PREGNANCY, MOTHERHOOD, AND ADDICTION:
A NARRATIVE INQUIRY INTO THE LIVES OF THREE WOMEN

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by
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Jodie Lynn Bigalky, candidate for the degree of Doctor of Philosophy in Nursing, has presented a thesis titled, *Pregnancy, Motherhood, and Addiction: A Narrative Inquiry into the Lives of Three Women*, in an oral examination held on May 10, 2018. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

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Abstract

The nexus between pregnancy and addiction is usually studied from the perspective of the fetus, quantitatively examining the risks associated with in utero substance exposure. With the focus on the fetal effects of maternal substance use, there has been little regard, in the literature, for the mother and her experiences. Addiction during pregnancy is complex and drug use represents only part of the problem. Issues of stigma and victimization are common with women describing alarmingly high rates of mental health disorders and traumatic life events. With an awareness of some of the challenges pregnant women with substance use disorders may face, I wanted to redirect my focus to the experiences of the women, as voiced by the women themselves. I wondered how pregnancy and addiction were situated within a much bigger picture of life experience and how perceptions of the women could be shifted so that more supportive care could be offered. Narrative inquiry was used as the methodology for this research. I relationally engaged with three women who self-identified as being addicted to alcohol and/or drugs. Formal and informal conversations, field notes, and a research journal were used to collect field texts. Narratives of pregnancy and addiction were co-constructed between myself and each woman. The women’s experiences suggested that pregnancy represents only a small glimpse into a substance using woman’s life. Narratives extended beyond pregnancy into a period of conditional motherhood where sobriety was fragile and motherhood was precluded by a social narrative that viewed drug using pregnant women as incapable mothers. This placed the women under the surveillance of social services where they were forced to meet state mandated conditions or risk loss of motherhood. The findings of this research have implications for practice, education, research, and policy. The time individual health care professionals spend with women is relatively short within the
context of the woman’s life. Professionals do not necessarily know the story each woman is living but must be aware of the possibilities so that more supportive care can be offered.

Key Words: Narrative inquiry, Pregnancy, Motherhood, Addiction, Substance Use Disorder
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Dedication

I dedicate this work to four women, without whom, this project would not have been possible. To Tammy, Angel, and Frankie, thank you for inviting me to come alongside you as you lived out your story. You each courageously shared your experience so that others might come to understand the reality of living with an addiction amongst a pregnancy. To my lost friend, although you will likely never know it, you are the reason that this narrative inquiry first took place. I thank you for the chance encounter that encouraged me to begin this research.

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CHAPTER ONE: Narrative Beginnings

I explored the experiences of three women who invited me to walk alongside them as they lived pregnancy amongst an addiction. Yet before I ever met the women, the methodology of narrative inquiry required me to first engage in autobiographical work and to world-travel\(^1\) to other landscapes; to other times, places, and relationships that have shaped who I am today. I invite you to travel with me as I explore my own narrative beginnings\(^2\) and the stories to live by\(^3\) that have compelled me to take this journey and have created within me a desire to explore the experiences of pregnant women with substance use disorders.

There have been several instances during my career as a registered nurse that have directed me to towards this research. In the midst of all my experiences; however, there is one story that stands out in my mind as the one that formed my curiosity and created a desire within me to inquire further. It will not take me long to tell my tale for it is only a short clip taken from the time I have spent as a practicing registered nurse; one photo taken from the album of my nursing career. The experience spanned only a few short hours, but it impacted me deeply and created long lasting effects. This is the story that caused me to wonder, the story that compelled me to take this journey . . . . .

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\(^1\) For Lugones (1987), “travelling to someone’s world is a way of identifying with them . . . . [and] only when we have travelled to each other’s worlds are we fully subjects to each other” (p. 17).

\(^2\) Narrative beginnings are autobiographical inquiries into experience that help to situate the research on a personal level (Clandinin, 2013).

\(^3\) Stories to live by are the experiences that contribute to personal and professional identity (Connelly & Clandinin, 1999).
A Lost Friend

I am startled out of my somewhat somnolent state by the ringing. I am not asleep, but not awake either – somewhere in that in between place. A wave of nausea rushes over me. It is the usual feeling of queasiness that often overcomes me in the very early morning hours of the night shift. It takes me a moment to sort out where I am. Just as I recall that I am the nurse assigned to the triage area of the Labour and Birth unit, my thoughts are interrupted by hearing that ringing again – I had almost forgotten about it. It takes every last bit of energy I have to lean over and pick up the phone. I answer it quietly. “We’re sending one up to you, and she’s a real prize” says the annoyed voice of the emergency room nurse. My feelings of tiredness and nausea suddenly vanish. I hustle into the assessment room and prepare for the patient who is soon to arrive.

The double doors of the Labour and Birth ward swing open as her wheelchair is pushed into the unit by a nervous looking porter. She is alone. I do not see her face at first; a blanket is draped over her head. I softly introduce myself to the cloaked body sitting in front of me, telling her my name and that I will be her nurse. No response. I offer to help her into bed. There is a slow nod of agreement from the blanketed head. She can

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4 I have used a font that is not typical of APA formatting to emphasize this section as a personal story.
hardly stand. She is so affected by the drug. I ask her if she is pregnant but the only answer I get is a soft snore as she drifts off into an intoxicated sleep. I see her swollen belly as she lies nearly motionless under the sheets. The rhythmical rise and fall of her chest is the only sign of life I see.

I open her chart, not recognizing the name at first. It is different than it used to be. So many words strike me as I read what is scrawled over the pages.

No prenatal care. IV drug use. HIV. Hepatitis C. Domestic violence. Assault.

She has been evaluated in the emergency department and has been cleared with no apparent injuries. Her pregnancy and the baby must now be assessed and monitored in Labour and Birth.

I place my hand softly on her shoulder and she awakens. Weakly, she holds out her emaciated arm, littered with scars and track marks. I assess her blood pressure. I ask her if I can check her temperature. She slowly pulls down the blanket that has been covering her face. I feel sick. I instantly want to throw up. There in front of me is a childhood friend from nearly three decades before.
She does not recognize me. In fact, she does not ever look me in the eye. She is so high from the drug. She mumbles and I can barely make out what she is saying. “I don’t know what they gave me; they took everything, even my clothes. They just left me there.” She has been the victim of a violent assault. Bile is rising in my throat, my eyes begin to water. I try to imagine what my lost friend has been through, not only tonight but since I last saw her, so many years before. I cannot. I have no idea. My head is spinning. Our lives are so very different.

I sit and observe this lost friend for the rest of my shift that night. When I return to work a couple days later, I ask what happened to her. I am disheartened to find that several tests and assessments were arranged for her during the day light hours but when she insisted on leaving the hospital to attend a previously scheduled court date she was discharged against medical advice. No tests and no assessments were completed; an opportunity to offer support and resources lost.

In the days following, I cannot eat. I cannot sleep. All I can think of is her. I wonder what got her to this place and what got me to mine. We were two children, the same age, starting out in similar places, yet our lives turned out to be so incredibly different. I think about what I remember
from our childhood and what I learned from reading her chart as she slept off her high and I sat monitoring the rhythmic beating of her tiny baby's heart.
1.1 A Brief Look at the Three-Dimensional Inquiry Space

I will use the three-dimensional inquiry space to inquire into my own narrative beginnings (Clandinin & Connelly, 2000). It may be helpful for the reader if I briefly explore what it is that constitutes the three-dimensional inquiry space. As I use my own story to inquire, I will look backward and forward, inward and outward, and will pay attention to place (Clandinin, 2013). This will situate my own story within a framework of a three-dimensional space of temporality, sociality, and place (Clandinin). Dewey’s (1938, 1958) view of experience has been credited as the philosophical underpinning of narrative inquiry research (Clandinin). In exploring the three-dimensional inquiry space, I find that it is derived from Dewey’s theory of experience, specifically his perception of continuity (temporality), interaction (sociality), and situation (place). These terms create the metaphorical three-dimensional inquiry space that provides the conceptual framework for narrative inquiry research.

To explore experience temporally is to look backward and forward, inquiring not only into the present but also into the past and the future of the people, places, things, and events that are under study (Clandinin, 2013). As Clandinin and Connelly (2000) point out, experience does not only occur in the here and now but is also on a continuum of time. Landscapes under study endure frequent changes which are contextualized historically and meaning changes over time (Clandinin & Connelly, 2000). To attend to sociality means that the narrative inquirer explores not only the personal conditions but also the social conditions in which an individual’s experience unfolds (Clandinin). The social circumstances that Clandinin refers to are “the milieu, the conditions under which people’s experiences and events are unfolding . . . understood, in part, in terms of
cultural, social, institutional, familial, and linguistic narratives” (p. 40). Lastly, place, is the concrete space where the inquiry and events take place, recognizing that people, place, and stories are all linked and that all narratives take place in some concrete area (Clandinin).

To consider my own story temporally, I will look backwards and forwards to the past, present, and future. I will also look outward to the social conditions and environment in which my experience unfolds and I will consider the physical space in which this story takes place. I will also look inward to the conditions and experiences that have shaped this story and have become my stories to live by in relation to this inquiry; entering practice, beginning graduate studies, and returning to practice.

1.2 Thinking Narratively: Unpacking Stories within the Three-Dimensional Inquiry Space

The story of providing care for a pregnant woman with a substance use disorder is not uncommon. I have seen it many times in my practice. The actors are always different women but they often tell a similar story of hardship and addiction. The story of my lost friend struck me because of the personal connection I had with the woman. As I work with this narrative, I recognize that many of the stories from my practice are linked, as are the stories that the women in this research shared. Researcher and participants’ narratives are somewhat nested together and one cannot be told without impacting the other (Clandinin & Connelly, 2000).

In the following section, I have unpacked the story of my lost friend from the three-dimensional inquiry space by distinctly addressing temporality, sociality, and place. However, I recognize significant overlap exists. It is nearly impossible to completely
separate out each of the three dimensions. I invite you to use your imagination and envision the interconnectedness between temporality, sociality, and place within my lost friend’s story.

1.2.1 Temporality. As I explore this story temporally, I first look backward to understand how the past has shaped the present narrative. When I think about my childhood friendship, I remember that our companionship began when our caregivers, my mother and her grandmother, worked for the same employer. As small children we frequently played together during work functions and when we visited our caregivers at work. Our friendship did not span a great length of time but it must have made enough of an impact on me that I would remember her so many years later. Our lives took different paths when my friend’s grandmother retired from working. No longer would I see my young friend at my mother’s work and consequently our friendship would abruptly end. At the time, I did not realize that I would not see my friend again, or at least not until our paths crossed many years later under such extremely different circumstances.

As I reflect on this story, I begin to wonder . . . had our paths not crossed that night, would I have remembered her? My experience with her has shaped who I am today. Without her, I wonder, would I even be on this journey with this research? Seeing her, generated memories of the past and allowed me to travel backwards, to another time, a time of carefree play with my young childhood friend. As I travel back to that place, I can see how our lives then were very different than they are now. As children, we had few worries and little responsibility. As I return back to the present time, I see a very different world; an adult world, where we each now have our own worries and responsibilities. But within this world, I see many differences in our current lives and I
begin to wonder about these differences. I force myself to world-travel (Lugones, 1987) to a different place. How did our two worlds become so very different? What contributed to the very different paths we are on today? I see the storied landscape I live as very different than the landscape my friend lives. My story is a story of privilege. I have grown up in a middle class world where I have wanted for nothing. I have been encouraged to follow my dreams and have learned that if I work hard enough, I can achieve success. I wonder how my friend might describe the storied landscape in which she was raised and now lives?

I remember hearing that my friend eventually went to live with her mother – a woman who could not provide for my friend at birth given her commitments to her other children. For this reason, my friend was raised by her grandmother for the first several years of her life. When I look back now, I consider some of the potential contributing factors that caused our lives to become so very different.

1.2.2 Sociality. As I look outward I see that, for my friend, living with her mother meant growing up in one of our community’s poorest neighbourhoods, a community whose name has become synonymous with poverty and crime. As I sat and read through my friend’s thick hospital chart that night, I came to realize that although her address frequently changed, she always lived within the borders of this community. I wonder what opportunities she might have had if she had grown up in a different family or in a different neighbourhood. What are the familial and social narratives that have contributed to shaping who she is today and how are these narratives different from my own? Was it her upbringing that robbed her of a chance at success and made her a victim of violence and horror that I cannot imagine from my middle class world? How did she
become so tangled up in a life of intravenous drug use? She lived a dangerous lifestyle that contributed to her contracting both hepatitis and HIV. I learned that she had given birth to several babies but that she did not have custody of any of her children.

I admit that as I attempt to world-travel (Lugones, 1987) to her place now, I have difficulty. I think about my own two small children and I cannot imagine my life without them. Yet I recognize that my childhood friend has a story, and it is within this story that I might come to understand her experiences; how she has been shaped into who she is today. As I think more about my encounter with my friend that night, I realize that I am only seeing a very small glimpse of a life that is so much more than one hospital admission. I enter this story in the midst of both my own life and the life of my friend (Clandinin & Connelly, 2000). It is because of this story that I begin to wonder how pregnancy and addiction are situated within a much bigger narrative of life experiences.

1.2.3 Place. When I think about place, the first thoughts that come to my mind are of an institutional setting. The acute care obstetrical unit within a hospital is where this story first takes place. As I think about this setting, I wonder how difficult it must have been for a woman like my friend to enter this place. I recall that my friend arrived in Labour and Birth unaccompanied. I wonder how it must have felt for her to be pushed in a wheelchair through the double doors of the unit, alone and unsupported, met by the faces of strangers. I also wonder how her previous experiences in a hospital setting might have contributed to her current feelings and I am reminded of the words of that emergency room nurse: “We’re sending one up to you, and she’s a real prize.”

In their work with pregnant women with substance use disorders, Lefebvre et al. (2010) identified that substance using women often have very negative experiences with
health care professionals, especially those in acute care. Women in the Lefebvre et al. study described feeling stigmatized and marginalized and identified that communication was frequently judgmental and lacked respect. During my own practice, I have heard and observed similar situations frequently. I wonder what story my friend might tell of her previous experiences with professionals in acute care. Had she come to expect to be judged by the professionals in this setting? Was this the reason she arrived to the unit with a blanket draped over her head; seemingly evading eye contact? Was this her attempt to avoid health care professionals who had previously judged and been disrespectful to her? Does this experience transcend across other settings and into the community?

As I reflect on my experience with my friend that night, I am reminded of an institutional narrative frequently embedded within health care settings. The health care professional is viewed as the authority, demanding patients do as they are told, without respect for the knowledge the patient holds (Radcliffe, 2011). The authoritative role of the health care professional dates back to the late 1800’s. In *The Birth of the Clinic* (1973), Michel Foucault, discussed the 18th century rise of modern medicine. The *gaze*, a term used by Foucault, emphasized the prominence of the medical diagnosis and the power of medical knowledge (Foucault). As I reflect on what I learned in the days following the encounter with my friend, I wonder how she had come to understand how she would be treated in health care settings. She was discharged against medical advice because she needed to attend a previously scheduled court date. This reminds me of the authority that health care professionals have over patients. Who are we to tell a woman that remaining in the hospital is more important than attending a court date? In this
instance, the opportunity to provide resources and develop a therapeutic relationship with a woman who would likely benefit from extra support was lost.

In thinking about place, I recognize that I am only attending to place in the present context of this story. Addiction during pregnancy is complex (Finnegan, 2013) and transcends far beyond health care settings. When I think about place in terms of this research, I realize that this work and the stories of the women took place in a variety of different physical spaces. The women described varied stories and experiences that moved in and out of different places. I will return to exploring these places and spaces as I later share the women’s stories.

1.3 Coming to Inquire about Addiction in Pregnancy

Research interests often derive from our own experiences and it is the narratives of these experiences that shape the plotlines of our inquiries (Clandinin & Connelly, 2000). My research interests focus on the experiences of pregnant women with substance use disorders. However, in narrative inquiry research, it is not enough for me to simply state this interest. Narrative inquiry research is relational research (Clandinin, 2013). As a narrative inquirer, I am challenged to engage in autobiographical work that encourages me to see who I am in the narrative inquiry with pregnant women with substance use disorders. What are the stories that I am living and telling? As I think about this question, I am reminded of Downey and Clandinin’s work in which they state:

“Narrative inquirers tell stories about the stories they and others live and tell, keeping in mind how their own stories shape how they understand and tell the stories of others” (2010, p.19). It is not easy to relive and retell my own storied experiences. I feel a sense of vulnerability as I temporally travel back in time to revisit the stories that shape who I
am in this inquiry. Yet, I recognize the importance of this work. Clandinin reminds me that “without autobiographical narrative inquiry, our studies can lead to work that is too technical or too certain. Beginning with autobiographical narrative inquiry allows us to see that we, too, are under study in the inquiry” (p. 82).

My interests, as they often are in narrative inquiry research, are derived from my experiences with patients in practice. Carper (1978) identified four fundamental patterns of knowing that conceptualize nursing knowledge. One of these patterns, personal knowledge, is “essential to understanding the meaning of health in terms of individual well-being” (Carper, p. 18). Through interpersonal relationships between the nurse and the patient, nurses strive to come to know their self as well as the self of the other (Carper). The client is not an object but rather creates an opportunity for a personal relationship between two persons (Carper). The experiences I have had in practice with women like my lost friend have contributed to my personal understanding of pregnancy and addiction. I would be amiss to state that the empirical knowledge related to pregnancy and addiction has not informed my understanding of this phenomenon; however, it is the experiences I have shared with patients that has encouraged me to want to know more; to inquire further. My background as a registered nurse, practicing with patients in an acute care obstetrical setting, has led me to this inquiry that frames addiction in pregnancy in terms of narrative knowing.

1.4 Preliminary Thoughts on Sharing My Narrative Beginnings

As I sat down to write of the experiences that have brought me to this research, I was continuously reminded of how vulnerable this process makes me. I must address some of my most prevalent concerns from the outset. I look inwardly and feel
apprehensive about how my story and the stories of the women might be perceived. I do not want to suggest that all professionals who provide care for pregnant, substance using women are judgmental and I certainly do not want to create a negative perception of the systems that are designed to support women. However, I will question whether these systems actually provide support that is useful and desired by the women. Based on my observations in practice, the care that is provided by each professional hinges on their comfort level and their knowledge. When care professionals lack an understanding of the complexities associated with drug addiction during pregnancy, care may be provided in a critical and insensitive manner. Professionals are doing the best they can based on the knowledge they possess and the systems they work in.

In sharing my narrative beginnings, I also do not want to negate or criticize the work that has already been done to create and build upon existing resources and supports for pregnant women who struggle with addiction. However, in order to take advantage of the opportunities that exist to improve how this population of women is treated, a thorough understanding of their experiences is first needed. If we have an understanding of the women’s experiences, programs and policies that meet the needs of the women can be developed. The experiences of the women should be explored and valued so that care that meets the needs of the women can be offered. An understanding of the women’s experiences can be gained by exploring their storied lives. This inquiry is not about the professionals, it is about the women; the women who find themselves pregnant while living with an addiction.
1.5 Stories to Live By

As I think about my own narrative beginnings and continue to look inward, I realize that there are several other stories that have contributed to who I am and my choosing of this research. I revisit temporality here so that I may journey back, beyond the story of my childhood friend. There are other narratives that have made the story that I have told influential for me. Several experiences have impacted me along the way and have ultimately placed me on the path I am on today. The following accounts shape my stories to live by, the stories that have contributed to my personal and professional identity (Connelly & Clandinin, 1999) in relation to this inquiry. These stories are linked to my practice as both a clinical nurse and researcher and my interest in choosing the particular research project with pregnant women with substance use disorders. It should be noted here that the following stories have been adapted from my own personal journal that I used to document and reflect upon some of my first thoughts as I began to explore narrative inquiry and its fit with this research. I was largely brought to this work because of my professional experiences. What I observed in practice touched me in an emotionally evocative way. I was innately bothered by what I observed in practice and I was driven to inquire further. Although I do not explicitly discuss temporality, sociality, and place, in this section, I do attempt to attend to each of these, remaining committed to the three-dimensional inquiry space.

1.5.1 Entering practice. When I graduated with a degree in nursing, jobs were plentiful. I completed my final practicum on the Labour and Birth unit of a tertiary care centre and was offered a job almost immediately. I was apprehensive about working in a specialty area so soon after graduation. I had been cautioned by nursing instructors that it
was wise to seek employment on a medical or surgical unit in order to develop and practice basic nursing skills. Therefore, in addition to working on Labour and Birth, I also accepted a position in a surgical setting. In hindsight, this was a good decision. Not only did working on the surgical ward teach me valuable nursing skills, it also solidified my love for obstetrical nursing. I learned from my practice that my future was not in surgical nursing and that my career would focus in maternal and newborn health. After a few years of employment, I shifted to working solely in obstetrics. Once all of my time was concentrated in one setting, I really began to learn more about high-risk obstetrics. The longer I practiced, the more I was assigned to provide care for patients with complicated medical, obstetrical, or social histories.

1.5.1.1 The professional knowledge landscape. In hindsight, it was during this time in my career that I arrived on the “professional knowledge landscape” (Clandinin & Connelly, 1995). The professional knowledge landscape, as defined by Clandinin and Connelly (1996), is the place in which practice and theory unite. It was through my practice alongside other nurses that I came to know and learn about caring for pregnant women with substance use disorders. According to Clandinin and Connelly (1996), the professional knowledge landscape shapes what is known about effective practice; what practitioners know about practice; what knowledge is necessary for practice; and who creates new knowledge for practice. My time on the professional knowledge landscape has shaped the stories that I know and tell about providing care for pregnant women with substance use disorders.

Clandinin and Connelly (1996) discussed two fundamentally different places on the landscape. They stated that professional knowledge is the information shared by
professionals such as researchers, policy makers, and administrators. To borrow the example that Clandinin and Connelly used in education, this is the knowledge that is derived outside of the classroom by researchers, policy makers, or administrators and is expected to be implemented in the classroom – “a place littered with imposed prescriptions” (1996, p. 25). These theory driven views of practice tell the sacred stories of teaching (Clandinin & Connelly, 1996). Practical knowledge represents the stories and information that are developed through practice. To continue to use education as an example, this is the knowledge that teachers develop by working with children in the classroom. Throughout a day, teachers move in and out of places on the landscape: places behind classroom doors (the practical knowledge landscape) and places with other professionals (the professional knowledge landscape) (Clandinin & Connelly, 1996).

When providing care for pregnant women with substance use disorders, nurses frequently work on the practical knowledge landscape. It is on this landscape where care is provided behind the safety of closed doors and nurses are “free to live stories of practice” (Clandinin & Connelly, 1996, p. 25). These stories are often secret stories, shared only by those on the practical knowledge landscape (Clandinin & Connelly, 1996) and may differ from the sacred stories that suggest how nurses should act on the professional knowledge landscape. When sacred stories and secret stories differ, one might tell a cover story to fit into the range of stories that is seen to be acceptable on the professional knowledge landscape (Clandinin & Connelly, 1996).

The dissonance that I found myself experiencing occurred when the sacred stories I had learned to be acceptable when caring for pregnant women with substance use disorders were different from the secret stories I observed behind the closed doors of the
clinical practice environments. As a result, I found myself living a cover story in which my words and actions were chosen to fit the context of the area I was working. The following story emphasizes the discord I lived between sacred and secret stories in my practice. This is only one of many similar stories that contributed to my puzzling and created a desire within me to inquire into the experiences of pregnant women with substance use disorders.

Pregnant women with substance use disorders were often considered to be complicated patients and many of the nurses avoided being assigned to provide care for them. I did not mind being assigned to these patients. I enjoyed the challenge of caring for a complicated patient, but mostly, I liked hearing the women’s stories. They had lives that many of the other staff did not seem to recognize. They were women, and although they often described complex medical and social histories, they deserved to be cared for like any other patient. Many health care professionals have difficulty seeing the person through the addiction. As a result, they have trouble understanding why a woman would use potentially harmful substances while pregnant.

I distinctly remember one of the first women I looked after who had a drug addiction. She was in labour and she was not coping well. She was thrashing in the bed, yelling and swearing. Her pain was very poorly controlled. None of the other nurses wanted to provide care for her. I also remember that she was hepatitis C positive. I was in the room with her, providing labour support, when another nurse arrived to provide relief for my break. The nurse entered the room fully gowned and wearing gloves, a mask, goggles, and a hat. At the time there was no risk for body fluid exposure.
Looking back, I imagined how ostracized and judged that patient must have felt. My heart ached for her. Here she was, having a baby. It was supposed to be one of the most exciting times of her life, yet she was being treated like an outsider, as if she had a highly contagious disease. I should have spoken out, should have advocated for my patient, but instead I remained silent. As I think back, I wonder why it was that I remained silent. Did I lack confidence, afraid to speak out against a cultural narrative that made the behavior of this nurse acceptable on this unit? Or was I living out a cover story, fearful to address the discord between the sacred story of how I had learned women were to be cared for during labour and the secret story of how women with substance use disorders were actually treated behind closed doors?

During my years of practice, there have been several experiences like this, involving many different women. I always provide the same care for a woman who has been using substances during her pregnancy as I would for any other woman. I spend time with my patients and I develop therapeutic relationships, often getting to know some of the intimate details of their lives. These experiences contributed to a curiosity in me and made me want to know more; made me want to inquire further. I wondered how the women situated their experiences during pregnancy within the larger context of their lives and how they described their experiences with nurses and other professionals.

1.5.2 Graduate studies. After six years of working as a registered nurse, I returned to school. I began a Master of Nursing program. My thesis work focused around the prenatal care experiences of Aboriginal women. Two of the women who participated in my exploratory study described a history of drug addiction. Although I
only heard a small piece about their addictions, as they discussed their prenatal care experiences, this glimpse captured my interest.

One participant described her experience with a health care professional. Despite barriers, the woman had accessed prenatal care, yet when she attended the care, she felt judged and that a lack of respect existed because she was using drugs during her pregnancy. As a consequence, she did not return for further care for several months. This simple story impacted me. This was a woman who could have potentially benefited from the intervention, support, and resources offered during prenatal care but because of one negative experience with a health care professional, this opportunity was lost. Here was a woman who was trying to do the best she could for her unborn baby, but she required an environment that would be supportive of her and her addiction. I was beginning to see a pattern. This particular narrative seemed all too common for pregnant women struggling with substance addiction. I wondered how many other women would describe similar situations and if these types of experiences occurred in other settings.

When I returned to practice, I returned with a critical view. I was more acutely aware of the discrimination that pregnant women with addictions encountered when accessing care.

1.5.3 Back to practice. Following the completion of my master’s degree, I returned to practice with an increased sensitivity for how pregnant women with substance use disorders were treated. My experiences from my earlier years of practice, as well as my thesis research, allowed me to observe what I may not have otherwise noticed. I saw the complex medical and social situations that so many of the women described. I noticed the prenatal care and treatment barriers that left large gaps in the women’s
antenatal care. I recognized the large number of complications the women seemed to experience when compared to women who were not using substances.

As a result of my observations, I began to wonder. As an outsider looking in, I could see that the women were frequently faced with challenges during pregnancy that often seemed insurmountable. Additionally, my exploration of the story of my childhood friend helped me to see that pregnancy is only a small part of a life lived amongst many other stories. I wondered about the experiences of pregnant women who struggle with addiction and how this experience was situated within the larger context of life stories. My stories to live by; entering practice, beginning graduate studies, and returning to practice have shaped me both personally and professionally and have sparked an interest in the experiences of pregnant women with substance use disorders. My experiences led me to this inquiry so that I may explore my wonders and search for potential answer to questions related to meaning and social significance.
CHAPTER TWO: Uncovering the Literature

The narrative beginnings I presented have justified the inquiry on a personal level. However, in narrative inquiry, it is not enough to provide only the personal justifications for the research (Clandinin, 2013). The inquirer must also attend to the practical justifications, or the possibility of shifting or changing practice and the social justifications, concerned with situating the work in terms of new disciplinary knowledge (Clandinin). My understanding of the existing literature, related to the experiences of pregnant women with substance use disorders, has influenced how I justify this inquiry at a practical and social level. I have also come to see that my understanding of the terminology associated with addiction arises not only from my practice experience, but also from the relevant literature.

2.1 Defining Addiction

Addiction is multifaceted with no single definition that has been widely accepted. The numerous and partially overlapping definitions are somewhat problematic when attempting to determine how addiction is constructed. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) suggested that the multitude of existing definitions is a result of the complex nature of addiction and its social construction that lacks a clear physical entity (EMCDDA, 2013). Given the complexities in defining addiction and the negative connotations that are often associated with the term, some individuals and organizations avoid using the word altogether (EMCDDA). Although many have abandoned addiction and replaced it with words such as dependence and abuse, reasons exist to explore and clearly define addiction. One of these reasons can be attributed to the American Psychiatric Association’s (APA) elimination of the terms
dependence and abuse from the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) (APA, 2013). The APA has instead adopted one overarching category, terming it *substance-related and addictive disorders*.

Substance-related and addictive disorders, as defined in the *DSM-V*, encompass 10 different classes of drugs including: alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, anxiolytics, stimulants, tobacco, and other substances (APA, 2013). In addition to substances, the *DSM-V* also includes behaviours that have the potential to become addictive. For the first time, gambling has been included as an addictive disorder (APA). It is expected that other behavioural addictions will be included in future editions of the *DSM*, as the scientific evidence to support such disorders accrues (Clark, 2011). The inclusion of behavioral addictions in the *DSM-V* broadens how the concept of addiction might be defined.

Historically, addiction referred to an individual’s passion for a certain activity (Maté, 2009). Maté stated that only recently has the term included more of a pathological sense. This is evident in Levine’s (1985) classic paper on the discovery of addiction. He wrote that up until the 19th century, it was believed that individuals used alcohol not because they had to but because it was enjoyable. It was not until the 1800’s that individuals first reported they were experiencing an overwhelming desire to use alcohol (Levine). As a result, early theories of addiction, using terms such as *overwhelming*, *overpowering*, and *irresistible*, were developed for alcohol and later extended to other substances. Addiction came to be defined as a disease with *loss of control* as the main feature of the condition (Levine).
In more recent years, defining addiction has become much more complex. In their attempt to clearly describe addiction, the EMCDDA (2013) critically explored a plethora of the existing definitions. They found that some definitions referred exclusively to substances while others included behaviours, such as gambling, that could become problematic in an individual’s life. Words such as withdrawal, tolerance, brain abnormality, loss of control, and impaired control were used in some of the definitions but not in others. Following careful consideration, the EMCDDA finally settled on the definition of addiction as “a repeated powerful motivation to engage in a purposeful behavior that has no survival value, acquired as a result of engaging in that behavior, with significant potential for unintended harm” (p. 27).

Maté (2009), who has adopted a broad view of substance and addictive disorders, explored the question: What is addiction? He suggested that a specific process of addiction exists and this process is expressed through a multitude of different behaviours that can be highly destructive. Addiction as defined by Maté is “any repeated behaviour, substance-related or not, in which a person feels compelled to persist, regardless of its negative impact on his life and the lives of others” (p. 128). He goes on to say that “compulsion, impaired control, persistence, irritability, relapse and craving . . . are the hallmarks of addiction – any addiction” (p. 129).

The World Health Organization (WHO) also provided a definition of addiction; this definition focuses solely on the use of substances without the inclusion of behavioural addictions. Addiction, as defined by the WHO (2014, para 24) is:

*The repeated use of a psychoactive substance or substances, to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substance, has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain the substance by almost any*
Typically, tolerance is prominent and a withdrawal syndrome frequently occurs when substance use is interrupted.

When I reflect upon the term addiction and the multitude of definitions that exist, I come to see the complexities that are associated with the terminology. Over time, definitions of addiction have evolved to encompass a wide range of substance and non-substance related behaviours. Although substantial variations in definitions do exist, I would argue that addiction as a term continues to be very useful and highly functional within the literature and society. I recognize the importance of broad definitions of addiction, such as those cited by the EMCDDA (2013) and Maté (2009). However, addiction in this inquiry will focus on substances, thus the WHO definition is most applicable.

The terms substance use disorder (as defined by the APA, 2013) and addiction (as defined by the WHO, 2014) will be used throughout this research. I recognize that when using these terms in practice, I must use extreme sensitivity. These terms carry the potential for a negative connotation (EMCDDA, 2013) and have a pathological sense about them (Maté, 2009). In my clinical practice, I have observed the negative connotation that can be associated with addiction and substance use disorder terminology. When a woman is labeled as “an addict,” she is frequently perceived negatively by health care professionals. When the substance user is a pregnant woman, the negative association can be magnified. In this chapter, I have chosen to provide definitions of addiction and substance use disorder because it is important to understand how these terms are constructed. However, I used extreme caution when using this terminology with the women in this inquiry. While engaging with the women, I found that they most commonly used the term addiction to refer to their relationship with drugs. As a result,
this was the terminology I used with the women. However, the terms addiction and substance use disorder are used interchangeable throughout this dissertation.

2.2 Pregnancy and Addiction: A Stigmatizing Problem

A social stigma surrounding the use of substances exists and this stigmatization is further compounded when the user is a pregnant woman (Finnegan, 2010). As a result, pregnant women who experience substance use disorders are often embarrassed or hesitant to reveal a history of addiction in order to avoid the impending societal consequences and rejection that may occur. Complicating matters further is the fear associated with the potential for child apprehension. In their qualitative studies, Kruk and Banga (2011) and Roberts and Pies (2011) found that women may not disclose a substance use disorder because they are fearful that their baby will be automatically apprehended at birth. This threat often prevents women from seeking care or the resources that may help to provide support (Kruk & Banga; Roberts & Pies).

Other researchers have echoed the findings of Kruk and Banga (2011) and Roberts and Pies (2011), suggesting that stigma is a barrier to care access. In their 2009 study, Best et al. found that drug using women experienced stigma and were treated differently than other mothers by maternity care providers. In her report to the Canadian Centre on Substance Abuse, Finnegan (2013) stated that pregnant women may avoid medical and obstetrical care because of negative experiences and feelings of stigmatization when engaging with health care professionals.

In their research exploring the provision of pregnancy and addiction care, both Lefebvre et al. (2010) and Radcliffe (2011) found that when health care providers were not specifically educated to work with pregnant women with substance use disorders, the
women were more likely to feel stigmatized. In their focus groups, Lefebvre et al., found that the women felt stigmatized and marginalized and described communication that was judgmental and lacking respect. Conversely, Radcliffe (2011), who explored the workplace discourse of antenatal staff working with addicted mothers, found that health care providers who had developed specialized knowledge or education were more accepting and empathetic of the women and less stereotypical in the care they provided.

2.3 Psychosocial Issues and Victimization

Addiction is multifaceted with compulsive substance use presenting only part of the problem. Many women turn to alcohol or drugs because of a history of psychosocial issues or victimization. Combined with stigma, psychosocial issues and victimization further prevent women from easily accessing care (Finnegan, 2013).

2.3.1 Mental health disorders. The presence of mental health disorders is common in substance using women with depression, anxiety, eating disorders, and post-traumatic stress disorder (PTSD) identified as the most frequent diagnoses (Benningfield et al., 2010; Greenfield et al., 2007; Kovalesky, 2004; Taylor, 2010; Tuchman, 2010; Wachman, Byun, & Phillipp, 2010). In their retrospective chart review, Wachman et al. found that of 276 opiate dependent pregnant women, 40% had been diagnosed with at least one psychiatric disorder and 26% were taking a minimum of two medications related to their diagnosis. In another study, Benningfield et al. stated that of 174 opiate dependent pregnant women, about 65% reported psychiatric symptoms. Since mental health disorders frequently co-exist with substance use disorders, women may perceive their issues to be related to the psychiatric diagnosis rather than the addiction.
2.3.2 Traumatic life events. Women with substance use disorders frequently described traumatic life events and high rates of victimization that have perpetuated a life of addiction (Taylor, 2010). Taylor reported some of these traumatic life events as sexual assault, incest, and molestation. In their review of treatment centres across Canada, Cormier, Dell, and Poole (2004) established that women with substance use disorders were frequently the victims of violence, incest, rape, sexual assault, and physical abuse. In her study of 98 women with substance use disorders in Ontario, Cormier (2000) stated that over 85% reported a history of physical or sexual abuse.

Women are also victimized by their partners. The rate of intimate partner violence among women with substance use disorders is alarming. In their examination of women in treatment, El-Bassel, Gilbert, Shilling, and Wada (2000) found that nearly three quarters of the women in their study had experienced intimate partner violence at some point in their life and over one quarter had been assaulted in the previous one year. Over half of the women in this same study had experienced childhood abuse.

An exploration of the stigma and victimization associated with maternal substance use highlights some of the complexities associated with addiction and treatment in this population. Compulsive drug taking represents only a very small piece of a much bigger picture (Finnegan, 2013). Pregnancy offers a very unique time when substance use impacts not only the mother but also the unborn baby. As I reflect upon my experiences with women and the literature that often portrays substance using pregnant women as stigmatized and victimized, I consider how the women themselves described their own experiences. The knowledge that I have gained from the existing literature helped to inform the conversations that I had with the women in this inquiry. However, their
stories did not always align with what I had read. This inquiry was driven by the women and their experiences. Although I came to the inquiry with knowledge of the stigma, psychosocial issues, and victimization that pregnant women with substance use disorders often experience, I set these stories aside as I focused on the perspectives of these three women.

2.4 Uncovering the Women’s Perspective

The nexus between pregnancy and addiction is usually studied from the perspective of the fetus, quantitatively examining the risks associated with in utero substance exposure (Finnegan, 2010, 2013; Helmbrecht & Thiagarajah, 2008; Irner, Teasdale, Nielsen, Vedal, & Olofsson, 2012; Keegan, Parva, Finnegan, Gerson, & Belden, 2010; Pinto et al., 2010; Viteri et al., 2015). The scientific focus on fetal outcomes is not only limited to recent years, but dates back to the 1960’s when researchers first became interested in pregnant women with substance use disorders as a specific subset of the addicted population (Murphy & Rosenbaum, 1999). As they prepared for *The Pregnancy and Drug Use Study*, Murphy and Rosenbaum noted a gap in the existing literature. They stated that “while extensive and sophisticated knowledge concerning fetal outcome was available, there was a paucity of information about the mother herself” (p. 13). Their landmark study would be one of the first to critically explore the experiences of pregnant women with substance use disorders in an attempt to map the details of her social world and provide recommendations for policies that would reduce the harms associated with maternal drug use (Murphy & Rosenbaum).

It has been nearly two decades since Murphy and Rosenbaum (1999) first wrote about the experiences of pregnant women with substance use disorders, documenting
lives complicated by poverty, violence, abuse, and trauma. What have we learned during this time? We have learned that addiction during pregnancy continues to be a problem. Earlier, I discussed that pregnant women with substance use disorders have been portrayed in the literature as stigmatized and victimized as a result of how they are perceived in society and the high rates of mental health disorders and trauma they experience. The literature focuses on the fetal effects of maternal substance use with little regard for the mother. Given that maternal substance use is seen as contradictory in contributing to a healthy pregnancy (Kropp, Winhusen, Lewis, Hague, & Somoza, 2010; Lewallen, 2004; Murphy & Rosenbaum), it is not surprising that the focus of health care professionals is often on the newborn, not the mother. I have observed this countless times in my practice. Once the mother gives birth, the attention of care providers shifts away from the mother and to the health of the newborn. The mother and her needs related to her addiction are forgotten as she becomes secondary to the infant.

Murphy and Rosenbaum (1999) were the first to comprehensively explore the experiences of pregnant women with substance use disorders. It was not until 2010 that a thorough exploration of the women’s experiences would again occur, this time by Krausz. He suggested that by listening to the women’s narratives, a lot could be learned about their experiences. Women in both studies each participated in one interview in which they told their story. An opportunity existed to further explore the women’s experience by joining them on a more in-depth journey through pregnancy and into the postpartum period, developing a trusting relationship and sharing stories of experience along the way. Narrative inquiry, as conceptualized by Clandinin and Connelly (2000), provided a means for conducting this important research.
With an awareness of some of the challenges that pregnant women with substance use disorders may face, I wanted to redirect my focus to the experiences of the women, as voiced by the women themselves. Caine et al. (2017a) stated that the starting point of narrative inquiry research should be the lives of the participants. When research is framed around a predetermined problem, researchers risk trying to fit peoples experiences into predetermined issues and as a result “the policies and practices that extend from such research might miss the very issues or problems they were intended to address or resolve” (Caine et al., 2017a, p. 7). Exploring the women’s experience was critical to understanding how pregnancy and addiction are situated in a much larger and complex array of life experiences. My intention was first to attend to the lives of the women. Therefore, I will not explore the literature further in this section. The women’s experiences were used to drive how their stories were explored and later situated within the relevant research.

2.5 Research Puzzle

Narrative inquiries are framed around a research puzzle, emerging from the inquirer’s wonders, rather than around a research purpose or question (Clandinin, 2013). When I reflect upon my own experiences and my brief exploration of the literature, I am puzzled about the experiences of pregnant women with substance use disorders. I see my wonders as two-fold. The first is related to the life experiences of the women. It has been identified that addiction during pregnancy is complex and that compulsive drug use represents only part of the problem (Finnegan, 2013). Issues of stigma and victimization are common with women describing alarmingly high rates of mental health disorders and traumatic life events (Krausz, 2010; Linden, Torchalla, & Krausz, 2013; Lund et al.,
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2013; Murphy & Rosenbaum, 1999; Torchalla, Linden, Strehlau, Neilson, & Krausz, 2015). These issues coupled with my own exploration of my narrative beginnings caused me to wonder how pregnancy and addiction are situated within a much bigger picture of life experience.

The existing literature has not explored pregnancy and addiction within the larger context of lives lived. An opportunity existed to more thoroughly explore the women’s experiences by joining them in their journey through pregnancy; laying stories side by side and contributing to an understanding of the narratives that shape the women’s lives. This understanding may help to shift how care is provided for this population.

This brings me to my second wonder. The literature suggested that women often have very negative experiences with health care professionals, especially those in acute care settings (Lefebvre et al., 2010). Women described feeling stigmatized and marginalized and that communication was frequently disrespectful and judgmental (Lefebvre et al.). This stigma was a common barrier to care access (Chan & Moriarty, 2010; Jackson & Shannon, 2012a; Krausz, 2010; Kruk & Banga, 2011; Murphy & Rosenbaum, 1999; Roberts & Nuru-Jeter, 2010; Roberts & Pies, 2011; Soderstrom, 2012; Varty & Alwyn, 2011). Women recognized that they may benefit from resources and support offered by care providers but feelings of being judged prevented them from accessing care (Murphy & Rosenbaum; Varty & Alwyn).

My narrative beginnings also spoke of observing women who were judged within the acute care setting. I wondered what stories the women might tell of their experiences and how these narratives might differ across different settings such as the community and acute care. Would these stories suggest opportunities to change how care is provided for
pregnant women with substance use disorders? The women’s experiences can be drawn upon to identify and develop programs and policies that meet their needs. Narrative inquiry provides a means for exploring the narrative experiences of the women so that these wonders can be addressed.
CHAPTER THREE: The Methodology of Narrative Inquiry

Narrative inquiry was used in this research to guide the exploration of the storied experiences of three pregnant women who self-identified as having a substance addiction. In congruence with narrative inquiry methodology, I lived alongside the women throughout their pregnancies and into the postpartum period. My relationship with one of the women ended around the same time she gave birth to her baby. This highly relational work required me to think narratively, not only about the women’s experiences, but also about my own experiences (Clandinin, 2013). I became a part of the women’s lives and they too became a part of mine.

As Clandinin writes: “We are not objective inquirers. We are relational inquirers, attentive to the intersubjective, relational, embedded spaces in which lives are lived out. We do not stand metaphorically outside the inquiry but are part of the phenomenon under study” (2013, p. 24). As I engaged in this inquiry with the women, my life stories were laid alongside the stories of the women. This was not easy work. This work made me vulnerable; vulnerable to the women, to myself, to my committee, to other professionals, and to my family and friends. Yet I believe this work was important. The opportunity to contribute to a better understanding of women’s experiences, with the intent of shifting practice and adding to disciplinary knowledge, far outweighed the personal risks of engaging in the research.

3.1 Narrative Inquiry

Narrative inquiry is a useful means for conducting nursing research (Green, 2013). Green stated that nurses are interested in making sense of people’s lives and that

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5 A process of intentionally being in relation with participants while thinking narratively about our own experiences and the experiences of the participants (Clandinin, 2013).
this can be accomplished through stories. However, documented use of narrative inquiry in nursing literature is limited. For example, a CINAHL search using the keywords narrative inquiry and nursing yielded only 35 peer reviewed, research articles in the English language. A review of these articles suggested that several different understandings of narrative inquiry exist in nursing. The majority of the authors do not clearly articulate what is entailed in narrative inquiry and thus do not commit to a precise approach for conducting the research. For example, narratives may be used only as a means for data collection or data analysis. The use of stories or narratives in any form seems to automatically equate to narrative inquiry as methodology. This creates an unclear understanding of what is entailed in narrative inquiry research. This blurred understanding is not unique to nursing. Caine, Estefan, and Clandinin (2013) cautioned that when using narrative inquiry, ontological and epistemological commitments must be made clear so that all research involving narratives is not placed under one umbrella heading.

3.1.1 Epistemological and ontological commitments. During the late 1980’s and early 1990’s, researchers began to develop a methodology that is now known as narrative inquiry (Connelly & Clandinin, 1990). Although Clandinin and Connelly have been hesitant to provide a definition of narrative inquiry, preferring instead to discuss what it is that narrative inquirers do, they did provide this discussion of its characteristics:

[Narrative inquiry is] a way of understanding experience. It is collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus. An inquirer enters this matrix in the midst and progresses in the same spirit, concluding the inquiry still in the midst of living and telling, reliving and retelling, the stories of the experiences that made up people’s lives, both individual and socially (2000, p. 20).
Despite this description, considerable blurring between narrative inquiry research and narrative research in general has occurred over the past number of years. For this reason, it is essential that researchers engaging in narrative inquiry research, as conceptualized by Clandinin and Connelly (2000), are dedicated to the ontological and epistemological commitments of the methodology.

In their discussion of the methodological commitments of narrative inquiry research, Caine et al. (2013) said the two terms, narrative inquiry and narrative research, are used almost interchangeably. Multiple and differing uses of narrative in what is frequently labeled as narrative inquiry are described by Caine et al. as “[hearing] people talk about telling good stories, representing research findings as stories, or using stories to tell – in more compelling ways – of problems, encounters, or observations” (2013, p. 575). As a result, the epistemological and ontological commitments of narrative inquiry have become somewhat unclear in the existing literature (Caine et al., 2013; Clandinin & Rosiek, 2007). Given the unclear sense of how narrative inquiry is understood and the need for more transparency, it is necessary to explore the epistemological and ontological commitments of the methodology.

Narrative inquiry is more than just methodology; it is a means for understanding experience as well as studying experience (Clandinin, 2013; Clandinin & Connelly, 2000). Narrative inquirers adopt a distinct conceptualization of experience as a narratively composed phenomenon. Lives are lived and constituted from experience and this experience is formulated narratively (Caine et al., 2013; Clandinin; Clandinin & Connelly, 2000). This understanding of experience is what makes narrative inquiry uniquely different from other forms of narrative that are framed by differing
philosophical viewpoints (Caine et al., 2013; Clandinin; Clandinin & Connelly, 2000). Narrative inquiry is then epistemologically grounded in the notion that experience is knowledge for living (Clandinin; Clandinin & Connelly, 2000).

John Dewey’s (1938, 1958) view of experience is often credited as the philosophical underpinning of narrative inquiry (Clandinin & Connelly, 2000). His criteria of experience – interaction, continuity, and situation provide the basis for the ontological commitments of the methodology (Dewey, 1938, 1958). Dewey emphasized experience as interactive, both people and the contexts in which they exist are dynamic and ever changing (1938). As individuals live in relation, they live and tell stories that represent their experiences. These stories are not only personal, but are also social. Clandinin and Rosiek wrote that “stories are the result of a confluence of social influences on a person’s inner life, social influences on their environment, and their unique personal history” (2007, p. 41). They also stated that experience does not simply appear to be connected over time, it is continuous. As a result, “inquiry is an act within a stream of experience that generates new relations that then become a part of future experience” (Clandinin & Rosiek, p. 41). Essential then to the ontology of narrative inquiry is the view that experience is relational, social, and continuous (Clandinin, 2013).

Earlier in this dissertation (Chapter One), I discussed the three-dimensional inquiry space. I situated my own story within the context of temporality, sociality, and place. These terms provide the conceptual framework for all narrative inquiry research (Clandinin & Connelly, 2000). Throughout an entire inquiry, the inquirer must constantly revisit these terms, ensuring the research is situated within the three-dimensional inquiry space. “Studies have temporal dimensions and address temporal
matters; they focus on the personal and the social in a balance appropriate to the inquiry; and they occur in specific places or sequences of places” (Clandinin & Connelly, 2000, p.50). Thus this inquiry into the experiences of pregnant women with substance use disorders was guided by a conceptual framework that placed experience within the context of temporality, sociality, and place.

3.1.2 Tensions. Clandinin and Connelly (2000) identified several tensions that might be encountered when using narrative inquiry as methodology. They suggested that these tensions are grounded within the context of how social science research has historically been conducted. Using their experience in education, Clandinin and Connelly (2000) discussed the typical plotline of their disciplinary research as focused on measurement. They questioned “if our interest as researchers is lived experience – that is, lives and how they are lived – how did our research conversations become focused on the measurement of student responses (p. xxii)?”

When I reflect upon my own experience with research, I can see a parallel between Clandinin and Connelly’s (2000) discussion of educational research and how nursing research has traditionally been conducted. Nurse researchers are often interested in the lives of people (Green, 2013). Yet some of our most common research methods demand us to reduce people’s experiences to variables that can be measured (Clandinin & Connelly, 2000). Even conventional qualitative methods encouraged researchers to seek out the commonalities among individuals, rather than the variations that are vital in nursing practice (Thorne, 2018). These methods “assumed that the point of the research was to establish knowledge that stood the test of time, rather than taking a more nursing view that clinical insights will inevitably evolve and become more rich and complex over
time, a dynamic process that nursing celebrates” (Thorne, p. 44). Thorne stated that because of this, nurse researchers were forced to choose between methodological rigor and research designs that were more consistent with nursing practice. Nursing research conducted from this perspective or from a reductionist approach have come to be accepted as the grand narrative (or what is commonly accepted) in the social sciences.

If we return for a moment to Dewey’s 1938, 1958 work, we are reminded that research can and does involve the study of experience. Therefore, experience can be the starting point for any social science research (Clandinin & Connelly, 2000). However, this is where problems that have the potential to create considerable tension lie. As narrative inquirers, we are concerned with studying the experienced lives of people, yet the dominant story of the grand narrative causes us tension as we are tempted to bump up against or cross over into other ways of thinking. These places of tension are termed by Clandinin and Connelly (2000) as boundaries.

I will use Clandinin and Connelly’s (2000) example of their work in revising the Bloom’s Taxonomy as an exemplar to highlight the tensions that can arise when narrative thinking crosses with the grand narrative. Clandinin and Connelly (2000) do not negate the importance of research conducted under the grand narrative, but they see their work in understanding how lives are lived as better understood by exploring the narrative knowledge of experience. In their experience of revising the Bloom’s Taxonomy and working with individuals situated within the grand narrative, Clandinin and Connelly (2000) identified five tensions that are at the boundary between thinking narratively and thinking in terms of the grand narrative: temporality, people, action, certainty, and context.
One of the central terms in narrative thinking, temporality, creates some of the most tension when working among those who are grounded in the grand narrative (Clandinin & Connelly, 2000). Earlier, I identified that when using narrative inquiry, events do not occur only in the moment but rather can be placed on a continuum where the past and the future are also important because experience occurs over time. When thinking in terms of the grand narrative, events and things seem to be and a sense of timelessness is adopted. Closely linked to the tension of temporality is that of people. The narrative inquirer recognizes that individuals are in a state of constant change while the narrative histories of people are seen as somewhat irrelevant under the grand narrative. For example, in their experience, Clandinin and Connelly (2000) argued for the importance of understanding the educational history of a child – what lessons had previously been taught? What was the child’s narrative story? In contrast, those working under the grand narrative saw narrative histories as unrelated and suggested that a certain level of content be universally applied at certain grade levels regardless of the child’s story (Clandinin & Connelly, 2000).

The third tension, action, or more specifically, how an action is understood in narrative inquiry is seen as a sign requiring an explanation. This is in contrast to the grand narrative, where an action is taken as directly evidential. Clandinin and Connelly (2000) used the example of a child taking a test. Using a grand narrative point of view, the child’s score on that test is connected to cognitive level. Clandinin and Connelly (2000) argued that an explanation between the test score and its meaning for that child is required in terms of a narrative history. The fourth tension is certainty. For the narrative inquirer, interpretation always includes some uncertainty and an event could always be
interpreted otherwise. This is different from the grand narrative in which causality is believed to lead to certainty. Lastly, context is central to narrative inquiry. Although context is acknowledged in the grand narrative, the main interest is the universal case rather than in narrative thinking where the person is at the center of the study (Clandinin & Connelly, 2000).

Given the dominant nature of the grand narrative, in social science research, it was essential to have an awareness of the existing potential tensions prior to beginning this inquiry. This encouraged me to think narratively and to be cautious of the places where I might step over the metaphorical line that separates narrative inquiry from the grand narrative. It also provided me with knowledge to methodologically defend how my narrative inquiry was designed and carried out. A strong grasp of the potential tensions allows me to engage in educated, scholarly conversations with those who may not be as familiar with narrative inquiry research.

Until this point, I have discussed the tensions that might exist at the boundary between narrative inquiry and the grand narrative. However, there are other places where tensions have the potential to exist. Clandinin and Connelly (2000) discussed narrative thinking at the formalistic boundary. They refer to formalists as individuals who strictly adhere to prescribed forms. A formalist’s view then is one in which the world is seen from a particular “social structure, ideology, theory, or framework” (Clandinin & Connelly, 2000, p. 39). For a formalist, research begins with theory. This creates one of the central tensions between formalism and narrative inquiry. While a formalist begins with theory, a narrative inquirer begins with experience as told through stories (Clandinin & Connelly, 2000). As a narrative inquirer, I began this dissertation with a story, the
story of my own beginnings in relation to this inquiry. This is in stark contrast to the formalist who would begin by positioning the research within a theoretical framework.

The tension associated with the place of theory in narrative inquiry extends beyond the beginning of the research. Instead of a separate literature review section, the narrative inquirer frequently weaves literature throughout a finished inquiry (Clandinin & Connelly, 2000). Although I have included a brief chapter in this dissertation that explores the relevant literature, the intent of this chapter is only to provide background information and definitions related to the research. A brief exploration of the literature, coupled with my own experience, has contributed to the development of the research puzzle for this inquiry. Instead of including the literature in one chapter, I have attempted to weave it throughout the entire inquiry, linking theory to the women’s narrative experiences.

A tension closely related to the placement of literature is that narrative inquiry is seen by some as “not theoretical enough” (Clandinin & Connelly, 2000, p. 42). The narrative inquirer seeks to “offer readers a place to imagine their own uses and applications” (Clandinin & Connelly, 2000, p. 42). Clandinin and Connelly themselves described this tension in their own work feeling that it may be perceived as “somehow weak, effete, and soft; somehow lacking in rigor, precision, and certainty” (2000, p. 27). I expected to experience this tensions while carrying out this research. I, for example, have struggled with when and how to situate the existing literature into the inquiry. Although I recognized the relevant literature as important, I have also learned that narrative inquiry is a way of thinking and doing that generates knowledge from experience lived through stories. By committing to a narrative way of thinking and
recognizing that this will occur at the boundaries between other ways of thinking, the inquirer can develop meaningful narrative knowledge. This inquiry into the experiences of pregnant women with substance use disorders has contributed to the existing body of knowledge by deriving an understanding of the women’s experiences as told by the women through stories co-constructed with me.

3.1.3 Philosophical borderlands. Clandinin and Rosiek (2007) identified that a need existed for philosophical clarification that classified the differences between telling stories and stories that are lived and told. Earlier, I discussed the considerable blurring between narrative inquiry and what has been coined as narrative research. Narrative inquiry is situated within a Dewey inspired ontology of experience. This conceptual grounding of narrative inquiry is what makes it different from other forms of narrative research. Having understood how narrative inquiry is conceptualized, it is now possible to contrast narrative inquiry with alternative forms of scholarship. Clandinin and Rosiek explored the conceptual borders between narrative inquiry and research grounded in other philosophies. They suggested that there may be times when inquirers are tempted to cross into the borderland between narrative inquiry and other philosophical traditions. These other philosophical traditions, named by Clandinin and Rosiek, are: Post-positivism, Marxism, and post-structuralism. I will discuss the conceptual border between narrative inquiry and each of these three philosophical traditions. I will take the time to identify where I, in my own research, was tempted to step away from narrative inquiry and into one of these borderlands.

3.1.3.1 Post-positivism. The borderland between post-positivism and narrative inquiry is one in which reductionism is forefront (Clandinin & Rosiek, 2007). Simply
put, positivist philosophies begin with a theory, making claims about the nature of reality based on that theory (Clandinin & Rosiek). Narrative inquirers who inadvertently cross into the borderland with post-positivism might find themselves trying to explain the universal case. Instead of acknowledging the person and their human experience, the researcher might endeavor to identify common themes in an attempt to develop research findings that are generalizable (Clandinin & Rosiek). I recognized from the outset of this inquiry that the findings of my research would not be generalizable in a statistical sense. This may be viewed by post-positivists as a drawback to conducting narrative inquiry research. However, there was benefit in exploring the experiences of pregnant women with substance use disorders. There was much to be learned from the women’s stories that can contribute to a better understanding of their experiences. This understanding has the potential to help shift perceptions and may contribute to an improved provision of care.

The movement away from seeking the universal case to exploring both commonalities and differences addresses the nature of knowledge that nurses need (Thorne, 2018). Langlois, Tuncalp, Norris, Askew, and Ghaffar (2018) have recently identified that qualitative research is being used to understand socioeconomic contexts, health systems, and communities to improve guidelines and health decision making. Identifying variations from the norm is essential to nursing practice and contributes to how research findings are holistically applied to nursing practice (Thorne). As a result, research findings must be accessible and usable to practitioners working in the areas of clinical practice and program implementation (Sandelowski & Leeman, 2012). Yet when qualitative researchers attempt to disseminate their findings, they frequently face
challenges. Ellis and Clark (2015) described some of the challenges they experienced. They suggested that although qualitative approaches are methodologically and philosophically valid, they are lacking in the relevant discourse because clinical decisions are largely made on quantitative findings (Ellis & Clark). However, qualitative research often answers clinical questions and produces trustworthy findings that can and should be translated into clinical settings (Ellis & Clark).

3.1.3.2 Marxism. Narrative inquirers also negotiate borderlands with Marxists. Although both Marxists and narrative inquirers may be concerned with large institutions and the impact of living and working within them, a Marxist is more concerned with the macrosocial sources of oppression in the system (Clandinin & Rosiek, 2007). For example, both a Marxist and a narrative inquirer might be interested in the experiences of pregnant women with substance use disorders when they enter the institutional acute care setting. While the narrative inquirer will focus on the woman’s narrative experience in this setting, the Marxist may be more concerned with the systems of oppression that are encountered within the institution. While not completely ignoring the macrosocial structure, the narrative inquirer focuses first on individual lived experience and the meaning of that experience (Clandinin & Rosiek). As I engaged in this inquiry it was easy to look to the influence of social structures that disempowered the women; however, I recognized that I needed to first hear the experience of each woman. As I engaged in this inquiry, I needed to be acutely aware of the borderland between Marxism and narrative inquiry so that my first focus was always the experience of the women.

3.1.3.3 Post-structuralism. The final borderland that Clandinin and Rosiek (2007) discussed as particularly occupied occurs between narrative inquiry and post-
structuralism. They explained that a post-structural influenced researcher may be tempted to fit stories into a particular metaphor or discourse rather than first listening to the individual’s story. As I carried out my narrative inquiry, I needed to be cautious of the potential to cross into this borderland space. It would have been easy to prematurely place the women into a discourse of marginalization or oppression. However, I learned that I first had to listen to the women’s individual narrative experiences to determine how the women viewed themselves.

When narrative inquirers cross into the borderlands of other philosophical stances, tension and disagreement as to what narrative inquiry is and what it is that narrative inquirers do begins to take shape (Clandinin & Rosiek, 2007). In an effort to avoid such tensions, I was cautious from the outset of the research as to where I might cross into these metaphorical borderlands. By articulating specific examples and being consciously aware of where I might see my inquiry potentially crossing into these borderlands, I attempted to avoid situations of tension and disagreement. Developing a comprehensive understanding of the Deweyan ontology of experience that conceptually framed this research also contributed to my commitment to narrative inquiry as methodology. As I reflected upon the other philosophical stances and this research, I constantly faced the question: Why narrative inquiry? I see the answer to this question as complex, but at the same time, very simple. As Clandinin and Connelly wrote “the answer to the question, Why narrative? is, because experience” (2000, p. 50). Experience was essential in this inquiry.
3.2 Inquirers

Pregnant women, living in a mid-sized urban centre, who self-identified as being addicted to drugs and/or alcohol were invited to participate in this inquiry. In keeping with narrative inquiry terminology, the participants are also referred to as the inquirers throughout this dissertation. This term reflects the reciprocal nature of narrative inquiry research. As a result, both the researcher and the participants are referred to as inquirers. However, to avoid confusion, I sometimes refer to the participants as inquirers and at other times as the women. The term inquirer is also used interchangeably with researcher.

The inquirers were a minimum of 18 years of age and had a drug and/or alcohol addiction. The WHO definition of addiction was used as a guide in defining addiction in this research. Given the chronic nature of addiction (Metz, Comer, Wuerzl, Pribasnig, & Fischer, 2014), women who were not currently using drugs or alcohol but had a significant history of a substance use disorder were also included. Women were invited to participate in the inquiry when they were between 12 and 28 weeks pregnant. The lower gestational age limit of 12 weeks was chosen because the chance of miscarriage decreases substantially after the first trimester (Watts, 2015). The upper gestational age limit of 28 weeks was selected because narrative inquirers must develop an ongoing and close relationship with participants (Clandinin & Connelly, 2000).

In this inquiry, I lived alongside the women during their pregnancy. Although my relationship with the women extended into the postpartum period, I was mostly interested in their experiences while they were pregnant. In order to develop the intimate relationship that was essential to creating a meaningful inquiry, I needed to spend time
with each woman on multiple occasions. For this reason, women needed to be invited into the inquiry at an early enough gestational age so the opportunity to develop an ongoing relationship during the pregnancy existed.

Tammy, Angel, and Frankie came alongside me to become the inquirers in this research. These three women self-identified as having a drug and/or alcohol addiction and were between 20 and 28 weeks gestation when they were invited into the research. The women’s lives were complicated and at times their stories were difficult to follow as they moved in and out of the past and present. Brief timelines of Tammy (Appendix A), Angel (Appendix B), and Frankie’s (Appendix C) lives are included to help the reader follow each of their stories. More will be learned about each of these three women as their narratives are shared later in this dissertation.

Since conversations with the women took place during pregnancy, I recognized, from the outset, that the possibility existed for a pregnancy loss to occur after a woman had begun participation. In the research proposal, I identified that if a pregnancy loss occurred after a woman had begun participation, she could choose to continue in the inquiry, if she desired. The experience of pregnancy loss was part of her story. Frankie gave birth to a stillborn baby girl after entering the inquiry. We discussed whether she wanted to continue or withdraw from the study. Frankie chose to continue. You will learn more about her story later in this narrative inquiry.

Ethical approval for this research was obtained from the University of Regina Ethics Board (see Appendix D) as well as the Regina Qu’Appelle Health Region Research Ethics Board (see Appendix E) prior to inviting the women to participate.
3.2.1 **Number of inquirers.** Narrative inquiry studies are generally conducted with a small number of inquirers. Interactions between the inquirers are in-depth, ongoing, and often an intimate relationship develops. Many layers of narratives exist and these must be adequately explored within the inquiry space (Clandinin & Connelly, 2000). For these reasons, narrative inquiry studies are justifiably small (Clandinin, 2013).

Clandinin and Connelly (2000) cited two doctoral dissertations as exemplars, both conducted with three participants (He, 1998; Rose, 1997). Nursing research using Clandinin and Connelly’s (2000) method of narrative inquiry has also used small sample sizes. Chan, Cheung, Mok, Cheung, and Tong (2006) aimed to understand the meaning of health and the means in which it is constructed and expressed with four individuals. In her narrative inquiry into operating room nurses’ experiences of patient safety, Moszczynski (2013) explored the stories of four nurses. Haydon and Van Der Riet (2014) included four registered nurses in their exploration of how nurses respond to patients’ use of humour and Compton (2014) explored the experiences of three older adults in relation to place. Similar to these identified projects, the stories of three women have been included in this dissertation. A fourth woman was invited into the research and began a relationship with me. However, we were unsuccessful in developing the meaningful relationship required for narrative inquiry research. As a result, her story has not been included in this dissertation. The decision not to include her story will be explored further in Chapter Ten.

3.2.2 **Inviting potential inquirers.** Women were invited into this inquiry through their participation in programs offered for pregnant women with substance addictions at a
health centre. This health centre offers a variety of services and programs aimed to help individuals, families, and the community develop health and wellness (RQHR, 2015).

One of these services is the Healthiest Babies Possible Program. This multidisciplinary program supports high-risk women and their families during pregnancy and after birth (RQHR, 2015). Although not all of the women accessing this program are addicted to drugs and/or alcohol, one stream of the program is devoted to supporting women with a significant history of substance use (N. Jones, personal communication, February 23, 2016).

I initially asked the multidisciplinary team of health care professionals working at the health centre to help me identify women who might be willing to participate in this inquiry. I spent time with the staff, explaining the inquiry, and its importance. By developing a relationship with the staff, it was my intention that they would recognize the importance of the inquiry and assist me with identifying potential women for invitation into the research. Since the staff already had preexisting relationships with the women, they provided an optimal means for helping me to gain access to this population.

I anticipated that the staff would be the first individuals to contact potential inquirers. After meeting with the staff, I asked them to provide a brief background of the inquiry to women who they felt might be a good fit with the research. If the woman was interested in participating, the staff would obtain permission to pass her contact information on to me. I would then approach the potential inquirer and provide a more thorough explanation of the research. This means of recruiting women was not successful and I soon learned that if this project was going to be successful, I would need to immerse myself into the setting. I began to attend programming at the health centre.
This allowed me to not only develop relationships with the staff, but also encouraged me to get to know the women who might be interested in participating. During a prenatal program, I informally engaged with the women in attendance and introduced my research. Women who were interested in participating approached me. When women showed an interest in participating, a mutually agreeable meeting time was arranged to negotiate participation. During this meeting time, if the woman agreed to participate, verbal consent was obtained.

I chose verbal consent for this project for a variety of reasons. Given the methodology of narrative inquiry, in which a mutual relationship is developed between the researcher and the inquirers, I felt that obtaining a verbal consent would help to decrease the potential hierarchy between myself and the women. A large number of the women who access services at the health centre are of Indigenous descent. As a result, it was more culturally appropriate to obtain verbal rather than written consent. Lastly, women in similar studies have been described as unemployed, having less than a high school education, and living at a low socioeconomic level (Jackson & Shannon, 2012a, 2012b; Krausz, 2010; Linden et al., 2013; Murphy & Rosenbaum, 1999; Torchalla et al., 2015). The possibility existed that women would not be able to read a written consent form even if it was written at a low grade level. For these reasons, verbal consent was appropriate for this project. A consent guide (Appendix F) was read with each woman. Once the consent guide was read and the woman indicated that the contents were understood, it was signed and dated by myself. A copy of the consent guide was given to the woman.
Women were also encouraged to self-nominate to participate in the inquiry. I placed posters (Appendix F) advertising the inquiry at the health centre so potential inquirers were aware of the inquiry being conducted. Although women were predominately invited into the inquiry through their participation in prenatal activities at the health centre, any woman who was interested in participating and met the eligibility requirements (as discussed under Inquirers) was considered as a potential inquirer.

3.3 The Field

Narrative inquiries take place in the field (Clandinin & Connelly, 2000). The field for this inquiry was a mid-sized Canadian city. Women participating in the Healthiest Babies Possible Program at a health centre in this city were initially invited to participate. At the beginning of recruitment, 28 women, who were largely of Indigenous descent, received support, in varying degrees, from the addiction stream of this program (N. Jones, personal communication, February 23, 2016). This particular health centre is located in a community that faces challenges with crime, unemployment, poverty, and addiction (Leo, 2014). Although the narrative inquiry began at the health centre, it quickly moved out of the health centre and into the places and spaces that the women were most comfortable. These places will be explored in relation to the three-dimensional inquiry space of place later in this dissertation.

3.4 Field Texts

Narrative inquirers use a variety of different field texts as their means for data collection (Clandinin, 2013; Clandinin & Connelly, 2000). Clandinin and Connelly (2000) stated that all field texts represent reconstructions of experience and are therefore subject to an interpretive process that is shaped by the researcher-participant relationship.
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For instance, the story that the participant tells may be impacted by factors such as trust and how comfortable the participant feels with the researcher. For this reason, I was attentive to the on-going relationships that I developed with the women. Clandinin and Connelly (2000) suggested that a research journal, in which relational circumstances are documented, should be kept. I used a research journal in this way to document my personal thoughts and feelings as a field text. The novice narrative inquirer may perceive journal writing as time consuming and may worry that journal entries are inconsequential to the final research project (Clandinin & Connelly, 2000). However, Clandinin and Connelly (2000) suggested that the same journal entries that seemed insignificant, often take on a pattern when interwoven with other field texts.

As a second field text, I used field notes. Clandinin and Connelly described field notes as “the most important way we have of recording the ongoing bits of nothingness that fill our days” (2000, p. 104). These notes are the daily details of our experience in the field, providing the story of the inquirer’s experience (Clandinin & Connelly, 2000). What is not said is just as important as what is said in narrative inquiry research and it is often the field notes that capture this silence (Clandinin & Connelly, 2000). My field notes, in combination with my research journal entries, provided a reflective balance during the research process. In order to be useful, they were completed routinely and rigorously and I worked to ensure that I was including rich detail.

The narratives of the inquirers can begin by either listening to the participants tell their stories or by living alongside participants as they live and tell their stories (Clandinin, 2013). I lived alongside the participants as they lived and told their stories. To promote the telling of narrative experiences, the final field text I used was
conversations. I chose to use the term *conversation* because the term *interview* has a sense of inequality about it (Clandinin & Connelly, 2000). Given the intimate relationship I intended to develop with the women, I preferred that a more relaxed conversation took place rather than an interview that may be viewed as formal and constraining. Conversations are not guided by a set of interview questions, but instead create a place for the participant’s story to be heard (Clandinin). I focused on creating a relational space where the women felt comfortable to share their stories. As a result, I did not identify specific questions that would be asked of each inquirer from the outset of the research. Instead, conversations were allowed to occur naturally within the negotiated space between myself and each woman.

Some conversations were digitally recorded and all digital recordings were transcribed. I asked each inquirer for permission, prior to beginning any audio recording. Since I was living alongside the women, some conversations were very informal. These conversations were not digitally recorded. At other times, I felt that it was not appropriate to turn on the recorder. In these instances, I created written notes of my interactions with the women as soon as possible after the conversation. I recognized that I was entering the research relationship in the midst of both my own life and the life of the woman as each of our complex and multiple experiences were unfolding (Clandinin, 2013). As I moved throughout the inquiry, constructing field texts, and working with participants, I continually reflected on how the inquirers and myself were each situated within the three-dimensional inquiry space of temporality, sociality, and place.

Conversations took place in a comfortable, quiet place. The women were given the choice to meet with me at the health centre or in another private place. Initially, all of
the women wanted to meet with me at the health centre. I arranged for a private meeting space where formal conversations took place. To help promote a comfortable atmosphere, I offered the inquirers coffee or tea and something to eat at the beginning of each meeting, as appropriate. Given that I planned to live alongside the inquirers, I also needed to be present at more informal times. This included accompanying the women to informal programs at the health centre. I also informally spent time with the women by meeting them for coffee, driving them to appointments, or helping them to complete errands. As I got to know the women better, I began to meet with two of them in their homes. My meetings with the women did not take the place of their regular health care appointments. This was discussed with the women.

The means in which I spent time with the women was mutually negotiated and occurred in safe places. An honorarium was provided to each of the inquirers to compensate them for their time. Given the multiple meetings and the time commitment that was required of each woman, an honorarium was provided on two different occasions. The women received an honorarium of 30 dollars at the end of the first meeting and again when final research texts were written. The honorarium was provided in the form of a gift card and was chosen by each inquirer so that a gift that was useful for her could be provided. A small gift for the newborn was also provided, as appropriate. Childcare and transportation costs were covered as required.

3.5 From Field Texts to Research Texts

One of the most difficult transitions for narrative inquirers is moving from field texts to research texts (Clandinin & Connelly, 2000). Clandinin and Connelly (2000) stated that narrative inquirers must explore not only personal interests but also the larger
social significance of the inquiry, as expressed through the narrative experiences of participants. This inquiry arose from my own personal experience and knowledge. However, the work needed to move beyond my interests and into a larger domain where the relationship between addiction and pregnancy was explored from a societal perspective. As I composed research texts, I remained committed to the conceptual framework of the inquiry by continually revisiting the narrative view of experience as it related to the three-dimensional inquiry space.

As I began to analyze and interpret field texts, I read and reread all of the data. Many hours were spent immersed in field texts to determine what was contained within different sets of data (Clandinin & Connelly, 2000). This helped me to prepare and intimately know the data so that I could determine a means for sorting all of the information. Clandinin and Connelly suggested “careful coding of journal entries, field notes, documents, and all the rest, with notation of dates, contexts for the composition of the field texts, characters involved, perhaps topics dealt with, and so forth” (2000, p. 131). I initially coded field texts in this manner.

Clandinin and Connelly (2000) emphasized that narrative inquiry is far more complex than merely writing down a story that has been told. The initial analysis addresses “character, place, scene, plot, tension, end point, narrator, context, and tone” (Clandinin & Connelly, 2000, p. 131). As analysis continues, the inquirer adds narrative codes such as “names of the characters that appear in field texts, places where actions and events occurred, story lines that interweave and interconnect, gaps or silences that become apparent, tensions that emerge, and continuities and discontinuities (Clandinin & Connelly, 2000, p. 131). I used these suggestions to co-create each woman’s story.
Clandinin, (2013) used the term *interim research texts* to refer to the retelling of each inquirer’s story. Interim research texts are situated somewhere between field texts and the final completed research texts. Clandinin suggested that interim research texts are frequently narrative accounts of experience that relate to the research puzzle and are co-composed between the researcher and the participant. They are a means for re-telling stories and are often shared with inquirers. I wrote interim research texts that reflected the stories of the women that I worked with. These stories were co-composed to differing degrees between each woman and myself. I used interim research texts to complete the first level of analysis. I then situated each woman’s story within the relevant literature. The final phase was to look for common threads and important pieces of data in the women’s stories.

As further analysis and interpretation were considered, questions of meaning and social significance were explored (Clandinin & Connelly, 2000). The transition from field texts to research texts is complex, without a list of steps to follow. A process of back-and-forth ensues between field texts and stories are revisited frequently. Clandinin and Connelly (2000) stated that the responses to questions of meaning and social significance ultimately transition field texts into research texts. They also suggested general questions that I used during analysis such as “what is the meaning of this transcript and these field notes?” and “what can we learn about the phenomenon that we have not learned from other theories or methods?” To complete this level of analysis, I looked across the stories of all of the women, seeking coherences and tensions and working to contextualize the work both socially and theoretically. It is the final research texts that contextualize the work socially and theoretically (Clandinin & Connelly, 2000).
In the words of Clandinin and Connelly “we cannot . . . call a text narrative inquiry if it leaves out description and narrative and gives only argument. Nor can we call a text narrative inquiry if it is pure narrative without description and argument” (2000, p. 155).
CHAPTER FOUR: Addressing Research Ethics Boards

The relational ontology of narrative inquiry brings forth several potential ethical issues that must be considered when addressing research ethics boards. Josselson (2007) has written extensively about the ethical issues common to narrative research. Narrative inquirers enter a dual role in which an intimate relationship is often developed with participants, yet a professional responsibility must be maintained. Josselson suggested that the simultaneous obligations of researchers in each of these roles can lead to ethical uncertainties. In addition, the relational aspect of narrative inquiry research makes it nearly impossible for the inquirer to identify all of the ethical concerns that might arise during a project. To address some of these issues, Josselson recommended that researchers be aware of potential ethical concerns but also realize that not all issues can be identified from the outset of a project. When ethical issues do arise, researchers should be encouraged to consciously think through each dilemma to determine a solution that best meets the needs of the participants while maintaining standards required by research ethics boards.

Narrative inquirers, like all other researchers, are required to comply with standards set by research ethics boards. An essential component of all projects involves obtaining ethical approval prior to beginning the research. Clandinin and Connelly (2000) suggested that obtaining approval prior to negotiating the research with participants somewhat undermines the relational ontology of narrative inquiry. As a result, narrative inquirers are in a difficult position. They must meet institutional requirements, yet obtaining ethical approval, prior to approaching participants, limits the relational ontology that is fundamental to the methodology (Clandinin & Connelly,
In my experience, obtaining ethical approval, prior to conducting the research, did not limit the relational ontology in this project. The ethics application was written broadly enough that it encompassed a wide variety of possibilities while still meeting the requirements of the research ethics boards named in this study.

4.1 Dilemmas of Informed Consent

As a requirement of research ethics boards, participants are required to provide consent prior to participating in a study. However, by using a consent process, the relational aspect of the research is somewhat limited. Clandinin and Connelly (2000) and Josselson (2007) have discussed the dilemmas of informed consent. Clandinin and Connelly (2000) stated that the details of the informed consent are written prior to beginning the research, which does not allow for the relational negotiations that underpin narrative inquiry. Similarly, Josselson discussed the difficulty that exists in precisely articulating what the participant is consenting to given the relational negotiations that are yet to take place. As a result, Clandinin and Connelly (2000) and Josselson, question the meaning of informed consent in narrative inquiry research.

Josselson (2007) stated that many aspects of the informed consent are explicit and fairly straightforward. This would include statements as to who the researcher is, why the research is being conducted, that the participant can withdraw at any time, and so on. These types of explicit statements were included in the consent guide for this inquiry. Beyond these explicit statements, Josselson suggested that the relationship between the researcher and participants contains an implicit contract, the terms of which are difficult to articulate. For instance, stories told by participants are influenced by the trust and rapport that is developed with the researcher. Consequently, participants can never be
fully informed about what they are consenting to, as much of what will unfold during the inquiry is unforeseeable (Clandinin & Connelly, 2000; Josselson). Clandinin and Connelly (2000) suggested that as a result, researchers may find themselves in situations in which the ethics become unclear. If the project is to proceed, inquirers must think in terms of relational ethics and consider their responsibilities to participants.

As I reflected on my own responsibilities and the need to address the requirements of the research ethics board, I saw that I had an obligation to obtain informed consent but I also had to be accountable to the methodology by working in a relational realm that did not put constraints on the stories that were told by the women. I addressed the requirements of the research ethics board by first presenting an overall research proposal. As suggested by Clandinin (2013), I wrote a research proposal, including a consent guide, which addressed how I anticipated the research to unfold within the relational realm of the inquiry. If I had found, after engaging with the women and negotiating the research that the original ethics submission and consent did not capture the relational aspect of the research, I would have needed to resubmit a revised application that met the requirements of the research as well as the needs of the inquirers. The ethics application was written broadly enough that I did not need to return to the research ethics board during this inquiry.

Consent must be an ongoing process in narrative inquiry research, despite obtaining formal documentation only at the beginning of the project (Josselson, 2007). Given the close relationship and the multiple meetings that occurred between myself and each woman, consent was revisited throughout each step of the inquiry. To address the requirements of the research ethics board, I obtained verbal consent from each woman
upon recruitment into the inquiry. During subsequent meetings, I informally reminded each woman that she was participating in a research project. Additionally, given the nature of some of the meetings, in which I was exploring the women’s experiences and later sharing and negotiating written texts, their continual consent to participate was somewhat implied by their recurrent participation.

Although the consent process did not constrain the stories that were eventually told by the women, I sensed that reading the consent guide impacted the initial relationships I developed with them. The women seemed uneasy when I read statements that warned of potential emotional upset, embarrassment, loss of privacy, or stress from remembering unpleasant events. Further statements that suggested the women could be referred to counseling if they became overly upset only seemed to cause the women to further question what they were agreeing to during the research. Although I did not want to undermine the importance of such statements, I felt they initially made the women skeptical of me and the research. Over time, these feelings lessened as I developed relationships with the women and they came to understand that they were in control of the stories they shared.

4.2 Addressing Anonymity and Confidentiality

Addressing anonymity and confidentiality is important in qualitative research. Munhall (2010) stated that anonymity refers to protecting the identity of the person participating in the research while confidentiality refers to protecting the information that the person has shared. Research ethics boards are concerned with maintaining the anonymity of individuals participating in research and the confidentiality of the information they share (Josselson, 2007). This can be particularly difficult to navigate in
narrative inquiry research. Narrative inquiry often takes the inquirers out of private interview rooms and into public settings where they might be recognized and associated with the research. As I came alongside pregnant women in this inquiry, I informally accompanied them to prenatal activities and health care appointments. I also helped the women with errands and met them for coffee. I recognized that my presence with the women, in public settings, made anonymity particularly difficult to navigate. Initially, I worried how I would respond if a health care professional asked who I was seeing while at the health centre. Clandinin and Connelly (2000) emphasized that if researchers or participants publicly acknowledge that they are engaged in a research relationship, anonymity is jeopardized.

Thinking about anonymity in terms of relational ethics was helpful in addressing this problem. I came to see that I needed to identify the relational responsibility I had with each of the women. Very early on in the research relationships, I had a discussion with each woman about her anonymity while at the health centre. I found that issues of anonymity were not particularly important to the women. They were all willing to be associated with the research as our relationships unfolded. The professionals at the health centre had pre-established relationships with the women. The women were comfortable in having the professionals know they were involved in the project and I did not have to worry about maintaining the women’s anonymity while at the health centre. However, I also needed to ensure each woman understood the potential for her story to be recognized into the future (Clandinin & Connelly, 2000).

The potential for women to be recognized as having participated in the study by individuals outside of the health centre existed. It was discussed with each of the women
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that if she had shared her story with others, those individuals may be able to identify particular comments or experiences, compromising her anonymity. Each woman expressed that this was understood. Steps were taken to protect the confidential information the women shared. The women were asked to choose a pseudonym, if they desired, as soon as they were recruited into the inquiry. Two of the women chose to be referred to by their own names. The third woman wanted to be referred to by a pseudonym but it took until the research was almost completed for her to decide on her name. In the meantime, a number was assigned as her name and her field texts were associated with this numerical code. Any family members or friends that were named by the women were provided with a pseudonym.

4.3 Potential for Risk

The potential for participants to experience harm is a concern for research ethics boards (Josselson, 2007). Although I believed that the inquirers in the proposed inquiry would be exposed to very minimal risk, I recognized that the potential for psychological or emotional discomfort existed as a result of revisiting and retelling stories. Josselson, who has written about the potential for harm in narrative research, would disagree with me. She discussed the risks associated with participating in narrative research. Much of her discussion focused on the clauses included in consent forms that draw attention to the potential harmful effects of interviews, such as becoming upset by revisiting previous experiences. Josselson suggests that such statements jeopardize the relational aspect of the research, causing suspicion that the interview will be an unpleasant experience. She believed that participants would only disclose information they were comfortable sharing and that warnings about being upset were unnecessary.
Josselson’s (2007) discussion disregards the on-going and intimate relationship that is often developed in narrative inquiry research. If a relationship of trust is developed between the researcher and the participant, there is a chance that the participant will share stories she never imagined herself telling. Whenever anyone is put in a position to relive and share the intimate details of her life, the possibility that she will become upset exists. The nature of this research, in which I developed on-going relationships with the women, allowed me to check-in with them on an on-going basis. As I engaged with the women, I was aware of their emotions. The women displayed a variety of feelings including guilt, sadness, and anger, but I never sensed they were unduly distressed by sharing their experiences with me. Although the women discussed many difficult stories, they also shared experiences of happiness. The combination of these stories seemed to offset each other. In the event that a woman became unduly distressed by engaging in this research, I had a plan in place to refer her for counseling. Culturally appropriate counseling was also available if needed. This plan was not implemented during the research because it did not become necessary.

A large segment of women who access services at the health centre, where women were invited into the study, are Indigenous. As a result, I met with an Elder from the outset of the inquiry to discuss the research. The Elder worked at a health office that was associated with the health region where the research took place. In his role at the health office, this Elder was concerned with improving health service delivery to better meet the needs of Indigenous peoples. As I planned the research, we met to discuss the design of the inquiry and how I planned to engage in research relationships with Indigenous women who might become a part of the study. I shared my ideas of using
narratives to explore the women’s experiences with pregnancy and substance use disorders. According to this Elder, this process was culturally appropriate. As I met with the women, they seemed genuinely interested in sharing their experiences. The method of using stories as a means for data collection really seemed to resonate with them.

The Elder supported using stories and engaging in on-going relationships with the women to co-construct their narratives. Together, we agreed that this process would support the development of relationships rather than encouraging me to briefly enter the women’s lives and use their stories solely for the benefit of the research. He cautioned me to continuously reflect on the sacredness of their narratives and to represent the women’s experiences in a way that would not cause harm to the women or to their stories. On several occasions, he stated to me “Let the women guide the stories.” The methodology of narrative inquiry supported this approach. Over time, I worked with the women to co-construct their stories while also reflecting, in my research journal, about the process and how the stories were represented.

The consent process, including the consent guide, as well as the recruitment poster, were also reviewed by the Elder. Given the ongoing nature of the relationships I was planning to develop with the women, he reminded me of the importance of always asking for permission prior to recording any conversations. He stated that although Western societies record and document their histories, this is not typical for Indigenous peoples who traditionally share their experiences orally. He wanted to ensure that I was vigilant in asking for permission prior to recording any conversations. As I carried out the research, I was cautious to ensure I obtained permission from all of the women (not only women who identified as Indigenous) prior to beginning any recording.
This Elder was also concerned about the cultural appropriateness of any counseling services that would be offered to Indigenous women. He suggested that in addition to typical Western counseling, an option for Indigenous women to meet with an Elder needed to be available. He volunteered to meet with women, as necessary, or to find a more suitable, potentially female Elder if required. Although this did not become necessary during the research, the option was arranged in the event that it would be needed. The rest of the consent process, including the consent guide, as well as the recruitment poster were identified as acceptable for use with Indigenous women.

Once I entered the field, I was introduced to a second Elder. I was encouraged by the staff at the health centre to develop a relationship with this person and to discuss my research with her. In her role at the health centre, this particular Elder spent considerable time working with all of the women who attended programming there. However, most of her work focused with Indigenous women. She was especially experienced in engaging with Indigenous women with substance use disorders. We attended some of the same informal group activities and programming at the health centre. It was during these times that I discussed the research with her. She shared her experiences of working with pregnant women with substance use disorders and provided me with guidance as I developed relationships and worked with Indigenous women.

She echoed the advice of the initial Elder, cautioning me to let the women share their stories with minimal probing questions. This would allow the women to share only the experiences they felt comfortable sharing. As I engaged with all of the women, I let our relationships guide the stories that were told. As we became increasingly comfortable with each other, the women shared more intimate details of their lives. I did
not have to ask a lot of questions. Rather, we shared experiences in the relational space that developed as the research unfolded.

This Elder was less concerned about the women becoming unduly upset by sharing their experiences. She believed that the women would only share the experiences they were comfortable sharing as long as I used a caring, non-invasive approach. I was consciously aware of how I interacted with all of the women throughout the research.

As I began engaging with the women, I became concerned that I might offend a woman or ask an inappropriate question as a result of being naively uninformed about a certain cultural practice or experience. I was worried that a woman might discuss a cultural experience that I had little knowledge about. I discussed this concern with the Elder. She shared that my being aware of my own potential lack of cultural knowledge was important. The women were the experts in this area and it was suitable for me to ask them to share their knowledge with me. The Indigenous women did discuss some of their cultural practices and spirituality and I was able to learn about these experiences from them. It was experiences such as these that contributed to the building of mutual relationships.

As time went on, and I developed relationships with the women in this study, the research moved out of the health centre and I attended programs less often. I met less with the Elder but the initial guidance she provided encouraged me to develop the meaningful relationships that were necessary for this research and the co-construction of the women’s narratives. As I reflect now on how the research was conducted I realize that I could have returned to the Elder throughout the entire project. My relationships with the women moved out of the health centre but I could have continued to check-in
with the Elder. This would have allowed me to implement her advice in the field and return to her with my experience. Further advice could have then been offered and implemented.

In hindsight, given the usefulness of the Elders’ initial contributions to this research, it likely would have been useful to have on-going guidance throughout the entire project. The initial supervisory committee for this research included an Indigenous woman. However, upon her departure from the university, she was not replaced on the committee. Future research with Indigenous women might involve including an Indigenous Elder and/or Indigenous women on an advisory council so that on-going consultation is sought throughout the entire research project.

4.3.1 A vulnerable population. In this inquiry, it was essential to ensure that the women were not exposed to any unnecessary risk and were not harmed as a result of their participation. When the population that is participating in a research project could be considered vulnerable, protecting them from risk becomes particularly important. Although I did not want to label the women participating in this inquiry as vulnerable, I recognized that this population is frequently perceived to fit into this category. I entered the inquiry with the intention of listening to the women’s storied experiences and then engaging with the women to identify the meaning of their experiences. Consequently, I was cautious about prematurely labeling the women. The women may not perceive themselves to be vulnerable and in fact, vulnerability in this inquiry was considered a social construct.

Schrems (2014) has written about vulnerability in the context of relational ethics. She stated that “vulnerability is defined as a relational construct between the health status
of a person and the extent to which the individual is dependent on the researcher and the research context” (p. 838). The focus is not on how vulnerability is socially constructed for a particular population but rather on the individual participant and their social and environmental context (Schrems, 2014). Although pregnant women with substance use disorders were not defined as vulnerable at the outset of this inquiry, I recognized that this population has historically been described using this terminology.

Vulnerability is a complex term. It has been defined as a human experience in which a particular population is at a greater risk of harm than other groups (Gwyn & Colin, 2010). Individuals can be considered to be medically, economically, and or socially vulnerable (Gwyn & Colin). Schrems (2013) stated that vulnerability could be applied to any individual who is at risk of harm. Therefore, every person could potentially be viewed as vulnerable to some extent. Individuals with substance use disorders have been identified in the literature as potentially extraordinarily vulnerable (Gwyn & Colin). In their discussion of vulnerability, Gwyn and Colin explored the population of individuals who abuse alcohol. They suggested that this population may be doubly vulnerable because the stigma associated with alcohol abuse is coupled with subgroups of people who may include “women; older adults; incarcerated, socioeconomically disadvantaged, and mentally ill individuals; as well as people from racial minorities” (p. 38). To apply the example used by Gwyn and Colin to this inquiry with pregnant women with substance use disorders, the women might have been considered as doubly vulnerable from the outset as a result of their substance use as well as by being members of certain subgroups of the population such as women, pregnant
women, socioeconomically disadvantaged individuals, and members of minority populations, including Indigenous women.

Nordentoft and Kappel (2011) found that it is not always possible to identify who is vulnerable prior to a study. With knowledge that the literature defined women with substance addictions as potentially vulnerable, but not wanting to prematurely place a label on the women, I entered the inquiry cautiously. What I found was that the women did not see themselves as vulnerable. As you will learn in their narratives, the women described themselves as fighters, or as women who battled for their children and for their motherhood. Attaching a label of vulnerability positioned the women as weak; these women were anything but weak. I refrained from attaching any labels to the women prior to carrying out the research.
CHAPTER FIVE: Tammy’s Narrative

I remember the first day I met Tammy. I attended the Moss Bag and blanket making program for prenatal women at the health centre. The intention of my attendance at this informal program was to get to know the women by spending time with them. Through informal conversation, I had the opportunity to introduce the women to my proposed research and provide further information to women with an interest in participating.

Tammy was one of the first women to arrive at the Moss Bag making group. She sat at a spot at the corner of two tables. She looked older than the other women and I guessed her age to be around 40. She was short in stature and slightly overweight. As other women arrived for the group and began to work on their Moss Bags or blankets, I noticed that Tammy mostly observed the other women, speaking briefly to them or to the professionals overseeing the group. I never saw Tammy begin to work on her own Moss Bag or blanket that day.

As I observed Tammy, my first impression was admittedly somewhat unnerving. Tammy appeared anxious and unsettled to me and her appearance was somewhat disheveled. The shoulder length brown hair that framed her round face was unkempt and her baggy clothing was tattered and dirty. She appeared tired and was pale. I noticed dark circles around her eyes. I could not determine her race from her skin tone but I guessed her to be Caucasian. She sat and watched the others. Despite not knowing anything about Tammy, I was apprehensive to approach her. I spoke with several other women prior to summoning the courage to talk to her. When I finally approached her, my feelings of unease were immediately put to rest. Tammy was pleasant and very
receptive to me. As I began to tell her about my proposed research, she excitedly interrupted me and said, “Oh, you’re that nurse that wants to know about addiction and pregnancy. I heard about you and wanted to talk to you but I didn’t have a way to call you!” In that instant, Tammy began to provide me with a glimpse into her story.

She told me that she had been pregnant several times, was currently four months pregnant, and had struggled with addiction and mental health issues for 15 years. I told her a little bit more about my project and she seemed eager to share her story. When I asked Tammy if she would be interested in hearing more about the project and potentially engaging in this research with me, she smiled and said, “I know a lot about pregnancy and addiction and I would like to spend some time with you. I don’t have much else to do anyway.” We made a plan to meet a couple days later to review the consent process and discuss the project. As I went on to talk with other women, I noticed that Tammy continued to sit alone and mostly observed her surroundings. At one point she removed herself from the group to lie down on a nearby couch. When it was time for me to leave, I thanked the women for welcoming me to their group. As I left, Tammy looked at me, smiled, and enthusiastically said, “See you Thursday!”

Tammy shared her story with me over the next seven months. Our relationship would grow from the early days at the health centre where our meetings seemed like interviews to later visits in Tammy’s home where it felt more like we were old friends enjoying a visit over a cup of coffee. As our relationship developed, and Tammy shared her story with me, I learned some of the most intimate details of her life. There were times when I directly shared in Tammy’s experiences as I lived alongside her in the present. I was there as she navigated through some very difficult times but I was also
there to share in some of her most exciting triumphs. During these times I really got to know Tammy. Tammy gifted me not only with her story but with the opportunity to live alongside her and to develop insight into what it might be like to live with a substance addiction during pregnancy.

As I share Tammy’s story now, it is my hope that others might begin to learn the reality of living with an addiction, especially as it is laid alongside the story of pregnancy. To say that Tammy’s story is complicated would be an understatement and would not do justice to the complexities that Tammy has had to navigate. I have been profoundly impacted by the time that I have shared with Tammy. Tammy’s story has enlightened me to the complexities that are experienced by women like her. Because of Tammy, I am more understanding and more empathetic and I am less likely to judge and stereo-type pregnant women with addictions who cross my path in my practice as a registered nurse.

By sharing Tammy’s story, I am hopeful that others will also gain insight into the experience of being pregnant amongst an addiction. Perhaps by reading Tammy’s story, you too will learn something from Tammy that you can hold onto and take with you on whatever journey you might be on. It has taken a lot of courage and strength for Tammy to share her story. We can thank Tammy for taking this risk by using what we have learned from her to help shift the perspective on pregnancy and addiction and to inform future practice. There needs to be more compassion and more empathy for the very real struggle that women like Tammy face on a daily basis. I encourage you to walk with Tammy and me . . .
Life before Addiction

For Tammy, there was life before addiction. She could recall a distinct time period in her life when drug use was not prevalent. When I asked Tammy what life was like during this time she said, “Good. I was a good mom. I used to look after foster children. I used to have eight foster children at a time. I used to do respite for all special needs children.” Before drugs, Tammy saw herself as a good mother. In fact, she saw herself as even better than a good mom. She was an exceptional mom. She would care for several foster children at one time including children with special needs. She went on to say, “And I was good at it. I was good with children.” But with the addiction, Tammy felt she was robbed of her ability to be a good mother. She told me that when her addiction began to take a hold of her, her ability to mother “went all away. I just walked away from my children.”

Tammy did not talk a lot about her life before addiction, but when she did, it was always within the context of being a good mother. This might have been because many of our conversations focused on pregnancy and mothering, resulting in Tammy’s focus on this area. But it might also have been a direct result of Tammy’s longing to be a good mother. She wanted to demonstrate that she could once again live a life without addiction and that in this time she would be able to be the good mother that she had always wanted to be to her children. As I got to know Tammy more, I sensed that the latter was more likely. Tammy just wanted to be a mother to her children, but the addiction and the fight\(^6\) to stay clean prevented her from being the good mother she desired to be.

\(^6\) The word fight is not used in the physical sense here. Rather it is the term the women used to describe the internal struggle they experienced.
5.2 Initiating Drug Use and the Constant Fight to Stay Clean

Tammy’s first experience with drugs was at the age of 15. She described living on the streets and being introduced to drugs there. She remained on the streets, living a life of drug and alcohol use, before returning home at the age of 19. We did not talk a lot about this part of Tammy’s life. I am not sure if it was that she could not recall or that she did not want to recall this time. After returning home, Tammy quit using drugs. “I stopped everything. I was clean for years . . . I had my oldest daughter at 21 and I still had no addictions then. And then I met my ex of 15 years and he was addicted to crack cocaine. And he did it for years before I even touched it. And one day, he was like, ‘do you want to try it?’ So I tried it and it was downhill from there.” This was a pivotal moment in Tammy’s life. As I got to know her, and we spoke more about her addiction, I came to see that from this point onwards, Tammy was constantly faced with the desire to use drugs. Although there were long periods of time where Tammy described not using drugs, these times were never easy for her and she constantly fought to stay clean.

There were several contributing factors in Tammy’s fight to stay clean. Threaded throughout her story were feelings of loneliness, isolation, and boredom. Tammy and her current partner lived separately and often went long periods of time without seeing each other. She had very few friends; her family wanted little to do with her, and all of her children had been apprehended. Even in my early encounters with Tammy, I sensed her loneliness. When I would ask her if she had time to meet with me, she frequently replied that she did not have anything else to do anyway and wanted to spend time with me. It was in her times of loneliness, isolation, and boredom that the urge to use drugs would surface. In many ways, Tammy was trapped by these feelings. She fought loneliness,
isolation, and boredom, against the urge to use. She emphasized this when she said, “I have my boyfriend but he’s not there as much as I want him to be . . . I don’t get to see him basically at all. So I’m there with my dogs. And my mind wanders lots. And it goes into the stage of wanting to use. Second is that, I don’t have no, maybe I have like two friends. I don’t have no life, I don’t have no friends. It’s me. And it’s hard.”

Tammy recognized that being housebound and isolated put her at risk for using drugs. She described not only trying to get out of her house, but also trying to get away from the feelings inside her own head. “That’s why I try to come here [to the health centre] as much as I can. Because it gets me out of the house and away from my head . . . I just want to get out of my house. Yesterday, just to get out of my house, at five o’clock, I walked down to the Salvation Army . . . and then I walked to Toys R Us and then I walked to my boyfriend’s. And then we walked back to my house at nine o’clock. Just to get out of my house. I don’t want to be in my house all of the time. I just need to get out of my head. I get it in my head and that’s when the depression starts in, the bad thinking and, yeah . . . it [the addiction] can pop out at anytime. Especially when you’re down like that.”

The environment that constantly surrounded Tammy also proved to be a potential trigger for her. The individuals in Tammy’s life and the physical locations of where she was forced to live left her vulnerable to drug use. Tammy often found herself living with individuals who used drugs. When we talked about one of her previous pregnancies and what it was like to try and stay clean she said, “I’d fight with my roommate, I’d fight because she was using crystal meth, my roommate at the time. And her boyfriend was
using cocaine. And so it was all around me so I’d try to stay clean and it was like, fuck, all around me.”

In her current home, Tammy continued to be surrounded by drug use. The first time that I was invited into Tammy’s home, I noticed that she had very little furniture and the walls were bare. Several visits later, I arrived at Tammy’s home and noticed that she had rearranged the furniture, decorated, and hanged pictures on the wall. I mentioned that the place was looking really nice. She said, “Well I didn’t do anything at first because I wasn’t supposed to live here for long. But since it looks like I’ll be staying, I guess I better make it a home.” Tammy had been hoping to move out of the downtown area and closer to her boyfriend but she was struggling to find adequate, affordable housing.

When I first met Tammy, prior to her living in the current house, she was looking for a new house. She told me that her home was “not safe for kids” and that she would need to get a different one if she was to get custody of her children. She had a mouse infestation. She described mice being everywhere and that they would chew her personal belongings and get into her food. I asked her what she was looking for in a new house and she told me about one that she had found. “This one is baby safe. It has carpet, it has a fenced in yard. No mice, it’s perfect. No stairs or nothing. Yeah, so it’s good. I think it’s good for a baby.” I marveled at the very basic conditions that Tammy wanted in a house.

Tammy planned to move into this house but at the last minute, the landlord decided he did not want to rent to her. She found another house. The day she was to get possession she found out there was a plumbing problem and she would not have running
water. I asked her what she was going to do. She replied that she would just stay in the house with no running water. She would walk five blocks to her boyfriend’s house to use his water. It was the middle of winter and temperatures were forecasted to be bitterly cold in the coming weeks. Tammy never did move into that place and would eventually find the house she was currently living.

I asked her what she did not like about the current house. She said, “It isn’t the house, it’s the neighbourhood. Do you know what it’s like to live with drug houses on either side of you? When I have my bad days it’s really hard. I see the [drug] traffic and I see the drop offs. It’s hard not to just go over.” Tammy went on to tell me that the house she was currently living in was “an old drug house” and that she used to come to this place to use drugs and to get high. It was incredibly difficult for Tammy to have memories of using drugs in this house and to watch the drug trafficking that constantly occurred right outside her own front door. In a desperate voice, Tammy said to me, “I need to get out of this house.” When Tammy and I ended our relationship, she was still living in that house. When I drive by that house now, I wonder if Tammy is still living in that place. She recognized the physical place, including her house and the neighbourhood, as potential triggers for drug use. In this sense, these places could contribute to preventing Tammy from staying clean and becoming the good mother she wanted to be.

5.3 Pregnancy and Addiction

During one of our first meetings, Tammy told me that she had been pregnant eight times. This would be her eighth baby. As Tammy and I spent more time with each other and she referred to her multiple pregnancies, I had difficulty following her story. I asked
Tammy to help me sketch out a timeline of her life so that I could more easily understand how her story was composed. We worked together to identify the name, birth date, and age of each child. I noticed almost immediately that Tammy had difficulty recalling this information and often mixed up the birth order of the children. I admit that in that moment, I began to judge Tammy. As a mother of two young children myself, I could not understand how she could have difficulty recalling what I valued as such important information about her children. As I spent some time reflecting on this, I came to see that Tammy’s experience of pregnancy and motherhood was vastly different from my own. All of Tammy’s children had been apprehended. Several of the children had not been in her life for many years. She was justified in not being able to recall the numerical birth details of children that she had never really come to know. Tammy and I talked about her different pregnancies. She could recall some of the pregnancies more easily than others. What I noticed was that threaded throughout the story of her pregnancies was the constant presence of addiction.

Tammy did not use drugs during her first two pregnancies. It was not until her third pregnancy that she really began to struggle with addiction. “I, with my third pregnancy, I smoked drugs throughout that pregnancy. . . . My fourth child . . . I actually did drugs through the labour. It had control over me. You know, I’d cry every day. I didn’t want to do it. It had a hold of me, really hard.” As Tammy spoke more about her pregnancies, I began to fathom the real tension between her pregnancies and her addiction. In some of her pregnancies, Tammy had used drugs and her children had been born healthy. In other pregnancies, Tammy’s children were born with developmental delays that she saw as consequences of her drug use. She felt an overwhelming sense of
guilt and self-blame for the damage she felt she had caused to some of her children yet she was thankful that other children were seemingly unaffected.

Even though Tammy had smoked drugs during her third pregnancy, her son had grown up to be a very successful soccer player. “I’m thankful that he’s an awesome soccer player today. And I’m thankful for that, right?” But in other pregnancies, Tammy perceived consequences of her drug use. It was very evident that she blamed herself for the deficits in some of her children. In speaking about her fourth pregnancy Tammy lamented, “And he has a bit of some learning disabilities. I blame myself for it. But, I don’t know, it’s just you struggle, between, you know, your baby is going to be okay, it’s not going to affect the baby. Just because you have one child who came through and even though you used drugs and it’s fine, doesn’t mean the rest are. Because, I mean, I took that chance. And I wrecked my child, my children.” Tammy went on to talk about her most recent pregnancy. “My two year old, I did drugs for the first two months of her pregnancy. And she has learning disabilities. And I blame myself as well, right? And there’s nothing I can do to take that back or make it better. The damage is done and I wish it upon nobody.”

In an attempt to handle the guilt and self-blame she experienced as a result of her addiction, Tammy tried to manage the present as best as she could. She could not take back what had happened, but she could try to do better now. Tammy was working towards getting custody of her youngest daughter and her unborn baby. As she moved forward, she accessed services for her daughter that would help to counter the damage she felt she had caused.
“Yeah, I have her in speech. I had to put her in physio because she wasn’t walking at the time she was supposed to be.” Tammy accessed these services in an attempt to manage her guilt and self-blame. This was evident in her comments like, “She’s a little bit slow. And I look at her everyday and I say ‘I’m sorry.’ But I can’t take it back. But she’s a happy bright little girl. And I have her in help, I have her in speech. And therapy . . . she’s progressed . . . So you know I’m thankful for that.” For Tammy, hope existed. Hope was revealed in the progress of her daughter. It was because of this hope that Tammy could manage her feelings of blame without feeling an overwhelming sense of guilt.

In addition to trying to stay clean from drugs, Tammy did the best she could to contribute to the health of her current pregnancy. This included attending pregnancy related health care appointments. But for Tammy, barriers frequently existed that prevented her from accessing health care.

I knew that Tammy was to have an ultrasound a few days after one of our meetings. When I saw Tammy the following week, I asked her about the results of her ultrasound and whether she had found out what she would be having. Tammy told me she had missed her appointment for the ultrasound because it was scheduled for 7:50 in the morning and she had overslept. I wondered why the appointment had been scheduled so early. The appointment time certainly did not align with the demands of Tammy’s life. She had previously told me that she often sleeps well into the morning. Most activities at the health centre do not even begin until the afternoon to support the attendance of the women. I wondered why no one had advocated for a more appropriate appointment time for her.
Coincidentally, as we were talking, one of the workers from the health centre came to remind Tammy that she had an appointment to see the obstetrician at 1:00 that afternoon. It was currently 1:00 and the appointment was on the other side of the city. Tammy had forgotten. She said, “There’s just so much going on. I forgot.” She was visibly panicked. I helped Tammy to find the phone number to the office and she used my cell phone to call and ask if it would be okay if she arrived late. The receptionist said the doctor would still see her. Tammy hung up the phone only to realize that she did not have transportation to the office. I offered to drive her. As we drove, I considered the multitude of barriers that Tammy faced in attending one appointment. Tammy went in to see the physician and I waited outside in the lobby area.

When Tammy finished her appointment, I got my first real glimpse into the poverty that she experienced. On her way out of the office, Tammy noticed a pizza place in the same strip mall. She asked if we had time to go in and I replied that we did. I followed Tammy as she entered the pizza place. I observed as she carefully priced out the menu and counted the small amount of change in her wallet. She decided on a panzerotti and placed her order. As we waited for the order, Tammy told me that she had not eaten anything yet that day. I did not know if I should feel sad or angry; sad because Tammy was six months pregnant and had not eaten anything all day or angry because she experienced such an injustice.

Tammy got her order and we went to the car. She ravenously ate the panzerotti, not even waiting for it to cool down. When we arrived back at the health centre, Tammy thanked me for driving her to the appointment. Later that afternoon, during a prenatal group, I noticed Tammy eating several muffins during snack time. This is when I began
to realize just how much Tammy struggled with food security. Here she was, trying to stay clean from drugs and have a healthy pregnancy, but the poverty she faced made this difficult. As I got to know Tammy better, I saw firsthand how living in poverty impacted her.

Tammy sent me a text that read, “I’m so broke it hurts.” I asked her if she had time to meet and she agreed by asking if I could pick her up at her house. This was the first time that I had been invited to Tammy’s home. I arrived at the house at 1:00 in the afternoon. From the outside, Tammy lived in a small very run down bungalow in the downtown area. I noticed a couch in the front yard. The basement windows were boarded up and the front screen door was torn with no door handle. It was slamming open and closed in the cold prairie wind.

I parked in front of the house, not sure if I should go in. I decided to wait in the car. A few minutes later, I noticed that the front door had opened. I was not sure if this was an invitation to come in. I waited. Soon after, I saw Tammy waiving me in from the window. As I walked towards the door, I noticed the front walk was covered with several inches of ice. I went inside. The living room had only a couch and a television. I sat down and asked Tammy how things were going. She started to cry. She told me that she had expected a cheque from Social Services and that it had not arrived. She was running out of necessities like toilet paper. Her phone had no minutes and her WiFi had been disconnected. Yesterday, she had gone to Tim Horton’s and had just enough money to buy a small coffee so she could sit in the restaurant and use the WiFi.

I asked Tammy what it was that she really needed. “Smokes and toilet paper” were her reply. She said, “I’m getting desperate, usually, I’d just go work the street but I
can’t right now because I’m so pregnant.” She was tearful. “I used to work the street and sell drugs but I can’t do that now because I’m too pregnant and I’m trying to get my kids back.” I sensed her desperation and I told her we would figure something out. She said, “I just need smokes. It’s the only addiction I have left. If I can’t get smokes I’m going to get desperate.” She told me that she had been trying to borrow ten dollars from someone, but she had no friends and no one to go to. The night before she had gone to the Casino and smoked cigarette butts. “It’s gross and it’s dirty but I’m desperate.”

Tammy asked if I could take her to the health centre to get her milk voucher so she could get a few groceries. When we arrived at the health centre, Tammy got her milk voucher and spoke with the nurse. Tammy heard that the afternoon snack had been served earlier than usual. She asked if she could eat before we went to get her groceries. Tammy had a snack and the health care workers also made her a “to go” package.

On the way to the grocery store, Tammy spoke out loud as she tried to figure out how she would get some toilet paper. Her milk voucher would only cover 12 dollars worth of specified items like milk, yoghurt, fruits, and vegetables. She decided she would use the bathroom in the store and take a little extra toilet paper so she would have some for the night. She just needed enough to get by until her cheque arrived. I could sense Tammy’s desperation and I did not want her to do something she might later regret. I decided to give Tammy 10 dollars and told her that I would come into the store and buy her some toilet paper. “I’m so embarrassed, I’ve never been this broke, but I planned on getting that cheque” she said. She thanked me over and over again. I could not help but feel worried for Tammy and what she might have done had I not helped her that day.
Despite the struggles that Tammy faced during her current pregnancy and the fact that she did not know if she would be allowed to keep the baby after it was born, she seemed to be developing a bond with the unborn child. She frequently showed off her growing belly to me with a smile. One afternoon, when I was visiting Tammy in her home, she told me she had something she wanted me to see. She turned on an old computer monitor and showed me the ultrasound pictures of her baby. She was beaming with pride and I could tell she was very excited to meet the baby.

Tammy had been diagnosed with gestational diabetes. This meant she would be induced a couple of weeks before her due date. Tammy was counting down the days until the baby was born. I asked her where the baby would go after birth. She said that her workers would not guarantee that she would be able to bring the baby home but if she continued to do well, it was a possibility. I sensed that it was the hope that she would be able to bring this baby home and be a mother to it that kept Tammy going. I was fearful of what would happen to Tammy if this baby was apprehended at the hospital.

5.4 Losing Her Children

Despite her addiction, Tammy parented her first four children for intermittent periods of their early lives. After the birth of her fifth child, Tammy was incarcerated for six months for drug trafficking. When she was released from jail, all five children were placed into her care. She felt she had not been adequately supported and that she had been set up by social services. “And I failed” she said. All five children were subsequently removed from her care. The first four children were placed in the care of Tammy’s now estranged mother. The fifth child was to be adopted by Tammy’s sister, but after caring for him for over a year, Tammy’s sister decided to have him adopted out.
of the family. Tammy’s sixth child was apprehended immediately at the hospital and placed into the care of Tammy’s mother.

Tammy would occasionally visit her children in her mother’s home. Tammy’s mother also cared for foster children. About six months after having her sixth baby, Tammy was visiting her children at her mother’s home. She saw a boy who she did not recognize and asked who the new foster child was. Her oldest daughter looked at her and said, “Mom, that’s your baby.” Tammy said, “I picked him up and I just held him because as far as I knew he was given up for adoption. And there he was. But I didn’t have that bond with him. I never had him from birth, right. So that bond was gone.”

Realizing that she did not have a bond with her youngest child and that the relationships with her other children were slipping away, sent Tammy into a downward spiral. She spent the next seven years living a life of drugs and crime. Tammy did not want to talk about this time in her life and I suspected that it was a very dark and painful story, one that she did not want to revisit.

In 2013, Tammy found herself pregnant once again. Recognizing that she had not really raised her other children, Tammy saw this pregnancy as another chance to be a mother. This was a motivational time for her and she stopped using drugs and attempted to clean up her life. She desperately wanted the opportunity to mother this child but her history would prove to be too much to overcome. “She [Tammy’s daughter] got taken for all the wrong reasons. My car got stolen. I reported my car stolen. They retaliated, came back, kicked in my front door and shot off a gun. Yeah. So she got taken away because it wasn’t safe. . . . I thought, okay this is my last chance to be a mom. I messed that up. She got apprehended too. So it’s a big failure to me because I’ve never got to
Tammy solely desired to keep one of her children. When she found out she was pregnant with the current pregnancy, she thought, “And so here I am, pregnant again and this is my last chance of not failing right? And I want to be able to have a child and keep it right? And with no interruptions, no social services, no nothing, because really I’m so sick of it. I just want to be with my child. It seems to me that everything I try is just not good enough. Everything I do is just failing. That’s how I feel.”

In many ways, Tammy acted as her own advocate during the current pregnancy. She recognized who held the power at social services and made an appointment to see that person. “I don’t want to get to the hospital and then not take the baby home or get the baby apprehended. That’s not going to happen. I will probably lose my mind and that’s probably a mistake to do. So to prevent that I want to know ahead of time what’s going to happen. No maybe this and maybe that. I want to know. I have the right to know. This is my child and I’m not prepared to give him up. So I am hoping that because I have been doing good and coming to program and everything that they have no reason to even try. Because they said I have to work really hard. But I have been doing good. Everything they ask I have been doing.” Despite all of Tammy’s efforts to show that she could be a good mother to this baby, she was left hanging, not knowing until the last moment if she would get her chance at being a mother.

During the second last week of her pregnancy, I stopped by Tammy’s place. Tammy looked really down. She told me that one of her workers had been by earlier in the morning to tell her that there was a good chance this baby would be apprehended when it was born. Although the decision was not final, she most likely would not take the baby home from the hospital. Tammy appeared defeated. She told me that she was
scheduled to be induced the next week but then said, “Now I just want this baby to stay in. It’s the best chance I have at keeping him.” I felt heartbroken for Tammy. She was really hoping to take this baby home from the hospital. She was really trying. She was doing everything that was asked of her. She saw her last chance at being a mother slipping away. The unknown was so incredibly difficult for her. Through tears, she kept saying over and over, “I’ve done everything they’ve asked. I don’t know what else I can do.”

Tammy went on to say that she had a meeting scheduled for the next Thursday. At this meeting, it would be decided whether she would get to take the baby home from the hospital. Tammy was scheduled to be induced the day after the meeting. Tammy was upset that this decision had been left to the last minute when she had been completing all of the programming that she had been asked to attend over the last nine months. The day the meeting was scheduled, Tammy went into labour. She never made it to that meeting.

5.5 The Denial of Motherhood

In the past, Tammy attempted to raise her children while using drugs. The addiction profoundly impacted her ability to mother her children. I asked Tammy to tell me what it was like to use drugs and simultaneously try to mother children. For Tammy, the reality of using meant she could not provide even the most basic necessities for her children.

“You’re up all night getting high. And in the morning, you’re hard to wake up. You’re not sending your kids to school. And you know feeding them, you know what I mean? You’re sleeping. So really that affects you, a lot, a lot. And you’re not buying
everything you need for them because you are using that money to get high. For drugs. So there’s lots of different ways it affects you and your children. It not only affects the children, it affects the home. Because then you don’t pay all your rent and you get evicted and you gotta move again. So addiction messes up your life in every which form possible. It eventually takes it. And then you get mad. Mad because you know what, it’s your own fault . . . I wish I would have stopped it. Before, in its tracks. But I didn’t. It went deep.”

One of the biggest impacts of Tammy’s addiction was losing her children and consequently losing the opportunity to be their mother. From the time that the children were apprehended, all Tammy wanted was to be a mother but because of her past, she was continuously denied this opportunity. One afternoon, I noticed that the walls of Tammy’s house were decorated with baby pictures. I asked Tammy who the kids in the pictures were and she softly replied, “Mine.” There was profound sadness in her voice. Here, displayed in her home were pictures of the children she never had the chance to mother. “I just wish I could have my kids and be happy. But it doesn’t work that way right now.”

When I met Tammy, her six oldest children had been permanently removed from her care. She had been repeatedly denied the opportunity to be a mother to these children. Much of this deprival stemmed from Tammy’s own mother. Tammy’s mother had been granted long term custody of five of the six oldest children. Tammy described her attempts at trying to have a relationship with the older children. “When I try to phone my kids, talk to them and stuff, my mom just says, stop calling all the time. . . . She’ll always think I’m a druggie. She’ll always think that I’m the addict. She’ll always think
that I’m not good enough.” Tammy’s mother was not supportive of Tammy’s attempts to get custody of the youngest children.

“When I was pregnant with [my two year old], she [Tammy’s mother] was trying to get my cousin to adopt my child when I was pregnant. And now again with this one. She doesn’t think that I’m going to get my children back.” But Tammy felt otherwise; she was adamant about getting custody of the two youngest children. In fact, the one thing that I noticed very early on in my relationship with Tammy was the fight that came from deep within her to have her children with her. She said, “I am getting my daughter back and I will have this one home from the hospital. They’re not up for adoption.”

It was clear that Tammy was desperate to be a mother to the youngest two children. She was 41 years old when she found out she was pregnant and she knew that this would likely be her last pregnancy. She often spoke about her fight for the opportunity to be a mother to the youngest children. “It’s my last chance to be a mom. Cause I’m fighting for her [my 2 year old] and now I’m pregnant with another. So, it’s still my last chance. Because I walked away from my other kids. . . . But I can’t take back what I’ve done. I’m not walking away, I’m fighting. Because, I’m sorry, I didn’t fight . . . I let my addiction take me down. And it took me over and I walked away from my other kids. Cause I knew they were safe. This one, I can’t walk away, I can’t . . . I’ll fight, fight, fight.”

It was at this point in her life that my path crossed with Tammy’s. I had the privilege of living alongside her, in the present, as she fought for custody of the two youngest children. As I spent time with Tammy, I could not help but notice how she seemed to be denied motherhood with every step she took. When I first met Tammy, her
two year old was in short term foster care. Tammy had been granted short, supervised visits, three times a week, with her daughter during this time. Tammy told heartbreaking stories of the lack of bond between her and her daughter. At the completion of each visit, Tammy’s daughter was not saddened to leave her mother. “She’s ok when they take her. It’s just so normal to her now. When it’s time to go, she just goes. Before she used to cry. And now she just goes. Like it’s so normal to her now. That’s her normal right? It hurts. It’s just normal to her and it shouldn’t be. You know I’m glad she doesn’t cry and everything and she’s accepted it but it hurts. I miss her so much. I just want to go take her home.” Tammy desperately wanted to be a mother to her daughter.

If the visits went well, they would be increased and Tammy would have the opportunity to see her daughter more frequently. Tammy’s progress was closely monitored by her many workers. It was the workers who determined when and for how long Tammy got to see her daughter. Tammy had been anxiously waiting to hear if she would be permitted an extra visit with her daughter for Halloween. When I arrived at the health centre to meet with Tammy one afternoon, she excitedly yelled across the parking lot, “I am so excited today. My worker said I can take my daughter out for Halloween!” I shared in Tammy’s excitement but couldn’t help to also feel some sadness. She had missed out on so many opportunities with her children that most mothers take for granted. Yet here she was, in this moment, so excited in the simplicity of taking her daughter trick-or-treating.

I saw Tammy the day after Halloween and asked her how things had gone. Her face lit up. She told me about taking her daughter trick-or-treating at the mall and how her daughter had “just loved it.” It was her daughter’s first time trick-or-treating and I
could tell that Tammy was so happy she could be a part of it. Yet as her story went on, there was also sadness and I saw another instance of how Tammy was denied motherhood; this time from the workers at the foster home. When Tammy took her daughter back to the foster home, the workers took the child’s bucket of candy away. She would be allowed to have only small amounts at a time. Although Tammy agreed that her daughter should not have all of the candy, she questioned why the workers would not just give her daughter the bucket. Tammy felt that it was the bucket that her daughter really wanted, not the candy. As I listened to Tammy’s story, I was saddened. She wanted to mother her children in one way but she was forced to watch as others “mothered” in a different way.

There were other occasions when Tammy was denied motherhood by the workers. One afternoon, on my way out of the health centre, Tammy was waiting at the front doors for her daughter to arrive for a visit. She asked me if I wanted to stay and meet her daughter. I replied that I would love to meet her. As we waited, the time when her daughter was supposed to arrive came and went. Tammy called her daughter’s workers and found out they had forgotten to bring her for the visit. Tammy was clearly and obviously upset. I stayed with her for awhile, not saying much, just being with her. But I felt angry; instances like this were oppressive and were hurtful. Tammy was waiting, dependent on a service that would deny her of the opportunity to spend precious time with her daughter. Tammy did not see her daughter that afternoon. As I spent more time with Tammy, I learned of other similar instances – many late or missed visits. Tammy was dependent on others for her opportunity to be a mother. This opportunity was frequently denied. I empathized with Tammy. In these instances, my heart ached for her.
Tammy shared more of her story with me. As I learned more about Tammy and who she was as a mother, I could see countless instances in her past where she had been denied motherhood. One of the most heartbreaking stories of denied motherhood that Tammy shared with me was about “meeting” the son that had been adopted out of the family. Tammy seemed to know a lot about the family who had adopted her son and I got the sense that Tammy’s other children had a limited but ongoing relationship with their brother.

Tammy described a time several years ago when she had been at an outdoor swimming pool with some of her older children. Her daughter recognized the boy who had been adopted out of the family and pointed him out to Tammy. “‘Mom, there’s Cole.’ ‘Where?’ She said, ‘there, there’s Cole’s dad.’ So Cole was off catching butterflies so I went up to the dad and I said ‘Hi, I’m Cole’s mom.’ I said, ‘I would love to thank you for being amazing parents to my child.’ And he just lit right up and said ‘thank you. Thank you for giving him to us.’ It was an awkward moment because he [Cole] came up to me and was like ‘you like butterflies and stuff?’ It was hard not to reach down and hug him. But I didn’t. I kept my distance. I was like ‘yes I like butterflies.’ I was just talking to him. And watching from there.” Tammy described wanting to act in a motherly way by hugging the boy but she knew she was no longer the mother to this child. She was forced to observe from a distance.

Tammy was driven by experiences like these that denied her the opportunity to be a mother. She had hope that she would get custody of her youngest children and she was willing to do almost anything to fight for them. Social services required Tammy to attend several programs in order to prove she could be a mother to her children. Tammy

\footnote{Name has been changed}
perceived that if she did exactly what she was told to do by social services, she would have the opportunity to mother her youngest child and unborn baby. Tammy described attending programs and classes at several different agencies and keeping pregnancy related appointments all while organizing her commitments around the scheduled visits with her daughter. Tammy’s days were full. The schedule of programs and appointments was similar to a full-time job.

In addition to all of her commitments, Tammy was on the waitlist for one last program. Tammy saw this program as the last step in getting her children home. “I need this [program] in place in order for me to keep this child right? And in order for [my daughter] to come home. I have to have that in place. So it’s like, ok, how long is this waiting list? Is it a year? Am I going to lose this child?” Tammy had no idea how long it would be until she got into the program.

Tammy would only be allowed the opportunity to be a mother if she met the conditions outlined by social services. Yet these conditions were not realistically attainable because the programs were not always available. “So it’s just sit and wait. I don’t have time for that. I need something in place so that I can have my child. Because I am not prepared to give up this one. They’ll have a fight. I’m sorry. I don’t want that to happen but you know what I mean. It’s my child. . . . I am doing everything they ask right? And the only thing that is standing between me and this daughter is [the program]. It’s frustrating. And scary.” Tammy was doing everything she could but she still risked being denied motherhood. Eventually Tammy did get into the program but she continued to be uncertain about the custody of her youngest children.
Even though Tammy did not know if she would get to take her baby home from the hospital, she held onto the hope that she would be afforded this opportunity. She prepared to bring the baby home. I noticed that Tammy had gathered supplies for the baby. She wanted to show she could be a good mother. “I got everything. I’m going to try and breastfeed. But I got formula. And I got diapers. I got the bottles, the body washes, the lotions, I got everything.” Tammy did all of this while facing a constant turnover of workers. It seemed that every time I met with Tammy, she had a new worker. She knew that she had to have the workers on her side. “I think they gotta be on the same track with the decisions we already made. Yesterday, I’d been wishing I would go into labour, but then I was like no, I don’t want to be. I don’t want to go into labour yet. Cause I’m trying to have everything in place for baby. Make sure baby comes home.”

And then, just like that, Tammy sent me a text that said, “Well he is seven pounds, eight ounces and yes I get to take him home with me tomorrow morning!” I asked Tammy if I could stop by the hospital to see her. She agreed. When I arrived, Tammy was so excited to show off her new baby. She had him dressed and bundled in a blanket that she had bought for him. A few of her workers had been by and had brought gifts. Balloons and stuffed animals colored the beige hospital room. Tammy told me that she had met with her workers that morning in the hospital. She was thrilled to be taking her baby home and was smiling from ear to ear.

But her opportunity to mother this baby came with significant conditions. A worker would drop in on her twice a day. Tammy’s partner was required to stay every night in Tammy’s home to help provide support for her and the baby. I thought that this was an odd and almost impossible condition considering that Tammy did not seem to
have a strong relationship with her partner. They saw each other infrequently and lived in separate homes. But Tammy felt good about the plan and the support she would have at home. She hoped her youngest daughter would be permanently home soon too.

Were things working out for Tammy? Would she finally have the opportunity to be the mother she so desired to be? I was cautiously excited for Tammy. I desperately wanted things to work out for her but I worried about how she would adjust with the baby and the conditions that had been placed upon her when she arrived home.

Things started off well for Tammy. When I would visit her, she seemed happy and to be bonding with the baby. She told me things were really good. Tammy was taking several medications for mental health issues. Previously, she had expressed concern about breastfeeding while on these medications. I asked her what she had decided to do about feeding the baby. She told me she had decided to bottle feed him. “I just don’t think it’s safe to breastfeed when I’m on all these meds. And they are upping them too. I don’t think it’s fair to give him all those meds. It’s just not good for him.” While I was with Tammy I noticed how good she was with the baby. She changed him, fed him, and cuddled him just like any other mother. She looked so happy when she held him. It looked to me that she could not cuddle and kiss him enough. I felt the love that Tammy had for this baby but I could not help but worry when the fairytale would end.

A few weeks after the baby was born, I stopped by Tammy’s home and I could tell that she was upset. Right away, she asked me if I would drive her to her boyfriend’s house. I asked her if everything was okay and she told me they had an argument the night before over text messages from another woman. He had stormed out of her home and was not answering any of her messages now. Tammy was upset about the argument
but she was more concerned about how she would meet the conditions for keeping her baby. “If he is not here I could lose my baby but I’m not going to let that happen. If he wants to sleep in the bedroom with our son, I can sleep on the couch. But I need him here so I can keep my baby.”

The conditions that were placed on Tammy’s motherhood continued to be a problem for her. She struggled with the workers dropping by her house twice a day at unannounced times. “It’s hard with all of these workers in place. Like yesterday, I missed group. I fell asleep. And they are banging on the door at 2:15. ‘We’re worried about you. Can we check on baby?’ He’s fine. I was sleeping. Not a big deal. . . . I’m not off doing anything stupid. Usually I don’t miss group. But I was tired. I thought I would lay down for a bit.”

Tammy also perceived that the workers were telling her how to mother. The workers were concerned about Tammy’s dogs around the baby. They would say, “Always make sure, if you have a bath, or if you do laundry, always make sure you have to have your dogs put away and put baby in the play pen before you do anything.”

Tammy told me about another instance when the baby was sleeping in the bedroom. Tammy was having a nap on the couch when one of the workers arrived. “And the worker came and said ‘you should use a baby monitor.’ Well I can hear him. ‘Well I think you should have a baby monitor.’ He’s in the next room! You know what I mean, that’s a bit much. I can understand if he’s upstairs or something but not the next room! I’ve never set it up because I’ve never needed it!”

Despite Tammy’s stories of constantly fighting to mother on her own terms, I did not realize how truly vulnerable she was to the system that was supposed to be supporting
her. I arrived one day to find Tammy in total distress. She shared with me a story from the night before. She described needing to go to the grocery store. Instead of bundling up her newborn and taking him out in cool damp weather, she left him with a friend who had stopped over. “I fed him and I changed him. I thought, it’s ok, I’m just running to the store for dog food and smokes.” But when she returned home, “The social worker was here. I just about lost him. They thought I was off getting high or something. That’s just what they thought. But I came in the door with dog food and smokes. So now I’m on watch right. I do anything wrong and they are phoning the workers. And it’s not even that I do anything wrong, maybe I made a poor decision and I shouldn’t have left the baby. I understand that. And it won’t happen again. I didn’t leave him in any danger and I did nothing wrong. But to them I did.”

Even though Tammy had finally been given the opportunity to be a mother, this opportunity was conditional. Because of her history, she was constantly being watched and monitored, afraid of making one poor decision. Tammy was scrutinized for doing things that other mothers could do without being questioned. Taking a nap in the afternoon or leaving the baby with a friend for a quick errand are common for new mothers. But for Tammy this standard was not acceptable. I asked Tammy how she felt and she replied, “Like a kid. Like I don’t know what I’m doing. They are controlling everything. I always have someone on my back. And God knows how long for.” Simply being a mother to her children was not simple for Tammy.

5.6 Moving Forward: Recreating Motherhood and the Family

During the six months that I spent living alongside Tammy, I repeatedly witnessed her desire to be a mother and to have her family together. The future held
considerable uncertainty, but Tammy’s drive to obtain and sustain permanent custody of her newborn and youngest daughter were what kept her going. She had a conscious awareness of the mistakes she had made in the past and she did not want to see herself as a failure anymore. “I just don’t want to be a failure all the time. I feel I failed.” She wanted to prove she could be a good mother and have a family again. She could not change the past but she could impact the future. “What I can do is be a better mother now to this child. Just being a mother again. Being a mother all over again. . . . [My youngest daughter] and my other youngest are eight years apart so it’s a fresh new start. Starting all over again.”

I wondered how Tammy would do with her “fresh new start.” In the time that I had known her, I certainly had seen her doing well. When I first met Tammy, she had supervised, two hour visits with her daughter, three times a week, at the health centre. I watched as Tammy’s visits progressed in length, frequency, and to being partially unsupervised in her home. I also watched as Tammy brought her newborn home from the hospital. Tammy continued to plan for increased visits with her daughter. “I have her for an hour tomorrow by myself. I have her for two hours with supervised and then an hour unsupervised. So I have her for three hours total. . . . It’s a big jump there. So next week, I’ll be more unsupervised. . . more unsupervised than supervised. . . . They [the workers] are saying let’s get her more by herself. We want to see how she does. . . . And I think starting next week, I’m going to have her another day unsupervised. So, yeah. The more unsupervised visits I get, it leads to overnights.”

Tammy saw the increased visits as an opportunity to improve the bond between herself and her daughter. I could attest to how much that bond had grown in the short
time that I had known Tammy. During the first few times that I met Tammy’s daughter, I observed as she played almost independently from her mother. But as time went on, I saw them interact more, I saw them cuddling and I saw the love that they had for each other. Tammy saw this too. “Monday she fell asleep in my arms. And today she was cuddling with me too. First [before she was apprehended] all she wanted to do was cuddle and so it is coming back. Cause it’s how it used to be. Always cuddle. Cuddle, cuddle, cuddle. Now she’s getting back there again.” Tammy also spoke of doing “normal” family activities with the two young children. “I took [my daughter] and baby to the park last week. It was nice out so I thought we would go to the park. [My daughter] didn’t want to leave.” Tammy was attempting to recreate motherhood and her family by doing what she perceived as regular family activities with her children.

I noticed that Tammy was beginning to include her youngest children in her future plans. Previously, she did not have to worry about how she would manage the children while she attended her programming. Near the end of our relationship, Tammy spoke about how she would arrange her programming while having the children in her care. “My kids will start coming to the daycare at the [program]. Cause right now I only go to Tuesday and Wednesday group. But they want me to go to Thursday but not till the kids are in daycare . . . . I’m going to have to start getting into a pattern with them. Of having to take them out. I might as well start out now. If I’m going to manage two kids.” Tammy was definitely progressing towards a future of mothering her two youngest children. But she also longed to have her entire family together.

Tammy’s oldest daughter, no longer a minor, lived on her own and maintained a very limited relationship with Tammy. The relationship they did have was strained and
had led to physical violence in the past. Tammy’s youngest daughter’s birthday was approaching and Tammy wanted to invite her oldest daughter to the birthday party. “I asked the worker on Monday if my oldest daughter can come for the birthday on Monday. And she said yes. Yesterday she phones me back and goes, ‘I’m sorry, Tammy, your daughter can’t come. I didn’t realize what happened between you two.’”

Tammy and her oldest daughter had been involved in a physical fight in front of the youngest daughter almost a year ago. As a result, they were not allowed to be together when the young child was around. Tammy was conflicted. She wanted to have her family together for her daughter’s birthday but she also had to do what was mandated of her by social services. “The thing is I could do it behind their backs but I did it properly and asked and everything and it’s . . . whatever. But the thing is they are keeping siblings apart. Like how fair is that? And they say it has to be in a more controlled environment for her to visit. It’s her sister. She’s not a danger to her sister.”

In the end, Tammy was forced to do as she was told by social services in fear of losing the visits with her youngest daughter. “I’m fighting for her to come home so I don’t need something like this to pull her away. But the thing is they can’t keep them apart forever. They can’t.”

Tammy wanted to have all of her children together and she saw this as the next step for her family. She spoke about wanting to have custody of all of the children. “And after a year, after baby is born, I can apply for my boys to come home. And I told them the option. I said, if I go to court, and if I do get you guys home, I said, you don’t have to come home. If you choose, you want to stay with Nan, that’s your decision. I won’t be mad. But they want to come home. But when it comes down to it, it’s going to
be up to them, where they want to go, where they want to stay. I’m not going to force them to come home.” But Tammy recognized that having her whole family together would be unlikely. Her older children had been gone a long time. She had never really been a mother to them. Through tears Tammy said, “It’s not fair. I should have been there for them. But I wasn’t . . . it hurts, it still hurts you know? I love them to death but my chance is gone. I can always apply for them back right? But if it’s too late, I don’t know. I don’t know if they want to [come home]. They say they do but . . . they say they do but really? Do they really?” Tammy was beginning to face the harsh reality that she likely would never have her whole family together.

It is difficult to say what the future holds for Tammy. Will she continue on the current path and successfully recreate motherhood and her family? Or will she relapse, and risk losing everything, like she has done so many times in the past? Regardless, Tammy will need on-going, appropriate support. She will undoubtedly face challenges and she will need help to navigate the difficult times that await her; but she will also need someone to share in her successes. Right now, Tammy doesn’t have a lot of support outside of the agencies where she attends her programming. She tells me that she will be followed for up to six months after the birth of her baby. I am not sure that Tammy is being realistic in this statement. She has been closely monitored by the agencies that are supposed to support her for the better part of two decades. I am doubtful that she will be left on her own six short months after the birth of her baby. Either way, I am hopeful that Tammy will find and utilize other supports. Her partner and the few friends she has named during our time together may be supportive as she transitions in her role as mother.
Tammy’s story does not end here, but my time with her does. My daily commute sometimes takes me past Tammy’s home and I wonder how she is doing. The truth is, I may never know. But somewhere, Tammy’s life continues on, independent of my own. And I wonder how she’s doing; is she becoming the mother that she always wanted to be?

5.7 Making Sense of Tammy’s Story

As I spent time with Tammy and co-constructed her story with her, I could not stop thinking about pregnancy and motherhood. To me, this was what Tammy’s story was about. She desired to be a mother to her children without interruption. Almost everything she talked about connected back to being a mother. Tammy voiced that she was a good mother to her own children, to foster children, and to children with special needs. But in the presence of addiction, this was all taken from her. Tammy was robbed of the ongoing chance to be a mother to her own children.

The time I spent with Tammy caused me to reflect on my own motherhood. I came to see that my own motherhood came from a place of privilege. I am privileged to mother my own two children uninterrupted, and unmonitored, with little question from anyone else. Tammy had a history of addiction and because of this, she was not afforded the same privilege. She mothered from a place where she was constantly being watched, always under surveillance; a place where one wrong decision could change her life. Yet, I would argue that if Tammy was not pregnant or was not actively trying to obtain custody of her children, she would not have been under such close observation. Pregnancy and motherhood coupled with addiction placed Tammy in the arc of social services. I began to wonder . . . Who is permitted to be a mother and how is this decision
made? My capabilities as a mother had never been contested. Tammy, on the other hand, was required to continuously demonstrate that she could adequately mother her own children.

5.7.1 Institutional power and motherhood. The work of Foucault (1977) has contributed to my understanding of Tammy’s motherhood. In this work, Foucault provides the obvious example of the power that the prison has over its prisoners. Simply by being incarcerated, prisoners expect that they are continuously being observed; constantly under the gaze of the watchful eyes of prison guards. It is unbeknownst to the prisoners when they are actively being watched. As a result, they constantly strive to act good in fear of being caught acting poorly. Foucault termed this phenomenon as the *panopticon*. Under the panopticon, institutions exercise power over people. This phenomenon can be applied to settings outside of the prison such as health care, schools, and social services. The power that the state held over Tammy may be viewed very similarly to the power that prison guards have over their prisoners. Tammy’s addiction imprisoned her and placed her within the view and jurisdiction of social services.

Tammy was held under the power of the state. Her children had been apprehended in the past and as a result she was now forced to comply with the state mandated conditions set out for her. This included attending programming, regardless of whether the programs were available or useful to her. Looking back now, I am reminded of some of the times that I judged Tammy. Now that I understand the institutional power that Tammy was under, I am beginning to see why she may have acted in certain ways. As I watched Tammy in group those first few days she seemed withdraw, like she did not care. She did not participate in the activities that the others were completing.
Instead, she rested on the couch, helped prepare snacks, or visited with other women; seemingly insubordinate to the tasks she was to be completing. As I revisit this time now, I consider how I would feel if I was in Tammy’s place; if I was forced to attend a blanket making group. It would not appeal to me and it likely did not appeal to Tammy either. But she came and she participated in her own way. She did not have a choice. She was under the power of the state. Her history of addiction put her within the view of social services where her pregnancy and motherhood were contested and made conditional. If she ever planned on getting custody of her youngest daughter and her unborn baby, she needed to do as she was told. I was witness, over and over again, to the multiple state-sanctioned conditions that Tammy was forced to meet if she wanted to be permitted to be a mother again.

I saw Tammy struggle to secure suitable housing for herself and her children. I watched as Tammy attempted to navigate the seemingly endless programs, appointments, and visits with her daughter. She did all of this while under constant surveillance. When she wasn’t actively being observed, she lived knowing that at any moment, one of her workers could be watching. She lived under a panopticon; accustomed to the many workers stopping in at her home, unannounced, several times each day. The workers were there to check in on Tammy but they also provided unwanted, and often impractical, advice on how to mother. It was not Tammy who was in control of who was permitted to see or care for her baby; it was social services that dictated who was suitable and allowed to be in the presence of the newborn. Tammy herself was not even permitted to be alone with her own baby at night. She was dependant on her partner, a relationship that seemed unstable at best, to support her. Tammy’s addiction, while pregnant, positioned her under
surveillance, subject to the will of the state. Her motherhood was fraught with conditions; conditions that she had to meet while under the watchful eyes of the state.

5.7.2 Exploring motherhood. Exploring motherhood and how it is conceptualized for women with substance use disorders, is helpful in attempting to make sense of Tammy’s story. Motherhood is a socially constructed phenomenon with various meanings across different cultures. In Western society, women are generally expected to portray the qualities of a good mother. Researchers have identified a set of characteristics that help to define the good mother. The good mother provides limitless love, caring, and patience to children and spends endless quality time with them (Brown, Small, & Lumley, 1997; Couvrette, Brochu, & Plourde, 2016; Lupton & Fenwick, 2001). The social construction of the good mother assumes that she is an appropriate age, White, middle class, and has healthy children (Lupton & Fenwick; Phoenix & Woollett, 1991). Mothers of infants are expected to place the needs of the baby above their own and to cope with the sleep deprivation that is often associated with caring for a newborn (Lupton & Fenwick). Using drugs and being a mother is not considered to be socially acceptable. Consequently, the titles of “drug addict” and good mother are incompatible (Banwell & Bammer, 2006; Haritavorn, 2016; Martin, Smith, Rogers, Wallen, & Boisvert, 2011). The historical context of pregnancy, motherhood, and addiction has contributed to this societal view.

5.7.2.1 A historical look at pregnancy, motherhood, and addiction. During the 1960’s and 1970’s, addiction in pregnancy was frequently associated with heroin use and researchers were beginning to view pregnant women with substance use disorders as a special subset of the addicted population largely because of their child bearing and
mothering roles (Murphy & Rosenbaum, 1999). As a result of the emerging interest around pregnancy and addiction, an exponential growth in scientific research occurred. The literature largely focused on the risks associated with pregnancy and heroin use (Blinick, Wallach, & Jerez, 1969; Glass, 1974; Kandall et al., 1976; Naeye, Blanc, Leblanc, & Khatamee, 1973). With the development of this large body of knowledge came literature that supported claims that maternal substance use was dangerous for both mother and child.

In the 1980’s, the use of cocaine increased dramatically, creating the perception that it was the most commonly used illicit drug among pregnant women (Murphy & Rosenbaum, 1999). The attention of the scientific community shifted away from heroin and to the risks associated with maternal cocaine use. Landmark research by Ira Chasnoff demonstrated the adverse effects of in utero cocaine exposure such as spontaneous abortion, placental abruption, infant respiratory and urinary problems, sudden infant death syndrome, and poor neurological behaviour (Chasnoff, 1985, 1988; Chasnoff, Burns, Burns, & Schnoll, 1986). The findings of such research coupled with Chasnoff’s (1989) estimate that between 10% and 17% of all pregnancies in the United States were exposed to cocaine fueled a media frenzy (Murphy & Rosenbaum). Crack babies became the news story of the year and mainstream media was inundated with images of cocaine using pregnant women and their addicted children who were labeled as developmentally delayed and incapable of becoming contributing members of society (Murphy & Rosenbaum; Ortiz & Briggs, 2003).

Although others had questioned the credibility of early research, (Coles, 1993; Frank, Bresnahan, & Zuckerman, 1993; Litt & McNeil, 1997) it was not until 2001, when
Frank, Augustyn, Knight, Pell, and Zuckerman published a ground breaking systematic
review that the crack baby phenomenon was largely challenged. Frank et al. wrote:
“After controlling for confounders, there was no consistent association between prenatal
cocaine exposure and physical growth, developmental test scores, or receptive or
expressive language” (2001, p. 1613). The use of cocaine during pregnancy was found to
have very little, if any effect on the children of using mothers (Ortiz & Briggs, 2003).
More recent literature has confirmed that the research investigating the long term effects
of in utero cocaine exposure on neurodevelopment and growth is contradictory and
biased (Viteri et al., 2015). Yet the damage had already been done. More than a decade
of biased research and media attention had successfully contributed to a moral panic that
portrayed the maternal substance user as an incapable mother (Coles; Litt & McNeil)
and inadvertently racialized and gendered addiction (Ortiz & Briggs).

During the 1980’s, young, White males were among the group that used cocaine
most frequently (Ortiz & Briggs, 2003). However, media attention focused on poor
African and Latino mothers, portraying them as heavy crack users (Ortiz & Briggs). As a
result, the moral panic surrounding the crack baby phenomenon became a racialized
moral panic (Litt & McNeil, 1997). Minority women of low socioeconomic status were
perceived as maternal villains and consequently lost custody of their children and were
frequently arrested and incarcerated (Bush-Baskette, 2000; Coles, 1993; Litt & McNeil).
The commitment of the United States to a War on Drugs, which focused on abolishing
the use of all illicit drugs through criminalization and heavy law enforcement, became a
war largely against impoverished, minority women (Bush-Baskette). Although substance
use disorders impact women of all socioeconomic strata, it is minority women, who
frequently face economic vulnerabilities, who are most likely to experience compounded stressors and be affected by cumulative barriers during pregnancy (Marcellus, MacKinnon, Benoit, Phillips, & Stengel, 2014; Wong, Ordean, & Kahan, 2011).

Tammy identified as Caucasian despite her familial background that suggested she was a Métis woman. Her father, an Indigenous man, had not been a part of Tammy’s life. As a result, she did not identify with having any Indigenous heritage. Although Tammy did not identify with her Indigenous background, she was not immune to the stereotypes faced by many minority women. In fact, I would argue that Tammy was treated as a minority woman. She lived in a community where the vast majority of the women were Indigenous. A lot of the adversity she experienced was related not only to her history of addiction but also to being a minority, impoverished woman.

5.7.3 The good mother and addiction. Despite not fitting the typical and accepted model, women who use drugs want to be good mothers. In their study that explored the experiences of childrearing women who used illicit drugs, Banwell and Bammer (2006) found that regardless of personal, social, and financial challenges, women wanted to position themselves as good mothers. However, the women identified that the time they spent with their children was not valued by society in the same way as the time non drug using women spent with their children. Often, women who used drugs remained at home with their children, which they identified, was more than could be said for mothers who worked outside of the home (Banwell & Bammer).

Throughout the time I spent with Tammy, I observed her in her role as mother. I watched as she interacted with her newborn and her young daughter during their visits. She displayed characteristics of a good mother by devoting her attention to the children.
and showing her love for them. I had no doubt that their needs were met. At this point in her life, Tammy demonstrated that she could be a good mother despite her addiction. However, Tammy’s history of heavy drug use and the risk of relapse were a continuous threat to her present motherhood. Her history meant that the state was always present in the background; one wrong decision and Tammy sensed that her children would be removed from her care. She recognized that there were times she could have been a better mother. Her feelings of this time are echoed in the research. Banwell and Bammer (2006) found that women recognized that despite being physically present with their children during times of heavy drug use, these mothers may not have been mentally or emotionally available. It is during these times of heavy drug use that the role of good mother and the safety of the children are potentially threatened.

Martin et al. (2011) explored the experiences of mothers with alcohol or drug addictions. Women in this study suggested that they had multiple roles. They highly valued their role as mother and despite their addiction desired to be good mothers. In a different study, Haritavorn (2016) explored the experiences of injection drug using mothers in Thailand. The women in this study identified that they could not be good mothers when they were subjecting their children to a lifestyle associated with drug use. The women struggled with reconciling two sets of expectations; those societal expectations of a good mother and those associated with the drug subculture. As a result, if women wanted to perform their ideal maternal roles, they were forced to cease their drug use (Haritavorn). Both Martin et al. and Haritavorn identified that women recognized their addiction interfered with their role as mother and they displayed feelings of remorse for the impact they felt their addiction had on their children.
I saw evidence of a similar tension in my interactions with Tammy. She desired to separate herself and her children from the drug subculture but it seemed to follow her with every step she took. As a result of her addiction, Tammy lived in poverty. She was unemployed and her previous means for making an income such as selling drugs and working the sex trade were no longer suitable. From Tammy’s perspective, a good mother did not engage in the illegal activities of drug trafficking and sex trade work. But this meant having the financial resources to support her family was nearly impossible. Tammy was forced to live in an undesirable neighbourhood. Drug use and drug trafficking surrounded her. Tammy’s environment was a daily reminder of her time as a heavy drug user and provided her with the constant temptation to use. Despite the odds that seemed to be against her, Tammy was determined to move forward in a direction that would support having her children with her. She fought the addiction while trying to demonstrate she could meet the conditions of motherhood as forged by social services. She was committed to being a good mother.

5.7.4 Working to be a good mother. Using drugs and being a mother was not easy. Radcliffe (2009) found that women who had a history of substance use underwent a considerable amount of work to demonstrate they could manage their identity as a good mother. Women in this study described attending a multitude of appointments, providing drug screens, and carrying out treatment plans (Radcliffe, 2009). I was in awe of the number of health care related appointments, programs, and classes that Tammy attended at several different organizations. She did all of this while also arranging her schedule around agency-planned visits with her young daughter. The number of appointments she attended consumed more of her days than a full-time job. Near the end of my
relationship with Tammy, she had her newborn in her care. Most mothers with newborns are granted maternity leave from their jobs but Tammy did not have this luxury. In the time after the birth of her son, it was ever more crucial for her to attend all of her appointments and programming. Tammy had to prove she could meet the state mandated conditions that were put on her motherhood. One missed appointment to have a nap in the afternoon meant that program workers would be banging on her door.

5.7.4.1 Securing housing. Tammy struggled to find housing that would be appropriate for her and her family. Grant et al. (2011) discussed the difficulties that drug using women experienced in finding suitable housing. Women were expected to locate a home that was deemed to be appropriate for children. However, this often presented a dilemma of conflicting circumstances. Finding a suitable home was complicated because women needed to have their children in their care to qualify for housing. Yet, custody of the children was often not relinquished to the mother until she could demonstrate that she had adequate housing (Grant et al.).

Tammy experienced a similar dilemma. She qualified for low income family housing in a better neighbourhood, but because she did not have custody of her daughter, she could not apply. Once her baby was born, she described a waiting period before she could submit her application. Tammy was left with no choice but to raise her children in an arguably unsafe neighbourhood. The unrealistic conditions that drug using mothers face are even less achievable when policies and professionals seem to work against them.

5.7.4.2 Facing inadequate support. Often, the focus of professionals is on the welfare of the child, rather than on supporting the mother (Radcliffe, 2009). Nurses have been found to be unsupportive to mothers, advocating for child apprehension instead of
providing support (Banwell & Bammer, 2006; Mirick & Steenrod, 2016). Moreover, programming designed for substance using mothers does not necessarily provide the support that women need (Mirick & Steenrod). Tammy described attending multiple programs that she felt did not meet her needs.

Women’s experiences of lack of support are further complicated when they are negatively judged by others. In their study that explored the experiences of substance dependent mothers, Fowler, Reid, Minnis, and Day (2014) found that feelings of guilt and shame were common among the women. Women in this same study provided examples of how they were judged by others. Health care providers were found to be a source of criticism and distress rather than a source of support. This proved to only push women away from accessing care, rather than encouraging attendance (Fowler et al.).

Not only did Tammy experience a lack of support from the programs that were supposed to help her, she was also unsupported by her own family. Tammy’s relationship with her mother was especially strained. Tammy’s mother was the caregiver for several of Tammy’s children. This undoubtedly stressed the already fragile relationship. Tammy’s motherhood had been taken from her by the state when her children were apprehended and placed in the care of her mother. In reality, it was no wonder that their relationship was strained; instead of supporting her in her motherhood, Tammy’s mother worked alongside the state, keeping Tammy’s children from her. Tammy’s mother even attempted to have some of the children adopted by other family members and she did not support Tammy in her efforts to establish custody of her youngest daughter and newborn.
In his exploration of the oppressor and the oppressed, Freire (1970, p. 28) identified that oppression is often produced as a reciprocal process between the oppressor and the oppressed. Tammy was oppressed by her mother and over time she had come to accept this narrative. Her mother cared for her children and dictated when and how Tammy could have a relationship with them. In this way, Tammy’s mother held power over Tammy’s motherhood. However, as I got to know Tammy better, I found that she would not continue to accept the view of herself as an inadequate mother. According to Freire, the oppressed yearns for justice and strives to regain their humanity. For Tammy, reclaiming her humanity meant once again being a mother to her children and liberating herself from her oppressor. Tammy was working to regain custody of her youngest daughter and desperately wanted to maintain care of her newborn. She was writing a new narrative of her motherhood in the absence of the oppressive behaviours of her own mother.

5.7.5 Apprehension of the children. When substance using mothers are not adequately supported, a downward spiral can ensue that often ends in child apprehension. Recent literature has suggested that apprehension is harmful to the mother, child, and family and is associated with significant social and economic costs (Cleveland, Bonugli, & McGlothlen, 2016; Du Rose, 2015; Fowler et al., 2014; Grant et al., 2011). In a qualitative study exploring the mothering experiences of women with substance use disorders, women described that their futures were centered on keeping their children (Cleveland et al.). When women looked to the future, they imagined having their children with them. As a result of constantly being haunted by the fear of apprehension, women were motivated to abstain from drug use. They described that if they were to lose
their children, they would not care about anything else and would likely turn back to
drugs (Cleveland et al.). In addition, when children were removed from their mother,
Grant et al. found that that there was likelihood for the mother to desire a *replacement
baby*. This resulted in the birth of a subsequent child who was also often apprehended,
compounding the already significant social and economic costs (Grant et al.).

Were Tammy’s many pregnancies her effort to have a replacement baby? After
each of her older children had been apprehended, she was quickly pregnant again. She
desperately wanted to be a mother and during the time I spent with her, she often
described her current pregnancy as her “last chance.” In a parallel story, Scott (1985)
explored the acts of resistance employed by a peasant group of Malaysian people. In his
account of their acts of resistance, this powerless group of people refused to accept the
terms of their subordination. They used ordinary weapons such as false compliance,
slander, arson, and sabotage to rebel against their oppressors. In a way, I suggest that
Tammy’s act of repeatedly becoming pregnant was her own means of resisting against
the denial of her motherhood. Pregnancy was her ordinary weapon for fighting back
against the state imposed apprehension of her children.

**5.7.5.1 Anything for the children.** Tammy was motivated by her children. When
my relationship with Tammy ended, she had custody of her newborn son and was well on
her way to also getting custody of her youngest daughter. She knew that if she wanted to
obtain and maintain custody of the children, she would have to stay clean from drugs and
meet the conditions expected of her. She had to prove to the state that she could be a
good mother.
Tammy would do anything asked of her if it meant she could keep her children. As I reflect back now on Tammy’s story, I see that this made her vulnerable. I witnessed the power that the state held over her. All Tammy wanted was to be a mother but this would only be allowed if she met the conditions outlined for her. She was expected to punctually attend a multitude of appointments and programs. Absences were inexcusable. This expectation seemed to be somewhat unrealistic. When a required program was overcapacity and thus inaccessible to Tammy, she was forced to wait months until an opening was available for her. She risked not getting custody of her unborn baby through no fault of her own; she risked not getting custody of her unborn baby because of a mandatory program that was not available to her.

When the timing of home visits with her daughter were inconvenient or overlapped other required programming, Tammy was expected to attend everything, juggling her many commitments and responsibilities. Tammy was held to the conditions of her motherhood and she was forced to comply. Again, the institution had power over her and she did as she was told.

Every move that Tammy made was monitored and there were potential serious consequences if it was decided by the state that she made a wrong decision. When Tammy left her baby in the care of a friend who was not determined to be suitable by a social worker, potential life changing consequences threatened her. Tammy left the newborn for only a very short time, while she completed an errand. When she returned, there were workers from social services in her home, threatening to apprehend her son. Although the newborn was eventually left in Tammy’s care, she was punished with even closer surveillance than what she had already been experiencing. The old cliché states
that it takes a village to raise a child but I would argue that Tammy was not permitted to have a village. Instead, she had the watchful eyes of the state looking over, dictating and evaluating her every move. In a way, the state held more power over her than her addiction.

5.7.5.2 An uncertain future. I knew that if Tammy lost custody of the children, heavy drug use would likely follow. She had alluded to this before; this had happened before. Previously, when things were difficult for Tammy, she turned back to drugs. Tammy’s past, coupled with knowing that women who lose their children often revert back to drug use (Cleveland et al., 2016) caused me to worry about Tammy and what the future held for her. Tammy’s future with her children was uncertain. The expectations placed on her were demanding, perhaps unreasonable, and I wondered how long it would be before she could no longer meet the conditions of her motherhood.

5.7.6 So who is permitted to be a mother? As I began to make sense of Tammy’s story, I asked: Who is permitted to be a mother and how is this decision made? It is because of Tammy and her story that I have come to question how motherhood is constituted. When one portrays the qualities of a good mother, motherhood will not be contested. However, if a woman is deemed by society to not act as a good mother, she is forced to constantly and continuously prove she is able to care for her children. This is what happens when a mother is also a substance user. Tammy was not permitted to mother on her own terms because of her history with addiction. Pregnancy positioned Tammy under the surveillance of the state and forced her to meet state mandated conditions. If, like in Tammy’s case, a mother’s children have been apprehended, she will spend an eternity trying to prove that she can once again be a good mother. She is
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sentenced to a life time of living under the watchful eyes of the state. I would argue that this approach is not helpful and using child apprehension as a consequence for substance addiction is not only harmful to the woman and her identity as a mother but also to the child, the family, and society.
CHAPTER SIX: Angel’s Narrative

I first met Angel when I attended the Moss Bag and blanket making program offered for pregnant women at the health centre. I had attended this program a few times before but had not yet met Angel. Her attendance at prenatal programs was sporadic. Yet, on this particular day, both Angel and I attended the same program and our paths crossed for the very first time. I noticed Angel as an Indigenous woman I had not yet met, sitting alone, at a table away from the rest of the group. She had an average build and her long dark hair was secured neatly in a bun on top of her head. She wore brightly colored make-up that over accentuated her features. She sat quietly while intermittently attending to the small child with her.

The room was almost full with women and their young children. I was not sure if Angel chose to sit alone or if this was the only spot available when she arrived for the group. While I spoke with other women, I watched Angel. She worked diligently on her blanket and got up several times to ask the leader of the group for help with her project. She did not interact with any of the other women. I wondered why she sat alone, isolated and seemingly unwilling to socialize with the other women. Was she an unpleasant person? Was she disliked by the others or did she prefer not to interact with them? I was hesitant to approach her; uncertain of what her personality might be like. How would she perceive me and my project? When I finally found the courage to approach her, I very quickly found Angel to be a reserved, pleasant woman who easily engaged in conversation.

I introduced myself to Angel and explained my attendance at the Moss Bag and blanket making program. Angel showed me the blanket she was making and told me she
was expecting a baby boy in the New Year. I told her about my research project. She did not hesitate to tell me that she struggled with substance addiction and was currently on the methadone program. I asked her if she might be interested in participating in my project and she replied that she wanted to learn more. We moved to a quiet, private room and I explained more about the research. Angel appeared to be very interested in the project. She wanted to tell her story. She felt she could offer a lot to the project and that telling her story would be good for her too. She provided consent and we made a plan to meet again.

My first assessment of Angel’s personality was that she was quiet and reserved. I was concerned that it would be difficult to establish the in-depth and ongoing relationship necessary for narrative inquiry research. I was wrong. As our relationship developed, Angel told me about her pregnancies, her children, and what it was like to struggle with addiction both inside and outside of pregnancy. I learned that Angel was pregnant with her fifth baby and although she had custody of her youngest daughter, her other three children were permanent wards of the government. She desperately wanted to keep this baby but the constant struggle with her addiction made this an uncertainty.

From the very beginning of our relationship, Angel shared what seemed to be some of the most intimate details of her life. Yet, I got the sense that there was much more, like I was only hearing the tip of the iceberg; the stories that she was accustomed to repeating over and over to health care professionals. These were the standard narratives she had developed over time. And of course, I expected this; I was just coming to know Angel and her story. Because of my background as a registered nurse, it was difficult for

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8 Methadone is a maintenance medication for opioid dependant individuals. It works by decreasing drug cravings and is the standard of treatment in pregnant women (Finnegan, 2013).
her to initially see me as anything other than a health care professional. I later learned that Angel struggled with trusting others. As our relationship grew, Angel began to trust me and I got to know more about her. I noticed that she often repeated similar stories, but each time she told me a story, there was always a little more, another layer that she had not included before. At times, she was tearful as she shared her story. Her past was full of painful experiences, many of which remained a secret even after the completion of our relationship. At other times, we laughed together, as we shared common stories of relationships and motherhood. I learned a lot from Angel and I enjoyed the time that I spent with her.

Angel abruptly ended our relationship. She led a complex life, always struggling to navigate her many responsibilities and appointments. There were countless times when we arranged to meet but for a variety of reasons, Angel cancelled at the last minute. She was always respectful of my time. Even amidst her complex life, she contacted me or promptly replied to my messages to arrange for another meeting. Until one day, shortly before her baby was to be born, she did not arrive to meet with me and I would not hear from her again. I made several attempts to contact Angel but they all went unanswered. I later learned that she had given birth to a healthy baby boy who went home from the hospital with her. I am uncertain what changed after the birth, but Angel no longer wanted to engage in a relationship with me. Yet, she still wanted her story to be told. Although I will always wonder what changed in Angel’s life and how her story continued, I am respectful of her decision. I encourage you to keep this in mind as you read Angel’s story. Perhaps I did not develop the on-going relationship that continued beyond the birth of the baby, as I had hoped. But I did learn a lot about Angel and her
story up until that point. Most importantly, this is the story that Angel wanted to be told. We can only imagine the endless possibilities of how her life has unfolded since the unexpected ending of my relationship with her. This is Angel’s story.

6.1 Life before Addiction

Angel was not a stranger to addiction. From a very young age she was surrounded by alcohol and drug use that permeated her earliest childhood memories. When we talked about what her childhood was like she said, “As far as I can remember, my childhood was a lot of drinking. My mom and dad. There was a lot of drinking in my household.” The alcohol use contributed to the breakup of Angel’s family. Her first childhood memory was of being apprehended from her parents. Angel was six years old when she was first placed in foster care. She would spend the next five years of her life moving from one home to another. She was separated from her parents and permitted to see her nine siblings only once every two weeks. “I don’t remember too much of the younger years but . . . I remember being taken away. The police officers and the workers came to my school. They took me and my brother and then they separated us and I remember that it was hard and I was always lonely. Missing my mom. I grew up in a foster home for about five years. That was from group home to group home, foster home to foster home, and then back again. You know it was being bounced all over. That was hard . . . it was really hard growing up in foster homes. It was hard because I didn’t know who to trust. I didn’t trust anybody.” Angel alluded to secret stories of this time, stories that I would never come to learn about during our time together. “I’ve had things that I don’t really want to talk about. Things have happened to me as a kid.” I understood that many of Angel’s stories from her childhood were too painful for her to revisit.
Angel’s time in foster care was not all dark and painful. During her last two years in foster care, Angel was the only child placed in the home of one family. She described developing a “really good relationship” with this family. Their daughter became like a sibling to her. Angel finally had some stability in her life and described the home as a “really good place.” But the stability was short lived and Angel was returned to her parents when she was 11 years old. Angel was once again surrounded by alcohol addiction, but this time she was older. “I remember coming home after the workers were gone. And [my mom] started drinking again and she would leave us for a couple days. But at this time I was 11 or 12 and I had my younger sister now that I had to look after. And I just remember that we would cry and pray that she just comes home. It was tough, it was tough because I didn’t know if she was going to even come home or when she was going to come home.” At the age of 11, Angel became largely responsible for her younger siblings. When her father and mother were physically in the home, they were often absent as parents because they were using substances. When the family started to drink, Angel would take her youngest sister to another room. Together, they would hide behind a locked door, fearful of the violence that might ensue on the other side of the wall.

Angel’s childhood was plagued with violence. She watched as her father assaulted her mother. She watched as her father and older brothers physically fought each other. “It was always scary because I didn’t know if I was going to get hurt.” Angel was especially fearful of one of her eldest brothers. “My older brother always scared me. I used to always be scared of him when I would hear him start yelling or getting mad. I would go hide because I didn’t know what he was going to do, if he was
going to hit me. It was always like that with him . . . he was very violent and it was scary.” There was much uncertainty and instability in Angel’s life. It was no wonder that as an adult she continued to have difficulty trusting anyone.

As time went on, Angel’s mom got sick. This was difficult for Angel. This was difficult for the entire family. “My mom started getting sick with diabetes. The drinking and diabetes wasn’t good at all for her; her health. She ended up in a wheelchair. Getting her leg amputated. That was a really hard time on all of us. . . . seeing our mom cry and having to have these changes. It was kind of like alcohol was her way to cope with it.” Angel started to act out. She started running away from home and she began to make decisions that would eventually lead her down a path to addiction; a similar path to the one that so many of her family members had already taken. “I would leave for months. I would pack a bag and I would leave. [My mom] would be worried but I always told her I could handle my own. But when I look back now I was so young and it was dangerous what I was doing. I started working the streets at a really young age. And it was just the wrong crowd. But I guess that’s what I was used to . . . it was a cycle and my mom’s mom was an alcoholic and my dad’s mom was an alcoholic. It just seems like a cycle that doesn’t end.” Addiction was not only in Angel’s immediate family, it had been present for generations.

Angel’s childhood was beset with negative memories. She told me that there were some good times, but she never shared a childhood story that had a happy ending. Her stories were mostly painful, darkened by addiction and violence. Angel would blame these early stories of her childhood and her background as an Indigenous woman for contributing to her addiction. “I find that a lot of First Nations women, we keep all of
this stuff bottled up. A lot of us have grown up in substance abuse homes and a lot of us have worked the streets or we’ve been sexually molested as kids and things have went wrong in our life. . . . I used to say it was okay to drink and to get high because this is how I grew up. This is normal, this is a normal thing. But then as I started meeting new friends, new people, I started seeing how their homes were. And sometimes I would just cry because I would come home and everybody is passed out and there’s nothing to eat and how come I just can’t come home and things will be just how it is with my friends? I don’t know. It was really tough. I don’t know. It was really, really tough growing up as a kid and I think that’s a lot to do with the choices that I made.” Many of these choices involved alcohol and drugs.

6.2 Initiating Drug Use and the Constant Fight to Stay Clean

Angel’s introduction to alcohol and drugs occurred at a young age. She witnessed alcohol use by many of her family members and she became curious. She started stealing alcohol from her mother. She saw how her family members “would change from being sober and then how they would act having the alcohol in them.” She wanted to know what being drunk felt like and this precipitated her addiction. Not long after the alcohol use began, harder drugs followed. “I started out drinking, then smoking weed, then popping pills. My best friend, she started using injection drugs at 14 or 15 because her family was doing it. I remember getting beat up one day and I went over to their house. And they were all doing it and I was drunk. So I was like, well let’s try it. I tried it and right there I went on a binge . . . and I was just so young. I was 14 or 15 when I first started using. I couldn’t do it myself, of course. I would always ask one of them to do it but then I slowly picked up on how to do it and by the end I knew exactly what I was
doing on my own.” From this point onward, Angel struggled with a morphine and
cocaine addiction. She tried to “get clean” but she was constantly surrounded by drug
use and it was easier to use drugs than to stay sober, especially during difficult and
painful times.

There were multiple attempts to stop using drugs. However, whenever she faced
a challenging time, Angel quickly reverted back to alcohol and drugs as a means for
coping. Angel told me that she had quit using drugs near the end of her first pregnancy.
Her baby was apprehended at the hospital anyway. Returning home from the hospital,
alone, a few days before Christmas and her birthday caused a downward spiral. “When I
went home it was just before my birthday. . . . It was supposed to be Christmas. I was
going home for my birthday, being alone, and knowing I was supposed to have this baby.
And I didn’t have my partner. He was in jail. I slipped back into using right away. I
went out and got drunk because how else am I going to cope? How else am I going to
numb this? The next morning I woke up and I felt more horrible. It’s Christmas day and
I don’t have anybody with me. That was really ugly.” Eventually, Angel’s partner
returned home and together, they managed to stop using alcohol and drugs. This time of
sobriety and being clean was short lived.

Angel was pregnant with her third baby. The other two children were in foster
care but the couple was in the process of getting their kids home. The children would
come home for days at a time. They were on the right path. Then tragedy struck.
Angel’s mother-in-law died followed very closely by the death of her father-in-law.
Angel and her partner once again turned to drugs to help them cope with their grief.
They didn’t have any other means to manage. “We started just smoking. Smoking crack
and I got drinking . . . and then it turned into the needle. We were starting to go off the path. And things just started changing. It was like how do we deal with this? I was doing it [using drugs] every day.” Angel and her partner continued to work towards getting the children permanently home but they were facing a difficult time and they were unsupported. “No workers came around. The only worker that came around was the Aboriginal Family Services worker but she would barely come around . . . like barely.”

The children were eventually completely removed from the home again. Angel and her partner were devastated. They repeatedly attempted to stop using, but every time something went wrong, they turned back to alcohol and drugs. The downward spiral continued.

The environment that surrounded Angel and her partner, also contributed to their drug use. “Where I was living, everyone was coming in and getting high . . . . You see people who are always drinking.” Angel and her partner lived in the city’s poorest neighbourhood, where addiction and crime were common. They moved several times, attempting to avoid the temptation of drug use, but no matter what home they lived in, they were always within the borders of this community. “We moved . . . and there, we were still kind of using but it wasn’t as bad. It wasn’t as heavy as it was when we were living on [a different] street. It is a little bit of a quieter street. There’s still people around but it’s not as active.” Angel and her partner again attempted to quit using drugs but family members and friends continued to come to their home to use drugs. They were constantly surrounded; constantly tempted. “The addiction is everywhere we go. Somebody is either smoking or drinking. . . . I see some of my friends, my in-law, every time she gets pregnant she uses right from the day she finds out, right until she has her
baby.” Wherever Angel and her partner went, alcohol and drugs followed. Daily use was accepted as the norm within the community that surrounded them. Now Angel is pregnant with her fifth baby and this time she wants to do things differently. This time, she wants to stay sober but she knows she will not be successful in an environment inundated by alcohol and drugs.

When I met Angel, she was doing her best to make choices that would support her in staying clean from alcohol and drugs during her pregnancy. It was not easy. Staying clean meant cutting ties with many family members and friends. “We try to keep to ourselves. We try to keep positive. We try to do family things. I try to come to group. But it does get stressful, it does get stressful.” Angel is motivated by remembering the challenging and painful times in her past. “I’ve hit rock bottom. I know what it’s like. I had no home with my kids. I had no food. I had nothing. It’s a really rough road. My addiction has taken me to places I don’t really want to go . . . . So this time we are doing it. We are trying our best. But it’s hard. It is. It’s hard. Especially when people come by . . . ‘Do you want to smoke a joint?’ No, if they find that in my baby’s system, my baby is gone. I don’t need to risk it. You guys can smoke it, you can smoke outside. Don’t bring any of that stuff. Leave your little cigarette butts or whatever outside.”

Angel is once again fighting the addiction, trying to stay sober; motivated by her pregnancy and the fear of returning to “rock bottom.”

6.3 Pregnancy and Addiction

When I met Angel, she was pregnant with her fifth baby. She confided that she had used drugs most heavily in her first pregnancy and that she took prescribed methadone during each of her subsequent pregnancies, including the current one. “My
first was the worst that I ever used when I was pregnant. I was six months when I found out I was actually pregnant and I was using cocaine, ritalin, morphine, everything. I just thought that it was the drugs stopping my cycle. Because I had been with this guy already a year. . . . We weren’t going to have any kids because we were using so hard together.” Angel was constantly using. When she wasn’t high she concentrated on how she would get her next high. Angel’s drug use was so heavy that she did not initially recognize she was pregnant. “I was going hard. Staying up all night getting high. I wouldn’t eat. Maybe I was just too high to notice my body changing. I couldn’t even tell I was pregnant. I didn’t have no signs of it. No nausea, no anything.” It was Angel’s partner who first noticed the growing pregnancy. “We were laying down one time and he said ‘I felt something move in your stomach.’ And I didn’t feel this because I was so out of it. So I went to the doctor. They did an ultrasound and I was already six months.” The news of the pregnancy was motivational. Angel was determined to decrease her drug use.

At first, Angel wanted to quit using drugs all together. She was advised against this in fear that the unborn baby, also addicted, would experience the harmful effects of withdrawal. “I didn’t want to carry on with the injecting. . . . I went in and told [the doctor] I [want to quit] cold turkey. The doctor said there’s a chance I might lose my baby. . . . she’ll go through the withdrawals too and her little heart might not be able to handle it.” Instead of quitting, Angel settled on decreasing her drug use and started the methadone program. “I got onto the methadone program. I still did use. I didn’t completely quit. It was about the last month and a half when I really tried to not use anything but I was still living that lifestyle of using.” When she gave birth, Angel saw
the harmful effects of her drug use in her newborn baby. “She was born really small, really small. She was only six pounds, almost six pounds. It affected her with a heart murmur. . . . I do feel that it was my drug use that kind of brought it on. . . . It was my daughter who suffered the most; the withdrawals, the heart murmur, how tiny she was, and she would shake really bad. . . . It was hard. It’s really hard, just to see my daughter go through that and the withdrawals. She did not deserve that, she didn’t.” Angel regretted her drug use during her pregnancy and she vowed to never expose another baby to heavy use again.

After the birth, Angel returned to drugs. But with each subsequent pregnancy, she was motivated to decrease her use; even if it meant cutting ties with family and friends. “As soon as I find out I’m pregnant, I quit. . . . I just don’t want my babies to [withdraw]. I saw how bad my first daughter had it because I had other drugs in my system, like cocaine, marijuana, and morphine.” Angel described her fourth pregnancy and how she was able to decrease her drug use. “And then I found out I was pregnant. And I knew it because I started getting morning sickness and so I made his sister move out. I told her I don’t think it’s really healthy if you stay here because I’m going to end up using and that’s something I don’t want to do. And she respected it. She moved out. And it was just me and him again. We stopped smoking weed. We stopped everything. And he said, maybe we might have a chance to keep this baby? And I said, I don’t think so. So I’m not going to get my hopes up like I always do. I’m not, cause then they go.”

Angel equated decreased drug use with the chance to have a healthy pregnancy and to keep her baby. “I went from having a six pound baby to a 10 pound baby with my second pregnancy. There was a lot of changes. I did things a lot better.” With her third
baby, Angel recognized the signs of pregnancy and once again tried to maintain a healthier life. “I knew I was pregnant because I was getting nausea. I got the signs and symptoms right away so I started taking my prenatal vitamins, doing drug screens regularly, putting up a fight for it this time.” Angel attempted to decrease her drug use and lead a healthy pregnancy, but remained on the methadone program with all of her pregnancies.

Angel felt guilty about her methadone use and considered it as much of a drug as the illicit drugs she had used so heavily. She felt guilty. Guilty that she continued to use drugs in her pregnancies and that the perceived the drugs to cause harmful effects in her newborns. “I always felt guilty. I did. I’ve always felt guilty. Especially when they are born I put myself on a bit of a guilt trip. They wouldn’t be going through this if I would have done right or gone off of it. . . . I cry when I see it because they don’t have to go through that. They don’t have to go through those withdrawals. They wouldn’t have to if it wasn’t for my stupid mistakes. But I think I beat myself up there again too and I think they wouldn’t even be going through this if I wasn’t on the methadone or I didn’t have the baby. . . . I dislike myself when they are born because they have to go through the withdrawals and I hate seeing that.” Angel managed the guilt related to her methadone use by doing what she felt she could to minimize the impact on her newborns. She used the lowest dose of methadone that still managed her symptoms of addiction. She also used breastfeeding to help ease the withdrawal symptoms in her newborns and to provide comfort for them. By doing what she could to ease the withdrawal symptoms, Angel managed her guilt but she still hated to see her babies suffer.
Angel’s first baby experienced the worst withdrawal symptoms. This baby was apprehended immediately at the hospital and Angel felt helpless knowing that her newborn was suffering. She felt that her baby was not given the appropriate treatment for the withdrawal symptoms. “They didn’t give her any kind of care; what they did with my others. They just took her right out and I knew she was out there suffering somewhere. . . . They just took her out of the hospital. They didn’t give her the treatment they gave my son. Like with my other babies. So I kind of felt that she suffered.” Learning from the past, Angel advocated for her subsequent newborns. “So the second time, when I had my son I made sure, I asked them, if he needs anything can you please give it to him because I had a bad experience with my first daughter.” Angel did her best for her children but pregnancy in the midst of an addiction was not easy for her. No matter how hard she tried to do better, she always found herself facing challenges. She said, “It’s just addiction is really a hard thing. Especially in pregnancy.”

6.4 Apprehension as Normalized

Angel’s first two children were apprehended from the hospital as a result of her drug use. By the time she gave birth to her third child, she was only using prescribed methadone. She expected her daughter to be apprehended immediately because her other children were in care. Apprehension of her children at birth was all she had ever known. “When she was born, I expected them to take her from the hospital even though I was clean. . . . I didn’t think I was going to be able to keep my daughter because of my other kids being in care. I thought for sure they are going to take her on me. I didn’t buy her anything because I was prepared for them to take her from me. But they didn’t.” Angel and her partner worked towards getting custody of their children. Angel was all too
familiar with this process; she had experienced it herself as a young child. It started off slowly with the two older children and the baby transitioning home. “First it started with weekend visits then it went slowly to more days.” Angel described that things were going really well until the children were permanently left without a lot of corresponding support. “Then one day they just dropped them off with everything. After that the workers didn’t really come by. . . . I kind of wished they kept coming by because we lost my mother-in-law and six months later we lost my father-in-law and we lost a brother-in-law. All his family. And that’s when we relapsed. . . . I just wish I had more support then or maybe if I would have reached out a little bit more, things would have been different.” It was at this point that Angel and her partner began to permanently lose custody of their first three children.

Angel attributed her past drug use as the cause for losing her children. “My three older [children] are permanent wards of the government because of my addiction. . . . I lost them because my addiction was taking a toll on everything. It was better for them at the time. . . . They were in a safe place where people weren’t using.” I asked Angel how the children became permanent wards of the government and she described what she felt had been a misunderstanding. She agreed to have the children placed in foster care for one year while she attempted to straighten her life out. She did not attend court that day because she felt all of the arrangements had been made. But in her absence, “It ended up turning into a permanent order because I wasn’t there in court that day . . . and that was really hard. I tried not to slip back into [using] cause that’s what it seems like, when something is wrong that’s what you run to right away. I tried to stay sober and still tried to see them. Now I don’t see them at all. . . . I have no contact, I get no pictures. It’s up
to whoever has them to let me see them which I knew wasn’t going to happen; that we weren’t going to see each other.” Angel does not know where her children are now. I tried to imagine what it was like for Angel to never see her children and to not watch them grow up. I was deeply saddened for her and her missed opportunities with her children. My life was so vastly different from Angel’s, yet I could empathize with how painful this must have been. I understood why she started heavily using again when her children were permanently apprehended. She left her partner for several months and went on what she described as, “My own little drug spree.”

By the time Angel gave birth to her fourth child, she was once again only using prescribed methadone. Angel took her baby home from the hospital. When I asked her about this time, she did not want to revisit it. But through tears of happiness she said, “They gave her to me and I left the hospital really happy because that’s the first time that I ever really got to leave with my baby. It was a big change and right from there, she was what really kept us happy, together, and sober. Because just waking up to her every morning . . . it was really a blessing because it changed our lives.”

I sensed that Angel felt there had been some mistake. She already had three children who were permanent wards of the government, yet she was somehow allowed to take this new baby home with her. Angel still worried that her now two year old could still be apprehended. Like the “mistake” could somehow be reversed. Angel was motivated by her young daughter and desperately wanted to also keep her unborn baby. But the sense of uncertainty persisted. Angel’s other children had been in and out of the home before they were permanently removed. Angel was fearful that history would repeat itself and she would lose her children all over again. “I don’t ever want to do that
to my daughter again. I don’t. . . I don’t ever want to go back to that. We [Angel and her partner] were talking about it. He said ‘just think how we treated our other kids.’ And I said, ‘I don’t even want to think about it’ because it makes me really emotional and then I start crying, and then pregnancy emotions, and so I tried to tell him, ‘I don’t want to talk about it right now.’ But then there’s times that we do talk about it and we both end up crying. Because we know what we did and we both know we could have done better. We could have stopped this. We could have done better. . . . That’s where my addiction has really messed me up. With my kids.” Angel continues to be motivated by her daughter and the current pregnancy. She wants to be a mother to these children and to have her family together again.

6.5 Losing Motherhood and Reclaiming it

There were periods of time when Angel had the opportunity to actively mother her children. But these periods of time were intermittent as the children moved in and out of the home in correspondence with their parent’s drug use. Angel’s ability to mother her children was deeply impacted by her addiction. She described the struggle of trying to care for her children while she was actively using. “I would just try to keep my kids quiet. Turn on the TV. Just sit them in front of the TV and give them snacks. Okay sit there, watch your movie. And I’d be off in the other room. And they’d come banging on the door.” Angel tried to protect her children by not using in their presence but she recognized their basic needs for love and belonging were not met. “I would always try to go to the bathroom or the next room. I would never do it in front of them. But still, they weren’t given the love and attention that they deserve and that they needed. . . . I always tried to make sure that I had the diapers and their food. His brother was like ‘for people
that are doing as much dope as you guys, you really try to take care of your kids.’ I said ‘yeah, but they don’t get the love and attention that they do need . . . they don’t got their mom and dad showing them everything.’ Like getting the love that they really needed.”

Shortly before the three oldest children were permanently apprehended, Angel saw that her eldest daughter recognized that her parents were using. “My oldest, she knew. I’m sure she could tell the difference from when we brought her home to when we started using; not spending so much time with her; not doing so much. . . . It was really hard trying to give them that love and affection and then worrying about trying to get high.” Angel’s drug use was her primary concern. The children came second. When Angel spoke of this time in her life, I could feel her sadness and regret; tears streamed down her face as she revisited the memories of her oldest children and her lost opportunity to be their mother.

There were other times when Angel was denied motherhood. The two oldest children were apprehended immediately at the hospital. Although Angel would later obtain custody of these two children, she was not given the opportunity to initially care for them. Angel described her children being placed in homes that did not meet her approval. She described how her cousin cared for the children and denied Angel the opportunity to see them. “My cousin started pushing me away from her. Not having me around her. The worker said, ‘you can go visit, as long as you’re sober, you can go visit’ . . . . At first it was going smooth. But then she started saying that I was going over there drunk, I was going over there high, I was going over there just trying to take my baby. And I never ever did that once. I always went there when I was straight.” Angel was denied the opportunity to even see her children by her own family member. The children
were eventually moved to a different home. In the new home, Angel was able to visit the children but she was not permitted to have an opinion on how they were raised.

Angel was forced to watch as her children were cared for in what she perceived to be an unsatisfactory manner. She was in an in between state. She was the children’s mother yet she was powerless to mother them as her own. She often spoke about how her son was cared for while in foster care. “My son, she [the caregiver] would always bottle prop him in a car seat and she wouldn’t take him out and feed him. And now his head is kind of [flat] from always being like that. Flat a little bit on one side.” Despite observing the neglectful care that her son received, Angel was powerless. She was denied the right to exercise her opinion as his mother. When Angel eventually secured custody of the two children, she was finally able to advocate for them. She did what she could to support and help them but continued to blame herself for what had happened. “So when I got him home, I had to take him to rehab. He had to wear a little helmet, you know, and things like that. I thought it was me that did that but when the doctor really looked at it he said, ‘no it’s from always being on one side, always being bottle propped, not being held up and fed.’ I got really angry, you know, because I felt that he didn’t have to. His little head, his little brain is still developing.” Angel also described how her son’s speech was delayed. Again, she did her best to help by taking him to speech pathologist appointments. He improved but Angel still worried. “I was all worried that his brain might have been affected by it, the way his head was shaping.” Despite her drug use, Angel did what she could for the children, acting as their mother when she had the opportunity.
When Angel left the hospital with her fourth daughter, it was as if she was granted another opportunity to establish motherhood. “When she was born, I expected them to take her from the hospital even though I was clean and everything. There were social workers involved but they let me keep her and that’s what keeps me focused every day.” Although Angel cherishes the time with her youngest daughter and is grateful for this opportunity, it also highlights what she has missed with her older children. She expressed lament. “I just see the big difference and I really regret that. . . . I don’t want to do that again. . . . I don’t ever want to have to go through that again. I don’t want to put my baby [through that]. She’s used to everyday, going to the fridge, grabbing her little yoghurt, grabbing her treats. She’s used to that and I don’t want to be where I was when I was high.” Angel recognized she could not provide for her oldest children and that they were better off in a different place. Better off without their mother. “It was better that way because they are in a safe home, they are being looked after.” But Angel doesn’t want to make this mistake again. She is motivated by her daughter and the desire to continue to be a mother to her and the unborn baby. “We’re not using and I do [drug] screens regularly. . . . I know that they can’t take him [the unborn baby] from me because I have my daughter. I’m doing good. That’s always, always my worry . . . because I do have children that are in care and I have my addiction. I wasn’t doing very well. But they actually gave me a chance this time and I showed them I could do it. My daughter is two years old. I’ve had her for two years now. And we’re having another one so I know I can do it.”
6.6 Moving Forward: Recreating Motherhood and the Family

Angel is motivated by the hope that she will one day have her family back together again in its entirety. Since taking her daughter home from the hospital, she has focused on abstaining from drugs and alcohol and demonstrating that she can be a good mother. Given her history of addiction, Angel believes she has to prove herself. Constantly under the surveillance of social services, one mistake could lead to the apprehension of her daughter and her unborn baby; one mistake could end her chance of ever having her family back together again. Unlike most other mothers who raise their children independently of the watchful eye of the state, Angel considers every decision she makes and how it might impact the future of her family. Her focus now is proving she can be a good mother so her family can be reunited. “I’m just looking forward to this baby being born and maybe after he’s born I think I might start the court process because I already have two of them and I’ve been clean. They can get all my screens from the methadone clinic. I’m clean. What more can I do to get them back? Cause I’ll do anything, I will. I would give anything to get them back. . . . [Social services] wants a longer period of stability and I’ve been at it for almost three years. I’m trying my best to carry on cause I know we’ll be back together.”

Angel is also motivated by the memories of her childhood. Not that long ago, it was Angel who was the young child in foster care, longing for her own family. She knows firsthand what it was like to be the child separated from the family and she feels guilty for subjecting her own children to this same upbringing. She lamented. “They are old enough to understand . . . they are wondering where we are and how come they don’t see us no more. As a kid, I was in care and when I got home I was really mad that my
mom had my little sister and not me. But now I know how come it goes like that. Now I understand. I just don’t want my kids to have that anger towards me, like you left me, kind of thing. I don’t want to wait until they are 18 and have to come find me on their own. I want to try and get them back before then if I can do it. I know I can. . . . Like how my daughter is now, I just see the big difference and I really regret that but I can only make it better for the kids I have now and when I get them back I can only try make up for it.”

Angel has witnessed other mothers who have been successful in getting custody of previously apprehended children. This gives her hope. “I have a friend who got her kids back. They were a permanent ward of the government and that’s what really gave me hope, when I heard her story. . . . I know I have the right to go back to court and say, okay at this time in my addictions, yes I didn’t show up at court. I was doing this, this, this. I can give any excuse I want, it doesn’t make it right you know. But I’m here now and these are the changes that I’ve made. This is what I’ve done. It’s a really big change, it really is. And I think maybe that’s the cycle that keeps going and that’s what I want to try and break for my kids. I was just talking to my counselor the other day about getting back our other three and he told me it’s not too late. So there is some hope right. I just want to try break that cycle. I don’t want to raise my kids how I was raised.”

Angel recognized that if she was to reunite her family, she would need to be supported. She described her first three pregnancies and the lack of supports that were available to her.

“I just wish I had more support then, or maybe if I would have reached out a little bit more things would have been different. Because I see these programs they have now and
they have a program that they can actually take your family in. Maybe they brought it up after realizing how many families can still be together if it’s brought up before it gets out of hand. . . . I don’t know, I just really wish somebody would have stepped in or maybe had a little more support. It would have been different. Cause this time I did have support at the hospital. I had a lot more people. And it was because I was going to meetings, I was going to meet with people.” Angel felt that the increased support she had with her last pregnancy had contributed to her being able to take her baby home from the hospital.

As I got to know Angel, I learned more about her support systems. Angel named her partner’s Godmother, the people at several agencies, and most importantly, her partner as her main supports. “His Godmother, like she’s a really good support, a support system. She’s really positive and she’s always there. Because I don’t have a mom and he doesn’t have a mom. She’s like our mother figure . . . she’s the one that really helped us. She would always come check on us.” Angel also felt supported by the people at several agencies. For example, she discussed the methadone clinic. “The people at the methadone clinic are really wonderful people and they work with you. Like they’ve been through with me so much and it’s just the relationship that I have with my counselor. He tries to support us the best he can, the way he can. You know, he asks me ‘what can I do for you guys?’ I just sit down and tell him how things are going. And he’s a good support to us.” Participating in therapeutic groups has also been a good resource for Angel. “Every Thursday I go to group, it’s the same people, it’s like a little family. We get together, we have supper and what not. We all talk, I get really emotional there too. Because somebody will bring up this topic. And I’ll be like, ugh, I don’t really want to
talk about that but maybe it is better to talk about it than keep it bottled up inside. And they are very supportive.”

Although Angel has several good supports, perhaps her greatest support was her partner. Together, they worked as a team to stay sober. “My partner, he understands it . . . so that’s a really good thing. He’s supportive . . . and he’ll put his foot down. Like one New Year’s I was trying to go out and have a drink. He said no and I kind of let it go. And we didn’t. And it felt good not having to wake up and go get my daughter at a babysitter all hung over. He’s really supportive. [We] have been through so much, I’m just happy to have someone that supports me. . . . Yeah, we argue sometimes but it never gets out of hand . . . cause he leaves, he goes for a walk. He says, ‘okay I’m going.’ I know he is coming back, he’s not going to go get high or go drink. He’ll just go for about a 20 minute walk and he comes back and after that we’re cool. . . . I don’t really have to worry about it because he knows that what he does kind of, not really affects what I do, but it’s a support system right? If he wants to be high and drunk and then come home, how’s that supposed to help me to stay sober?” Together, as a team, Angel and her partner are working to create a positive environment to support their family.

Angel and her partner are making better decisions than they have in the past in the hopes of creating an improved future. In the past, the couple used alcohol and drugs to cope with the grief of losing family members. When they more recently lost his sister, they used other strategies to cope. “When his sister died last year we dealt with things a lot differently . . . . He said, ‘you know, I don’t want to go the way we went last time. I see when I lost my mom and my dad that I used that to start using again and we lost our
home. We lost everything and our kids got taken.’ [This time] we dealt with things a lot differently. I guess you can make changes.”

Angel and her partner are learning to make other positive changes. “I know there is such thing as change and hope but you have to want it. You have to want it. And that’s why people ask me and my partner, how did you guys quit using? What made you? You know, I just thought about it, I hit rock bottom. Some people say, you don’t know what you have until you hit it. I’ve hit it. I know it. I’ve lost and I don’t want to do that again. I don’t. And I know that if I see that happening again to ask for help this time. Suck up my pride and ask for it because it can be changed before it escalates.” If a better future means leaving the past behind, Angel is willing to do it, even if it means relocating. “We could have stopped this. We could have done better. So this time we are doing it. We started off smoking it and then it turned into the needle. And I saw how it started. And if I see that happening again, I’m going to push myself away. If I have to move away then I’m going to move away. . . . Now we know from our mistakes. We can’t let that happen again. I don’t ever want that to happen again. Things can get tough, times get tough. We still try to stick by each other even though sometimes we want to tear each other’s heads off. But who doesn’t fight, who doesn’t argue? So things have changed a lot, our relationship and how it used to be. For the good, it’s all changed for the good. . . . Now I just want my family back.”

I do not know what the future holds for Angel and her family. What I do know is that when my relationship ended with her, she was on the path to reuniting her family. I am hopeful that with the right supports and resources, Angel and her partner will continue on this path. They have worked hard to change the direction of their lives.
They want to have their family back together again. I often think about Angel and her family and will always wonder if they were ever reunited. Were they able to navigate the complexities of their lives and continue on this positive path? Or did the path change directions, taking them back to a life of alcohol and drugs . . . a life they had always known. Perhaps I will never know.

6.7 Making Sense of Angel’s Story

When I reflect back on the time I spent with Angel and the stories she shared with me, it seemed that for the majority of her life, Angel faced an uphill battle. Her life reminded me of the Greek mythology character known as Sisyphus. Sisyphus was condemned to a lifetime of rolling a heavy boulder uphill. Only, each time he was about to reach the top of the hill, the boulder would come crashing down and he would be forced to start at the beginning once again (Encyclopedia of Greek Mythology, 2018).

There were times when things went well for Angel and her family; times when they were happy and together. However, these times were infrequent and short lived. Whenever things seemed to be going well, a period of crisis soon ensued; the boulder would come crashing down, bringing Angel along with it. During these low times, Angel’s days were filled with depression and loneliness. Knowing no other means to cope, Angel turned to what she had always known. She turned to drugs and alcohol to falsely help her cope. When Angel was faced with unexpected crashes, like the deaths of close family members, again alcohol and drugs were her means for coping. Angel never seemed to know what lay ahead. As I reviewed my field notes, I was reminded of the countless times when Angel and I had arranged to meet but at the last moment she was forced to cancel. She was constantly faced with the complexities of navigating her many
commitments and responsibilities; trying to maintain her sobriety amongst the many ups and downs that permeated her life.

6.7.1 Recognizing pregnancy amongst the addiction. Through Angel’s narrative, it is clear that alcohol and drugs were a part of her life for as long as she could remember. Her childhood was filled with memories of familial substance use. As a young teenager, Angel was introduced to alcohol and drugs by family and friends. Cleveland et al. (2016) identified that many drug using women are initiated to substance use at the young age of 14 or 15 by close relatives or friends. Heavy substance use persisted into Angel’s first pregnancy. Angel described using “so hard” that she did not recognize she was pregnant. Angel’s experience of a delayed recognition of pregnancy is reflected in the literature.

According to Jessup and Brindis (2005) drug using women seemed to have a lack of awareness of their own reproductive health, contraception, and reproductive capacity. Data from the Canadian Maternity Experiences Survey suggested that women who used drugs were at increased risk of experiencing an unintended pregnancy (Oulman, Kim, Yunis, & Tamim, 2015) and in her exploration of drug use and motherhood, Radcliffe (2009) found that pregnancy was rarely planned. Similarly, Murphy and Rosenbaum (1999) and Soderstrom (2012) reported a delayed recognition of pregnancy by drug using women. In these studies, it was unclear whether the women knew they were pregnant and disregarded it or if they were truly naïve. Several of the women believed they were infertile given their addictive lifestyles and irregular menses (Murphy & Rosenbaum; Soderstrom). None of the women in Haritavorn’s (2016) study of injection drug users identified their amenorrhea as a sign of pregnancy. Rather, they attributed it to their drug
use. Symptoms of pregnancy were frequently misinterpreted as symptoms of withdrawal which resulted in heavier drug use (Soderstrom). Overall, women perceived themselves as infertile as a result of their addiction (Soderstrom).

The delayed recognition of pregnancy signs makes very late detection of pregnancy common (Silva, Pires, Guerreiro, & Cardoso, 2012; Cleveland et al., 2016). As a result, women have inadequate prenatal care and limited time to prepare themselves for motherhood (Silva et al.; Cleveland et al.). Angel’s first pregnancy presented much like this, with recognition not occurring until well into the sixth month. She believed she could not get pregnant because of her heavy drug use. This resulted in a lack of prenatal care attendance during the first part of her pregnancy. Angel immediately sought out health care upon recognizing she was pregnant. Unlike women in other studies, Angel readily disclosed her drug use to her care providers.

6.7.1.1 Barriers to health care access. Women feared disclosing their drug use to health care providers because of the stigma associated with addiction and pregnancy. Fear of stigma was a common barrier to health care access (Chan & Moriarty, 2010; Haritavorn, 2016; Jackson & Shannon, 2012a; Krausz, 2010; Kruk & Banga, 2011; Murphy & Rosenbaum, 1999; Roberts & Nuru-Jeter, 2010; Roberts & Pies, 2011; Soderstrom, 2012; Varty & Alwyn, 2011). Women recognized a need for help but shame and feelings of being judged by care providers prevented them from accessing care (Murphy & Rosenbaum; Varty & Alwyn). Complicating matters further was a fear of child apprehension (Chan & Moriarty; Krausz; Kruk & Banga; Murphy & Rosenbaum; Roberts & Nuru-Jeter; Roberts & Pies; Soderstrom). Women described avoiding care because of this fear (Kruk & Banga; Roberts & Nuru-Jeter; Roberts & Pies).
In hindsight, I am unsure why Angel immediately disclosed her drug use and accessed health care upon recognizing her pregnancy. Was she unaware of the stigma and risk for child apprehension that potentially faced her? Did she simply want to do what she felt was best for her and her child? In hindsight, these would have been good questions to explore with Angel. Our relationship ended abruptly and I did not have the opportunity to return to Angel with some of my questions. What I do know is that Angel was motivated by her pregnancy and was immediately willing to do what she could for her unborn baby. Angel sought prenatal care and explored decreasing her drug use.

6.7.1.2 Pregnancy as a motivational time. Researchers found that pregnancy was a motivational time for women with substance use disorders (Bohrman, Tenille, Levin, Rodgers, & Rhodes, 2017; Couvrette et al., 2016; Haritavorn, 2016; Jackson & Shannon, 2012b; Jessup & Brindis, 2005; Krausz, 2010; Kruk & Banga, 2011; Murphy & Rosenbaum, 1999; Radcliffe, 2009; Silva et al., 2012; Soderstrom, 2012). For many women, pregnancy coincided with the beginning of drug treatment (Radcliffe, 2009; Silva et al). Jackson and Shannon (2012b) found the top motivator for pursuing treatment to be pregnancy. Similarly, Jessup and Brindis identified that impending motherhood acted as a life turning point and women sought care out of concern for the fetus. Motherhood provided an incentive to change and to start over for the new child (Couvrette).

In their study that explored problem drinking in low income mothers, women described that they stopped drinking because of their children (Bohrman et al., 2017). However, completely abstaining from substance use was not always realistic. Cleveland et al. (2016) established that women were counseled to avoid abruptly stopping their drug
use because it would put the fetus at risk of withdrawal symptoms that could result in pregnancy loss. Even when women attempted to decrease or stop their use, recovery was not always successful and resulted in relapse (Silva et al., 2012).

As I spent time with Angel, I learned that between her pregnancies, she often returned to heavy drug use. Her relapses were frequently preceded by a situation of crisis. When her mother-in-law and father-in-law died within a short time period, she returned to drug use. When her children were apprehended, she returned to drug use. When her oldest children became permanent wards of the government, she returned to drug use. Every time that Angel faced crisis, she returned to drug use. Yet pregnancy somehow served to interrupt this pattern of drug use. Angel was able to successfully decrease or stop using drugs each time she found herself pregnant.

Soderstrom (2012) identified that for women in her study, pregnancy gave them hope that they could change their lives. She discussed one woman’s experience of hope. “One woman confessed that she had no hopes of getting out of addiction. She saw herself heading towards death. The unexpected pregnancy gave her a reason to live and the motivation to scale down and eventually quit taking drugs” (p. 462). Pregnancy gave Angel hope that she could recover. However, as I look back now, I see that it was more than pregnancy that motivated Angel. Pregnancy seemed to offer her a time when she could decrease or stop her drug use. She needed this time to regain a bit of control over her life as well as an opportunity to recover. However, her sobriety was fragile. Until Angel could find another means to cope, she would return to drug use every time she faced adversity.
6.7.1.3 Maintaining sobriety. During the time I spent with Angel, she identified that the only drug she was currently using was prescribed methadone. Since the birth of her now two year old, she managed to stay sober. We explored what was different this time that allowed Angel to maintain her sobriety. Angel described that this was the first baby she got to take home from the hospital. She was motivated by this. In response to taking her daughter home she said, “She was what really kept us happy, together, and sober... it changed our lives.”

I continued to discuss how Angel maintained her sobriety after returning home with her baby when she had failed so many times before. Angel described having more support than she had in the past from care providers at the hospital and upon returning home with her baby. In their study that sought to distinguish the experiences of mothers who kept their children from those who did not, Grant et al. (2011) found that services that were relevant to the family’s needs had to be available. Women also needed to perceive benefit in the programs they were attending. After the birth of her daughter, Angel not only described having increased support but she identified that she attended programs and groups that were beneficial to her and her recovery.

Angel had the support of her partner. Together, they were working towards changing their lives. This meant severing ties with their drug using family and friends as well as changing their environment. Cleveland et al. (2016) stated that families who were successful in preventing relapse, worked together to separate themselves from drug using people and neighbourhoods. Angel and her partner recognized that they couldn’t stay sober if they remained immersed in a drug using environment. They were a team and they worked together to prevent returning to the “rock bottom” they had experienced so
many times before. I suggest that this was what truly motivated them. They remembered the first-hand despair they felt when their other children were removed from their care. They were willing to do everything they could to avoid this happening all over again.

6.7.2 Providing for the children amongst the addiction. When Angel and her partner were actively using they did their best to provide for their children. Angel talked about always ensuring that she provided the basic necessities such as food, diapers, and shelter for her children. In a study by Couvrette et al. (2016), substance using mothers also identified that despite their addiction, they ensured their children’s basic needs were met. The women defined basic needs as material things such as clothes, furniture, and food. They felt that, despite their drug use, their children were not neglected because they lacked nothing in terms of basic needs. However, they failed to recognize their children’s needs beyond concrete or tangible objects.

Hiersteiner (2004) explored the experiences of women in recovery centers. She found that until women entered treatment, they were blind to the needs of their children. When mothers were using drugs, their children did not receive the attention they needed (Hiersteiner). Now in a period of sobriety, Angel described a very similar circumstance. Although she provided food, clothing, and shelter for her children, she identified that they did not receive the love and attention they deserved. She tried to protect them by using drugs in a different room but this only proved to compound the time she was away from them. Although Angel was physically present in the home with her children, she was not emotionally available to them when she was using.

In their work that explored the transition to parenthood of addicted mothers, Silva et al. described a phenomenon they termed “Functional (or minimal) Parenting” (2012, p.
A functional parent provided the child’s basic needs such as bathing, dressing, feeding, sleeping, and attending medical appointments. However, beyond these basic needs, the parent was not available to the children. Parenting was dysfunctional and distorted; seen merely as a function to provide basic needs. When the mother was required to be patient, set rules, or meet the emotional needs of a child, difficulties arose. It was not until mothers were no longer actively using that they could begin to see how their children’s needs had not been met (Silva et al.).

Now in a period of recovery herself, Angel’s description of her parenting, while she was actively using, exemplified that of a functional parent. Angel provided food, clothing, and shelter for her children, but beyond these concrete things, their needs were not met. In his work that explored human motivation, Maslow (1943) described a pyramid of basic needs. The base of the pyramid was titled physiological needs and contained those needs that were necessary for human survival. The needs that Angel described providing for her children such as food, clothing, and shelter were physiological needs.

Maslow’s (1943) work has been contested by scholars. In his extensive critique exploring Maslow’s theory of motivation, Neher (1991) suggested that the ranking of needs, as illustrated in Maslow’s pyramid, was not accurate for all individuals. He suggested that satisfying lower level needs does not always encourage the individual to accomplish higher level needs. Individuals might be satisfied by accomplishing only lower level needs and may not strive to achieve self-actualization as placed at the top of the pyramid (Neher). Maslow’s work also does not account for environmental factors or variances across cultures (Neher). Whether you accept or reject Maslow’s ideas, I would
argue, based on Angel’s narrative, that the needs of her children, as identified in the remainder of the pyramid, for safety, love and belonging, esteem, and self-actualization were only partially met when she was using drugs.

Angel’s drug use caused her to blame herself for not meeting the needs of her children. However, there are many mothers, who do not use drugs, who may not provide beyond the basic needs for their children. I reflect on my own experience of being a working mother and full-time graduate student. There are times when I likely have not provided more than basic needs for my own children. Yet because I am not a drug using mother, I do not blame myself and I am not judged in the same way as Angel.

When Angel was using drugs, she could not meet the needs of her children. They were subsequently apprehended. In her period of recovery, Angel recognized that the children did not get the love and belonging that they needed. Although she longed for her children, she understood they were in a better place where their needs were satisfied. She managed her sadness by believing that the children were in a good place and by holding on to the hope that they would one day be reunited. She held on to this belief as she attempted to continue to move forward.

6.7.3 A deeply ingrained problem. Angel was determined to prove that she could recover from her addiction. However, she knew her recovery would not be easy. Angel described a cycle of addiction that was deeply ingrained in her family of origin. Generations of family members had used alcohol and drugs as a means for coping. Angel described the substance use, violence, sexual abuse, and illegal activities that were common in her family. These had come to be normalized in her life and the lives of other Indigenous families.
In an exploration of the literature, Scrim (2017) found that when compared to other Canadians, Indigenous peoples experienced disproportionate rates of crime and victimization. Moreover, Indigenous women were greatly over-represented as victims of violence, sexual assault, and as being involved in sex trade work (Scrim). Colonialism accounts for these inequalities. A history of colonialism and intergenerational trauma has caused Indigenous peoples to lose their culture, land, and language with devastating results on their communities (Scrim). In her discussion of colonialism, Moore stated “it is much harder at times to feel at peace with all of the suffering we [Indigenous peoples] witness and experience, not only in our lives but in the lives of the people that make up our nations” (2012, p. 43). Colonialism had caused and continues to cause suffering amongst Indigenous peoples.

In their study that examined the impact of life events on substance use problems in Indigenous peoples, Ross, Dion, Cantinotti, Collin-Vezina, and Paquette (2015) found that an understanding of traumatic histories including residential school attendance and abuse is needed. Traumatic events are linked to substance use problems that permeate through more than one generation of survivors (Ross et al). In their discussion of historical trauma amongst Indigenous peoples, Bombay, Matheson, and Anisman (2014) stated that trauma in one generation goes on to influence trauma in subsequent generations. Addiction is a means for coping with the suffering, composed by colonialism, that impacts generations of Indigenous peoples.

As a result of colonialism and intergenerational trauma amongst her family members, Angel had not learned basic strategies for coping with adversity. Her family members had long used substances to help them manage the trauma they experienced.
Substance use was the only means for coping that Angel had learned in her family of origin. Perhaps this was not a cycle of addiction, as Angel had expressed, but rather a problem that was deeply ingrained in a family’s way of life. Angel did not know any other way.

6.7.3.1 A desire for change. It is not uncommon for women who experience addiction to describe growing up in traumatic environments with family members who also used alcohol and drugs. Virokannas (2011) found that women who used drugs often had parents with alcohol or drug problems. The mothers in a study conducted by Couvrette et al. (2016) described growing up in broken homes where violence, sexual abuse, and drug use were common. Similarly, women interviewed by Martin et al. (2011) described having dysfunctional upbringings and living in toxic environments with abuse, neglect, and drug use. Despite troubled childhoods and their current addictions, women desired to raise their own children differently than they had been raised.

Also, women wanted to achieve a traditional family with both a mother and a father (Couvrette et al., 2016). They desired this family structure not only for their children but also for themselves. Couvrette et al. suggested that this desire was rooted in an aspiration to raise their children void of the broken homes and traumatic events they had experienced. Bohrman et al. (2017) found that women wanted to stop using drugs in fear that their children would recognize their addiction and Haritavorn (2016) identified that women did not want their children to follow in their footsteps; growing up to also be drug users. During the time I spent with Angel, I found she had similar desires. She desperately wanted to change her life so she could improve the future for herself and her
family. She did not want her children to follow the path that she and so many other family members had previously gone down.

6.7.4 An unknown future. I do not know what the future holds for Angel and her family. What I do know is that considerable instability has complicated Angel’s life. When I think about Angel’s past and the stories of her childhood, I see the brutality she has likely experienced. Her childhood was full of violence, addiction, and pain. It is almost no wonder that Angel’s life has turned out the way it has; from the very beginning she did not seem to have a chance. In her adulthood, Angel has made several attempts to change her path; however, every time she moved in a positive direction, she encountered adversity that sent her back down the path of addiction. Much of this adversity was related to the apprehension of her children.

In this section, I wanted to understand the experiences of mothers whose families were disrupted or whose children were removed from their care. What I found is that a body of literature describing this phenomenon does not exist. The experiences of substance using mothers whose children are apprehended is not known. Rather, the literature focuses on the children and the disparities they potentially face. The drug using mother is forgotten, seemingly invisible because of the family disruption she is blamed for causing. Ostensibly, the mother is seen as choosing her addiction over her children; however, the reality of the women’s lives is so much more complex. I hope that Angel’s story can pave the way for providing insight into the experience of being a drug using mother when children are apprehended. Until this area is explored further, women like Angel will continue to be viewed as inadequate mothers who choose their addiction over their children.
CHAPTER SEVEN: Frankie’s Narrative

I received Frankie’s contact information from one of the nurses at the health centre. Frankie heard about my project and was interested in participating. She gave the nurse permission to pass her contact information on to me. After a few attempts of contacting Frankie by text messages, she replied and agreed to meet with me that day. Our first meeting took place in a small, private room at the health centre. I noted Frankie to be a young Indigenous woman. She was average height with a small frame. Her shoulder length, dark hair hung loosely along her thin face. She had a plain appearance. I never saw her wear make-up or anything other than sweat pants and a sweater.

Frankie brought her 15 month old son to our meeting. He happily played while his mother and I talked. I could tell that Frankie was nervous in meeting with me. Her body language and communication suggested that she was a quiet and reserved young woman. I wondered if she would be willing to share some of her life with me. Would we be able to develop the intimate relationship that was required for the nature of my research? I soon found that having her son at our meetings seemed to break the tension. As I met more with Frankie, I came to see that the young boy was an essential part of our meetings. His goofy smile and giggle put his mother at ease. It was probably fortunate for me that Frankie never went anywhere without him. Having her son at our meetings, allowed Frankie to take time to tend to his needs while she contemplated what to share with me. His presence was just as important as the presence of Frankie herself. Without him, I am not sure that Frankie would have been comfortable enough to share her story with me. Frankie and her son were a package deal and I got to know them both.
During our first meeting, I told Frankie more about the project and she continued to express an interest in participating. Her consent was audio recorded. Following the consent process, I turned the recorder off. With other women, I had used the recorder during our first meeting but I got the sense that Frankie would be more comfortable and I would have more success in developing an initial relationship with her if our conversation was not recorded. As soon as I turned the recorder off, Frankie seemed to be at ease and began to tell me about herself. I learned that she was pregnant with her third baby. She had a six year old daughter who was at school and the 15 month old son who became an integral part of our meetings. Between the two children there was a miscarriage. She was currently five months pregnant and excitedly told me that she was having another girl. Frankie had struggled with intravenous drug use for the previous five years. Her drug use was preceded by heavy alcohol use. She continued to actively struggle with her drug addiction in the current pregnancy. She was also taking prescribed methadone.

Near the completion of our first meeting, Frankie told me that her partner was currently in drug rehabilitation which left her as a single parent for the two children. This was the longest she had ever been apart from her partner and she described it as a difficult time with both her and the children missing him. He was to complete his program in nine days and she was looking forward to having him home once again. We made plans to meet the next week but at short notice, Frankie was unable to make our meeting. She continued to struggle with the complexities associated with her addiction which made it difficult for her to commit to the demands of the research. I remained flexible and open and this seemed to work for our relationship. When Frankie was
available, we would meet. However, there were many missed meetings as Frankie struggled to manage the other commitments in her life. I recognized that I needed to be available at short notice and that I also needed to provide Frankie’s transportation to our meetings. With the arrival of spring, we began to meet at Frankie’s home. These meetings were easier for her to attend. We would sit outside and visit, enjoying the nice weather and the company of each other. As I got to know Frankie more, I learned to adapt our meetings to her needs.

Despite my attempts to support Frankie in attending our meetings, there were long periods of time when we did not meet. Early in the New Year, Frankie went to drug treatment. Although she attended the treatment program as an outpatient, she was required to be at her program five days a week. She was also expected to attend some meetings in the evenings. Her treatment commitments, combined with her pregnancy, left her tired and with little time to meet with me. Although we communicated occasionally via text messages, Frankie did not have the time, or the energy, to meet with me. I respected this. Just as Frankie completed treatment and we began to meet again, her pregnancy took an unexpected turn. Less than a month before she was due, Frankie gave birth to a stillborn baby girl. After the birth, I did not hear from Frankie and my phone calls and text messages went unanswered. Given her loss, I was unsure if she would want to continue the relationship with me. I gave her space and time to grieve.

I waited a month and then spoke with Frankie’s nurse at the health centre. Frankie no longer had her mobile phone, which was likely the reason I had been unable to contact her. She did have a landline but I did not have the number. In a last attempt to maintain my relationship with Frankie, I asked the nurse if she would be willing to
contact Frankie on my behalf to see if she was still interested in meeting with me. The nurse called me that afternoon to say that Frankie wanted to see me. With Frankie’s permission, I was provided the new telephone number. At first I was excited but my feelings quickly turned to apprehension. What would I say when I called her? I had provided nursing care for many women with pregnancy losses in my career but this was different. I never had a prior relationship with those women. I summoned the courage to call Frankie. It was hard; harder than I anticipated. I had come to know this woman and her loss impacted me more than I expected. When she answered, I told her how sorry I was for her loss. She was emotional. I felt badly for calling and having this conversation over the phone. I asked her if she would still be willing to meet with me and she agreed.

For the next few weeks, Frankie once again had difficulty making our meeting times. I made the decision to just stop by her house. This had worked in the past but I recognized that I needed to be astutely sensitive. I wanted to continue the relationship with Frankie but it needed to be a mutual relationship; I did not want her to feel that I was intruding on her and her story. I realized that she was potentially more vulnerable since her recent stillbirth.

When I arrived at Frankie’s house, shortly after lunch time, she was out on the front lawn playing with her son. She immediately walked over to my vehicle when she saw me pull up. She looked happy to see me. She told me that she wanted to meet with me but was having trouble finding the time. She asked if I wanted to meet right then. Unfortunately, I was on my way to another meeting and only had a few minutes. Frankie invited me to stop by the next day. From this point onwards, I would stop by Frankie’s
home on a loosely prearranged day. If she was available, we would sit on her front step and talk. If she was not, we would make a plan for another day.

During the time I spent with Frankie, I learned so much from her. She taught me how unpredictable life can be and although I recognized how complex the lives of women like Frankie are, I truly had little insight into what that actually meant. Frankie provided me with a glimpse into her life and a sense of how difficult it can be to navigate pregnancy amongst an addiction. Frankie also helped me to understand the flexibility that is necessary when working with women whose lives are complex. I not only have new found respect for women like Frankie but I also have a new appreciation for the health care providers who work closely with this population. I hope that by sharing Frankie’s story, you too will come to understand just how difficult it is to navigate a pregnancy in the midst of an addiction. There is so much that we can learn from Frankie’s story. I want to thank you, Frankie, for being brave enough to share your story with me even when your pregnancy did not end as you had planned. Your courage did not go unnoticed. And with that, here is Frankie’s story.

7.1 Life before Addiction

Life before addiction did not exist for Frankie. For as long as she could remember, she was either using substances herself, or was immersed in an environment where almost everyone around her had an addiction. She grew up in a home where her parents were alcoholics and she largely attributed their alcohol use to the development of her own addiction. She blamed her parents and their addictions for her unstable home life. “I never had that stability in my life. I was always around alcohol. I pretty much dropped out of school. We basically raised ourselves.” Frankie’s father was an
intravenous drug user. Frankie wondered if her father’s drug use had contributed to how her own addiction had manifested. “I guess I always kind of wondered, if it wasn’t for him, would I have thought of using needles? I don’t know.” The only reasonable path that Frankie saw for herself in life was the one that was similar to what her parents had already chosen. It was what was normal to her. Her addiction started off similar to that of her parents’ with heavy alcohol use. It was not until later that the intravenous drug use started. “Before the needles, I was an alcoholic.”

Frankie was vague when it came to discussing her childhood. She never provided specific stories about what the early years were like and I sensed this was how she wanted it. She did question what her life would have been like if she was not raised in an unstable home with alcoholic parents. “I wonder if without [addiction] our lives would have been better?” Frankie was witness to friends who grew up in homes without alcohol or drug addiction. “When I was a teenager, I remember, my best friend had both of her parents and they were normal. Well, I guess what you would consider “normal.” Both of them were working and . . . they always kept it together. My friend, she went to school and she graduated. And so that has a lot to do with me. I think it would have been a lot different had I grown up like that.” Addiction was the only life that Frankie had ever known. Constantly surrounded by instability and substance use, she would turn to addiction at a young age herself.

**7.2 Initiating Drug Use and the Constant Battle to Stay Clean**

Frankie could not recall a specific story that she equated with the beginning of her addiction. What she did tell me was that the alcohol use started early and was followed

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9 Unlike Tammy and Angel who used the word fight to describe their internal struggles, Frankie used the word battle.
by illicit drug use at the age of 21. “I started drinking at a very early age . . . then the morphine. Then that went away. For the past two years we’ve been battling with cocaine.”

By the time Frankie gave birth to her first daughter, she was in a fragile relationship with the baby’s father and she described herself as an alcoholic. She left that relationship and met her current partner. This is when the illicit drug use started. “We started with morphine. And the morphine, I don’t know. I was thinking back to it. We lived on the reserve and I guess [my partner’s] cousin, she got into a car accident and something happened to her hip and . . . she got a prescription, she got morphine . . . and we were stupid enough to get on board with it and we started.” Frankie’s description of her initiation to morphine use seemed so innocent. But from the time she tried it, there was no turning back. She was instantly addicted. Frankie and her partner only ever used morphine as a pill. They never injected it.

Frankie never imagined that her drug use would turn to intravenous injection. She had seen her father use intravenous drugs and she vowed she would never follow in his footsteps. “I said I would never do it because I seen him do it. But then at the same time, I don’t know, it was just a drunk thing. One drunk stupid mistake with coke and that was it.” Once again, the first use seemed so accidental but one hit and she was hooked. Frankie’s cocaine use started in isolation. Her partner did not know that she was injecting. When he found out she was using intravenous drugs, he was angry with her and he left the relationship. They did not stay apart long. When he returned, the couple started using cocaine together. They would do anything to support their habit.
At first, Frankie and her partner tried to make enough money to buy drugs without using illegal means. In the wintertime, the couple would canvass neighbourhoods, looking for anyone who would allow them to shovel their driveway for a few dollars. But in the absence of consistent employment, it was nearly impossible to support their drug habit without engaging in illegal activity. Frankie was desperate; she started working the sex trade. Many of her memories of this time have been blocked out or are heavily clouded by alcohol and drug use. What she does remember is how terrible this work made her feel. “When I was a prostitute . . . I can’t seem to remember some certain things there. I remember how I felt though, after I had done it. The next day, when I was sober. I never worked when I was sober, ever. I always had to be drunk when I done it.”

The drug use escalated and things continued to get worse for Frankie. She was constantly in trouble with the law and even sustained a head injury as a result of a fall while she was using drugs. Frankie lost everything to her addiction. “It took everything away, your morals, everything is completely gone. . . . Cause when we were coming down that’s when we really wanted it so bad and we would do anything to get it.” When Frankie’s work in the sex trade was not enough to support their drug habit, the couple had to get more creative. “We had two vehicles, no three vehicles in the time we were using and the first one we sold because we wanted to get high. We ended up selling our vehicle. We sold our vehicle and . . . then we had absolutely nothing to show for it. We were up [high] for three days and then we sold the car and that kept us going for the fourth day.”

I was stunned. Frankie and her partner were so desperate that they sold their only means of transportation to get high for one day. Frankie’s decisions were strictly driven
by her addiction. Her stories went on . . . “And then we went through another car. In fact, what we used to do was loan it to our [drug] dealers. Loan our vehicle to our dealers if they wanted to have different vehicles so they wouldn’t attract heat [attention from law enforcement]. And in turn we would get our pieces [drugs].”

Frankie tried to help me understand what it was like to be addicted to cocaine and why, in its presence, she made such reckless decisions. She shared how the drug had control over her. “The way you think, everything. . . . You don’t think right after so long of doing it. You don’t think the same way. . . . And you think why would you want to feel like that? Why would you want to feel like that? Why do you do that to yourself? But it’s just the addiction. . . . It will change a person completely. In and out. They will do things that they wouldn’t normally do had they not been using. You lose all self-respect. Your morals. Everything. And you will do everything to get it.” Frankie believed that anyone using cocaine could not be trusted. “Basically with cocaine, you really don’t have no friends. You can’t trust anyone with cocaine. It’s a very shady, very shady [drug] . . . and it doesn’t matter if you’re family or not.”

From the time I first met Frankie, she was constantly battling to escape her addiction. She desperately wanted to quit using but it was difficult. “It is really hard. And it feels like when you first quit that it comes around. You try and get away from it but it sucks you back. There will be people like ‘Oh you want it? Here’s a hit. . . go ahead. . . . ’ It just finds a place, I swear it just finds ways, to just carry you back into it. And it is so hard. It’s all about having will power. Frankie had attempted to quit on her own, many times before, but had never been sober for long. Just before I met her, she went to detox for the first time. She lasted four days. She could not stand to be away
from her children. “I wasn’t really having problems with the addiction part, it was just being so lonely for my babies. I just couldn’t handle it.” Frankie returned home to the children and her partner went to detox. He successfully completed the program. Upon his return home, he shared what he learned with Frankie. She wanted to quit but she knew she could not be away from the children. She found an outpatient program. She could attend the program during the day while her partner was home with the children. She would return home every night. Frankie successfully completed the program.

“Treatment was very informative and it felt really good waking up every day and having somewhere to be.”

After treatment, things were not easy for Frankie but she was supported by her partner and together they worked hard to stay sober. “It is just a constant reminder. I can’t change my past. You know, I can’t change, I have to walk through and I am healing and I am so happy for [my partner]. If I didn’t have him, sometimes I think that I would have fell off again. When he was away, I don’t know it just seems to come from boredom, or you know they say ‘idle time is the devils playground.’ That’s so true, it really is. Being in program, the meetings are really crucial in the process of quitting because . . . you need that constant reminder as an addict that . . . you’re always going to be an addict and an alcoholic. The only thing you can do is accept it and move on.”

Frankie recognized that there were areas she could improve to help promote her success. “I’m not using meetings the way I should, the way I should be going. But I know it would be easier if I did it. It’s just so hard with my babies. Making time for it. There’s a meeting, it’s at lunchtime, downtown . . . and now the weather is getting nicer it will be a bit easier to go. It’s something I need to start making time for.” Frankie did not
want to relapse. She knew that each time she relapsed it was harder to quit again. “We learned that it’s a progressive disease. It gets worse the more you quit and then do it again. I didn’t know that actually until going into detox. And that’s when they told me it gets harder to quit after you relapse and it gets harder and harder.”

So Frankie and her partner carry on. They do what they can to stay sober. “As the time goes on, it gets easier, it does. . . . You have to give yourself up to a higher power and your higher power . . . could be anything. It could be the group itself. I think that you need to have that in order to defeat the addiction.” I asked Frankie what the higher power was for her. She replied “The Creator. That’s what I use. As much as I turn my back on my culture, my culture never turns its back on me. It was always there. It’s the only consistent thing in my life that is always there. Without it, it would be impossible to quit. It really would be. When all else fails I bead. And the beading is good.” Frankie is determined to use these resources to help her stay sober for her children.

7.3 Pregnancy and Addiction

Pregnancy served as a motivational time for Frankie. Long periods of alcohol and drug use seemed to be interrupted by pregnancy. Frankie actively used alcohol and drugs for many years, but each time she was faced with a pregnancy, she was successful in decreasing or stopping her use. I sensed that Frankie had a strong sense of spirituality and this is what gave her the motivation to quit. Frankie and her partner had tried to conceive a pregnancy for several years. When they were initially unsuccessful, a period of heavy drug use began. “It is so weird how it happened because me and [my partner] were trying to get pregnant for years. . . . and it seems as soon as we started using [drugs]
we got pregnant. And it was almost like, I don’t know, maybe I’m superstitious, but it was like our loved ones, our past on loved ones, were watching us and knew that we would quit, try and quit, if I got pregnant.” But decreasing the drug use wasn’t easy. Frankie spoke about what it was like to experience an addiction during pregnancy. It was “hard, even with this [pregnancy] it was hard. After I was done being pregnant [last time] I started again. I fell off. And then I continued for a year. And now, I’ve been clean for . . . like 50 days I think. Something like that. But there was a slip in between, before, and it’s very hard.”

Despite Frankie’s ability to decrease or stop her drug use during pregnancy, she did not always do this immediately. She shared with me how she would ignore her pregnancy for as long as possible. If she was not pregnant, she would not have to stop using. “I taught myself to put my pregnancy on the back burner, almost as if I pressured myself to believe I wasn’t pregnant.” Frankie could justify her continued drug use if she did not acknowledge the pregnancy. “I managed to do that with my pregnancy, where I just, I don’t know, I told myself I wasn’t pregnant. Made myself justify it. . . . It justified my using basically until I couldn’t ignore it all together.” But this did not mean she did not feel guilty about her continued drug use. Looking back on her pregnancies, Frankie lamented, “I feel remorse for everything I done to my girl and to my unborn child . . . knowing that I had this little life inside of me. And you know, it’s not right to ignore it in the first place. It’s what I should have done from the start. So much would haves and should haves. . . . The guilt is there. . . . It’s all guilt for me. Knowing that I should have done it differently.”
Frankie used prescribed methadone to help ease her withdrawal symptoms. She hated using it during pregnancy, just as much as she hated using the other drugs. She saw her oldest two children’s methadone withdraw symptoms after birth. “It was very difficult in the beginning. With the methadone it was super difficult. [They] would have had to been weaned off of the . . . methadone with morphine. . . . It was terrible to see.”

Frankie desperately wanted to quit taking methadone in her current pregnancy. “I was on the methadone when I was pregnant. . . . And I thought that the doctors were lying to me actually because . . . they told me to not get off of it or I’d have a chance of losing my baby. And I didn’t believe them. And I tried to quit cold turkey. . . . And then it was the third day into it that I started spotting. So I jumped back on and I haven’t tried to do that since.” Despite trying to do what she felt was best for her unborn babies, two of her pregnancies ended in heartbreaking loss.

Frankie had a miscarriage between her two children. But the loss she felt with that pregnancy was nothing compared to the heartache she experienced when her current pregnancy ended in a way she had not expected. Frankie learned that the baby had a heart defect but was told that it was not serious or life threatening. The baby would be evaluated after birth. However, things took an unexpected turn, when on a routine ultrasound, Frankie’s baby was found to not have a heartbeat. Frankie gave birth to a stillborn daughter just one month shy of her due date. Frankie blamed herself and her addiction for her loss. She grieved for the baby that would never be. “After everything that happened with the stillborn, after my daughter, it was really hard. It was so hard to, excuse my language, but to keep my shit together. It was, I just, I lost it. I lost myself, but I managed to come through it and so far, I’m taking one step at a time.” When my
relationship with Frankie ended, the birth of her stillborn daughter was relatively recent. Her emotions were raw and she was not ready to discuss her loss in detail. She may never be ready to revisit this painful time.

7.4 Almost Losing her Children

Unlike many young women who struggle with addiction, Frankie’s children were never apprehended by the government. It was not because Frankie did things better or differently than other women; rather she was supported by her family. She was convinced that had she not had the support of her family, she would have lost custody of her daughter. “When my daughter was [age] one till three, if it wasn’t for my family, then my daughter would have definitely been gone. . . . I am so happy for my family. She could have been gone, you know if it wasn’t for them.” Coincidentally, it was Frankie’s father who provided her the most support. The man who had previously been an alcoholic and an intravenous drug user, now came to the rescue of his daughter; the daughter who had followed in his footsteps. “He came up [to the city] shortly after he knew that I was drinking and using quite a bit. That is when he stayed with us and he was always here for my daughter.”

Frankie’s father lived with the family for several years. He ensured that Frankie’s daughter, and later on, Frankie’s son, were taken care of when their parents were using drugs. Frankie described the close relationship that developed between her daughter and her father. They spent a lot of time together. “He was a heavy equipment operator on the reserve before he came to stay [with us]. So she used to be in the back hoe with him and they would be driving around together. . . . It was actually pretty cute to see her in
there. . . . But I mean, them together, it was partners in crime . . . . They are still very close.”

Although their basic needs were met by their grandfather, Frankie recognized that her continued drug use impacted the children. “They don’t have your full attention. [My daughter] never had my full attention that she deserved as a child.” Frankie’s daughter was old enough to recognize that her parents were using. “She knows too much and she shouldn’t.” Frankie also had trouble providing for her family. All of her money was used to buy alcohol and drugs. “It was quite difficult, the financials.” But her family helped, purchasing what was needed for the children. The help that was provided by Frankie’s family did not go unnoticed. The children “went through so much like with not having their mom. I am so thankful for my family, my dad. If it wasn’t for them, I swear our babies would have been in care. I am so thankful for my family. . . . I feel very, very thankful, very lucky.” Even though the children were never removed from the home, there were times when Frankie was not the mother that she wanted to be for her family.

7.5 Mothering amongst the Addiction

Frankie’s drug use robbed her of precious time with her children and impacted the family. “It was hard to be a mom and use and drink . . . my daughter went through so much.” Frankie recognized that when she was using drugs, she was not actively present as a mother to her children. She wanted to do better. Motivated by the children, she entered drug treatment. But treatment was difficult for a young mother who had never been away from her family. “I didn’t complete it. I was way too lonely for my son. It was terrible. You can’t even call them or see them. Or anything. There is no contact . . . days with no contact.” A few days after beginning treatment, Frankie could not bear to
be away any longer and returned home to her family. She continued to struggle with addiction. Eventually, she did find a program to meet her needs. She attended treatment as an outpatient and returned home to her family each evening.

Frankie completed the treatment program. She now blamed herself for the impact her drug use had on the children, especially her daughter. Without the presence of drugs in her life, Frankie wanted to repair the damage she felt she had caused to her daughter.

“It affected her attitude. We’ve been working on getting her out of that attitude because she would act out; she would act out quite a bit. And there’s been a difference in her attitude since we have quit. She’s so much more happy.” Frankie is now working on abstaining from alcohol and drugs so that she can make a better life for her children.

“My kids were the main reason for quitting.”

Frankie also had other reasons for quitting. She perceived her drug use as the cause for her stillbirth. She blamed herself and she felt guilty. “The guilt is there. But I guess as time goes on it gets easier. . . but basically it’s all guilt for me, knowing that I should have done it differently.” Frankie was to have some investigations done to attempt to determine the cause of the stillbirth. She did not go for the tests. “But I got to go do that soon. Go and get some blood work done and they have a lab waiting on me. And a doctor is going to run some tests on me to find out what happened.” I suspected that the reason Frankie had not completed the tests was because she blamed herself and her drug use for the loss. She did not need any other confirmation.

When Frankie gave birth to her stillborn baby girl, she was instantly denied the chance to be the infant’s mother. In this sense, her addiction had deprived her of the opportunity to be a mother to this child. Frankie continued to struggle with her loss, but
with time she was healing. “Actually, the other day, was the first time I seen a baby girl. Well not the first time I seen a baby girl, but the first time I let myself see a baby. I always look away. You know, not try to pay attention. But I actually paid attention and I looked. And I smiled. It’s a part of my healing process, I guess.” Frankie is motivated by her children. “This little man, [referring to her son], it was impossible, it was hard to stay [depressed]; he really uplifted my spirits after the stillborn and it was impossible to stay depressed with him.” Frankie continues to move on for her children. “I don’t want them to have to go through what I went through.” She wants to create a better future for her family.

7.6 Moving Forward: Recreating Motherhood and the Family

    Frankie’s focus now is accepting her past and moving forward. “I can’t change my past. You know I can’t change, I have to walk through and I am healing . . . . You’re always going to be an addict and an alcoholic. The only thing you can do is accept it and move on.” But leaving the alcohol and drugs behind will not be easy. In order to be successful in their quest for abstinence, Frankie and her partner were forced to leave behind many family members and friends. They could not stay clean while surrounded by people who were using. “We broke ties with everybody. In fact, we even told them that we were quitting using. They know the struggle too and they’ve known enough to stay away and to not be in contact with us or anything. Cause they know how hard it would be if they were to come and try and come around.” In the absence of alcohol and drugs, Frankie and her partner were seeking ways to improve their lives.

    One of the opportunities that Frankie was pursuing was new housing. I remembered the first day that I drove up to the family home. I was surprised by the nice
neighbourhood that seemed to surround the house. The home, in disrepair, looked out of place in a quiet, family neighbourhood. But living in a nice neighbourhood meant that Frankie had to pay more in rent. She was looking for more affordable housing that would allow the family to have more money to spend each month. She had found a suitable home.

One day when I arrived to see Frankie, she had just returned from meeting with the owner of a potential new rental home. She described having to go through an interview process to see if her family was deemed to be suitable to live in the home. “I was really nervous about the interview because it’s a really nice home and I am hoping that we will get it. It’s also three hundred dollars cheaper than the home we are currently living in. . . . It is less [money] and it is bigger. And it is upstairs and downstairs. . . . There is an en suite with the master bedroom. It is really good.” Three hundred extra dollars a month would mean a lot for Frankie and her family. They were living in poverty. Three hundred dollars was a lot of money. It all seemed to be too good to be true; and in a way it was. The downfall of the new home was that it was located in a neighbourhood known for drug use and crime.

Frankie did not seem concerned about the location of the new home but I was worried for her. I was worried that she would not stay clean if she were to live in a community where she was suddenly surrounded by alcohol and drug use. She had purposefully severed all ties with her drug using family and friends and now she would be immersing herself back into that environment all over again. Frankie and her partner had thought about this and seemed to have a plan. “We were talking about that actually and basically I think it is just keeping to ourselves and if we do that we’ll be fine. I think
we’ll be fine.” Frankie had also found a recovery group that was located a block away from the new home. She felt the convenient location would encourage her to attend programming more often.

The one concern Frankie did have was related to the school that her daughter would have to attend. She did not want her children to go to school in the new neighbourhood. She felt they were currently attending a better school. But if the family were to move, there would be little choice. Frankie wanted to be able to drive her daughter to the current school but her driver’s license was suspended and she could not afford the fine to get it back. The family also no longer owned a vehicle. Frankie could not realistically pay for her license and find a reliable vehicle she could afford. Frankie and I both knew that if the family moved, her daughter would have to attend school in the new neighbourhood. Frankie was left to decide if this was the right decision for the future of her children.

Frankie and her partner were focused on beginning a new sober life together. They recognized that there would be challenges, but Frankie was choosing to focus on the positives and moving forward. Her partner was now working a construction job and although the job was not long term, Frankie was thankful for the extra money. Frankie was eagerly looking towards the future. “Right now I am in the process of business admin and the application process. I just need to get my transcripts and fax that away and see what the next step will be . . . . I can’t wait, if I get accepted into school . . . . I’m just excited to see this new chapter . . . going to school and maybe eventually getting a career for myself . . . . Maybe a possibility of social work.” Although Frankie was focused on
creating a future for herself and her family, she recognized that this would take time and that she also needed to improve the present.

Frankie was looking for short-term work. She was currently accessing an employment program but obtaining any kind of work through this program was not easy. “The things is, you have to be there at six o’clock in the morning in order to get a job. And even earlier because they are lined up outside, lined up outside. Everybody who goes doesn’t get a job. You have to be one of the first ones on the list in order to get a job. To get one. And then you get paid daily. It’s only minimum wage but it is a lot better than nothing. . . . I am going to use that [money] to help pay off my license.” I admired Frankie’s determination. Her circumstances were far from ideal, but she was doing the best she could to manage her present situation so she could improve her family’s future.

Together, Frankie and her partner are moving forward with a plan and with hope. “It’s a cycle of addiction and I want it to stop here with my family. With my children. So they don’t have to see that. And when they have babies, they won’t have to deal with it either. . . . I’m still kind of embarrassed about what our life got to. But I think we are both trying not to go there again. I mean we both had to go through hell with each other to get to this point. I mean we’ve been together seven years off and on, I think. I keep thinking there’s nothing bad, nothing worse than what we’ve already been through.” I hope that Frankie and her partner will successfully continue on the path that will take them to the better future they so decidedly want.

There came a point in my relationship with Frankie when we were revisiting the same stories. I felt that there were many more stories; deeply buried secret stories, that I
likely would never hear from a somewhat private and reserved young woman. Frankie talked about being to hell and back but I never really came to understand what that meant to her. And I respected that. Frankie had been open and honest with me to an extent, but I believed there was a lot more to her story. I wondered who knew these stories? Did anyone? Although Frankie had always willingly invited me to share time with her, I sensed she did not want to share any further details of her life with me. I began to feel that my presence took her back to times she did not really want to revisit. She knew that I was exploring pregnancy and addiction. My presence took her back to a time of heavy drug use and pregnancy loss. I did not want her to feel that she had to continue to revisit her painful past on my account. I sensed it was time to end our relationship.

Ending my relationship with Frankie was not as difficult as it had been with other women. I had not developed as strong of a bond with her. Nevertheless, it was not easy. I continue to wonder what happened to Frankie and her family. Did they decide to move to the new home? How are they managing in the new neighbourhood? Will there be more children? The not knowing is what is so hard. Our lives crossed paths through this research, and I heard some of Frankie’s story. My life will be forever changed because of her. My last memory of Frankie is from the rear view mirror of my car as I drove away from her family home for the last time. She stood holding her young son’s hand as he eagerly waved good-bye to me. In a way it feels as if I left them in the past. That, in my mind, they will forever be standing at the end of that driveway waving good-bye to me. It is easier for me this way. They are safe and they are together. The young woman and the sweet little boy who I came to know for a short time; forever etched in my memory standing together at the end of that driveway.
7.7 Making Sense of Frankie’s Narrative

As I think about the time I spent with Frankie, I am reminded of the many tensions she experienced. Frankie was often confronted with decisions that forced her to weigh the future of her family against her addiction. Similar to a tug of war, Frankie was pulled in opposing directions. She wanted to make decisions that would be best for her and her family but her addiction always threatened, pulling her in the opposite direction. I learned of some of the internal tensions that Frankie experienced: Ignore the pregnancy and continue with drug use or recognize the pregnancy and stop using? Enter drug treatment and leave the family behind or remain with the family and struggle to recover alone? Take prescribed methadone and watch the newborn withdraw or quit taking prescribed methadone and risk pregnancy loss? Continue to live in a desirable but expensive neighbourhood or move to a more affordable home surrounded by drugs and crime? These decisions had a moral component and were far from easy to make. She constantly struggled to make what seemed to be an impossible choice.

Every decision Frankie made was associated with guilt. She felt responsible for the harmful effects she perceived her drug use had caused for her children and her family. She blamed herself for the stillbirth of her daughter and for the withdrawal symptoms her other children had experienced. Yet she carried on. She was driven by the hope that the lives of herself and her family members could get better if she made the right decisions. I witnessed as Frankie experienced heartbreaking loss with the stillbirth of her daughter. Yet I also watched as she experienced small triumphs. With the support of her family, she was motivated to change her path, to return to school, and to secure employment so she could provide for her children. Frankie was motivated to re-story her life.
7.7.1 Acknowledging pregnancy and making decisions. Prior to her pregnancies, Frankie faced issues related to her addiction such as poverty and crime. Pregnancy represented yet another problem, a problem she did not want to face. In her exploration of the mental preparation during pregnancy in women with substance addictions, Soderstrom (2012) found that women experienced a delayed acknowledgement of pregnancy. However, as the pregnancy progressed, women in this study were eventually forced to recognize the increasingly difficult to ignore signs of pregnancy. Women were faced with subsequent decisions around what to do about the pregnancy and the addiction (Soderstrom). Some women chose to terminate their pregnancies while others continued with a plan to parent. When pregnancies continued, women were faced with decisions about their drug use (Soderstrom).

Although Frankie never identified that she considered ending any of her pregnancies, she experienced a tension related to continuing or stopping her drug use. Like women in the Soderstrom (2012) study, Frankie ignored her pregnancy for as long as she could. This allowed her to continue to use drugs without the associated guilt. However, there came a time when the pregnancy could no longer be ignored. Frankie was faced with a decision. She could continue to use drugs and risk giving birth to a baby that she perceived would be damaged by her drug use or she could stop using drugs. Frankie wanted to stop her drug use. Soderstrom found that pregnancy was a motivational time for drug using women. Pregnancy gave women the motivation to live, to decrease their drug use, and for some women, to eventually stop using drugs (Soderstrom). Despite Frankie’s desire to stop her drug use, it was not easy. She was constantly pulled back to drugs.
7.7.1.1 Entering treatment. One of the first tensions Frankie faced was related to entering treatment. Frankie wanted to begin a drug treatment program but she could not bear the thought of being away from her children. In their research that examined the barriers and motivators for substance abuse treatment among pregnant women, Jackson and Shannon (2012a; 2012b) found that issues with childcare and needing to be home with the family prevented women from accessing care. Similarly, Kruk and Banga (2011) found that women were hesitant to enter treatment when they could not bring their children along. Frankie struggled with her decision but eventually decided to try treatment. This meant leaving the children behind with their father and having little to no contact with them. Being separated from the children was too much for Frankie to manage. She returned home after only four days. Frankie tried to do the best she could for her pregnancy but an in-patient program that met her needs as a mother did not exist. Frankie needed to be with her children as she recovered. The program that was designed to help her had actually failed her as a mother.

Hiersteiner (2004) explored the experiences of mothers in recovery centers and how they view programs that include children in daily treatment. She identified that policy makers have long maintained that children should be in residence with their mothers. When children remain with their mothers, barriers to treatment are removed. Hiersteiner went on to say that keeping children with their mothers is in the best interest of the woman and her family. Women in this study had a wide variety of responses when asked about their experiences of having their children with them in recovery. Although they identified challenges with having to care for their children and share space with them, women identified that they preferred to have their children with them. When the
children were with their mothers, the women knew they were taken care of and were safe. Women did not have to fear being separated from their children (Hiersteiner).

Although Hiersteiner (2004) identified benefits of children attending treatment programs with their mothers, she also cautioned policy makers. Although women like Frankie may choose to have their children in residence with them, not all women may desire this approach to treatment. They may feel overburdened by attending treatment and providing care for their children. Hiersteiner stated “what began as a policy to better meet the needs of women and their children may inadvertently serve oppressive ends because it also assumes that all mothers should take care of their children all the time and at all costs” (p. 61). Regardless, women should, at the very least, be given the option.

For Frankie, bringing her children into recovery might have resulted in an earlier, more successful treatment regime. Instead, she was forced to return home early and her pregnancy continued on while she still used drugs. Frankie was determined. As a second option, her partner, also a substance user, attended treatment while she remained home with the children. When he returned home, he brought with him what he had learned and shared it with his wife. Later, Frankie did find and attend an outpatient program that allowed her to come home to her children every night. Although she was successful in completing this program, she identified physical stressors of travelling back and forth between treatment and home. Silva et al. (2012) have identified that when parents are engaged and committed to their recovery programs there is the least negative impact on the children and the family. For this reason alone, treatment programs that are practical and accessible should be available to all mothers.
7.7.1.2 Considering methadone treatment. A second tension that Frankie struggled with, in relation to her treatment, was whether she should take prescribed methadone. Radcliffe (2009) identified that women often seek methadone programs during pregnancy. The women in Radcliffe’s (2009) study felt that they were perceived by society as more acceptable mothers if they used methadone rather than illicit opiates. However, even though methadone was a prescribed drug, women continued to express medical and ethical concerns related to its use. Women felt they were negatively judged and worried about the effects of the drug on their newborns (Radcliffe, 2009). Frankie described similar feelings. She desperately wanted to stop taking methadone but she was worried about the risk of pregnancy loss and harming her baby.

Abruptly stopping methadone during pregnancy can cause fetal distress and subsequent miscarriage (Radcliffe, 2009). Conversely, newborns that have been exposed to methadone during pregnancy experience opiate withdrawal known as neonatal abstinence syndrome (NAS) (Radcliffe, 2009). Babies experiencing NAS show physical signs of suffering that can be distressing for mothers to watch (Haritavorn, 2016). This was the source of Frankie’s tension. If she stopped taking methadone, she was at risk for miscarriage but if she continued, her newborn was at risk for NAS. After weighing the pros and cons, Frankie decided to stop taking her methadone. A few days later she experienced signs of miscarriage. She was forced to turn back to methadone and risked helplessly watching the later symptoms of withdrawal in her newborn. From Frankie’s perspective, there was no winning; each decision carried equally negative potential outcomes. For Frankie, the guilt associated with methadone use was overwhelming.
7.7.2 Overwhelming guilt and self-blame. Feelings of guilt are not only associated with methadone use, especially when the drug user is a pregnant woman or mother. Haritavorn (2016) identified that women described feeling depressed and blamed themselves when their babies experienced withdrawal. Similarly, Fowler et al. (2014) and Hiersteiner (2004) found that women felt an overwhelming sense of guilt associated with their perception of not fulfilling their role as mother. In a sense, they felt as if they had abandoned their children and their families (Hiersteiner). Frankie spoke of this guilt but it was incomparable to the guilt and self-blame she experienced related to the stillbirth of her daughter. Frankie blamed herself and her drug use for her daughter’s death.

Addiction is associated with an increased rate of stillbirth (The Stillbirth Collaborative Research Network Writing Group, 2011). However, literature exploring the experiences of pregnant women who use drugs and experience stillbirth does not seem to exist. I suspect that because society does not view drug use during pregnancy as acceptable, the loss that these women experience is not recognized. Consequently, this population of women has been left out of relevant research. If health care professionals had a better understanding of the experiences of these women, better support could be offered as they journey through healing and recovery in their loss.

Frankie was overwhelmed with feelings of guilt and self-blame after the stillbirth of her daughter and she demonstrated symptoms of depression. But these feelings did not last long. Just as quickly as the depression had set in, I noticed a change in Frankie’s behavior. She was motivated to improve her future. She did not want to continue on her current path. She was driven to change her life and the lives of her family members by
leaving her addiction in the past. Frankie recognized that addiction had been a part of her life for as long as she could remember; addiction had been present in her family for generations. She did not want to continue this way. She wanted the cycle to stop with her.

7.7.3 Changing the future. Women interviewed by Torchalla et al. (2015) identified that patterns of trauma and addiction had existed with their parents and continued on into their lives. Trauma and addiction were passed from one generation to the next. Like Frankie, women in this study desired to stop the addiction and trauma cycle. Further research has supported the findings of Torchalla et al. In their study that explored problem drinking among mothers, Bohrman et al. (2017) found that women wanted to raise their children differently than they had been raised. Women interviewed by Couvrette et al. (2016) desired a traditional family that included a father, a mother, and the children. Couvrette et al. concluded that this desire represented the women’s aspirations to avoid the broken homes, violence, and parental addictions that they had been exposed to as children. They wanted to be better parents than their parents had been to them (Couvrette et al.). Lastly, Haritavor (2016) found that women desired to change their lifestyles so their children could have a better future. They did not want their children to grow up to be drug users too. The research is clear that women want to change their lives so that they can stop the generational pattern of trauma and addiction and improve the future for their children. The challenge the women face is successfully making this change amongst a past and present that knows nothing other than a life associated with addiction.
For many women, successful recovery meant distancing themselves from the physical place of their drug use (Cleveland et al., 2016). Frankie and her partner were forced to end relationships with their drug using family and friends. They lived in a neighbourhood where drug use was not common, but they considered moving to a new home where they would be surrounded by drugs and crime. Frankie recognized that this move would not support a drug free environment but she considered it anyway. She saw the financial savings that the new home would provide for her family as too good to pass on. Again, Frankie experienced tension. It was incredibly difficult for women like Frankie, who lived in poverty, to completely separate themselves from the drug subculture. She had a plan to continue to attend programs and recovery groups in the new neighbourhood and she recognized she would need the help of supportive family members and friends.

7.7.3.1 Support as pivotal to recovery. Frankie relied on her partner and family members for support. Soderstrom (2012) found that the partners and parents of drug using women often provided support that was pivotal to recovery. These positive relationships helped to improve women’s self-confidence and gave them hope for the future. The role of Frankie’s father was invaluable when Frankie was actively using and he continued to be an important part of her recovery. Several researchers identified that it was the women’s parents who often provided care for the children. (Banwell & Bammer, 2006; Haritavorn, 2016; Silva et al., 2012). Now in a period of recovery himself, Frankie’s father came to help his daughter when she was unable to care for her children. Unquestionably, it was his support that prevented Frankie’s children from being apprehended. Frankie’s father continued to provide support to the family in the present.
They would need his on-going support if they decided to move to the new neighbourhood where they would undoubtedly find themselves surrounded by drugs once again.

7.7.3.2 Hope for a better life. As my relationship with Frankie ended, she seemed to be in a transitional period of attempting to re-story her life. She wanted to leave her drug using life in the past and move towards a better future for herself and her family. For Frankie, her pregnancies held a higher meaning. She believed that her pregnancies were sent from her ancestors who preceded her. Each pregnancy was sent as motivation to change. In their exploration of the mothering experiences of women with substance use disorders, Cleveland et al. (2016) found that women believed their pregnancies held a higher meaning than just giving birth. Women in this study identified similar feelings as what Frankie described. They believed that their babies were sent from a higher power to help them decrease or stop their drug use. Moreover, women felt that if they had not become pregnant, they would have continued using drugs, never considering treatment or recovery (Cleveland et al.).

After the loss of her baby, Frankie had two choices. She could return to drug use or she could do what she believed her ancestors wanted; she could continue in her period of recovery and attempt to re-story her life. Frankie was choosing the latter and I hope that her attempt will be successful.

Hiersteiner (2004) found that women who attempted to re-story themselves required on-going support to help them live out their new narratives. If Frankie is going to be successful in making and sustaining positive changes in her life, she will need continued support. Frankie was also motivated by her children. She spoke of wanting to return to school so that she could get an education and secure a stable job that would
provide for her and her family. In their review of the literature, Bohrman et al. (2017) found that motherhood was often a motivational time that encouraged women to abstain from alcohol and drugs so they could return to school and get a job. Frankie was driven by what she saw as an opportunity to secure a better future. She recognized that the odds were against her, but she was willing to do almost anything that would help her to change the path she had previously taken. By re-storying her life, she had the opportunity to change not only her future, but the future of the generations that would come after her. Frankie was ready to stop the cycle.
CHAPTER EIGHT: Looking Across the Women’s Stories

Three women bravely and courageously allowed me to enter their lives so that others might come to understand what it is like to be pregnant amongst an addiction. The women, who each identified as having a history of substance addiction, invited me to live alongside them during their pregnancies. In varying ways, I became a part of the women’s lives, and in turn, they became a part of mine. I shared in the women’s stories as they navigated the complexities of pregnancy amongst an addiction. Each woman’s unique experience has contributed to my understanding of pregnancy, addiction, and subsequently, motherhood. In the preceding chapters, the women’s stories have been shared so that others may learn about the realities these three women faced. Their individual experiences contribute to our understanding of pregnancy and addiction.

Although there is value in sharing each woman’s individual story and learning from her experience, looking across all three of the women’s stories can further augment our understanding of this experience.

An exploration of the women’s experiences that looks across all three of their stories can contribute to a more comprehensive understanding of pregnancy and addiction. Although I will look across all three stories, I will engage in this process cautiously. I do not want to devalue the individual experience of each woman, nor do I want to discount the sacredness of each of their stories. Other methods of qualitative research look to derive common themes from individual experience (Clandinin, 2013). As a narrative inquirer, this is not my intent. I do not wish to synthesize the women’s experiences into categories, but rather explore the places of narrative coherence and
narrative tension that exist across all of the stories and intersect with what I personally have come to know about pregnancy and addiction (Clandinin).

8.1 Narrative Coherence and Narrative Tension

Typically in narrative inquiry, coherence and tension are terms that are used to discuss the relationships within one story (Clandinin, 2013). Places of coherence exist when stories flow seamlessly and do not bump up against what we have come to know individually (Carr, 1986). An example of narrative coherence was Tammy’s experience of bonding with her unborn baby. Tammy’s story tells of her showing off her growing belly and excitedly sharing her ultrasound pictures with me. This is a common story of pregnancy and is certainly coherent with the experiences of other mothers as well as with my own personal experience. Places of tension exist when stories do not flow seamlessly or bump up against what we have come to know individually (Clandinin). An example of narrative tension was my observation of Tammy’s difficulty in recalling the names and birth order of her children. This observation bumped up against my experience and what I had come to know about motherhood in my own life. It was not narratively coherent for me and caused me ongoing tension. I had to work within myself to reconcile this tension. Although I saw and experienced places of coherence and tension in the women’s individual stories, I also began to notice that these areas existed across the narratives.

It was during the time that I spent with the women and the period that I was immersed in each of their field texts that I came to further develop my own understanding of pregnancy and addiction. This understanding was compiled not only from the women’s individual experiences, but also from the areas of narrative coherence and tension that I found amongst their collective stories. I believe that there is value in
looking across all three of the women’s stories to understand these areas. In addition, there were places where the women’s stories bumped up against what I had come to know and understand through my own experiences of pregnancy and motherhood. I felt tension as my own stories and beliefs were challenged. By exploring areas of narrative coherence and tension across all of the stories, we can come to have a more insightful understanding of what pregnancy and addiction really was like for these three women. In doing so, some of the prevailing narratives around pregnancy and addiction are challenged.

8.2 Revisiting the Three-Dimensional Space

Until now, I have not explicitly situated the women’s stories within the three-dimensional inquiry space. However, temporality, sociality, and place are weaved throughout each of the women’s individual stories. As I look across all three of the women’s stories, I will use the three-dimensional inquiry space as a framework. For this reason, it might be useful to briefly revisit temporality, sociality, and place so the reader is reminded of how this framework is composed. Caine et al. (2013) provided a brief overview of temporality, sociality, and place. They stated that from a narrative view of experience, we attend to each of these within our own life stories and within the experiences of those who participate in our inquiries with us. Each story is also understood within larger cultural, social, familial, and institutional narratives (Caine et al., 2013).

Clandinin reminded us that “attending in temporal ways points inquirers toward the past, present, and future of people, places, things, and events under study” (2013, p. 39). When attending to sociality, narrative inquirers explore both the personal conditions
(of the researcher and participants) and the social aspects that impact the inquiry (Clandinin). Lastly, place is the physical space in which the inquiry takes place (Clandinin). I will attempt to situate the women’s collective stories within the three-dimensional inquiry space as well as in the larger cultural, social, familial, and institutional narratives in which they live. I will do this by thinking with stories rather than thinking about stories (Morris, 2002). When we think about stories, narrative becomes an object; however, when we think with stories, narrative becomes a process in which the stories begin to work on us as researchers (Morris). By thinking with stories, I am encouraged to attend to the women’s experiences from the three-dimensional inquiry space to develop a more complex understanding of pregnancy and addiction.

8.2.1 The nature of temporality. An obvious temporal dimension existed in all three of the women’s narratives. Their stories moved in and out of the past and the present and it very quickly became evident to me that the women’s past experiences impacted both the present and the future. Angel and Frankie each described a lifetime of stories of addiction. Their own addictions did not come first but rather it was their childhoods that first exposed them to alcohol and drugs. Addiction was the only life they had ever known. Tammy’s upbringing was different. She grew up in a home where addiction was not common, yet she somehow ended up on a similar path as Angel and Frankie. The past experiences of each woman likely contributed to their present addiction. Clearly, Angel and Frankie experienced addiction early on in their lives which likely contributed to their own problematic substance use. This was very different from Tammy’s experience. How was it that these three women had come to addiction so differently?
8.2.1.1 Coming to addiction through intergenerational trauma. I want to start by exploring Angel and Frankie’s upbringings. Angel and Frankie both identified as Indigenous women and were raised in Indigenous families. They described living in unstable homes where substance use, violence, and crime were common. This was present not only in their own childhood homes but had existed in their families for generations. Angel and Frankie experienced a deeply ingrained cultural and familial narrative that was likely a result of intergenerational trauma.

The terminology associated with intergenerational trauma was initially used to describe the experiences of Holocaust survivors; however, Brave Heart (1998) was the first to apply the concept to Indigenous peoples, describing symptoms of trauma such as depression and anxiety in a group of Lakota people. Menzies (2014) and Brave Heart both agree that intergenerational trauma occurs when trauma is left untreated. Bombay, Matheson, and Anisman (2009; 2014) further discussed the intergenerational trauma of Indigenous peoples in Canada. They stated that trauma often occurs at an individual level but can also occur within a collective group. They go on to state that when trauma occurs within a group, it can be present for generations and impacts the children and grandchildren of those affected. Indigenous peoples in Canada have been exposed to a shared collective of traumatic experiences through years of colonization and forced assimilation (Bombay et al., 2009). These traumatic experiences pose physical and psychological stressors that are associated with certain behaviours (Bombay et al., 2009). One of these behaviours is problematic substance use and many Indigenous communities continue to struggle in this area (Marsh, Coholic, Cote-Meeks, & Najavits, 2015; Marsh, Cote-Meek, Young, Najavits, & Toulouse, 2016; Maté, 2009; Menzies, 2014).
In selected studies of pregnant Canadian women with substance use disorders, about half of the women identified as Indigenous (Krausz, 2010; Kruk & Banga, 2011; Linden et al., 2013; Torchalla et al., 2015). In Canada, Indigenous peoples represent 4.9% of the population (Statistics Canada, 2017). Therefore, Indigenous women were over-represented in the study samples. This may be the result of Indigenous Canadians experiencing higher rates of heavy drinking when compared to other Canadians (Statistics Canada, 2015). Problematic drug use has also been identified as a major challenge for Indigenous communities (Canadian Centre on Substance Use and Addiction, 2017).

Angel and Frankie were the products of their environments. The story of intergenerational trauma was present within both of their families of origin. Their ancestors were direct survivors of colonization and forced assimilation which likely precipitated the generations of familial substance use disorders that continued to exist into the present. Over time, the destructive substance use had come to be accepted and almost normalized within Angel and Frankie’s families as a means of coping with trauma. This led to generation after generation of suffering from the same problem. Angel and Frankie’s personal stories of addiction unfolded from a larger cultural and familial narrative.

Angel and Frankie lived the intergenerational trauma that contributed to their own addictions. Their lives unfolded like so many of their family members who had gone before them. Now Angel and Frankie found themselves at a crossroad as they each looked towards the future. They were faced with a decision. They could change the future for their children by fighting against the trauma and addiction or they could revert
back to what they had always known; a life associated with substance use, violence, and crime. Angel and Frankie wanted to change the future but this would be a challenging process.

Generations of Angel and Frankie’s family members had suffered as a consequence of the trauma they experienced. Changing the future was far more complicated than changing their personal lives. Healing was needed not only at the individual level but also among the family and the Indigenous community. Indigenous communities can begin healing only when the underlying causes of addiction, including historical trauma and abuse are addressed (Ross et al., 2015). The Truth and Reconciliation Commission of Canada (TRC) (2015) identified 94 calls to action to address the intergenerational trauma, largely caused by the residential schooling of Indigenous peoples. If implemented, these calls to action provide an opportunity for reconciliation and healing. The women’s stories support opportunities to address and implement calls to action specifically related to health and child welfare. These opportunities are further discussed in Chapter Nine.

In an environment absent of reconciliation and healing, I worried that Angel and Frankie would not have the resilience to overcome the intergenerational trauma they had lived to create a different future for their own families. I do not know what the future holds for these women and their families. Will their children find themselves in a similar place one or two decades from now? Will the intergenerational trauma continue? What will it take to change the future for women like Angel and Frankie and their families?

8.2.1.2 Addiction that does not discriminate. Not all women come to addiction through intergenerational trauma. Addiction is not just a problem for Indigenous women.
Tammy identified as Caucasian. She suggested that her childhood was absent of problematic substance use yet she turned to addiction in what seemed to be such an innocent manner. Tempted once by a partner, Tammy was instantly drawn into a world where she was controlled by her addiction. I knew that addiction could happen to anyone regardless of race, class, or gender but it was Tammy who really taught me that addiction does not discriminate; it can cunningly enter the life of any unsuspecting individual.

Drug using women in selected studies were found to be generally unemployed, had less than a high school education, and were living at a low socioeconomic level (Jackson & Shannon, 2012a; 2012b; Krausz, 2010; Linden et al., 2013; Murphy & Rosenbaum, 1999; Torchalla et al., 2015). However, it is unlikely that this sample represents an accurate picture of all pregnant women with substance use disorders. The prevalence of drug use and abuse is rising in Canada (Government of Canada, 2015). Among women of childbearing age in Canada (15-44 years), 76.7% reported using alcohol, almost 11% used cannabis, and over 2% had used illicit drugs in the past year (Health Canada, 2012). In 2015, 10% of women reported they had used one of six illicit drugs in the previous year (Government of Canada). Although these statistics represent usage in the past year and not solely substance use disorders, it may be hypothesized that they cut through all socioeconomic strata. Middle and upper class women with substance use disorders may be underrepresented in the research because they do not require the same support and resources that are needed by underprivileged women. This may make them less likely to reveal their drug use.

Tammy’s addiction strongly influenced both her present and her future. It was because of her addiction that she had to constantly fight for her children and prove that
she could be an on-going mother to them. Like the other women, Tammy was in a period of recovery now and she desperately wanted to recreate her family. She was willing to fight against her addiction so she could improve the future for herself and her children.

8.2.1.3 Addiction interrupted by pregnancy. The three women, who agreed to share their stories with me, were all pregnant when I entered into their lives. I suppose this was a given provided that I was seeking women who were pregnant with a history of addiction to engage in this project with me. What I found to be somewhat out of the ordinary was that all three of the women were in a period of attempting to recover from their drug use. I understood from the literature that pregnancy was a motivational time for substance using women to seek care out of concern for their unborn baby (Bohrman et al., 2017; Couvrette et al., 2016; Haritavorn, 2016; Jackson & Shannon, 2012b; Jessup & Brindis, 2005; Krausz, 2010; Kruk & Banga, 2011; Murphy & Rosenbaum, 1999; Radcliffe, 2009; Silva et al., 2012; Soderstrom, 2012). However, this bumped up against the stories that I lived in my clinical practice.

As a registered nurse, who worked with pregnant women, I had come across many women in my practice who were actively using drugs. My practical knowledge (Clandinin & Connelley, 1996) was not narratively coherent with what I experienced in my research or what I had found in the literature. Over the past several months, I have reflected on this observation and have come to wonder if the actively using women that I have met in my practice are in fact a minority. Perhaps the women who are actively using drugs in their pregnancies are relatively small compared to the number of women who are attempting to decrease or stop their drug use. Perhaps, it is the actively using women who are highlighted in my memories because their drug using behavior is in stark
contrast to what is accepted as the norm both by me and by society. Or perhaps many pregnant women with a history of substance use are mistakenly labeled by health care professionals as actively using with no attempt to decrease or stop their use. Nonetheless, I have come to see that two very different groups of women with addictions exist during pregnancy.

One group of women is actively using drugs with no intention of decreasing or stopping their use. The second, and perhaps the substantially larger group, is the one that includes women like Tammy, Angel, and Frankie. These women require much different support and resources than the women who continue to actively use. Through my relationships with Tammy, Angel, and Frankie, my practical knowledge has been challenged and is now more aligned with the professional knowledge that Clandinin and Connelley (1996) described as that which is developed by researchers, policy makers, and administrators. I have learned that women with substance addictions often do attempt to decrease or stop their drug use. I witnessed the motivation and determination that Tammy, Angel, and Frankie each had during their pregnancies.

8.2.1.4 Addiction after pregnancy. As I spent time with the women and learned about their past pregnancies, I found that for all three of the women, their periods of abstinence or decreased drug use were short lived after pregnancy. Tammy described avoiding alcohol and drugs when she was pregnant. However, once the pregnancy ended, she returned to drug use. Tammy’s story included a time period of seven years between two of her pregnancies. She described this as a time of heavy drug use and crime. Yet somehow, at the end of the seven years, when Tammy found herself pregnant once again, she successfully decreased her drug use. Angel described a similar story. Even when her
first pregnancy was diagnosed in the third trimester, she attempted to decrease her drug use. However, once her baby was born, she returned to drugs. Pregnancy was also a motivational time for Frankie. Long periods of alcohol and drug use were interrupted by pregnancy. Frankie even entered treatment during her pregnancy. Like the others, each time she was faced with a pregnancy, she was successful in decreasing or stopping her use. This was not narratively coherent for me. I wondered how the women were able to decrease or stop their drug use with each pregnancy and why they often returned to drugs after the births of their babies.

In an exploration of the collective stories of the women, I have noticed that when each woman returned to drugs, it seemed to be triggered by a stressful event. As examples, when the women faced the deaths of loved ones, the apprehension of their children, or when they experienced a lack of bonding with their babies, they returned to drugs. The women demonstrated a very low tolerance for stressful experiences. I was beginning to understand why the women often returned to drugs after birth. The only means of coping they knew was drug use. As a result, their time of sobriety was very fragile and they temporally shifted in and out of periods of drug use. The women were in a constant struggle with their addiction. The social conditions they faced around addiction, pregnancy, and motherhood also seemed to impact their drug use. These aspects can be explored under the three-dimensional component of sociality.

8.2.2 The nature of sociality. When I began this research, I expected to explore stories of pregnancy and addiction. As I developed relationships with the women, I very quickly found that their stories were about much more than just pregnancy and addiction. I realized that I was naïve to think that other aspects of their lives would cease to be
important in the presence of pregnancy. The women were all mothers and their stories truly were about motherhood. Through each of their stories, we have learned that the women were denied motherhood, in varying forms, as a result of their addictions. I witnessed first-hand the determination that these three women possessed in their attempts to reclaim their motherhood and recreate their families. But it was not easy. Their history of addiction and the societal views associated with pregnancy, motherhood, and drug use, made it challenging for the women to be the mothers they desired to be.

8.2.2.1 Motherhood and addiction. It was Tammy who first introduced me to the complexities associated with being a mother in the presence of addiction. Perhaps this was because Tammy had been a mother prior to her addiction. Before her drug use, Tammy described herself as a good mother who cared for her own children, for foster children, and for children with special needs. But when addiction entered her life, Tammy saw her ability to be a good mother fade away. All of her children were eventually removed from her care. It was the stark contrast between the good mother that Tammy described herself as once being and the failure that she currently saw herself that highlighted the complexities that women like Tammy navigate in their quests for motherhood amongst an addiction. During the time I spent with Tammy, I heard her stories and I watched first-hand as she fought for her motherhood.

I witnessed similar stories of determination in Angel and Frankie’s experiences. Angel had intermittently parented her first three children before they were permanently apprehended. She described that she would do anything to get them back. Although Frankie had always retained custody of her children, she recognized that she had missed out on precious time with them because of her drug use. She also blamed her drug use as
the cause of her stillbirth. She believed that it was her addiction that had robbed her of
the chance to be a mother to this baby. Frankie was determined to change her life so that
she could be a better mother to her children.

As I reflected on motherhood and how it was constructed for these three women, I
saw that the women were caught in an in between place; a transitional state of
motherhood where they wanted to be mothers again but were not yet fully reincorporated
into this narrative. I saw glimpses of this in Frankie’s story as she attempted to reclaim
her motherhood after stillbirth. But it was in Tammy and Angel’s stories where this
phenomenon was highlighted most. Tammy and Angel were previously mothers to their
children but now, as a consequence of state defined motherhood, they struggled to
reclaim what they had once been. I listened as the women told stories of not being
allowed to mother their children while the children were in foster care. Sometimes these
stories were very simple. Tammy only wanted to allow her daughter to have her
Halloween bucket, but this was not allowed in the foster home. Sometimes the stories
were more complex. Angel was forced to watch as her son was cared for in a way she
perceived to be unsafe and caused damage to his head. The women were powerless.
They were caught in an in between place where they were mothers, yet they were not
mothers.

8.2.2.2 A mother but not a mother. Van Gennep (1960) first described rites of
passage with three phases. He identified that in the first phase, individuals separated
from their current status. In this case, Tammy and Angel were separated from their
motherhood when their children were apprehended. The second stage, the liminal phase
is a process of transition as individuals move towards the third phase where they
reincorporate into society with a new status (Van Gennep). The liminal phase is perhaps the most significant to this discussion because it represents the stage where the women seemed to be located. Turner (1969) built on the work of Van Gennep to further explore the concept of liminality. Turner described the liminal phase as an ambiguous state where individuals are “neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremonial” (p. 95). The women were in a liminal space with respect to their motherhood. They were mothers, yet they were not allowed to be the mothers they wanted to be as a result of the conditions that were placed upon them and the power that the state had over them.

All three women wanted to be mothers to their children. Their past history of addiction played a role in preventing them from being mothers but there were also other factors. Certainly there were times when the women were heavily using substances. They identified that they could not provide for their children during these times. Research exploring the experiences of mothers who use drugs has had similar findings (Banwell & Bammer, 2006; Haritavorn, 2016; Martin et al., 2011). However, heavy drug use was only part of the women’s stories. There were many times when the women were not actively using substances and wanted to be mothers to their children. During these times, it was not their drug use that prevented them from being mothers but rather a social narrative that viewed drug using women as incapable and allowed the state to control their motherhood and enact a conditional motherhood.

8.2.2.3 A social narrative precluding motherhood. Mother and addict are two titles that typically do not go together. I witnessed this in my practice as a registered nurse. I noticed that when women admitted to using substances during pregnancy they
were frequently treated differently than other women. It was common for me to observe women being judged and ostracized within the acute care setting. I listened as health care professionals made negative comments when they thought the women were not listening. Findings in the research support my experiences. Lefebvre et al. (2010) and Radcliffe (2009) both explored the pregnancy care experiences of women who use drugs. Women in these studies described feeling stigmatized and experienced communication they perceived to be judgmental. Perhaps the way the women were treated was rooted in a complex social narrative that suggested women who used drugs should not become pregnant.

Pregnant women are expected to care for and protect their unborn children by committing to a lifestyle that includes only the healthiest of behaviours (Kropp et al., 2010; Lewallen, 2004; Murphy & Rosenbaum, 1999). The use of alcohol or drugs is regarded as irresponsible and precludes a healthy pregnancy (Kropp et al.; Lewallen; Murphy & Rosenbaum). As a result, women who use alcohol or drugs while pregnant are viewed as failures in their reproductive role and are frequently among the most stigmatized and victimized groups in society (Boyd, 1999; Finnegan, 2010, 2013; Murphy & Rosenbaum).

This story was narratively coherent for me. I had witnessed the negative treatment of women in my practice and I had heard the stories of Tammy, Angel, and Frankie. Yet I felt conflicted. The social narrative that seemed to prohibit drug using women from being mothers to their children did not sit well with me. Because of Tammy, Angel, and Frankie, I learned that women desperately wanted to be mothers despite their history of addiction. I witnessed how the women interacted and provided
for their children. I believed they could be good mothers if they were given the opportunity and provided with individualized, supportive resources. However, this was not what I witnessed in my experience with the women.

8.2.2.4 Surveillance and power. Tammy and Angel told slightly different stories of motherhood when compared to Frankie. I believed this was because their children had been apprehended in the past. Because of their history, Tammy and Angel were under constant surveillance from the state and they had to prove they could adequately mother their own children. As a result, their motherhood was conditional on meeting state mandated requirements. If the requirements meant attending a multitude of programs, even if the programs did not meet their needs, the women obliged. If the requirements meant providing weekly urine drugs screens, the women obliged. If the requirements meant reliving their story over and over again to health care professionals, counselors, and random workers who showed up at their door, the women obliged. Truthfully, the women did not have a choice. If they wanted to mother their children they had to do as they were told. The state held power over them and ostensibly dictated their every move.

The work the women were forced to demonstrate as mothers was not specific to this narrative inquiry. Radcliffe (2009) found that women underwent considerable work to prove they could be good mothers. This meant attending a multitude of appointments, providing drug screens, and following treatment plans (Radcliffe, 2009). Women were expected to adhere to state mandated programs and treatment. Those who were not compliant would be punished through closer surveillance or child apprehension. In her work that explored the governance of female drug users, Du Rose (2015) discussed state imposed surveillance as a technology of power. Technologies of power are the means in
which government authorities use programs, techniques, and tactics to control people (Foucault, 2000 [1982]). Du Rose identified prohibition and punishment, medicalisation, and welfarisation as the key techniques used to govern female drug users. Foucault refers to these types of techniques as “technologies of domination” (Foucault, 2000 [1982], p.225). These types of power practices are used to control behavior (Du Rose).

The technology of prohibition is used to control the use of certain drugs by law (Du Rose, 2015). In 1961, the Single Convention on Narcotic Drugs created the drug treaties aimed at internationally abolishing the use of all illicit drugs (Room & Reuter, 2012). As a result, emphasis was placed on drug prohibition, or a political policy of a War on Drugs. Policies of prohibition have not contributed to decreased drug use but instead have resulted in the spread of diseases associated with drug use and have increased the number of individuals incarcerated for drug related charges (Du Rose; Room & Reuter). Pregnant women are not exempt from these consequences. The prohibition of drugs has greatly increased the number of women, especially minority women, incarcerated for drug use and is responsible for the rising child apprehension rates (Boyd, 2004; Bush-Baskette, 2000; Du Rose). Instead of discouraging drug use, prohibition has been economically and socially destructive (Maté, 2009).

Medicalisation has led to non-medical problems coming to be defined and treated as medical issues and is deeply ingrained in the disease model of addiction (Du Rose, 2015). Tammy, Angel, and Frankie all lived in poverty. Du Rose identified that “medicalization operates as a form of social control and regulation whereby social structural issues, such as poverty and social inequalities, are individualized and regarded as symptoms of a disease” (91). In this way, the extreme poverty faced by the women
was blamed on their drug use rather than on a larger social problem. The women were seen to be responsible for their social predicaments.

Welfarisation is a technology of power that constructs individuals as needing support or as not being worthy of the resources offered to others (Du Rose, 2015). Female drug users are governed under this process and I observed parallels in the women’s stories. Tammy was especially controlled by welfarisation. We saw over and over again how she was required to adhere to the programs and resources that were designed to support her. However, these mechanisms were rarely supportive and more often were used as a form of surveillance that led to control over her. When Tammy did not comply, there were consequences. When she overslept and missed a program, she was subjected to closer surveillance. Every move Tammy made was closely observed; she was at the mercy of a system that was supposed to support her but instead controlled her. The forced participation was not helpful for Tammy; instead it was intrusive, coercive, and punitive (Du Rose).

The literature, coupled with my experiences with the women, caused me to question the rationale for the state imposed power over the women. The state was always lurking in the background, seemingly waiting for the women to make one mistake, one bad decision, that would provide evidence that they fit the social narrative; that they were unfit mothers, incapable of caring for their own children. I questioned: Did the state not want these women to be mothers? I actually did not think this was the case, but rather the motive for the constant surveillance came from a different place. The state was there to protect the children and to ensure their needs were met. But this was done at a cost to the mothers. This story existed because of a social narrative that suggested drug using
women were unfit mothers. As a result, it was perceived by society as acceptable for an institution to have constant surveillance over women. The state was there, patiently waiting for the time when the women would undoubtedly make a mistake. Instead of being supportive, the state would swoop in and save the children. But apprehending the children came with a terrible cost; a cost to the mothers, to the children, and to society.

8.2.2.5 The cost of apprehension. Child apprehension is harmful to women and children and is associated with significant economic costs (Cleveland et al., 2016; Fowler et al., 2014; Grant et al., 2011). Cleveland et al. found that women frequently returned to heavy drug use when their children were removed from their care. This was true for both Tammy and Angel. They returned to heavy alcohol and drug use when their children were apprehended. Yet when the children remained in their care, the women were motivated to abstain. I watched as Tammy attempted to get custody of her two year old and unborn baby. Her desire to have her children in her care outweighed her cravings to use drugs. When Angel gave birth to her fourth baby, she took her baby home from the hospital. She described being motivated by taking her baby home and that her baby kept her happy and sober.

When women with a history of addiction take their babies home from the hospital or get custody of previously apprehended children, they need to be provided with support that is individualized to their needs. This was exemplified in the women’s stories. Angel described a time when she attempted to get custody of her oldest three children. Things were going well for Angel and her partner until they were given custody of the children without a lot of accompanying support. Providing for all three children without support was too much for the couple to manage and they relapsed. The children were removed
from their care. Angel identified that she had been able to later maintain custody of her youngest daughter because she knew where to seek support this time. She did not want to make the same mistakes she had made in the past and risk having her daughter apprehended. I noticed that it was Angel herself who sought out the support she felt she required. Although Frankie never lost custody of her children, she identified this was only because her family had supported her. She believed that if her family had not supported her during her time of heavy drug use, her children definitely would have been apprehended.

Tammy struggled to maintain custody of her children. This might be associated with the lack of support she experienced and the poor resources she was forced to rely on. Tammy and her partner had an unstable relationship. Yet, as a condition of her maintaining custody of her newborn, her partner had to support her and the baby at night. This was an impossible condition. As a result, Tammy experienced stress and anxiety when she felt her relationship with her partner was potentially ending. Tammy really had no one to turn to for support. When she left her newborn with someone she considered a friend while she went out to complete a few errands, the custody of her newborn was put into jeopardy. Tammy risked losing her baby because of her lack of support.

All Tammy wanted was to have her children in her care. With every child that was apprehended, she saw herself as a failure. Yet with every new pregnancy, she saw another opportunity to be a mother. When children are removed from their mother, a desire to have a replacement baby can occur (Grant et al., 2011). For women like Tammy, their only means for fighting against the apprehension of their children is to
have another baby. Often times, this results in subsequent children being apprehended, compounding the already significant cost to the economic system (Grant et al.).

Given the harmful effects on the child, mother, and family of removing children from the home and the associated economic costs, apprehension might be considered only as a last resort. I make this statement cautiously, as I do not want to imply that children should be left in dangerous environments. However, when the risk of removing children from their mother outweighs the risk of leaving them in the home, careful consideration of the available resources might occur so that families can be supported in staying together.

There are harmful effects of removing children from the home. The goal of care providers should be to avoid apprehension and the associated disruption to the family that can cause long lasting negative effects. Earlier, I identified that there are two groups of drug using women in pregnancy. One group continues to use drugs with no intention of decreasing or stopping their use. We have learned from the literature and from the accounts of Tammy, Angel, and Frankie, that these women are unable to adequately care for their children during this time. But when women are ready to decrease or stop their drug use and mother their children, they need to be provided with the supportive resources that will help them to be successful in keeping their children. I think it is time that we reconsider who the substance using woman is and begin to see her as a mother who requires support rather than as a woman incapable of caring for her children.

8.2.2.6 Guilt and self-blame. Threaded throughout each of the women’s stories was a common burden they all experienced. In varying ways, each woman described feeling guilty and blamed herself for the impact her drug use had on her family. This
common narrative of guilt and self-blame was supported by the literature. Women felt a sense of guilt when they were unable to fulfill their role as mother and could not provide for their families (Fowler et al., 2014; Hiersteiner, 2004). The women perceived their addictions as having a negative effect on their children. When the women used drugs during pregnancy, they felt guilty knowing their drug use impacted their newborns. Angel blamed herself when her first baby was born smaller than expected with a heart murmur. Frankie shared feelings of guilt for harming the life inside of her and she blamed herself and her drug use for the stillbirth of her daughter. Tammy’s young daughter had a learning disability. Tammy blamed herself for this and openly discussed her perception that she had damaged her daughter.

Angel and Frankie both used methadone in their pregnancies. After the birth of their children, they were forced to watch as their newborns experienced withdrawal symptoms. The women blamed themselves for taking a medication that helped them manage their own addiction symptoms. Their babies shook uncontrollably and had inconsolable high-pitched cries. Watching their babies withdraw was hard and they felt responsible.

As the children grew older, the women continued to feel guilty about how they had not adequately provided for their children during periods of heavy drug use. When they were using drugs, the women could only provide the very basic necessities for their children. Higher level needs such as love and belonging were most often not met. The women suggested that their social situations and the poverty they currently experienced were a result of their drug use. All of the women wished they could go back; that they could reverse time and stop the drug use before it started. But they could not undo what
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had already been done. Now they were forced to live with the guilt and self-blame related to the consequences they felt their children and families experienced as a result of their drug use.

Although the guilt and self-blame the women experienced was profound, I sensed that there was something else to their stories; something deeper that helped them manage their guilt and self-blame. Lament has been defined as a passionate expression of grief that is often born out of regret (Oxford dictionary, 2017). Nursing research has not explored the concept of lament. However, in their 2005 study that explored the caring expressions of surgical nurses, Enns and Gregory, identified a major theme of lamentation among surgical nurses. They described lament as “an expression of grief and mourning” (p. 339). Threaded throughout each of the women’s stories were accounts of lament.

Tammy lamented when she said “and he has a bit of some learning disabilities. I blame myself for it. But, I don’t know, it’s just you struggle, between, you know, your baby is going to be okay, it’s not going to affect the baby. Just because you have one child who came through and even though you used drugs and it’s fine, doesn’t mean the rest are. Because, I mean, I took that chance. And I wrecked my child, my children.”

Angel said “I just see the big difference and I really regret that. . . . I don’t want to do that again. . . . I don’t ever want to have to go through that again. I don’t want to put my baby [through that]. She’s used to everyday, going to the fridge, grabbing her little yoghurt, grabbing her treats. She’s used to that and I don’t want to be where I was when I was high.” And Frankie said “I feel remorse for everything I done to my girl and to my unborn child . . . knowing that I had this little life inside of me. And you know, it’s not
right to ignore it in the first place. It’s what I should have done from the start. So much would haves and should haves. . . . The guilt is there. . . . It’s all guilt for me. Knowing that I should have done it differently.”

These examples represent only one of each of the women’s many accounts of lament. The women experienced overwhelming loss; loss of their children; loss of their motherhood; loss of the hopes and dreams they had for healthy children. Through their laments, they were able to manage their losses. The women blamed themselves for the losses they experienced in the past and they felt guilty. They managed their sorrow and guilt by holding on to hope for the future; a future where their families would be reunited and where they would attempt to reclaim their motherhood.

8.2.2.7 Addiction as an animate being. As I spent time immersed in the field texts, I noticed something unique in Frankie’s story. She referred to her addiction as an outside force. She spoke about it like it was somewhat of a living thing; a monster that entered her life that she had little control over. She repeatedly referred to her addiction and drug use as an “it,” like her addiction was somehow infused with a life force. I first noticed this in her statements: “It took everything away, your morals, everything is completely gone. . . . Cause when we were coming down that’s when we really wanted it so bad and we would do anything to get it” . . . “But it’s just the addiction. . . . It will change a person completely. In and out. They will do things that they wouldn’t normally do had they not been using. You lose all self-respect. Your morals. Everything. And you will do everything to get it.” . . “It just takes everything away from you and the first time you try it you’re pretty much gone.” According to Frankie, she did not control her addiction; it was an outside force that controlled her.
I wanted to better understand how Frankie constructed her addiction. I told her how I was coming to understand addiction through her story and I asked her thoughts. Although she mentioned other forms of addiction models, such as the biomedical model and addiction as a disease, she continued to refer to her addiction as this animate being; like it was always there, lurking in the background, waiting to attack. She spoke about trying to quit using drugs but that the addiction was everywhere she went. “It feels like when you first quit that it comes around. You try and get away from it but it sucks you back . . . It just finds a place to, I swear, it just finds ways to just carry you back into it.”

In reflection now, I see a parallel between Frankie’s construction of addiction and how Indigenous peoples have come to understand other conditions. The story of Nanabush and the Stranger (McLeod, 1982) used a metaphor that has helped Indigenous peoples to understand diabetes. The story tells of Nanabush’s first encounter with a personified character named Diabetes. Diabetes tells Nanabush about himself and this is how Nanabush comes to understand Diabetes (Hagey, 1984). Frankie seemed to construct her addiction metaphorically. Although this finding was only noted in Frankie’s story, I wondered if it was common to other Indigenous women who experience addiction. Future research might explore how addiction is constructed by Indigenous women.

8.2.3 The nature of place. As I prepared to enter this inquiry, I did not expect place to be a significant factor in the women’s lives. I imagined the project unfolding under more of a two-dimensional framework of temporality and sociality. I came to this research with an understanding from the literature that the women’s lives would unfold temporally; that their stories would likely transition in and out of the past, present, and
future as we explored the people, places, things, and events under study (Clandinin, 2013). I also brought my own experiences to the research. As a person, woman, mother, and registered nurse, I had my own understanding of pregnancy and addiction. I recognized that I would need to attend not only to the personal conditions, of myself and the women, but also to the significant social conditions as the women’s stories unfolded (Clandinin). I wondered how place would fit into the inquiry.

**8.2.3.1 Places of interview and conversation.** As I expected, the women’s stories and experiences occurred within temporal and social dimensions. At first, I did not recognize the importance of place to the women. In my attempt to think narratively, I was constantly reflecting on the three-dimensional inquiry space; trying to force the significance of place. I started to think about the places in which the women and I met. Were these places significant? In a way, I suppose they were. The interactions I initially had with the women reflected a format similar to an interview. These initial conversations took place in small meeting rooms where the women also attended formal appointments with their health care professionals. The women likely viewed their initial meetings with me as another appointment with another health care professional. This created a very formal aspect to initial conversations. As I got to know the women and our relationships developed and moved to other places, the conversations became more comfortable. The increasingly comfortable conversations were likely a result of developing relationships, but the places our meetings occurred were also significant. As the meetings moved to more comfortable places, such as the women’s homes or yards, the women were more relaxed and the conversations flowed much more easily. Some of the best conversations I had with Tammy occurred as we travelled to different places in
my vehicle. The places that I interacted with the women were important and contributed to the depth of the experiences and stories they chose to share with me. However, as I got to know the women more and shared in their stories, I came to see another very important aspect of place in their lives.

8.2.3.2 The physical and social environment. I did not initially notice the impact of both the physical and social aspects of the environments that surrounded the women. However, as I got to know the women and hear more about their lives, I learned that the environment they were immersed in was an important aspect of their stories. Martin et al. (2011) found that mothers who experienced addiction were impacted by both the social and physical environment in which they lived. They suggested that addiction and environment were tangled together making it almost impossible for women to extract themselves from the lifestyle of addiction (Martin et al.). All three women similarly described living in an environment intertwined with addiction.

The physical places the women lived were potential triggers for their drug use. Tammy and Angel both lived in neighbourhoods where drug use and drug trafficking were common. The drug trafficking was so close to Tammy’s house that she could watch it occurring right outside her own front window. I pictured Tammy sitting in that front window, watching the drugs go up and down the street; only a pane of glass separating her recovery from her relapse. I was also shocked to find out that the house Tammy currently lived was a place she had previously come to use drugs. Tammy was forced to raise her family in a place where her memories took her back to times of heavy drug use. Angel described moving multiple times in her attempt to escape drugs. However, every move she made was still within the perimeter of a drug using neighbourhood. The
physical places in which the women lived proved to be constant reminders of their drug use even when they were not actively using. These places constantly provided the women with the temptation to use.

Some might question why the women would not simply move away from the places in which they were surrounded by drugs. Tammy spoke in desperation about trying to find a new home but affordable housing was not accessible to her. Cleveland et al. (2016) suggested that women needed to create physical distance between themselves and their drug using environments. But in truth, this was nearly impossible. The women were like prisoners in their own environments. All three of the women’s lives were complicated by poverty. Banwell and Bammer (2006) found that mothers who used drugs frequently experienced financial insecurity. To say the women experienced financial insecurity is a stark understatement to the dire poverty they lived. When I first met Tammy, she lived in a mouse infested home and later considered moving into a house with no running water. Living in a neighbourhood without drugs was not practical or even possible for her. She barely had enough financial resources to live in a house that provided the basic necessities to maintain human life.

Unlike the other two women, Frankie lived in a neighbourhood where drug use was not as prevalent. But living in a well-kept, family neighbourhood came with a monetary cost. Frankie could not afford the costly rent and was considering moving back to a more affordable neighborhood where she knew she would once again be surrounded by drugs.

The social environments associated with the physical places where the women lived influenced their stories of addiction. Within their physical environments, the
women were constantly surrounded by people who were using drugs. Family, friends, and roommates provided the women with the constant temptation to use. Often, the women did not even have to leave their homes to get drugs. The drugs came to them when family members and friends arrived to their homes. Angel described feeling like drugs followed her everywhere she went. If the women wanted to abstain from alcohol and drug use, they were forced to sever ties with their drug using family and friends.

In their exploration of the mothering experiences of women with substance use disorders, Cleveland et al. (2016) described similar findings. Women in this study described needing to get away from the neighbourhoods and the people who used drugs. In their attempts to recover and become good mothers to their children, all three women had distanced themselves from the social environments that contributed to their drug use. Although this was helpful in creating a distance from drugs, it left the women feeling lonely and isolated. The women’s social systems were built into their drug using lives. Their attempts to abstain from alcohol and drugs meant giving up their social networks. No matter what decision the women made, there simply was no winning; adversity faced them with every step they took. Yet, they continued on, committed to changing their lives and writing a new story for their futures.
CHAPTER NINE: Learning from the Women’s Narratives

I came to this research with questions that helped to form my research puzzle. My knowledge of the existing literature and my practice as a registered nurse contributed to my wonders about pregnant women with substance use disorders. As a reminder, my wonders from the outset of this inquiry were two-fold. Firstly, I wondered how pregnancy and addiction were situated within a much bigger picture of life experience. Secondly, I wondered what stories the women would tell of their experiences with health care professionals and how these narratives might differ across different settings such as the community and acute care. I suggested that exploring the women’s experiences might contribute to an understanding of the narratives that shape their lives and that this understanding might help to shift how care is provided for this population. It very quickly became evident that the experience of addiction during pregnancy did not occur in a silo, independent of other life events. The women’s stories revealed that pregnancy and addiction were only very small pieces in a much bigger picture of motherhood and of life. The women did not focus solely on their experiences with health care professionals; rather their experiences were told in a much broader context of their lives and intersected with multiple professions.

As I think about what can be learned from the women’s narratives, I cautiously place the women’s lives in the context of addiction because I do not want the women to be defined solely by their history of drug use; these women were so much more than just drug users. However, every part of their lives was touched by addiction, creating a tangled web that makes it impossible to separate the addiction from the life lived. The stories that Tammy, Angel, and Frankie each shared highlighted the complexities they
experienced as they navigated through life with an addiction. There is so much that we, as professionals and as a society, can learn from the experiences of these three women. Most importantly, we have learned that change is needed. Women with substance use disorders who become pregnant and subsequently mothers, need to be supported rather than judged. The existing perception that women who use drugs are unfit mothers needs to be dispelled so that when they are ready, women can be supported to successfully raise their children. Addressing and making changes in the areas of practice, research, education, and policy will help to create environments that are more supportive for the women.

Narrative inquiries must be justified at a personal, practical, and social level (Clandinin, 2013). Caine et al., 2017a reminded me that when we live alongside people and write research texts, we become awake to the possibilities of shifting lives and institutional narratives. I have justified the research at a personal level, identifying why this research was important to me (Clandinin) as I explored my own narrative beginnings. As I explore opportunities for practice, research, education, and policy, I will attend to the practical justifications (opportunities for practice), or the possibility of shifting or changing practice, and the social justifications (opportunities for research, education, and policy), concerned with situating the work in terms of new disciplinary knowledge (Clandinin). Through the personal, practical, and social justifications of this research, we can begin to shift the existing perceptions of pregnant women with substance use disorders.
9.1 Opportunities for Practice

The women who we meet in our clinical practice become part of our lives for a moment in time. Sometimes these moments are very brief. In my practice as a registered nurse, on an acute care obstetrical unit, I might provide nursing care for a woman for only a few short hours. In other settings, such as in the community, care might be provided during multiple visits, over an extended period of time. Regardless of the amount of time professionals of varying disciplines spend with women, they must recognize they are only seeing a brief snapshot of the woman’s life. The time individual professionals spend with women is relatively short within the context of the woman’s life. As professionals, we need to be cognizant that we are likely naïve to the experiences that each woman brings with her when she accesses care.

We have learned from Tammy, Angel, and Frankie that women with substance use disorders frequently lead complicated lives. Their lives are often so complicated that stating this almost undermines the complexities they experience. Childhoods inundated with violence and crime, poverty unimaginable to most professionals, surveillance that does not allow for one mistake, and children taken away, never to be returned are only a few examples of what the women face on an ongoing basis. As professionals, we do not necessarily know what story each woman is living but we must be aware of the possibilities. It is only when we have an understanding of the women’s potential experiences that we can begin to demonstrate empathy, caring, and compassion in the care that we provide.

When I began this project, I wanted to learn about the women’s experiences with health care professionals. What I found was that the women did not separate their
experiences with health care professionals from their experiences with professionals in general. Although the women experienced some supportive relationships, they also described some very negative experiences. As a health care professional myself, I will focus in this area; however, it is important to mention that the women’s experiences intersected through various disciplines. Pregnant women who use substances described negative experiences with health care professionals including communication that was judgmental and lacked respect (Lefebvre et al. 2010). When women had negative experiences with professionals, they did not continue to access care (Chan & Moriarty, 2010; Jackson & Shannon, 2012a; Krausz, 2010; Kruk & Banga, 2011; Murphy & Rosenbaum, 1999; Roberts & Nuru-Jeter, 2010; Roberts & Pies, 2011; Soderstrom, 2012; Varty & Alwyn, 2011).

Nurses and other professionals are well positioned to provide positive, supportive care that encourages continued utilization of services. This means providing care that is non-judgmental and does not create a fear of stigma (Banwell & Bammer, 2006; Fowler et al., 2014). When judgment is reserved and care is supportive, the stress women experience as a result of poverty, lack of resources, and health disparities is decreased (Cleveland et al., 2016). Understanding women’s traumatic histories might help professionals provide care that is non-judgmental and absent of stigma (Fowler et al.).

Women in this study described experiencing unintended pregnancies and accessing late pregnancy care. They believed that because of their drug use they could not get pregnant and consequently did not recognize the signs of early pregnancy. As a result of heavy drug use and their current social situations, there is little opportunity to recruit women into care earlier. However, when women do arrive, they need to be
provided the same non-judgmental care, absent of stigma, just like any other mother. When women have negative experiences they often do not return for care (Chan & Moriarty, 2010; Jackson & Shannon, 2012a; Krausz, 2010; Kruk & Banga, 2011; Murphy & Rosenbaum, 1999; Roberts & Nuru-Jeter, 2010; Roberts & Pies, 2011; Soderstrom, 2012; Varty & Alwyn, 2011). Since substance using mothers often present for late pregnancy care it is even more imperative that they are retained with care that is perceived as supportive. This creates opportunity for timely intervention and implementation of appropriate health promotion strategies to help decrease maternal and fetal morbidity and mortality (Eriksen, Pilliod, & Caughey, 2016; Smith & Bassett-Novoa, 2015).

Ideally, all health care professionals would recognize and understand the complex lives and traumatic histories that women with substance use disorders often experience. However, the experiences of the women in this research, coupled with the existing literature, suggests that positive, supportive care that is provided by non-judgmental professionals is lacking across disciplines. So then, I ask, how do we shift health care professional’s perceptions of pregnant women with substance use disorders so that supportive care can be provided? How can nurse’s perspectives be realistically repositioned across acute care and community practice settings to encourage an understanding of the complexities of the women’s lives?

Nurses have a responsibility to provide safe, compassionate, competent, and ethical care to all patients (Canadian Nurses Association, 2017). When the patient is a pregnant woman with a substance use disorder, all nurses must still provide non-judgmental, compassionate care, regardless of their own personal beliefs about addiction.
(McKeever, Spaeth-Brayton, & Sheerin, 2014). Browne et al. (2012) have suggested strategies to promote equitable care for all individuals. Several of these strategies can be used as a guide in caring for pregnant women with substance use disorders.

Browne et al. (2012) have identified several approaches aimed at the organizational level such as clearly articulating commitment to equity in statements such as the mission and values of the organization. However, Browne et al. also suggested strategies that can be implemented at the level of direct patient care. Promoting unconditional positive regard is essential in all interactions with patients. Browne et al. caution care providers that these interactions go beyond those that occur with health care professionals and also include the communication that takes place at reception desks and over the phone. Small gestures such as inquiring about a person’s day or using non-verbal communication such as smiling, to acknowledge the presence of an individual help to create accepting, non-judgmental environments. In-services for all staff, including health care professionals and other individuals who may come in contact with patients, is essential. These in-services can explore approaches to care that take people’s histories into account so that safe environments can be created. The impact that the social determinants of health have on individuals should also be addressed at a basic level. For example, when working in the community, care providers recognize that access to a phone or an internet connection is often not realistic for some individuals. Lastly, optimizing place and developing relational spaces that support the development of therapeutic relationships needs to occur from entry to the health care setting including waiting rooms and reception areas. Small strategies implemented at the level of direct
patient care can have a big impact on how patients perceive their experiences so they feel supported to return for subsequent care (Browne et al.).

All of the women in this study described wanting to decrease or stop their drug use once their pregnancies were identified. Pregnancy was a motivational time for the women. This finding is well supported by other research (Cleveland et al., 2016; Kruk & Banga, 2012; Radcliffe, 2009; Soderstrom, 2012). Knowing that pregnancy is a motivational time for women means that professionals need to provide support and resources that will help women successfully decrease or cease their drug use when desired. When women are successful in changing their patterns of drug use, support needs to be continued after the birth of the baby. Tammy, Angel, and Frankie all described returning to drug use after previous pregnancies. When they were confronted with stressful events; they turned back to drugs. Women have been found to return to pre-pregnancy drug use patterns within two years of birth (Bailey, Hill, Hawkins, Catalano, & Abbott, 2008). The women were forgotten when their children were apprehended. The focus of care providers shifted away from the women to the children. Women need to be taught ongoing coping mechanisms and provided with meaningful support so they are equipped with strategies to help prevent the return to drug use.

Similar to the women in this narrative inquiry, McKeever at al. (2014) identified that the risk to return to drug use was highest after birth. Supportive programs that meet the needs of the women need to be available and easily accessible. In addition, McKeever et al. stated that women should be supported in their decision to breastfeed because of the enormous benefits of maternal attachment to the infant. If women choose to breastfeed, tremendous lactation support is required because newborns of mothers with
substance use disorders often experience challenges with breastfeeding (McKeever et al.). Breastfeeding support that meets the needs of the mother might include care that is provided in the home to help decrease barriers to care access.

Lastly, the women experienced overwhelming guilt and self-blame for the harm they perceived they caused their children. Angel and Frankie described watching the physical suffering of their infants as they experienced withdrawal symptoms. Feelings of extreme shame and guilt have been associated with mothers who observed their infants as they withdraw (Cleveland et al., 2016). Instead of blaming women for their newborn’s withdrawal symptoms, care providers need to be sensitive to the mother’s feelings and build therapeutic relationships that exhibit trust and respect. In addition, Cleveland et al., suggested that nursing care should be focused around reducing maternal stress by teaching infant soothing techniques that help to increase the mother’s confidence and promote attachment. Despite their circumstances, the women in this study wanted to be good mothers.

9.2 Opportunities for Research

The stories and experiences shared by the women helped to contribute to our understanding of pregnancy, addiction, motherhood, and substance using women’s lives. However, the completion of this inquiry has left me with further questions that may be addressed in future research. Frankie’s story has suggested that Indigenous women may experience addiction differently than other women. Future research might seek to better understand the experience of addiction in Indigenous women.

As I spent time with all of the women, and heard about their previous pregnancies, I learned about stories of relapse that occurred shortly after the births of
several of their other children. All three women were in a period of recovery when our relationships ended shortly after the births of their babies. Knowing that the women had returned to drugs after other pregnancies and that women in other research returned to pre-pregnancy drug use patterns after birth (Bailey et al., 2008) caused me to wonder. I wondered what stories the women would tell if I were to spend the next six months living alongside them. How would they cope when stressful events threatened their sobriety? Would they eventually turn back to drugs? What would precipitate their return to drugs? Would their children be apprehended? Developing an understanding of substance using women’s experiences after birth may help professionals to provide better support and develop programming that meets the needs of the women. Enhanced support and practical programming may help women maintain periods of recovery which will ultimately promote families in staying together.

As I listened to the women’s stories, I was especially struck by the fight that seemed to come from deep within each of them. The women described how they fought or battled for their children and for their motherhood. Their experiences were replete with loss yet they did not give up; they continued on with hope for the future. Individuals with a history of drug addiction have been considered to be vulnerable (Gwyn & Colin, 2010). I would conclude that these three women were anything but vulnerable. They possessed a resilience that helped to carry them through some of their most difficult times. Future research may explore the notion of resilience in pregnant women living with addictions.

Keeping families together during the provision of drug treatment also warrants further exploration. We learned about the emotional tension Frankie experienced when
she was forced to leave her children to enter drug treatment. As a result, she was unsuccessful in completing her program. She returned home to her family, pregnant and still using drugs. Women are reluctant to enter treatment programs before or after birth when they cannot take their children with them (Kruk & Banga, 2011). Comprehensive treatment programs that offer multiple services and allow children to stay with their mothers are available but are extremely limited in number (Hiersteiner, 2004; Jackson & Shannon, 2012a; 2012b). Programs that are on-going, affordable, and attend to the distinct needs of women must be made readily available. Once comprehensive programs are available, evaluation of these programs needs to occur to determine if they are in fact effective solutions for recovery and for removing barriers to treatment access.

As I spent time immersed in the women’s field texts, I wondered about other areas for future research. The women told of periods of relapse when children were apprehended. I wanted to know more about the experiences of drug using mothers whose children were apprehended. In my exploration of the literature, I found a dearth of knowledge on this topic. The existing literature focused on the experiences of the children and the impact on their attachment. I learned from the women that once their children were apprehended, they received little, if any, support. I wondered: Who cares for the mothers?

When I learned of Frankie’s stillbirth, I wondered the same question. Drug using pregnant women who experienced a stillbirth described it as a traumatic event and feared for future pregnancies (Cleveland et al., 2016). Stillbirth and pregnancy loss in this population were associated with negative emotions including fear, shame, and anxiety (Cleveland et al.). Yet when I wanted to know more, I could not find any answers.
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Literature exploring the experiences of drug using women who experienced a stillbirth does not exist. Future research exploring the experiences of women whose children are apprehended and the experiences of women who experience a stillbirth would help to contribute to a more in-depth understanding of these two populations and inform future programs of care.

9.3 Opportunities for Education

An opportunity exists to improve how pregnant women with substance use disorders are viewed by professionals and by society in general. I believe that awareness and education are key to bettering how this population of women is perceived. I came to this research with an understanding of pregnancy and addiction. However, it was not until I heard the stories that Tammy, Angel, and Frankie shared with me that I really came to understand the stark realities they faced. Stories are powerful ways to share and learn about experience (Estefan, Caine, & Clandinin, 2016). For this reason, I would suggest that professionals be exposed to the stories of women like Tammy, Angel, and Frankie. This might be accomplished by sharing narratives like those included in this dissertation or inviting a panel of women to share their experiences at a work place.

In addition, undergraduate education programs for students who might work with women with substance use disorders, such as nurses, physicians, midwives, and social workers should include relevant theory in curriculum. Practical implications for including such theory may begin at the theoretical level and continue into experiential opportunities that create the possibility for students to be exposed to the first-hand experiences of women. A theoretical basis related to addiction and the experiences of women with substance use disorders would provide foundational knowledge for the
students. However, until students are exposed to the experiences of the women, they will likely not develop a realistic understanding of what it is like to experience addiction amongst pregnancy and motherhood. I reflect on my own experience with this research. When I entered this narrative inquiry, I believed that I had a good understanding of women’s experiences. As I engaged with the women, I quickly learned how naïve I was to the complexities in their lives. Encouraging students to develop a more thorough understanding of women’s experiences can occur on varying levels.

I was most impacted by the observations of poverty I experienced during this research. Poverty is perhaps the most influential determinant of health (WHO, 2018). Reid and Evanson (2016) stated that it is essential for students to learn about poverty including its impact on health. However, teaching students about the realities of poverty is challenging. Clinical experiences in areas such as homeless shelters or public health agencies may help to expose students to the realities of poverty. These experiences should be used and implemented in undergraduate education programs; however, creating this opportunity for every student may not be realistic given limited availability and accessibility of placements (Reid and Evanson). Reid and Evanson instead suggested combining clinical experiences with other learning opportunities. For example, they identified a variety of poverty simulation tools that may be used in combination with clinical experiences. These opportunities would encourage students to develop a broad understanding of poverty and its impact on people. However, further consideration of how students can develop a more specific understanding of the experiences of women with substance use disorders is also warranted.
Not every student will have the opportunity to practice in a clinical setting with women who experience addiction. Therefore, educators should seek out alternative learning experiences that, at the very minimum, expose students to the realities women face. This might include inviting an expert in the field to provide a guest lecture in the classroom. Alternatively, if a woman like Tammy, Angel, or Frankie can be located and is willing to tell her story, she might be invited to share her experience with students. Students can also be encouraged to reflect on their own values and beliefs related to addiction, pregnancy, and motherhood and these can be explored in small group settings within the classroom. Only when we learn about what women have experienced, can we truly demonstrate empathy, caring, and compassion in our interactions. This learning needs to begin at the undergraduate level.

9.4 Opportunities for Policy

Opportunities for policy development are evident as a result of this research. Among the most apparent is the need to address intergenerational trauma and substance use disorders in the Indigenous population. Indigenous women in this inquiry experienced intergenerational trauma that contributed to their problematic substance use. Angel and Frankie described traumatic childhoods where the only means they learned for coping was the use of substances. Health care professionals have been called to address disparities such as addiction that are experienced by Indigenous peoples as a result of intergenerational trauma (Canadian Association of Perinatal and Women’s Health Nurses, 2017; TRC, 2015).

The TRC (2015) identified specific calls to action that address the health disparities between Indigenous and non-Indigenous communities. Several of these calls
to action are supported by this research. The TRC calls the government “to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people” (p. 2). The TRC goes on to call the government to work with Indigenous peoples to close the gaps in health outcomes between Indigenous and non-Indigenous communities. Indicators directly relating to this research such as infant mortality, maternal health, addictions, birth rates, infant and child health issues, and the availability of appropriate health services are identified as areas to be addressed. In order to attend to the specific health care issues of Indigenous peoples, their distinct needs must be recognized (TRC). Angel and Frankie’s narratives have demonstrated unique health needs related to their addictions.

As health care professionals, our role includes advocating for the implementation of treatment programs that address intergenerational trauma and substance use disorders (Marsh et al., 2015; Marsh et al., 2016). Ross et al. (2015) suggested that a holistic means for treating addiction includes addressing the perceived cause of the addiction such as historical trauma or a history of abuse. The calls to action, identified by the TRC (2015), support this approach. The government is called to fund healing centres to address the physical, mental, emotional, and spiritual harms caused to Indigenous peoples and to recognize the value of traditional healing practices (TRC).

Treatment programs that blend traditional Indigenous healing practices with mainstream interventions have demonstrated dramatically reduced rates of substance use in Indigenous populations (Rowan et al., 2014). When this blend of interventions is used to target substance use disorders and post-traumatic stress disorder, positive impacts on
behaviours associated with addiction and intergenerational trauma have been demonstrated (Marsh et al., 2016). Changes in policy, making blended treatment programs that address intergenerational trauma accessible to Indigenous peoples are needed. Healing is possible, but an understanding of the generations of trauma that Indigenous peoples have experienced is required (Marsh et al., 2016). Only when policy addresses the generations of trauma will the cycle of addiction begin to end.

A second opportunity that can be addressed through policy is related to the child welfare system. This narrative inquiry has identified that two groups of women who use drugs during pregnancy exist. Women in the first group continue to heavily use drugs throughout their pregnancies. Most often, these women are unable to adequately provide for their children (Hiersteiner, 2004; Silva et al., 2012) The second, and perhaps the most important to this research, is the group of women who attempts to decrease or stop their drug use during pregnancy. All three women in this study were in a period of recovery during their current pregnancy and described being motivated to stay sober by their children. However, when children are apprehended, women frequently return to their drug use (Cleveland et al., 2016) and there is increased risk for a subsequent substance exposed infant (Grant et al., 2011). Tammy and Angel’s stories are reflective of heavy drug use when their older children were apprehended.

Child apprehension is harmful to the family and is costly to society. For this reason, policy that prohibits apprehension unless children are subjected to danger needs to be in place. Strict guidelines that clearly identify when children should be removed from their families must be available and carefully adhered to by professionals. When children do remain in the home, women need to be supported. This support must be
individualized and planned with the family so their needs are met. An array of services needs to be available so that women are not required to attend programming that does not meet their needs. Only when women are adequately supported and have access to useful resources will the work of mothering amongst an addiction become easier. A model of care that does not act as a means of surveillance over women but rather encourages and supports them to mother their children is crucial in keeping families together.

More specifically, the TRC (2015) has identified calls to action that directly relate to the child welfare of Indigenous children. The government is called to reduce the number of Indigenous children in foster care by providing adequate resources that support keeping families together (TRC). Policies that support safely keeping families together would help to reduce the number of children in the welfare system. As a strategy, the TRC supports a need for culturally appropriate parenting programs. Additionally, professionals who conduct child welfare investigations need to be adequately educated about the history of Indigenous peoples and need to seek solutions for healing from Indigenous communities and families (TRC).

If women are expected to successfully mother their children, the dire poverty they experience must be addressed. Women in this study described challenges with securing affordable, safe housing for their families. They struggled with financial resources that meant providing basic needs such as food, diapers, and clothing were challenging. The current welfare system does not provide women with sufficient means to raise their families. Policies that advocate for mothers to have adequate resources to meet their basic needs must be implemented. Women with a history of substance use disorders cannot be expected to raise their families in neighbourhoods where they are surrounded
by drug use. Putting a woman with an addiction into an environment where she is tempted to use only sets her up to fail. Women require affordable, safe housing and financial resources considered reasonable to support a family. Once women are in a period of stability, they require further support to seek out opportunities for education and to enter the workforce with the goal of sustaining recovery over the long-term.

As my relationships with each of the women ended, I asked myself: What will it take to change the future for Tammy, Angel, and Frankie? The women were in a period of recovery and each desperately wanted to improve the future for themselves and their families. I wondered if the women would be successful in leaving their drug use in the past. Would they keep their families together as they moved into the future? How would they re-story their lives? Policies that advocate for women like Tammy, Angel, and Frankie need to be available so that women are supported in their attempts to move towards a better future.

9.5 Opportunities to Address Theoretical Implications

Narrative inquiry, as conceptualized by Clandinin and Connelly (2000), was used as the methodology for this research. With the completion of this research, I have the opportunity to reflect on the methodology and its effectiveness for this work. First, I want to return to the definition and discussion of narrative inquiry that I first explored in Chapter Three:

[Narrative inquiry is] a way of understanding experience. It is collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus. An inquirer enters this matrix in the midst and progresses in the same spirit, concluding the inquiry still in the midst of living and telling, reliving and retelling, the stories of the experiences that made up people’s lives, both individual and socially (Clandinin & Connelly, 2000, p. 20).
Narrative inquiry is both phenomenon and methodology for understanding experience (Clandinin, 2013; Clandinin & Connelly, 2000). As a narrative inquirer, I adopted a distinct conceptualization of experience as a narratively composed phenomenon. Lives are made up of experiences that formulate into narratives (Caine et al., 2013; Clandinin; Clandinin & Connelly, 2000). Narrative inquiry is then epistemologically grounded in the notion that experience is knowledge for living (Clandinin; Clandinin & Connelly, 2000).

Caine et al. (2017a) stated that research problems often derive from institutional practices or policies that are seen as problematic. Narrative inquiry is different in that our research puzzles are driven by personal experience (Clandinin and Connelly, 2000). My experiences in professional practice as a registered nurse, lead me to this work. My professional stories of how pregnant women with substance use disorders were treated in my practice caused me to want to inquire further. I wanted to know more and this approach allowed me to address what I saw as a real problem in my practice. In this way, I see narrative inquiry as an effective means for exploring practical problems that are identified through experience in practice. Narrative inquiry provides an opportunity to address questions that are important to registered nurses who are practicing at the level of direct patient care.

Although my experiences in practice were central in constructing this research, the experiences of the women who came alongside me were essential in developing an understanding of pregnancy and addiction. This approach is central in narrative inquiry research. In their work that explored how social justice issues might be addressed using narrative inquiry, Caine et al. (2017a) identified that when researchers name social justice
issues and frame research problems around these, they risk fitting people into predetermined problems. This makes the complex lives that are composed by individual people invisible. Narrative inquiry allowed me to first see the women and the lives they were composing, rather than viewing them as a representation of a social problem (Caine et al., 2017a). The narratives that have been relationally co-constructed by the women and myself bring forward the human experience and the realities of living with addiction in the presence of pregnancy and motherhood. As Caine et al. (2017a) have suggested, when the women’s experiences are retold in research texts, we can become awake to the possibilities of how lives and institutional narratives can be shifted.

As I reflect on the women’s experiences and what can be learned from them, I return to a quote from Clandinin and Connelly (2000) that first drew me to narrative inquiry as methodology for this research. In their answer to the question: “Why narrative inquiry?” Clandinin and Connelly answered “because experience” (2000, p.50). The experiences of the women and how their lives were narratively composed were absolutely essential to this research and what can be learned about pregnancy and addiction. Narrative inquiry was a useful means for exploring experience in this way.

As a reminder, John Dewey’s (1938, 1958) view of experience is credited as the philosophical underpinning of narrative inquiry research (Clandinin & Connelly, 2000). His criteria of experience – interaction, continuity, and situation provide the basis for the ontological commitments of the methodology (Dewey, 1938, 1958). Thus, this research was situated within the context of temporality, sociality, and place. These terms provide the conceptual framework for all narrative inquiry research (Clandinin & Connelly, 2000). “Studies have temporal dimensions and address temporal matters; they focus on
the personal and the social in a balance appropriate to the inquiry; and they occur in specific places or sequences of places” (Clandinin & Connelly, 2000, p.50). The women’s experiences were explored temporally, socially, and in reference to place. Although the three-dimensional inquiry space was useful in exploring the women’s stories in this narrative inquiry, I have come to question whether there is not a fourth dimension to not only the women’s stories, but also with respect to narrative inquiry.

9.5.1 Revisiting the three-dimensional inquiry space. Each of the women’s narratives was replete with moral-ethical components. If we are to understand the women’s narratives, an exploration of their moral-ethical experience is needed. Morals are “concerned with the principles of right and wrong behavior” (Oxford Dictionary, 2018a, para 1) while ethics are defined as the “moral principles that govern a person’s behavior or the conducting of an activity” (Oxford Dictionary, 2018b, para 1). Many of the choices the women were forced to make were grounded in the moral-ethical component in which principles of right and wrong weighed heavily on their decisions. However, many of the decisions the women faced did not have a right or a wrong answer or outcome. They were frequently caught in a paradox where the conclusion or outcome was difficult to understand or was conflicting in nature. There was a lot at stake for the women and how their lives unfolded impacted not only themselves, but their pregnancies, their children, and/or their families.

The women’s narratives were fundamentally replete with paradox. Their lives unfolded as profoundly moral-ethical and what was at stake for each of them was core to each of their narratives. Acknowledging the moral-ethical realities, core to the women’s lives and how their narratives unfolded, was necessary to understand their experience. If
for instance, we return to Frankie’s narrative, we see the moral-ethical component in her life. Earlier, I wrote of several of the paradoxes she faced. Frankie was forced to make decisions: Ignore the pregnancy and continue with drug use or recognize the pregnancy and stop using? Enter drug treatment and leave the family behind or remain with the family and struggle to recover alone? Take prescribed methadone and watch the newborn withdraw or quit taking prescribed methadone and risk pregnancy loss? Continue to live in a desirable but expensive neighbourhood or move to a more affordable home surrounded by drugs and crime? None of the decisions were simple and each carried a moral-ethical component where there was no desirable outcome. Frankie’s narrative was not unique to this phenomenon; each narrative was full of similar experiences.

Moral-ethical components permeated through the women’s lives and this was evident in their experiences. Kleinman and Kleinman discussed “experience as an intersubjective medium of microcultural and infrapolitical processes in which something is at stake for participants” (1991, p. 275). How the women constructed their experience was essential to this narrative inquiry. The women’s experiences, and their narratives constituting such, revealed what was at stake for each of them. The substance of their lives, revealed in the structure and composition of their narratives, was profoundly moral-ethical. To understand their realities was to understand what was at stake for each of them. As such, moral-ethical components cannot be disregarded as this creates false subjects that do not accurately reflect the reality of the experience (Kleinman & Kleinman). If this domain is removed, individuals become dehumanized (Kleinman & Kleinman). Thus the implications for narrative inquiry are potentially profound.
Throughout this narrative inquiry, I was witness to the women’s profoundly moral-ethical lives. This was reflected in their everyday lives and became crucial to understanding their experience, as well as the construction of their narratives. However, the women’s everyday experience made up only part of the moral-ethical context of their lives. The women’s lives were further complicated by the policies and processes to which they were subjected. These policies and processes were often not supportive of them. For example, the women were denied motherhood by state controlled policies and processes that held power over them. They were forced to adhere to conditions set forth by the state or they risked losing their motherhood. This type of control had a fundamental moral-ethical impact on their lives and in the substance of their narratives. The women’s experiences were governed by state mandated policies and processes that controlled their decisions and their actions.

The current three-dimensional inquiry space of temporality, sociality, and place attests to what is important to understanding the construction of a narrative; that narratives unfold over time, that they occur within a specific context, and that they take place in concrete spaces (Clandinin & Connelly, 2000). To come to know a narrative necessitates that relational ethics pervades throughout the entire inquiry (Clandinin & Connelly, 2000). However, missing in this process is the idea that narratives are fundamentally moral-ethical and substantively reveal what is at stake for each participant. At present, narrative inquiry lacks this dimension. For this reason, I would suggest that the three-dimensional inquiry space of temporality, sociality, and place be amended to include a fourth moral-ethical dimension. Including this fourth dimension will strengthen narrative inquiry as a methodology and the narratives co-constructed therein. The
suggestion for a methodological addition of a fourth dimension is based solely on this study. It would be important for other researchers to consider this dimension and evaluate its effectiveness in future narrative inquiries.

### 9.5.2 Considering the definition of addiction. In Chapter Two, I spent considerable time defining and discussing the concept of addiction. I chose to do this because addiction is a complex term with no single definition that is widely accepted in the relevant literature. After considerable reflection, the definition of addiction that was adopted for this research was:

*The repeated use of a psychoactive substance or substances, to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substance, has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain the substance by almost any means. Typically, tolerance is prominent and a withdrawal syndrome frequently occurs when substance use is interrupted* (WHO 2014, para 24).

Although I recognized the importance of broad definitions of addiction, I chose to use this definition because it focused on substances and I felt this was most applicable to the research. Throughout this dissertation, I have used the terms substance use disorder (as defined by the APA, 2013) and addiction (as defined by the WHO, 2014) interchangeably; however, the term I used most frequently with the women was addiction because this was how they referred to their relationships with alcohol and/or drugs.

Now that I have completed the research, I want to reflect on the usefulness of the terms substance use disorder and addiction to this narrative inquiry. When I first began exploring the topic of pregnancy and addiction, I needed to have an understanding of the terminology associated with the research and as a result, I clearly articulated the definitions I would be using. This approach was useful at the outset of the study because
it contributed to my understanding of the terminology; however, once I entered the field, the terms became less important.

The women were living their own experiences of addiction and my technical definitions of the associated terminology became somewhat irrelevant. They perceived themselves as having an addiction to alcohol and/or drugs and this was established long before they ever engaged in a relationship with me. Perhaps what was most important was not defining the technical terms for the research but engaging in the relational negotiations that underpin narrative inquiry research to identify if the women wanted to participate and if in fact they were a good fit for the project. I found that it did not matter how I defined addiction but rather the women’s experiences were essential in contributing to the understanding of pregnancy and addiction in this narrative inquiry.

9.5.3 Considering motherhood and the notion of “mothering.” This narrative inquiry began as a result of my wondering about the experiences of pregnant women with substance use disorders. However, as I engaged relationally with the women, I very quickly discovered that their narratives encompassed much more than just pregnancy and addiction. Tammy, Angel, and Frankie were all mothers and this was reflected in their stories. I have written about how the women’s narratives extended beyond pregnancy and into a period of conditional motherhood that was precluded by a social narrative that viewed drug using pregnant women as incapable mothers. This particular narrative placed the women under the surveillance of social services where they were forced to meet state mandated conditions or risk loss of their motherhood. They were in a liminal state (Turner, 1969) where they were mothers, yet they were not fully incorporated into this narrative. As a result, they constantly fought to recreate their motherhood.
The conceptualization of motherhood and mothering might be explored beyond the findings of this narrative inquiry. This may include looking to the work of feminist pragmatists to develop other insights into how a mother, with a history of a substance addiction, is conceptualized. Feminist pragmatism builds on the ideas of early philosophers, such as Dewey (1906), a classic pragmatist, who proposed that there is truth in knowledge only when there are practical applications. In particular, Jane Addams, has been credited with a version of feminist pragmatism that closely aligns with Dewey’s pragmatic ideas (Haddock Seigfried, 1999).

Addams and colleague, Ellen Gates Starr, were responsible for co-founding a settlement home known as Chicago’s Hull House (Addams, 1912). The work of these two women at Hull House led to a social welfare movement that continues to speak to current feminist issues such as the “manner of inclusion in society of diverse persons, marginalized by gender, ethnicity, race, and sexual orientation” (Haddock Seigfried, 1999, p. 207). In her work, Addams called upon middle class women to use their domestic abilities beyond their own homes (Addams). She suggested that the traditional role of housekeeper should move out of personal homes and into the civic setting where it could be used to help others.

The foundation of Addams’ work was set in a pragmatic theory of engaged understanding (Haddock Seigfried, 1999). In an attempt to parallel her work at Hull House with her own pragmatic ideas, Addams moved to the poorest neighbourhood in Chicago. It was in this neighbourhood where Addams believed she could learn about the experiences of others and further contribute to social good (Addams, 1912). Addams encouraged other middle class women to stand with the women at Hull House so that
together they could learn and develop shared experiences (Haddock Seigfried). She believed that it was only when women stood together that they would be able to see beyond their own race and social class and contribute to a greater good. My own experience in this narrative inquiry, as well as Addams’ work at Hull House, might be used as exemplars in designing future research that explores the experiences of motherhood and mothering in women with substance use disorders.

The concepts of motherhood and mothering convey differentiated meanings. Adrienne Rich (1976) was one of the first to make this differentiation in her classic feminist analysis of the institution of motherhood. In her 1976 book, Rich explored the institution of motherhood including the often unachievable, or even undesirable, societal demands that are placed on and expected of women in their role as mothers. She distinguished “between two meanings of motherhood, one superimposed on the other: the potential relationship of any woman to her powers of reproduction and to children; and the institution, which aims at ensuring . . . all women – shall remain under male control” (p.2). Rich herself identified that she did not aim to attack the family or mothering, but rather disagreed with how motherhood was restricted under patriarchy. According to Rich, the experience of mothering is often different than the socially constructed expectations of a mother role. She suggested that “the social institutions and prescriptions for behavior . . . have not necessarily accounted for the real lives of women” (p. 42).

In her reflection on Rich’s work, O’Reilly (2004), more clearly differentiated between motherhood and mothering. She suggested that motherhood refers to a male dominated, patriarchal institution, which has power over women and is consequently
oppressive. Alternatively, mothering relates to a female defined experience that empowers women (O’Reilly). It is the institution of motherhood that feminists like Rich and O’Reilly seek to disrupt.

The experiences of Tammy, Angel, and Frankie speak to the power of the institution over motherhood. It was the state that controlled whether the women were permitted to be mothers and consequently made their motherhood conditional. Yet, in my experience with the women, I witnessed how they could successfully perform as mothers. They cared for and loved their children. It was not the women themselves who did not want to act as mothers but rather a state defined narrative that precluded their motherhood. In a parallel story, Boyd (1999) challenged a similar ideology of motherhood that viewed drug using women as unfit mothers. In her attempt to transcend the myths related to mothers who use illicit drugs, she suggested that drug using women can and should mother their children. The work of women such as Rich (1976), O’Reilly, (2004), and Boyd, (1999) might be used as a foundation for future work that explores the institution of motherhood and the aspects of mothering that were apparent in the stories of the women in this inquiry. This may contribute further clarity in understanding the nexus of pregnancy, addiction, motherhood, and mothering.
CHAPTER TEN: Relational Ethics

Relational ethics must pervade the entire narrative inquiry because “every aspect of the work is touched by the research relationship” (Josselson, 2007, p. 537). In their discussion of the touchstones of narrative inquiry, Clandinin and Caine (2013) first addressed the relational responsibilities of the researcher, stating that ethical matters are marked by relational ethics. Relational ethics are at the heart of narrative inquiry as researchers first consider how they are situated in relation to the phenomenon under study. As the researcher negotiates entry and exit to the field and the ensuing research project, relational ethics continues to be at the forefront of the inquiry.

Relational ethics has been considered a means for thinking about ethics in a relational way, a relational responsibility, that encourages the researcher to explore how to ethically live alongside participants (Clandinin, 2013; Clandinin & Connelly, 2000). Others, outside of narrative inquiry, have provided definitions of relational ethics. In their book, Gabriel and Casemore provided a definition of relational ethics as “a co-constructed ethical and moral encounter, with associated relationship experiences and processes, that both influences and in turn is influenced by the complex multidimensional context in which the relationship occurs” (2009, p. 1). Bergum (2004) discussed relational ethics in nursing as a morally located relational space between the nurse and others. It is within this space that one is constantly questioning the right thing to do and acting in a way that leads to goodness (Bergum, 2004). She goes on to say that some tentativeness always exists because there is never complete certainty in what is in fact the right thing to do. In an earlier publication, Bergum (1999) stated that relational ethics is
marked by self-reflection, contemplation, openness, and uncertainty. I practiced each of these as I negotiated and carried out this narrative inquiry.

Working from the discussions of each of these authors, it might be suggested that a precise means for carrying out relational ethics does not exist. Instead, relational ethics might be referred to as a relational responsibility, a means for acting morally and ethically within relationships. This is referred to by Charon and Montello (2002) as the ethics of everyday life. There is not one correct way to carry out a relational responsibility but instead, the right thing to do is dependent on the relationship in which the ethics are situated.

Throughout this narrative inquiry, I faced several potential ethical issues. Some of these issues were minor and easily addressed as I navigated my relationships with the women. Others caused me to experience tension and I struggled to decide how to best attend to each situation. As I contemplated my decisions, I found relational ethics to be a useful guide. By using relational ethics to direct my actions, I was encouraged to reflect on how I might morally and ethically address situations. Thinking in a relational way allowed me to think not only about myself and the issue I was confronted with but also the relationship in which the issue was situated. Relational ethics encouraged me to ethically live alongside the women and reflect on the relationships I developed with them.

During this narrative inquiry, I learned a lot about the realities of conducting research with women who experience substance use disorders. Within the context of relational ethics, I would now like to share my experience. It is my hope that others working in this area will learn from my experience and this will contribute to continued relational research with women who experience pregnancy amongst an addiction.
10.1 Entering the Field

Terminology around entering the field is often associated with ethnographic research but is also significant in other qualitative methods (Chughtai & Myers, 2017). According to Chughtai and Myers, how the researcher enters the field impacts the entire research project. They suggested that accessing the field is very different from entering the field. Kunda (2013) expanded on this idea by stating that gaining physical access to a research site is very different from being accepted in the field and successfully living alongside people there. I quickly learned that, although administration had granted me access to the health centre, I needed to develop relationships if I was going to successfully enter the field.

Caine et al. (2013) stated that negotiating entry into the field is one of the central ethical concerns in narrative inquiry research. I began to negotiate entry into the field long before I ever met any of the women. I was familiar with the health centre that would create the field for this research and I had pre-existing professional relationships with a few of the staff. However, before I could enter the field, I first needed to develop a relationship with the professionals, as a whole, working at the health centre. My initial plan of sharing my proposed research with the staff and asking them to identify potential women for the project was not successful. They were not familiar enough with me and my research to feel adequately comfortable in discussing it with their clients. I realized that I first needed to develop a relationship with the staff.

In consultation with the health centre manager, I decided to start attending a weekly informal Moss bag and blanket making program offered for prenatal women. During the group, I interacted with staff and clients, telling them about myself and my
proposed research. Attending this group was crucial to the development of my relationships not only with prenatal women but also with the professionals working at the health centre. The staff began to recognize me and became familiar with my research. As a result, they were much more willing to brainstorm potential participants and refer interested women on to me. It was because of the time that I spent at the Moss bag and blanket making program that I was able to successfully enter the field. I learned that when the inquirer is an outsider to the field, they need to begin to develop relationships by immersing themselves into the setting. However, as I reflect back on this time now, I am not sure I would have done anything differently. It took time for the manager to invite me into the group setting. It was not until I was asked to join the prenatal group that I felt comfortable in respectfully entering a group that I had not previously belonged. I could then begin to invite women into the inquiry and develop relationships with them.

10.1.1 Inviting women. The first woman I invited into the study was Tammy. After what felt like an eternity of not successfully recruiting a single woman, I was so thankful for Tammy. There were times when I worried that there were not any women who would want to participate. I desperately wanted to begin the research. Completing my dissertation was contingent on me successfully recruiting women into the study. In my journal I wrote “It seems really surreal that I actually have a participant. I’ve spent several sleepless nights lately worrying that no one will want to participate and wondering what I will do. Will I finish this PhD? Will I be seen as a failure if I don’t? This woman has come into my life . . . [and] I am thankful for her and how our paths crossed today.” Yet I treaded cautiously. My first responsibility was not to myself, it was to the women (Canine et al., 2013). If I wanted to ethically carry out this project, I
needed to engage with women who were genuinely interested in developing a mutual relationship with me. I tried to keep this in the forefront of my mind for every woman I invited into the inquiry. I did not yet know about the in-depth relationship Tammy and I would develop but I wanted to ensure from the outset that I was not asking her to be a part of the research simply because I was desperate for someone who fit the criteria.

Tammy, Angel, and Frankie were not the only women who were invited into this inquiry. There was a fourth woman, Jaclyn who consented to be a part of the research. Jaclyn contacted me after she saw one of my posters at the health centre. We met for the first time a few days later. Jaclyn was initially very open with me, sharing that she was on house arrest. I learned that as a condition of her house arrest, Jaclyn was required to attend programs at the health centre. She told me that her home was not a safe place for me so we planned our meetings at the health centre. Jaclyn seemed to be very interested in participating in the research. However, during subsequent meetings, Jaclyn’s mood changed and it became very difficult to engage with her.

Jaclyn’s answers to my questions were abrupt and I noted that she seemed very standoffish towards me. There seemed to be an imaginary wall between us and I could not get through it. I could not identify what had changed from our initial meeting. I suppose I could have asked Jaclyn but I recognized that I was intimidated by her and I did not feel comfortable enquiring further. We met only a handful of times but our interactions became shorter and shorter. There was not an official ending to our relationship. I think we both realized that this was not going to work. Neither of us made further attempts to arrange to meet and our research relationship subsequently ended. I
would occasionally see Jaclyn at the health centre. We would politely greet each other and then continue with our own commitments.

Jaclyn’s story has not been included in this research because we did not develop the ongoing relationship that is required in narrative inquiry research (Clandinin, 2013). At first I felt like I had failed in my relationship with Jaclyn. I now realize that some research relationships simply do not work as we intend them to and that this is okay. Similar to our personal experiences, we would not expect every relationship we enter to become a significant part of our lives. The only reason I mention Jaclyn here is to highlight that not all relationships will become the ones that are required for meaningful narrative inquiry work (Clandinin, 2013).

There were several other women who I met with as I worked to invite others into the research. Some of the women simply did not want to be a part of the inquiry while others did not meet the criteria for the study. There were a few women who wanted to participate but because of external circumstances, we never had the opportunity to meet. Pregnant women with substance use disorders have an increased risk of pregnancy complications (Finnegan, 2010, 2013; Helmbrecht & Thiagarajah, 2008; Irner et al., 2012; Keegan et al., 2010; Pinto et al., 2010; Viteri et al., 2015). As I planned to meet with a few women, their babies were born prematurely, limiting the required ongoing research relationship that was needed. Other women led lives that were so complex that despite wanting to meet with me, they could not find time amongst their many commitments. Although these women never did enter the study, their experiences highlight how truly complicated the lives of women with substance use disorders are. As I explored inviting other women into the research, I was developing in-depth
relationships with Tammy, Angel, and Frankie. I made the decision to move forward with the research with these three women.

10.2 The Researcher as Relational

I became part of the storied landscape that I was studying (Clandinin, 2013). My previous experiences shaped who I was in this inquiry and this consequently influenced the research I was conducting. Self-reflection and contemplation were essential throughout every aspect of the study (Bergum, 1999). As I carried out the project, I recalled Clandinin’s suggestion that it was essential for me to pay close attention to who I was in this inquiry and how this was impacting not only the research but the relationships with the women who came alongside me. In fact, the process of self-reflection began well before I entered any relationships with the women. You might recall that as I explored my own narrative beginnings, I was encouraged to think about how my own stories situated me in relation to the phenomenon I was about to study. When I began the research, the process of situating myself and my experiences in relation to the research did not end but rather continued throughout the project and continues even now after the inquiry has been completed.

10.2.1 Developing relationships. As I set out to begin the research, I asked myself: Who are you in this narrative inquiry with pregnant women who experience substance use disorders? I wondered how my background as a registered nurse might impact the relationships I developed. I also considered my race and social class and how each of these might influence my ability to develop and sustain relationships with the women. Would the women see me as an authoritative figure rather than as someone who they could develop a relationship and openly share their stories? How would I promote
an environment in which a hierarchy was lessened? I considered these questions from the outset of the project knowing that I might be perceived by the women as having a higher status and that this might impact the relationships we would develop.

**10.2.1.1 Minimizing the power imbalance.** Tuttle and Seibold (2003) suggested that a non-hierarchical relationship can be established with participants by using an approach that is conversation like and focuses on empathetically and respectfully asking questions in a non-confrontational manner. Similarly, Elmir, Schmied, Jackson, and Wilkes (2011) stated that a major concern when conducting interviews is minimizing power imbalances. They identified that beginning interviews with questions and discussions that are not of a sensitive nature helps to build rapport with participants. As I engaged in relationships with the women, I used these strategies, but I also developed my own way of attempting to decrease the power imbalances that existed between me and the women. Although I was successful in developing relationships that promoted the sharing of experiences and stories, I found that it was impossible to completely level the existing hierarchy. I came to this research from a vastly different place than the women.

As an example, you might recall my decision to purchase toilet paper for Tammy and provide her with a small amount of money. I acted in a kind and caring way, like many others would have done. However, by carrying out this act of kindness, my power over Tammy was revealed. I admit that I did not initially see the power imbalance that was evident when I provided Tammy with the money. After taking some time to reflect, I saw that Tammy felt indebted to me. She thanked me over and over and acknowledged that she felt embarrassed for having to take the money. I had power over Tammy because of my socioeconomic background and no matter what I did, I could not
completely level the hierarchy between us. I still held more power. As a result of examples like this, I had to be constantly aware of my professional and personal background so that I could consider how it was impacting our relationships. I also recognized that meaningful relationships would not happen in an instant; time and patience were required.

During initial conversations, I felt that all three of the women were telling me the stories they thought I wanted to hear. Almost immediately, they provided me with what seemed to be some of the most intimate details of their lives. At first I was a bit taken aback and I wondered why the women seemed to so easily share their stories. I soon came to realize that the women were accustomed to sharing their experiences with health care professionals and this is likely how they initially viewed me. After one of my first meetings with Angel, I wrote this excerpt in my journal: “I was surprised that Angel seemed to just open up to me and began to tell her story . . . I wonder how much more there is to her story? Is she just telling me what is on the surface? Is this the story that she is used to sharing with health care professionals?” My thoughts after initially meeting with Frankie were very similar. “Like the other women, she easily and readily told me about her history with addiction – what I believe to be the story she is used to telling to health care professionals.” As I spent more time with the women, I surmised that the initial stories I heard were cover stories (Clandinin & Connelly, 2000). These were the smooth stories the women were used to telling to the professionals who entered their lives.

I realized that it would take time and that I would need to develop relationships with the women if I wanted to learn anything beyond the cover stories they were used to
sharing. I focused on keeping early conversations light and on trying not to explore stories that involved adversity or traumatic experiences. I established an initial rapport with the women by working with them to develop a timeline of their history. This experience was different for each of the women. Angel and Frankie preferred to speak to the important aspects of their history, while Tammy drew a timeline with me. These annals, as termed by Clandinin and Connelly (2000), provided a starting point for later constructing personal and social history. This exercise was also useful in helping me to initially develop relationships with the women without exploring events in detail.

A second strategy I found useful, as I attempted to develop relationships with the women and create a safe environment for them to share their experiences, included turning the audio-recorder off at appropriate times. I found that when the recorder was not on, the conversation shifted from what seemed like an interview to something that was much more relaxed. I first observed this in my interactions with Tammy. In my journal I wrote “Tammy was waiting for a cup of tea to brew. We had the chance to just talk without the recorder on. I think these types of conversations really help us to develop more of a mutual relationship rather . . . than one where Tammy perhaps sees me as the researcher or as the nurse.”

The places conversations took place also impacted how relationships developed. Some of the best conversations Tammy and I had were during the informal interactions that occurred in my vehicle as I drove her to appointments or helped her to complete errands. Likewise, Frankie appeared much more comfortable during conversations that took place outdoors at her home rather than at the health centre. However, initial meetings did not take place outside of the health centre. It took time to develop
relationships that allowed for meetings to transition to other environments. The women needed to trust me and to be comfortable enough in our relationships to invite me into their homes and to travel with me in my vehicle. Similarly, I initially would not have felt comfortable in the homes of the women. The relationships were reciprocal and this was an integral part of the research.

**10.2.1.2 Reciprocal relationships.** Elmir et al. (2011) suggested that research relationships should be reciprocal, involving a mutual exchange of information. I recall back to the time before I began the research. I felt tension as I considered that I might share too little or too much about myself with the women. Too little, and I was worried that I would jeopardize the relational aspect of the research; too much and I feared that I would cross an invisible line into potentially unethical territory. Thinking about ethics in a relational way helped me to understand that my relationships with the women needed to be based on a mutual and reciprocal understanding (Clandinin & Connelly, 2000). Very early on in their work, Clandinin and Connelly wrote: “Mere contact is acquaintanceship, not friendship. The same may be said for collaborative research, which requires a close relationship akin to friendship” (1988, p. 281). I too believe that if the relationship is to be mutual and reciprocal, it cannot be one sided; the woman cannot be the only one who is expected to share her stories. As I think about the research in a relational way, in which a friendship-like relationship is developed, I see that I was required to share some of myself. However, I was only obligated to tell those stories that I was comfortable sharing based on the ethical and mutual relationship negotiated between myself and each woman. In narrative inquiry research, sharing stories between
the researcher and the inquirer is not only ethical, it is essential to the relational ontology of the methodology.

In congruence with narrative inquiry methodology, I engaged relationally with the women; listening to their stories, but also sharing some of my own experiences. Initially, this was difficult for me and I recognized that several of the conversations were one sided. After one of my first meetings with Tammy I wrote: “As I listened to our audio-recording this morning, I felt I could have done more to contribute to the mutual relationship needed for narrative inquiry work. It felt as if Tammy was telling her story – very one sided. . . . I want to work on this so we are having more of a conversation – less one sided.” I was required to lay my own stories alongside the stories of the women (Clandinin, 2013). As time went on and my relationships with the women developed, this got easier.

Like the women, I was a mother. My daughter was very similar in age to the youngest children of all of the women. Together we shared stories of motherhood and of parenting. This sharing of similar experience helped to promote a friendship-like relationship that was necessary for the research. I also tried to demonstrate that I cared about the women and that the stories they shared were important to me. For example, shortly before Halloween, Tammy told me she was very excited to have the opportunity to take her daughter trick-or-treating. When I saw Tammy shortly after Halloween, I remembered to ask her how trick-or-treating had gone and we shared the Halloween experiences of both of our families. This type of conversation helped the women know that their stories were valuable to me and that I did not forget about what was happening in their lives between our meetings.
Our relationships developed. The women became a part of my life and I believe I became a part of theirs. For instance, I can recall the time when my relationship with Tammy began to change. Our meetings shifted from formal interview-like discussions to much more mutual. Tammy had always come to meet with me at the health centre when she attended other programs. On one particular day, the formal group was cancelled but Tammy came to see me anyway. It was at this point that I recognized the time we spent together was important to Tammy too. She began to initiate contact with me and even amongst her many commitments, she always made time for me. Instead of meeting formally, Tammy began to ask me to help her with simple errands like going to the grocery store. I needed to be available to her. I also noticed that I could spend time just being with Tammy. We did not always need to be engaged in a formal conversation. 

Our developing relationship contributed to the stories we felt comfortable sharing with each other. As I got to know each of the women more, I began to experience profound feelings and emotions associated with our relationships. They were no longer just women participating in my research, they had become part of my life.

I developed feelings for the women. I shared in their triumphs and I cried with them as they lived through and revisited heartbreaking times. I also began to worry about the women. There were periods of time when I was unable to contact Tammy and Frankie. Around Christmas time, Tammy became depressed. She did not attend programs at the health centre and I was unable to contact her. I worried about her. Would she be okay? Would I ever see her again? Eventually Tammy did resurface and we continued our relationship but I lived in the constant fear that she would disappear again.
When Frankie experienced the stillbirth of her baby, it felt like it was my loss too. After the stillbirth, I had difficulty contacting Frankie and it felt like I lost her too. In hindsight, I can see that I was deeply impacted by the stillbirth of Frankie’s baby and the thought of losing my relationship with her. I was relieved when Frankie agreed to see me again. We did not talk a lot about her loss but I think it was therapeutic for both of us to spend time with each other once again. Frankie had agreed to participate in the narrative inquiry of pregnant women with substance use disorders. I did not want her to think that because her pregnancy ended in loss that her story was no longer important to me. I learned that as I lived alongside the women, I had to constantly negotiate and re-negotiate my relationships with each of them.

A list of ethical requirements for what to do when engaging with inquirers does not exist (Caine et al., 2013). Instead, Caine et al. (2013) suggested that the thinking of a narrative inquirer comes from being in relation with others. In this way, the inquirer must be aware of their ongoing relational responsibilities, acting in a way that is both ethical and moral as the relational space unfolds (Clandinin, 2013). I learned to adapt to the on-going experiences of the women as well as to our developing relationships. It is within the relational space that a close relationship, akin to a friendship, frequently develops. As a result of this relationship, participants might feel comfortable to share some of the most intimate details of their lives. What researchers do with these intimate details is a matter of relational ethics. As I lived alongside the women and learned about their experiences, I was faced with the difficult task of representing their stories.
10.3 Researcher-Inquirer Negotiations

Caine and Estefan (2011) wrote about the obligations that researchers have as a result of the field texts they collect. These obligations largely involve a responsibility to protect the stories shared within the relational space (Caine & Estefan). Similarly, Clandinin (2013) stated that researchers must care for the stories that they are privileged to hear and become a part of during an inquiry. One way that researchers can care for these stories is to act in a respectful and sensitive manner as the intimate details of people’s lives are shared (Clandinin). Moreover, researchers need to ensure the stories are represented in a way that is agreeable to the participant. Relational ethics inundates this process as the researcher strives to act in a respectful and sensitive manner and considers the responsibility to protect the inquirers’ stories.

From the outset of the research, I recognized that the women’s stories would likely include topics of a sensitive nature. As a result of my understanding of the existing literature, I knew this particular population of women frequently led complex lives, complicated by stigma, victimization, and trauma (Cormier, Dell, & Poole, 2004; Finnegan, 2010, 2013; Krausz, 2010; Taylor, 2010). In his study that explored the experiences of pregnant women with substance use disorders, Krausz identified that stories of trauma were common. He described difficulty in establishing trust with the women and feeling that this impacted the stories the women told. I anticipated that some of the women’s stories would be painful to revisit. These would be stories that would be difficult for the women to share and that would be hard for me to hear. Although I initially feared being unsuccessful in developing the meaningful and respectful relationships that are required in a narrative inquiry, I recognized that it was within a
trusting, negotiated space that the women would most likely feel comfortable to share their most personal stories with me.

I was successful in developing a trusting, negotiated space with each woman and this contributed to the stories they felt comfortable sharing. As I discussed earlier in this chapter, the ability to decrease the power imbalance between each woman and myself helped me to develop trusting relationships. As a result of the sensitive stories the women shared, I recognized that I had a responsibility to respectfully listen and represent their narratives in a manner that was mutually negotiated within the relational space. This was my responsibility to the women.

**10.3.1 Negotiating research texts.** The responsibility to represent the inquirers’ stories in a respectful way is never more evident than when final research texts are written. The researcher is guided by an ethical obligation to ensure research texts respectfully represent the participants’ stories in a manner that the participant would feel comfortable (Caine & Estefan, 2011; Clandinin, 2013). Similar to all other phases of narrative inquiry, negotiation is an essential aspect of this part of the research. Clandinin suggested that using interim research texts is an appropriate means for negotiating the move to final research texts. Interim research texts are situated somewhere between field texts and final research texts and include a retelling of the participant’s story (Clandinin). I used a form of interim research texts to share the uninterrupted stories of the women.

Negotiating interim research texts can be accomplished in varying ways. Clandinin (2013) identified that sometimes, several meetings occur between the participant and the researcher as interim research texts are co-composed. At other times, the researcher shares the interim research text during only one meeting with a participant.
In either case it is imperative that the participant is provided the opportunity to negotiate the text and that a back-and-forth process ensues (Clandinin). Prior to beginning this research, I identified that I would take written interim research texts back to the women for their review. I suggested that I would leave blank spaces where text could be added and I would pose questions that would encourage the women to clarify, add, or delete details as they saw necessary (Clandinin). In reality, this process was not successful for several reasons.

The first interim research text I worked on was Tammy’s. I returned to Tammy with a portion of the written text. However, establishing the necessary co-composition based on this method did not work. Together, Tammy and I reviewed what I had written and she identified that it was “fine.” She did not appear to feel comfortable in providing feedback on the written text and as a result, I could not develop the meaningful co-composition that was required for this work. As a result, I made the decision to alter how I would address the co-composition of the texts and I moved to more of an on-going verbal discussion with all of the women. This allowed me to discuss what I was thinking and writing and in turn, the women provided me with verbal feedback.

In hindsight, there were several contributing factors for why my originally planned method for co-composition failed. Most importantly, I do not think it was suitable for this population of women. Tammy may have viewed it as academic work; something she may have felt incapable of doing. Although I did my best to decrease the power imbalance between the women and myself, they continued to recognize me as a professional. As a result, Tammy may not have felt comfortable providing me with feedback on my written work. When it came time to co-compose Frankie’s narrative, I
avoided the written process, fearing a similar situation as that which had occurred with Tammy. I moved to an on-going verbal discussion of how she wanted her story written. The process of co-composition with Angel also occurred on an on-going basis during our meetings. The relationship with Angel ended abruptly. This impacted the co-composition of her story. Although we discussed her story on an on-going basis, I did not have the opportunity to return back to her with final questions of how she wanted her story to be told. I struggled with this when deciding whether her story should be included with this research. However, up until the birth of her baby, Angel was committed to wanting to share her story. As a result, I felt an obligation to Angel to include her narrative in this research, despite not being able to return to her with final questions about her story.

Clearly the planned process for co-composing interim research texts with the women needed to be altered. Yet, upon reflecting on how this process was eventually carried out, I find myself questioning whether the women had enough of an opportunity for a back-and-forth co-composition of their stories. In reflection, if I were to conduct a narrative inquiry with a similar population of women in the future, I would change the process for how the stories were written. After an initial period of getting to know the woman, I would use a blank piece of paper to collectively write the important aspects of her story with her. Rather than me coming to the woman with portions of her story already written, she would have the opportunity to be involved in the writing from the very beginning. I am not suggesting that we would sit together and write the story in its entirety, but the woman would provide guidance on the most important aspects to her
from the outset. An on-going discussion could then follow as I continued in a more in-depth writing of her narrative.

10.3.1.1 Negotiations of anonymity. Clandinin (2013) suggested that there may be times during the writing of interim research texts that a participant is concerned that the text makes her too vulnerable or too visible. In this case, a strategy of fictionalizing times and places is useful in helping to contribute to the anonymity of the participant (Clandinin; Caine et al., 2017b). I anticipated that I would need to fictionalize aspects of the women’s stories in order to protect their anonymity. However, as I co-composed stories with the women, I learned that they did not want their narratives to be fictionalized; they wanted to be associated with their stories. In fact, on the most part, the women wanted to be referred to by their actual names, rather than by a pseudonym. This also ensured they were connected to their story. In a way, the women protected themselves from their own vulnerabilities. I sensed throughout their narratives that there were many hidden secret stories (Clandinin). The women alluded to living “in hell” or “hitting rock bottom” but I never came to truly know their stories of these times. These were stories that the women did not share, perhaps as a way of protecting themselves from experiences that were too painful to revisit. In my endeavor to responsibly represent the women’s narratives, I moved to final research texts with an understanding that there would always be untold stories related to the women’s experiences.

Moving from interim to final research texts can be a tension filled process. Clandinin, Murphy, Huber, and Orr (2010) discussed the tensions they felt when composing final research texts. These texts are the documents that become visible to public audiences when reports are written or study findings are published. Clandinin et
al. described their feelings of vulnerability and concern for participants in recognizing that others would read their research texts. As an example, they discussed a research project in which teachers challenged the dominant stories of schools. By making these stories public, Clandinin et al. were concerned that certain teachers would face significant consequences such as job loss or lack of promotion as a result of what they had said during the research. I considered the impact for each woman of having her story written and made public. I anticipated that if read by health centre staff, family members, or friends, there would be potential consequences; that the women would become vulnerable and perhaps ostracized by those who recognized their stories. I felt an obligation to discuss my concerns with the women. I needed to ensure the women understood the potential impact of sharing their stories. Despite my concerns, the women wanted their stories to be told. They hoped that by making their stories public, they would be helping to contribute to a better future for women with substance use disorders.

10.4 Exiting the Research Relationship

Exiting the research relationship is a complex aspect of narrative inquiry that differs for every researcher-participant dyad. A relational space is developed as participants and researchers look backwards and forwards, inwards and outwards and tell their stories (Caine et al., 2013). An intimate connection is often made and the stories that are told and heard frequently make lasting impressions (Caine et al., 2013). Researchers have written about the intricacies of exiting the research relationship. In their article that explored the long term relational responsibilities in narrative inquiry, Caine and Estefan (2011) each tell of a relationship they developed with a participant. They each described being deeply impacted by the research relationship and yearning for
continued interaction with the participant, long after the research had been completed. Caine and Estefan emphasized that people’s stories are not forgotten once the research ends. The stories continue to impact both the researcher and participant as each wonders who they are in the ongoing narrative of the other (Caine & Estefan).

In their article that examined exiting research relationships with vulnerable populations, Morrison, Gregory, and Thibodeau (2012) identified that developing trust and rapport with research participants is particularly important when carrying out qualitative research. When trust and rapport are developed, intimate conversations often take place. Moreover, qualitative research often occurs over an extended period of time. Intimate conversations coupled with the on-going nature of qualitative research can foster emotional dependence between the researcher and participant, making ending the project particularly difficult to navigate (Morrison et al.).

Morrison et al. (2012) stated that it is insensitive for the researcher to suddenly identify that the research is complete and the relationship be terminated. They suggested that exiting the relationship must be mutually negotiated and perhaps be participant-researcher driven rather than ended by the researcher. The participant should have a voice in indicating how the relationship is ended or redefined outside of the research (Morrison et al.).

As I began and carried out this narrative inquiry, I continuously reflected on the work of Caine and Estefan (2011) and Morrison et al. (2012). Realizing that ending research relationships would be a sensitive process, I was thinking about it from the very beginning of the research. Even now, as I read through my journal, I notice that threaded throughout my writing are thoughts of how each relationship would end. After one of my
first meetings with Angel I wrote: “I feel anxious about how the relationship might develop and how close I may become with Angel and the other women. Since I began exploring narrative inquiry, I have feared ending the relationships with the women. That fear was magnified today. . . . I could feel my heart wrenching for her [and] I found myself getting teary right along with her. It was at that moment that I realized how hard this was going to be. My life will be impacted and will be changed as a result of coming alongside these women.”

The relationship I developed with each woman was different. As a result, the process for ending the relationships differed. From the outset of the research, the women knew our relationships were temporary. They each agreed to share their experiences during pregnancy and for the first six weeks after birth. However, this plan was not necessarily followed and the ending of each relationship had to be adjusted based on each woman’s experience. For example, my relationship with Angel ended abruptly when she decided she no longer wanted to engage in the research with me. The ending of this relationship was driven by Angel without consultation from me; I did not recognize it was ending until it was already over. I will always wonder what contributed to Angel’s decision to abruptly end her participation in the research. Although I did not have the responsibility of ending the relationship, the way it ended left me with unanswered questions. Had something in Angel’s life changed? Had I offended her or did she simply no longer have time for me? I will never know the answers to these questions; I will never know what happened to Angel. That is a difficult part of this research.

The ending of the relationships with Frankie and Tammy were driven by me. However, I consulted with each woman when I sensed the end was drawing near. I
continued to meet with Frankie for a period of time that was longer than six weeks after her stillbirth. After the stillbirth, it took time for Frankie to be ready to meet again. When we did reconnect, we needed to reestablish our relationship. This took time and patience. Six weeks was no longer an appropriate follow-up time. I decided to continue to engage with Frankie and I watched for clues that she was ready to end the relationship. Eventually I noticed we were revisiting many of the same stories over and over again and I wondered if Frankie did not want to share any further experiences with me. Although she made time for me, I felt my presence was becoming an inconvenience to her. I also wondered if spending time with me reminded Frankie of her loss and of times of heavy drug use. In order for Frankie to move on from her loss, she needed to disengage from the research. During our last couple visits, I suggested that it might be a good time to end our relationship. Frankie’s almost immediate agreement suggested it was time. We established that I could continue to contact her if I had further questions about her story and she could contact me if she wished. I have not heard from Frankie since.

By far the most difficult relationship to end was the relationship with Tammy. Of the three women, I had developed the strongest bond with her. We had shared stories and Tammy had come to trust and count on me. We truly had a reciprocal relationship. Like with Frankie, I started introducing the end of the relationship several weeks before it actually occurred. The timing was not as clear to me as it had been with Frankie but we had reached an appropriate place to end the research. Perhaps the best way to share my feelings about ending the relationship with Tammy is to provide a portion of the final journal entry I wrote after leaving Tammy’s home for the last time. “Our meetings have been winding down and Tammy has known that I would journey with her until her baby
is about six weeks old... I found it hard to leave Tammy today. We agreed that I will continue to be in touch as I continue to write her story and that she can contact me if she wants. I felt that the ongoing relationship was best left up to her. She knows the door is open and she can access it if she wants. I have found it very hard learning about Tammy and her life over the last six months and now just walking away. Over this short time, I have seen her struggle, and I have seen her triumph. The hardest part now is not knowing what will happen to Tammy. Will she keep her baby? Will she get custody of her daughter? Will she turn back to drugs? I have learned a lot about Tammy and her time with me has been impactful. Our lives have crossed and I have heard her story. My life will be forever changed because of her.”

10.4.1 Considering ongoing relationships. Often, as an expectation of research ethics boards, relationships with participants end when the research is completed. Narrative inquiry research is different. Given the methodological implications of a relational ontology and the closeness that is frequently developed, researchers and/or participants might desire an ongoing relationship. Huber, Clandinin, and Huber (2006) described the tensions associated with maintaining long term relationships with participants. They discussed the geographical and situational barriers that often keep researchers from sustaining contact with participants. They described feelings of loss when ongoing relationships were unachievable.

If a continued relationship is desired, it should be negotiated and might take on several different forms. For instance, an ongoing relationship might be preferred. In this instance, it would be appropriate to leave the woman with contact information, inviting her to contact the researcher if she would like to communicate or meet for a visit. Other
women might prefer alternative ways of maintaining a relationship. As an example, a woman might be invited to be involved in future research projects, such as serving on an advisory board. This would create an opportunity for continued engagement, without continuing a formal relationship. There may be other women who prefer not to carry on a relationship at all. Their wishes would need to be respected. Huber et al. (2006) suggested that when navigating the ongoing relational responsibilities in narrative inquiry research, a simple answer does not exist. What seems essential to me is the recognition that there is diversity in relationships and that each must be negotiated so that the participant and researcher are satisfied with the means for moving on at the end of the research.

When I entered this narrative inquiry, I was unsure if I would consider ongoing relationships with the women who would come alongside me. I recall that I felt tension as I considered the ethical implications of negotiating long-term relationships with participants. I wondered how hearing the women’s stories might impact me and how participating in the inquiry might impact the women. I wondered how I would feel as I prepared to end the research and negotiate exiting the relationship. Like Caine and Estefan (2011), would I long for a continued relationship with the women? Would the women want to continue a relationship with me? What was my long-term relational responsibility to the women? I continued to consider these questions throughout the research and especially as I prepared to end the relationships with the women. If it had been my choice, I likely would have continued informal relationships with the women where we kept in touch on an infrequent basis. However, this was not my decision. As suggested by Morrison et al. (2012), the possibility of an ongoing relationship was left
open but the final decision was with the women. I would not say that I long for an ongoing relationship with the women but I do think about them often and I wonder how they are doing now.

I was deeply impacted by the time I spent with the women. The women and their stories became a part of me and my stories. Even now that my time with the women has ended, I continue to think about them and I wonder if they ever think about me. Perhaps the hardest part about engaging in and then ending the ongoing research relationships with the women is navigating through the unknown. When I least expect it, I am reminded of the women and I begin to wonder where they are now. When I pass the health centre, a place where I frequently met with Angel, I wonder what happened after the birth of her baby that caused our relationship to end. When I provide nursing care for a young mom experiencing a stillbirth, I wonder how Frankie is doing and if she will ever have another pregnancy. When my morning commute occasionally takes me past Tammy’s house, I wonder if she is still living in that place. The truth is, I may never know what happened to each of these women and it is the unknown that is by far the hardest part of this research.

10.5 Researcher Risk

As I prepared to begin this narrative inquiry, I recognized that I might be exposed to risk as a result of engaging in this research. I knew narrative inquiry research would require me to develop ongoing, meaningful relationships with women (Clandinin, 2013). I also knew that women with substance use disorders often experienced stigmatization and had histories of traumatic events. I anticipated the women would tell stories that would be difficult for me to hear and that these stories would make lasting impressions
on my life. I recognized I would be a different person at the end of the project than I was before I began.

Campbell-Crofts, Field, and Fetherstonhaigh (2013) stated that nurses must be aware of their own wellbeing and the potential for personal distress when conducting research that could be considered of a sensitive nature. Others have echoed the thoughts of Campbell-Crofts et al. by stating that conducting interviews on sensitive topics can be challenging and researchers often have difficulty separating themselves from the research (Elmir et al., 2011). Elmir et al., go on to say that this is particularly true when potentially distressing information is revealed. Other researchers have written about their experiences when conducting research with drug users. During her PhD research, Kappel described experiencing feelings of hopelessness and powerlessness when conducting interviews with drug addicted individuals (Nordentoft & Kappel, 2011). These types of feelings can threaten the researcher’s wellbeing leading to fear, grief, and intrusive thoughts (Elmir et al.). I recognized that I might experience similar feelings as I engaged in the research and I saw the potential for being deeply impacted by coming alongside the women. What I did not recognize was what this truly meant. I entered the field with a false sense of confidence; I was naïve to the reality of what I would face.

10.5.1 Maintaining relationships. On a personal level, this work was hard. It was hard for two reasons. Firstly, I saw benefits in this research and I was committed to completing it. However, it was very difficult to maintain relationships with the women over an extended period of time. As I have alluded to earlier, the women led complex lives. There were countless times when the women and I arranged to meet and at the last minute, they would cancel or miss the meeting. I did not believe the women wanted to
miss our meetings but rather they had obligations that took more precedence. They described unexpected appointments with workers and parole officers, family obligations, and issues with transportation as barriers to attending our meetings. I came to realize that I could not take the missed meetings personally and if I wanted to establish successful relationships, I needed to be patient as well as available whenever the women were able to see me. This meant that if one of the women contacted me, I needed to be ready to meet her. This led to some challenges with rearranging my personal life so I could meet with a woman at a moment’s notice; the women could not plan ahead as I was accustomed to doing in my own personal life. I soon realized that if I was going to develop ongoing relationships with the women, I would need to adjust to them. As I adapted to meeting with the women on their terms, I came to see an added benefit. When I was available to the women, it contributed to the development of trusting relationships. They knew I would be there when they needed me.

Despite adapting meetings to better meet the needs of the women, there were longer periods of time when I did not see each of the women. As you already know, my relationship with Angel ended earlier than I anticipated. The cell phone number I had previously used to contact Angel was no longer in service and I knew she did not have a home telephone. Angel and I had only ever met at the health centre, so I did not know where she lived. At first, I was unsure if Angel wanted to continue to see me and the only means for contacting her was through the health nurse. I did this cautiously, thinking about my ethical obligation to respect the anonymity and confidentiality of research participants. In reality, I recognized that because of the close relationship the nursing staff had with their clients, they knew who was participating in my project. I
decided to ask the health nurse to discuss Angel’s continued participation in my project the next time she stopped by her home. By now, we all know how this ended and that Angel declined further participation with me. The reason I tell this story now, is to highlight how easily women in this population can be lost in ongoing research. As narrative inquirers, we need to be prepared for this possibility in our research.

I had already lost Angel and there were times when I thought I might lose Tammy and Frankie too. Tammy entered a time when she was depressed. During this time, Tammy did not leave her home. At this point, I did not yet know where Tammy lived. Complicating the situation further was that Tammy’s cell phone number constantly changed. If I did not see her, I had no way of learning her new number. Knowing Tammy, I decided to give her time and hoped she would eventually return to the health centre. This was a time filled with uncertainty and worry for me. I did not know if I would see Tammy again. Eventually she did return to the health centre and we continued our relationship.

There were two periods of extended time when I did not see Frankie. The first was when she entered treatment. Although we maintained contact through text message during this time, Frankie was overwhelmed with her pregnancy and treatment obligations and did not have time to see me. The second extended absence was when Frankie experienced her stillbirth. Given this unexpected event, I was unsure if Frankie would still want to see me. My text messages went unanswered. I thought this was strange given that she had always responded to my texts in the past. I later learned that Frankie no longer had a cell phone. I did not know Frankie’s home telephone number, and although I knew where she lived, I felt I was overstepping my boundaries as a researcher.
by stopping by when I had not been invited. Again, I turned to the health nurse. After a conversation with Frankie, the health nurse informed me that Frankie still wanted to see me and with Frankie’s permission, provided me with her telephone number.

At first Frankie and I just spoke on the phone. We made a few plans to meet but these never worked out. Soon my phone calls went unanswered and there was no option for leaving a message. Once again, I was faced with losing Frankie. In a last attempt to maintain my relationship with her, I wrote Frankie a letter, leaving my contact information for her and asking her to call me if she wanted to continue to see me. I drove to Frankie’s home with the intention of dropping the letter in her mailbox. When I arrived at the home, Frankie was outside. I was unsure what to do but Frankie looked happy to see me and immediately walked towards my vehicle. Frankie and I had a conversation about the potential for continuing our relationship. She identified she wanted to continue but was having difficulty finding time. She asked if I could just stop by her home in the afternoons once or twice a week. If she was available, we would meet, if she was not available, I would try another time. This method of meeting with Frankie seemed to work and we continued our relationship in this way.

I have discussed the challenges I experienced with maintaining contact with Angel, Tammy and Frankie because there is a lot to be learned from my experience. My experience highlights the complex lives the women lived and the need for patience, adaptability, and availability when initiating and maintaining relationships with this population. Yet, there needs to be recognition that despite the researcher’s efforts, there may be some women who will be lost in ongoing research. This can be a frustrating experience. I found that the women’s contact information was constantly changing. If I
were to conduct similar research in the future, I would identify all contact information the
woman wished to share from the outset of the project. In this narrative inquiry, the
nursing staff at the health centre proved to be a valuable resource in helping me to
maintain contact with the women. This speaks to the value of developing relationships
not only with the women, but also with the professionals working at the health centre. I
would continue to utilize professionals as a means for helping me to maintain
relationships when it is appropriate and ethical.

10.5.2 Exposing my privilege. I mentioned that this work was hard for two
reasons. The second reason this research was difficult was that no matter how prepared I
thought I was to live alongside the women; I was not equipped to experience the
disparate conditions of their lives. Working with the women highlighted my privilege
and I felt guilty going home to my middle class neighbourhood knowing the women were
experiencing overwhelming disparities.

The poverty they lived in was previously unimaginable to me. Tammy
experienced deplorable living conditions. Her home was in disrepair and infested by
mice; Tammy recognized she needed to move. I was shocked when she considered
moving into a house with no running water. It was one thing that she even considered
this house, it was another for me to realize that such a home even existed in the city
where I lived.

Tammy was poor. I witnessed as she struggled to find 10 dollars one day. She
needed to purchase what she considered necessities: toilet paper and cigarettes. As I
watched Tammy struggle, I felt guilty. Before meeting Tammy that day, I had ordered
my groceries online. I paid little attention to how much each item cost as I ordered from
my personal computer. Later that day, I watched as Tammy carefully priced out her
grocery items with the 12 dollar prenatal voucher she had received from the health centre.
That night I wrote in my journal: “It’s hard to see how she struggles so much when my
life, in comparison, is so much easier.”

I am not sure if I could have been better prepared for my experiences with
Tammy and the other women. The shock of witnessing the disparities she experienced is
still very real to me. Maybe with time and continued exposure, I would become less
overwhelmed with witnessing the poverty that women like Tammy experience. Maybe I
do not want to become numb to the disparities they experience. What I do know is that if
I were to conduct a similar study again, I would budget for emergencies like I saw
Tammy experience. I struggled as I observed Tammy’s desperate need for 10 dollars. I
was unsure if it was ethical for me to provide her with my personal money, yet I could
not watch her desperation over an amount that was unsubstantial to me. I did not want
her to think I pitied her but I was a caring human; I had to provide her the money.

My experiences with Frankie and Angel were very similar to that of Tammy. My
daughter was about the same age as all of the women’s youngest children. Although this
connected me with the women, it also highlighted my privilege. One afternoon, I saw
Frankie and her children coming into the health centre. It was the middle of winter and it
was freezing cold outside. Frankie and her family had walked to the health centre in the
bitter cold. Later that afternoon, when I bundled up my daughter and drove the one block
to the school to get my son because I felt it was too cold to walk, I remembered Frankie
and her family; only their rosy cheeks and noses visible as they entered the health centre
after their long walk in the cold. Again, I felt guilty for leading a privileged life; for
having a vehicle to drive one block in the cold. In comparison to Frankie’s life, this suddenly seemed absurd.

The family that I was born into contributed to the “good life” I lived. I can recall sitting with Angel one day, talking about her upbringing. She experienced a traumatic childhood, complicated by violence and crime. Her early years were unstable as she moved from foster home to foster home. After Angel left the health centre that day, I sat in the private meeting room that we had met and wrote: “. . . and then I think about my own privileged life. I can’t even begin to imagine what Angel has been through. I feel guilty. Guilty to lead a privileged life. To be White. To have grown up in a stable home, to have an education, to have income at my disposal to use as I wish – so I never really want for anything. And here I sit with Angel. It seems that everything has been stacked against her. Yet she tries to turn her life around, for her daughter and for this baby. I’m not sure I’d have the strength to do the same.” It was experiences like these that changed me and humbled me and perhaps highlighted how inadequately prepared I was for what I experienced during this research.

10.5.3 Preparing to engage. As I prepared to enter this narrative inquiry, I identified strategies I would use to help protect myself from the potential personal risks associated with engaging in this research. Elmir et al. (2011) suggested that researchers should take time for reflection following each interview and should have the option for debriefing. I used a reflective journal as a field text. Not only did this text contribute to the finished project of the inquiry, it also offered me the opportunity to reflect on my interactions with the women. The journal was a useful tool that encouraged me to reflect on my experiences.
Prior to the research, I identified that my co-supervisors and committee members, as a team of highly skilled, multidisciplinary professionals could assist me in debriefing. I suggested I would take time to regularly debrief with my co-supervisors and would contact them immediately if I was feeling overwhelmed by the research relationships. In hindsight, I wish I would have debriefed more often with my co-supervisors. Although we met regularly, we focused more on the field texts I was collecting, rather than on how I was feeling. In reflection now, I also believe that in the moment, I did not recognize how deeply the research was impacting me on a personal level. It was not until the research was almost completed that I started to realize how much of a burden I was carrying related to the relationships I had developed with the women. Perhaps if I had reflected on this earlier and talked about it more, I may not have felt as overwhelmed by the end of the research.

Before beginning the research, I suggested that my prior experience as a registered nurse had prepared me to deal with the consequences of developing close relationships and listening to the women’s stories. For a large portion of my career, I had worked with pregnant women, many of whom experienced substance use disorders. I had engaged with the women and I had listened to their stories. I can now say with absolute certainty that I was wrong. Caring for women in acute care was exponentially different than living alongside them in the community and conducting this research. I saw and heard far more than I anticipated. My practice as a registered nurse did not prepare me for this experience.

You are likely coming to understand that this narrative inquiry was not easy work. In fact, it was very difficult work. However, I believe that this research was so important
in contributing to the understanding of the women’s experiences and potentially shifting future practice. Despite everything, I am thankful that I accepted the challenge of conducting this inquiry. I certainly was exposed to some risk but I believe that the benefits far outweigh the risks I experienced. I am changed as a result of conducting this inquiry. However, this change is a change for the better; a change that can be used to improve how pregnant women with substance use disorders are perceived and cared for in society and health care settings. If I was faced with conducting similar research again in the future, I would not think twice about doing it again.

10.6 A New Beginning

Thank you

It is quiet. Everyone is sleeping. I should be sleeping. But I find myself sitting in this place; a place that has become so familiar over the past year or so. Another late night of just me, my computer, and the orange glow of the office light. I sit in the quiet, listening only to the soft hum of the furnace on a cold winter's night. And I think. I think about the past year and what it has all been for. What has changed? I know I have changed and I wonder if they have changed too.

I have been deeply impacted by relationally coming alongside Tammy, Angel, and Frankie in this narrative inquiry. I will never be the same practitioner, educator, or researcher because of them. I will never be the

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10 I have used a font that is not typical of APA formatting to emphasize this section as a personal story.
same nurse. I will never be the same mother. I will never be the same person. But what does it matter? It matters because I have more understanding. It is because of this research that I have come to have a new understanding of the realities of pregnancy and addiction for women like Tammy, Angel, and Frankie. The nursing care that I personally provide will be more compassionate and more empathetic because of this understanding. I can advocate, through my practice, research, and education of undergraduate nursing students for better care that goes beyond just me.

I naively entered this research, thinking that I understood. But I did not understand. I had no idea. Perhaps I still do not truly understand but I have had a glimpse into the lives of these women. Witnessing first-hand how the women lived was truly eye opening. I never imagined that mothers in my own city lived without running water, in mice infested homes. I never imagined that something so basic, like toilet paper, would be a luxury to some. I never imagined that the systems I thought were designed to support women and families actually acted as a form of surveillance. Rather than supporting women, these systems put conditions on their motherhood. But most importantly, I never imagined that in the presence of such adversities, these women would still have a fight that came from deep within
them. They fought for themselves, for their sobriety, for their children, and for their families. Even in the most hopeless times, they found hope and they moved forward, desperate for a better future for themselves and their families.

I sit here in the quiet and I reflect on how thankful I am for Tammy, Angel, and Frankie. I am thankful that they entered into my life and that they changed me. But even more importantly, I am hopeful. I am hopeful that because of these three women and the stories they shared in this narrative inquiry, that others will come to understand pregnancy and addiction in the way that I have. I entered this narrative inquiry because I wanted to understand the context of the lives of pregnant women with substance addictions. I certainly accomplished that. But I also wanted to begin to shift the perception of women with substance use disorders who become pregnant so that care can better meet their needs. I am hopeful that the stories shared in this narrative inquiry will be the first steps in providing better care for pregnant women with substance use disorders but I recognize that there is much more work to be done. I look forward to this work.
I want to thank Tammy, Angel, and Frankie for having the courage to come alongside me and share their stories. Without them, this work would not have existed. Yet, there is one more person who I must also thank. Even though she will likely never know it, this work is because of her. One night I had a chance encounter with a long lost friend. That encounter was a gift and because of it I began this journey. This work would not have happened without Tammy, Angel, Frankie, and my long lost friend and to each of them I owe my deepest gratitude.
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PREGNANCY, MOTHERHOOD, AND ADDICTION


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PREGNANCY, MOTHERHOOD, AND ADDICTION


Appendix A

Tammy’s Timeline

1990
15 years old
Leaves home
Starts using alcohol and drugs

1994
Returns home
Stops using alcohol and drugs

1995
Birth Child 1

2000
Starts using alcohol and drugs again

2004
Birth Child 4

2005
Birth Child 5
Adopted out of family

2006
Birth Child 6
Apprehended

2007
Incarcerated
Children apprehended

2013
Pregnancy
7
Decreased drug use

2014
Birth Child 7
Apprehended months later

2017
Birth Child 8
Appendix B

Angel’s Timeline

<table>
<thead>
<tr>
<th>Event</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood</td>
<td>14 years old</td>
</tr>
<tr>
<td>Surrounded by substance use and violence</td>
<td></td>
</tr>
<tr>
<td>14 years old</td>
<td></td>
</tr>
<tr>
<td>Begins using alcohol and drugs</td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td></td>
</tr>
<tr>
<td>Heavy alcohol and drug use</td>
<td></td>
</tr>
<tr>
<td>Home without baby</td>
<td></td>
</tr>
<tr>
<td>Increased alcohol and drug use</td>
<td></td>
</tr>
<tr>
<td>Pregnancy 1</td>
<td></td>
</tr>
<tr>
<td>Quits using alcohol and drugs</td>
<td></td>
</tr>
<tr>
<td>Baby apprehended at hospital</td>
<td></td>
</tr>
<tr>
<td>Pregnancy 2</td>
<td></td>
</tr>
<tr>
<td>Decreased alcohol and drug use</td>
<td></td>
</tr>
<tr>
<td>Baby apprehended at hospital</td>
<td></td>
</tr>
<tr>
<td>Pregnancy 3</td>
<td></td>
</tr>
<tr>
<td>Decreased alcohol and drug use</td>
<td></td>
</tr>
<tr>
<td>Baby apprehended at hospital</td>
<td></td>
</tr>
<tr>
<td>Working to get children home</td>
<td></td>
</tr>
<tr>
<td>Pregnancy 4</td>
<td></td>
</tr>
<tr>
<td>Deaths of father-in-law and mother-in-law</td>
<td></td>
</tr>
<tr>
<td>Increased alcohol and drug use</td>
<td></td>
</tr>
<tr>
<td>Children apprehended</td>
<td></td>
</tr>
<tr>
<td>Pregnancy 5</td>
<td></td>
</tr>
<tr>
<td>Takes baby home from hospital</td>
<td></td>
</tr>
<tr>
<td>Heavy alcohol and drug use</td>
<td></td>
</tr>
<tr>
<td>Maintains sobriety and custody of youngest child</td>
<td></td>
</tr>
</tbody>
</table>
Appendix C

Frankie’s Timeline

Childhood
Surrounded by substance use and violence

Birth Child 1
Continues to use alcohol after pregnancy

21 years old
Begins using illicit drugs

Birth Child 2
Continues using intravenous drugs after pregnancy

Enters outpatient treatment

Pregnancy 3

Stillbirth of pregnancy 3

Grief and recovery

14 years old
Heavy alcohol use begins

Meets current partner

Begins using intravenous drugs
Involved in crime and sex trade
Appendix D

University of Regina Research Ethics Board Certificate of Approval

The University of Regina Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol, consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS
In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: http://www.uregina.ca/research/for-faculty-staff/ethics-compliance/human/forms1/ethics-forms.html.
Appendix E

Regina Qu’Appelle Health Region Letter of Research Ethics Board Approval

September 9, 2016

Dr. Glenn Donnelly
University of Regina
3737 Wasacna Parkway
Regina, SK S4S 0A2

Dear Dr. Donnelly,

RE:       REB-16-97, U of R 2016-141
Title:    Stories of Pregnancy and Addiction

Your application for research ethics review has undergone a harmonized review by the Regina Qu’Appelle Health Region (RQHR) and University of Regina (U of R) Research Ethics Boards (REBs). In accordance with the Research Ethics Review Reciprocity Agreement signed by the University of Saskatchewan, University of Regina, and Regina Qu’Appelle Health Region, the RQHR REB accepts the Certificate of Approval issued by U of R REB.

This letter is issued to you in lieu of a Certificate of Approval by the RQHR REB. This letter permits you to conduct research activities as approved by the U of R REB, provided that you maintain a valid and up-to-date Certificate of Approval.

All continuing ethics review will be conducted by the U of R REB. The U of R is authorized to share all communications pertaining to this file with the RQHR REB at their discretion. The RQHR REB may provide input into continuing ethical review activities, as agreed upon by both REBs.

The RQHR REB reserves the right to revoke the privileges described in this letter at any time in order to conduct their own independent research ethics review of your project. Such a decision would be communicated to you and the U of R REB in writing.

This letter also serves to acknowledge that you have obtained all necessary departmental approvals within the RQHR and are permitted to proceed with this research on operational grounds. Approval for this study has been received from the following:
- Lareena Trutch (Primary Health Care – Central Network)

If at any time you will require resources, participants, or data from any additional departments, you must provide the RQHR REB with the required signatures before proceeding.

Best wishes for your continuing research endeavours.

Sincerely,

[Signature]

Dr. Jennifer St.Ongé, Acting Chair
Research Ethics Board
Regina Qu’Appelle Health Region

cc. University of Regina Research Ethics Board

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Research Ethics Board
2180 - 23rd Avenue, Room M-704 • Regina • SK • S4S 0A5
Phone: 306-766-6451 • Fax: 306-766-6530 • Email: ResearchEthics@rquhealth.ca • Website: http://www.rqhr-rpa.ca/
Appendix F

Consent Guide

Project Title: Stories of Pregnancy and Addiction

Researcher: Jodie Bigalky, PhD Candidate, Faculty of Nursing, University of Regina
(306) 537-0929; JodieBigalky@uregina.ca

Supervisors: Dr. david Gregory, Faculty of Nursing, University of Regina
(306) 585-5608; david.gregory@uregina.ca

Dr. Glenn Donnelly, Faculty of Nursing, University of Regina
(306) 337-8544; glenn.donnelly@uregina.ca

Purpose of the Narrative Inquiry (Research):

- The purpose of this narrative inquiry is to explore the storied experiences of pregnant women who have substance addictions. This may lead to an increased understanding of the women and improve how health care is provided.
- The results of the narrative inquiry will be shared with health care workers who work with pregnant mothers with addictions. The narrative inquiry will also be part of the researcher’s dissertation and will be published and presented.

Procedures:

- You are asked to participate in an on-going relationship with the researcher during your pregnancy and for a few weeks after your baby is born. The on-going nature of the relationship between yourself and the researcher will be discussed and agreed upon. The researcher would like to meet with you every one to two weeks during the pregnancy. This may include having the researcher attend health care activities or appointments with you or informally spending time with you such as going for coffee. You will also be asked to tell your story of pregnancy and addiction and work with the researcher to ensure that she tells your story as you want it to be told. The researcher may audio tape or take notes of some conversations but will always ask your permission prior to doing so. Meeting places will be chosen by you and arranged by the researcher. Meetings can take place in an area where no one will see that you are participating. Meeting places
will be discussed with you so that you are comfortable with where conversations take place. It is estimated that three to four women will take part in this inquiry.

- Please feel free to ask any questions about the inquiry and your role.

**Potential Risks:**

- There is a small risk of emotional upset, embarrassment, loss of privacy, or stress from remembering unpleasant events during this inquiry. If you find that you become upset by talking about your experiences, arrangements have been made for you to talk to someone not connected with the inquiry.
- You can decide to not answer any question at any time.
- If you reveal any information that is against the law and requires reporting, such as child abuse or intent to cause violence, this will have to be reported.

**Potential Benefits:**

- You may not benefit directly from this study; however, results of this study may be used to suggest how health care workers can improve care for pregnant women with substance addictions.

**Compensation:**

- You will receive a 30 dollar gift card at the end of the first meeting to thank you for participating in the inquiry. The gift card will be discussed with you so that a gift that is useful can be given. You will receive a second gift card for 30 dollars after the birth of your baby. Any childcare or transportation costs will also be covered.

**Confidentiality:**

- Although the information from this inquiry will be published and presented, the information will be summarized so that in most cases no one will be able to tell that you said it. Although things that you say during the inquiry will be reported, you will be given a fake name (if you choose) and any information that would make someone know that it was you that said it will be removed. It cannot be guaranteed that no one will know who has participated in the inquiry or who has made certain comments. For example, if you have shared your experiences with others or told others that you took part in this inquiry they may be able to identify something that you have said or something that has happened to you. If you choose to use your real name and be connected to your story, others will know that you have participated in this inquiry.
- **Storage of Data:** Interview tapes, written information, and contact information will be stored in the supervisor’s office in a locked cabinet and will be destroyed after five years. Consent forms will be stored separately from other documents so that it is not possible to connect your name with responses. Electronic data will also be destroyed.
Right to Withdraw:

- Participation in this inquiry is voluntary and you can answer only those questions that you are comfortable with. Whether you choose to participate or not will have no effect on your health care services or how you will be treated.
- You can decide to not take part in the project at any time. Nothing will happen to you if you decide to stop at any time and this will not affect the health care services that you are a part of. You may choose whether the information that you have already provided can be used in the inquiry. If you do not want your information used, it will be destroyed.
- You may request that the recording device be turned off at any time. You will be completely free to discuss anything that you want and you will not be forced into answering any question or giving any information that you don't want.

Follow up:

- You will work with the researcher during meetings to ensure that your story is told as you wish it to be told. On an on-going basis, the researcher will discuss how your story has been written so that you have the option to add, alter, or delete, information as you see fit.

Continued or On-going Consent:

- You will participate in more than one meeting with the researcher. Consent will be informally visited at the beginning of each meeting. You will be reminded that you are participating in a research project. Your continual participation will imply that you agree to continue to participate.

Questions or Concerns:

- Contact the researcher or supervisors using the information at the top of page 1
- This project was approved by the University of Regina Research Ethics Board on (insert date) and the Regina Qu’Appelle Health Region Research Ethics Board on (insert date). For any questions with regard to your rights or treatment as a participant in this project contact the University of Regina Research Ethics Board (306-585-4775 or research.ethics@uregina.ca) or the Regina Qu’Appelle Health Region Research Ethics Board (306-766-5451 or researchethics@rqhealth.ca). Out of town participants may call collect.
“I read and explained this Consent Form to the participant before receiving the participant’s consent, and the participant had knowledge of its contents and appeared to understand it.”

<table>
<thead>
<tr>
<th>Name of Participant</th>
<th>Researcher’s Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

Researcher’s Initials (Complete and initial one):

___________ agrees to be referred to by pseudonym ________________ in the results.

___________ agrees to have responses attributed to her name in the results.

A copy of this consent guide has been provided to the participant.
Faculty of Nursing
University of Regina

PARTICIPANTS NEEDED FOR RESEARCH IN

Pregnancy and Addiction

We are looking for volunteers to take part in a narrative inquiry into the stories of pregnant women with addictions.

As a participant in this study, you would be asked to tell your story of addiction during pregnancy.

Your participation would involve meeting with the researcher every one to two weeks during pregnancy and in the first few weeks after your baby is born.

In appreciation for your time, you will receive two separate gift cards.

For more information about this study or to volunteer please contact:

Jodie Bigalky, PhD Student
Faculty of Nursing
306-537-0929 or JodieBigalky@uregina.ca

This study has been ethically approved by the Research Ethics Board, University of Regina and Regina Qu’Appelle Health Region.