels of retention in treatment, lower rates of illicit opioid use, fewer self-reported adverse events, including fatalities, and lower criminal activity (National Institute for Health and Clinical Excellence 2007).

Maintenance treatment aims to provide stability and enhance overall function in people's lives by reducing craving, preventing withdrawal, eliminating the hazards of intravenous injecting and freeing them from the preoccupation with obtaining illicit opioids (National Institute for Health and Clinical Excellence 2007). To do this methadone is usually prescribed at a higher dose to prevent withdrawal symptoms. Usual dose range is between 60-120mgs a day. However during pregnancy methadone doses should be increased and decreased back to original levels 6 weeks after delivery.

Opioids and opiates

Opioid is a term used for all morphine-like compounds which are not directly obtained from opium. Some authors use this term to represent all natural or synthetic drugs with a morphine-like action (Robson 1999).

Heroin (diamorphine) is a semi-synthetic drug produced from the opium poppy. It is easy to smuggle because it is odourless and less bulky. Pure heroin is increasingly cut with other agents which may or may not be harmful to the intravenous user. For instance where cut with sucrose this is harmless, however with flour, bleaching agents and barbiturates it becomes potentially lethal.

'Supply' side

Opiate is a generic term for all drugs directly obtained from opium. Raw opium is obtained from the seed capsule of the *Papaver somniferum*, a poppy. Opium is made by boiling the juice from the slit seed capsule in water for several hours until converted into a dark, malleable paste. Main active ingredients are morphine, codeine, papaverine, and thebaine. Of illicitly prepared opium stocks, 30% is used as opium 70% of which is converted to heroin.

In 2007 there was a surge of illicit drugs (UNODC 2008). Opium production doubled between 2005 and 2007 because of a record opium harvest in Afghanistan. The total area under cultivation rose to 235,700ha, an increase of 17% from 2006, but about the same amount in 1998 (238,000 ha). Opium production almost doubled between 2005 and 2007, reaching 8,870 megatonnes in 2007, an unprecedented amount over recent years.

Afghanistan accounts for 82% of world opium cultivation. The *World Drug Report* states that up to now the world drug problem has been contained, inasmuch as it has been stabilised. This is now under threat, and progress made in drug control over the past few decades could now be undermined. The current upsurge in supply, new trafficking routes, especially through Africa, could strengthen already existing demand and even create new markets.

‘Demand’ side

Illicit drug-use has been contained to 5% of the adult population (yearly incidence rate for people aged 15-64). Problem drug-users, those who are severely drug dependent, are limited to about 0.6% (26 million) of the planets population (6.5 billion). In Europe, including the UK, opiate is the main problem drug (as reflected in 60.1% of treatment demand) for 2006. Cocaine by contrast constituted just 9.1% treatment demand. In comparison with other so called developed global sectors; North America 31.2% of treatment demand was for cocaine, with 9.8% treatment demand for opiates. In Oceania, including Australia and New Zealand, 32.8% treatment demanded for opiates, with 18.2% for cocaine. By contrast and probably reflecting the areas of illicit drug production in the Andean region; in South America highest demand for treatment was for cocaine (54%) with opiate treatment just 2.6%. In Asia these figures are reversed (again reflecting Asian production areas of Afghanistan and Myanmar), 63.3% opiate and 19.1% cocaine treatment demand. In Africa 63.6% treatment demand was for cannabis, with 15.7% opiate and 9.6% cocaine.

The annual prevalence of opiate abuse, 0.9% of population aged 15-64, continues to rank the UK equal second in Europe with Luxembourg and Latvia (UNODC 2008). Estonia has the highest prevalence with 1.5% of population. As the primary drug of abuse amongst people treated for drug problems, in the UK this was 59.6% (cocaine 9.3%). By contrast this is a fall from 69.3% in 2002 (a rise for cocaine 6.2%).

The same *World Drug Report* states that from 2000 figures 0.6% of the population in the US were abusing opiates. In 2001 in the US there were 1.4 million potential mothers who were currently using opioid derived drugs: heroin, analgesics and methadone (Wilbourne *et al.* 2001). These opioids were not only illicit substances. They were being prescribed for chronic pain conditions but were also open to being abused by diversion onto the open black market. Any chronic use of an opioid can cause dependency. According to US post-partum reports of prenatal substance use at the time of gestation (National Pregnancy and Health Survey 1992); 3,600 women were using heroin, 48,700 were using illicit use of analgesics and 305,200 were reported using prescribed analgesics.

Problematic Drug-use: Definitions

United Nations Office on Drugs and Crime: Problem drug-users are people who are severely drug dependent (UNODC 2008)

Drugscope UK's leading independent centre of information and expertise on drugs. Aim is to inform policy development and reduce drug-related harms – to individuals, families and communities. Problem or problematic drug-use tends to refer to drug-use which could either be dependent or recreational. In other words, it is not necessarily the frequency of drug-use which is the primary 'problem' but the effects that drug taking have on the user's life (*i.e.* they may experience social, financial, psychological, physical or legal problems as a result of their drug-use).

Home Office: Higher funding is linked to engaging and treating heroin and crack users. The Home Office states it is safe to assume that those convicted or cautioned for

possessing opiates and crack cocaine drugs are likely to be problematic users whereas the same could not be assumed for drugs such as cannabis and powder cocaine which are commonly used intermittently. A pattern of drug-use that constitutes a problem for one individual may not constitute a problem for another although opiates and crack cocaine are commonly considered to be the drugs that cause most harm to an individual and communities. Non-problematic use of opiates and crack cocaine is comparatively rare (Home Office 2006).

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APPENDIX 1 A Centre of Excellence: The Nottingham Case study

On Friday 29th January 2010 I visited Sheena Prentice, specialist midwife in substance misuse Nottingham. The two Nottingham hospitals, City and Queens, attract pregnant women from across wide geographical area. The delivery rate per annum is approximately 10,000. According to audits kept annually from April 2002 to March 2009, a total of 257 opiate using mothers were delivered over this 7 year period, an average of 37 births/year. This underlines the fact that populations of opiate using mothers constitute very tiny client groups; in Nottingham's case, just 0.37% of the total deliveries.

The post of specialist midwife in substance misuse was established in May 2000 with the aim of engaging and retaining pregnant drug using women during the antenatal period by linking them to appropriate agencies to improve the health outcomes for mother and baby. Safeguarding elements of the specialist midwife role is of major concern. Joint working with both family and agencies continues throughout the antenatal period to ensure the best outcomes for mother and baby.

Sheena is employed by Nottingham City PCT with funding for the post coming from Nottingham City Crime and Disorder Partnership, and Nottinghamshire County Drug and Alcohol Action Team (DAAT) treatment budgets. She works closely with the Pregnant Women and Families Drug Worker at the John Storer clinic, the community based substance misuse service in Nottingham. Due to the success of Sheena's work in Nottingham a new clinical midwife for substance misuse was created in September 2009. This is a developmental post designed as an interface between generic midwife and specialist services. They term mothers they work with as 'extreme users' inasmuch as they are Class A drug users, including heroin and other opiates/opioids.

There are 3 auditable goals for their specialist midwife posts:

1. To facilitate the access of pregnant drug using women to antenatal services
2. To reduce the incidence of neonatal abstinence syndrome.

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3. To reduce the incidence of crisis social service intervention

For the purposes of this study I am concentrating on the first two goals; using information on opiate using mothers as recorded within three Nottingham specialist midwife in substance misuse audit reports dated 2006-7, 2007-8 and 2008-9.

1st goal: To facilitate the access of pregnant drug using women to antenatal services. In the following table, N is the total number of pregnant substance abusing mothers referred to the service.

Appendix Table 1: Number of referrals of pregnant opiate using women

Audit Report	N	Referrals of opiate using mothers	Heroin and/or methadone	Heroin and/or buprenorphine	Pethidine/diamorphine	Drug free at delivery
2006-7	133	80 (60%)	57 (71%)	17	2	4 (5%)
2007-8	160	83 (52%)	67 (81%)	14	2	0
2008-9	150	85 (57%)	80 (94%)	5	0	0

Appendix Table 2: Number of opiate using mothers delivered in Nottingham

Audit Report	Deliveries	Normal deliveries	Miscarriages	Termination Of Pregnancy	Never pregnant
2006-7	40 (50%)	32 (80%)	6	7	0
2007-8	46 (55%)	37 (80%)	9	4	4
2008-9	37 (44%)	28 (75%)	6	8	9

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2nd goal: To reduce the incidence of neonatal abstinence syndrome.

Appendix Table 3: Details of deliveries in Nottingham of opiate using mothers

Audit Report	Admissions to NNU for NAS	≥ 37 weeks gestation	< 37 weeks gestation	Birthweight ≥ 3 kgs	Birthweight 2.6 – 2.9 kgs	Birthweight ≤ 2.5 kgs
2006-7	0	37 (93%)	3	19 (47%)	11 (2.7%)	10 (25%)
2007-8	1	43 (93%)	2	20 (44%)	19 (42%)	6 (13%)
2008-9	0	29 (78%)	6	10 (27%)	15 (41%)	11 (32%)

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Other social factors

	Breastfed	Male partners: non users	Male partners: heroin/ methadone Users	Male partners: NOT in opiate treatment
2006-7	12 (30%)	30 (75%)	27 (68%)	6 (22%)
2007-8	16 (35%)	23 (59%)	33 (72%)	9 (27%)
2008-9	7 (19%)	25 (67%)	30 (81%)	13 (43%)
		2006-7	2007-8	2008-9
Ages: 16-19		1	4	6
Ages: 20-29		44	44	37
Ages: 30-39		34	23	37
Ages: 40-44		0	2	3
Ages: unknown		0	0	2
Children in local authority care		54	34	63
Social worker involvement		23/80 (29%)	26/83 (31%)	38/84 (45%)
Hepatitis C positive		10	8	9
Selling sex		9	13	10
Homeless		9	8	20
Victims of domestic violence		7	8	9
On probation		7	7	7
Syphilis positive		4	3	2
Medical conditions: epilepsy		2	2	2
Mental health problems		1	1	2
Pregnant whilst in prison		1	2	1
Medical conditions: diabetic		1	3	1
Medical conditions: thrombosis		0	6	10
Hypertension		0	0	1
Learning difficulties		0	0	2
Previous sudden infant death syndrome		0	0	1

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Reflections

Based on the above information and conversations on Friday 29th January 2010; with Sheena, specialist midwife and Emma, a drug worker for pregnant women and families.

The numbers of substance abusing women range from 133-160 over the three year period, 160 being referred in 2007-8. Just over half (range 52-60%) were using opiates.

Of these opiate using women between 71- 94% were using heroin and/or methadone. Only 4 (5%) of mothers in 2006-7 were drug free at delivery. The goal of abstinence is not the priority in Nottingham, it is one of engagement and keeping the mother in treatment. However, keeping the mother in treatment, unlike writers who argue that higher doses of methadone helps protect the mother from using illicit substances, the average dose of methadone in Nottingham is kept to around 45mls. They support their approach to treatment by acknowledging some mothers will use illicit heroin on top of their prescribed dose of methadone. Where mothers continue to use illicit heroin they are advised of the increased concern from social services after delivery. Over the three years the numbers of mothers with social service involvement has increased from 29% in 2006/7 to 45% in 2008/9.

Emma told me of a woman who was prescribed 120mls methadone before her pregnancy and reduced to 80mls when pregnant. She did not use any illicit heroin. This was her 5th pregnancy and she breastfed for 3 months. The rationale for keeping the methadone dose to a minimal level is believed to minimise the incidence of NAS.

One further argument Nottingham specialist maternity services use to reduce the incidence of NAS is the use of benzodiazepines. NAS is particularly prevalent after use of opiates and/or benzodiazepines. A large proportion of opiate users also use benzodiazepines to help control anxiety and help sleep. These can either be prescribed or bought illicitly on the street. In Nottingham pregnant mothers are prescribed a reducing dose of benzodiazepines (it is very dangerous to stop suddenly) so at the time of delivery the risk of NAS is minimised. This together with the social model of care

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and positive parenting; swaddling and keeping mother and baby together, is reflected in the numbers of mothers breastfeeding, between 19 and 30% which is comparative to national breastfeeding rates. Babies were not admitted to the NNU for treatment of NAS. Under the positive parenting model, mothers and babies are kept together on the ward and are usually discharged together after 4-5 days, with longer stays if needed.

The baby who was admitted to the NNU in 2007/8 for pharmacological treatment of NAS was treated for one day. The mother had declined prescribed opiate replacement treatment 4 weeks before delivery. The infant was prescribed oral morphine for a day and removed into the care of social services at birth.

The incidence of NAS is an accepted phenomenon and not a medical crisis in Nottingham. Symptoms are monitored via an amended version of the Finnegan scale, the Rivers Chart, but is the subject of debate whether it is helpful or not. Mothers are aware that their children are being monitored as information about the chart is included in the information leaflet given during pregnancy. The use of charts is subjective and not always scored at the right time, *i.e.* when the baby is relaxed and happy. The emphasis on noting down symptoms which are accredited to NAS dangerously overlooks the possibility of other pathophysiology. The majority of babies born in Nottingham are full term babies; nearly 100% in years 2006-2008. In 2008/9 the numbers declined to just over three quarters, with one mother of a preterm baby having previous experience of a sudden infant death.

From the data it is interesting to note that over the years from 2002 to 2008 there has been an increasing trend for delivering more opiate using mother; age range 32 (2002) to 46 (2008). However in 2008/9 the trend was reversed with 37 deliveries, the same number as in 2004/5. Although none of the infants were admitted to the NNU for NAS there were lower numbers of breastfed babies; 7 compared to the rising trend from 4 to 16 over the previous 6 years. The social factors may help explain why this year bucked the trend.

APPENDIX 1 A Centre of Excellence: The Nottingham Case study

Looking at the data for the year 2008/9 the numbers of mothers using heroin and/or methadone was highest that year; 94% compared to 81% in 2007/8 year earlier and 71% in 2006/7. The numbers of deliveries to these mothers continued at around 50% with a similar number of normal deliveries; slightly lower at 75% compared to 80% in the preceding years. However less were full term; 78% compared to over 90%, with 73% of those infants weighing less than 3kgs, with preceding years rising from 28% to 55%.

Of interest are the numbers of male partners who were listed as heroin/methadone users who were not in treatment; 43% compared to 22% and 27%. A higher number of partners used heroin/methadone; 81% compared to 71% and 62%. Their continued use and reluctance to enter treatment might have affected the mothers' decision to breastfeed; 19% compared to 30% and 35% in the preceding years.

Further examination of the data demonstrates older mothers who were probably more entrenched in their drug use. More mothers in 2008/9 suffered thrombotic related illnesses associated with long term intravenous drug use; deep vein thromboses and pulmonary emboli. More were described as being homeless and social service involvement was higher; 45% compared to 31% in 2007/8 and 29% in 2006/7. The numbers of women selling sex were relatively consistent across the 3 years; range 9-13, the highest in 2007/8. Two had learning difficulties.

APPENDIX 2 Details of literature references, listed according to Areas 1, 2 and 3

AREA 1

Is breastfeeding by a MMT mother safe for her baby?

Area	Author	Year	Methodology	Participants	Conclusions	Comments
1	Kacew	1993	Discussion	0	Advantages of breastfeeding for infant development outweigh the potential adverse consequences.	Very old paper. Discussion about all prescribed drugs, not specifically methadone
1	Hepburn	1996	Discussion paper	0	Breastfeeding: benefits to baby, but can be culturally unpopular with women.	Old paper
1	Geraghty <i>et al.</i>	1997	2 case reports & literature review	2	Minimal transmission of methadone into breast milk regardless of methadone dose.	Minimal new biomedical evidence to support breastfeeding with methadone.
1	Wojnar-Horton <i>et al.</i>	1997	Examination of plasma and milk samples	12	Minimal exposure of breast fed infants to methadone, MMT mothers should not be discouraged from breast feeding.	Overall conclusion to these types of study is that methadone is minimal and women should breastfeed
1	McCarthy and Posey	2000	Breast-milk analysis	8	Methadone level is small and consistent with those in other published reports. There were no adverse events associated with breastfeeding or weaning.	Old but consistent with findings
1	Begg <i>et al.</i>	2001	Venous blood and breast-milk samples where methadone >40mgs/day	8 pairs Mother and baby.	Breastfeeding during Medium to high dose methadone appears to be 'safe'. Absolute dose dependent on maternal dose rate.	Biomedical. Doses of methadone received via milk are unlikely to be sufficient to prevent the neonatal abstinence syndrome.
1	Wilbourne <i>et al.</i>	2001	Literature review	0	Breastfeeding OK when dose <20mgs, also when in treatment & can be s/v	Old paper

APPENDIX 2 Details of literature references, listed according to Areas 1, 2 and 3

Area	Author	Year	Methodology	Participants	Conclusions	Comments
1	Yeung <i>et al.</i>	2001	Literature review	0	No definite case of mother-to-infant transmission of HCV via breast milk has been reported.	Old paper
1&2	Ballard	2002	clinical observation	10	Breastfeeding safe and sound Rx for managing NAS (need further research here). 2.2% maternal daily dosage in breast milk	Biomedical. Useful early research, small scale, baby focussed but refers to mum
1&2	Heinrichs <i>et al.</i>	2002	Literature review on physiological responses	0	Conclude that blunted anxiolytic response to stress in women could be counterbalanced if the acute stress occurs later than 1 h after suckling.	Biomedical physiological responses to breastfeeding.
1	Anderson <i>et al.</i>	2003	published studies and case reports	100	Breastfeeding rarely needs to be discouraged or discontinued when a mother needs drug therapy.	Biomedical. All drugs were licit, <i>i.e.</i> no drugs of abuse. Cautious approach to advising breastfeeding.
1&2	Berghella <i>et al.</i>	2003	Retrospective review of case notes	100	Value of breastfeeding for mothers noted. NAS scores higher in mums with <80mgs methadone. NAS not correlated with dose of methadone.	Biomedical. Useful dialogue with Dashe <i>et al.</i> 2002. and selves. NAS scores still found in 70% babies.
1&2	Phillip <i>et al.</i>	2003	Discussion paper on policies which encourage more to breastfeeding	0	Although benefit of breastfeeding is demonstrated, asks the question: will professionals allow?	Useful paper, base on which this project is based. If breastfeeding safe , what is stopping mothers?
1&2	Jansson <i>et al.</i>	2004	Literature review	0	Breastfeeding safe. Paper reviews arguments for and against breastfeeding	Aimed at clinical staff. Could be considered an old paper
1	Briggs <i>et al.</i>	2005	Textbook: reference guide to foetal and neonatal risk	0	Amounts of methadone in breast milk, considered negligible. NAS in 60-90% infants.	No study, just facts

APPENDIX 2 Details of literature references, listed according to Areas 1, 2 and 3

Area	Author	Year	Methodology	Participants	Conclusions	Comments
1	Hepburn	2005	Newsletter report on substance misuse management in primary care	0	Mothers health maintained through stable dose of methadone. Breastfeeding keeps baby and mother together	Paper dated but very useful as ideas about care of pregnant mothers appear radical in its thinking.
1	Abdel-Latif <i>et al.</i>	2006	6 yr retrospective chart r/v	190 (85 breast-milk group: 58 breastfed + 27expressed)	Reduced symptoms. No difference between breast fed or expressed for ameliorating symptoms.	Biomedical. 1st large scale to demonstrate amelioration of NAS. Response to Jansson <i>et al</i> 2008a.1 & Liu & Nanan 2008 re physical benefit of feeding
1	Jansson <i>et al.</i>	2007	Quantitative measurements	12, over 4 days	Recommends breastfeeding for MMT women regardless of methadone dose.	Biomedical, quantified levels of methadone, 4 days at peak and trough
1	Glatstein <i>et al.</i>	2008	Literature review	0	Describes insignificant amounts in breast milk, 1-5% maternal daily dosage.	Ambivalent conclusion re benefits of breastfeeding result of methadone in breast-milk or physical benefits of breastfeeding.
1	Jansson <i>et al.</i>	2008a	Quantitative measurements, comparison study	16, quantified levels of methadone in breast-milk and plasma	Breastfeeding neonates required less pharmacotherapy for NAS than formula fed but not statistically significant.	Biomedical
1	Jansson <i>et al.</i>	2008 b	Examination of plasma and milk samples	4	After immediate post natal period up to 6 months, methadone levels in breast milk remain low	Encourages long-term breastfeeding
1	Jones <i>et al.</i>	2008	Literature review	0	Breastfeeding safe. Low amount in breast milk, reference to Abdel Latif and Malpas. Avoid abrupt stopping	Did not generate new information, another review by a research unit.

APPENDIX 2 Details of literature references, listed according to Areas 1, 2 and 3

Area	Author	Year	Methodology	Participants	Conclusions	Comments
1	Liu and Nanan	2008	letter	0	Benefits of breastfeeding might be associated with physical benefits, rather than levels of methadone	letter (response to Jansson 2008a) not a study
1	Jansson <i>et al.</i>	2008a .1	Letter in response to Liu & Nanan's (2008) letter to Jansson's paper	0	NAS scores maybe dependent on physical contact	Talked about difficulty of doing comparative study due to low population rates. See Abdel-Latif.
1	Winklbaur <i>et al.</i>	2008	Literature review	0	Breastfeeding benefits baby in reducing NAS symptoms	Limited value. Concentrates on benefits of breastfeeding for infant
1	Dryden <i>et al.</i>	2009	2yr retrospective cohort case note review study	450 MMT pregnant mothers	High methadone dose is associated with higher incidence NAS	Biomedical. 45.5% developed NAS requiring pharmacological treatment, breastfeeding >72 hrs reduces need for NAS treatment.
1	Hamdan	2009	Textbook by Clinical Assistant Professor of Pediatrics	0	Advise breastfeeding for the mother who is receiving maintenance doses of methadone if she receives no more than 20 mg of methadone per 24 hours and is not abusing other drugs. Only small amounts of methadone are detected in breast milk.	Although continues to advocate advocating breastfeeding when doses are small and mother enrolled at a rehab programme
1&2	Backes <i>et al.</i>	2011	2 year retrospective review	121	Breastfeeding more common in combined inpatient and outpatient treatment of NAS with decreased hospital stay.	Biomedical. Breastfeeding mothers included in study although not the focus of research interest
1	Bogen <i>et al.</i>	2011	plasma and breastmilk samples 1-6 days after delivery	20	Even at high methadone doses (40-200mgs), breast milk methadone concentrations were relatively low.	Biomedical. Measurements of methadone in breast milk, no discussion of relative NAS scores in babies

APPENDIX 2 Details of literature references, listed according to Areas 1, 2 and 3

Area	Author	Year	Methodology	Participants	Conclusions	Comments
1	Isemann <i>et al.</i>	2011	retrospective review of pharmacotherapy for opiate withdrawal	128	Severity NAS maybe mitigated by titrating methadone to the lowest effective dose during pregnancy and by encouraging breast milk feeds. 5% infants admitted to hospital again for rebound withdrawal following reduction of breast milk intake	Biomedical. The more the infant exposed to breast-milk the shorter the hospital stay.
1	McQueen <i>et al.</i>	2011	Retrospective chart review	28	Compared to infants who were combination fed or predominately formula fed, breastfed infants had significantly decreased severity and duration of NAS symptoms.	Good comparative study to prove that breastfeeding is beneficial
1	Müller <i>et al.</i>	2011	Literature review	0	MMT women are allowed to breast feed their new-borns. The advantages of breast feeding prevail the risks of an infant opiate intoxication caused by methadone or buprenorphine.	Yet another literature review. Not producing any new information
1	Hendrickson and McKeown	2012	Review evidence of specific common opioids and infant toxicity.	0	Short-term maternal use of prescription opioids is usually safe and infrequently presents a hazard to the new-born.	No new data.
1	Pritham <i>et al.</i>	2012	2 year retrospective descriptive study	152	Length of stay was shorter in breastfed neonates than formula-fed neonates or neonates who received formula and breast milk. Breastfeeding advised to shorten hospital stay	Beneficial for hospital to breastfeeding

APPENDIX 2 Details of literature references, listed according to Areas 1, 2 and 3

AREA 2

What are the physiological and psycho-social benefits of breastfeeding for mothers?

Area	Author	Year	Methodology	Participants	Conclusions	Comments
2	Lvoff <i>et al.</i>	2000	All deliveries 6 years before and 6 years after implementation of UN Children's Fund Bay-Friendly Hospital Initiative.	26,616 (15,802 vs. 10,814)	Breastfeeding, mother to infant contact, rooming in low cost method of keeping mother and baby together	Interesting Russian paper, no mention of DU mothers, but raises question: is separating DU mothers similar to abandonment?
2	Abrahams <i>et al.</i>	2007	Retrospective cohort study	106	Ease baby's transition into life, promote more effective mothering, reduced demand for NAS	No mention of breastfeeding mothers

APPENDIX 2 Details of literature references, listed according to Areas 1, 2 and 3

AREA 3

What is known in the literature from the perspective of the mother about their experience of motherhood?

Area	Author	Year	Methodology	Participants	Conclusions	Comments
3	Klee	1998	Qualitative interviews (gathered from other studies)	250	The stereotype of the 'junkie' parent, like most stereotypes, may be the product of ignorance and prejudice, but although it is challenged at times, it has not been subject to objective analysis. This paper examines qualitative data on parenting from diverse research samples to evaluate the evidence	Good perspectives on coping mechanisms from parents, not breastfeeding. Suggest need more support and help in conclusion
3	Goode	1999	PhD study. Qualitative interviews, grounded theory	48	Mothers struggle to hold traditional views of motherhood, sense of powerless & responsibility for the wellbeing of their children	Very akin to this thesis, aiming to address gap in knowledge addressed
3	Murphy and Rosenbaum	1999	In-depth interviews	120	Need for women-centred treatment and healthcare, coupled with compassion and empathy, to help alleviate problems faced by this group of women	Although interviewed post-natal mothers, there was no mention of any of them wanting to, or actually breastfeeding
3	Goode	2000	Discussion paper on PhD study	0	Accessing this population proved very difficult because of such factors as the women's involvement in illegal activities, lack of stable housing, and the stigma of being a mother with a substance-use problem.	Methodological problems of accessing this population. Some insights about how it feels to be as DU mother, see PhD study 1999.

APPENDIX 2 Details of literature references, listed according to Areas 1, 2 and 3

Area	Author	Year	Methodology	Participants	Conclusions	Comments
3	Banwell and Bammer	2006	Comparative study. in-depth interviews & participant observation	60	All women, found living on a low income, social isolation or being at home with young children difficult. However, women who use illicit drugs are often blamed for these difficulties in ways that other groups of women are not. They also do not receive the same levels of social support that other women enjoy.	Compares DU mothers with other mothers with mirrored correlates. Useful as discusses my discussion with this group of mothers. Refers to Brook, Maher and McKegney
3	Hall and Teijlingen	2006	Qualitative interviews into most important aspects of ANC	12	Non-judgemental attitude of staff.	Prenatal only care
3	Ettorre	2007	Book	0	Embodiment of risk	Very useful. Seminal work, at times written in dense academic text.
3	Saurel-Cabizolles <i>et al.</i>	2007	Questionnaires	2799	High proportion of women showed symptoms of anxiety and depression. Efforts should focus on risk factors for psychological distress in women and on preventive measures beyond the post-partum period.	Not drug-using women, but useful for comparison with normal women

APPENDIX 2 Details of literature references, listed according to Areas 1, 2 and 3

Area	Author	Year	Methodology	Participants	Conclusions	Comments
3	Lizke	2008	PhD discourse analysis	7	Mothers in treatment for drug and alcohol abuse have the right to represent and constitute their own identities in a society which has historically demonized and criminalized them merely for being mothers. The analysis of the mothers' conversations revealed the following: a) the mothers' constructions of motherhood included an identity of a mother as one who is "there" for her children, b) the mothers experienced a connection or bond with their children in spite of separations from them, and c) the mothers' discourse revealed both resistance and acceptance of the public discourse about them.	Useful to use to identify what substance mothers feel about being drug-using mothers
3	Radcliffe & Stevens	2008	Qualitative interviews	53 Problem Drug Users	Addresses problems of stigmatisation and concludes that treatment agencies should address these issues, including through the provision of more drug services in mainstream settings, in order to ensure that drug services are not seen to be suitable only for one particularly stigmatised category of drug user	Not specific to drug-using mothers but very relevant regarding stigmatisation

APPENDIX 2 Details of literature references, listed according to Areas 1, 2 and 3

Area	Author	Year	Methodology	Participants	Conclusions	Comments
3	Fraser <i>et al.</i>	2009	semi-structured interviews and a 'Draw and Write	25	Access to methadone prescriptions had helped stabilize the lives of ex-heroin users. Wanting to look after their children properly - powerful motivator for change.	Paper from social worker perspective and child protection
3	Radcliffe	2009	Interviews with pregnant or delivered within 24hrs	17	Mothers are engaged in a process of managing spoiled identities in order to present themselves as committed and motivated mothers, to present themselves as regulated consumers by keeping to substitute prescribing regimes, keeping appointments with a multitude of agencies and aligning themselves with a normalised discourse of motherhood. Interview accounts emphasise the importance of caring networks in personal lives and in the service with which they are engaging.	No breastfeeding but gives a perspective of what it is like to be a drug-using mother
3	Radcliffe	2011	Literature review on gendered identity and motherhood	0	Opportunities needed for pregnant and postpartum drug users to engage with services and that their progress needs to be acknowledged by professionals in order that non-stigmatising identities can be endorsed. Women seeking help are motivated to act in the interests of their children	A sociological paper that bears out a lot of the evidence found in this research. Mothers work to present themselves as plausible and need to have that work acknowledged by professionals

APPENDIX 3 CJ's Vignettes and imagined responses

The following uses a free-style of writing to describe three vignettes. They are all based on fact. The *drug using woman* wants to give up drugs to have a baby and is written with thanks to a female client who shared her memories and hopes with me. *The opiate using mother* is a reflection on the woman's experience from my perspective as her counsellor. *The drug counsellor* frames the empathy I have for the woman from my own life experience. The final section concludes by drawing on Percy Shelley's thoughts on the use and abuse of the female 'tame slave', mirroring society's contempt for today's female drug user.

A drug using woman who considers motherhood a time for change

I am 41 years of age and for the past 30 years I have known nothing else but heroin and the life around it. I am skinny because I don't eat well, and my teeth are rotting, whether from the heroin or methadone I don't know, but some of them are black and others missing. I wear dentures. My contact with heroin started when I was just a teenager. My life has been shit up to now.

No father and a mother who didn't know how to mother. I was the eldest sibling at 8 when she abandoned me in charge of my brothers and sisters. At that time I was gang-raped by some boys for my doll. I was left 'hung out to dry'. From there I went into care and ran away to London at 13. I lived in squats where my natural homemaking and organisational ability positively influenced the squats furniture. The social services found me after two years and flew me back home in handcuffs. I left after a year and got a job in a café. A policeman wanted my brother and so leant on me. I leant on him through the window and smashed a glass in his eye. He was blinded, I was banged up, the youngest inmate in an adult prison.

So as you see my life didn't start particularly well, so why should it suddenly get better? The only companions I had were other users. My behaviour, language and looks immediately made me different. I stood out. Didn't give a fuck really. Had a baby, baby taken away due to my drug habits and chaotic behaviour. Still have the tattoo of his name on my arm. Don't allow myself to think about him at all. Another

APPENDIX 3 CJ's Vignettes and imagined responses

baby, born to an American gangster, was left behind with him when the violence became too much. She died at the age of 14 in a cross-gun fight where she just happened to be in the way. No fucking luck eh? Now I'm with a man I love and who loves me. He uses heroin occasionally, we have our arguments but he is my family. I love him and his mum who cooks wonderful food.

So in a nutshell, you have a dismal outline of my dismal life. I want to change it now. I want for the last time to become a mother and keep my child. First of all have to sort myself out. What am I taking? Heroin, cocaine, cannabis, valium (from the doctor) and occasionally alcohol. I also have a diagnosis of Paranoid Schizophrenia. Not sure about that one. One doctor in Germany told me that years ago. I take stelazine which helps to calm my mind. Not sure about hearing voices, whether they are mine from now or from the past. Are they out to get me? Everyone has been out to get me from when I was a child, what has changed? So I am in a hostel for people who suffer from a mental illness. Have a chance of getting my own flat if I behave and stop the drugs. I have a history of violence and selling myself for sex. Oh and another thing, I am Hep C positive.

So all in all not a pretty picture. When I mention I want to have a baby I can see the panic in my counsellors eyes. She calmly tells me one step at a time. Doesn't she realise I have never in my life taken 'one step at a time'? This is where our worlds clash. She sits there, listening but not realising the depths to which the drugs and life can drag you. I had no self-respect. Still don't but I'm trying. I need someone to believe in me and not give up when things go wrong. I need her to accept me as I am so that I can discover who I am. I don't need to talk about my life before; I just need a space to talk now. A safe space. It's scary for me because I have never done anything like this before. Wonder how it feels for her.....?

APPENDIX 3 CJ's Vignettes and imagined responses

As her counsellor I continue the woman's story.....

The opiate using mother

Without drugs she becomes aggressive and out of control. With them she is also out of control. Her drug using life has led her into contact with other users and dealers and she's had to consider the unthinkable. At one stage she was selling herself to help meet a £200-a-day habit. At the mercy of the dealers she despises with the deepest loathing any human can feel. Men have abused and used her. Other women she treats with suspicion. Her life has been hard. She has used drugs to cope.

She now realises as she is in her 40's her body clock is against her. She realises she can't continue her present life and that she wants a baby with her husband. Her other children have been taken away from her. This will be the last time she can contemplate having a child and radically altering her life. She is in a loving marriage.

She is also engaged in treatment. Not a mean feat where treatment is treated with suspicion. Doesn't like it when people become involved in her life and start asking questions. Usually end up being too involved and controlling. Don't like the systems, prefer to keep parts of her life private. Finds that professionals' insistence on asking questions about her past life, especially her childhood, too distressing for her. The memories are too painful and she prefers to keep them buried. Painful memories stimulate craving and illicit use.

She feels she has worked hard to remain motivated and keep engaged with the services. Doesn't like methadone because it worse coming off it than heroin but agrees that this is the best on offer at the moment. At least it keeps her craving under control and she's not on the street scoring. She attends her appointments at the GP surgery for her prescription of 80mls methadone and sees me every week. Our relationship has grown over the past 12 months into a therapeutic safe space for her. She feels she can trust me.

APPENDIX 3 CJ's Vignettes and imagined responses

Becoming pregnant isn't easy. Once again she will need to meet with other professionals. In formal assessments they will ask questions which will trigger memories of last time when her baby was taken away from her. However she has been reassured that if she remains engaged with the drug services, the ante natal services and the social services, she won't lose this one. Main overdriving instinct is one of suspicion. She wants her pregnancy and experience of motherhood. Something her own mother never had. She wants to breast feed. When she talks about having a baby and caring for it she describes experiencing softness within her. Softness of the realisation that as a woman she can experience being a mother. Says her 'tits' are not just there for men's delights but also for her baby. She wants to succeed in being a good mother. If not and the baby is taken away from her what is she left with? Nothing. Like she says, nothing to work for, might as well remain a junkie.

Drug counsellor

I am also a middle aged woman and a single mother. My ex-partner used to use heroin. I met him when he was coming to the end of this. He was skinny and suspicious of people. This remains with him, as too his need to talk. I lived for a time amongst drugs users, in India and Australia. Not a pretty picture really of seeing peoples personality coming apart under the influence and drive of the narcotic.

All were heroin users. I remember sitting in a squalid room in Delhi, occupied by 3 lost souls. It was a dirty cheap room, of moderate size. The door from the corridor outside opened directly into a room which was dark. The window to the left was small and dirty. Immediately on my left was a single bed with a dirty mattress. Behind the door on my right were 2 other beds, whose paltry frames were covered by the same dirty mattresses. In between the beds was an archway and a step up into the toilet and shower area, both open to each other and the sleeping room. There was a tap next to the toilet that dripped onto the concrete floor. The occupants of the room and others sat on the beds. There was a mixture of European languages, mainly Spanish and Italian, but French and English was also spoken.

APPENDIX 3 CJ's Vignettes and imagined responses

I stood next to the bed nearest the grimy windows, wondering how on earth I had managed to get to this wretched place. Didn't know where to sit or fearful of what I was sitting on. I noted the walls were smeared by what seemed chaotic patterns of red narrow fountains. Some were red; others that were faded were brown in colour. The reason for these patterns on the walls nearest the beds soon became apparent. On one of the mattresses was a small white plate, centre of which was a small candle. Next to this candle was a dessert spoon and some cotton wool. Contaminated water from the tap next to the toilet, was poured onto the spoon and white powder added. The water was heated to boiling. A small piece of cotton wool dropped into the solution. A needle and syringe sucked up the solute for injection into someone's arm. Initially blood was drawn back to verify its position, this blood squirted out of the syringe onto the walls. The syringe and needle was shared by all the individuals present.

This miserable picture has remained with me for over 20 years. I also met up with a French couple who had sold their passports for heroin and were now basically stateless. He lived off her earnings; they lived in a poor part of Delhi, a heartless city to their own poor. She sold herself to foreign, mostly Arab, business men. However not sure how much longer she could do that, the toll of living that life was stripping away the life in her body and face. She looked pale, gaunt with a spotty complexion.

Heroin seems to demand the soul of those that use it. Easy to start and comforting to use. I have spoken to female users who describe it as the best feeling ever, it makes them feel warm and safe, wrapping around them like blankets. However to stop takes tremendous courage and motivation. Nobody has ever died of heroin withdrawal, unlike a heroin overdose. And yet the withdrawal is feared. Drug users don't stop using for fear of dying from an overdose. Drug users can't seem to see beyond the physical. They replace one chemical with another. Stress is a major reason for relapse. Loneliness and boredom are also feared. Boredom has been alleviated by drugs. Everyone they know uses drugs. In this world it is very unusual to see people being truly successful in stopping and remaining abstinent, so when a user pronounces her desire to stop it is never taken seriously. Somebody always manages to come around in

APPENDIX 3 CJ's Vignettes and imagined responses

the early hours of the morning with a little offer that is difficult to refuse when you are 'clucking' and feeling fragile.

Everywhere they go they are being set up to fail. Everyone including themselves.

Some other thoughts

Does anyone believe a drug using woman can hope for a baby and want to breastfeed? Note this quotation from Shelley regarding society's attitudes to prostitutes. Percy Shelley, the 19th century poet and political and social radical, wrote extensively about the status of women and in particular on prostitutes who are forced by poverty to sell themselves to satisfy the lusts of men.

Society declares war against her, pitiless and eternal war: she must be the tame slave, she must make no reprisals: theirs is the right to persecution, hers the duty of endurance. She lives a life of infamy. She dies of long and lingering disease: yet she is in fault, she is the criminal, she the forward and untameable child, ... and society, forsooth, the pure and virtuous matron!' (Foot 1980: p.107)

Prostitutes are maligned for their actions, not the men who buy them or keep them penniless and dependent on drugs, the '*long and lingering disease*'. She doesn't have the chance to hold her head up to society which lacks compassion and understanding, remaining aloof as the '*pure and virtuous matron*'.

Drugs users, especially female ones, are infamous. Not only do a majority of prostitutes have a drug problem, prostitution is synonymous with an individual who resorts to anything, including the sale of her own body, to get what she wants and needs. A drug user prostitutes her body and health in the never ending search for drugs, especially heroin.

APPENDIX 3 CJ's Vignettes and imagined responses

And yet....there might be a window of opportunity to reverse all this given proper support, careful monitoring and encouragement. Breastfeeding, such a simple, free and intimate link between mother and baby, could be that powerful window opportunity with wide ranging social and health benefits for her, her baby, her family and society.

APPENDIX 4 Copy of ethics approval letter



National Research Ethics Service **London - Surrey Borders Research Ethics Committee**

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11th August 2008

Ms Rosemary Jambert-Gray
Primary Care Drug Liaison Nurse
South West London & St George's Mental Health NHS Trust
Addiction Treatment Centre
Queen Mary's Hospital
Roehampton
SW15 5PN

RECEIVED
13 AUG 2008

Dear Ms Jambert-Gray

Full title of study: The impact of breastfeeding on the identities of
methadone-treated mothers
REC reference number: 08/H0806/48

Thank you for your letter of the 17th July 2008, responding to the Committee's request for further information on the above research and submitting revised documentation, subject to the conditions specified below.

The further information was considered at the meeting of the Sub-Committee of the REC held on the 8th August 2008. A list of the members who were present at the meeting is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

This Research Ethics Committee is an advisory committee to London Strategic Health Authority
*The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England*

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Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application	5.6	20 May 2008
Investigator CV		20 May 2008
Protocol	2	17 July 2008
Covering Letter		17 July 2008
Covering Letter		20 May 2008
Letter from Sponsor		23 May 2008
Interview Schedules/Topic Guides		
Letter of invitation to participant	2	17 July 2008
GP/Consultant Information Sheets		20 May 2008
Participant Information Sheet	2	17 July 2008
Participant Consent Form		20 May 2008
Response to Request for Further Information		17 July 2008
Letter to General Practitioner	2	17 July 2008
Copies of advertisement Material		20 May 2008
Statement of indemnity		23 May 2008
CV for supervisor (student research)		20 May 2008

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

APPENDIX 4 Copy of ethics approval letter

08/H0806/48

Page 3

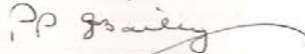
We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

08/H0806/48

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely



Dr Hervey Wilcox
Chair

Email: lsbrec@stgeorges.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting.*
"After ethical review – guidance for researchers"

Copy to: Ms Jayne Ingles
Faculty Research Ethics & Governance Committee
c/o Clinical Research Centre for Health Professions
University of Brighton, Aldro Building
49 Darley Road, Eastbourne
BN20 7UB

APPENDIX 5 Participant Information Sheet



University of Brighton

INFORMATION ABOUT THE RESEARCH

Date: 5th October 2008

Study Title: The impact of breastfeeding on the identities of methadone-treated mothers

PART 1: Purpose of the research study and your part in it

What is the purpose of the study?

Very little is known about the effects of breast feeding on mothers receiving methadone treatment. For the purposes of my doctorate degree I want to find out more about the effects of breast feeding on the self image of methadone treated mothers. The outcome of this study may prove to be useful to mothers and health professionals in the future.

Why have I been invited?

You have been invited to take part because you are prescribed methadone and are considering breastfeeding your baby. I would like to invite a total of 5-6 mothers into the study over the next 12 months.

Do I have to take part?

No. It is up to you to decide whether or not you wish to participate. Before making your decision I would like to talk to you to describe the study and answer any questions you may have. If you are already participating in another research you might want to consider what participation in more than one study will mean for you.

Once you are satisfied that you understand the project and agree to take part, I will ask you to sign a consent form. You will be given a copy of this consent. You are free to leave the study at

APPENDIX 5 Participant Information Sheet

any time without giving a reason. If you chose to leave it will have no impact on the care you normally receive.

What will happen to me if I take part?

I would like to interview you 4 times over 4 months, every time in a private and separate place where we cannot be overheard. Each interview, in the form of a guided conversation, will take about an hour and will be tape recorded. We will explore your experience of breastfeeding in your own words.

- **Interview 1:** At the One Stop antenatal clinic before your delivery.
- **Interview 2:** On the hospital ward 5 days after your baby is born. If you are breastfeeding at this time you will be invited to continue with the study.
- **Interview 3:** When your baby is 6 weeks old.
- **Interview 4:** When your baby is 3 months old.

I would like to meet you for the third and fourth time when you are collecting your prescription. This may either be at your GP surgery or your drug treatment clinic. Where this is not suitable we can arrange to meet in a private place where you will not be overheard. If you decide to change from breastfeeding to formula feeding your baby after you leave hospital, I would still like to continue meeting with you for the next two interviews.

Expenses and payments

The interviews are planned at times when you are receiving hospital care and afterwards within your usual routine of collecting your methadone prescription so it will not cost you any extra expense in travel and child-care.

What will I have to do?

The start of the each interview is very brief and simple and gives you time to tell me a little bit about yourself; *e.g.* your age, education and housing, as well as how you are and of any changes since last we met. As I will need to contact you again I will ask you for some contact details. After this very brief introduction I will use two sets of drawings to help you think about the effect breastfeeding is having on you.

What are the possible disadvantages and risks of taking part?

There are no right or wrong answers; I am interested in your opinions and personal experiences. You may feel a little embarrassed to tell me about this. If you feel uncomfortable

APPENDIX 5 Participant Information Sheet

please let me know. I will not ask any sensitive or intrusive in-depth questions about your life or anything that is not necessary for the research.

What are the possible benefits of taking part?

Your involvement in the project will not help you directly. Your participation will be in the interests of benefiting future methadone treated mothers. However you may enjoy the experience of participating because of the time given to think and talk about yourself as a breastfeeding mother.

What happens when the research study stops?

The study will be written up for publication to be read by health care professionals and service users.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence as described above. The details are included in Part 2.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

PART 2: More detailed information about the conduct of the study

What if relevant new information becomes available?

Sometimes we get new information about the situation being studied. If this happens, I will be able to tell you and discuss whether you should continue in the study. If you decide not to carry on, you will be able to leave the study. If you decide to continue in the study I may ask you to sign an updated consent form. If the study is stopped for any other reason, I will tell you.

What will happen if I don't want to carry on with the study?

APPENDIX 5 Participant Information Sheet

If you decide to leave the study, I will destroy all information that might be able to identify you. I will acknowledge your wish to leave in writing including my contact details should you wish to contact me later. I will need to use the data collected up to the point at which you left. All information that might identify you will be destroyed to make it anonymous.

What if there is a problem?

Complaint

If you have any concern about any aspect of this study, you should ask to speak to me on 07904 10 32 08. I will do my best to answer your complaints. If you are concerned about the way the study is being conducted you may wish to speak with Professor Val Hall, one of my academic supervisors at Brighton University. Her phone number is 01273 644015.

If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure at the Royal Sussex County Hospital 01273 696955 Ext. 4029/4588.

Harm

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Brighton, but you may have to pay your legal costs. Please contact Charles Bench or Amanda Roberts, at the University of Brighton, 01237 600900 extension 2726.

However given the nature of the research design I do not foresee any harmful consequences in taking part in this study.

Will my taking part in this study be kept confidential?

All information, including the tape recordings, collected about you during the course of the research will be kept strictly confidential, and any information about you which leaves the confines of the hospital will have your name and address removed so that you cannot be recognised.

To prevent unauthorised access from other persons I will be locking your consent form, questions, drawings and tapes in a secured filing cabinet at work. I will not leave any papers out on the desk for others to see and read. Instead of your name I will use code numbers on all

APPENDIX 5 Participant Information Sheet

data collection material. Any identifiable data; your code number, name, address and phone number(s) will be held in a sealed envelope within a locked cabinet. The computer will be password protected. No-one will be able to see the computer screen except myself.

As your personal information gained remains under your implied control, you have the right to check the accuracy of the data held about you and will be able to correct any errors. If you would like I can arrange for you to have a copy of our taped conversations. The tapes will be destroyed after I have completed my degree. I will respect the data you give me and will be taking great care to record research results accurately. As required by research councils, universities, and some journals, research data will be stored in a secure holding for three years.

Involvement of the General Practitioner (GP), drug key-worker, midwife and health visitor

After gaining your informed consent, I will be informing your GP, drug key-worker, midwife and health visitor of your involvement. I will be sending them a copy of the signed consent form together with the participant information sheet.

This is done to help you. If you become distressed during the interview, and at any time before or after as a direct consequence of taking part in the study and I am unable to help you at that time, I could liaise with them to arrange a follow-up appointment with the most appropriate person. For instance if you are worried about anything to do with feeding problems, with your permission I could contact your health visitor on your behalf to arrange an appointment. Having information beforehand will make it easier for you to talk to any or all of them about your participation in the study.

However as a result of being involved in the study, you may feel you would like some counselling support outside of the people discussed above or the NA helpline listed below. We can talk about this at the time so that I can put you in contact with the most appropriate support suitable for your needs.

What will happen to the results of the research study?

I will be writing up this research for other healthcare professionals and service users to read. With your permission I intend using direct quotes from our conversation. Even though I will

APPENDIX 5 Participant Information Sheet

not be using your name, there may be a slight risk you will be recognised by people who know you. To protect your identity, I may consider altering some unimportant details.

Who is organising and funding the research?

My study is being sponsored by the University of Brighton. It is not funded and I am not being paid for including you in this study.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by London-Surrey Borders Research Ethics Committee.

Further information and contact details

- If there are any issues raised by the interviews that cannot be dealt with during our time together, I advise you contact your GP, keyworker or midwife/ health visitor. You can do this by yourself or I can arrange an appointment for you (see above).
- For out of hours help and advice on drugs please contact the 24 hour Narcotics Anonymous Helpline: 0845 373 33 66 and 0207 730 0009. NAHelpline@ukna.org
- For enquiries regarding the study please contact me:
Rosemary Jambert Gray. 07904 10 32 08. rjambert@sgul.ac.uk

APPENDIX 6 Consent form



University of Brighton



CONSENT FORM*

Title of Project: The impact of breastfeeding on the identities of methadone-treated mothers

Name of Researcher: Rosemary Jambert-Gray

Please initial
box

I confirm that I have read and understand the information sheet dated..... for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

I agree to my participation in the study being audio taped by the above named person and transcribed by Voices Consultancy, professional transcribers who operate within a recognized ethical and confidentiality agreement.

I agree to take part in the above study.

I agree to my GP being informed of my participation in the study

I agree to my midwife/ health visitor being informed of my participation in the study

I agree to my drugs keyworker being informed of my participation in the study

If I withdraw from the study before completing 4 interviews, I consent to my data collected up to this time being entered into the study. I understand the data will be anonymised.

I consent to the use of anonymous direct quotes for publication

Name of Participant

Date

Signature

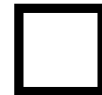
Name of Person taking consent

Date

Signature

* When completed: 1 for patient; 1 for researcher site file; 1 (original) for midwife kept in medical notes, 1 for GP, 1 for Health Visitor, 1 for drug services. (total: 1 original, 5 copies)

APPENDIX 8 Baseline information



Section 2 (T0). Baseline information

Date:

Questions are based on findings from the 2005 Infant Feeding Survey, previous research, *Hidden Harm and Maternity Matters*.

<p>2.1 How old are you?</p>	
<p>EMPLOYMENT 2.2 Are you:</p> <ul style="list-style-type: none"> • Working and on maternity leave? • What do you do? • Unemployed? <ul style="list-style-type: none"> • State benefit? (prompt: JSA/ IS/ Disability) • Other not working (please specify. Prompt: housewife, student) • What was your last job? 	
<p>EDUCATION 2.3</p> <ul style="list-style-type: none"> • How old were you when you left school? • What exams did you pass before you left school? (Prompt: GCSE, AS levels, A levels) 	
<p>HOUSING 2.4</p> <ul style="list-style-type: none"> • What kind of housing do you live in? (Prompt: rented, private, LA; owned, family) • Do you have any housing problems at the moment? • YES: What are they? 	<p>Yes/No</p>
<p>PREGNANCY 2.5</p> <ul style="list-style-type: none"> • Is this your first pregnancy? • When did you realise you were pregnant? • At what stage of your pregnancy did you start coming to the BUMPS clinic? • Where do you get your main antenatal care? (Prompt: GP/ BUMPS/ community midwife/ other (what?)) 	<p>Yes/No</p>

APPENDIX 8 Baseline information

<p>METHADONE 2.7</p> <ul style="list-style-type: none"> • How much methadone are you prescribed each day? • Who prescribes this for you? (Prompt: drug clinic, GP) • How long have you been treated with methadone? • Was your dose of methadone increased during pregnancy? <ul style="list-style-type: none"> ○ YES. What was the dose before you were pregnant? ○ NO. Do you think it should have been increased? <ul style="list-style-type: none"> ▪ YES. Why and to what dose? 	<p style="text-align: right;">Yes/No</p> <p style="text-align: right;">Yes/No</p>
<p>FURTHER CONCERNS 2.8</p> <ul style="list-style-type: none"> • Are you receiving any other prescribed medication? <ul style="list-style-type: none"> 1 2 3 • Are you using any other drugs, including alcohol, as well as taking your methadone? <ul style="list-style-type: none"> 1 2 3 • YES: Why and what are they? (Prompt: remember this information is confidential) • Are the social services working with you at the moment? • Do you feel there are any child protection issues? <ul style="list-style-type: none"> ○ YES: What are they? 	<p style="text-align: right;">Yes/No</p> <p style="text-align: right;">Yes/No</p> <p style="text-align: right;">Yes/No</p> <p style="text-align: right;">Yes/No</p> <p style="text-align: right;">Yes/No</p> <p style="text-align: right;">Yes/No</p>

APPENDIX 8 Baseline information

<ul style="list-style-type: none">• Are you worried about anything at home? (Prompts: within the family, partner, violence) <p>YES: Are they to do with: (tick which one(s) is/are applicable)</p> <ol style="list-style-type: none">1. Work?2. Money?3. Housing?4. This pregnancy?5. Your new baby?6. Your partner?7. Your children/8. Your family support?9. Your prescription?10. Others? (what are these)	
<p>IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD OR COMMENT ON?</p>	

APPENDIX 9 Interview schedule

Points for consideration using the IPA framework

1. What is the overall area to be tackled in the interview?

- Exploring the impact of breastfeeding on the identities of mothers treated with methadone for an opiate addiction.

2. What are the broad ranges of issues?

- Profile of breastfeeding mother engaged on methadone stabilisation treatment
- Methadone treated mothers' perceived changes in relationships with significant others, including drugs, over the time of breastfeeding.
- Methadone treated mothers perception of self-esteem over time from before her baby is born to when her baby is weaned.
- Methadone treated mothers own description of their self-construct over this time.

3. What sequence should the topics be listed with regard to the most logical order and the most sensitive (most personal)?

Filter questions based on the inclusion and exclusion criteria are completed first.

After initial consideration of participant suitability, the interview is then laid out in the following order, with section 4 and 5 being the most personal topics, 5 probably being more sensitive than 4.

- Section 1: Contact details T0
- Section 2: Baseline information T0
- Section 3: Update on change in circumstances T1,T2,T3
- Section 4: Relational Map drawing T0,T1,T2,T3
- Section 5: Drawings of the non/ideal mothers T0,T1,T2,T3
- Section 6: After the interview. T0,T1,T2,T3

APPENDIX 9 Interview schedule

It is anticipated the interview will take about an hour to complete, depending on how much the mother feels able to share.

With reference to the first of the broad range of issues listed above. Sections 1 – 3 are intended to collect contact details, baseline data and changes in social circumstances. Data collected will help to describe the participant. All sections have been deliberately designed to be easy to answer, non-intrusive and short to help engage and relax the mother at the start of the interview. I will be completing her responses on the question paper.

Section 1 is designed to list contact details and locate a code number for mothers intending to breastfeed. This will be held in a locked cabinet for my use only. Added to this will be an outline of estimated dates for the next three interviews in the project. These will be based on the expected date of delivery. In addition there will be details of further help if needed after the interview. She will be given a copy of this page.

Section 2 and 3 are designed to collect data and any change in social circumstances over the four interviews. The purpose of these tools is to amass simple demographic data and information on employment, education, housing, pregnancy, family and support, methadone and any further concerns. Section 3 is used at each postpartum interview and asks after the welfare of the mother and baby, breastfeeding and change in circumstances. The questions asked stem from the conclusions and discussions from the conclusions of the 2005 breastfeeding survey, previous research and the two reports *Hidden Harm* and *Maternity Matters*.

Section 4: The Relational Map Drawing for addressing the second issue on the above list.

The purpose of this therapeutic psychological tool will be to record the mothers' perceptions of significant other relationships in her life, including that of

APPENDIX 9 Interview schedule

methadone. Over time it will be interesting to note whether methadone becomes less important as she continues to breastfeed.

The mother will be given a blank piece of paper with ME written in a circle at the centre of the page, laid in 'landscape' fashion. All mothers will be given photocopies of this paper. The mother can then decide to draw her own lines, of varying length to represent the significant relationships in her life, as well as the position she gives drugs. Those closest to her will have the shortest lines.

Although the tool is used as a catalyst for discussion it would be interesting to keep a record of those on her relational map. It is designed as a conversational tool rather than a strict measure of distance than can be compared over time. However it will be interesting to note if there are relational changes in her life, not only towards methadone but also to those she considers important in her life.

Section 5: Drawing of the non/ideal breastfeeding mother for addressing the third and fourth issues on the above list.

The purpose of this tool will also be used to facilitate discussion of the mothers' experiences of breastfeeding, including changes in their self-esteem and construct. This tool was developed initially by Consultant Psychologist Heather Moran for clinical therapeutic use in child and adolescent mental health. She hasn't used it as a research tool but has written that it is well suited for that purpose. It has been slightly amended to help mothers' exploration of their development and changes in self-esteem and construct over time.

This tool is designed to be asked in the order in which it is written. According to Moran it is a simple technique to use. It takes the form of a conversational approach supported by drawing and writing. It has four parts. Part 1 explores the kind of imaginary mother, feeding her baby; the participant would not like to be like. Part 2 explores the kind of imaginary mother, feeding her baby; the participant would like to be like.

APPENDIX 9 Interview schedule

The mothers will not have access to these questions. I will be reading from the prepared list of questions and prompts, I will keep my voice slow and clear, allowing for silence and repetition to help the mother to think of her answers as they pop into her mind. The eight sections are repeated twice for each imagined scenario of the kind of person they would and would not like to be like. Each section is written in the same space on each paper for ease of comparison. The aim is to use as few prompts as possible in order to allow the interview to flow. At the end of each section I will reflect her answers back to her verbatim for clarification and agreement on what is written. She won't have an option to alter an answer.

At the end of these sections I have devised a set of seven questions to act as prompts to help the mother reflect on what she has drawn, especially in identifying which mother or mothers would have a history of drug use. This is done to help tease out whether an ideal mother is always one who has never used drugs. This will obviously exclude all mothers in my client group.

Part 3 is a rating scale which allows the participant to explore her view of her development over time influenced by breastfeeding. It provides a very personal measure of self-esteem: how she compares herself to the kind of mother who is feeding her baby she would like to be like. She is asked to rate where she sees herself now and two points in the future, in the short and long term. We spend some time exploring how she can move to these points. Again this will raise issues of confidence and esteem. For instance is she more likely to identify difficulties outside of her control? Or will she feel more empowered to take control over her own life? This section is concluded by examining where others may place her. This will help uncover what she thinks about how others may rate her. For instance will she be rated lower by professionals such as her health visitor who will stereotype her as a 'drug user' or higher because she feels she is good at hiding the truth from people?

APPENDIX 9 Interview schedule

Part 4 is the important discussion section. It is the final step in the process in which we both discuss through conversation what sense the drawings make to us. I have devised 6 open ended questions to act as prompts in this section.

Most sensitive and personal part of the interview

I imagine the most sensitive time of the interview will be when they draw their ideal mothers. This will raise various fears, real or imagined concerning her construct as a drug using mother and of her own experience of being mothered. How would they react to not moving towards her over time? Will stagnation or move towards the less ideal mother stress their lack of confidence in themselves?

4. What are the most appropriate questions related to each area, including possible probes and prompts?

Questions

The aim should be to encourage the mother to talk as much as possible with as little prompting as possible. Questions should be gentle. I will inform the mother of my area of interest and am fascinated to hear what she has to say. I will be aware of not asking questions that are closed, requiring yes or no answers. They will be neutral, devoid of jargon or professional language that may increase the gap between the mother and myself.

Techniques for asking questions

It will be important to find a venue that is private, comfortable and quiet as the interview could become long, intense and involved. I anticipate and appreciate she will have her baby with her. Hopefully there won't be too many interruptions. My role as researcher will be to facilitate and guide the mother. It may not be necessary to follow the sequence as designed although the tools should follow in sequence. Even though the questioning may be fluid, the questions for the drawing of the non/ideal mother must be asked in the sequence written.

APPENDIX 9 Interview schedule

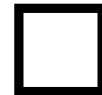
I must be aware not to rush the questions, asking one at a time, giving her plenty of time to respond, especially when she is providing some rich and full answers. Probes should be minimal *e.g.* ‘could you give me an example of that?’

All the way through, especially when describing some sensitive areas, I will be monitoring her for signs of distress and being uncomfortable. Especially non-verbal cues. When this happens I will try asking more gently or even back away. There may be issues over the tape recording. Some mothers may not want to be taped. A discussion on what they are worried about may help.

Section 6: End of the Interview

I intend using some time at the end of the interview to find what impact the interview has had on the mother. If I feel she would like to talk more I will advise her to contact the relevant professional as listed on the first page. She will be reminded of the NA helpline number should she want some help out of hours. She will also have my phone number if she would like to phone me later with a query.

APPENDIX 10 Update of baseline data



Section 3 (T1, T2 and T3)

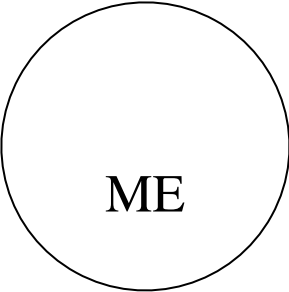
Date:

Questions are based on findings from the 2005 Infant Feeding Survey, previous research, *Hidden Harm* and *Maternity Matters*.

T1 ONLY: WHEN WAS YOUR BABY BORN?	
WELFARE	
3.1	
<ul style="list-style-type: none">• How are you?<ul style="list-style-type: none">○ Any problems? • How is your baby?<ul style="list-style-type: none">○ Any problems? • Who is helping you with your baby?	
BREASTFEEDING	
3.2	
<ul style="list-style-type: none">• Are you still breastfeeding? • NO. Why not? • Are you supplementing with bottle feeding? YES. How often? • Are you experiencing any difficulties related to feeding?	<p>Yes/No</p> <p>Yes/No</p>



Date:



Appendix 12 Relational Map Index

Relational Map: Index of Important People in your life

Please list from the shortest to the longest lines, identifying what relationship they are and adding initial you have used on your map. For example: Partner R, Mum K, Daughter J, Friend S. or Ross p, Kay m, Jess d, Sarah f etc.

A _____

B _____

C _____

D _____

E _____

F _____

G _____

H _____

I _____

J _____

K _____

L _____

M _____

N _____

O _____

P _____

Q _____

R _____

Date:



Appendix 13 Ideal and non-ideal mother drawings

The kind of mother, feeding her baby, I would not like to be like.

Date:

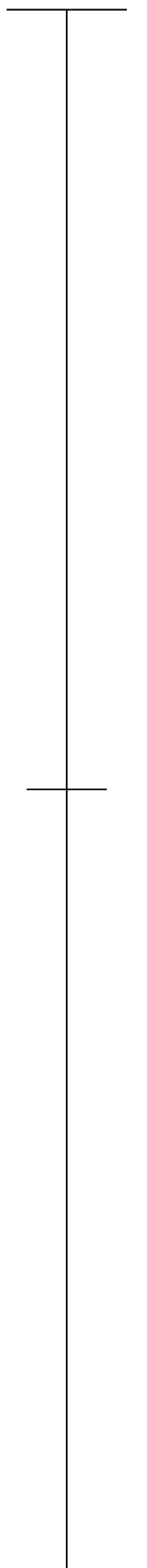


Appendix 13 Ideal and non-ideal mother drawings

The kind of mother, feeding her baby, I would like to be like.

Date:





Appendix 14 Questions for ideal and non-ideal mother drawings

Section 5. Drawing of the non/ ideal mother

- **The impact of breastfeeding on the identities of methadone-treated mothers**

Drawing of ideal self (mother) is designed to help answer the following sub-question:

- How do mothers experience the impact breastfeeding has on them?

Introduction of the session to the mother.

I am asking you to describe two imaginary mothers who are feeding their babies. The first one will describe the kind of imaginary mother, feeding their baby, you would not like to be like. The second will describe an imaginary mother, feeding their baby, you would like to be like. We will take each in turn. **It is important that you draw and use what you think of first and not what you think I will want to hear. I can write using your own words if you don't want to write yourself.**

Part 1 and 2

On 2 separate pieces of A4 paper, portrait way up.

1. Drawing of the *Imagined Non Ideal Mother* headed:
The kind of mother, feeding her baby, I would not like to be like.
2. Drawing of the *Imagined Ideal Mother* headed:
The kind of mother, feeding her baby, I would like to be like.

Questions for each drawing, taken separately for Part 1 and Part 2.

1. **Description. Think about the kind of mother feeding her baby you would (not) like to be like. This is not a real person. Please draw a quick sketch of this mother and the way she is feeding her baby in the middle of the page.**

How would you describe this mother who is feeding her baby? What kind of a mother is she? Tell me three things about what she is like? Write labels for her (or I write them in using her own words). 90/c position!

Prompts: Remember she is the kind of mother you would (not) like to be like.
Repeat back answers at end of section.

Appendix 14 Questions for ideal and non-ideal mother drawings

- 2. Bag: This mother, who is feeding her baby, goes out each day and takes her bag. What kind of bag would that be and would be inside it? Sketch the bag and draw or label three items. Work anticlockwise from above.**

Prompts: Remember she is the kind of mother you would (not) like to be like.

Repeat back answers at end of section.

- 3. Birthday present: What does this mother, who is feeding her baby, like for her birthday? Sketch and label the present.**

Prompts: Remember she is the kind of mother you would (not) like to be like.

Repeat back answers at end of section.

- 4. With her family: How would this mother, who is feeding her baby, be like with her family? Sketch and give three descriptions.**

Prompts: Remember she is the kind of mother you would (not) like to be like.

Repeat back answers at end of section.

- 5. With her friends: How would this mother, who is feeding her baby, be like with her friends? Sketch and give three descriptions.**

Prompts: Remember she is the kind of mother you would (not) like to be like.

Repeat back answers at end of section.

- 6. Greatest fear: Everyone is afraid of something. What is this mother, who is feeding her baby, afraid of? Sketch and label.**

Prompts: Remember she is the kind of mother you would (not) like to be like.

Repeat back answer at end of section.

- 7. History: How did this mother, who is feeding her baby, come to be like this? What is her history? Was she always like this from birth or did she become like this? What happened to her?**

Prompts: Remember she is the kind of mother you would (not) like to be like.

Repeat back answers at end of section.

Ethics alert: This section may stimulate raise memories of being abused, either as a child or adult. Abuse can be physical, emotional or mental. Drugs can be used to

Appendix 14 Questions for ideal and non-ideal mother drawings

numb emotional scars or emptiness. Information gathered here may trigger unnecessary distress for which I will give time and space before continuing. It should be remembered I am asking about an imaginary person and hence the client may not draw on her own experiences in the first person when responding to this question.

8. Future: What will this mother's, who is feeding her baby, future be like? What will become of her?

Prompts: Remember she is the kind of mother you would (not) like to be like.

Repeat back answers at end of section and at the end of each drawing.

Each section is then repeated for Part 2 the kind of mother, feeding her baby, you would like to be like.

- I will then place the two drawings side by side on the table. The drawing of the imagined feeding mother they would **not** like to be like is placed on the left. The drawing of the imagined feeding mother they **would** like to be like is placed on the right.

Comparison of the drawings in a discussion with the mother:

- Which mother is a drug user?
- Could they both have a history of drug use?
- What drugs would they use?
- Would they be receiving a methadone prescription?
- Why? What kind of problem did they have?
- Can they explain their answers?
- Any other reflections? (Prompt; difference in size of mothers?)

Consider offering a BREAK at this point.

Part 3: Mapping development and movement towards the mother she wants to be like.

Appendix 14 Questions for ideal and non-ideal mother drawings

- A third piece of paper, in ‘landscape’ layout, is laid out in between the two drawings. Linking the 2 drawings, a horizontal line is drawn across the length of the page with a marked midpoint.
- This construct line of self is used for the respondent to rate **herself** as she refers to her two imagined extremes.

FIRST MARKS

- **Where do you see yourself now? Please mark it ‘NOW’ with today’s date.** (Observation: where does she mark herself? On the right of the midpoint and nearer her ideal mother indicates a higher sense of self-esteem than if she rates herself below the midpoint.)
- **Where would you like to see yourself in the long term? Please mark it ‘IDEAL SELF’.**

HOW COULD YOU MOVE TOWARDS YOUR IDEAL?

- **Can you think of, and list 3 things UNDER the line, that will help you move from where you are NOW to your LONG term goal, labelled ‘IDEAL SELF’?**
(Prompt: This may be things they are able to do themselves or what others can do to help them in the long term).
- **Could you please explain what you have written?**

MAPPING DEVELOPMENT OVER TIME

- **Where would you like to see yourself in the short term, for instance over the next few weeks before our next interview? Please mark it ‘FUTURE’.**
- **Can you think of, and list 3 things ABOVE the line, that will help you move from where you are NOW to your SHORT term goal, labelled ‘FUTURE’?**
(Observation: Asking this taps into the mother’s ideas about what she construes the causes of movement and what factors will promote/hinder future progress.).
- **Could you please explain what you have written?**

Appendix 14 Questions for ideal and non-ideal mother drawings

MAPPING DIFFERENT VIEWS OF THE CLIENT

- Where would **other, familiar, people** say you were along this line? People who know you (**FP**)? For instance your **partner/ other children/ mother/ sister/ friends?** (Prompt: mentally refer to relational map)
- Professional contacts? **Midwife/ health visitor/drugs worker/GP (PP)?**
- **Where would you place yourself if you weren't breastfeeding (NB)?**
- Are you able to explain the **differences in views?**

Part 4: Discussion

The final step in the process is **to consider what sense the work makes to me and discuss this with the mother.**

- **When you look at your drawings and markings on the line, is there anything that what surprises you?**
- **What is it? (Prompt: where she positions herself in relation to both her ideal and non-ideal mothers. The nearer to the ideal the higher her self-esteem.)**
- **Is there something in the drawings or on the line that you wouldn't have thought about before now?**
- **What is it?**
- **What effect do you think breastfeeding your baby has had on the way you rate yourself? (Prompt: for instance on your self confidence, self-esteem and as a mother with a history of drug use?)**
- **Is there anything else you would like to say?**

BEFORE FINISHING

Before completion of the interview I will revert back to the Relational Map on section 4 to ask about the future position of methadone.

On the Relational Map, where do you think you will place methadone when we next meet or when you finish feeding your baby? Mark it M Future. What is/are the reason(s) for putting it there?

Data analysis

Appendix 14 Questions for ideal and non-ideal mother drawings

The whole approach, from part 1 – 4 is designed to explore the mother's view and to elicit discussion and reflection on their experience of being a breast feeding mother. I aim to transcribe the discussion that has taken place. I will not be showing the pictures to other people. If I do change my mind later however, I will be contacting her for her consent to do so. I would also ask whether she would like a copy of her drawings. I will do this at the end of our appointments together.

Appendix 15 Summary of the pilot study

The pilot study and amendments made

Since considering the methods suitable for my epistemology I undertook four pilots on the two psychological tools over September and October 2007. They all took about an hour to complete, the longest being one hour and 15 minutes.

Initially a psychologist colleague, familiar with Moran's drawings tested the drawing of the non-ideal/ideal mother on me. We tried to imitate a possible scenario as we were both unable to meet in quieter surroundings. We sat in a café on a busy London high street where after a time we had to move as the café was closing. We completed the interview on a bench on the side of the road. Although the drawings were very simple and interesting, I found the exercise quite tiring, especially when I had to think about rating myself.

As a result of the exercise and long discussion afterwards, I decided to amend it by simplifying it to my research needs. I decided that the drawings should be of mothers *feeding their babies*. This part was initially omitted but caused a lot of confusion when trying to answer the questions on feeding. Also we discussed the importance of having others rate the mother, although of course she is still rating herself. I decided to include somebody who knows her well and a professional who knows her. In addition I decided to add a non-drug using mother as a term of reference. It will be interesting to monitor whether she considers others perceptions of her as less or more important. This may act as an indication of the effect motherhood has on her confidence and esteem within her own self-construct.

The second two pilots were undertaken with two university colleagues. The fourth pilot was helped by a female psychiatrist that works on my team at work. One took place in a colleague's work place, with all the interferences this entailed. The latter two took place in my office at work in which I felt comfortable and at ease. I didn't have a tape recorder for two of them. One interview was taped completely without a hitch. During the final interview the tape recorder switched itself off indicating it was full. This was a malfunction as the recorder is not full. However I need to take into account mechanical difficulties to protect the data and use a second recorder. I will

Appendix 15 Summary of the pilot study

take great care to download the data from the digital recorder to the computer after each interview.

All pilots were very positive about the kind of data that would be elicited as 'enormous and very rich'. Although the methods were extremely simple the amount of data generated promised to be very rich. All felt the drawings would help to answer the questions.

During that time I further developed and refined the questionnaires used for collecting baseline data. I was able to try them out in two of the pilots, especially the last one where I used both introduction sections, except names and addresses; section 2 designed for the first interview (T0) and section for the subsequent, post-delivery interview (T1,T2,T3). We continued with the drawings, pretending she was 6 weeks postpartum. The first interview may not always be collected at the antenatal clinic. Although this is the safest place to conduct a first interview it might not always be possible. This may raise some health and safety implications I will need to address at the time by liaising closely with professionals that know her well and informing them when I visit and when I leave any private premises.

I became increasingly aware of the importance of setting out a clear plan to know when she has had her baby as I didn't expect to be able to call her on her mobile in hospital, especially in the event of an earlier than expected date of delivery. I had to be very careful as the numbers in this client group are very small and didn't want to lose any potential participants. I developed very good working relationships with the primary gatekeepers, namely the specialist midwives in London and Brighton.

Appendix 16 Detailed progression of data analysis

Category Colaizzi's 4 th stage	Theme Cluster	Themes	Formulated meanings Colaizzi's 3 rd stage	An exemplar statement taken from Colaizzi's 2 nd stage
<p>1. Internal, emotional world of a MMT breastfeeding mother</p>	<p>1.1 Positive emotional transition</p>	<p>1.1.1 The power of love. 1.1.2 Life changing event. 1.1.3 Sudden and dramatic. 1.1.4 Being a calmer mother.</p>	<p>Being a mother; Being a drug-user; Being interviewed; Experience of breastfeeding; Love; Responsibility; Facing reality.</p>	<p>'...when you're breast feeding it's the closeness, the way they sleep and it's more comfortable and you can feel it. You are comfortable It makes you realise that you are (a mother)' (Beth: Interview 3).</p>
	<p>1.2 Negative emotional transition</p>	<p>1.2.1 Influence of drug-user identity 1.2.2 Anxious about opiate withdrawal in baby 1.2.3 Scared of professionals 1.2.4 Busy proving their capability to mother 1.2.5 Uncertain 1.2.6 Frustrated and resigned</p>	<p>Anxiety as a drug-using mother; Anxious about baby; Attending demand to attend meetings; Attitudes about breastfeeding; Attitudes from professionals: negative; Being a drug-user; Being judged; Defeated; Feeling scared; Experience of breastfeeding; Influencing</p>	<p>'I've been waiting. Every little sneeze, every little cough I've been jumping up saying does he feel hot? Is he this? Is he that? So I'm more stressed out than most people anyway' (Anna: Interview 2).</p>

Appendix 16 Detailed progression of data analysis

			professionals; Relationship with professionals; Unusual as a breastfeeding mother in treatment; Trying to breastfeed.	
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Appendix 16 Detailed progression of data analysis

Category Colaizzi's 4 th stage	Theme Cluster	Themes	Formulated meanings Colaizzi's 3 rd stage	An exemplar statement taken from Colaizzi's 2 nd stage
<p>2. External world of being 'the Other'</p>	<p>2.1 Describing what it is like to be 'the Other'</p>	<p>2.1.1 Feeling stereotyped 2.1.2 In the minority 2.1.3 Treated differently from other mothers</p>	<p>Treated differently to other mothers; Being judged; unusual as a breastfeeding mother in treatment; Valuing self; Treated differently to other mothers.</p>	<p>...'this woman [nurse] who's looking after [baby]....and the... child next to me, and the way she was with them, she was always laughing, you know, talking nice to the baby and that. Well, when she come to us she would talk to the baby nice, but she would not even like smile or talk nicely or anything like that. (Chloe: Interview 3)</p>
	<p>2.2 What mothers feel when treated as 'the Other'</p>	<p>2.2.1 Feel unimportant 2.2.2 Feel distrusted, isolated and disempowered 2.2.3 Feel recipients of negative and punitive professional attitudes</p>	<p>Attitudes from professionals: negative; Lack of communication; Being judged; Relationship with professionals.</p>	<p>'We really hadn't realised why [baby] had gone upstairs [to NNU] because someone just said to us, 'Oh, she's hit 10 on her scores and she needs to go</p>

Appendix 16 Detailed progression of data analysis

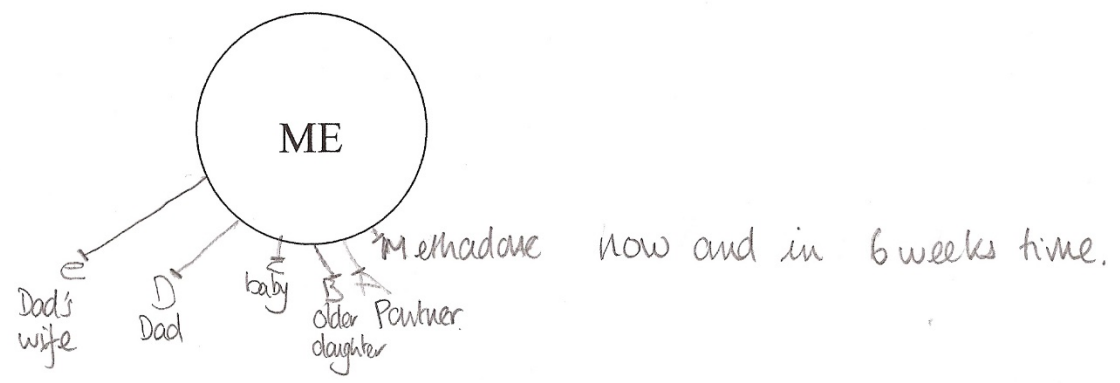
			upstairs'. We didn't know what she was being scored for. We didn't understand. It had never been explained to us'... (Doris: Interview 3).
2.3 The impact on the mothers lives by being 'the Other'	2.3.1 Victim of circumstance 2.3.2 Feeling powerless 2.3.3 Defeated 2.3.4 Alone 2.3.5 Feeling valued 2.3.6 Expert patient	Treated differently to other mothers; Victim of circumstance; Lack of communication; Attentive mother; Feeling powerless; Feeling unimportant; Missing breastfeeding; Defeated; Trust others; Attitudes to professionals: positive; Valuing self; Being a drug-user; Feeling valued; Relationships with professionals.	'I've seen people just come in here just to have a baby... I've seen people after two hours go home and I'm really jealous because I just want to go home...I know I'll cope better at home because I've got my son at home' (Anna: Interview 2).

Appendix 16 Detailed progression of data analysis

Category Colaizzi's 4 th stage	Theme Cluster	Themes	Formulated meanings Colazzi's 3 rd stage	An exemplar statement taken from Colazzi's 2 nd stage
<p>3. Tension between internal changes and external world as experienced by mothers</p>	<p>3.1 Becoming the good- enough mother</p>		<p>Being a drug user; Attentive mother; Love; Valuing self; Relationship with self; Self- esteem; Being judged; Being interviewed.</p>	<p>'Self- confidence...believing...and self-worth really. That's important because I used to hate myself. I thought no one else could possibly like me, I didn't even like me...I've spent so many years trying to be different from who I am, and now I'm starting to say well, this is who I am' (Anna: Interview 3).</p>
	<p>3.3 Becoming the Insightful mother</p>		<p>Acknowledging others stereotypical attitudes; Being a mother; Influencing professionals; Relationship with methadone.</p>	<p>'It's [methadone] very important right now in my life. Keeps me stable so I reckon that used to do the things that I need to do on a daily basis, help my child, you know, do all the things for my children, and at the same time, you know, so I can talk to all these meetings. If I don't have it I won't have the strength' (Chloe: Interview 3).</p>

Appendix 17 A sample of Chloe's drawings

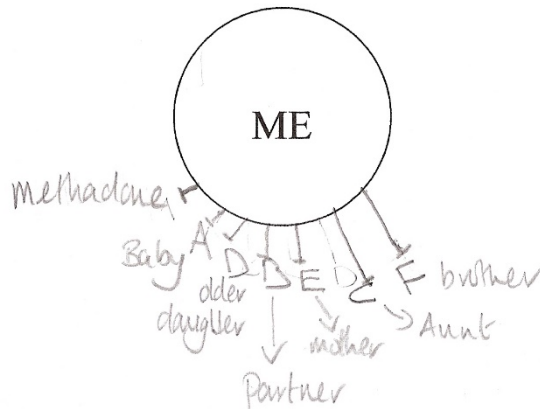
Date: 7.8.09 2/4 TI 3



Appendix 17 A sample of Chloe's drawings

Date: 27.10.09

T3 3



Companion:

- 1) current drug user - looks preoccupied
- 2) msly heroin

3) Prescribed methadon but msly on top

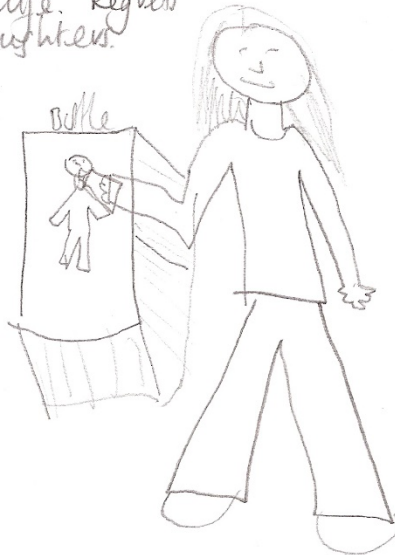
The kind of mother, feeding her baby, I would not like to be like.

Future

- ① 2 way future - happy but not completely happy
- ② Regrets in her life. Regrets not trying with daughters.

Description

- 1) not caring
- 2) not caring
- 3) lazy



History

- ① parents took her child off her when she was young.
- ② I don't think she know how to comfort a child.
- ③ Her mum & dad made her like that.

Fear

spiders

Friends

- 1) Good with her friends
- 2) likes them more than family
- 3) Has a laugh with them

Family

- 1) Half are close and 1/2 are not
- 2) close with 3 sons
- 3) Not close with her 2 daughters and ex-partner

handbag

- 1) small bottle milk
- 2) her things
- 3) 1 nappy

Birthday Present
Silver Jewellery

Date: 7.8.09

2/4

T1 3

companion:

- 1) Hx of drug use
- 2) Using heroin before 1st child.
reduced slowly

- 3) methadone helping to keep her off heroin
- 4) going to stop soon, already cutting down

The kind of mother, feeding her baby, I would like to be like.

Future

- 1) Nice life
- 2) Having a job
- 3) watching the kids grow up
- 4) kids love her and want to be with her

Description

- 1) selfless
- 2) caring
- 3) very happy

Baby bag

- 1) Nappies
- 2) wipes
- 3) breast pump



Birthday Present

Anything - picture of her daughter

History

The birth of her first child changed her into a good person.

Fear

Death of her children.

Friends

- 1) has a few friends, not too many
- 2) likes to be with them but not all the time
- 3) chatty and happy

Family

- 1) getting better with her family
- 2) starting to get her family back

Date: 7.8.09

2/4

TI 3

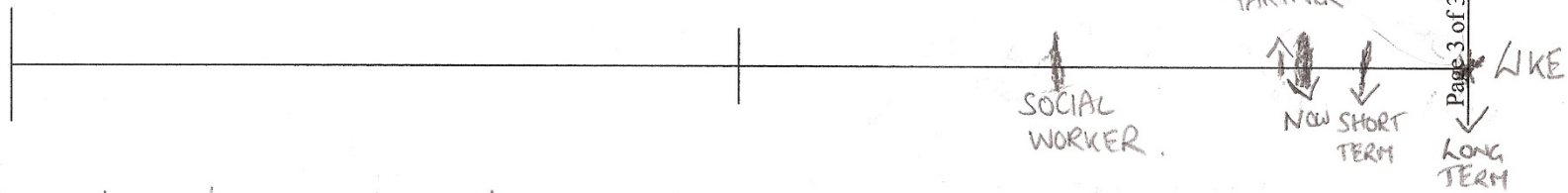
Appendix 17 A sample of Chloe's drawings

How to achieve short-term goal

- ① Support
- ② Motivation
- ③ Thinking of my kids
- ④ Being hurted and not expected to go back onto heroin with the stress.

06/08/2009

NOT
LIKE



How to achieve long-term goal

- ① Keep motivated
- ② Support of family; dad and partner
- ③ Thought of my children to not let them, my family or myself down.

RJG Ideal/non mum Ver 1

7.8.09 2/4 ③ T1