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Women with Histories of Cocaine or Heroin Use
Who Lose Child Custody

by

Andrea Kovalesky

A dissertation submitted in partial fulfillment
of the requirements for the degree of

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Abstract

Women who Use Cocaine or Heroin and Lose Child Custody

by Andrea Kovalesky

Chairperson of the Supervisory Committee: Associate Professor Susan Flagler,
Department of Family and Child Nursing

This exploratory study used grounded theory methodology to develop a substantive theory regarding women with histories of cocaine or heroin use who lose child custody. The primary aims were to obtain information directly from women, to identify common concepts evidenced in their stories, and to suggest hypothetical relationships among the concepts.

Audio-taped interviews were conducted with 15 women recruited through 3 sites who had lost custody of 1 to 4 children each. All women had abstained from drug and alcohol use from five days to three years at the time of the first interview and the majority of them were white. The 32 children lost to custody ranged in age from newborn to 11 years at the time of custody change. Published personal narratives were also reviewed.

The constant comparative method was used to analyze the verbatim interview transcripts and narratives. An overarching process that accounted for much of the variability in the data was Handling the Hurt. Hurt and pain were frequently mentioned by the participants, not only regarding the custody loss of the child but also regarding actual or potential negative effects on the child associated with prenatal drug use and/or drug usage in the home, the mother's own family of origin/ childhood issues, and/or frequent histories of abuse. Strategies that women used for Handling the Hurt were:

- Numbing Out (using drugs to cover or escape feelings),
- Giving Up (having suicidal/ despairing thoughts or behaviors),
- Running Away (physically leaving an unsafe or problematic locale),
- Cleaning Up a Little (making temporary efforts to remain abstinent),
- Cleaning Up a Lot (using treatment and other resources to build trust and develop a balance between parenting and recovery), and
- Dealing with Feelings (addressing feelings without the use of drugs/ alcohol).

The women's stories demonstrated fluidity among all strategies except for Dealing With Feelings, which could only be truly attained through Cleaning Up a Lot.

Professionals may be better able to assist mothers who use drugs to maintain abstinence and utilize available services by being aware of the mothers' hurt and the strategies they may use to handle this hurt.

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CHAPTER I

INTRODUCTION

Mothers who use drugs have become a focus of societal interest in the last decade primarily because of the direct and indirect effects of their drug use on their children and because of the increase of children experiencing such effects. Concerns about the effects of drug use on the mothers themselves are addressed in public circles much less frequently. This introductory chapter will provide the reader with brief background of a wide variety of issues surrounding child custody loss of women who use cocaine or heroin. This background information will be followed by definitions of terms, the purpose, specific aims, and significance of the study, as well as the background and assumptions of the researcher.

Background

Available statistics indicate that 4 to 18% of infants born in the United States are exposed to illegal drugs and/or alcohol in utero (Cook, Petersen, & Moore, 1990). In addition, an unknown number of children live in households in which drug/alcohol use is problematic. Some of these children may have had prenatal drug exposure, but others have parents who became involved in drug use after the children were born. Studies have validated that children whose mothers are chemically dependent are at increased risk for physical and emotional abuse and abandonment in their home environment (Jaudes, Ekwo, & Voorhis, 1995; Kelleher, Chaffin, Hollenberg, & Fischer, 1994; Mitchel & Savage, 1991; Regan, Ehrlich, & Finnegan, 1987). Cases such as children who have died while under the care of an abusive chemically dependent parent have received notable media attention (Conklin, 1996; Hampson, 1995). Each occurrence reinforces society's desire to prevent similar future events.

One major response of American society has been to promote the removal of the child from the chemically dependent mother's care or to encourage the alcohol or drug involved mother to give up custody of the child. In 1991, a federal government survey found that 78% of young children in foster care in the three states with the largest foster child populations (California, New York, and Pennsylvania) had at least one parent who was abusing drug or alcohol (United States General Accounting Office, 1994). The main reasons these children had been removed from their homes were neglect or the absence or incapacity of the primary caretaker. The role of substance abuse in out of home placements for children has increased substantially from 52% in 1986 to 78% in 1991.

However, removing a child from a mother's custody does not mean that the mother will not expose future children to drugs prenatally. A cycle of custody loss/recurrent pregnancy is not uncommon among women with histories of chemical dependency. For example, Raskin (1992) interviewed 15 pregnant women in Chicago with concurrent histories of substance abuse and identified that of the 13 multiparous women in the study, 12 had lost custody of a previous child for some period of time. Streissguth, Grant, Ernst, Phipps, and Gendler (1994) noted in their Seattle-based program for chemically dependent women that 55% of the mothers had at least one child that was not in their care.

Historically, mothers in American society have been thought of as either being good or bad mothers (Chesler, 1986; Kaplan, 1992). Kaplan notes that during the Enlightenment, a period in the 18th century which continues to have influence over our society today, women were taught only that which prepared them to be mothers. The female was designated to the private domain, and nature, not culture, was assumed to be the grounds for this. Men—ministers, journalists, professors, doctors, lawyers—historically have continued to define the mothering role, consisting of such

characteristics as tenderness, piety, purity, domesticity, and submissiveness. This ideological approach of what constitutes a good mother has also been supported by religious groups, many early television shows, and novels. Mothers are typically viewed by society as being either wholly good or wholly bad. Yet social scientists and others have argued for a "good-enough" parent, one who can provide a safe and nurturing environment for a child even in the face of economic or other limitations (Bettelheim, 1987, Chesler, 1986).

In current American society, mothers who have used cocaine or heroin during pregnancy are usually considered as being of the bad or unfit type of mother. For example, the mother's drug usage implies she is impure. The exposure of her child to drugs prenatally implies her lack of tenderness and concern for her child. In many American circles losing child custody indicates a woman's total failure as a mother.

Of interest, however, is that society does not fault mothers who have chronic or genetic health problems that can be passed on or affect a child. One possible explanation is that society believes that women who use drugs during pregnancy do so willingly, while mothers with chronic illnesses inadvertently pass on any health problem. Yet this belief about mothers who are chemically dependent is not supported by statements from the women themselves. For example, one mother of a drug exposed child shared,

I believe it's not a natural instinct for women to want to hurt their babies. Pregnant women don't want to use. They don't want to hurt their babies. I know I didn't want to hurt mine. But two days before I had my daughter I was in desperation....I said, 'God help me, I can't stop, help me.' I started crying....They took both girls away from me in the hospital. (Corser & Adler, 1993, p. 23) [This mother went into treatment/recovery and eventually was reunified with her children.]

Data from qualitative studies support that these mothers do not usually intend to hurt their unborn children through their drug use (Armstrong, 1992; Kearney, 1993). When

the mother's addiction is seen as a disease rather than an act of will observers can better understand the mother's behaviors.

As stated, one of the main reasons that society is concerned about illicit prenatal drug exposure is that findings from research indicate that such exposure carries risks for a variety of health problems for the developing fetus, either during the perinatal period or later in childhood. While some of these infants may have little, if any, effects from such exposure (Hite & Shannon, 1992), others can have significant consequences, such as withdrawal symptoms (Finnegan, 1986), decreased birth weight (Handler, Kistin, Davis, & Ferre, 1991), cognitive effects (Azuma & Chasnoff, 1993), and sudden infant death (Durand, Espinoza, & Nickerson, 1990). Only recently have researchers recognized that mothers of drug-exposed children have concomitant health and social problems which can affect infant outcomes. For example, Hurt et al. (Hurt, Brodsky, Betancourt, Braitman, Malmud, & Giannetta, 1995) evaluated 101 cocaine-exposed children and 118 control children. All children were 30 months of age or less and all were from families in lower socio-economic status. The authors concluded that "in our cohort of children, low socioeconomic or minority [racial] status may have had a substantial influence on BSID [Bayley Scales of Infant Development] scores whereas in utero drug exposure did not" (p. 29). In another case-control study of cocaine use in pregnancy, lack of consistent prenatal care and prenatal maternal cigarette smoking were the two factors which contributed to lower birth weight (Miller, Boundreaux, & Regan, 1995). When these factors were excluded, "identifiable differences in birth weight between cocaine and control mothers were no longer present" (p. 180). Long term, better designed studies to control for potential confounding variables are only in the early years of data collection (Lester, LaGasse, Freier, & Brunner, 1996; Neuspiel, 1994).

Another problematic area regarding women who use illicit drugs during pregnancy and lose child custody involves gender, ethnic, and class biases. Brewer (1993), in her historical analysis of black women's labor and multiple oppressors, points out that it is not the addition of oppressors (race + class + gender) that yields a valid equation of oppression. Rather, it is the product/interaction of them. That is, race x class x gender provided the more correct basis for her focus of inquiry. The researcher of the current study believes that such interweaving of problematic areas also holds true for mothers with histories of drug use.

Notable gender issues concern the scant amount of research that has been done about women and addictions in general, treatment programs that have been traditionally oriented toward men, and difficult life circumstances that confront women more intensely than men, such as economic factors, risk for abuse, childbearing, and childrearing responsibilities (Boyd, 1993; Hagan, Finnegan, & Nelson-Zlupko, 1994; Pursley-Crotteau, 1994). Histories of sexual and/or physical abuse in their childhood, adolescent, and adult years are frequent (Bennett & Kemper, 1994; Regan et al., 1987; Rohsenow, Corbett, & Devine, 1988; Teets, 1995). In a position paper on Women and Drug Abuse by the United Nations System (1994), the first conclusion was that female drug abusers are less accepted than male drugs abusers in most societies. The paper provides an extensive gender analysis of drug abuse. Still another gender issue concerns how women are frequently introduced to drug usage, that is, through male relationships. Finally, an obvious gender issue is that pregnancy is invisible. Until the recent employment of DNA testing, fathers could often keep their paternity hidden. Recently, studies have begun to address what role preconceptual drug use by fathers can have on the developing baby, both in the pre- and postnatal periods.

Racial biases are reflected in convenience samples, media blitzes, and general societal prejudices which incorrectly infer that most mothers of drug exposed children are poor women of color (Neuspiel, 1996). For example, when Charleston, South Carolina, developed their Interagency Policy on Management of Substance Abuse During Pregnancy in the late 1980s, it was applied only to those women seen in the obstetrics clinic at the Medical University of South Carolina in Charleston (Jos, Marshall, & Perlmutter, 1995). This clinic primarily serves women on welfare, many of whom are African-American. The policy did not apply to private obstetrical patients. As a result, a class action suit was filed against the Interagency Policy, and the program was halted pending legal action. Another noted case of racial disparity occurred in the late 1980s in Pinellas County, Florida (Chasnoff, Landress, Barrett, 1990). At that time, urines from all pregnant women were anonymously collected for one month. Collection sites included five public health clinics which had predominantly African-American clients and 12 private obstetrical offices which had mostly white clients. Although the overall use of illicit drugs was almost identical between white and African-American women (15.4% v 14.1%), the African-American women were ten times as likely to be reported to health authorities for substance use than the white women ($p < 0.0001$). The incidence of cocaine use among African-American women was higher than among white women in this county (7.5% v 1.8%), but the usage of marijuana was higher for the white women (14.4% v 6.0%).

The Pinellas County study also exemplifies the interaction of class with race, as most of the white women were seen in the private clinics. A related class issue regarding child custody is that women of higher socioeconomic background who use drugs can hire caretakers for their children or send their children to lengthy day care programs. In addition, these women usually have stable housing, a vital element in maintaining custody of a child. In contrast, women who are of low socio-economic

status have often required welfare for assistance with child-rearing, making these women more visible to those in authoritarian societal roles.

In addition to race, class, and gender issues, mothers who use drugs also experience the oppressive forces associated with various stigma. First, they are known drug-users and therefore are often identified as part of a different world or culture than the mainstream of society (Statman, 1993). The stigma of such usage can bring about a variety of oppressions that are also experienced by other rejected groups, such as persons with same sex orientations. Second, women who use heroin or cocaine are engaged in illegal activities simply by using these illegal drugs as well as by how they frequently finance their usage. Such activities make them at risk for becoming involved in the legal/judicial network and the stigma and issues that are associated with legal infractions.

Definition of Terms

The following operational definitions are provided to assist the reader in understanding how some terms which often have a range of meanings in general usage are used in this study.

- *Cocaine use* or *heroin use* are self-reported behaviors by the participants. *Drug use* indicates the use of heroin and/or cocaine.
- *Chemical dependency* and *addiction* are terms conceptually similar to *substance dependence* as defined in the DSM-IV Diagnostic Criteria (American Psychiatric Association, 1994). Some of the criteria include the development of tolerance (e.g., needs more of the drug to achieve the desired effect) and withdrawal (psychological and/or physiological responses when access to the drug is inhibited), in addition to unsuccessful attempts to cut down. Chapter IV provides the self-reported drug treatment history of the participants in this study which indicates that all of them had been or were in treatment for chemical dependency.

- *Recovery* in this study indicates that the woman: a) has been abstinent or "*clean*" from drugs and alcohol; b) voices commitment to continued abstinence; and c) is participating in activities which help promote abstinence and increase coping skills, such as going through drug treatment, regularly attending 12-Step meetings, and avoiding known drug-using environments. This definition is based on recovery as a process, rather than recovery as an outcome. *Early recovery* indicates abstinence of six months or less along with the voiced commitment and behavioral actions as described above.
- *Custody* refers to one's legal rights in being the primary caretaker of a child.
- *Caretakers* are those persons who provide the day-to-day care and supervision of the child. Some women allow a relative or friend to provide the majority of care to their child but make themselves available when a signature for the child's medical care or other event for which legal authorization is needed.
- *Giving up custody* or *losing of custody* is defined as the transfer of legal caretaking of a child to another adult or legal designate such as the state.
- *Relinquishment* is defined as the permanent termination of parental rights of a particular child by a biological parent to another party, such as the state, a private agency, or other adult(s). In this study this includes women who have their parental rights involuntarily terminated, as well as those who have chosen to give up custody of a child on a permanent basis.

Purpose and Specific Aims of the Study

The purpose of this retrospective, exploratory, interpretive study was to develop a substantive theory regarding women with histories of cocaine or heroin use who lose child custody. The specific aims were:

- 1) To obtain information directly from women with histories of cocaine or heroin use who lose child custody;
- 2) To identify common concepts evidenced in these stories and other sources of data;
- 3) To suggest hypothetical relationships among the identified concepts; and
- 4) To explore the use of grounded theory methodology with this population.

Significance

While at least 25 studies or reports have focused on pregnant or parenting women with drug abuse histories, only one (Raskin, 1992) was located which specifically addresses related child custody loss issues. Raskin's pilot study was based on clinical interview and chart review data and focused on maternal bereavement regarding prior child custody loss and/or fear of such loss in the perinatal period. The 15 women in the study were all referred for substance abuse consultation from the obstetric service of a large, urban public hospital. (See Chapter II for additional discussion of this study).

The current study differs from Raskin's in a number of ways. First, the data for the current study were collected in a more natural setting, that of the women's residence or treatment site rather than in a large public institution. Second, the sample includes mothers in any stage of their lives, not just in the perinatal period. Third, the women are from a more broad based sample. That is, the women in Raskin's study were all from the obstetrical service of one large urban public hospital, while the women in the current study were recruited from several different sites. Fourth, the methodological approach of grounded theory provides the opportunity for more input regarding context surrounding the child custody loss experiences. Finally, the results of the current exploratory study go beyond the descriptive findings of Raskin, while fully validating her preliminary findings.

As Raskin's sample and other clinical data exemplify, women who have lost or given up custody of a child because of the women's drug use, frequently become pregnant again. Recurrent use of drugs during pregnancy or while providing care to a child activates many of the issues discussed in the beginning of this chapter, such as the child's risk for physical, cognitive, or behavioral problems or for abuse.

How child custody loss may influence continued drug use or motivation for recovery is not clear. Clinical data suggest that many of these women will have repeated loss of custody experiences. Yet scant information about the experiences of these women currently exists because for various reasons the women have been essentially voiceless. The results of the current study may provide insights needed by professionals to assist women with chemical dependency to decrease drug use and to promote their recovery efforts. Further, the findings of this study can help build the knowledge base for future clinical intervention studies for this population.

Background and Assumptions of the Researcher

The researcher for this study is a middle-aged, childless, white woman with no history of drug or alcohol abuse. Her interest in the study developed through her four years of clinical work as a registered nurse with a home based project for mothers who were chemically dependent. This project was located in a suburban, primarily white county in the Pacific Northwest. During that time the researcher heard many narrations by women and decided that their experiences needed to be explored in a more systematic way.

The assumptions of the study are:

1. Women with current or past histories of heroin or cocaine use are capable of sharing reliable accounts of significant events in their lives, as long as the women are

not currently under the influence of any drugs or alcohol and do not have a concurrent mental or cognitive impairment which might significantly alter the ability to remember.

2. The clinical experience of the investigator supports that permanent child custody loss related to a woman's heroin or cocaine use continues to be a long-term loss experience for the woman.

3. Long-term loss experiences can influence other aspects of a woman's life, including her identity, drug use, recovery efforts, and her relationships with significant others such as her children.

Summary

This chapter has provided an introduction to the current study about women with histories of heroin or cocaine use who lose child custody. Specifically, statistical and historical information about the wide variety of issues surrounding this problem, including issues related to gender, race, and class, was reviewed. Operational definition of terms, the purpose and specific aims of the study, and the significance of the study were also presented. Finally, the researcher briefly addressed her background and assumptions. In Chapter II more detailed background information related to relinquishment and custody loss in general, and then specifically to mothers who use drugs, will be reviewed.

CHAPTER II

REVIEW OF LITERATURE

This chapter provides background information related to relinquishment and custody loss. It is divided into four sections: (a) historical aspects of maternal relinquishment and custody loss in the United States, (b) review of recent studies on relinquishment and child custody loss (c) legal issues concerning custody by mothers who have used drugs during pregnancy or after delivery, and (d) recent studies about women with addictions. The reader may wish to note how issues of gender, race, and class are interwoven into these sections.

Historical Aspects of Relinquishment and Custody Loss in the United States

Experiences of White Single Mothers

Since 1900, relinquishment has primarily occurred among single white women, often middle-class adolescents, who have had unplanned pregnancies. Early in this century the general societal attitude toward a single woman who became pregnant was that the woman had some type of mental deficiency which had caused her to behave in such a way (Solinger, 1992, p. 149). The woman's deficiency was considered immutable, making her child both at genetic and moral risk and hence basically unadoptable. To prevent the mother from abandoning her baby, maternity homes devised various mechanisms to promote maternal infant bonding. One often cited example is the Minnesota Three Months Nursing Regulation, started in the 1930s, which forced women staying in maternity homes to breast feed their infants for at least three months. Solinger (1992) describes the effectiveness of this approach by quoting a young woman who said, "You have no idea how great the attachment is that grows up

between you and the baby in three months" (p. 150). Another strategy, used in Florence Crittenton Homes in the 1930s and 1940s was to circulate a letter called "I am the abandoned baby", which chastised any mother who would relinquish an infant (Solinger, 1992, p. 151).

After World War II, the infants of white women were in great demand by couples trying to attain the idealized nuclear family. Single mothers began to be viewed as neurotic rather than mentally deficient and their neurosis was viewed as treatable (Kunzel, 1993, p. 144). As a result, the infants of these mothers were no longer thought to be damaged and so single mothers were frequently pressured into surrendering their children to help meet the demand for white infants. Interestingly, agencies and maternity homes which before the war had promoted retention of infants by these mothers now began only to serve women who were seriously intending to give up their child after delivery. Private adoption agencies proliferated (Pelton, 1987, p. 87). Debates arose about whether a mother should see her infant or not. Length of stays after delivery were reduced to avoid promoting attachment. Yet the transition in philosophy was neither smooth nor total. A founding member of the Florence Crittenton Mission said in the late 1940s, "[An unmarried mother] must not be rushed into a decision to give up her baby for adoption until every other avenue has been explored and every other door opened" (Solinger, 1992, p. 158).

Part of the treatment process involved assisting the single mothers in coming to realize that through relinquishing the child both the woman's future life could follow the path of normalcy (that is, eventual marriage and then motherhood) as well as that of her infant's (living in a two parent household). In general, women who wanted to keep their children were considered more unstable, selfish, immature, and unfit (Meyer, Borgatta, & Fanshel, 1959; Yelloly, 1965). Court decisions often denied women seeking custody of their child, and adoption abuse often thwarted the woman who wanted to

rescind her decision to terminate custody. For example, some women were told that their children had died, when in reality the children had been quickly placed out of state (Solinger, 1992, p 165).

The experience of these mothers often went unnoticed because they stayed in maternity homes, changed jobs, or relocated out of town, keeping their pregnancy and subsequent relinquishment a secret. As one mother shared:

I became pregnant out of wedlock and gave up my baby girl for adoption... I moved to a small apartment a short distance from the hospital, where I continued to work as a staff nurse until my pregnant state threatened to be obvious. Then I did private duty nursing. (Anonymous, 1974)

Even among family and friends who were aware of the pregnancy, the women often felt they had to refrain from discussing their experience. For example, Devaney and Lavery (1980) share this story of a 20-year unmarried woman.

The denial in the home was so great that just two months prior to delivery, during her three-day visit home, no one mentioned Linda's bulging abdomen. When she returned home for a week-long postpartum recovery, [she] pretended to have a sprained ankle and said she needed to have a rest from college life....Her family, aware that she had given birth, took care of her as if she actually had a sprained ankle. The birth was never mentioned. (1980, p. 376)

These cases imply that white women who relinquished children made such a decision on their own. In reality, however, until the 1970s many women were forced into this decision through family pressure and societal custom. The cases also indicate that historically women who relinquish children start to plan for this transition during pregnancy. As a result, the vast majority of children who have been relinquished have been infants. Nursing literature provides some of the few available articles about assisting women in the perinatal period to decide and prepare for their relinquishment (Devaney & Lavery, 1980; Harvey, 1977; Tennyson, 1988).

Experiences of Black Single Mothers

As for black single mothers, nineteenth century societal attitudes carried over well into the twentieth century; these women were considered to be hyper-sexed but nevertheless providers of good child care. Media images of mammies and black matriarchs reinforced these attitudes (Collins, 1991a) and hence some professionals believed that societal support would neither be helpful for the presumed biological sex tendencies nor needed for their child rearing practices.

Agreement exists between black and white historians that generally relinquishment was infrequent among black single women (Ladner, 1971). Bachrach, Stolley, and London have estimated that less than two percent of black single mothers relinquished their children in the years before 1973 (1992, p. 29). "I'd grieve myself to death if I let my baby go" seems to be a representative statement of many black single women (Solinger, 1992, p. 201). The use of othermothers, described by Collins (1991b) below, has historically provided an alternative to full custody loss.

In African-American communities, fluid and changing boundaries often distinguish biological mothers from other women who care for children. Biological mothers, or bloodmothers, are expected to care for their children. But African and African-American communities have also recognized that vesting one person with full responsibility for mothering a child may not be wise or possible. As a result, othermothers [sic]—women who assist bloodmothers by sharing mothering responsibilities—traditionally have been central to the institution of Black motherhood. (p. 119)

By the 1960s, a more punitive approach toward black single women developed, based on concerns that many of these women received welfare benefits. Laws were enacted to remove their children or their welfare benefits. Little did most of society realize that the majority of children receiving Aid for Dependent Children were white. "Of unwed white mothers who kept their children, 30 percent, or nearly twice as large a percentage as blacks, were receiving Aid to Dependent Children grants in 1959" (Solinger, 1992, p. 193).

Ladner's pivotal sociological work about black adolescents (1971) articulated the question of whether many black female adolescents in the 1960s learned to equate womanhood with motherhood. African-American/ Women's Studies professor James has likewise addressed the issue of the meaning of maternal identity to African American women's identity (James, 1993). She notes that historically reproduction has been highly valued in African communities and that mothering "incorporates the symbolism of creativity and continuity, and as such forms an integral aspect of women's identity" (p. 45). Similar findings are described by both white and black women in Women's Ways of Knowing (Belenky, Clinchy, Goldberger, & Tarule, 1986). "Many women... experience giving birth to their children as a major turning point in their lives...In response to our question, 'What was the most important learning experience you have ever had?' many mothers selected childbirth. It is as if this act of creation ushers in a whole new view of one's creative capacities" (p. 35).

Relinquishment Among Other Ethnic Groups of Women in the U.S.

Relinquishment by American women of Hispanic or Asian background is almost non-existent (Collins, 1991b; James, 1993; Solinger, 1992). When a mother from one of these ethnic groups could not care for her child, family and community members stepped in to assist. This was also the tradition for Native-Americans until the late 1800s, when large numbers of children began to be placed outside of tribal communities. In 1978, the Indian Child Welfare Act was passed to severely restrict such out of tribe placement (Cross, 1986; Horejsi, Runner, & Pablo, 1991; Potter, 1980).

Recent Historic Trends Effecting Relinquishment and Custody Loss

The 1960s brought consumer access to birth control, and the 1970s saw abortion becoming legally available following the Roe v. Wade (1973) decision. Women's sexuality is no longer as intricately tied with pregnancy / motherhood as it has historically been. Attitudes regarding women's sexuality have broadened and the issue of illegitimate children has changed remarkably. As a result, the number of children relinquished by white women has decreased markedly, approximating the low rate among black women.

Another trend involves the number of adoptions that are now being handled by public agencies versus private and independent agencies. In 1951, 18% of adoptions were handled by public agencies such as the Department of Social and Health Services in Washington state. From 1971 to 1982, Pelton (1987) estimated public agency adoptions to be 38% (p. 89-90). Many of these children have special needs or are older. In addition, many children remain in foster care status for a variety of reasons. Currently about half of all foster parents are relatives of a foster child's parents and as stated in Chapter I, the majority of young children in foster care in some states have at least one parent who was abusing drug or alcohol (United States General Accounting Office, 1994).

In the 1990s the vast majority of children adopted in the United States are those who are adopted by a step-parent. Pelton (1987) estimates that another 10-20% of U.S. adoptions are children who are foreign born (p. 91). Figures regarding the percentage of adopted children whose mothers used drugs or alcohol during pregnancy are not available. However, a high demand for adoptable white infants continues to exist.

Another trend involves the style of adoptions. Through the 1970s closed adoptions were widely prevalent. Such adoptions offered no contact among the

adoption triangle, that is, the birthparent, child, and adoptive parents (Sorosky, Baran, & Pannor, 1978). An excerpt from a 1969 pamphlet by the County of Los Angeles Department of Adoptions entitled "What is best for you and your child?" illustrates the philosophy of closed adoptions:

No Need For Worry

When the decision is made and the Adoption Agency has accepted your child for placement in his new home, your part will be finished and no one will again communicate with you about this adoption. Even if a problem should arise, you would not be involved. Your identity will never be revealed to the adopting family.

Yet research consistently shows that birthmothers do worry (Condon, 1986; Sorosky et al., 1978). Hence, various styles of open adoptions have gained increasing popularity. Depending on the agreement among the birthparent, agency, and adoptive parents, the birthparent may have occasional visits with the child, have phone or written contact, be sent pictures and information about the child at designated times, or minimally, help select the adoptive family (Berry, 1991).

Trends of Custody Loss Concerning Women with Histories of Drug Use

Statistics indicate that 4-18% of all children born in the United States are exposed to drugs or alcohol during their gestation (Cook, Petersen, & Moore, 1990), yet the number of children of mothers who use drugs or alcohol in pregnancy and are relinquished is unknown. The age of a child lost to custody of a woman with a history of drug use can vary from a newborn to an adolescent, which is quite different from the historical pattern of custody loss at the child's birth. Similarly, the age of the mother can vary from adolescence to the late childbearing years, which is also different from the historical pattern of adolescents or young adult women being the primary ones to relinquish. Because addiction affects women of all ethnic backgrounds, the researcher speculates that women from ethnic groups which have not historically used

relinquishment are being involved in this societal practice now more than in the past.

For example, in an attempt to determine the custody status of 99 consecutive infants who tested positive for cocaine following delivery in a public hospital of a large metropolitan city, a retrospective cohort design was done (Neuspiel, Zingman, Templeton, DiStabile, & Drucker, 1993). Ethnic background of the mothers was 49% black, 40% Hispanic, and 11% other or unknown. Parity, the sex of the child, and the child's birthweight were controlled. Thirty-eight percent of the infants were discharged home with their mothers, 25% were placed in relative care, and 36% were placed in public foster care. Factors which negatively affected the child going home with the mother included any prior history of the mother with child protective services, black ethnicity, and the mother not having her own residence. This study also illustrates how many women with histories of drug use have their parental rights terminated in a more involuntary manner than the traditional relinquishment process described in previous sections. Elaboration of this involuntary process and contributing factors are presented below.

Women Who Have Relinquished a Child or Lost Child Custody

Women With Histories of Substance Abuse

Of the studies identified in the literature which focus on mothers who have relinquished a child or lost child custody, only one was found which specifically addressed women with histories of substance abuse. Raskin's descriptive study, "Maternal bereavement in the perinatal substance abuser" (1992) identified both the fear of loss of custody in pregnant or newly delivered women with histories of substance use and the unresolved grief of the multiparous women who had temporarily or permanently lost custody of previous children. Using a pilot convenience sample,

Raskin interviewed ten pregnant and five newly delivered women referred for substance abuse consultation from the obstetric service of a large city's public hospital. Issues related to maternal bereavement were addressed as part of the overall psychiatric referral. Clinical records were also reviewed. All of the women were of low socioeconomic status. Fourteen of the 15 mothers expressed worry that their child would be removed from their custody. Six of the mothers had already lost permanent custody of a child and six others had lost custody for interim periods. Raskin noted that

All 15 patients had clinical symptoms of grief related to past or anticipated custody loss. These included preoccupation with the lost child(ren), sadness, rumination, and yearning for reunion....Several carried photographs of their child(ren) prior to custody loss. Ongoing fantasies about the child's activities and development and fantasies about parenting the lost child were described. Several reported anniversary reactions including private observation of the child's birthday. (p. 150)

In her discussion, Raskin notes that mothers with histories of substance abuse and child custody loss also frequently have histories of rapid subsequent pregnancy which could indicate the mother's attempt to replace the lost child.

Single Mothers Who Relinquish

Other recent studies about women who relinquish or lose custody of a child tend to focus on the mother who relinquished a child shortly after the birth of the child. None of these studies indicate any maternal drug use and the reader assumes that such drug use was not influential in the relinquishment process. The vast majority of these mothers were single and often were adolescents at the time of relinquishment.

Cushman and her colleagues (Cushman, Kalmuss, & Namerow, 1993) conducted a longitudinal prospective study of 215 unmarried women under the age of 21 years ($M = 17.9$) who placed their infant for adoption. The women were recruited from 23 maternity residences and seven adoption agencies in 13 states. The study was

designed to systematically document the impact of the services the women received from before delivery to six months after the birth of their children. Both quantitative and descriptive data were collected. Ninety-three percent of the mothers were white and seven percent were black; women from other ethnic backgrounds were excluded from the study because anticipated numbers of other ethnic backgrounds were not expected to provide adequate power for statistical analysis. Trained interviewers conducted in-person and telephone interviews. Findings indicated that the vast majority of the women did not feel pressured into deciding about placing their child for adoption. Open adoptions were common and included the mother helping to select the adoptive parents, being introduced to prospective adoptive parents, receiving pictures or letters regarding the children from the adoptive parents, and contacting the adoptive parents through agencies. Women who had their children placed immediately with the adoptive family experienced lower levels of grief than mothers of children who were placed in interim settings. Women who wanted to see or hold their baby prior to relinquishment had this opportunity. Many women shared that the actual signing of parental termination papers was more difficult than other anticipated difficult moments such as the last months of pregnancy or the first days after delivery.

In an even larger prospective longitudinal study from Australia, 7,691 women were interviewed in their first obstetrical visit and followed until one month after delivery (Najman, Morrison, Keeping, Andersen, & Williams, 1990). Of the women who gave birth, 64 (0.83%) relinquished their child for adoption, 61 of them immediately after delivery. Mothers who relinquished their children tended to be single adolescents from the lowest socioeconomic group who were not living with a partner and had an unplanned pregnancy. The authors noted, "There is little evidence that

mothers relinquishing a baby are mentally or emotionally disturbed around the time the baby is relinquished" (p. 188).

Lauderdale (Lauderdale, 1992; Lauderdale & Boyle, 1994) studied self-selected women who had relinquished a child shortly after the child's birth. Using a retrospective ethnographic design, Lauderdale conducted two to three interviews each with twelve women who had placed a child with non-relatives. The ages of the participants at the time of the interviews were 18 to 53 ($M = 35.5$). Four of the women had recently relinquished their child, and the other eight mothers had done so 5 to 16 years before the interviews. All mothers were 23 years or younger at the time of relinquishment except for one, who was 30 years. One mother relinquished two children, and the other 11 relinquished one. Ten of the infants were first-born children for the mothers. Eight women had subsequent children after relinquishing a previous child. Lauderdale identified four sequential major themes: a) reaction to the pregnancy; b) deciding to relinquish; c) the delivery of the baby; and d) living with the relinquishment. Two general portraits of relinquishing birthmothers were deduced from the data, that of the Grateful Giver and the Reluctant Giver. Women who were Grateful Givers tended to develop more attachment to the baby during pregnancy, had more control in the decision to place the infant, were active participants in the adoptive proceedings, and had more acceptance of the loss than women who were Reluctant Givers. All of the women shared themes of shame, some detachment from the fetus, a moral basis for their decision to place the infant, a marginal state in society during and after the pregnancy, and feelings of loss and grief.

Since the 1970s, clinicians and researchers have reported that many women who relinquish a child experience much grief from this loss and have not had adequate opportunities to express this grief (Condon, 1986; Deykin, Campbell, & Patti, 1984; Harvey, 1977; Lauderdale & Boyle, 1994; Millen & Roll, 1985; Morrin, 1983; Pannor,

Baran, & Sorosky, 1979; Raskin, 1992; Rynearson, 1982; Silverman, 1981). Primary sources for samples in these studies were often birth parent organizations (Condon, 1986; Deykin, Campbell, & Patti, 1984; Lauderdale, 1992) and psychiatric departments (Millen & Roll, 1985; Raskin, 1992; Rynearson, 1982). Most of the samples were convenience samples with inherent sample bias. Sample recruitment problems tended to result in smaller sample sizes, often without enough power to adequately conduct quantitative analyses, limiting the generalizability of their findings to more diverse populations (Bachrach, Stolley, & London, 1992). Condon (1986) noted that "It is extremely difficult to recruit a truly representative sample of relinquishing mothers" (p. 118). Perhaps this is because mothers who have adjusted to the relinquishment experience or those who wish to remain hidden do not come forward to participate in studies.

How authors operationally defined relinquishment determined who was included in a sample. Several studies provided a definition (e.g., Lauderdale, 1992) but others implied relinquishment to be the voluntary termination of a mother's parental rights regarding a specific child. Yet in the 1940s to early 1970s parental and societal influence for unmarried pregnant women to relinquish their child was quite strong (Pelton, 1987, p. 100-102). Hence, decision-making was limited among these young women who formed the majority of the samples in the reviewed studies. Limited decision making may also be true for many women who are addicted to street drugs or for women involved in contested marriage dissolution cases, as other persons such as relatives or state officials may pursue termination of the mother's rights.

Many studies about relinquishment and custody loss have been descriptive. (For example, Devaney & Lavery, 1980; Herrerias, 1985; Lauderdale, 1992; Millen & Roll, 1985; Minkler & Roe, 1993; Raskin, 1992; Rynearson, 1982; Tennyson, 1988). Bachrach, Stolley and London (1992) noted that "the perfect research design for

studies of relinquishment is likely to remain out of reach...<numerous design> problems underscore the importance of integrating research findings from a wide range of imperfect studies, and of piecing together the results of studies with different approaches and different limitations" (p. 32).

Mothers Who Have Lost Child Custody Through Divorce

Although the majority of studies about mothers who experience child custody loss are about mothers who have relinquished a newborn, studies about mothers who have lost child custody through divorce proceedings provide additional insight into mothers with histories of drug use who have lost child custody. One similarity between these two groups is that the age of the child is usually beyond the newborn period when the custody loss occurs. Related to this is that mothers involved in divorce or substance use child custody losses are usually older than mothers who have traditionally relinquished an infant.

Herrerias (1995) interviewed 102 noncustodial mothers aged 22 to 49 years (mean was 35.7) in the mid-1980s. In addition, these and 28 other noncustodial mothers completed clinical scales on self concept, self-esteem, nonpsychotic depression, and parental attitude. All mothers also completed a 137-item life history questionnaire. This convenience sample was recruited in the Southwestern United States, and most of the women were white and had some college education. Eighty-six percent of the mothers cited multiple factors (average 3.3) for voluntarily giving up custody of their child. The primary factors (\geq to 40% of all respondents) were emotional problems, financial issues, threats of legal custody fights, and a destructive relationship with the former spouse. Ninety-five percent of the children were living with their fathers following maternal custody loss. As Herrerias notes:

The decision to relinquish custody of one's children is a difficult, painful act often complicated by a series of uncontrollable events. Clearly, custody relinquishment was not something that had been planned over a long period of time....By definition, the respondents are all voluntary relinquishers, however, the compelling nature of the majority of the factors identified as influencing relinquishment question the true voluntariness of this decision. (pp. 243-244)

Almost all of the women (97%) continued to have active relationships with their children. One-quarter of the mothers visited their children weekly and another quarter saw their children on a monthly basis. Slightly more than a third had quarterly visits and almost eight percent had annual visits.

Grief and Pabst (1988) also conducted their survey of 517 noncustodial mothers in the mid-1980s. Of these mothers, over 100 were interviewed by phone or in person. Women were recruited nationally through self-help groups such as Parents Without Partners or Mothers Without Custody. Most were white and college educated. The major groupings of mothers' reasons for being noncustodial were related to money (33.8%), the mother's inability to parent (32.2%), the children selecting the father as their custodial parent (23.5%), the best interests of the child (23.1%), and the decision of the courts (11.9%).

Chesler (1986) interviewed over 300 mothers, fathers, children and custody experts in an eight year span. She notes in her preface

As a society, we tend to view "custody" as a contest between a "winner" and a "loser", not as a series of questions about the conditions under which women mother, men father, and children grow up and about who determines these conditions. (p. xxvii)

Throughout her book Chesler develops her concerns about the gender issues in the United States which influence child custody decisions related to divorce proceedings. For example, she cites numerous cases in which a father is given child custody because of economic advantage or despite a reported history of emotional or physical abuse to the mothers or the children.

Legal Issues Concerning Custody By Mothers Who Have Used Drugs During Pregnancy Or After Delivery

A tension about how much volitional control a person who is chemically dependent has about their drug usage is reflected in various court decisions . In 1914, the Harrison Narcotics Act stated that alcoholism and opiate usage represented a disease. This was upheld in 1962 in Robinson v. California. Professional organizations such as the American Medical Association and the American Nurses Association have likewise stated chemical dependency is a disease. Yet despite this many persons still believe that chemical dependency is really a matter of volition, that if a person is motivated to be drug free that person can indeed refrain from using drugs or alcohol. Likewise, if the person chooses to use illegal substances the person is committing a criminal activity because the act is considered volitional.

Prenatal Drug Use

Current societal interest related to the medical issues regarding prenatal drug use places the fetus, not the mother, as the primary focus. However, in the legal realm a conflict often occurs between the legal rights of a woman and the legal rights of the fetus exposed prenatally to drugs.

Regarding the fetus, Roe v. Wade (1973) has supported that a fetus is not a person and therefore has no constitutional rights. However, this landmark case has also said that once a fetus reaches the stage of viability (about six months) the state develops a compelling interest to protect the child:

The State does have an important and legitimate interest in preserving and protecting the health of the pregnant woman...and that it has still another important and legitimate interest in protecting the potentiality of human life. These interests are separate and distinct. Each grows substantially as the woman approaches term and, at a point during pregnancy, each becomes "compelling." (Section 22, 28)

One of the early cases involving a woman who was chemically dependent being charged for prenatal abuse was Reyes v. Superior Court (California, 1977). In this case a woman's twin sons experienced neonatal abstinence syndrome because of the mother's use of heroin during pregnancy, even though she had been warned about such effects during her pregnancy. However, since the fetuses were not considered to be persons no sanctions were imposed. This case is in contrast to the Charleston, South Carolina, Interagency Policy described in Chapter I, in which 42 women had been arrested because they did not follow up on recommended treatment for their chemical dependency after they had a positive urine for cocaine (Jos, Marshall, & Perlmutter, 1995).

Yet the National Association for Perinatal Addiction Research and Education (NAPARE) notes in its annual legislative update (Marshall, 1993) that the trend in new legislation continues to be toward treatment/prevention rather than punishment. This approach is evident in the case of Michigan v. Bremer (1991), in which a 33 year old attorney admitted to her obstetrician that she used cocaine and was reported to authorities for monitoring. When her infant daughter tested positive for cocaine at birth the woman was charged with drug delivery to a minor via the umbilical cord during the time when the baby was out of the mother's body but the umbilical cord was still attached. The prosecuting judge ruled, however, that

The prosecution of these women is likely to have the opposite effect. Women addicted to cocaine may very well turn away from seeking prenatal care for fear of being discovered. Women who do seek prenatal care may be less than candid with their physician about their addiction for fear of being prosecuted. The state's interest would be better served by making treatment programs available to pregnant addicts, not driving them away from treatment by criminal sanctions. (Fiesta, 1991, p. 15)

In a similar well-publicized case, Florida v. Johnson (1989), a woman was initially sentenced to one year of community control and fourteen years of probation for delivery of drugs to her infant via the umbilical cord. But this conviction was

overturned by the Florida State Supreme Court in July 1992 by unanimous decision. The American Nurses' Association (1991) has also taken a stand against criminal prosecution for women who have used drugs during pregnancy.

In the Matter of Stefanel Tyeshia C. (1990) a mother was referred to court for child neglect when her daughter tested positive for cocaine at birth. The initial court dismissed the charges for failure to state a cause of action for neglect because the infant's condition at birth was non-problematic. But the New York State Supreme Court Appellate reversed this opinion, stating that prenatal street drug usage suggests later drug usage and probable cause of action for child neglect. Here we may be seeing a trend to prosecute parents for future effects their drug usage may have on a child.

Postnatal Drug Use

Child abuse and child neglect are two primary reasons for maternal child custody loss when marital dissolution is not involved. Many mothers who use drugs neglect their child while under the influence of the drugs or while securing drugs. Less frequently, some mothers physically abuse their children. In addition, the children are at increased risk for emotional, physical, or sexual abuse when the mother has an abusive partner.

States vary as to the laws and public agency that oversee the welfare of children. In most states the public agency is called Children's Protective Services (CPS). When a child is referred to a CPS agency, an investigation does not always ensue. However, in cases where abuse or neglect is strongly suspected or identified, the CPS worker must file for dependency action through a court order to remove the child temporarily from the parent's custody. About half of all children placed in foster care are now being placed in relative or kinship care. While the initial goal of a dependency action is the protection of the child, the ultimate goal of dependency

actions according to the Adoption Assistance and Child Welfare Act of 1980 is to reunite the child with his or her parent. Hence, a plan must be presented to the court concerning how reunification with the parent will be promoted. To better ensure consistent and fair approaches for parents while providing protection for the child, written protocols and shared decision-making are being encouraged. Nevertheless, the practices of states and local agencies vary widely. Further, if the mother has not complied with the court plan after a specified period of time, the court terminates the mother's parental rights. A placement plan is then formulated for the child, with the goal being that the child will be adopted as soon as possible by a relative or other interested family.

Women With Histories of Drug Use

Recent literature about women with substance use histories has focused on gender-specific treatment issues and lifestyle needs of women. In addition, the literature is beginning to include women with addictions other than to alcohol (Lex, 1994) and these studies in turn are beginning to focus on aspects beyond fetal outcome in pregnancy.

Hagan, Finnegan and Nelson-Zlupko (1994) identified three factors regularly overlooked in treatment and research related to women with addictions: 1) broader issues of dependency in women; 2) the impact of chaotic early interpersonal relationships on developmental levels; and 3) diagnostic criteria and treatment goals appropriate for women. The authors note, for example, the problems of housing, employable skills, and childrearing that are different for many women in treatment than for men. The authors conclude that "women need specialized services, whether alone or as parenting women, and that traditional male-oriented treatment approaches may not result in successful recovery for women" (p. 170).

Wallace (1994) argued that women today have experienced a varied trauma base in their lives, and that such trauma must be addressed if relapses are to be prevented and treatment become successful (p. 72-72). Wallace identifies:

1) the trauma sustained in childhood when growing up within a dysfunctional family; 2) the typical trauma of experiencing some form of abuse in adolescent and adult relationships; and 3) the trauma of violence in the streets and drug culture. (p. 72)

Other authors support this history of trauma, citing histories of physical abuse, sexual abuse, or parental substance use as being frequently seen in the histories of women with cocaine or heroin addiction (Bollerud, 1990; Boyd, 1993; Davis, 1994; Rohsenow, Corbett, & Devine, 1988).

Women with histories of drug use frequently have criminal histories related to their drug use or procurement (Ruhle, 1992). In one study of 439 persons using methadone (Mathis, Navaline, Metzger, & Platt, 1994, p. 340) 73- 81% of women had been arrested at least once. In another study 63.8% of women in jail who had children had used cocaine in the month before being incarcerated and 58.4% of them had used heroin (Kemper & Rivara, 1993). The special needs of women in prison, including their histories of substance usage, are only beginning to be addressed (Berkowitz, Brindis, Clayson, & Peterson, 1996).

Rosenbaum (Rosenbaum, 1979; Rosenbaum, 1981) conducted one of the earliest qualitative studies about women with drug addictions, providing much needed psychosocial data about this group. Her sample consisted of 100 women who were active heroin users; 70 of these women were mothers. Regarding all of the women in the study, 43% were white, 38% were black, and 14% were Latinas. Median age was 28. Grounded theory guided data collection and analysis.

For all of the women, Rosenbaum identified funneling or narrowing of options as the basic overarching process. That is, as women's lives became more centered

around heroin, fewer non-drug related options were available to them. Rosenbaum noted that many of these women did not have many options prior to their drug use, as they often came from poverty backgrounds and frequently faced racial and gender inequalities. Motherhood for many of the women was "one of the only viable roles" (Rosenbaum, 1979, p. 441). For the sample of mothers, difficulties in taking care of business was the core finding. That is, not only did mothers have to take care of business in regard to finding and administering heroin, but they also had to provide care to their children. Conflict between these two activities often developed. When the women's options narrowed even more because they were unable to provide safe child care secondary to their addiction, loss of child custody often followed. This loss in turn resulted in increased drug use.

Kearney and her colleagues, Murphy and Rosenbaum, have reported several grounded theory studies. One, entitled "Mothering on crack", was part of a larger study and based on single semi-structured interviews with 68 mothers who were heavy active cocaine users (Kearney, Murphy, & Rosenbaum, 1994). Seventy-two percent of the women were African-American, 21% were white, and 6% were Latina. The mothers had an average of 2.5 children each (range 1-7). Their average age was 34 years (range 20-58). Forty-four percent had not completed high school, while 19% had several years of college. The primary basic psychosocial process identified for this sample was defensive compensation, in which the mothers tried to maintain their dual identity as a mother and a crack user. Four strategies that the mothers used to accomplish defensive compensation were identified. First, mothers tried to separate their drug use from their children. This often meant waiting until the children were asleep or not at home. Second, the mothers at times tried budgeting, that is, separating the money for household expenses from money used to buy drugs. Third, mothers would isolate, either from areas which had easier drug availability, or from others who

might frown on the mother's drug use. Finally, the last resort was to give up the children, usually to relatives. Sixty-nine percent of these mothers reported losing temporary or permanent child custody. The authors noted that "the basic problem crack cocaine presented to mothers was its drain on their attentiveness, their financial resources, and their efforts to be appropriate role models for children" (Kearney et al., 1994, p. 354).

Demographic data from a five-year study in progress about African-American women who continue to use crack cocaine or are in treatment is indicating high rates of familial substance abuse (Boyd & Guthrie, 1996). Of 156 women, 65% of the women said that one or both of their parents had a problem with drugs or alcohol. Sixty percent of the 96 women with one or more siblings had a sibling with a drug or alcohol problem. Of the 95 women responding to the question on substance abuse in spouses/ male partners, 59% indicated that the men had substance abuse problems. The authors indicate that these data and those of others are raising the question of how the drug use by their significant others influences the women's drug use. "Women-socialized to maintain relationships and 'caretake' within a tight social network--may come to their drug use as a way to 'connect' with drug using siblings, parents, or lovers" (p. 164).

Other reasons about how and why some persons become addicted have been proposed. Biological factors such as genetic predisposition have been found in women with alcoholism (Hill, 1995); genetic studies regarding persons with drug addictions and the risk of cross-addictions are ongoing (Secretary of Health and Human Services, 1993). Gender hormonal differences have recently been identified in persons who use cocaine (Bowersox, 1996). Social factors, such as the one described by Boyd and Guthrie above (1996) and intergenerational theories of substance abuse (Sheridan, 1995), are beginning to gain more attention. Finally, psychological factors such as

addiction as a form of self-medication (Hutchinson, 1986a; Khantzian, 1985) and as a means of handling loss-grief (Beechem, Prewitt, & Scholar, 1996) have gained much support.

The complex interrelationships among biological, social, and psychological factors have led many practitioners to support a biopsychosocial causation for the development of substance abusing problems. The strength of various factors change from person to person and perhaps over time in any one individual's life.

Summary

This chapter has provided background information to help the reader better understand historical and current issues for mothers with histories of cocaine or heroin use who lose child custody. Specifically, historical aspects and studies of relinquishment and custody loss in the United States were reviewed. In addition, recent legal decisions and studies about mothers with addictions were presented. From this review the reader can see that studies which specifically address the sample in the current study have not occurred. Raskin's study (1993) of mothers with chemical dependency identified the importance of the custody loss component as a finding, not as a criteria for sample inclusion. The study by Neuspiel and colleagues (1993) focused on the custody status of the infant who tested positive for cocaine at birth and associated maternal and infant demographic factors; direct input from the mother was not collected. Studies of mothers who lost child custody through divorce and studies of mothers who relinquished a child at birth indicate that demographic characteristics of these women can be quite different from mothers who have lost child custody related to the mother's drug use.

In the next chapter, the methodological principles underlying the current study will be discussed.

CHAPTER III

METHODOLOGY

This study of women who have lost custody of a child because of the woman's heroin or cocaine use is based on an exploratory, interpretive design, with grounded theory and an overarching feminist perspective providing the methodological guidelines. Following a general description of these methodologies the researcher reviews the sample, procedure, and analysis specific to the study.

Research Design

Grounded Theory

In brief, grounded theory is a unique interpretative approach, the goal of which is to inductively develop a conceptual theory which becomes evident from the patterns and/or relationships identified in a particular data set; that is, the theory is grounded in the specific data. Because of this, grounded theory and other interpretive methods imply that multiple realities exist and that knowledge is relative to specific circumstances as different participants provide different interpretations. A number of nurse researchers have noted that grounded theory methods are often confused with other qualitative approaches (Baker, Wuest, & Stern, 1992; Becker, 1993; Benoliel, 1996; Lowenberg, 1993).

Benoliel (1996) has recently reviewed the array of nursing studies that have used a grounded theory approach and noted that grounded theory has often been used to formulate pragmatic substantive theories about vulnerable groups, especially when few, if any, studies have been conducted on the particular group. In the field of chemical dependency qualitative methods, including that of grounded theory, are now recognized as important approaches in studying the numerous population groups,

many of them hidden or marginalized, who abuse drugs or alcohol. For example, a recent monograph by the National Institute on Drug Abuse (Lambert, Ashery, & Needle, 1995) summarizes how qualitative methods have been used in drug abuse and HIV research. As in nursing, one major value of qualitative studies in chemical dependency is in collecting preliminary empirical information about groups who have not been amply addressed in prior studies. When qualitative studies provide this background, future research studies—many of them quantitative or a combination of qualitative and quantitative—can focus more clearly on the specific group.

Grounded theory was specifically chosen for this study over other interpretive qualitative methods such as ethnography or phenomenology for a number of reasons. First, grounded theory allows for concepts to be directly drawn from the data set, including a core variable that represents a chief concern or problem of the sample, rather than have these concepts be preconceived. Second, grounded theory recognizes different social contexts and processes over time. Third, the researcher can generate hypotheses about the concepts and develop a substantive theory which integrates these hypotheses to account for much of the variation of behavior in this group about whom we have so little empirical information. In their early work, however, Glaser and Strauss (1967) stress that the generated theory continues to unfold even after it has been reported.

Our strategy of comparative analysis for generating theory puts a high emphasis on theory as process; that is, theory as an ever-developing entity, not as a perfected product. To be sure, theory as process can be presented in publications as a momentary product, but it is written with the assumption that it is still developing. Theory as process, we believe, renders quite well the reality of social interaction and its structural context. (p. 32)

Grounded theory has its roots in symbolic interactionism. Symbolic interactionism, developed by Herbert Blumer (1969) and based on the works of John Dewey (1922) and George Herbert Mead (1934), states that our social worlds are

constructed by our social interactions. The meanings that we give to and get from our interactions help form our self-identity. Mead, a representative of the Chicago School of symbolic interactionism, stated that the use of language and our mental capacities allow us to respond to situations differently and that the self is constantly changing. "These socially derived meanings are continually being revised in social interactions. The sociological symbolic interactionist perspective, therefore, conceives of reality as dynamic rather than static. It focuses on processes that exist within the individual or groups of individuals rather than on social structure" (Baker et al., 1992, p. 1357). Or as the qualitative nurse-researcher Hutchinson succinctly put it, "reality is a social construct" (1986 b, p. 113).

Grounded theory was first explicated by Glaser and Strauss (1967), both sociologists, following their lengthy qualitative study of dying patients. While various trajectories have since occurred in the evolution of grounded theory (for example, Lincoln and Guba, 1985; Schatzman, 1991; Strauss and Corbin, 1990), it is the approach used by Glaser that has been primarily followed in this study (Glaser and Strauss, 1967; Glaser, 1978, 1992). That is, the study has used multiple sources of data, theoretical sampling, constant comparative analysis, theoretical coding, memoing leading to theory emergence, and theoretical sorting leading to integration and write-up.

Multiple sources or "slices" of data are used in grounded theory studies. Such slices range from interviews and participant observations to exploration of various available media such as television, newspaper, and magazine clips. This encompassing view of data also permits the researcher to read and consider theories developed by others that may shed light on the developing theory. However, grounded theory according to Glaser prevents the researcher from entering the research process with any preconceived ideas for exploration or verification.

Grounded theory is based on theoretical sampling and involves the use of samples from various groups or other data sources that can help contribute towards the developing theory. Unlike selective sampling promoted by Schatzman (Schatzman & Strauss, 1973; Strauss, 1987; Strauss & Corbin, 1990) in which all informant groups are identified prior to any data collection, theoretical samples are identified only as the study progresses and the need for certain input is identified. In theoretical sampling the researcher decides what group to sample next, based on theoretical criteria and recognizing that an infinite number of comparisons exists. As Glaser and Strauss describe in their early work (1967), "group comparisons are conceptual; they are made by comparing diverse or similar evidence indicating the same conceptual categories and properties, not by comparing the evidence for its own sake" (p. 49). However, identifying key informant groups is often used in the beginning of grounded theory studies.

The type of analysis as used by Glaser is the constant comparative method. This is a circular analytical process which begins shortly after interviewing has begun and continues throughout data collection and report write-up. The process starts with open coding, in which incidents in each interview are coded into as many conceptual descriptors as possible. The identified codes are then compared to additional incidents and other concepts; new codes are added as necessary. Memos are frequently written by the researcher to help develop and sort out theoretical concepts, their properties, and relationships. As patterns and re-occurrence of concepts occur the researcher can combine some of these into more abstract or overarching categories.

Ultimately the researcher looks for a core category, that is, a major variable which seems to capture much of the variance found in the data. When contextual features are noted to influence the core variable, a basic social psychological process (BSP) which transcends time and conditions can be identified. Ideas for the core

variable and BSP may change as more interviews are analyzed, theoretical drafts are explored in memos and with previous or new participants, and as previous data slices and relevant literature are reviewed. The researcher may stop coding data and categories which are not fitting into the developing theory (selective coding) or which represent categories that are already saturated, that is, categories with well-defined properties (theoretical saturation). The theoretical modification and refinement process continues until all pertinent categories and their properties are saturated and hypotheses about associated theoretical constructs seem to account for the diversity of the data. This final result is called theoretical completeness and differs from other types of completeness, such as comparative completeness (since more comparative units will always be available) or descriptive completeness (which has limited duration; Glaser, 1978, p. 125). Premature closure of a theory is prevented through allowing adequate time for data collection, analysis, and theory development and through discussion of the developing theory with participants.

As in other qualitative studies, replicability of grounded theory studies is unlikely. The chance that any two researchers will identify the same basic social process and core categories is small (Hutchinson, 1986 b, p. 116; Sandelowski, 1993). Furthermore, according to symbolic interactionism the participants themselves are continually changing.

Glaser and Strauss (1967; Glaser, 1978, 1992) identified four criteria by which to evaluate a well constructed grounded theory. First, a grounded theory must readily *fit* the data and related realities from which it is drawn. This criteria prevents the researcher from starting with preconceived categories and possibly forcing data into them. Second, the theory must *work*, that is, explain what happened and predict what will happen. "It will explain the major variations in behavior in the area with respect to the processing of the main concerns of the subjects" (Glaser, 1992, p. 15). Third, "it

must be *relevant* to the action of the area" (Glaser, 1978, p. 4), that is, to the identified basic social psychological process. And finally, the theory must be *modifiable* to allow for new data and insights. In addition, Glaser notes that parsimony and scope of the emergent theory provide additional criteria for determining "good scientific inducted theory" (1992, p. 18).

Feminist Methodology

Since a goal of feminist methodology is to promote action or emancipation for the group of women addressed, it is hoped that the findings from this study will in some way improve services for the population addressed. In her review of grounded theory studies in the nursing literature, Benoliel (1996) noted that while the majority of the studies provided practical knowledge about the specific groups addressed, some studies had "an emancipatory focus in that they point to interactional and environmental constraints" (pp. 417-418). The inclusion of contextual influence is important to both feminist and grounded theory perspectives (Campbell & Bunting, 1991; Glaser, 1992; Wuest, 1995) and seems to be one important distinguisher between practical and emancipatory theories. Therefore, pertinent contextualization of the data slices was a major goal in the analytic process of this study.

Other features in the current study which represent feminist research perspectives are described below. Nurse-researchers such as Kearney (1993), Keddy, Sims, and Stern (1996) and Wuest (1995) have previously described how feminist research perspectives can be supported in grounded theory studies.

One feature is that this study addressed an issue that is relevant to women, that is, a change in one's status as a mother because of the mother losing custody of her child. While all the participants in this study were women, it is not the gender of the participants that classifies any study as feminist but rather the focus of the research

question. Furthermore, the particular group of women who participated in the current study has been marginalized and voiceless because of the women's histories of street drug usage and custody loss and related stigmas. Very little information is known about their experiences.

Second, the participants in the current study had some elements of control in the research process. Lather (1991) notes that reciprocity between the researcher and the researched is vital to feminist research as a means of decreasing the power imbalance that usually exists in research studies. In the study the participants chose what to tell in their story and could refuse to pursue a line of discussion that the researcher promoted. In addition, after each transcription was typed it was returned to the participant when circumstances permitted so that each woman had the opportunity to make any changes before data analysis. Participants were also involved in establishing fit, workability, and relevancy of the researcher's category determinations and conceptual scheme.

Third, Stacey (1991) notes that "often field work research offers to particular research subjects practical and emotional support and a form of loving attention, of comparatively non judgmental acceptance..." (p. 117). The study provided some of the individual participants with experiences of catharsis and support and several women made specific remarks to this effect as exemplified in the following:

Researcher: I don't want it to be too fatiguing for you, because I know it's very emotional. I know it's emotional for me, like I said.

Participant: Actually, it's not as bad as I thought it would be. I got a few tears in there, but it's not as bad as I thought. And it helps, I think. It gets kind of therapeutic, I think. (61/800)

This excerpt also illustrates how the researcher's feelings and thoughts were at times shared with a participant to provide additional reciprocity.

Finally, to promote dissemination of the findings to the participants, a version of the findings written in lay format will be distributed to those for whom the

researcher still has current addresses. This presentation of the findings will also be made available to women at the two sites that helped in the recruitment of participants.

Sample

The population of women with histories of chemical dependency and custody loss is an unknown fraction of all of the women who lose custody of a child and is a relatively new sample to be addressed in both chemical dependency and custody studies. The sample of women interviewed in this study was recruited in several ways, as discussed below. The initial inclusion criteria for participants were:

- 1) Be a woman at least 18 years old at the time of the study;
- 2) Speak and understand English (could be illiterate);
- 3) Have relinquished or lost custody of at least one child and did not anticipate regaining the custody for at least 6 months if at all;
- 4) Report a history of cocaine and/or heroin use at the time of loss of custody;
- 5) Demonstrate ability to comprehend informed consent;
- 6) Be geographically accessible to the investigator.

Sample Frame

The first participant was recruited through the investigator's prior work site (Site A) after the participant responded to a flyer given to her by a staff member. This site was part of a suburban medical center that had received state funding to provide home based services to mothers with chemical dependency.

Five women were directly recruited through Site B, a halfway house for persons in early recovery located in a midsize city in a large suburban area. Some of these participants were recruited after the researcher gave a brief presentation to a women's group there. Others contacted the researcher through a recruitment flyer (Appendix A)

which was posted in the women's dormitory. Two additional women were recruited through flyers posted in Site B's non-medical detoxification unit and four more women were recruited through snowball sampling via Site B. All interested women were instructed to call a toll-free private voice mail number.

Three women were recruited through Site C which includes a transitional housing program for pregnant women and mothers in recovery who have children of all ages. Although this site is located in an isolated rural town in a western state, women who participate in this program come from all parts of the state. Participants at this site responded to the flyer left in a treatment counselor's office.

Demographic Background

At the end of the taped portion of the initial interview each participant was asked to complete a two page demographic data questionnaire, with the researcher going through each question with the participants and stressing that participants could skip any questions they wanted. This questionnaire was done at the end of the interview to help prevent the establishment of a question-answer type of dialogue during the taped portion of the interview.

Data Collection

In keeping with the theoretical sampling procedure and multiple source data collection of grounded theory, data were collected from two types of sources. The major source was interviews with mothers with histories of cocaine or heroin use who lost custody of a child. A second source included published written narratives.

Interviewing Procedure

Human Subjects Review and Confidentiality Certificate

This study was reviewed and approved by the Institutional Review Board of the University of Washington after suggested modifications in the original proposal were made. All procedures in the final form approved by the Institutional Review Board have been followed, except for one occasion when the researcher's attempts to follow the script following a group presentation at Site B had to be disregarded. This occurred because only one phone was available at Site B and the women who were interested in the study were all lined up, passing the phone back and forth to schedule interviews. As they needed to get to other appointments and because the women had heard much of the content of the script at the group presentation, the researcher proceeded to schedule interviews with interested women.

After the University of Washington's Human Subjects Committee approval was received, the study was reviewed and approved by the hospital at Site A. In addition to these reviews, the administrators of Site B and Site C also approved the study since their agencies do not have a direct association with any Institutional Review Boards.

Prior to any interviews a Confidentiality Certificate was obtained through the National Institute on Drug Abuse, Public Health Service, National Institutes of Health. As stated in the granting letter, "This certificate affords the Principal Investigator the privilege to protect the privacy of research subjects by withholding the names and other identifying characteristics of those subjects from all persons not directly connected with the conduct of this research." A renewal of this certificate was obtained to ensure this privilege throughout the entire period during which participants were recruited.

Informed Consents

A number of participants began to share their stories shortly after the researcher arrived for each interview. When this occurred the researcher had to gently but quickly stop such remarks, explaining that the comments were most valuable but that the consent document (Appendices B and C) had to be reviewed and signed before any exchange could go on. The researcher then orally reviewed what the consent said and gave a copy of the consent to the participant with the instructions that the participant should take her time to read it thoroughly, ask any questions, and that a copy was available for her own records. While all participants made an attempt to start reading the three-page consent about half of them quickly turned the pages and said they were ready to sign. In these cases, the researcher, being concerned that perhaps the participant did not have the literacy skills to adequately read the consent, again orally reviewed the critical components before having the participant sign the consent. When follow-up interviews were more than six months after the initial interview, a second consent for the follow-up component was obtained. The consents are being kept in a locked file to protect the identity of the participants.

Mini Mental Status Examination

When the study was initially planned the researcher anticipated that some participants might still be actively using illicit drugs and therefore might be under the influence of drugs or alcohol during the interview. As a result copies of the Mini Mental Status Examination (Folstein, Folstein, & McHugh, 1975) were kept in the researcher's brief case. However, the Examination was never used because no participant gave any behavioral or physical indications of current illicit drug usage or alcohol intoxication that were apparent to the interviewer and all participants reported being abstinent for variable length of times, the least amount being five days.

Compensation to Participants

Each participant recruited through Site A and B was given \$20 in cash immediately after the consent was signed at the initial interview. The compensation was given at that time in the interview to help decrease any misunderstandings by the participant that she might have to say certain things or speak for some length of time to receive the compensation. One participant was paid an additional \$20 when the researcher discovered at the end of the initial interview that the microphone had not been working and a "follow-up" initial visit was conducted ten days later. Because it was anticipated that the interviews through Site C would be shorter as they were designed to help the researcher establish fit and relevancy of the developing theory, each participant was paid \$15. However, in reality the interviews through Site C were no shorter than through other sites because each participant through Site C felt she needed to tell her full story. The three women who provided follow-up in person interviews each received \$10 in cash at the time of the follow-up interview.

The debate about cash compensation to persons with histories of addiction has occasionally surfaced (Cottler, Compton, & Keating, 1995; Deren, Stephens, Davis, Feucht, & Tortu, 1994; Wiebel, 1990). On the one hand this researcher wanted to avoid bribing women into participating and did not want to financially support any drug or alcohol usage. On the other hand, the researcher strongly believes that each person's time is valuable and that the participants in this study should be compensated for their time just as in any other study. Vouchers or gift certificates were considered but these presume that all participants have the same needs or interests and that transportation to redeem the vouchers is readily available. The women living in the dormitories received \$38 each month for their expenses beyond room and board so an additional \$20 was quite influential. Yet each of the participants from this and all other recruitment sources participated in an engaging

manner with the interviewer; if any participant was involved purely for the cash compensation this remained unknown to the researcher. Furthermore, the fact that several women signed up to participate and then changed their mind indicates that the cash compensation, at least for those women, was not a strong enough factor to overcome their other thoughts about participation.

Recorded Interviews

The location of the interviews was planned during phone contact, either at the participant's residence or in a private classroom or office at the treatment site. Following the signing of the consent and giving of the compensation the participant was informed that it was time to turn on the audio tape recorder and formally begin the interview. The researcher mentioned to each mother that initially the presence of the recorder might make her feel awkward but that usually after a couple of minutes most mothers did not seem bothered by it. Open-ended (in-depth, unstructured) interview style was used to begin each of the initial interviews. That is, each participant was asked to tell her story as she chose. Some women began in the style common at twelve-step meetings: "My name is ____ and I have been using drugs/alcohol since the age of ____." Then the women would review their drug use history. Other women seemed unclear how to start so the researcher suggested that they begin by telling the researcher about the child(ren) lost to custody. A dialogue-type conversation was promoted, with the researcher asking questions or making comments directly related to the mother's narration at the moment. The researcher also at times would say, "Some mothers have said ____, what is your experience" or "What do you think/feel about that?" These questions allowed the researcher to pursue additional information about categories that were being developed through coding.

Follow-up Interviews

While multiple interviews are promoted in feminist studies to allow for in depth exploration, the researcher determined that several reasons existed why single interviews might be more appealing to the participants. First, the women live busy lives, filled with numerous appointments, meetings and other demands for their time. Second, many of the women were in transition and were often in the process of relocating to other areas. Hence, the actual completion of follow-up interviews might be difficult. Third, the subject matter was of a very personal nature and was expected to elicit numerous difficult feelings for the participants. Requesting one interview seemed more likely to be acceptable to the target sample than asking for multiple interviews. In case any women wanted to talk about their feelings regarding or resulting from the interview another visit with the researcher was available, with the women being informed of this during the signing of the consent.

Formal follow-up interviews directed at the fit and relevancy of the developing theory were arranged with participants who were geographically available. Each participant was paid \$10 in cash at the time of the follow-up interview for her efforts. These interviews were all audio-taped but only selected portions were typed. All of the these participants received the transcriptions of the typed portions from these interviews to review for changes and keep for their own files.

Published Written Narratives

An additional source of data reviewed was a collection of photographs, personal narratives and poems by women with histories of addiction that has been promoted by the March of Dimes entitled When the Bough Breaks (Corser & Adler, 1993). This book was included because it added breadth to the original sample of 15 women in that the women in When the Bough Breaks came from additional geographic

areas. Furthermore, several of the women's narratives were collected over two to three years, providing additional longitudinal perspectives to the current study. In reading When the Bough Breaks this researcher became satisfied that theoretical saturation had been met for the major concepts identified in the in-person interviews.

Data Analysis

Transcription of Interviews

Initially the researcher planned to use a transcriptionist. Based on the difficulty the first transcriptionist experienced, the decision was made that the researcher would transcribe all of the interviews herself. All initial interviews were typed verbatim but follow-up interviews were selectively typed for data related to the core category and sub-categories only. Transcribing allowed the researcher to become very familiar with the data prior to more formal data analysis.

During transcription each proper name was replaced with an alphabetical code. For example, children were labeled in order: aaa (mother's first child), bbb, and so forth. Dates of births, names of cities and services, and any other identifying information were also removed. At the time of the interview arrangements were made with each participant about how she could receive a confidential copy of the typed interview.

Coding and Constant Comparison

The researcher began the formal analysis process with open coding. That is, the researcher read the transcript from the first interview and began to freely label individual components and events within the transcript. Generic questions proposed

by Glaser were used to assist in this process (Glaser, 1978, p. 57). For example,

- What are these data a study of?
- What is the main story here?
- What category or property of a category does this incident indicate?

The first interview, from Site A, was coded shortly after transcription. However, because the initial presentation at Site B yielded a number of participants within a short time frame it was not possible for the researcher to collect each interview, transcribe it, and do open coding before collecting additional interviews from that site. Seven interviews were collected before related coding occurred. As a result, open coding occurred on 8 of the 15 initial interviews before a core category was pursued in further interviews. Numerous codes were developed during the open coding process. Some codes were descriptive and some were more abstract.

Constant comparison of patterns among incidents and interviews is an essential part of grounded theory analysis. In this study preliminary comparison occurred as the researcher transcribed the initial taped interviews. Constant comparison with open coding allowed for the eventual development of selective coding during the initial coding of the first eight transcripts, as certain codes were being identified as continually re-occurring. In selective coding only data related to potential core categories is considered for analysis, and additional data about these categories are gathered. As additional data were collected and analyzed in this study, the selective interviewing and coding focused on those categories which continued to support the developing core process. Furthermore, transcripts from earlier interviews were systematically re-read for categories that were formulated or refined as the coding and constant comparison processes progressed. Case history abstracts of many transcripts were also formulated to help see patterns more clearly within and among the participants' stories. By the end of the analytic process each transcript and

the published personal narratives had been read numerous times to help refine the developing core category, related properties, and sub-categories. Follow-up phone and in-person interviews also assisted this process.

Although the researcher was well acquainted prior to data collection with much of the literature about pregnant and parenting women with addictions and continued to build her reference library on this topic during data collection and analysis, the researcher made a concerted effort to follow Glaser's advice to avoid comparing findings in the literature with the researcher's own findings until the core category was well advanced (1978, p. 51). This approach helps prevent the researcher from advancing to selective coding before open coding has been adequately done. With Glaser's advice in mind, this researcher initially hesitated to use the identified core category in this study because of her awareness of the primacy of this category in the literature about mothers who have relinquished a child.

Saturation

Categorical saturation occurs when no new categories related to the core category are developed. This researcher believes that categorical saturation was reached through the fifteen initial and seven phone and in-person follow-up interviews. Theoretical saturation in which no new properties of a category are identified was also reached for the core category as well as for several of its sub-categories. The entire data collection/data analysis process occurred over 24 months. For eight months during this time period the researcher was on a leave of absence related to family matters.

Memos and Sorting

Once the coding process began the researcher intermittently formulated memos about possible categories, properties, and theoretical relationships. In grounded theory memoing is a way of ensuring that one's thoughts about the data and developing theory are recorded throughout the data collection/ data analysis process so that none of these thoughts and conjectures is lost. Dating memos was one way of helping this researcher keep track of developing ideas.

Theoretical sorting occurs after data collection is completed and before the actual writing of the theory starts. Sorting involves taking one's pertinent memos regarding the core category and related sub-categories and piecing conceptual material together in the way that the researcher anticipates reporting them. Memoing continues throughout this process. This researcher stapled, clipped, and taped together numerous memos, frequently reconfiguring of them during the theoretical sorting process.

Summary

In this chapter the researcher discussed the interpretive study design, grounded theory methodology, and feminist approach used in collecting and analyzing the study data. Specific findings from this study are reviewed in the next chapter.

CHAPTER IV

FINDINGS

This chapter reports the findings from this interpretive study of women with histories of cocaine or heroin use who have lost child custody. First, the demographic background of the interview participants is presented, followed by specifics of the interview process pertinent to the study. Then, in the main body of the chapter, the study findings are presented. The chapter closes with a description of the grounded theory which resulted from the identified concepts, supportive contexts, and hypothetical relationships.

Demographic Background

The following demographic information is provided to assist the reader in understanding some characteristics of the women who participated in the interview portion of the study. Information about the mothers and about the children lost to custody is provided separately.

About the Mothers

General background of the 15 participants follows and is also reported in Table 1. All of this information was obtained via self-report. The average age of the participants was 30.8 years, with a range of 24 to 38 years. Most of the participants were white (73%). Educational background varied widely, from a quarter of the women having less than a high school education or equivalency, to a third having one to three years of college.

As seen in other studies, many of the women had histories of sexual or physical abuse and family drug use. Of the 10 women who reported a history of abuse, 60% of

Table 1
Demographic Characteristics of Mothers (N = 15)

Characteristic	n	%
Age, years (M = 30.8)		
21-25	3	20
26-30	4	27
31-35	4	27
36-40	4	27
Ethnicity		
White	11	73
African-American	2	13
African-American/ Native American	1	7
Native American/White	1	7
Education (highest level)		
< 12th grade education	4	27
High school diploma	3	20
GED (general equivalency diploma)	3	20
Some college (1-2.5 years)	5	33
Marital status at time of custody loss		
Single, never married	6	40
Married	3	20
Separated/divorced	6	40
Primary composition of family of origin		
2 parents (including step-fathers)	9	60
1 parent (mother)	2	13
Foster care (family or state)	4	27
History of physical or sexual abuse		
None reported	5	33
Abuse reported	10	67
Sexual abuse	9	60
Physical abuse	8	53
Psychological Conditions		
Depression	6	40
Attention deficit/hyperactivity disorder	4	27
Anxiety disorders (Not PTSD)	4	27
Post traumatic stress disorder (PTSD)	3	20
Drug of choice (some women had used both)		
Cocaine	11	73
Heroin	4	27

Table 1 continued

Characteristic	n	%
<i>History of family drug use</i>		
No family history	2	13
One or both parents	9	60
One or more siblings	11	73
<i>Length of abstinence at time of first interview</i>		
< 100 days	7	47
6 - 12 months	5	33
2 - 3 years	3	20
<i>Treatment course history (M = 2.6)</i>		
One course (current one)	5	33
Two courses	4	27
Three courses	2	13
Four courses	3	20
Six courses	1	7
<i>Treatment program history (58 programs; detoxification centers not included)</i>		
Inpatient (< 30 days)	22	100
Residential (Inpatient > 30 days)	9	60
Recovery house	8	53
Outpatient programs	4	27
Transitional housing programs	8	53
Unknown	7	
Programs completed (52 of 58)	52	90
Programs for women or mothers (33 of 53)	33	63
<i>Legal histories</i>		
No arrests reported	3	20
1 arrest reported	6	40
3 arrests reported	1	7
Ten or more arrests reported	5	33
<i>Types of more common legal infractions</i>		
Theft/breaking in	6	40
Forgery	5	33
Drug possession	4	27
Prostitution	3	20
Domestic violence	3	20
Driving without a license	3	20
Drug dealing	2	13

them reported histories of sexual abuse and 53% reported histories of physical abuse. Forty percent of women reported histories of both. In addition, seven of the women reported a history of violence in their adult life without being directly asked about this. All but two women reported histories of family drug use. Sixty percent of all participants reported problematic drug or alcohol use by one or both parents (including step-fathers) and 73% reported problematic drug or alcohol use by one or more siblings. Since the researcher had neglected to ask participants if they had siblings, this 73% reported sibling use is remarkable.

Most of the participants (73%) stated that cocaine was their drug of choice. However, almost half of the women had used both cocaine and heroin extensively in their lives. All of the participants had less than three years of abstinence, with almost half of them having less than 100 days of abstinence.

Thirty-nine treatment courses were recorded at the time of the initial interview; the range was one to seven, with an average of 2.6 per woman. Each course represents a chronological series of one or more types of formal drug treatment during a given abstinent period. For example, one woman went to an inpatient program which was followed by a recovery house stay and then an outpatient program. Although this represents three types of treatment, only one course is counted. In a prior recovery attempt, the woman went to inpatient treatment and then relapsed after discharge; this also represents one course.

A total of 58 separate treatment programs had been or were currently being utilized by the participants. The most common type was inpatient treatment (38%). All of the participants had been in an inpatient program at least once. In addition 9 women had been in residential treatment (> 30 days), 8 had been in a recovery house (> 30 days but much less structured than inpatient or residential), 4 had participated

in outpatient programs, and 8 had been or were currently in transitional housing programs. Detoxification-only admissions were not counted. Of the 51 known treatment types, the vast majority had been completed, and more than half were designed for women or mothers.

About the Children and Custody Loss

Table 2 provides descriptive information about the children and custody losses. The 15 interview participants gave birth to 38 children, including one set of twins. Of these, 32 children were involved in custody loss, with an average of 2.1 per mother. At the time of the first interview 13 children had been permanently removed from the mother's custody and another 13 children had been at least temporarily removed. Several of these children were later permanently placed out of the mother's custody while other children were placed back with the mother or remained in foster care. Four of the 32 children were given up unrelated to their mother's drug use: two mothers each relinquished one child when the mothers were young adolescents, and one mother gave up custody of two children because of the mother's depression. In addition, four of the 38 live-births had been born to participants since their loss of custody experiences. Since these children remained in the mother's custody, they are not included in the data except as noted in Table 2. Also not included unless otherwise stated are the one child that died in infancy and an older child that remained in the mother's custody. All data are from the mothers' self-reports.

One-quarter of the 32 children were less than three months old at the time of custody loss. Almost half of them (44%) were five years or older. Two-thirds of the children had been given up or lost to custody within the last three years. Almost 60% of the 32 children were initially placed in relative care, although some transition from relative care to state care or vice versa had occurred after the initial placement.

Table 2

Descriptive Information about the Children and Custody Loss

Descriptor	n	%
<i>Outcome of pregnancies (range = 1-6. 13)</i>	<u>61</u>	
Live births (includes one set of twins)	38	62
Pregnant at time of first interview	4	6
Therapeutic abortions	17	28
Miscarriages	3	5
<i>Number of children lost to custody per mother</i> (Average = 2.1)	<u>15</u>	
One child	4	27
Two children	6	40
Three children	4	27
Four children	1	7
<i>Reasons associated with custody loss</i>	<u>32</u>	
Loss related to mother's drug usage	28	87
Loss not related to mother's drug usage	4	13
<i>Child's sex</i>	<u>32</u>	
Boy	17	53
Girl	15	47
<i>Age of child at time of custody loss</i>	<u>32</u>	
< 3 months	8	25
3-14 months	2	6
15-35 months	3	9
3-4 years	5	16
5-7 years	8	25
8-11 years	6	19
> 12 years	0	0
<i>Length of time since child custody loss</i>	<u>32</u>	
< 6 months	7	22
12-18 months	4	13
2-3 years	10	31
4-6 years	7	22
8-11 years	3	9
16 years	1	3

Table 2 continued

Descriptor	n	%
<i>Type of initial out of home placement</i>	<u>32</u>	
With relatives/ friends of mother	19	59
In state foster homes	10	31
With adoptive family through private lawyer	3	9
<i>Placement of child at time of first interview</i>	<u>32</u>	
Temporarily placed out of mother's care	13	41
Permanently placed out of mother's care	13	41
Placed back in mother's care (at least part-time)	6	19
<i>In utero drug/alcohol exposure of children</i>	<u>42</u>	
(Includes 4 new babies in mother's custody, 4 unborn children, 1 child who died in infancy, and 1 child not lost to custody)		
No reported exposure	6	13
Cigarettes only	2	5
Marijuana +/- cigarettes	11	28
Alcohol +/- cigarettes	2	5
Amphetamines +/- cigarettes	1	2
Cocaine +/- cigarettes	6	15
Opiates +/- cigarettes	0	0
Polydrugs (2 or more of: alcohol, cocaine, opiates)	14	33

As for drug / alcohol exposure in utero, 14% of the children had no reported exposure and another 14% had been exposed to cocaine prenatally. Twenty-six percent were exposed to marijuana with or without nicotine exposure and 33% had been exposed to polydrug usage in utero. The remaining 12% of children were exposed to cigarettes only, or to alcohol or amphetamines with or without nicotine exposure.

Interviews

All 18 in-person interviews occurred from April of 1995 through December of 1996. The interviewer arranged to meet with each participant as soon as possible, usually within 24 to 48 hours. Of all 18 face to face interviews, 11 were done in the woman's apartment or home. Since dormitory rules at Site B prevented outsiders from entering residents' rooms, the remaining seven interviews were done in a nearby private classroom or office at a recovery house.

The average taped portion of the 15 initial interviews was 61 minutes, with a range of 20 - 105 minutes. The interviewer tried to be sensitive to each mother's fatigue level and emotional state and would remind each participant that she could end the interview any time that she wanted. The shortest taped portion of 20 minutes was with a woman with five days abstinence who was leaving the next day for inpatient treatment in a different part of the state. As the woman was recovering from illness, malnourishment, and homelessness and was in detoxification, the researcher made a concerted effort to keep the interview short.

Follow-up personal and / or phone interviews occurred with seven women. These interviews occurred from 4 to 21 months after the initial interview and were expressly done to obtain input from the participants about the fit and relevancy of the developing theory. No woman requested a follow-up interview to process feelings resulting or regarding from the initial interview.

The typing of the transcripts by the researcher created a backlog in getting the transcribed versions back to the participants. Because three participants were leaving the day after the interview and could not leave a forwarding address it was known that these women would not be receiving a copy. Three other women changed residences within two months of the interview. Their copies were left in a secure mail hold at the site of the interview but it is unknown to the researcher if the participants ever received their copy. None of the transcripts had any changes made to them. However, one woman shared, "I just read over the report, the transcript....I can't believe how accurate it is. Thank you very much!" (61/ phone call). She then said that if she knew who her child's adoptive parents were she would send portions of the transcript to them so that the adoptive parents could better understand the mother and tell the child what she was like.

Study Findings

As stated in Chapter I, the purpose of this study was to develop a substantive theory regarding women with histories of cocaine or heroin use who lose child custody. Attainment of the first study aim, to obtain information directly from the women, was described in Chapter III and in the previous section of this chapter. The second and third aims were to identify common concepts evidenced in the women's stories and other sources of data, and to suggest hypothetical relationships among the identified concepts. Discussion of how these aims have been met is described in the following sections of this chapter. The fourth aim, to explore the use of grounded theory methodology with the population of mothers with drug histories who lose child custody, is discussed in Chapter V.

Introduction

An overarching basic psychosocial process identified in the participants' stories was that of Handling the Hurt. One major source of hurt for most of the participants was child custody loss. However, numerous other sources of hurt were identified by the women. After discussing these various sources of hurt the major categories supporting Handling the Hurt will be presented. These categories—Numbing Out, Running Away, Giving Up, Cleaning Up a Little, Cleaning Up a Lot/Becoming Fit, and Dealing with Feelings—represent strategies the women have used to deal with their hurt and pain. For this particular sample, consisting of women who were all in recovery, Cleaning Up a Lot/Becoming Fit was the largest category and had three sub-categories: Doing Everything, Building Trust, and Balancing Parenting and Recovery. Numbers in parentheses following quotations refer to the mother's study number and transcript line number on which the quotation begins.

Handling the Hurt

Reference to hurt abounded in the women's stories. The women gave example after example—many unsolicited—of the various types of hurt they have experienced. Frequently the women used the word "hurt" directly. Other times they talked of emotional pain, sadness, shame, guilt, anger, and fear. Therefore, in this study hurt has been defined as a medley of negative feelings related to specific past or current negative life events which results in some level of emotional and/or physical discomfort. The more discomfort, the greater the hurt. Many participants also repeatedly mentioned how hard the experience of these hurts had been for them. Therefore, identified general properties of hurt include level of discomfort, perceived location of the cause of the hurt (external or internal to the mother), and

perceived difficulty in resolving the hurt. Handling the Hurt describes how an individual seeks to resolve the associated discomfort.

A number of mothers shared that, particularly in their earlier drug use, feeling good was a major reason for using drugs repeatedly. Even several years into recovery one woman said, "I do love cocaine. I love it" (62/481). Other reasons for women using drugs have been cited in Chapter II. Therefore, while Handling the Hurt was not the only reason for mothers in this sample using drugs or alcohol, the mother's repeated references to hurt and pain and the frequent use of the strategies described below support that Handling the Hurt was a major reason for maternal drug use.

Causes for Hurt

Child Custody Loss

In this study, the most frequent causes for the women's hurt were related to child custody issues. For many mothers, hurt resulted from the uncertainty about if and when they would ever see their child again. "I didn't know if I would ever get my kids back, you know. Cause I had always heard that if they get taken by CPS [Child Protective Services] it's really hard to get them back. So I was really scared, hurt, depressed" (57/360). Hurt was especially poignant for women who no longer had access to their children and when the mother's parental rights were officially terminated. For example, when an out of state relative with child custody suggested several years into the custody change that a formal adoption occur, the mother said: "I didn't really want to do that...my heart ached so bad from the pain. I thought, 'I'm gonna have a heart attack'" (63/210). Even for women who continued to have child access, visits could be painful. One mother said, "Every time I'd go there [to visit] I'd end up drinking or you know, something, because I wanted to take them back so bad"

(59/40). Another shared, "It hurts when (daughter) says, 'I want to go home with you.' And I just have to tell her, 'Momma's sick right now. Momma's trying to get better and as soon as I'm better you'll come home with me'" (51/890). The mother of an infant in a group home for newborns with opiate withdrawal shared the following story.

After a while it was getting real hard for me to see the baby because I knew I wasn't gonna get to take her home....I started seeing her less and less. And I thought about her every day. I don't think a day went by for months and months that I didn't cry....Sometimes I just tried to pretend that I'd never even been pregnant. It's not cause I didn't love her. It's just that it was too painful to think about it. (61/189)

This mother had a second baby several months after the initial interview and was doing well in her recovery program. In a follow-up interview fourteen months later, her continued hurt about losing custody of the first child was still apparent: "I think about her every day [mother is crying]. I can't talk about her without crying" (61/974).

Holidays such as Halloween, Christmas, Easter, and Mother's Day, as well as the child's birthday, were especially difficult for many women. One woman's children were placed with foster parents that did not have Santa Claus at Christmas, and this lack of following family traditions made the holiday season even more painful for the mother. Another woman cited a cultural inconsistency in the child's placement.

Effects of Mother's Drug Use

In this study another frequently cited source for a mother's hurt was the effects of the mother's drug use. Mothers worried that their drug use during pregnancy would create health or other problems for the child. For women who used opiates in pregnancy, awareness that their baby might go through opiate withdrawal was particularly painful. One mother described how she was unsuccessful in preventing this, despite her attempt to lower her dosage:

She had real bad withdrawals from the methadone....And there was nothing I could do. She would jump easily. Her upper body was real stiff. She had diarrhea....It was just real hard. I didn't like seeing her like that. (61/42, 712)

Women who used drugs in the home after the child's birth were concerned about potential effects on the child.

I had a lot of drug dealers coming to my house and my kid was identifying with them which was really scary. "These are really cool people! Look at their cars. Look at their clothes. They can take me to McDonald's anytime I want to go!" You know? And that's what really scared me. (53/187)

And another said,

I was coming in and out of her life, in and out of her life, you know. I would come and stay for a week when I was so burned out. Then I'd get my energy back. I'd leave while she was gone at school. And she'd come home and I wouldn't be there and it was just tearing her apart. (56/127)

Some mothers spoke of the disappointment in themselves about not being able to stay clean or to refrain from illegal activities. Others talked about how their drug use contributed to the custody loss or how it kept them away from critical events in their children's lives. For example, one mother's 17 year old son was killed in a car accident three years after the mother's last visit with him. Another woman could not be with her infant daughter through numerous heart surgeries related to a genetic defect.

Women also spoke of hurt related to how health providers treated them. They gave examples of being treated by staff with negative attitudes in labor and delivery, neonatal intensive care units, and emergency units. As one woman who was homeless and had a skin abscess said, "They treat you like you have leprosy or something" (60/162).

Family of Origin/Childhood Issues

A third major source of hurt for the participants concerned painful issues from their childhoods and families of origin. Some of these issues were related to problems

of parental addiction, parental mental illness, loss of a parent or other significant adult, or to experiences of childhood sexual or physical abuse. Several women spoke of missed childhoods, filled instead with responsibilities for siblings or fear of abuse.

Other Causes

Low-self esteem, domestic violence experiences, mental health limitations, and perceived lack of support by family, friends (including the baby's father), and professionals were additional reasons contributing to the mother's feelings of hurt. Often these reasons were linked to those cited above. References to low self-esteem were mentioned by the vast majority of participants. Domestic violence in adult relationships was reported by half of the women without the researcher specifically inquiring about this.

Numbing Out

One strategy identified by all of the participants for Handling the Hurt was Numbing Out. Numbing out consisted of using drugs or alcohol to cover up the mother's painful feelings. As one mother in an abusive spousal relationship said, "I didn't know how to deal with my feelings or anything. I covered it up. And I just kept stuffing my problems....[after one abusive episode] I was strung out for four days on coke" (54/66). Another woman who had been molested by her grandfather/guardian and whose grandmother refused to believe this left home at age 15. "After I moved...that's when I started getting high. Cause I was in so much pain and that was the only way I knew that would take the pain away" (59/163). And another woman with a history of family alcoholism shared, "I've always tried covering up my feelings, my emotions, my hurt, with drugs or alcohol" (53/601). Some women noted how Numbing Out was a form of self-medication.

I have known women use and have their kids taken away and then continue to use because the using just suppresses the feelings. You know, you don't feel, you don't feel....Sometimes they medicate so bad that they don't feel it at all. (56/535)

Numbing Out was common after women lost temporary or permanent custody of their children. For example, one woman gave temporary custody of her two children informally to her husband. But then her family got a lawyer and had the children formally removed from the mother's care. "I was really bummed out. For three months my drinking and drugging just got worse" (58/9).

The reinforcement of a quick high to erode any hurtful feelings made Numbing Out a popular coping mechanism for the women when drugs were readily available. To promote drug availability some women had sex with dealers or would stay in abusive relationships. Frequent drug use contributed towards the women developing tolerance for the drug and experiencing withdrawal when the drug was not available. During pregnancy these symptoms of chemical dependency caused even more pain for the women. One mother with a heroin addiction who was pregnant said:

Even when I was selling drugs I wouldn't sell them to a woman who was pregnant. I wouldn't do that. Yeah, really! Such morals. But I wouldn't do it. And here I found myself in the same situation. Here I'm using and I'm pregnant and I know it. And I wasn't trying to stop, you know....I was feeling so much guilt because I felt the baby kicking and I thought, "Oh, God, what am I doing? What's wrong with me?" I never really knew too much about treatment centers or anything, you know, or about being an addict or it being a disease. I thought it was just a lack of my will power. (52/189)

In addition to promoting or maintaining chemical dependency, Numbing Out was also associated with consequences of chemical dependency. Women talked of being in a constant fog and how the toxic effects of continued drug use impaired the ability to think clearly. If children were still in their care, neglect of them was inevitable during Numbing Out phases, both because of the mother's altered cognitive status during the actual usage and because of the impaired thinking related to prolonged toxic effects of the drugs. One mother who has since regained custody of her children shared:

I remember thinking at one time that I could get high every day, still take care of the kids and nobody would know....As long as I had them [the children] with me, even though I didn't take care of them, I was still a mom because they were with me....We [boyfriend and mother] were gonna do coke this one night, and then do heroin in the morning to come down. And we did that....I hadn't taken a shower in two weeks. My kids were eating peanut butter and jelly sandwiches, that was it. (65/107)

Other women also described how they thought they could continue to provide adequate mothering for their children while frequently using drugs. For example, another woman who also got custody of her children back and has been clean for several years, related:

He was what, 7 or 8 then. I took him with me [when seeking drugs]. Because I, in my mind I was gonna be the good mom and not leave him with a baby-sitter or something. I would take him with me. That way I made sure he'd played, he ate, and he slept. And he ended up, he could cook a rock [make crack cocaine]....he went through a number of drugs busts with me....I admit I really put that boy through some real trauma. (62/488)

Some women, however, were able to see that Numbing Out was not conducive to providing adequate parenting, and so they voluntarily gave up custody of their children, at least temporarily. For example, the mother who thought she could use cocaine in the night and heroin in the morning came to realize how her children were not receiving adequate care and voluntarily gave up custody of them to Child Protective Services. More commonly in this sample, however, women would give up custody of their children to relatives. One mother shared: "I knew my mom would be there for my son, you know. So it's like, I kind of like took advantage of her and started messing around with drugs again" (55/70).

As the descriptions of other categories will detail, women were often able to stop using Numbing Out to deal with Handling the Hurt. Some eventually tired of it and began Cleaning Up a Little, Cleaning Up a Lot, or in a few cases, tried Giving Up. A few saw inherent risks in their drug use. For example, one mother said, "I can't do this anymore. I'm killing myself" (54/73). However, some women's awareness of their

use of Numbing Out behaviors increased their pain and hurt and so a cycle occurred of pain resulting in Numbing Out, which in turn resulted in more pain. "You had to constantly use drugs in order to constantly keep the feelings bottled up and suppressed. Because the minute you started to come down the feelings would start to come that you didn't want to feel" (56/811). The possibility of returning to Numbing Out from all other categories was demonstrated in the participants' experiences.

Contexts which supported Numbing Out included perceived lack of control of events causing the mother's pain, ready access to drugs, and an inability to assuage the hurt through other means because of the mother's skill limitations or lack of environmental support for expression of feelings.

Giving Up

Giving Up is defined as a woman having suicidal/despairing thoughts and behaviors in response to the woman's hurt. While all the participants realized that overdosing or a fatal reaction was possible with their drug use, only the women purposefully trying Giving Up sought a fatal outcome. Giving Up was not as widely used as Numbing Out.

Temporary or permanent child custody loss was one major factor in women trying Giving Up. For example, a woman who had given custody of her five year old daughter to her sister and was having an unstable relationship with her boyfriend shared:

I was on a death mission at one time. When I finally lost my jobs and everybody had pretty much cut me off, that's when I said, "I'm really going for it this time." I had somebody introduce me to IV use. By then I knew that I was not even gonna get [daughter] back because I was so far gone. (63/181)

Her narration illustrates how lack of purpose, support, and hope promoted Giving Up. After several months of half-hearted attempts at Giving Up, the woman

realized "I'm not dying and I'm not liking this life that I'm living" (63/253). She then made plans for Cleaning Up a Little.

Other women echoed how the loss of their children created a huge void in their lives that led them towards thinking about Giving Up. Contributing to this void was the associated time vacuum of not caring for their children and the lack of hope that they would be reunited with their children.

Another example of Giving Up is from a woman who had lost custody of her three children to her mother and was pregnant with her fourth child at the time of the interview. This woman had not begun her drug use until her two oldest children were several years into elementary school. Her narration concerns the loss of custody of the third child, then four years old.

This last time I even thought about suicide [Interviewer: Because you're just so tired of going through everything and each time it's not working out?"] Exactly. An then it's like, you just feel so weak. I just get so tired of hurting my kids, you know. It is just so hard. (52/453)

This mother's story demonstrates how lack of energy and the pain of hurting others by her own behaviors contributed to Giving Up. Several women shared that although they had seriously thought about suicide, it was the thought of hurting their children more than they already had that prevented them from doing so. However, one of these women added, "If I wasn't pregnant at the time I don't think I would have made it. I really don't" (57/382). Her statement indicates that for her Giving Up was mediated by a hopeful aspect in her life, having a new baby. Another example of this mediation concerns a mother who had also seriously thought about suicide after temporarily giving up custody of her children and awaiting a treatment opening. Her family provided her with some emotional support which then lessened the mother's despair.

The use of suicidal gestures without strong suicidal intentions was shared only once in the interviews, by a participant who slit her wrists one time to get her

boyfriend's attention when he threatened to leave her. Dramatic behaviors such as self-mutilation or self-infliction were considered part of Giving Up only when the mother had the conscious intent to end her life.

Since long-term participant follow-up was limited, whether any women were successful at Giving Up is unknown. One woman believed, however, that one of her half-brothers with whom she was living committed suicide at the age of 11 because of the father's abusive behaviors; she herself had made several suicide attempts. Furthermore, participants gave evidence that women could go from Cleaning Up a Lot to Giving Up in a very short period of time, and vice versa, demonstrating the fluidity among categories.

Contextual elements for Giving Up include hopelessness about regaining custody, lack of support for the mother during a critical time, and a perceived lack of purpose in life by the mother. Not all mothers sharing Giving Up experiences had histories or clinical evidence of chronic mental health problems aside from their drug use, although a few shared histories of depression and post-traumatic stress disorder. Hence, another contextual element that may be contributory is the toxic thinking that can develop from chronic drug use, such as the paranoia that is sometimes seen in persons with cocaine dependency.

Running Away

Another less common but well supported strategy was that of Running Away, defined as a woman physically leaving one geographic area that was problematic for her and going to another or continually moving from place to place. Women who used Running Away had histories of domestic violence or childhood abuse. Women returned to the previous locations when they felt they could feel safe again or when they got tired of running.

One example concerns a woman who was in an abusive adult relationship. Her stepson said to her, "Just go. He's gonna kill you. Just go." The woman then described how she grabbed her daughter and left (59/191). For this woman, Running Away was a strategy that she repeatedly used in response to sexual or physical abuse, major life losses, following criminal activities, and when facing the possibility of losing custody of the only child she still had with her.

When I got out of jail, I...went straight to Children's Services and they said, "Yeah, you got arrested. But you know what? You haven't been convicted of being an unfit mother. Go get your child and get the hell out of here before your family takes her away." And so that's what I did. I got on the next ferry and got out of there. [Interviewer: Where did you go?] I don't remember. (59/480)

Her final remark supports how getting away was far more critical than having a plan of going towards someone or some place.

Another woman who also used Running Away extensively told of how she ran away from her abusive father and then an abusive husband. She had considered running away from treatment but then shared that a counselor helped her address this behavioral response.

Without adequate support women who used Running Away would turn to Numbing Out:

When I was running and hiding from him I would have nightmares so bad cause of the abuse that he put me through....My way of handling it was to crawl in the bottle and basically numb myself from all the pain I was feeling and the confusion. (63/83)

This woman later used Running Away after being misinformed by her sister that her unborn baby would be taken away by Child Protective Services following delivery. Although an opportunity to immediately enter treatment had been offered to the woman earlier that day, she went into hiding for several weeks secondary to what she described as paranoia from her drug use.

One variant of Running Away might include the behaviors of one participant

and a sister of another who got married as teenagers to get out of abusive home situations and quickly moved out of the state. However, other data about Running Away in these women's lives was unavailable to determine this.

Running Away differed from Running Off or Running Around, the latter two being terms women used to describe their pursuance of drugs or drug highs. One of the mothers said, "I was always good for running off. 'I'm going to the store' and you'd see me the next day" (56/77). Running Off and Running Around might be considered offshoots of Numbing Out.

The primary contextual factors for Running Away include concern for one's safety and perceived lack of support and control in one's immediate environment.

Cleaning Up a Little

Cleaning Up a Little is a strategy for Handling the Hurt in which a woman made a temporary personal effort to abstain from drugs or had short-term external constraints put on her to deter her from using drugs. These short-term activities were frequently done so that the woman could maintain custody or be reunited with her child. As one woman shared,

My idea on the way out there to that treatment center is, as I'm shooting dope all the way, is "I'm gonna go and I'm gonna get my son back and then I'll go back out and use. But I gotta get him back." (62/605)

Another mother who had given her child to relatives thought that by getting housing and becoming financially stable she could get her daughter back. But the woman developed a relationship with a boyfriend who was abusing alcohol and marijuana and her goals never materialized.

The desire to become pregnant or the knowledge that a woman was already pregnant provided strong personal motivation for some women to decrease or stop their drug use on their own, without the assistance of any drug treatment. For women

in this sample who reduced their drug usage without the assistance of treatment programs, their pre-pregnancy drug use eventually resumed after the pregnancy. However, pregnancy also provided the opportunity for women who wanted treatment to immediately start Cleaning Up a Lot because in the Northwest state in which the participants lived, treatment was made immediately available to pregnant women. "I was extremely shocked. I thought, 'Well, I'm going to have to wait two weeks before I get into treatment.' And when I called she said, 'Can you come in tomorrow?'" (56/458).

Some women who were not pregnant attempted maintaining abstinence on their own. For example, several woman used drugs heavily for a while after temporary custody loss, but then in an effort to improve the chance of getting the child back became abstinent for a number of weeks while waiting for treatment entry. For other women, however, the availability of drugs and its Feeling Good/ Numbing Out effects versus the unavailability of treatment made staying abstinent too difficult.

I was on the streets for that four weeks [before an opening for treatment became available]. I mean I was living in hotels. I'd get money somehow....But I called [CPS worker] every day. He told me, "Call me every day. I want to know where you are and what's happening". And I did. I called every day. And I'd just be like, "I want my kids back. I didn't make the right decision." And he'd be like, "Where are you living?" "Well, nowhere" "Do you have food?" "No, I don't." "Well, how would you feed your kids?"...And I'd be like, "You're right. The kids are in the best place." And...I'd get off the phone and I'd keep partying. (53/894)

This mother elaborated on her relationship with this Child Protective Service worker, explaining how much support he had given her prior to the child custody loss. His support above is also readily apparent. This mother went on to Cleaning Up a Lot.

A major limitation of a woman's personal efforts was her lack of skills needed to maintain abstinence, which then resulted in these efforts becoming temporary. For example, one woman shared this story from when she had been 18 years old:

My usage went skyrocketing and nine months later I was totally out of control. And I thought to myself, "This is too much. I got to do something." At the time I didn't know anything about NA [Narcotics Anonymous] or AA [Alcoholics Anonymous] or whatever, I just did it on my own. And I knew that I had to get out of that area [locale]. (56/28)

The woman moved back with her mother into a drug-free environment. However, when she began attending an alternative school for adolescent mothers, she started using marijuana and later gradually resumed her cocaine use. Again she was able to stop her usage, but when she moved into a different area to pursue college classes her drug use resumed. "From then on it was all down hill, all down hill" (56/66).

Critical life events other than child custody concerns could also lead to Cleaning Up a Little, followed by resumption of drug use. After one woman's son died in a car accident, she shared this: "[I'd] been cleaning up. You know, smoking pot and then not smoking pot. And then having a beer and then turning back to the hard liquor. Back to coke" (59/60).

Some women had strong external pressure to enter treatment from their families, especially if family members had custody of the children or from Child Protective Services. One mother said, "I kind of went in because I got tired of them. They were just nagging me, nagging me, nagging me" (56/113). During this treatment course the woman did not develop internal motivation regarding recovery and eventually lost permanent custody of the child. With a future pregnancy, however, she did enter Cleaning Up a Lot and continues to have custody of her child, who is now a toddler. Other participants commented about how they saw women come into treatment "because CPS has a hold on their child and they have to comply before they get their children back" (64/170). However, the mothers noted that some of these women did not seem sincere in their recovery efforts.

In contrast, some women who were forced into treatment because of family or legal pressure and who did not originally want treatment, went on to successful

recovery. "It's like we know that we should have done it and that it was good for us, but we would have never started it out on our own if we weren't made to do it" (61/954). The intentions for a temporary stay as seen in *Cleaning Up a Little* turned into a stronger investment, as seen in *Cleaning Up a Lot*.

Some women's commitment to recovery fell in between. One woman completed 60 days of treatment and then "moved right back in with a user" (59/518).

Interviewer: Now in treatment did they offer him anything? Or did they ask you, "Is your friend a user?"

Participant: They did, but I lied...I lied and said, "I'm going home to a clean and sober place....I wasn't ready. I was just doing it to keep, to get my daughter back really. Cause I had let her down. That was the reason.

Interviewer: So your daughter has been a pulling force for you.

Participant: Yeah. Oh, yeah. I mean, after the baby died I didn't want to lose her. I had already given my other kids away, you know .

Despite living in a using environment, this woman managed to stay clean for six months, going to 12-Step meetings daily. "But his pot use won".

Incarceration provided another type of an externally forced period of abstinence in which *Cleaning Up a Little* could occur. One mother with several jail experiences of up to three months each, shared:

You get clean in there and you feel good. Cause you're almost dead before you went. And you do good time in jail and you start feeling healthy and stuff and you want to change. But then it's just a matter of what you do when you walk out those doors. (64/181)

A similar type of external pressure occurred for a mother who was hospitalized for the last two months of her pregnancy because of gestational diabetes. During some of these *Cleaning Up a Little* episodes, the temporary abstinence allowed the women to be somewhat freed from toxic effects of the drugs and think more clearly. However, the subsequent availability of drugs, clean and sober support, maternal motivators, and attainment of skills for maintaining abstinence all played a role in whether the mother would go on to *Cleaning Up a Lot* or not. Therefore, contextual factors

involved in Cleaning Up a Little include pressures from external forces (family, legal system), maternal motivators (fear of fetal harm or custody loss), and availability of drugs, support, and treatment services.

Cleaning Up a Lot/Becoming Fit

The largest category for Handling the Hurt for this particular sample was Cleaning Up a Lot, in which the women made a long term commitment to maintaining abstinence. Cleaning Up a Lot also provided the best assurance that women who had lost temporary custody of their children might get custody back, and that women who were pregnant would maintain child custody after delivery. Because of this, Cleaning Up a Lot has a second title, Becoming Fit. This second title was given an ancillary versus primary role in recognition of the mothers who entered treatment at certain times unrelated to child custody issues. Cleaning Up a Lot/Becoming Fit has three sub-categories: Doing Everything, Building Trust, and Balancing Parenting and Recovery.

The effort required in Cleaning Up a Lot/Becoming Fit was quite high. Hence, each woman had to be sufficiently motivated to endure the demands of treatment centers and the multiple requests of those who had control over access to her child. Simultaneously, barriers to this motivation had to be minimized. Therefore, the contextual basis for Cleaning Up a Lot/Becoming Fit revolves around the following motivators and barriers. In brief, having access to the child, availability of appropriate treatment, and support to the mother are critical contextual elements.

Motivators

The main reason for the vast majority of women Cleaning Up a Lot was to regain child custody and/or to maintain child custody after delivery. As one mother

noted, "The kids got taken away in October. They went to a foster home. They were almost adopted out. That's when I decided to do something about my problem" (Corser & Adler, 1993, p. 61). A pregnant woman who had lost custody of her prior child thought to herself: "No. No. I can't do this again. I can't go through this [pain] again" (61/1039).

Two participants, however, stated that child custody was not a motivator at all. One mother said, "I was sick and tired of being sick and tired, of being alone. You can't numb yourself forever" (64/99). The other mother recognized that she was not going to survive if she maintained her drug use and related activities. "I just knew I was gonna die. I knew I was gonna die if I stayed out" (59/666). This recognition of possible death was different than for women in Giving Up, the latter who were seeking death rather than trying to avoid it.

Women often had a combination of motivators. In addition to child access, wanting to feel better, and wanting to survive, women shared several others. Some women saw that entering treatment ensured that their child would have adequate care or that their unborn baby would be spared further drug exposure. For example, when one mother became homeless she realized that she could not take care of her children anymore.

Several women shared that interaction with either a positive or negative peer role model helped motivate them. One mother who was in detoxification saw another woman she had used with in the past who was now clean and sober. Another mother looked at the persons using around her and decided she didn't want to be like them anymore.

Finally, support by a significant other at a critical time could help a woman make the decision to enter Cleaning Up a Lot. One mother who was considering treatment was able to see on very short notice a clinic nurse who had been supportive

to the mother in the past. Through this assistance the mother entered a treatment program for pregnant women that very same day. An example of support by a child protective services worker was described earlier in *Cleaning Up a Little*.

Barriers

For women to successfully enter treatment the motivators had to be stronger than the barriers. In this study six barriers were identified.

First, mothers noted that the toxic effects of the drug use impaired their ability to see the true effects of the drug use on their daily lives. When one woman's mother tried to tell her that she would lose permanent custody of her child unless she stopped her drug use, the woman minimized her mother's concerns, saying, "Yeah, Mom. Yeah. Whatever" (52/219). Another woman's cocaine paranoia made her believe that everyone was against her and that she would receive no support if she entered treatment.

Second, the thought of being separated from the child during any drug treatment made some women less inclined to seek treatment. Kinship placement of the children made such separation a little easier for some women, but others did not have relatives who were available for child care during the mother's treatment. One woman still in detoxification shared that "being away from the kids" was the hardest part for her (53/589).

Third, when non-pregnant mothers were ready to enter treatment, openings for treatment were not usually available. Women had to wait up to four months. One mother said, "You know, you only have those moments of clarities and they don't come very often. When they come you have to jump on it" (62/622). Another shared:

There's such a big, long, waiting list. And sometimes women will wait but a lot of times it's hard....You can't get to a phone or everyone's using so much that one day you want to get clean and you really mean it and you might

still mean it the next day but it's like, when you're using...maybe you're too sick to call or you're too loaded or you're asleep because you've been up for four days....And your self-esteem brings you down to a level where you feel like... "Why even try? I ain't worth it." (61/607)

After waiting for a long time, one mother finally got into treatment and noticed many vacant beds. She was told that numerous beds were usually vacant, waiting for clients who were privately insured. Women with jail or prison sentences shared that treatment was frequently not available at all or was often inadequate.

Fourth, available treatment was not always the best treatment. Women appreciated being in programs specifically designed for women or for mothers. Some women needed programs for persons with dual diagnoses, but these were few and far between. Women with attention deficit hyperactivity disorder found group meetings and lectures hard to follow or sit through. One mother who wanted inpatient treatment was randomly assigned to an outpatient program as part of a large study and continued to live in a using environment. She did not succeed in that particular treatment attempt.

Fifth, the mother's mental or physical health could preclude treatment entry or consideration. For example, as stated women with dual diagnoses often could not find pertinent treatment for both their chemical dependency and their other mental health problem. Also, some mothers' concerns about what they would experience during detoxification at times impeded treatment entry. For example, women with opiate addictions dreaded the withdrawal process.

Finally, lack of support by key others could impede a mother's decision about treatment. This was particularly true for women who had partners or spouses who were actively using and not considering treatment. Negative attitudes by health care or child welfare workers also contributed to women refraining from entering treatment.

Doing Everything

In *Doing Everything* the women began to (re)stabilize their lives by actively participating in recovery through the use of drug treatment and related services. "I'll do whatever I have to do" (52/300) was frequently their attitude when they entered treatment. A child welfare worker likewise noted: "When a woman is actually ready and willing to stop using she will do whatever she has to do" (Corser & Adler, 1993, p. 91). Once in treatment, women repeatedly talked about how they were *Doing Everything* and how busy their lives were. Several women even mentioned that they were *Doing Everything* and more. They made sure that they didn't miss any appointments. One woman shared that she even showed up early for them. Others began to keep calendars, often for the first time in their lives.

The multiple components of *Doing Everything* included participating in activities directly related to an individualized recovery program, such as full participation and completion of inpatient and/or outpatient drug treatment, 12-Step meetings, use of sponsors, opiate agonist treatment if applicable, and aftercare/relapse prevention programs. *Doing Everything* also involved developing a safe and sober support network; beginning to deal with feelings without the use of drugs/alcohol; and attending to mental and physical health concerns, including prenatal care. In addition, finding clean and sober housing, building daily life skills, improving parenting skills, becoming financially stable, and taking care of legal matters were components of *Doing Everything*.

Sometimes the actions expected of the mother were listed in court orders, contracts with Child Protective Services, or in statements by family members. Sometimes mothers who thought they were *Doing Everything* subsequently learned that the components of *Doing Everything* had changed. As one mother said, "Whenever I would fulfill it [the contract with CPS], it would change. And I would fulfill that and

it would change. And it would change like six to eight times." (62/775). Other times persons with input into the components of Doing Everything differed about how well a mother was addressing the components or what the components should consist of. Such difference in opinion, especially when it differed from the mother's opinion, was very frustrating for the mother. For example, one mother shared:

I went to treatment and I have been doing everything that CPS has told me to do in order to get (the children) back. And I went to a hearing last week and CPS told me I wasn't doing anything to get them back. They were really negative....It is really upsetting because I am doing everything. I have appointments almost every day of the week just to get things done that they tell me to. But they're not giving me any credit. I brought in letters from my counselors and they didn't even read them at the hearing. So it was really upsetting. (57/18)

To avoid such difference in opinion, some women made a point of keeping their workers regularly informed of all of the activities they were doing.

A few women shared that they entered Doing Everything with some hesitation. As one mother who had been in a residential program said, "For my first two months, every day I said, 'I'm leaving.' I didn't even unpack for two months" (52/330). Her comments provide another example of the fluidity among categories, as one must conjecture whether at that particular moment the woman was Cleaning Up a Lot or Cleaning Up a Little. Related discussion of this occurs in Chapter V.

Some women were able to Do Everything while the structure of treatment services were around them. However, when the women were no longer in a structured environment, their ability to stay clean waned. This was especially true of women who had boyfriends or spouses who were still actively using. One woman described how she graduated from a five-month residential program for mothers with children. The baby's father picked her up, "And within one week I was in a bar drinking alcohol" (64/51). Another woman shared how she was homesick after geographically

relocating for residential treatment. When she moved back near her family, she quickly fell in with a drug-using crowd.

Finally, women who resisted Doing Everything took away some of the groundwork for Building Trust, another sub-category of Cleaning Up a Lot. A major consequence of not Doing Everything and Cleaning Up a Lot was losing everything.

A major contextual factor for Doing Everything concerns clear communication about specific activities needed or helpful for regaining child custody. In addition, a drug-free environment which supports the women in these activities is essential.

Building Trust

Building Trust was strongly connected with Doing Everything. Not only did others build trust in the mother as she provided evidence of seriously pursuing recovery through Doing Everything, but mothers also built trust in themselves and in others. Figure 1 provides a diagram of the triadic nature of Building Trust.

Trust by others in the mother was essential if the mother was to regain or maintain child custody. Frequently treatment counselors were the first to establish trust in the mother. One mother summarized reasons for this: a) some of the counselors had been through recovery themselves; b) the mother had no history with them, so no "burnt bridges;" and c) "they've been in the profession a long time; they can...read a bull-shitter" (63/324).

Trust in the mother by child welfare workers was very important but at times hard to develop. The women spoke of how some workers were very supportive, while others were not. One mother noted, "It's just depends on the person you're dealing with at CPS" (56/471). Another said, "I had a great CPS worker" (65/288), a reflection echoed by other women. Yet some women had different experiences.

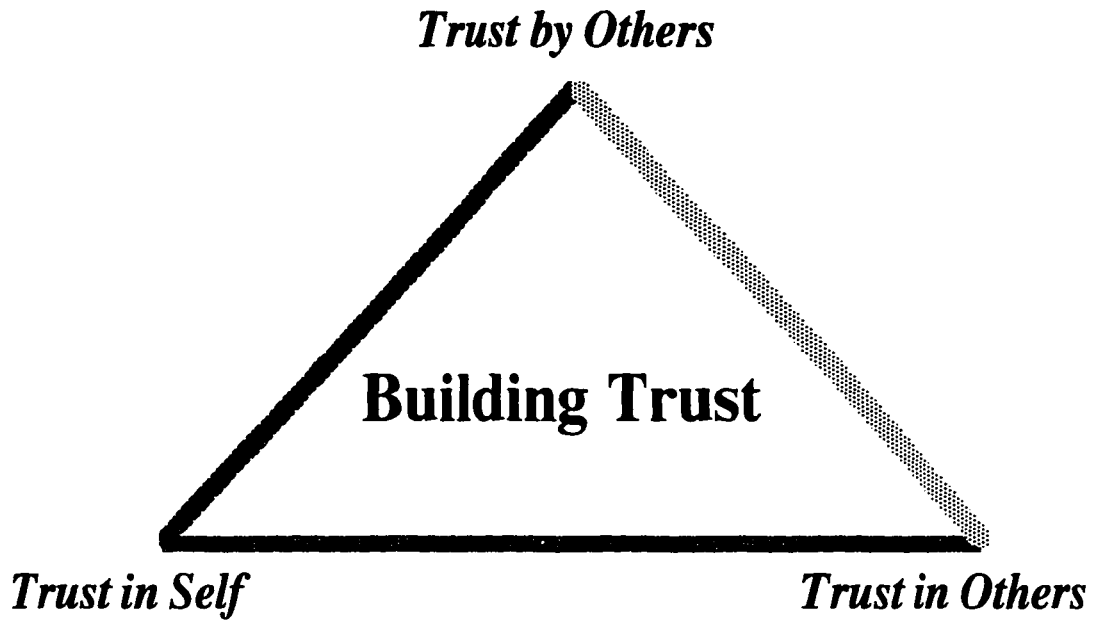


FIGURE 1: Diagram of triadic nature of Building Trust

For example, one mother said, "They are trying to throw things at me...to see if I screw up" (57/174). Several women shared that some child welfare workers did not seem to understand chemical dependency.

Some women shared that building trust with their families was often very difficult. Parents and siblings had learned to mistrust the mother because of her repeated lying and manipulation while she was actively using drugs. As one mother said, "I didn't destroy my family in a day and it's gonna take more than a day to get them back" (52/581). Some family members posed strict guidelines for the mother, such as the need to get clean housing or a job before interactions between the mother and the family could proceed. Several women saw these family demands as ultimately helpful. For example, one participant's mother reportedly said, "I'm not gonna rearrange my whole life because you screwed up yours....I'll help you move out but you're not gonna live here with the kids." The participant shared that she was glad her mother responded in this way: "She was trying to get me to be responsible and to take action for my life and my own destiny" (65/249). While in treatment this woman signed a consent so that treatment staff, the child welfare worker, and her family could discuss her progress with each other, a step which further led to Building Trust for all concerned parties. Another woman gave an example of how family members began to build some limited trust with the mother as they saw the mother Doing Everything: "My father, he'll help me. He sees that I'm really trying now and he'll help me some" (60/242).

Many women recognized that building trust with children who had been exposed to the consequences of the mother's drug use would take a long time. The following excerpts from a lengthy example demonstrate not only the child's hurt of being given up by the mother six years before to a relative but also the mother's skills learned through her recovery program in handling the child's hurt.

This last summer we [11 year old daughter and mother] have done a lot of healing. She came...for two weeks. I'd introduce her to the women around the apartment....Pretty soon I got so excited I said, "This is my daughter" because I couldn't hold it back. When we got back over to the house [the daughter] was really upset. "I don't want to meet any more people. Cause I'm not your daughter." Before too long she started saying, "And I'm mad at you." And she stopped, looking at me, and she could see that I'm making no tears. I had to be strong for her. [In previous visits the mother would feel so bad that she would start crying whenever the daughter tried to talk with her.]...I said, "You got to get it out. If there's anything more, get it out." And so she kept on, and finally when she was all done I grabbed her and I hugged her and I just started crying, saying, "[Daughter's name], I love you very much. You will always be my daughter and that's why it's really hard for me not to say that you are my daughter. I knew I was getting in trouble and I knew I was sick....Had I not done what I did the courts might have stepped in and taken you [versus being permanently placed with a relative]....Now it's very, very important for you to have a friend, somebody like a pastor or school counselor or teacher, somebody that you can trust, where you can tell things to....See what happens if you stuff it in....You've been carrying that for six years." (63/370)

This example also illustrates how another category, Dealing with Feelings, provided a healthy emotional outlet both for the mother and the daughter.

Another woman who regained custody of both of her children shared, "When I started using cocaine she [6 year old daughter] lost her mom and that was almost three years ago. So it's not just that she was in foster care and that's when she lost me. She lost me a long time ago" (65/421). Through the use of a family counselor the daughter has been able to talk about her experiences since her mother's drug use began.

Being trusted by others became a source of pride for some women.

To have people trust me to loan me money 'til I can pay them back is just, it's outrageous! But I love it. You know, people trust me now. I mean, they allow me to watch their children and play with their children and come in their house. (51/443)

But building this trust was not an easy process. In an earlier narrative about being able to have more lenient visits with her two daughters this mother said, "I've worked extremely hard for this trust" (51/285).

Being trusted by others also helped the mother develop trust in herself. One mother with 96 days of abstinence shared some interactions with others.

"Hey, let's go out for coffee....Let's go to a meeting....Let's do something."
Before it was never like that. I was always hiding out with my pipe. But
now that I'm clean and sober I feel a lot better about myself. (54/403)

Another mother with four months abstinence spoke about her discharge from the hospital following the birth of her second baby. "It felt good to be able to take her home" (56/500). This Building Trust in the self also helped the participants gradually increase their self-esteem.

Some participants shared how Building Trust regarding their ability to stay clean sometimes wavered. Cravings, dealing with chronic physical and emotional pain, and relapses had to be dealt with. One mother who voluntarily placed her children with child protective services shared, "There will always be another high in me. But there's not another recovery" (53/585). She then explained that being away from her children made the experience so difficult. Several women said that it was important for them to tell others of their addiction history to prevent setbacks. For example, one mother who was hospitalized for a musculoskeletal injury required intravenous pain medication. She told the providers in the emergency room and on the unit about her recovery. She was still given narcotic medication but later requested that this be stopped, as she felt that her recovery was in jeopardy. Another woman in treatment informed her obstetrician of her drug use and was quite pleased with the skillful care that he gave her.

Sharing isolated relapse events was more difficult, because of the lack of trust mothers had in those around them. Building Trust in others by the mother was often a tedious process. Prior life experiences had made many participants mistrustful of others. One mother who shared her childhood history of horrific abuse in some detail said, "There was too much trust lost for me and my sister as far as adults and authority to ever let them know what was going on. So we just lived through constant fear" (62/169). Yet mothers had to learn to trust that CPS workers wanted family

reunification whenever possible, that non-relative foster parents would provide safe and nurturing care to their children, and that prenatal health care providers would continue to provide quality care. Social workers as a group were particularly mistrusted by many mothers. For example, the previously mentioned mother who took her second baby home said;

When she was first born I kept her in the (hospital) room with me the whole time. There was this social worker that came in and when she told me she was a social worker...my heart dropped to my stomach and I thought, "I've been clean! I know you're not coming to take my kid!"....All of a sudden I just felt that impending doom again. (56/491)

The mother went on to explain that the social worker was only checking in to see if the mother needed anything.

Women also shared that women friends and men friends could not always be trusted. One woman from When the Bough Breaks (Corsler & Adler, 1993) describes how it has taken her three years to build such trust: "Something else that's totally different is my friends....It's all new to me, trust, I mean. I never trusted women. I never trusted men. I never trusted anyone" (p. 103). Another woman shared an early reaction to trusting others. She queried, "Why is that person being so nice to me? What do they want from me? And now I'm starting to realize, they don't want nothing. They just want to be my friend" (61/1098). Another mother, however, continued to avoid becoming too friendly with her neighbors in transitional housing, fearing a relapse if drug related activities were pursued.

Context factors for Building Trust includes a wide array of support for the mother's recovery, (re)stabilization, and parenting, as well as a drug-free environment.

Balancing Parenting and Recovery

As women progressed through Doing Everything and Building Trust, they began to get a feel for the kinds of activities, energy, and time commitment that successful

participation in recovery takes. In addition, they developed a more realistic understanding of what is needed to provide a safe, stable, and nurturing home for children. Balancing Parenting and Recovery describes how the participants blended these processes. Figure 2 illustrates how Balancing Parenting and Recovery relates to the other two sub-categories in Cleaning Up a Lot/Becoming Fit.

Many participants commented how a full commitment to recovery was essential. A woman with two months abstinence who was not yet able to see her children at her family's request shared that her mother was "trying to protect the kids and I can't blame her for that...I just have to concentrate on getting me well" (52/427). Another woman with five months abstinence in a transitional program who had custody of her new baby but had her parental rights terminated with an older child said, "If I'm not here for me then I can't help or do anybody else any good" (56/14). One mother used the analogy of an emergency on an airplane in which the adult must first put on the oxygen mask before doing so for a child: "If you're passed out you're not going to be able to help your children. If your children pass out, you're there for them" (62/1284). Making a commitment to recovery for their own sake, not for the children's or for any other reason, was characteristic of many of the women. One mother illustrated this by saying, "It has to come from within" (59/708).

Women in early recovery who had recently regained child custody or who had a new baby frequently felt a conflict between the demands of recovery and those of parenting. "You really can't work and take care of kids and do outpatient classes. You can't. So I'm kind of hoping that I won't have to work through the summer and just concentrate on that" (53/787). Another mother shared, "Every day I'm busy....Busy, busy, busy" (63/489).

One way of handling this conflict was to explain to an older child the importance of the mother's recovery activities. The mother of a six year old who had

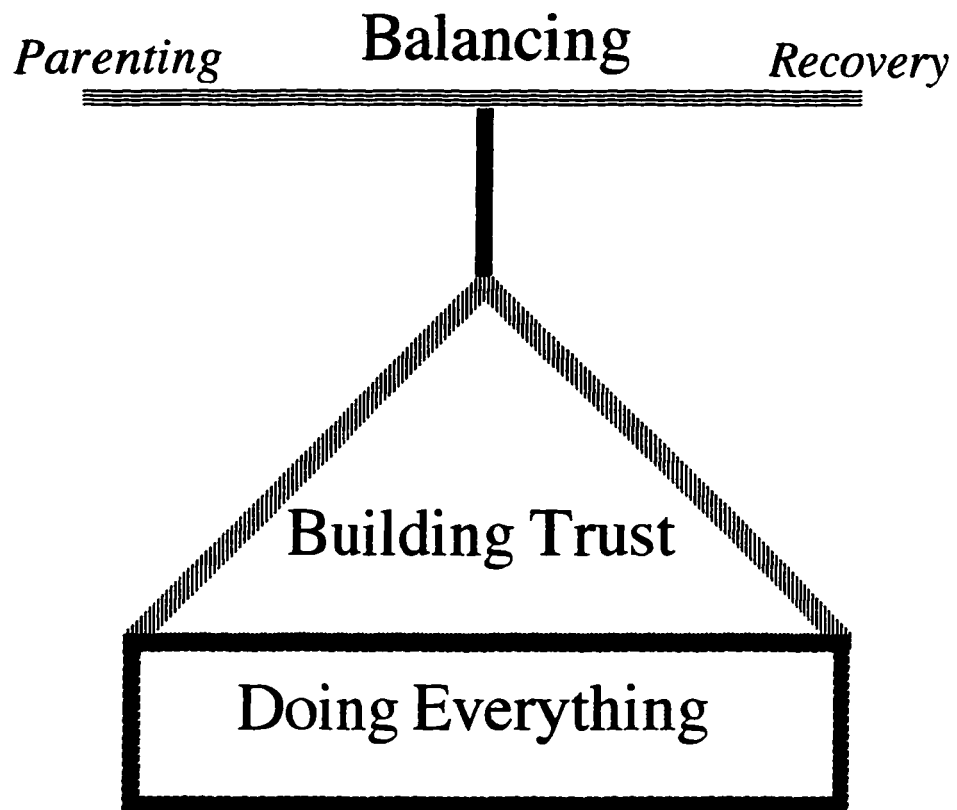


FIGURE 2: Diagram of the three sub-categories of Cleaning Up a Lot/Becoming Fit. Note how Doing Everything provides the foundation for the others.

been foster care for four months said, "She understands that the meetings that I go to are important for me because if I don't go to my meetings I don't have me, I don't have her and they [sic; her daughter and her son] don't have me" (65/417). Another mother with a six year old said her daughter likes to go to meetings and learn the "little prayers and certain phrases that are in sobriety" (64/178).

A mother's honest awareness of her readiness to resume parenting was often overshadowed by her eagerness to be with her child and the pressure to re-normalize her life. One mother who completed an inpatient program and was now in intensive outpatient shared, "All I could think about was getting my kids back. That's all I wanted. I was obsessed with it" (65/305). She got both children back when she had three months of abstinence. "My head was still kind of foggy. I got really stressed and I thought to myself, "Maybe I got them back too soon." But I didn't want to say anything...I had to have somebody coax me into saying it" (65/367). Being able to trust others was a critical element so that the mother could feel safe in reaching out for help.

This pursuance of feeling safe, both in terms of one's physical safety as well as protecting one's recovery, helped the women determine what roles fathers of the children would have. As stated earlier, some of the women had developed their drug use through relationships with men; a number of these men were drug dealers and frequently became incarcerated for drug related activities. One mother shared: "He didn't even know he had a child by me. Because he was still using drugs and I was clean and I couldn't associate myself with anybody, regardless of who they were, that were using drugs" (56/861). When this mother learned that the father had been incarcerated and was now trying to stay clean, however, she began to share information about the baby with him. While specific information about fathers was

not a focus of this study, information from the transcripts revealed that although many fathers were reported to have problematic drug use or were prone to domestic violence, not all were.

Women with new babies or who had regained custody of their children had developed parenting plans to assist them in providing safe and nurturing care to their children. They were involved in parenting classes, parent groups such as Parents Anonymous, and co-operative child care. Mothers who had been physically abused as children were very cautious about using any physical discipline with their children. As one mother said, "I know I can never, when I'm angry, touch my children. I can't do it. Because I'll hurt them. I know that" (62/182). Several mothers shared that they were teachable. "They taught me that the things I should have learned while I was growing up as a child, I'm not too old to learn those things" (63/357).

Some mothers however, eventually realized that they could not balance recovery and parenting, and that if they were to maintain their recovery they would have to give up the parenting role. One case history illustrates this. A woman in her mid-20s relinquished a child at birth in order to focus on keeping custody of her toddler. Following treatment the woman developed a relationship with a man who was actively using drugs. The woman became pregnant, and both she and her partner were jailed as a result of drug-related activities; the toddler was put in state foster care. The woman delivered her new baby while in prison and this child went to the same foster home as her sibling. During the mother's incarceration the toxic cocaine effects diminished and the mother became aware that she had a depressive disorder. She was also diagnosed with post-traumatic stress disorder related to childhood abuse. After her release the mother continued visiting her children but gradually realized that she could not adequately take care of them and simultaneously maintain her mental health and recovery. With much support from professionals with whom

she had established a trusting relationship the woman decided on her own to relinquish her parental rights to the other two children. "I know I made the right choice in not keeping them because they would have been worse off if I would have kept them....I have a hard enough time just taking care of myself sometimes" (51/740).

Several women who originally gave temporary child custody to a relative also decided that having primary custody of the children would be a great detriment to their recovery. One mother who now works full-time has her children every other weekend; the children's father has primary custody. As this mother said, "I think if I had them back I would be drinking and drugging again" (58). This woman shared no background of dual diagnosis nor did she give any evidence of this during two interviews.

In contrast to women who chose recovery over parenting when the two would not balance together, other women let their recovery efforts slip and eventually lost both. Indeed, this is how many of the participants initially lost child custody. Fear of relapse and its consequences were shared by several women. One mother shared how she uses imagery about how she would feel if she relapsed and lost custody of her child (56).

Contextual elements include access to recovery activities, drug availability, and support for re-stabilization and parenting.

Dealing with Feelings

Before recovery, women often tried *Numbing Out*, *Giving Up*, or *Running Away to Handle the Hurt*. But through participation in recovery women eventually began *Dealing with Feelings*. This means that the women dealt with either positive or negative feelings in a healthy way.

Most treatment programs promote the healthy expression of feelings early on. One woman in her first treatment site, a residential program, noted, "You deal with a lot of emotions and everything" (52/332). She later went on to say, "I don't stuff any more things now that I found out it's not healthy" (52/664). Another said, "I've got like three months clean and sober and I have so many feelings that, I never knew I could even have" (53/159). Another woman with two years abstinence said, "I've got feelings now!" (51/25). When she has feelings of hurt related to child custody loss such as on the children's birthdays or holidays, this mother uses tranquil activities or reaches out to close friends for comfort. She shared, "Today I listen to my feelings. I listen. Sometimes I don't always believe them but I do listen to what goes on. And I'm still not quite used to following what I'm hearing, but I'm doing better at listening" (51/729).

Sometimes learning to express feelings was related to the skills or relationship with a particular counselor. One woman said, "this counselor...she was just great. And the more I was talking and reading my papers, you know, it was like all this stuff that came out...Other counselors, they were good, but she...it was just like magic" (55/195). Other participants felt comfortable sharing their feelings with other women in similar situations. "You can share in a lot of that and not have to hold it all in" (64/166).

Women also mentioned the pain that comes with Dealing with Feelings. One mother gently cried as she described how her children did not come to her treatment graduation earlier that day, and that Mother's Day was a few days away.

Participant: And it hurts. Because I love my kids to death.

Interviewer: Uh-hum.

Participant: And I'm able to feel my feelings now. But before I couldn't.

Interviewer: Which is painful?

Participant: Yeah, it's real painful. (54/193)

The mother then went on to describe other recent losses in her life and how she is now aware that she has not grieved over them.

Yeah, my feelings are coming out now. I don't have nothing to medicate me with anymore. Which, I'm glad. I'll be going to [counseling center] for some serious counseling. Because I need it. I've got a lot of things going on in my life that I don't think I can deal with on my own. (54/221)

This example illustrates how support to women by counselors and friends was critical at such times to prevent the woman from Numbing Out, Giving Up, or Running Away. Women had to work hard to avoid the tendency to "get rid of these feelings" through their old habits. One mother shared how historically "I liked not being able to feel. I liked it" (Corser & Adler, 1993, p. 47). Another said, "When you're in your disease you don't even foresee yourself stopping. Cause then you'd have to feel" (64/145). Hence, *Dealing with Feelings*, while ultimately providing a healthy way of Handling the Hurt, also demanded a lot of energy and tolerance of discomfort by the mother.

For some women, perhaps related to the effort and energy required, *Dealing With Feelings* had to occur in steps. For example, one mother in *When the Bough Breaks* (Corser & Adler, 1993) shared that only in her fourth year of recovery was she learning to express her emotions (p. 103). Another mother talked about Numbing Out: "All the pain and fear was covered up when I was doing drugs. I really don't remember a lot of it" (Corser & Adler, 1993, p. 95). This brings up the questions of whether it simply takes time for the mother's feelings to emerge and whether for some mothers certain levels of trust and support must be present for this emergence to occur. Numerous women spoke of how it took months to clear one's mind from the toxic effects of the drugs. Still another woman recognized that she first had to get her addiction under control, and then she would have to deal with issues from her

childhood through counseling. "I need to work through that. Right now is not the time, though" (53/472). This developmental approach to Dealing with Feelings is pursued in Chapter V.

Some of the mothers also realized that they must allow their children to express their feelings. The lengthy excerpt in Building Trust provided one example of this. Another concerns a mother who had gotten custody of her children back and shared how at times the daughter would say she wanted to leave.

It hurts me when she says she doesn't want to live here. But I have to let her say how she feels. Because if I try to push it back in her then I'm just doing what I was doing when I was doing drugs. (65/406)

Critical contextual elements for Dealing with Feelings include adequate perceived support and a drug-free environment. Contact with a mental health professional is also highly desirable.

Hypothetical Relationships Among Concepts

Six strategies for Handling the Hurt were identified from interviews with 15 participants and a published narrative collection (When the Bough Breaks, Corser and Adler, 1993). Figure 3 contains a diagram of the grounded theory developed about these strategies and their relationship to Handling the Hurt. The circle represents the hurt in a mother's life. The researcher believes that this hurt continues to exist over a woman's lifetime. However, the amount of discomfort caused by a particular hurt and the amount of time that the hurt is causing discomfort can be significantly reduced through supportive positive contexts. Three of the strategy-concepts—Numbing Out, Giving Up, and Running Away—are associated with negative contextual elements. These negative elements include: ready drug availability; lack of support from family, friends and professionals;

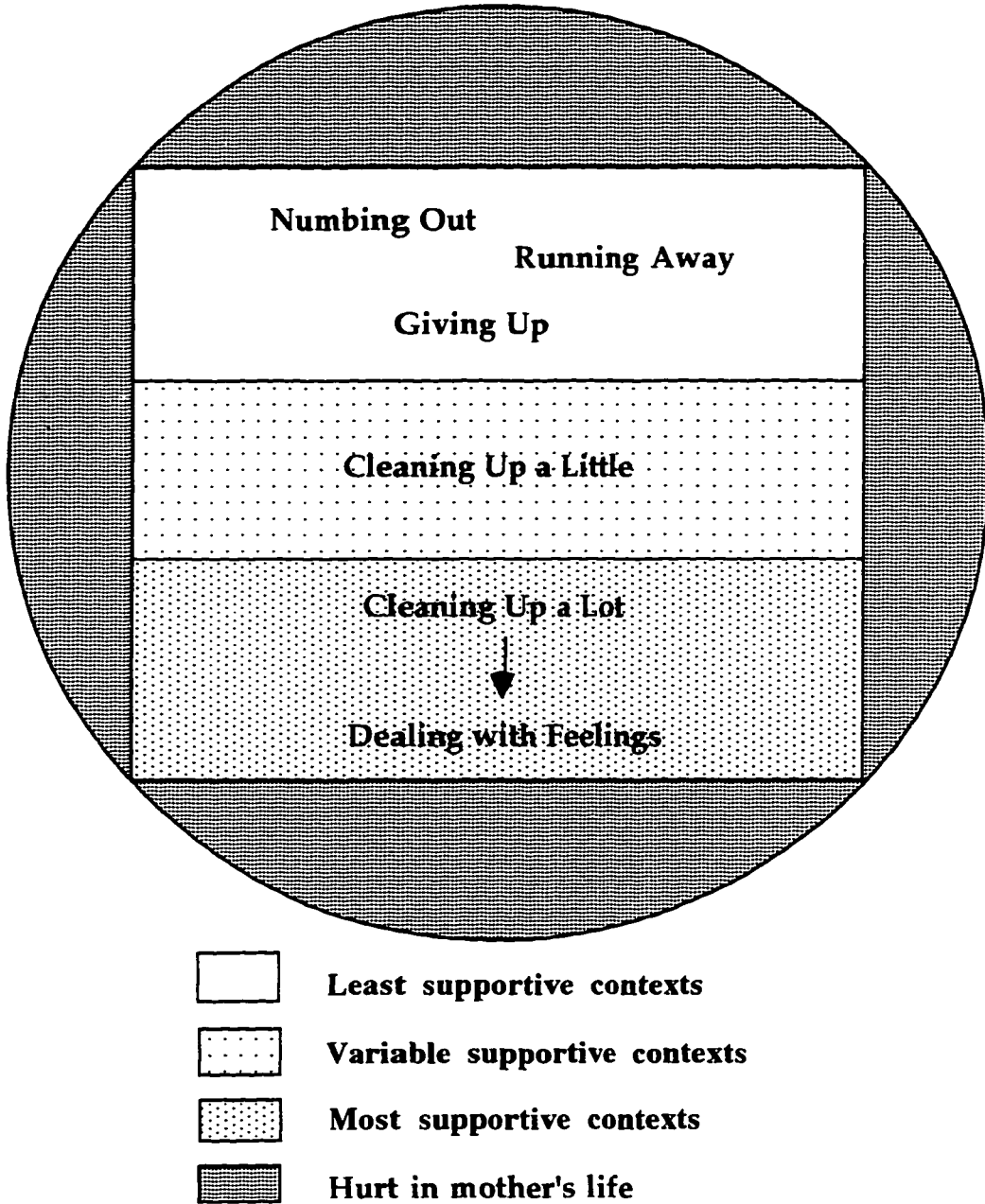


FIGURE 3: Diagram of developed grounded theory, Handling the Hurt. All categories can result from and lead to the others, except for Dealing with Feelings, which can only be truly attained through Cleaning Up a Lot.

unsafe environments; an imbalance between the mother's motivation and barriers to pursue her goals; and decreased skill repertoire regarding recovery, daily life activities, and parenting. Two other strategies—Cleaning Up a Lot and Dealing with Feelings—are promoted by positive contextual elements, including environments that are drug-free and safe and which provide support for recovery, (re)stabilization, and parenting. The types and amounts of supportive contexts found in Cleaning Up a Little vary from situation to situation.

Participants' stories supported the fluidity among all categories, except for Dealing with Feelings. This category could only be truly attained through Cleaning Up a Lot. However, a woman could go from Dealing with Feelings to any of the negative contextual categories if adequate support was not available to her when negative feelings were problematic. One explanation for the category fluidity is that when hurt comes to the forefront of a woman's life and adequate supportive contexts are not available, the woman can easily turn to her prior ways of Handling the Hurt. Likewise, when supportive contexts become more positive, a woman is more likely to handle her hurt in healthy ways or to develop the necessary skills to do so.

The researcher conjectures that the fluidity among categories is most likely due to dynamic changes in a delicate balance between individual characteristics of the mother and environmental factors. Critical individual characteristics include the prolonged affects of Hurt in the mother's life and her repertoire of skills. Important environment factors are the type and amount of available support and an environment that is drug-free and perceived as safe.

Summary

Chapter IV began by providing the reader with demographic background about the 15 participants in the interview portion of the study and about the involved children. The study findings were then presented, with the bulk of the chapter reviewing the concepts identified in the data that were related to the identified basic psychosocial process of Handling the Hurt. The chapter closed with a discussion of the developed grounded theory regarding Handling the Hurt and a related diagrammatic illustration. In Chapter V the purpose and aims of the study in relation to the findings will be reviewed, followed by a discussion of the findings from the current study to findings from other studies.

CHAPTER V

DISCUSSION

Chapter V begins with a discussion of the purpose and aims of the study, followed by a review of Glaser's criteria for theory evaluation and a brief discussion about categories as strategies. The bulk of the chapter will present the relationship between the six strategies and findings from other studies. A discussion of the limitations of the study and the researcher's experience regarding interventions during interviews is also included. The chapter will close with implications for nursing, recommendations for future research, and concluding remarks.

A Review of the Purpose and Aims of the Study

The purpose of the study was to develop a substantive theory regarding women with histories of cocaine or heroin use. The proposed grounded theory was presented in Figure 3, Chapter IV, and was a result of addressing the first three aims: a) obtaining information directly from women with histories of cocaine or heroin use who lose child custody; b) identifying common concepts evidenced in the women's stories; and c) suggesting hypothetical relationships among the concepts. The fourth aim, to explore the use of grounded theory methodology with this population, is addressed later in this chapter.

Criteria For Theory Evaluation

As stated in Chapter III, Glaser and Strauss (Glaser & Strauss, 1967; Glaser, 1978; Glaser, 1992) identified four criteria by which to evaluate a well constructed grounded theory. The first criteria was fit, that the theory and its subcomponents must fit the data from which they were drawn and fit the realities of the participants'

lives. The fit of the data from this study to the identified basic social psychological process (BSP) of Handling the Hurt and its related concepts was demonstrated in Chapter IV, in which supporting quotations and narrations from the various interviews and the published narrative were given. The six strategies present a wide range of behaviors that the participants have used in Handling their Hurt. Women in later initial or follow-up contacts continued to provide support and evidence for the BSP and categories, all of which had been developed through the constant comparative analysis method.

Evidence to support the second criteria, that the theory must work or explain what has happened or will happen, was also provided in Chapter IV. The critical focus here are the contextual elements which promote or diminish each strategy. When the contextual elements are less supportive it is likely that women will use the strategies of Numbing Out, Giving Up, and/or Running Away. Less supportive contextual elements include drug availability, decreased support from family, friends and/or professionals, unsafe environments, decreased maternal motivation and skills to stop using drugs, and increased barriers to drug treatment. When contextual elements are more supportive, women are more able to pursue Cleaning Up and Dealing with Feelings. Mothers using strategies promoted by less supportive contextual elements are at much greater risk for losing child custody than mothers who are using strategies that have more supportive elements.

The third criteria concerns relevancy to the action of the area, that is, relevancy to the women's lives. As the discussion in Chapter V will demonstrate, issues of hurt and strategies to handle hurt are apparent in numerous other studies about women with histories of drug use, particularly those who have experienced child custody loss. Explicating the contextual elements that are supportive to Cleaning Up a Lot can help

providers and policy-makers promote the development of these elements in drug treatment and related services for mothers.

Glaser and Strauss' fourth criteria states that the theory must be modifiable. The proposed theory of Handling the Hurt in this study and the related strategies that women have used are certainly subject to modification, without diminishing the first three evaluative criteria. That is, the proposed theory will continue to fit, be workable, and relevant to the participants in this study, even though additional strategies or contextual elements may be later identified. For example, Letting Go, Letting God, was a strategy for Handling the Hurt that had weak support in this study and was not identified soon enough for adequate exploration.

Categories as Strategies

Strategy has been the term used in this study to describe each of the six categories of Handling the Hurt. Glaser (1978) has noted that strategies are conscious acts to maneuver people (p. 76). When no conscious element exists, Glaser states that the behavioral pattern is not a strategy but a consequence of another behavior. In this study, behavioral patterns such as Giving Up, Cleaning Up (a Lot or a Little), and Numbing Out fit Glaser's definition of strategy. For example, in Giving Up a woman makes a conscious decision to entertain ideas about suicide. In Cleaning Up she is purposefully taking steps to get custody of a child back or to alter her life. A participant exemplifying Dealing with Feelings had chosen not to ignore her feelings or Numb Out. Numbing Out and Running Away are probably more unconscious patterns which the client has found to be successful in the past. At times a participant may be thinking, "I'm hurting so I'm going to get high" or "I don't want to get hurt so I'm out of here." However, the frequency of such conscious thoughts prior to Numbing Out or Running Away was not specifically explored in interviews.

Although the discussion below will provide information about how some of the individual strategies have been described or alluded to in other studies and theoretical papers, no one study has previously described the six strategies for Handling the Hurt as a comprehensive unit.

Numbing Out

Numbing Out describes a strategy used by all participants in this study in which a mother used drugs or alcohol to cover up her painful feelings. Such use of drugs/alcohol by women to control the pain of child custody loss, abuse, and other sources of emotional distress has been described in other studies and articles (Bennett & Kemper, 1994; Boyd, 1993; Corser & Adler, 1993; Hagan, Finnegan, & Nelson-Zlupko, 1994; Kearney, Murphy, Irwin, & Rosenbaum, 1995; Kearney, Murphy, & Rosenbaum, 1994; Pursley-Crotteau & Stern, 1996; Rosenbaum, 1979; Teets, 1995). Hagan et al., for example, state that "It appears that women abuse substances in order to medicate pain....substance abuse and the behaviors associated with the abuse often become normal reactions to abnormal situations. Normal emotions are medicated and negated" (p. 166).

Regarding the use of drugs in pregnancy, Rosenbaum (1979) noted in her large sample of mothers with heroin addiction how using drugs during pregnancy was not acceptable within the using population (p. 435). Armstrong (1992) noted how most of the 11 mothers in her phenomenological study of women who had used drugs in pregnancy felt guilt and remorse about such drug use. In the current study over half of the women used alcohol, cocaine, or opiates during their pregnancies, many as a means of handling their emotional pain. This example from the current study of a participant's guilt about using drugs during pregnancy was given in Chapter IV.

Even when I was selling drugs I wouldn't sell them to a woman who was pregnant. I wouldn't do that. Yeah, really! Such morals. But I wouldn't do it. And here I found myself in the same situation. Here I'm using and I'm pregnant and I know it. And I wasn't trying to stop, you know....I was feeling so much guilt because I felt the baby kicking and I thought, "Oh, God, what am I doing? What's wrong with me?" (52/189)

Other participants made similar remarks, supporting findings from previous studies.

Giving Up

Giving Up has been defined in this study as a woman having suicidal or despairing thoughts and behaviors in response to the woman's hurt. Findings from another study which supports Giving Up can be found in a recent Australian national survey of 267 women with alcohol or drug problems (polydrug usage was predominant) from over 40 treatment and 12-Step programs (Swift, Copeland, & Hall, 1996, p. 1146). Forty-four percent of the women reported that they had attempted suicide. The most frequent methods of attempt were overdosing (81%) and wrist-slashing (32%). Lesser used means were road accidents, jumping from heights, hanging, and shooting. As the Australian survey did not collect reasons for women making suicidal attempts, one can only speculate whether women did so in response to the emotional hurt they felt. Sixty-one percent of the 267 women were mothers. Of these, 29% had formally given up custody of their children and an unclear percentage of other mothers had informally placed their children with relatives. The percentage of mothers attempting suicide versus all of the women in the sample was not reported.

In an earlier interpretive study about chemically dependent nurses (Hutchinson, 1986), psychic and/or physical pain was identified as the basic social psychological problem and self-annihilation was found to be the basic social psychological process. "Self-annihilation refers to a self-destructive process....The process is unwitting, unarticulated, gradual or rapid, and may be aborted, but it generally progresses along

a downhill course" (p. 198). Hutchinson cited some examples of self-annihilation which resulted in death, stating that such an outcome was "the extreme end result of a completed self-annihilation process" (p. 198). Hutchinson's theory of self-annihilation shares similarities with both Numbing Out and Giving Up. The basic psychosocial process identified in her study and in the current study both focus on pain and hurt. Both samples used drugs/ alcohol to alleviate this pain and hurt. Hutchinson noted how the self-annihilation process could be aborted, indicating fluidity from this process to a more positive behavioral pattern which she identifies in a later article as self-integration (Hutchinson, 1987). However, unless participants in Hutchinson's study purposefully shared suicidal thoughts or had overtly destructive behaviors their self-annihilation behaviors would be labeled in this study as related to Numbing Out, not Giving Up.

Running Away

Running Away in this study has been defined as the physical relocation of a woman from an unsafe or problematic locale to another locale, or as the frequent physical relocation of a woman from place to place. Recent literature about runaway youth indicates that they have frequent histories of childhood abuse and/or come from homes where familial drug or alcohol use was problematic (Booth & Zhang, 1996; Gary, Moorhead, & Warren, 1996). As indicated in Chapter IV, the women in this study who used Running Away had histories of physical or sexual abuse. In addition, all of them shared histories of problematic parental or sibling drug use and obviously had extensive histories of drug use themselves.

Running Away as a strategy for women in adult domestic violence relationships was not verified in a limited review of literature about domestic violence. However, one recent article noted that physical and emotional paralysis was a behavioral

response of women in destructive relationships (Weingourt, 1996). That is, women often stayed in an abusive situation, being unable to leave for a variety of reasons. It is unclear why and how Running Away becomes a behavioral response for some women in unsafe situations but not for others.

While none of the mothers in the current study gave any indication that they abandoned a child in a hospital nursery following delivery, the question arises whether mothers who do abandon their infants have used Running Away in other situations and whether these mothers have a higher incidence of childhood abuse, adult violence experiences, and/or problematic familial drug use.

Cleaning Up

Cleaning Up a Little and Cleaning Up a Lot both involve the mother becoming abstinent from drugs and alcohol. The major difference between these two strategies is the longevity of the woman's recovery program. Women in Cleaning Up a Little make a temporary personal effort to abstain or have short-term external constraints put on them to deter drug use. Because of its short-term nature, women in Cleaning Up a Little can only describe the current program they are in, such as an inpatient program, a jail program, or maintaining abstinence on their own. These women are doing some things, but not everything. As a result, others do not build trust in the women in the same way as in Cleaning Up a Lot, and the Balancing of Parenting and Recovery is more difficult to achieve. In contrast, women in Cleaning Up a Lot are committed to a series of treatment programs and support systems which are intended to last indefinitely and which Build Trust and promote Balancing of Parenting and Recovery. Professionals less familiar with chemical dependency often assume that completion of one treatment program is all that is required for an individual to remain abstinent. Participants in this study completed the vast majority of the 58 treatment programs

they had been in, yet many of the women relapsed within six months of their completion. Rather, treatment programs are the first phase of a lengthy treatment course designed to help individuals build the skills needed to maintain abstinence and to develop clean and safe support systems while gradually decreasing the structure provided by treatment activities and professional support.

One of the most pronounced trends in recent literature about mothers with addictions is the description of pilot and ongoing programs for these women which have been developed over the last decade and which promote this continuity of the recovery process. All of the programs with histories of demonstrated success appear to offer services which provide women with opportunities for Doing Everything, Building Trust, and Balancing Parenting and Recovery, the three sub-categories of Cleaning Up a Lot.

For example, Carten (Carten, 1996) describes a purposive sample of 20 women who had successfully completed the Family Rehabilitation Program in New York City. This home-based program with a strong team approach is available to women with histories of drug use whose presenting problems do not compromise the safety of the child remaining in the home. The 20 mothers had been discharged from the program for at least 6 months at the time of this follow-up study and none had any new CPS reports. Carten noted, "the ever-present threat that their children would be placed in foster care provided the external pressure needed to continue in drug treatment" (p. 220). This motivation is very similar to the main motivation for women in the current study. The team services assisted the women in their early recovery efforts and (re)stabilization through a supportive versus a punitive approach, and the creation of additional support through family and significant others was likewise promoted. The activities by the mothers in Carten's sample are similar to activities which promote Doing Everything, Building Trust, and Balancing Recovery and Parenting in the current

study. Two major differences between Carten's sample and the participants in the current study were that the women in the New York study did not have long histories of severe substance abuse and only one of those women had ever had a child in foster care.

A study with a more similar sample to those in the current study concerns pregnant or parenting women (N = 405) who were mandated into the Options for Recovery (OFR) treatment programs in California by either the criminal justice system or through social services (Berkowitz, Brindis, Clayson, & Peterson, 1996). The alternative for these women was incarceration and/or placement of the child in foster care. The women received appropriate drug treatment and comprehensive case management. In addition, foster parents and relatives were recruited and given special training to provide supportive interim child care. Of the women who stayed in the program,

Many stayed out of concern for their children: to increase their chances of delivering a healthy infant if they were pregnant, to be reunited with children in foster care, to improve their effectiveness as parents, or out of fear of losing custody of their children. (p. 37)

Again, the motivation of mothers to Clean Up a Lot, or even Clean Up a Little, is often related to staying connected to their children. And again, the women were assisted in the program to develop a strong recovery program and restabilize their lives in a supportive, community-based manner. When compared to women who were not mandated into the OFR programs but instead voluntarily participated, the mandated women were more likely to complete drug treatment. The authors are careful to point out, however, that "these findings should not be interpreted to mean that coercion to treatment is the most effective motivation for treatment completion" (p. 37). They point out that numerous factors affect entry and completion of treatment programs, and that the reasons for mandating treatment varied.

Doing Everything

Women who are Doing Everything have begun to take steps to (re)stabilize their lives by actively participating in recovery through the use of drug treatment and related services. The parentheses around the prefix of (re)stabilize indicates that some women will be embarking on a path to stability for the first time in their lives.

Hagan, Finnegan, and Nelson-Zlupko (1994) noted how women have broader issues of dependency than men. For example, many mothers with addictions live below the poverty level, indicating their economic deprivation and dependence. Furthermore, women more often than men provide dependent care. These dependency issues raise the question of whether the activities needed in Doing Everything for women with addiction histories are more extensive and more difficult than Doing Everything for men with addictions. These authors also noted that changes and expectations when the mother carries out so many recovery and (re)stabilization activities can create feelings of anxiety, which in turn can lead to an isolated relapse or even Numbing Out.

Doing Everything implies that the mother is taking whatever action is necessary to become successful in her recovery efforts and/or to maintain or regain access with her child. On first appearance one might believe that the mother is in charge of what actions are necessary, as she is the one who coordinates and participates in them. This self-determination of what comprises Doing Everything has been demonstrated by couples in which the wife has breast cancer; following consultation with oncology experts the couple "does everything" to achieve the goal of the wife's survival without cancer (Zunkel, 1996). However, for women with drug use histories these actions are often mandated or requested by those in positions of authority. Several recent studies have indicated that parental compliance with court-ordered interventions has a significant impact on whether a parent maintains custody with a child. For example,

in one U. S. study, 97% of parents who did not comply with court recommendations lost permanent custody of their child (Jellinek, Murphy, Poitras, Quinn, Bishop, & Goshko, 1992). "The court's approach appears to be based on the reasonable premise that noncompliance under supervision is likely to predict future difficulties in caring for children" (p. 183). Substance use was not the only reason contributing towards maltreatment; some families had issues of homelessness, mental disorders, or domestic violence. In a Canadian study of 56 mothers, mothers who were less compliant had a greater risk of child custody loss (Atkinson & Butler, 1996). And Carten (1996), reporting the New York City program described earlier, noted, "Although participation is voluntary, the program is somewhat coercive because the most likely alternative to nonparticipation is foster care placement of children" (p. 220). Hence, Doing Everything for women with a history of drug use is not only a matter of activating the best plan to achieve the woman's goal of recovery and/or child custody but also is strongly associated with compliance to court and other mandated orders.

One similarity between the couple having a wife with breast cancer and a mother with a history of drug use and child custody loss is that Doing Everything does not guarantee that either party will successfully reach their goal. However, in the case of the mother, Doing Everything often leads to Building Trust.

Building Trust

Building Trust describes the process in which others build trust in the mother and the mother builds trust in others and in herself as her recovery progresses. The programs cited above describe how women participants learned to build trust with staff members and others (Berkowitz et al., 1996; Carten, 1996). Through Building Trust women are able to gradually demonstrate that they can provide safe and nurturing homes to their children while taking care of themselves. Without this trust

women who have lost custody of their children will not be able to regain custody. As stated, Building Trust is very closely connected to Doing Everything.

Balancing Recovery and Parenting

Balancing Parenting and Recovery refers to how a woman learns how to balance parenting and recovery in her life, giving recovery the top priority. The title of this category closely matches the basic social process "Balancing alcohol recovery and pregnancy" identified by Brudenell (1996) in her grounded theory study of 11 pregnant women self-identified as alcoholics/addicts. Brudenell's sample was more homogenous, consisting of all white women who began prenatal care in the first 12 weeks of pregnancy and who avoided any alcohol or drug use once their pregnancies had been identified. None of the women had any history of child custody loss. While this researcher's categories were reached independently of Brudenell's work, the striking resemblance between the two titles and other sub-components helps to affirm the trustworthiness of the findings from both studies.

As stated, Brudenell found Balancing to be the core category, not a sub-category. Three main types of strategies for Balancing were identified by her: protecting, progressing, and nonprogressing. The progressing strategies, which were used to maintain abstinence throughout pregnancy and transition to the role of mother, had several dimensions similar to sub-categories in the current study. For example, dealing with emergent feelings in Brudenell's study is similar to Dealing with Feelings in this study. Aspects of the sub-categories Brudenell identified including establishing the dual identity of alcoholic/addict mother, reordering family ties, and using professional help are similar to Building Trust.

Dealing with Feelings

In *Dealing with Feelings*, women learned to handle their positive or negative feelings in a healthy way. Hagan, Finnegan, and Nelson-Zlupko (1994) and others have noted that when drug use begins, emotional development is stifled. Emotional development can also be inhibited by experiences of abuse and trauma in a woman's growing years. Hence, when a woman begins to Deal with Feelings, not only must she learn to do so without the use of drugs or alcohol, but she must also do so at a developmental level that most likely does not correspond with her chronological age. Yet the range and depth of emotions that she must address are often beyond those of persons with healthy developmental trajectories. Therefore, this study's findings that *Dealing with Feelings* may need to be done gradually and with ample support are congruent with the current understanding of the effects of drug use and trauma on the developing psyche.

Relationship of Findings to Those of Other Recent Studies

The findings from a recent pilot study by Kearney (Kearney, 1996) using a grounded theory approach provide another holistic picture of women in various phases of recovery. Kearney's aim in interviewing 14 women in various phases of recovery and three substance abuse counselors was to describe the process and stages of pregnant and postpartum women's recovery from drug addiction. Almost 43% of the women had lost temporary or permanent child custody. Fifty percent of the sample had used cocaine as their drug of choice, 28.6% had used heroin, and 21.4% had used alcohol. Half of the sample was white, 21.4% were African American, and 28.6% were Latina. The average age was 32.1 years and the average number of children per mother was 2.7. "Reclaiming normal life" was identified as the overarching process in the data. "'Reclaiming normal life' was a slow process of reentry into

mainstream society, accompanied by changes in attitudes toward self, others, and the drug use experience" (p. 763) and consisted of four stages and one transitional point. The first stage, *Rescue or Refuge*, describes why the women became involved in drugs in the first place; this stage shares components with *Numbing Out*. The second stage, *No Fun Any More*, indicates that the problems associated with addiction had taken over the women's life. Theoretically, descriptions of *Numbing Out*, *Running Away*, and *Giving Up* would be expected in the data from this stage. The third phase, *Leaving Drugs But Not the Drug Life*, is somewhat similar to *Cleaning Up a Little*, in which women made some efforts to maintain abstinence, often on their own, but did not have the support or skills to do so. Kearney describes this stage as characterizing early recovery. Women progressed through a transition point, *Clearing Up*, through a strong motivator such as a pregnancy or child custody loss. Behaviors of women at this time are similar to those in *Doing Everything*. Kearney's final stage, *Building a Life*, seems a continuation of *Doing Everything*, as well as the other components of *Cleaning Up a Lot* and *Dealing with Feelings*. While the purposes of Kearney's study and the current study were different, findings from each of these do seem to complement the other.

Another recent grounded theory study (Pursley-Crotteau & Stern, 1996) with 19 pregnant or postpartum women with histories of crack cocaine use also has findings supportive of those of the current study. Child custody status of the participants was not revealed, but the average number of children was two per woman prior to the current or recent pregnancy. Most of the women were in recovery. A history of drug use as a means of self-medication and trauma was prominent in the women's stories. Pregnancy provided the opportunity for the women to *Create a New Life*, both for themselves and their baby. To create this new life, women found strategies for *Staying Clean*. Some of the dimensions of *Staying Clean* share components with *Cleaning Up a*

Little and Cleaning Up a Lot, including the development of internal motivation, the need for a drug-free supportive environment, and a gradual buying into an identity of being in recovery versus being an addict.

Limitations

Theoretical Sampling Issues

While the researcher intended that women in recovery as well as those still actively using would participate, all 15 participants were in recovery. That is, as defined in this study, the women claimed abstinence of one or more days and gave a verbal commitment towards abstinence that was accompanied by supporting behaviors. For example, the two women with 5 and 11 days of abstinence through detoxification were each leaving for inpatient treatment sites in the very near future. Other women were in halfway houses or transitional housing which had stringent rules regarding abstinence. Women who lived at home identified recovery programs involving frequent twelve-step meeting attendance and the use of sponsors.

As the study progressed the researcher recognized that in order to include women not currently in recovery it would be necessary to utilize the services of an outreach worker. Such services were beyond the budget and time frame of the study. However, as indicated above, the 15 participants had an average of 2.6 treatment courses each (range 1 - 7), indicating that many had a serious relapse after previous treatment episodes and so could provide related input from their own experiences, albeit retrospectively.

No attempt was made in this study to recruit women who are actively using heroin or cocaine but who have not lost custody of a child. This group, if willing to participate, would have provided a related theoretical sample. Although representatives from this sample would be somewhat difficult to recruit because of the

women's fear of losing child custody once their drug use was known, studies from the Institute of Scientific Analysis in San Francisco have shown that such recruitment is possible if deemed critical for future study (Kearney, 1993; Kearney, et al., 1994; Rosenbaum, 1981)

Two specific decisions were made regarding theoretical sampling during the interview process. The first decision reversed the original plan of excluding women who anticipated regaining custody of their children. Early in the course of the study a mother who anticipated getting custody of her children back in less than six months was included in the study, and later other women with a similar history also participated, including women who had already regained custody of their children. The second decision was to recruit from a rural area (Site C).

Furthermore, through general recruiting methods other theoretical samples were incorporated without special efforts. For example, four pregnant women participated in the study. The final sample also had variance in maternal age, education, history of abuse and domestic violence, health concerns, age of child at time of custody loss, length of time since custody loss, types of placement of the children, and to a small degree, maternal ethnic background. The researcher had desired a predominantly white sample to help counteract the tendency of some media portrayals of women who use drugs as primarily women of color.

Non-participants

A number of women who reportedly met sample criteria considered, but chose not to participate in the study. Information about these women is provided here so that other researchers in chemical dependency can have a better understanding of some factors which can affect participation.

Three women scheduled but did not keep the appointment. One of these women had abruptly left the treatment site earlier that day, within 36 hours of setting up her appointment. One woman was in a detoxification unit and was too uncomfortable to participate at the time of the scheduled appointment and did not reschedule. The third woman made her appointment while in obvious emotional pain regarding her child custody loss and the researcher suggested that the woman keep the appointment only if the woman believed that participating in the interview would be best for the woman.

At least three other women were informed of the study through the snowball effect but did not contact the researcher. Two women were sisters of participants and were reported to be still actively using cocaine or heroin. Another woman referred a friend in transitional housing who did not respond. The researcher also made a second presentation at Site C seven months after the first and shortly before a holiday season. The group actively participated in the brief discussion and applauded the researcher when she left. However, several interested women did not meet the sample criteria regarding the type of drug(s) used and one woman contacted the researcher but chose not to participate.

Other Grounded Theory Issues

Due to the nature of interpretive studies, findings from such studies cannot be presumed to apply to other samples. Instead the findings provide a framework which can be verified through future clinical studies. In the interim, however, because of the fit, relevancy and workable evaluative criteria, clinicians working with women with histories of drug use and child custody loss may wish to explore with other women the process of Handling the Hurt and the strategies that participants in this study had used.

Another limitation of grounded theory in this study was the initial rapid response to the researcher's recruitment techniques and the resultant inability of the researcher to transcribe and analyze so many interviews at once. Constant comparative analysis forms the basis of the grounded theory, yet the researcher was initially unable to carry out this process at the desired level. Researchers in other studies have also cited this problem. Because of the transient situation of many interested participants, arrangements to conduct interviews at more widely spaced intervals was not an option. Researchers using grounded theory should anticipate multiple responses and have adequate transcription services in place when sample recruitment begins. Even for researchers who plan on transcribing some of the transcripts themselves, a budget should be set aside for some transcription in case of multiple respondents so that the researcher can better focus on analysis. However, even with optimum transcription services in place it may be necessary for the researcher to conduct a number of interviews before the constant comparative method can be formally done.

An additional limitation was that the participants in this study often chose to tell their life story during initial interviews. At times this made focusing on selective codes more difficult as the analysis advanced. The researcher quickly recognized that all interviews could be long. Typically in grounded theory studies, later interviews aimed at pursuing selective codes are often shorter than initial ones which foster open discussion. Long interviews of emotionally-laden topics such as child custody loss can be quite fatiguing for both the participant and the interviewer. As a result, this researcher occasionally chose to drop follow-up of some selective codes when interviews became lengthy.

Nursing Interventions During Interviews

This researcher was faced during interviews with the issue of providing nursing interventions. Unlike the type of interventions used when confronting someone with an addiction problem, the interventions used by the researcher were spontaneous ones often used by clinical nurses during interactions with individuals. For example, several women cried for varying periods during the interview and several others were overtly depressed. Some shared thoughts about prior suicidal tendencies. When the researcher had any concern that the participant might currently be suicidal the researcher directly pursued questions to determine if the woman had current thoughts about hurting herself. Even though none of the participants admitted to any current suicidal thoughts or ideations the researcher reviewed with pertinent participants the professional support services in the woman's current life that could be used if suicidal ideations developed.

The researcher also noted infrequent times when she moved from the role of data collector to nurse clinician. One example is from the second half of an interview with a mother who had depressive features.

Participant: It took me a long time. But I've realized that I am worth it.
That I am somebody. I have, I had low self-esteem. But it's gotten better. I cut myself down a lot. But it's gotten better.

Researcher, aware of following question being asked more for therapeutic reasons than for data collection: So can you tell me something positive about yourself now?

Participant: Um. (Takes quite a while to respond, even with researcher coaxing her.) 54/10

Another example from this study regards the researcher's clinical knowledge of addiction.

A participant who was pregnant at the time is again talking about her methadone regimen towards the end of the interview:

"I'm gonna detox, you know."

Researcher: I always tell mothers, "Don't detox too fast".

Participant: Well, that's what they told me. And I understand that, too....I'm not gonna set myself up and use again.

Researcher: Yeah.

Participant: Because they, you know, I remember that 's a possibility, you know. There's no way I'm jeopardizing this and ruin everything.

Researcher (said more to strengthen researcher's previous statement rather than to flow with the conversation): A lot of new mothers stay on methadone for a while, while your body goes through hormonal changes after delivery. 52/14

Such unplanned role transition is not that uncommon in qualitative interviews, especially when the interviewer has clinical training in psychosocial interventions or in the substantive area. Swanson (1986) notes:

One major problem for nurses is the desire to make interventions. Unless the health of the respondent is threatened, the best way to deal with the need to make interventions is to carry them out at the end of the interview in order to avoid altering the respondent's response. It is necessary to consciously take off the hat of the researcher and put on the hat of the nurse (pp. 68-69).

During the current study the researcher tried to avoid the transition to nurse clinician for two specific reasons: (1) the contract for engaging with each participant expressly for data collection; and (2) the power balance between the interviewer and interviewee. In the latter the balance may rarely be perceived as equal yet seeks a more horizontal than vertical relationship during interpretive interviews. When the interviewer takes the role of clinician/provider the relationship becomes more vertical. However, the researcher also realized that opportunities arose during the interviews to promote a woman's recovery efforts. The researcher had to weigh whether the researcher's selected comments might be helpful given the dynamics of the interview up to that point and how much the dynamics of the interview might change once a comment was made. Despite this, the overall approach was to maintain the interviewer role and avoid that of the nurse-clinician.

Implications for Nursing

Pregnancy has been identified as a major motivator for women with histories of chemical dependency to seek treatment. This researcher posits from the current study data that the prevention of temporary or permanent child custody loss is another important motivator for women to seek Cleaning Up. Furthermore, this motivator has been vastly under-utilized. Women who are actively using may be unaware that through their efforts and the assistance of treatment programs child custody loss can be prevented. Three women in this study shared that they did not know what treatment involved or how to seek entry into treatment. Women's recovery efforts would be better supported by providers with increased knowledge of the addictive and recovery processes and accurate information about treatment options. Even brief exchanges with clients to increase their awareness of problematic behaviors and available community resources can be quite helpful. The motivational interviewing process described by Miller and Rollnick (Miller & Rollnick, 1991) is an example of one approach to brief exchanges which is widely used and has been shown empirically to work.

Unlike a woman who learns she is pregnant and can often get into treatment immediately, a woman who loses custody of a child may have to wait months to begin treatment. The non-pregnant woman may be indirectly given the message that her recovery is only important when she is carrying a baby. When she is not pregnant her recovery is deemed less critical than when her drug use can have effects on the developing fetus. Yet in this study the ages of 75% of the children lost to their mother's custody were beyond the newborn period. Half of the children were four years or older at the time of custody loss. Some of the participants did not begin their problematic drug use until after their children were born. As stated in Chapter I, a mother's drug use can have long-reaching consequences on not only her own emotional

and physical health but also on that of her children. Legislators and other policy-makers who support more programs for all women with addictions will be providing their communities with far-reaching long term benefits. Nurses can play an active part in influencing policy makers by sharing their experiences regarding mothers who are in recovery and by promoting the contextual elements that support Cleaning Up. To review, these elements include an environment that is drug-free and physically safe; support by professionals, family, and friends; and ready availability of treatment courses (not isolated programs) which provide the women with skills for recovery, restabilization, and parenting.

Treatment programs which can provide rapid entry for all women and those with child access are critical to prevent additional feelings of hurt and even hopelessness by mothers and feelings of abandonment by children. Acknowledgment of women's hurt and the reasons for this hurt needs to be addressed in all treatment programs by counselors with appropriate training. More services are also needed for children of all ages who have been exposed to their mother's drug activities or effect of such activities on their daily lives. Again, nurses in a variety of settings can provide such services. For example, psychiatric nurse specialists or practitioners can provide counseling to women with histories of abuse or other traumas or to children exposed to their mother's drug use. Community health nurses can identify women and children with such needs and make referrals.

Parenting skills education for mothers with addictions is also vital for the women to Balance Recovery and Parenting. Many of the participants came from homes in which parenting skills were limited. Hence, the participants had little modeling of preferred parenting behaviors. As stated in the findings, some of the women had very explicit parenting programs which assisted them in developing their parenting skills. Nurses can also develop more support services for relatives and

foster parents who provide temporary or permanent custody of children. While non-maternal caretakers were not the focus of this study, the impact of maternal drug addiction on families and the foster care system has expanded significantly over the last decade (Minkler & Roe, 1993).

For nurses to become more pivotal in these women's lives, an expansion of their understanding and skills regarding addiction and recovery is essential. The National Nurse's Society on Addictions provides a directory of over 1,000 nurses who are certified in addictions nursing (CARN) and who can provide education to other nurses. Some geographical areas have specialty programs for nurses to learn more about addictions. New York University, Ohio State University, the University of Connecticut, and the University of Washington, are examples of Schools of Nursing that offer specific content in addictions nursing. The University of California at San Diego's Extension Program has a professional certificate in Chemical Dependency Nursing. Several textbooks and curriculum models are now available that address nursing needs of persons with substance abuse problems (Burns, Thompson, & Ciccone, 1993; Naegle, 1992, 1996; Sullivan, 1995). National standards about addictions nursing practice have been formulated (American Nurses Association & National Nurses Society on Addictions, 1988). With all of these materials and programs now available nurses have more opportunity to broaden their knowledge base and skills about addiction and recovery.

Recommendations for Future Research

This researcher is analyzing data from this study using phenomenological methods, focusing on the mothers who have permanently lost child custody and how they compare and differ from reports of women who have relinquished a child unrelated to the mother's drug usage. One might anticipate some differences in that

mothers with histories of drug use and their children are generally older at the time of child custody loss than the typical descriptions in the literature of women who have relinquished a child. However, similarities may be evident in the reports of grief experiences by mothers without drug histories and the hurt and pain reported by the women in this study. Possibly, and unlike the mothers in the general relinquishment literature, the mothers in this sample usually had numerous other factors contributing to their pain and hurt and had all used the non-healthy behavior of addictive drug use to deal with this pain and hurt. A comparison of mothers who have lost child custody related to their drug use and mothers without such a history who have lost child custody through divorce would provide additional insight, as both groups share some common demographic characteristics such as older age, more life experience with their children prior to custody loss, and frequent histories of socioeconomic challenges.

Additional questions for future research abound. For example, would findings regarding Handling the Hurt be similar in samples of women who use alcohol but not illicit drugs and have lost child custody? How would inclusion of the experiences and reflections of treatment counselors and child protective service workers regarding child custody loss among drug using parents contribute to the design of interventions? What about additional data concerning experiences of relative and non-relative foster care providers and adoptive parents of the mother's children?

Future studies about interventions regarding the multiple losses that mothers with addictions often experience could provide research-based treatment recommendations. Other questions that could influence treatment protocols are whether the maternal treatment outcomes differ (1) between mothers who have lost custody of one child and those who have lost custody of several; (2) related to the age of the child at relinquishment; and (3) when relative versus public foster care is used.

Research is also needed about the effects of the custody loss on the child.

Would more frequent visitation promote increased motivation for mothers to participate in treatment and decrease the length of mother-child separation? Would training for foster parents about emotional coaching and the repertoire of children's behavioral responses to maternal separation be helpful? How do children's behaviors differ when separation occurs related to maternal drug use as compared to behaviors identified in earlier studies of maternal-child separation?

The list of intriguing research questions could go on and on and only supports that research about this population is still in its very early stages. Collaboration among researchers can provide the best opportunity for larger and more diverse samples and should form the basis of major research efforts.

Summary

This chapter reviewed the purpose and aim of the current study and how these related to Glaser's criteria for theory evaluation. Following this was a discussion of the findings from this study and how they relate to findings from others studies. In addition, a review of the limitations of this study regarding theoretical sampling, recruitment, and coding were explicated. The researcher also addressed the use of interventions during interviews as pertinent to this study. Finally, implications for nursing and recommendations for future research were presented.

Concluding Remarks

Child custody loss among women with histories of drug use is an important social phenomenon of the late twentieth century, mediated by racial, gender, and class issues. The phenomenon is propelled by concern for the emotional and physical well-being of the child, and to a lesser extent, similar concerns for the mother. Historical precedents regarding child custody loss indicate that mothers who use drugs and lose

child custody are generally given less decision-making into the child custody loss process than are mothers without known drug histories who have relinquished a child at birth or women who have become a non-custodial parent through divorce. For many ethnic groups, child custody loss to non-relatives is an alien practice. With the continually rising increase in our foster care system of children of mothers who use drugs, researchers, clinicians, and policy-makers must work together to explore alternative ways to provide a child with a safe, stable, and nurturing environment while decreasing whenever possible the emotional and economic costs of separating a child from his or her mother when the mother wishes to maintain child custody.

This study, *Women with Histories of Cocaine or Heroin Use Who Lose Child Custody*, has identified that at least for this sample, much hurt exists in the women's lives and that the women use a variety of strategies for Handling the Hurt. The findings about hurt are supportive of portions of findings from prior studies and clinical descriptions. However, to the researcher's awareness the substantive theory identified about Handling the Hurt has not been identified prior to this study. The researcher hopes that providers and policy-makers will become more aware of the hurt of women with drug histories who lose child custody and the related contexts which help the women use more healthy strategies to Handle the Hurt. The women's stories give evidence that parental drug use, abandonment, abuse, and neglect may unfortunately lead to another generation of children who will grow up filled with hurt and pain themselves, perhaps to even a greater level than their mothers. It is only by providing more appropriate and readily available treatment courses--not isolated programs-- for mothers with minor-aged children, along with a wide variety of social support and safe housing, that the number of children entering the foster care system because of a mother's drug use can begin to decrease.

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APPENDIX A

FLYER TO RECRUIT PARTICIPANTS

TELL YOUR STORY

Study Participants Wanted

Women who have used cocaine or heroin and have relinquished or lost custody of a baby or child related to that drug use are invited to tell their stories for a study being done by a nurse from the University of Washington. The purpose of this study is to learn more about your experiences and needs. This information may then help get more services so that other women can have better chances of keeping their children.

Women who agree to participate will be asked to tell their stories in private, at a convenient time and location. Conversations will be audio taped, will take about 1-2 hours, and will be kept strictly confidential. No one except the nurse-researcher will know who was in the study and who said what.

Women who are in treatment, have completed treatment, or are still using, are all invited to participate. Each woman who meets with the researcher will get \$20.00. So arrange to tell your story or let your friends know about this study. The study will stop at the end of 1995.

If interested call Andrea at (206) 744-2808. Leave a message at the signal and Andrea will get back to you as soon as she can.

Please take this sheet for yourself or your friends.

APPENDIX B

INFORMED CONSENT, SITES A AND B

University of Washington

Researchers:

Andrea Kovalesky, RN, PhC, 206-685-7030
Doctoral Candidate, School of Nursing, University of Washington, Seattle

Susan Flagler, RN, DNS, 206-543-8244
Associate Professor, School of Nursing, University of Washington, Seattle

Researchers' statement

Purpose and Benefits

The purpose of this study is to collect the stories and experiences of women who have either relinquished or lost custody of a baby or child. Also, all the women in the study have used cocaine or heroin during and/or after the pregnancy with the child. While participation in this study cannot change your situation it is hoped that by sharing your story better services can be developed for other women who use drugs and are at risk for losing custody of a child.

Procedures

1. First Interview

- A. You will be asked to tell your story about losing or giving away custody of your child. What you tell is up to you. The researcher will suggest several topics, such as;
- your feelings about the pregnancy,
 - your labor and delivery experience,
 - your support network (people who have been of help to you)
 - involvement by the father of the baby
 - your drug usage and related problems during and after the pregnancy,
 - any treatment for your drug usage during or after the pregnancy,
 - how custody of the child was lost,
 - your feelings about the change in custody,
 - what your plans are at the current time for having other children,
 - what you think could have helped you or could help other women.

However, instead of asking these questions one by one the researcher is more interested in you telling your story, and in hearing only what you want to share. The interview can take from 20 - 60 minutes, depending on how much you want to say.

The researcher will be recording your story on a tape recorder. A typist will listen to the tape and type up everything on the tape. In order to prevent anyone except you and the researcher knowing who said what, your name will not be used on the tape or the typed sheets. Once the tape is typed the investigator will listen to it, and then the tape will be erased; until the tape is erased it will be kept in a locked file. You will be given a free copy of the typed interview.

1B. You will be asked to fill out a two page information sheet, with the researcher going over the questions with you. A special code known only to the researcher will connect this information with your interview. The main reason for collecting this

information is for the researcher to describe the group of women who participate in the study. However, the researcher also wants some of this information to better understand your individual story. The requested information will include such items as your age, pregnancy history, drug usage and treatment history, health, birth control use and any history of incarceration. Completing this 2 pages with the researcher will take about 15 to 20 minutes. You may choose not to answer any of the questions.

2. Follow-up visit, if desired

If you wish, the researcher can come back and listen to any feelings or thoughts you had because of the interview or questions. This visit can be part of the study if you want and would therefore be tape-recorded, or it can be left out of the study and so would not be recorded. Some women might choose a combination of these. Participants will not receive any money for this visit.

3. Clarification interviews

Women who can be reached several months later will be asked if they want to participate in another interview. This interview will be to follow up on issues that have been raised by yourself or other women which the researcher would like to gather some more insights or clarification. For example, the researcher may say, "Some women have said - what do you think or feel about this?" All information from these additional interviews will be handled in the same confidential manner as in the first interviews. These clarification interviews should take about 45 minutes in total and will also be taped. Women who participate in these interviews will receive ten dollars in cash at the time of the interview. You can let the researcher know if you would be interested in participating in these. If so, the researcher will let you know when to call the study number.

Remember that throughout the study you are free not to answer any question you do not wish to answer.

Risk, Stress or Discomfort

For some women, talking about losing or giving up custody of their child makes them feel better. However, for others such talking and thinking may cause them to feel sad or upset or angry. Some women might think about or actually use drugs or alcohol to help get rid of the undesired feelings. The researcher does not want you to do this. That is why the researcher will be available to listen to you in case these feelings happen. At the end of the interview the researcher will discuss with you what other persons or services you can use if the interview caused any bad feelings for you. However, the researcher cannot be responsible for the costs that any other services or persons charge.

Both you and the researcher know that the use of cocaine or heroin and other street drugs is illegal. As a result you may be uncomfortable speaking about your use or be worried that someone else will learn of the things that you specifically said. To protect your privacy your full name will only be on this consent, and the consent will be kept in a locked file. As stated, the tapes will be erased after they have been typed up and listened to once by the researcher; until the tapes are erased they will be kept in a locked file. When the typist types the interviews she will drop all names and put non-names such as xxx in place of the names.

All of the information that you provide will be confidential. When the researcher shares or publishes information from the study she will make sure that there is no information shared that could identify any particular participant.

To further protect your privacy a Certificate of Confidentiality has been obtained from the Department of Health and Human Services (DHHS). This Certificate will protect the researcher from being forced to release any research data in which you are identified, even under a court order or subpoena, including civil, criminal, administrative, legislative or other proceedings, whether Federal, State or local. This protection, however, is not absolute. The researcher must report any current or ongoing child abuse or threat of imminent harm to yourself or others to Child or Adult Protective Services of Washington state, as nurses are required by law to report. You can also consent in writing to voluntarily disclose any identifying information, although the researcher does not anticipate the need for this. This Certificate does not represent endorsement of the study by DHHS.

Other Information

The information collected from the interviews and forms will be looked at to see what they may have in common. Quotations from the interviews may be used in professional talks or publications (professional magazines). At no time will your name or other identifying information ever be given; no one besides the researcher will be able to determine who said what. As stated, the tapes will be erased after they are typed and listened to by the researcher. The typed interviews will never have a name on them. If you say anything on the tape that could help identify you or another person the typist will remove that information and leave marks such as "< >" to show that such information was dropped.

Remember, you can decide to stop the interview or stop answering the questions anytime you want to. Whether or not you participate in this study will not in any way effect any other services you receive, since no one but the researcher will know who was in the study.

For participating in this study you will be given \$20.00 (twenty dollars) in cash at the time of your participation in the first interview, and \$10.00 (ten dollars) cash for any participation in the clarification interview.

Signature of researcher

Date

Participant's statement:

The study described above has been explained to me. I voluntarily consent to participate in this activity. I have had an opportunity to ask questions. I understand that future questions I may have about the research or about my rights as a participant will be answered by one of the researchers listed in the beginning of the consent.

Signature of participant

Date

Copies to: ___ Participant
 ___ Researcher's locked file

APPENDIX C

INFORMED CONSENT, SITE C

University of Washington

Researchers: Andrea Kovalesky, RN, PhC, 206-685-7030; Box 357263
Doctoral Candidate, School of Nursing,
University of Washington, Seattle
Susan Flagler, RN, DNS, 206-543-8244 Box 357262
Associate Professor, School of Nursing,
University of Washington, Seattle

Researchers' statement

Purpose and Benefits

The purpose of this study is to collect the stories and experiences of women who have either relinquished or lost custody of a baby or child. Also, all the women in the study have used cocaine or heroin during and/or after the pregnancy with the child. While participation in this study cannot change your situation it is hoped that by sharing your story better services can be developed for other women who use drugs and are at risk for losing custody of a child.

Procedures

1. Interview

- A. You will be asked to tell your story about losing or giving away custody of your child. What you tell is up to you. The researcher will suggest several topics, such as;
- your feelings about the pregnancy,
 - your labor and delivery experience,
 - your support network (people who have been of help to you)
 - involvement by the father of the baby
 - your drug usage and related problems during and after the pregnancy,
 - any treatment for your drug usage during or after the pregnancy,
 - how custody of the child was lost,
 - your feelings about the change in custody,
 - what your plans are at the current time for having other children,
 - what you think could have helped you or could help other women.

However, instead of asking these questions one by one the researcher is more interested in you telling your story, and in hearing only what you want to share. The interview can take from 20 - 60 minutes, depending on how much you want to say.

The researcher will be recording your story on a tape recorder. Later she will listen to the tape and type up parts of it. In order to prevent anyone except you and the researcher knowing who said what, your name will not be used on the tape or the typed sheets. Until the tape is erased at the end of the study it will be kept in a locked file. You will be given a free copy of the typed parts of the interview.

1B. You will be asked to fill out a two page information sheet, with the researcher going over the questions with you. A special code known only to the researcher will connect this information with your interview. The main reason for collecting this

information is for the researcher to describe the group of women who participate in the study. However, the researcher also wants some of this information to better understand your individual story. The requested information will include such items as your age, pregnancy history, drug usage and treatment history, health, birth control use and any history of incarceration. Completing this 2 pages with the researcher will take about 10 to 15 minutes. You may choose not to answer any of the questions.

2. Follow-up visit, if desired

If you wish, the researcher can come back and listen to any feelings or thoughts you had because of the interview or questions. This visit can be part of the study if you want and would therefore be tape-recorded, or it can be left out of the study and so would not be recorded. Some women might choose a combination of these. Participants will not receive any money for this visit.

Risk, Stress or Discomfort

For some women, talking about losing or giving up custody of their child makes them feel better. However, for others such talking and thinking may cause them to feel sad or upset or angry. Some women might think about or actually use drugs or alcohol to help get rid of the undesired feelings. The researcher does not want you do to this. That is why the researcher will be available to listen to you in case these feelings happen. At the end of the interview the researcher will discuss with you what other persons or services you can use if the interview caused any bad feelings for you. However, the researcher cannot be responsible for the costs that any other services or persons charge.

Both you and the researcher know that the use of cocaine or heroin and other street drugs is illegal. As a result you may be uncomfortable speaking about your use or be worried that someone else will learn of the things that you specifically said. To protect your privacy your full name will only be on this consent, and the consent will be kept in a locked file. As stated, the tapes will be erased after the study is over; until the tapes are erased they will be kept in a locked file. When the researcher types the interviews she will drop all names and replace them with non-names such as xxx.

All of the information that you provide will be confidential. When the researcher shares or publishes information from the study she will make sure that there is no information shared that could identify any particular participant. To further protect your privacy a Certificate of Confidentiality has been obtained from the Department of Health and Human Services (DHHS). This Certificate will protect the researcher from being forced to release any research data in which you are identified, even under a court order or subpoena, including civil, criminal, administrative, legislative or other proceedings, whether Federal, State or local. This protection, however, is not absolute. The researcher must report any current or ongoing child abuse or threat of imminent harm to yourself or others to Child or Adult Protective Services of Washington state, as nurses are required by law to report. You can also consent in writing to voluntarily disclose any identifying information, although the researcher does not anticipate the need for this. This Certificate does not represent endorsement of the study by DHHS.

Other Information

The information collected from the interviews and forms will be looked at to see what they may have in common. Quotations from the interviews may be used in professional talks or publications (professional magazines). At no time will your name or other identifying information ever be given; no one besides the researcher will be able to determine who said what. As stated, the tapes will be erased at the end of the study. The typed interviews will never have a name on them. If you say anything on the tape that could help identify you or another person or place the typist will remove that information.

Remember, you can decide to stop the interview or stop answering the questions anytime you want to. Whether or not you participate in this study will not in any way effect any other services you receive, since no one but the researcher will know who was in the study.

For participating in this study you will be given \$15.00 (fifteen dollars) in cash at the time of your participation in the first interview.

Date

Signature of researcher

Participant's statement:

The study described above has been explained to me. I voluntarily consent to participate in this activity. I have had an opportunity to ask questions. I understand that future questions I may have about the research or about my rights as a participant will be answered by one of the researchers listed in the beginning of the consent.

Date

Signature of participant

Copies to: ____ Participant
 ____ Researcher's locked file

VITA

Andrea H. Kovalesky, Ph.D., C.A.R.N.

EDUCATION:

- | | |
|------|---|
| 5/73 | Bachelor of Science in Nursing
University of San Francisco |
| 6/77 | Master of Science in Nursing, Perinatal Specialist Program
University of California at San Francisco |
| 6/90 | Master of Arts in Theology
Fuller Theological Seminary, Pasadena, California |
| 5/97 | Doctor of Philosophy, Nursing Science
University of Washington, Seattle |

DISSERTATION FUNDING

- | | |
|-----------|---|
| 1996 | Hester McLaws Dissertation Scholarship |
| 1995 | Psi Chapter-at-large, Sigma Theta Tau International |
| 1991-1994 | Predoctoral Fellowship,
Institutional Grant through School of Nursing
University of Washington, Seattle
National Institute of Drug Abuse
Grant #T32-DAO-757 |

CERTIFICATION

- | | |
|-----------|--|
| 1994-1998 | Certified as Addictions Registered Nurse |
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RECENT PUBLICATIONS

- | | |
|------|---|
| 1997 | Flagler, S., Hughes, T. L., & Kovalesky, A. Toward an understanding of addiction. <u>IOGNN, 26(4)</u> , (In press). |
| 1997 | Kovalesky, A., & Flagler, S. Child placement issues of women with addictions. <u>IOGNN, 26(5)</u> , (In press). |