Women’s Path-finding; Recovery from Substance Use:
A Critical Feminist Study

by

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Dedication of Thesis

"And if you spend yourselves in behalf of the hungry and satisfy the needs of the oppressed, then your light will rise in the darkness, and your night will become like the noonday" (Isaiah 58:10, New International Version).

This work is dedicated to my mother Dorine May Wyatt, who despite incredible oppression, adversity and hardship, loved her children with intensity and always did the best she could with what she had (Victoria Life Enrichment Society, 2004). Her determination to care for her children is aptly expressed by Oriah Mountain Dreamer (2005) who shares: "It doesn't interest me to know where you live or how much money you have. I want to know if you can get up, after the night of grief and despair, weary and bruised to the bone, and do what needs to be done to feed the children" (p. 2, italics in original). This thesis is written from my “Heart Space” (Cowling, Chinn & Hagedorn, 2003) to yours in memory of my mother and is offered as one path of many that might be travelled to illuminate and dispel the oppressive darkness that shadows the lives of countless women and their families.

![Dorine May Wyatt (1930 – 1984)](image)
Abstract

The research represented in this thesis was developed in response to identified social, political, economic and health inequities which Canadian women experience in the Kamloops, British Columbia region. This work explored seven women’s lived experiences of healing from problematic substance use within this small urban centre by asking the question: How do women with a history of substance misuse negotiate barriers and find paths to recovery? The overarching aim of Women’s Path-finding: Recovery from Substance Use: A Critical Feminist Study was to provide a forum through which women might share and better comprehend their recovery experiences.

Critical feminist methodology explored the gendered nature of power in modern society and the social construction of gender in women’s relationships. This was achieved by blending traditional semi-structured interviews with a progressive and emerging analytic method called the Listening Guide. A composite of seven women’s narratives demonstrated how disruption to family cohesiveness as well as an array of physical, psychological, social or spiritual abuse contributed to women’s altered sense of self and resultant shame, damaged self esteem and diminished self confidence. Women also uncovered their incredible strengths and resilience as well as their abilities to embrace health and wellness. Academically this study exemplified emancipatory nursing practice as a grassroots relational approach promoting women’s health through awareness, self-discovery and ongoing engagement with the community.
Glossary of Terms

**Aboriginal:** In Canada includes “First Nations, Inuit [Indigenous], and Métis peoples” (Ball, Dagger, Christian, Campbell, 2009, p. 221).

**Abuse:** May include one or more of physical, psychological, or spiritual harm caused by boundary intrusion inflicted by one person or persons toward another; usually abuse is inflicted by people with more power toward those with less power (Kasl, 1992).

**Addiction:** A general definition of addiction includes any persistent and harmful behavior that involves loss of personal control having negative consequences for oneself as well as others (British Columbia Medical Association [BCMA], 2009). Also refer to **Substance Addiction**.

**Bottom-end user:** At the lowest end of the drug culture hierarchy: Not involved in the “dealing” or selling of drugs only buying and using them (Sarah, personal communication, July 5, 2007).

**Boundaries:** “Define what belongs to an individual on a physical, psychological, and spiritual level” (Kasl, 1992, p. 234). Kasl denotes that a physical boundary is a person’s personal space, a psychological boundary defines one’s right not to be “analyzed, shamed, manipulated, lied to, or brainwashed” (p. 234) and “all objectifying, stereotyping, and defining one group of people as less than another group of people is a spiritual [boundary] violation” (p. 234, italics in original).

**Caucasian:** “Of or belonging to a racial group having light skin coloration . . . [syn: {white}] [ant: {black}]” (Wordnet, 2011).
Downtown East Side Vancouver (DTES): An area of approximately ten square blocks in the eastern downtown area of Vancouver, British Columbia, Canada. There are fifteen thousand residents living in this area most of whom live in “poverty and social dysfunction” (Vancouver & Downtown Eastside, 2008).

High-end User: At the highest end of the drug culture hierarchy: “Dealing” or selling drugs and using them (Sarah, personal communication, July 5, 2007).

Métis: “The word Métis means ‘mixed-blood’ in French. . . . The Métis people emerged out of the relations of Indian women and European men, mainly French-Canadians and British” (Thompson Rivers University, 2011, p. 49). Currently in Canada Métis may refer to anyone who identifies as Métis on the Canadian Census (Gionet, 2008). This is a less comprehensive definition than that adopted by the Métis National Council (2012, Citizenship) who state: “‘Métis’ means a person who self-identifies as Métis, is distinct from other Aboriginal peoples, is of historic Métis Nation Ancestry and who is accepted by the Métis Nation.”

Recovery: Includes approaches that holistically attend to women’s healing from trauma and substance use problems (Van Wyk & Bradley, 2007). In terms of a harm reduction approach to recovery from substance use; the amount and kinds of substances used while in recovery are determined by women’s own goals and from a strength-based approach women focus on resilience, ability to cope and adapt to life circumstances (Aston, Comeau & Ross, 2007). Recovery is defined in some contexts as abstinence from all drugs or alcohol (see Twelve Step Meetings).
Residential School: “Approximately 100 residential schools operated in Canada from 1849-1983. Indian Act legislation in 1920 made school attendance compulsory for all First Nations children between the ages of seven and 15” (Smylie, 2009, p. 289). Residential schools aimed to separate First Nations children from their families and assimilate them into mainstream cultures. As noted in Prime Minister Steven Harper’s June 11, 2008 apology to residential school survivors: “Two primary objectives of the residential school system were to remove and isolate [First Nations] children from the influence of their homes, families, traditions and cultures, and to assimilate them into the dominant culture” (Belanger, 2010, p. 113).

Substance Addiction: Chronic intake of drugs or chemicals, both licit and illicit, having psychoactive or consciousness-altering effects that may become harmful and problematic when resulting in psychological and physical dependence (Addiction Research Foundation, 1996; Alexander, 2008; BC Ministry of Health Services, 2004). Substance addiction is used interchangeably with substance abuse, substance and drug use as well as substance misuse in the reviewed literature and throughout this thesis.

Twelve Step Meetings: These are anonymous meetings in which participating individuals discuss a range of materials related to twelve different steps to recovery defined as total abstinence from all drugs and alcohol. There are many groups that utilize twelve step meetings depending on what addiction issues are being addressed for example Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and Overeaters Anonymous (OEA). “Alcoholics Anonymous [AA] was the first twelve step program, founded in 1935 by a New York
stockbroker and an Ohio doctor who both suffered from alcoholism. AA has
grown to more than two million recovered alcoholics world wide” (White, 2007,
p. 225).

**Vulnerable:** Pederson, Raphael and Johnson (2010) consider vulnerable groups
as those populations who have diminished life opportunities. As well as less
opportunity in life Gillis and MacLellan (2010) also suggest that vulnerable
populations “include underserviced groups with unmet needs for care that are
embedded in systems of inequality” (p. 1). Vulnerability as a concept may
describe individuals, groups, those in communities and distinct populations
(Walker, 2005).

**Acronyms**

BC: British Columbia

BCCEWH: BC Centre of Excellence for Women’s Health

BCMHS: BC Ministry Health Services

BCWHHC: BC Women’s Hospital and Health Centre

CARE: Clinic Action Research for Empowerment

DTES: Downtown East Side

HWC: Health and Welfare Canada

PTSD: Post Traumatic Stress Disorder

VANDU: Vancouver Area Network of Drug Users

VLES: Victoria Life Enrichment Society

WHO: World Health Organization
TABLE OF CONTENTS

Deakin University Access To Thesis – A ........................................ ii
Deakin University Candidate Declaration ................................... iii
Acknowledgements ........................................................................ iv
Dedication of Thesis ...................................................................... vi
Abstract ...................................................................................... vii
Glossary of Terms ......................................................................... viii
Acronyms ..................................................................................... xi

CHAPTER ONE: THESIS INTRODUCTION

Thesis Introduction .......................................................................... 1
Rationale for a Study of Women in Recovery from Substance Use ....... 1
Aims of a Critical Feminist Research Study ..................................... 3
Statement of the Questions to Explore .......................................... 4

Chapter Overviews .......................................................................... 5
- Review of the Literature ............................................................. 5
- A Critical Feminist Methodological Framework .......................... 6
- Blending of Traditional and Emerging Methods .......................... 7
Findings: Uncovering Women’s Experiences of Recovery from Substance Use ......................................................... 8
Discussion of Findings ..................................................................... 9
Final Thoughts and Understandings ................................................. 10

Summary ...................................................................................... 11

CHAPTER TWO: REVIEW OF THE LITERATURE

Introducing the Review of the Literature ........................................ 12
Health Care in Canada .................................................................... 14
Health: A Resource for Everyday Life ........................................... 15

Social Determinants of Health ....................................................... 17
- Political Impacts on Canadian Women’s Lives ........................... 18
- The Economy and Canadian Women’s Health ......................... 19
- Educational Impacts on Canadian Women Related to Social Security and Income .................................................. 21

Canadian Statistics: Substance Addictions .................................... 23
Canadian Systems of Service..................................................26

The Multiple Dimensions of Addiction........................................26

Canadian Women and Substance Use .......................................30
  Women with Problematic Substance Use History and Their
  Children...........................................................................32
  Women with Concurrent Disorders.......................................35

Canadian Women’s Experiences of Recovery...............................37

Truthful Self-Nurturing as a Theory of Women’s
  Addiction Recovery............................................................43

National Framework for Action to Reduce the Harms Associated with
  Alcohol and Other Drugs and Substances............................47

BC Ministry of Health Planning Framework:
  Every Door is the Right Door...............................................48

Funding for Women’s Treatment Services in BC.........................49

The Aurora Centre at BC Women’s Hospital and Health Centre......51

A Framework for Action: Four-Pillar Approach in Vancouver, BC......52

The Phoenix Centre in Kamloops, BC......................................53

It’s All ‘Bout You’ Women’s Conference..................................54

The Roles of Nurses Supporting Women in Recovery from
  Problematic Substance Use in Kamloops, BC..........................57

Summary..................................................................................57

CHAPTER THREE: THEORETICAL FRAMEWORK AND
  METHODOLOGY

Introduction of Theoretical Framework and Methodology...............59

Choosing a Theoretical Framework..........................................59

The Fundamentals of Critical Theory.......................................62

Ideology Paired With Power Produces Control..........................62
Hegemony and ‘Power Over’ ............................................. 66
Liberatory Social Power ................................................. 67

Critical Perspectives of Oppression and Liberation ................. 69
  Control as an Outcome of Established Ideology and
  Power Bases .......................................................... 70
  Enlightenment/Awareness through Empowerment and
  Transformation ....................................................... 71
  Personal Empowerment ............................................ 72

The Fundamentals of Feminist Theory ................................... 72

Feminist Perspectives of Oppression and Liberation .................. 73
  Women as Insiders and Outsiders ................................ 74
  Marginalization of Women ....................................... 74
  Lifeworld Colonization .......................................... 79
  Figure 1: Schema of Lifeworld Colonization .................... 80
  Women’s Voice and Agency ...................................... 81

Women’s Lifeworlds and Social Systems ................................ 81

Empowerment .................................................................. 83

Transformation .................................................................. 88

A Critical Feminist Theoretical Framework ............................. 89

Situated Within a Critical Feminist Framework: Three Perspectives .... 91
  Viewing Oneself ....................................................... 91
  Oneself and Seven Women: Positions of Power-sharing .......... 92
  Oneself and Epistemic Community .................................. 92

Self Narrative ................................................................. 93

The Discipline of Nursing and Emancipatory Practice ............. 97

Exemplars of Emancipatory Nursing Practice .......................... 101
  Exemplar 1: Voice: Challenging the stigma of addiction;
  a nursing perspective ............................................. 101
  Exemplar 2: Women moving beyond bars: Building equity in
  community partnerships – Presentation at the 21st Canadian
  Bioethics Society Annual Conference ............................ 103
  Exemplar 3: A ‘hands-off’ approach to community partnerships;
  a critical perspective – Posted paper prior to presentation at
  the 14th International Critical & Feminist Perspectives in
  Nursing Conference .................................................. 106
Critical Feminist Methodology .................................................. 110
Critical Feminist Methodology and the Gendered Interview .......... 110
Summary .................................................................................. 112

CHAPTER FOUR: METHODS FOR A CRITICAL FEMINIST STUDY

Introducing Methods for a Critical Feminist Study .................... 113
Ethical Considerations ............................................................. 113
Recruitment of Participants: Purposive Sampling .................... 115
Figure 2: Participant Demographics ........................................... 117
Data Collection ........................................................................ 118
Reflexivity and Trustworthiness within the Critical Feminist Project ... 119
Preliminary Analytic Methods .................................................... 120
Emerging Analytic Methods ...................................................... 121
The Listening Guide as an Emerging Method of Analysis:
The Multiple Layers of Women’s Narratives ......................... 122
  Reading 1: Central Story Lines and Reflexivity ..................... 124
  Reading 2: I’ Poems: Participants Perceptions of Self .......... 125
  Reading 3: Social Networks and Intimate Relationships ...... 126
  Reading 4: Micro-level Narratives and Macro-level Processes ...... 126

Summary .................................................................................. 127

CHAPTER FIVE: FINDINGS

Introduction of Findings ......................................................... 129

Odysseys of Seven Women: Path-finding – Discovery and
Transformation .......................................................................... 131

Sarah ...................................................................................... 132
  Sarah’s Odyssey .................................................................. 133

Lee ......................................................................................... 140
  Lee’s Odyssey .................................................................... 141
CHAPTER SIX: DISCUSSION OF FINDINGS

Introduction of Discussion of Findings........................................ 191

Women’s Path-finding: An Overview........................................ 191

Canadian Social Hierarchies and Class Structures...................... 193

The Theory of Dislocation...................................................... 198

Two Points of Dislocation...................................................... 199

The Oppression of Addiction.................................................. 202
  Broken Boundaries ......................................................... 203
  Abuse of Women and Girls................................................. 204
  Enmeshment as Codependency............................................. 206
  Social Exclusion............................................................. 208
Systems of Care................................................................. 214

Women’s Resources for Recovery in Kamloops, BC..................... 215

The Liberation of Recovery.................................................. 216
   Knowing and Knowledge.................................................. 216
   Personhood: Internal and External Knowing......................... 217
   Boundary Integrity: The Unique Self and the Distinct Other...... 217
   Belonging: The ‘I’ and the ‘We’ of Relationships.................. 218

Women’s Path-finding: Recovery from Substance Use............... 221

Figure 3: Emancipatory Nursing Practice................................ 227

The Implications of Emancipatory Nursing Practice.................... 228

1 Implication: Mainstream Support Followed by Community Support Promotes and Sustains Women’s Recovery, Autonomy and Self-care... 228

2. Implication: Addressing Broad Social Issues Including Abuse, Social Exclusion and Resource Allocation Potentiates Women’s Strength and Capacities............................................ 230

3 Implication: Self Knowledge, Healthy Boundaries and Belonging Promote Women’s Path-finding to Recovery.......................... 231

4. Implication: Women’s Communities of Care; Support Sustainable Recovery from Substance Use................................................. 232

Recommendations of the Critical Feminist Study: Women’s Path-finding; Recovery from Substance Use........................................ 236

Summary.................................................................................. 238

CHAPTER SEVEN: FINAL THOUGHTS AND UNDERSTANDINGS

Introduction of Final Thoughts and Understandings.................. 239

Rewards and Challenges........................................................ 239

Empathy in Sheer Places....................................................... 242

Moving Forward...................................................................... 243

Summary.................................................................................. 244

References.............................................................................. 245
Appendices

A  Deakin University Human Research Ethics Committee Approval ................................................................. 263
B  Thompson Rivers University Research Ethics Human Subjects Committee Approval ........................................ 264
C  Deakin University Human Research Ethics Committee Plain Language Statement ........................................ 265
D  Deakin University Statement of Interest Form ......................................................................................... 267
E  Deakin University Human Research Ethics Committee Consent Form ..................................................... 268
F  Interview Schedule ................................................................................................................................. 269
G  Path-finding: The Voice of Judy – Early into Substance Misuse; I Work, I Eat, I Sleep ........................................ 270
H  Path-finding: The Voice of Judy – Entering Recovery; I Stood Up; I Went .................................................... 271
I  Path-finding: The Voice of Judy – Further Along the Journey; I Live ......................................................... 272
J  Path-finding: The Voice of Lisa – Early into Substance Misuse; I Want More ................................................ 273
K  Path-finding: The Voice of Lisa – Entering Recovery; I’m Clean and Sober ..................................................... 274
L  Path-finding: The Voice of Lisa – Further Along the Journey; I Can ............................................................ 275
M  Path-finding: The Voice of Darby – Early into Substance Misuse; Ashamed to Talk ...................................... 276
N  Path-finding: The Voice of Darby – Entering Recovery; Reaching Out ......................................................... 277
O  Path-finding: The Voice of Darby – Further Along the Journey; an Inspiration ............................................. 278
CHAPTER ONE: THESIS INTRODUCTION

The following chapter begins by presenting the rationale for a study that has explored the lived experiences of seven Canadian women in recovery from problematic substance use. Following this, the primary research question regarding women’s path-finding and recovery, is then discussed. The interview schedule and specific aims of this study as well as subsequent chapter overviews then give a broad picture of how this exploration of women’s path-finding to recovery from substance use progressed. This thesis has been presented using the American Psychological Association [APA] (2001) fifth edition publication manual and formatted accordingly.

Rationale for a Study of Women in Recovery from Substance Use

The British Columbia Centre of Excellence for Women’s Health [BCCEWH] (2006, p. 25) notes that although much progress has been made in British Columbia [BC] for harm reduction programming for addictions, overall the “specific risks, barriers and health concerns of vulnerable girls and women” have not been adequately addressed and that this contributes to structural and social barriers to women’s health. The BCCEWH argues that women centred approaches are urgently needed in BC and recommends that health service providers as well as policy makers consider how gender contributes to women’s substance use; also that approaches for prevention, harm reduction and treatment be initiated at the community level. The research in this thesis has focused on the unique needs of women with substance addiction. It has built on other women-centred care models that have successfully been used in health care service. As the BCCEWH states: “women’s health advocates and providers
have also developed women-centred frameworks to address the social, political, economic, and health inequalities experienced by women in the context of their practice” (p. 12)

In the Kamloops, BC community traditional street outreach programs have struggled to contend with the health care needs of marginalized populations most notably women with substance use issues (Carriere, 2008). Carriere suggests that underserved women have received insufficient health care as a result of social inequality: “The social context of women’s lives includes structures of social inequalities including socio-economic status and social role responsibilities and expectations such as care-giving” (p. 206). Programs developed by Carriere (2004a) as part of a public health outreach service for women have included initiatives such as the It’s All ‘Bout You women’s conference. Events, including this conference, were implemented in response to a needs assessments completed by nurses who indicated that 46% of ninety eight Kamloops women appraised used illicit substances on a daily basis and that priority health issues identified by this group were related to mental health and personal safety concerns (Carriere, 2008).

The study represented in this thesis was developed in response to local women’s experiences of social, political, economic, and health inequality in the Kamloops, BC, region. These inequalities became apparent during informal conversations with women in the community such as the It’s All ‘Bout You women’s conference as well as from formal surveys including those employed by Carriere (2004c). Overall women, inclusive of those with substance use history, reported experiences of overt stigmatization in the community as well
as a lack of health options. The significant stigmatization of women, who use substances, particularly if they have families, is substantiated by Carlson (2006) who writes:

Stigma is still a tremendous obstacle to confronting substance use disorders. Moreover, the stigma associated with substance use disorders is often perceived to be greater among women because they often have higher expectations about being good mothers and caretakers of society in general. (p. 211)

It was the overarching ambition of Women’s Path-finding: Recovery from Substance Use: A Critical Feminist Study that women with a history of substance use would be offered opportunities to share their lived experiences of recovery. Additionally, this study aimed to integrate women’s self identified needs and priorities into substantive grassroots health initiatives within the Kamloops community.

Aims of a Critical Feminist Research Study

The aims of this critical feminist study were to provide opportunity for women living in Kamloops, BC with a history of substance use, to share personal knowledge, life experiences and stories regarding their journeys of recovery. This research intended to explore how women negotiated barriers to recovery so that they were able to further progress and heal. As women shared recovery experiences it was anticipated that they would become increasingly conscious of surrounding social systems and better understand how these have impacted their lives. Through this understanding it was hoped that women would identify and prioritize community supported grassroots initiatives.
Statement of the Questions to Explore

Critical feminist research poses questions that explore how women living with addiction history are able to connect the “articulated, contextualized personal with . . . social institutions that define and shape our lives [by asking:] How do things work? How do we contribute to the workings? How can we collectively change them?” (Maguire, 2002, p. 65, italics in original). To answer these broad overarching queries this research asked the question: How do women with a history of substance misuse negotiate barriers and find paths to recovery? During interviews with women with a history of substance use, sub-questions were generally asked sequentially although this was very flexible and participant directed. Sub-questions which were based on the main research question and on the aims of the project included the following:

- What led to your misuse of substances? (Further questions related to narratives)
- What does recovery from the misuse of substances mean to you?
- What made you decide to stop misusing substances?
- What keeps you from recovery (barriers)?
- How did you manage these barriers (note specific ones identified)?
- What (people/situations/decisions) make you feel strong and able to remain in recovery?
- What (people/situations/decisions) make you feel weak and unable to remain in recovery?
- Which situations in your life make you feel in control?
- What situations in your life cause you to lose control?
- What does community mean to you?
- When do you feel supported in community?
- When do you feel unsupported in community?
Chapter Overviews

The following section overviews the thesis chapters in the order that they appear. These overviews are presented as follows: Literature review, methodological framework, traditional and emerging methods, findings and discussion with the last chapter attending to final thoughts and understandings.

Review of the Literature

This chapter reviews literature that was important to a gender-based study involving Canadian women. The review was done with the intent of better understanding the nature of women’s lives within the context of Canadian political, economic and educational arenas. Canadian women’s health and health determinants situated within these arenas are discussed as well as the circumstances of women’s lives in terms of oppressive social systems that tend to marginalize or disenfranchise women who use substances particularly if they are pregnant, parenting or have issues such as concurrent disorders. The qualitative literature documented women’s personal recovery experiences from substance use and how they have achieved better health for themselves and their families through emancipatory and relational means. The review of the literature took an emancipatory approach intending to uncover women’s experiences of power and control within Canadian social systems although quantitative sources were also reviewed. Statistical data revealed the extent of harm and degree of addiction that has affected Canadian women and their families. Overall, this review presents examples of community based initiatives that demonstrate
how women are working in the Kamloops, BC community to uncover their personal experiences of social control and domination and how they are managing to achieve self empowerment through community based activities.

A Critical Feminist Methodological Framework

A critical feminist theoretical framework is discussed as the basis for this research with the belief that by promoting the health of women in recovery from substance addiction through liberatory action emancipatory outcomes occur. Using a critical feminist methodological framework systemic control of women’s lives in relation to hegemonic ideological processes were explored to understand how women have been able to locate healing paths while negotiating barriers to their recovery. This critical feminist methodology was informed by critical and feminist theoretical perspectives regarding the gendered nature of power in a patriarchal society as well as the social construction of gender in women’s relationships. Research questions, aims of the study and future interview questions were all developed against the backdrop of what would be most empowering and helpful to women in their recovery. Also important to this work was the concern for equal power relationships in the social context between myself as the researcher and participants so that resulting knowledge generation potentiated mutually empowering and emancipatory processes having liberatory outcomes. The promotion of mutuality and emancipatory processes aligned well with my ‘way of being’ as an emancipatory nurse researcher and were most suitable for this methodological framework that explored how women with a history of substance use negotiated barriers and located paths to recovery.
Blending of Traditional and Emerging Methods

Informed by emancipatory critical feminist foundations, this study blended some aspects of more traditional methods including a semi-structured interview schedule with a progressive and emerging analytic method called the Listening Guide. The Listening Guide included multiple readings of data so that varying participant positions situated within layers of narratives potentiated authentic participant accounts of their experiences. As well these methods permitted closer relationships of me as a nurse researcher with women participants within the research process. These methods deeply explored the social production of gendered relationships and systemic power and control by asking the question: How do women with a history of substance misuse negotiate barriers and find paths to recovery? From this primary question sub-questions were asked of the women regarding what led to substance use, barriers to recovery, issues related to control in one’s life and meanings of community.

Ethics proposals which addressed participant risk/ethical considerations were reviewed and granted by two universities: Deakin University in Australia and Thompson Rivers University in Canada in accordance with the requirements of the Canadian Tri-Council Policy Statement which stipulates that research by university faculty must undergo a review at all institutions related to the work. All seven women who were extended letters of invitation through purposive sampling responded affirmatively. Each of these women met the criteria established prior to the invitation in that they were over 19 years of age and cognitively able to represent themselves, English speaking and had one full year of self-defined recovery at some point in life as well as being in self-identified recovery at the
time of the one to one in-depth interviews. This research promoted participants’ and my own reflexivity and was sensitive to the idea of knowledge generation being constituted by both collaborative and emancipatory acts. The intention of uncovering meanings women attributed to both recovery experiences and to barriers encountered to recovery were paramount to this study with the idea that mutual transparency and meaning-making might strengthen and enhance the emancipatory potential in women’s lives.

Findings: Uncovering Women’s Experiences of Recovery from Substance Use

Critical feminist methods produced data transcripts that contained thick descriptions of women’s experiences as they walked paths of recovery from substance use. Immersion in the women’s narratives both at the time of one to one in-depth interviews as well as through multiple readings of their life accounts permitted an analysis that went far beyond a simple recounting of their stories. The multi-layered and multi-dimensional aspects of women’s lives became apparent through the processes of writing and interpreting their words always with the understanding that it was only one person’s interpretation. The authenticity of the women’s words were indeed replayed through ‘I Poems’ and my own narratives that tied commonalities and differences together into word pictures that were presented for others to see, explore and interpret as well. It was discovered that these accounts were unique and ever changing for each of the women participants and therefore could not be analyzed in a linear nor sequential manner. Instead, the analysis used very unstructured and non-linear processes that at times seemed to produce conflicted accounts even within each story. The networks of relations that women were situated within became apparent as did the
impacts of personal contexts and powerful social structures in the community. Women’s narratives were viewed in terms of individual understandings and meanings as well as within these differing contexts and societal structures.

There was depth to the analysis of seven women’s narratives related to substance addiction and the many differences and similarities became apparent. Divergences in women’s path-finding included childhood socioeconomic factors that impacted women’s ability to reintegrate back into the community. Similarities related to the cognitive abilities of all seven women who demonstrated advanced levels of discourse and much higher academic achievements than I had expected. A composite of the seven women’s narratives demonstrated further similarities in terms of disrupted families in childhood and an array of physical, psychological, social or spiritual abuse all of which contributed to their altered sense of self with experiences of shame and damaged self esteem as well as diminished self-confidence. However, women also uncovered their incredible strengths and resilience as well as their abilities to develop relationships within diverse community groups or networks of support from which they could develop a sense of belonging and meaningfulness.

Discussion of Findings

This chapter discusses how participants successfully circumvented oppressive barriers to their recovery from substance addiction as well as their life experiences that helped them locate the freedom and liberation that they found in recovery. As these experiences are explicated and discussed the links or interconnections between participants’ earliest childhood experiences and
present day difficulties are examined. The consequences of disrupted early relationships in families of origin are spoken about in terms of broken boundaries, abuse and shame, enmeshment as well as social exclusion and dislocation. The consequences of early trauma and its effect on women participants’ lives are presented and examined. Also discussed are the measures participants have taken to successfully address barriers to their recovery and how the degree of success in doing so are proportionate to work they have accomplished regarding internal knowing of self and external knowing of others in their lives. The ability that participants have developed to establish or reestablish boundary integrity is also explored along with the implications that this has for successful creation of sustainable relationships in supportive and caring communities. The discussion next turns from participants’ local relational experiences to talk about broader impacts in terms of social determinants of health and societal structures that influence women’s wellness. The relationship of women’s lifeworlds to complex systems is discussed in view of what most set them back and what most strengthened their resolve to move forward. Lastly, this chapter considers the implications derived from this work and makes recommendations for future initiatives and studies.

**Final Thoughts and Understandings**

The concluding chapter to this thesis overviews the final thoughts and understandings that were gleaned from this critical feminist project involving seven women participants with histories of substance use. As women shared their stories of childhood trauma and how they survived they were then able to understand the processes that led them to use substances. Moreover they were
able to understand the nature of their wounds and the strengths they possessed to move beyond these through recovery from substance addiction. Within this research participants better understood themselves as autonomous women who were capable of establishing healthy boundaries and nourishing relationships. As the nurse researcher I also learned from the women’s narratives even though, because of the rawness of their stories, I did at times feel burdened. However, at the end of this amazing study, the challenges that occurred seem almost inconsequential when balanced against the immense rewards.

Summary

This introductory chapter has given a succinct overview of the thesis chapters in the research thesis titled: Women’s Path-finding; Recovery from Substance Use: A Critical Feminist Study. An overview of this study has been presented in terms of literature review, methodological framework, traditional and emerging methods as well as findings, discussion of findings and a concluding chapter with final thoughts and understandings. The rationale for this work involving women with histories of substance use and their paths to recovery is given as well as the aims of this particular critical feminist research project. Additionally, the research questions have been presented to explicate the general flow of participants’ interviews. Overall, the intentions of this work as an emancipatory nursing project are clearly presented as foundational to each chapter in this thesis with the hope that this work will be useful to present and future initiatives.
CHAPTER TWO: REVIEW OF THE LITERATURE

This chapter commences with an initial overlay of the search terms and methods utilized for identifying seminal and current literature relevant to the topic of women’s experiences of recovery from substance use. From a broad literature review focused on the Canadian context in terms of the history of federal and provincial relationships for health care funding and service the review is honed to provincial, regional and then local sources. The World Health Organization [WHO] (1986) position of health as a resource is explored followed by discussion of health access as a social justice issue. Social determinants of health are reviewed specifically related to political, economic and educational impacts on women’s health. Statistics are then provided regarding the Canadian geographical context under which this study takes place followed by Canadian systems of service for those in recovery from substance use issues. The literature review, although recognizing the international relevance of a study of this nature, is focused on the local and regional landscape of literature in alignment with a grass roots research approach. Prior to the summary of this chapter specific literature pertaining directly to women’s recovery from substance use is identified and reviewed.

All investigation of sources for this study was framed by the research question: How do women with a history of substance misuse negotiate barriers and find paths to recovery? From this research question and subsequent central aims of the research project specific searches of both quantitative and qualitative literature were located from peer reviewed scientific journals and reports, statistical and governmental documents, books and online materials.
As well, grey literature was also reviewed including non-peer reviewed journals and reports, newspaper articles, unpublished dissertations and public on-line discussions.

Literature searches captured central concepts such as woman/women’s health, substance use/misuse/abuse/addiction and recovery from substance use/misuse/abuse/addiction in key word searches. Additionally other terms were combined with key central concepts using a strategy of searching terms and combinations of terms broadly and then narrowing the search to literature that was deemed most relevant to this study. For example women and health and addiction were broadly searched with relevant categories identified and catalogued under women’s health in terms of health status for women having addiction across the lifespan; physical, psychosocial and spiritual health; determinants of health, health care and then more narrowly in terms of specific literature regarding the health of women using substances. Specific literature included health information of women using substances who were of childbearing age, those who had concurrent physical or mental health challenges while using substances, determining the percentages of women able to meet basic determinants of health such as food security, shelter and income and the effects of geographical location such as living in urban versus rural communities.

The comprehensive and interdisciplinary nature of this review of the literature is demonstrated through the extensive use of multiple search engines or data bases. These included Academic Search Complete, BC Stats, Cumulated Index to Nursing and Allied Health (CINAHL), E-Stat and Statistics Canada,
Government of Canada Publications, Medline with full text, PsychARTICLES, Sage Journals Online and the Social Sciences Index. As well both online and text literature were accessed through searches of the Thompson Rivers University catalogue for specific periodical titles and additional grey literature was acquired from health related reports, statistics and newspaper articles.

**Health Care in Canada**

From confederation in 1867 to the present day, tension has existed between Canada’s Federal and Provincial governments regarding funding sources for health services and responsibility for delivery of health care (Storch, 2006). To establish service and funding arrangements between the provincial and federal governments Medicare or the 1966 Medical Care Insurance Act was invoked (Kenny, 2003). Medicare established a 50:50 cost sharing formula for provinces if they supported federal priorities for health services and abided by Medicare principles (Storch, 2006). Medicare principles required that “programs be universally available, comprehensive in coverage of services, portable across the provinces, and operated on a nonprofit basis” (Storch, 2006, p. 37). As the costs of Medicare increased, the federal government negotiated lower funding ratios for provincial health care. The federal government accomplished this by decreasing transfer payments to 33% of provincial health care spending costs. Provinces were then authorized to provincially tax for health services to acquire the remaining funding required (Department of Finance Canada, 2004). By authorizing provincial taxation the federal government ceded control to the provinces in terms of enforcement of Medicare principles including the application of extra billing. To address their concerns
regarding extra billing and to enforce Medicare principles the federal government subsequently passed the Canada Health Act in 1984 (Storch, 2006).

The Canada Health Act (CHA) supported the principles outlined in Medicare and also added the principle of accessibility which disallowed extra billing or discrimination based on levels of income (Storch, 2006). It is notable that, although the CHA provided a modicum of authority to the federal government, the provinces through provincial taxation currently retain the major control of health care delivery at the community level. Provincial authority over tax dollars as well as limited accountability to the federal government have resulted in a situation whereby at times it is obscure as to how the provincial government determines priorities for dispersing health care funding (Storch 2006).

The tenuous relationship, between Canada’s federal and provincial health care authorities, directly impacts addiction services within smaller communities including Kamloops, BC. Lack of funding sources and increasing health care costs contribute to this tension. At community levels, within the interior of British Columbia, there has been substantial loss of addiction treatment services for women at a time when statistics demonstrate significant need. As well, women’s provincial addiction services which are located in Vancouver disadvantage women requiring treatment if they are unable or unwilling to relocate to an urban centre for required services.

**Health: A Resource for Everyday Life**

According to the Canadian Public Health Association [CPHA], Health and Welfare Canada [HWC] and the World Health Organization [WHO] (1986) health
is “a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities” and is benefitted by promotion of equity within society. Fundamental prerequisites for health of citizens including Canadian women and their children include peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity (CPHA, HWC & WHO, 1986). As Raphael (2009) contends “these prerequisites of health are concerned with structural aspects of society and the organization and distribution of economic and social resources” (p. 6).

Equitable allocation of resources in a manner that promotes all people’s health is a social justice issue in Canadian society. Gutiérrez and Lewis (1999) view resource allocation as central to the concept of social justice or fairness and others also tie this to the political determination of the oppressed for social action and change (Freire, 1993; Ryles, 1999). Discussing the relationship of social justice to health determinants McGibbon, Etowa and McPherson (2008) argue that “the measure of a society is how it treats its most vulnerable citizens” (p. 24) and that for Canada’s most vulnerable the strongest determinant of health is poverty. Similarly, Pederson, Raphael and Johnson (2010) define vulnerability in terms of resource allocation and poverty with both referred to as determinants of health. It is noteworthy that poverty, having a direct correlation with vulnerability, has remained a profound health issue spanning decades for many Canadians living within local and regional communities (Interior Health, 2004).
Social Determinants of Health

“Social determinants of health are the economic and social conditions that shape the health of individuals, communities, and jurisdictions as a whole” (Raphael, 2009, p. 2). As well, these conditions are interlocked politically and influence individual’s access to health care (McGibbon, Etowa & McPherson, 2008). Gender also interlocks with each of these health determinants and is in its own right a separate determinant as well. As Raphael (2009) suggests “while it is important to recognize gender as a determinant, it is equally important to remember that gender pervades all the determinants” (p. 359). As well as gender influences, Canadian political and economic policies at all levels of the country, directly impact whose interests are served within the community. Stanford (2008) notes: “The economy is a realm of competing, often conflicting interests. Determining whose interests prevail . . . is a deeply political process” (p. 24).

Also interconnected to both political and economic arenas of influence are educative factors that include determinants of health in terms of employment opportunities. Awareness of how political, economic and educational institutional processes interconnect helps one assess the profound economic barriers that women encounter (Raphael, 2009). With an understanding of how these barriers are socially constructed nurses may advocate more effectively for women by addressing the inequities they experience through the development of sustainable and community derived plans for action.
Political Impacts on Canadian Women’s Lives

The political realm that is focused on in this thesis is around the politics of identity drawing from both traditional liberalism regarding individual rights to liberty and equality and from socialist perspectives which incorporate not only the rights to equality but also those of equity (Ball, Daggar, Christian & Campbell, 2009). The four functions within the politics of identity that Ball et al. outlines are the explanatory, evaluative, orientative and programmatic functions. The explanatory function explains the specific circumstances and social conditions of a group that is seen as oppressed and the evaluative function determines how much better or worse off they are than other groups. The orientative function attempts “to make members of oppressed groups conscious or aware of their oppression” (Ball et al., 2009, p. 234) with the idea that once people understand how they are situated in the world they will take action to change these oppressive circumstances. Furthermore, similar to Freire (1993) Ball et al. note that the oppressor lead by the oppressed must be brought to “see the injustice that he or she is doing, wittingly or unwittingly, to other human beings” (p. 235). The programmatic function builds on these previous understandings to address oppression through coordination of planned actions.

In terms of access to health care Bryant, Raphael and Rioux (2010) note that equal rights to essential health services is mandated by law and guaranteed under the Canadian constitution. Health equity is somewhat different in that it is not about equal distribution of health services but addresses specific needs of individuals or a population, in this case women who have a history of problematic substance use, from a social justice mindset (McGibbon, Etowa &
McPherson, 2008). Bryant et al. define health equity within a social justice framework as a public health commitment to address systemic disparities among those who have more advantage over those who have less. Warren, Heale, Haugh and Yiu (2012) state: “When differences in health status are experienced by various groups or populations and result from social conditions that are modifiable and seen to be unjust or unfair, this is termed health inequities” (p. 56, bold in original).

**The Economy and Canadian Women’s Health**

Coburn (2010) states that “the unique point of view of political economy is that it focuses on the links between health and the economic, political, and social life of people in different groups, classes, regions, or societies” (p. 65). Furthermore, Coburn suggests that while looking at these links a political economy perspective considers equity issues in terms of disparities in health among different groups of people related to equality or inequality of health care access while also attempting to understand why these discrepancies occur. When a political economy is able to effectively challenge or critique existing beliefs and ideologies by questioning how these might be changed it is imbued with a critical component and is then considered a *critical political economy* (Coburn, 2010, italics added). Stanford (2008) discusses the critical political economy in terms of competing interests within society as well as within the political process which determines whose interests are served. Stanford critiques the political economy from a “critical, grass-roots perspective” (p. 335) and outlines key principles to sort out what is real and what is simply engrained within ideological beliefs.
Stanford (2008) suggests that the economic system is not objectively governed by natural laws but is a subjective system which evolves and changes over time being influenced by people’s values and politics. As well, the economy’s existence depends on people’s paid and unpaid work with most paid work consisting of employment or working for others and unpaid work within the household.

A great deal of productive, necessary work occurs inside the household: out of sight, behind closed doors, and generally without pay. Most of that work is performed by women, whose opportunities in the “outside” economic world are constrained as a result. (Stanford, 2008, p. 337)

Lastly Stanford posits that the idea of a trickle-down effect in mainstream capitalistic systems from those who are most wealthy to the general population is unlikely to happen naturally but rather “workers and poor people get only as much from the economy as they are able to demand, fight for, and win” (p. 338, bold text in original). Rebick (2009) concurs with the idea that the fortune of the wealthy reaching the masses is indeed unlikely stating: “The promise of trickle-down prosperity has failed to deliver for the vast majority of people on the planet” (p. 7). Many women with a history of problematic substance use fit in the categories of being either workers or poor and when seeking recovery must contend with what Carlson (2006) calls the business side of addiction. Private for-profit treatment services for problematic substance use, particularly in small communities such as Kamloops, are beyond the means of the average person and certainly beyond the means of those who are poor. As a consequence, because of a lack of financial resources many women requesting
recovery opportunities must wait for space at government sponsored sites, travel to residential treatment centres in other cities, locate alternate methods of treatment such as at home detoxification/recovery or forgo recovery altogether.

**Educational Impacts on Canadian Women Related to Social Security and Income**

Ungerleider, Burns and Cartwright (2009) discuss the Canadian educational system in today’s world as being much more than a location for students to acquire knowledge regarding core subjects. Rather Ungerleider et al. propose that the educational system is one of the main purveyors of social values and citizenship: “Public schools are the institutions that we rely upon to bind us together as Canadians. They do it by communicating the values—fairness, respect for people, and a sense of social justice—that Canadians share” (p. 168). Schools are viewed as contexts in which socialization of children may be furthered yet many problems exist because as Ungerleider et al. suggest pre-school socialization is deteriorating because Canadian children have “relatively little supervision than at any previous time. Initial socialization that was once provided directly by family members is now provided by a combination of parents, caregivers, a child’s peers, and the media” (p. 159). A consequence of this deteriorating socialization is increased aggression within schools and subsequently within Canadian society generally. It is noted by Tremblay (2009) aggressive children become violent adults who negatively impact themselves, partners and their children as well as the communities in which they live.

Ungerleider et al. (2009) relay that the demographics of Canadian students who drop out of high school share a common profile in that these students remain consistently uninvolved both within their schools and within their
communities. It is noted that there are more young men than women not graduating from high school. Furthermore, of the students who do not graduate, a majority of those with children, over twenty-five percent, are female, and of those young women with children, half are single parents. The social implications in communities are great when one considers the combination of poor education resulting in poor job opportunities and a revolving cycle of intergenerational poverty. As Tremblay (2009) suggests job security is directly associated with economic security both of which provide citizens social security. Social security is attributable to the governmental models that are utilized for income redistribution and possess “a symbolic power in the construction of family roles” (p. 84).

Tremblay (2009) discusses the interplay of governing models in Canadian politics which affect people’s social security; those that look more internally to the relationship of income security to social roles and others that act more globally. Tremblay suggests that the dominant model presently existing in Canada is the latter type which is based upon a liberal ideology promoting global markets and exchanges viewing these as optimal mechanisms to ensure a prosperous Canadian economy. Tremblay opposes this model and argues that it: “endangers the very objective of economic security, especially for women, which is currently threatened, given the prevailing standards and conditions (unequal wages, discrimination, family responsibilities imposed on women, sole-support parents, etc.)” (p. 85). This liberal approach to social security places the main responsibility on the individual to look after themselves economically and does not see a role for government in equitable wealth
distribution all of which results in extreme hardship for many populations such as uneducated, minimally employed or low income women as well as lone parenting women (Raphael, 2007).

**Canadian Statistics: Substance Addictions**

According to Health Canada’s (2005) Canadian Addiction Survey [CAS]:

“Of Canadians who report having consumed alcohol during the past year, 44.0% drink at least once a week and 9.9% report drinking four or more times a week” (p. 20). Of these Canadians 15.1% of women exceed the low risk guidelines for alcohol consumption which is described as greater than 9 drinks per week or 2 drinks per day for females. In terms of illicit drug use of cocaine, speed, ecstasy, hallucinogens and heroin 12.2 % of female respondents used these substances during their lifetimes and 1.8% in the prior year (Health Canada, 2005, pp. 61-62). Within BC Ahmad, Poole and Dell (2007) note that the most common substance that women use is alcohol with the use of illicit drugs less common. However, although drug use is less common for BC women, it remains statistically notable for childbearing women when compared to the rest of Canada because “drug-related pregnancy and childbirth complications are all higher in BC than in other provinces” (BC Ministry of Health Services, 2004, p. 7).

The reasons for increased drug-related maternal child complications in BC are difficult to ascertain. Payne (2007) notes that pregnant women with substance use problems accessing Sheway and BC Women’s Hospital “have lives characterized by poverty and hunger, unstable living conditions, low levels of social support and histories of violence, of exploitation and, often, of having their children removed by
authorities” (p. 250). All of these substantial issues contribute to poor maternal child health for BC women and their children. As well, increased pregnancy and childbirth complications might well be related to geographical location such as the Downtown East Side (DTES) of Vancouver, BC where pregnant women using drugs experience poor nutritional status and lack of affordable housing (Poole, 2007a) or Northern BC where drugs are readily available and part of community culture. As participants in the Vaillancourt and Keith (2007) study of women in northern and remote BC communities report regarding the normalcy of drug use: “The widespread presence of substances was part of normal life . . . the abundance of alcohol and other drugs in the North fostered the development of ‘drug cultures’ and ‘drug communities’” (p. 45).

Kamloops, BC is a small urban centre located in the interior of British Columbia with a population of 87,110 (BCStats, 2010); in this community initiatives to address problematic substance use have been identified as priority issues (Social Planning and Research Council of BC, 2009). Although statistical information is not readily available within this community regarding women’s substance use, areas of Kamloops have been viewed as smaller versions of the DTES of Vancouver, BC, an area whose residents include populations experiencing pervasive mental health and addiction problems compounded by extreme poverty and homelessness (Vancouver & Downtown Eastside, 2008).

The area (DTES) is often referred to as the ‘poorest postal code’ in Canada, and has one of the highest poverty rates in North America. Nearly 75% of residents live below the poverty line, compared to the Vancouver average of 25%. . . . Thousands of those living in the DTES have mental health and/or
addiction problems. Many of these are among the city’s 2,500 homeless people. (Vancouver & Downtown Eastside, 2008)

In an interview with the ASK (AIDS Society of Kamloops) Wellness Society, it was stated that “Kamloops residents risk cultivating a ‘mini-East Vancouver’ in their own back alleys unless they take notice of the marginalized segments of their community” and that this risk was substantiated by the Kamloops’ Street Clinic needle exchange program which received up to 12,000 used needles in a single month and more than 100,000 in a single year (Macfarlane, November 3, 2003). Use of illicit drugs causes significant harm to Canadian women. In BC the Health Canada (2005) statistics indicate that 19.8% of female respondents have reported one or more harms over their lifetime and 16% of women in the previous year from drug use; harms included deleterious effects on friendships and social life as well as finances with the greatest reported harms experienced on physical health (Health Canada, 2005).

Similarly to use of drugs, Health Canada (2005) indicates that adverse impacts to alcohol consumption include harm to friendships and social life, to physical health and other areas such as work and finances and that “proportions of those reporting harm as well as the odds of reporting harm increase substantially and significantly with increases in the frequency of heavy drinking” (p. 37). The implications for women are particularly serious because heavy drinking of alcohol by Canadian women has increased from previous surveys completed in 1989 and 1994 (Ahmad et al., 2007).
Canadian Systems of Service

Formal Canadian health care systems support women with a history of substance use by addressing their needs in terms of service-based parameters. Graveline (1998) states that this formal “system refers to a powerful, interlocked bureaucracy that exercises power over both the providers and the recipients of services” (p. 6). Federal and provincial health care is composed of influential and interconnected agencies that allocate resources for women living with addiction by utilizing statistical funding formulas. Although complex governmental funding formulas function well at a macro level they are less useful at a micro level and therefore are unable to address the day to day problems that exist for women and their families in their everyday lifeworlds. Even though statistical information effectively provides an estimated financial cost for services to women in our communities it ineffectively tallies the human costs to society. How many dollars can be allotted to a woman’s life destroyed by violence or to her children raised in poverty? Conversely, what monetary value can be applied to those who are able to capably reach their full potential? These questions are weighty and not easily answered yet may be better understood through critical discussion of less visible but more ideological systems of care within which women live day to day.

The Multiple Dimensions of Addiction

In terms of the costs to the individual and society in general the BC Ministry of Health Services [BCMHS] (2004) notes that not all substances used are problematic; the use of some substances may instead have beneficial and therapeutic applications. The BCMHS locates the range of psychoactive substance
use in its framework on a linear spectrum with beneficial substances at the beginning point of the spectrum and clinical disorders designated at the endpoint. This framework considers prescribed drugs, coffee/tea, red wine, and ceremonial tobacco as beneficial to the person and views recreational uses of substances, while not necessarily beneficial, as non-problematic because they cause minimal health or social problems. When substance use becomes problematic on this spectrum it is because the health outcomes are significant for the person using as well as for society. The BCMHS notes: “Substance use may begin at one point on the spectrum and remain stable, or move gradually or rapidly to another point. For some people, their use of one substance may be non-problematic or beneficial, while their use of other substances may be problematic” (p. 8).

Addiction encompasses substance use, as well as a range of other activities some of which include excessive viewing of television, sexual activity, gambling, eating or internet use (Alexander, 2008; BCMHS, 2004; Maté, 2008). A general definition of addiction includes any persistent and harmful behavior that involves loss of personal control having negative consequences for oneself as well as others (British Columbia Medical Association [BCMA], 2009). Addictive use of substances, when resulting in physical and psychological dependence, not only affect the person using but may also affect their families, networks and society in general (BCMA, 2009; Freeman, 2001; McCrady, 2006; Moos, 2006). Substance addiction includes drugs or chemicals, both licit and illicit, having psychoactive or consciousness-altering effects that may become harmful and problematic when resulting in psychological and physical dependence (Addiction Research Foundation, 1996; Alexander, 2008; BCMHS, 2004). The Addiction Research
Foundation (1996) defines psychological drug dependence as occurring when, “a drug is so important in a person’s life that it is a focal point for ... thoughts, emotions, and activities [and] the need to continue using the drug becomes a craving or compulsion” (p. 9). The Addiction Research Foundation suggests that physical dependence occurs when there are physical responses to a drug and withdrawal symptoms when the drug is removed.

Maté (2008) views addiction from the perspective that chronic use of substances is a way for a person to alleviate distress and pain suggesting that rather than ask the question “Why the addiction?” people should be asking “Why the pain?” (p. 34). Maté writes:

Far more than a quest for pleasure, chronic substance use is the addict’s attempt to escape distress. From a medical point of view addicts are self-medicating conditions like depression, anxiety, post-traumatic stress or even ADHD [attention deficit hyperactivity disorder]. Addictions always originate in pain, whether felt openly or hidden in the unconscious. They are emotional anesthetics. (pp. 33-34)

Miller and Carroll (2006, p. 6) quoting George Bernard Shaw ‘Alcohol is the anesthesia by which we endure the operation of life’ are similarly referring to self medication as a way to alleviate the pain of life circumstances. As well, Kasl (2007) considers problematic substance use as a survival strategy adopted by those to protect themselves from pain and to “anesthetize feelings” (p. 402). These authors suggest the use of substances is the solution a person has chosen to address or cope with personal and individual issues and that people cope with similar situations in different manners. “Similar underlying issues and vulnerabilities could emerge as drug
dependence in one person, as sadness and isolation in another, as aggressive or criminal behavior in another, and as all of these in yet another” (Miller & Carroll, 2006, p. 6). From this perspective two people with common backgrounds and even common families of origin may well address issues and vulnerabilities in different ways, utilizing an array of coping mechanisms. Addiction would appear to be taken up by different people for different reasons.

Alexander (2008) has explored the historical roots of addiction in which it was defined as a state of devotion to a positive pursuit and as a self-chosen habit as described in the 1884 Oxford English Dictionary or as used in the text of the 1611 King James Version of the Christian Bible. According to Alexander from these initial usages of the word addiction four subsequent definitions were derived none of which suggested the positive notion of devotion. Firstly, came ‘addiction one’ in terms of alcohol and intemperance in which people who were addicted “were so overwhelmingly involved with drinking that they became different people, alien to their own society and to their own previous identities” (p. 31). Addiction one includes significant involvement with drugs and alcohol causing harm to the person with addiction and/or to society. Secondly, is ‘addiction two’ which in part includes the first type of addiction but also has segments of less frequent drug and alcohol use that causes problems for the person using them and/or to society for example illegal use of substances for chronic pain. ‘Addiction three’ is an overwhelming need for a person to pursue any habit or cluster of habits called an addictive lifestyle such as gambling, religious or political work, internet usage or power-seeking all of which are harmful to the person engaged in them and/or to society. Lastly, ‘addiction four’
is the “overwhelming involvement [passion] with any pursuit whatsoever that is not harmful to the addicted person or to society” (Alexander, 2008, p. 29).

Maté (2008) notes that any passion can develop into an addiction however not all passions do so. How one might tell the difference between the two is by determining which one controls the person. As Maté (2008) states: “It’s possible to rule a passion, but an obsessive passion that a person is unable to rule is an addiction (p. 109). Maté (1999) also notes that with passion one loves the goal of the process whereas with addiction it is the thrill of the behavior (p. 300). This study primarily explores the lives of women who have a history of using drugs and alcohol which caused harm to themselves and/or society when they were still active in their drug and alcohol use and would have been categorized by Alexander (2008) as ‘addiction one.’

**Canadian Women and Substance Use**

Dell (2007) notes that health research has traditionally underrepresented women and most particularly research related to women and substance use. Additionally, Greaves and Poole (2007) argue that the analysis of sex and gender for women who use substances is often not addressed in a manner that includes intersecting concerns. “Women often experience substance use problems alongside other social and health concerns, including mental illness, trauma, violence and HIV/AIDS. Poole, Greaves, Jategaonkar, McCullough and Chabot (2007) discuss women’s use of substances and the direct correlation to their experiences of violence. Similarly, the BCMHS (2004) discuss the interconnection between women’s experiences of violence and their quickened progression toward addiction when compared to male counterparts. Research
and policy often overlook these intersections, leaving substance use problems to be addressed in isolation from broader social and environmental determinants of health.

In terms of the relationship of women focused studies and concepts of sex and gender Johnson, Greaves and Repta (2007) consider the idea of sex as a biological construct and gender as female and male behaviours within a given society all of which are determinants of health for women. Furthermore Johnson et al. argue that historically “health research has assumed a gender-neutral or gender-blind stance . . . [while] the notion of gender as being distinct from sex is still a relatively new concept in medical discourse and research” (p. 1). The BCMHS (2004) concur with this perspective suggesting that understanding sex differences and the influences of gender to women’s substance use related issues is vital to treatment interventions, policy and gender-based research. It is suggested that biological or sex differences contribute to the disproportionate amount of detrimental effects from women’s substance use not only in relation to reproductive health or child bearing but also because there are:

More severe health consequences from drinking, smoking and illegal drug use, including lung damage, brain damage, cardiac problems, liver disease . . . [which may occur] partially because women metabolize alcohol and other psychoactive substances more slowly than men, allowing harmful metabolites to remain in the body longer. (BCMHS, 2004, p. 19)

As well, it is suggested that gender differences related to the development of problematic substance use occur more frequently in girls and women because of
the higher incidence of exposure to sexual and physical abuse, violence-related harm and significant barriers to treatment. The BCMHS suggest that: “Women face unique barriers to accessing treatment. Social stigma, discrimination and fear of losing their children may deter women from seeking help” (p. 19).

**Women with Problematic Substance Use History and Their Children**

“Problematic substance use is a complex issue that affects individuals of all ages and from all social groups” (BCMHS, 2004, p. 9) however, some individuals and many groups are more at risk than others of experiencing detrimental consequences related to problematic substance use or substance addiction. Vulnerable groups equated by Pederson, Raphael and Johnson (2010) as populations having diminished life opportunities include those who live in difficult and debilitating circumstances such as women experiencing violent relationships or living in poor neighbourhoods as well as those who are single parents with limited financial resources. In these contexts women have less power relative to more stable and privileged social groups and in actuality often contend with intersecting and thus compounding factors that produce extremely negative consequences (Vasas, 2005). Particularly disenfranchised are single parenting women living with low incomes or in poverty.

In Canada Reid (2007) outlines how low income is determined using a low income cut-off (LICO) benchmark as well as by comparing the proportions of income that individuals and families spend on basic needs for food, clothing and shelter relative to other Canadians. If a disproportionate amount of income is required for necessities of life compared to other Canadians; these individuals, families and their children are then considered to live below the
poverty line. Hurtig (1999), in *Pay the Rent or Feed the Kids*, states that “poor people have poor children” (p. 30) and that in Canada, one in five children (20%) live in poverty with 81% of these being single parenting women with children under the age of seven years of age. BCStats (2010) census profiles concur with Hurtig reporting that in both Kamloops and throughout British Columbia 80% of single-parent families are headed by a female. Raphael (2007) indicates similar statistics regarding child poverty and also notes that Canadian women have higher rates of poverty than Canadian men. As well, Raphael writes that BC has the second highest poverty rate in Canada, well over 60%, for women heading lone-parent families. This is supported by Townson (2009) who writes: “Canadian women heading lone-parent families had low incomes, even after taking into account government transfers and tax credits. In fact, the incidence of low income for female lone-parent families was almost five times as high as that of two-parent families and their children” (p. 6). When lone parenting is combined with poverty, mental health issues and problem substance use, the health and well-being of women and their children are further jeopardized (BCWHHC & BCCEWH, 2004). Child impoverishment, particularly in single-parent families, increases parental stress and hardship and may negate many of the benefits and outcomes of treatment and outreach initiatives for women having issues related to substance use.

From a feminist viewpoint, substance use by women is particularly problematic when considered in terms of social roles. In Canada women are most likely to be the principle caregivers for children, family or friends (BCWHHC & BCCEWH, 2004; Reid, 2002). Because care-giving is an
expected or taken for granted role for women in Canadian society it is not valued in terms of monetary compensation. Rather, care-giving is assumed to be 'natural' for women and one that ought to be taken up as it is required regardless of the physical and psychological cost. For example, the mothering role is assumed to automatically be the priority for women and even though many fathers do engage in care-giving of children it is not necessarily viewed as their expected or priority role and therefore does not carry the same health risks as it does for women. As Varcoe and Hartrick Doane (2007) suggest “because mothering requires material, economic, and social investments that are not usually compensated in material or economic ways, through mothering women are made more vulnerable to a variety of health risks, especially overwhelming workloads, poverty, and violence” (p. 297). When these health risks are compounded through single parenting, low income and substance use women are placed at even higher risk for health disorders and are often unable to reach out for assistance.

Women, who have substance addiction and have assumed socially expected parenting roles, including both single and partnered women, are reluctant to seek treatment for substance use because they fear losing custody of their children if they openly indicate they need support (Boyd, 2004; Poole & Dell, 2005; Poole & Greaves, 2007). As both the British Columbia Centre of Excellence for Women’s Health [BCCEWH] (2006), BC Ministry of Health Services (2004) and Poole and Dell note regarding parenting women’s barriers to treatment: “Foremost among these barriers is child welfare policy that makes it difficult for substance-using mothers to disclose that they need help, for fear
of losing custody of their children” (p. 9). As well, a woman may not access addiction treatment as she is fearful for the safety of her children if she should leave them for any period of time. This concern is well justified. The Addiction Research Foundation (1996) indicates the lack of appropriate non-violent and safe settings for a woman’s children impede her choice to access treatment. Parenting women living with problematic substance use not only have difficulty accessing the help they require but also become less connected to others in the community and therefore become increasingly isolated and unsupported (Addiction Research Foundation, 1996). The consequence of increased isolation and decreased access to social support networks is that parenting women with substance addiction, who are most often viewed negatively by mainstream social systems, experience a sense of oppression and diminished personal control (Boyd, 2004).

**Women with Concurrent Disorders**

Women who have a history of substance addiction and a mental health challenge at the same time are considered to have a concurrent disorder, multiple diagnoses, or a dual diagnosis (Austin & Boyd, 2010; BC Ministry of Health Services, 2004; Poole, 2007). The pairing of women’s mental health and addiction as dual disorders or concurrent disorders is common when addressing problematic substance use for women living in BC because of the high incidence of these in this population (Austin & Boyd, 2010; Poole, 2007). In BC “between forty and fifty-five percent of people with substance use disorders also have concurrent mental disorders. In some populations, such as women
with a history of cocaine or opioid dependence, the rate may be as high as ninety percent” (BCMHS, 2004, p. 20).

It is difficult to differentiate whether substances are used by women as a way to self medicate and cope with mental health challenges or whether the substances themselves contribute to or cause mental health problems. Austin and Boyd (2010) suggest there are four possible syndromes or patterns in which dual disorders are manifested. Firstly, substance use may be preceded by a primary mental illness which when treated alleviates both the mental illness and substance use which can subsequently be maintained through mental health support; an example of this pattern is the person who through exposure to trauma suffers from posttraumatic stress disorder [PTSD] (Austin & Boyd, 2010; Stewart, 2007) and is an individual who uses substances to cope with recount of traumatic experiences. In terms of support for women with PTSD Stewart suggests “gender-specific interventions, since women are thought to experience more interpersonal trauma than men, with different causes” (p. 207). A second pattern of dual disorders occurs when a person’s use of substances is followed by mental health issues both of which are treatable through sobriety; thirdly, both use of substances and mental health challenges may co-exist simultaneously often involving people having family histories including one or both of mental illness and substance use. This pattern of co-existing mental health challenges combined with substance use is difficult to treat separately and must therefore be jointly attended to. Lastly, mental illness and substance use may exist together as a consequence of common and causative risk factors for example genetic dopamine alterations or experiences of child abuse; again
individuals often have familial histories of either/or mental illness and substance use. When common risk factors are altered or alleviated in these situations so are mental health and substance use problems.

**Canadian Women’s Experience of Recovery**

Historically, women’s experiences of healing from problematic substance use have not been viewed through a gender lens resulting in a dearth of research regarding how women effectively circumvent barriers to recovery. However, Dell (2007) does suggest that women’s traditional underrepresentation in research studies is changing with notable increases in relevant research that is gender focused. Studies such as the research represented in this thesis, are increasingly able to address equality and equity issues through the use of feminist frameworks including gendered interviewing and feminist-based analytical methods for critical interpretation of data (Fontana, 2004; Beauboeuf-Lafontant, 2008).

Internationally and within the Canadian context there is recognition that methods of research employing women-centred analysis effectively presents women’s experiences (BCWHHC & BCCEWH, 2004; Hankivsky, 2007; Johnson, Greaves & Repta, 2007). This shift toward women focused studies potentiates understanding of differences experienced by those who are seeking recovery from substance addictions particularly when these are situated within education, research and policy frameworks. As Poole and Greaves (2007) note: “We see emerging support in Canada for research and practice that focuses on harm reduction and is women centred, taking into account sex, gender and diversity issues” (p. xiv). Even so, Greaves and Poole (2008) suggest that further advancement of research evidence remains urgently required to support a broad
understanding of women and girl’s alcohol and drug use so that effective current
day responses can be promoted and enacted.

Recovery from problematic substance use has been explored through
research utilizing both quantitative and qualitative methods both of which may
take a gendered perspective. Defining the nature of women’s recovery is a
complex endeavor and one which is based upon the world views of those
involved within a specific research enterprise. For example research with a view
of abstinence as recovery is quite different than that from a harm reduction
perspective. Brown and Stewart (2007) propose that a majority of Canadian
alcohol and drug recovery programs are abstinence-based and that they reflect
“the dominant disease-based model, which emphasizes the necessity of
abstinence and closes the door to alternatives” (p. 436). Abstinent models of
recovery are found within all forms of twelve step groups such as Alcoholics
Anonymous and Narcotics Anonymous whereas harm reduction models, which
are thought to be particularly effective for women, include abstinence on a
continuum of addiction as well as choice to use substances in a manner that
decreases potential harm from them. As Brown and Stewart (2007, p. 431) note:

Harm reduction, a concept that challenges the mainstream notion of
abstinence as a universal treatment goal for problem substance use, has
emerged as a promising approach for women . . . Harm reduction moves
beyond the dominant deficit-based, abstinence-focused, disease-oriented
interpretations of substance use problems and addiction, and emphasizes
empowerment and self-determination.
Primarily focusing on quantitative methods and the effects of alcohol consumption on women biologically Antai-Otong (2006) reports that as a result of lower water and higher lipid body composition, physiologically women reach higher blood levels of alcohol than their male counterparts after consuming similar amounts of alcohol to body weight. Increased blood levels of alcohol over time then cause deleterious effects such as organ damage more quickly in women than men. Furthermore, Antai-Otong suggests that studies also demonstrate that women experience more neurological effects, breast cancer risk, coronary heart disease and other alcohol related complications than do men from excessive alcohol consumption. Antai-Otong reports that unique to women is Fetal Alcohol Syndrome (FAS) which “is one of the most severe adverse effects of maternal drinking in pregnancy” (p. 37) causing a range of intellectual disorders in offspring including diminished cognitive functioning, decreased learning abilities and shortened attention spans.

Antai-Otong (2006) notes that “women who are moderate to heavy drinkers tend to minimize or underreport the amount they drink due to embarrassment, especially if they are pregnant. For this reason, addiction nurses need to develop gender-sensitive approaches using various screening tools” (p. 38). One of the gender sensitive and less stigmatizing tools identified by Antai-Otong for screening women was TWEAK [K=C] (Tolerance to alcohol, Worry by significant others, Eye-opener drinking, Amnesia and feeling a need to Cut Down drinking). Nursing care for women assessed with health concerns related to alcohol consumption depends on the acuity of the health concerns that women present with. For acute alcohol withdrawal medical intervention is
required whereas with chronic consumption a woman can actively participate in
directing her own recovery. “A gender-specific treatment enables the addiction
nurse to identify and address issues unique to women and bolster self-esteem
and confidence while avoiding interventions that heighten feelings of shame,
guilt, and inadequacy” (Antai-Otong, 2007, p. 40).

Using qualitative methods Bungay, Johnson, Varcoe and Boyd (2010)
explore the interrelationship between women’s health and crack use noting that:

Despite the specific health risks to women who use crack and the
detrimental effects of poverty, sexism, and racism for women’s health,

few studies have specifically focused on women’s health and crack use
within the structural and interpersonal contexts of their lives. (p. 322)

Of one hundred and twenty-six survey participants 92.9 % lived in the
Downtown East Side (DTES) of Vancouver, BC with 88.5 % living in poverty
and spending greater than half their income on the basics of food, clothing and
shelter (Bungay et al., 2010). Although the Bungay et al. findings did not
directly correlate crack use to women’s poor health this study did demonstrate
that “women’s health and the use of crack were intricately connected to the
social, economic, personal, and historical contexts of their everyday lives”
(p. 323). Also noted was that while health issues related to drug addiction were
relevant, equally important to street-involved women were health concerns such
as Post Traumatic Stress Disorder (PTSD) and pain.

A Canadian study by Poole and Isaac (2001) in BC, involving ninety-
seven women from Vancouver in the south and Prince George in the north,
demonstrated the use of a gender lens to explore the barriers that prevent
mothers in these locations from accessing addiction treatment. The most frequently recorded barrier to treatment for these populations was shame, with sixty-six percent of the women citing this as problematic. As well, sixty percent of the women stated that they had depression and feelings of low self-esteem. Major themes that emerged from the women’s stories were women’s self-image and women’s relationships. Key findings in the Poole and Isaac (2001) study were that “low self-image and low self-esteem are fundamental barriers to a woman’s decision to try to find help for substance use problems” (p. 14). Compounding these barriers Bungay et al. (2010) suggest that lack of access to health care also negatively impacts women’s quality of life and optimal health within their communities.

The Vancouver Area Network of Drug Users (VANDU) Women Clinic Action Research for Empowerment (CARE) team known as the VANDU Women CARE Team (2009) report that women who use drugs in the DTES of Vancouver continue to experience ongoing health inequities and barriers to accessing primary health services. As well, The VANDU Women CARE Team suggests that even with considerable research occurring in the DTES and “significant national and international attention paid to the health and social conditions of women” (p. 3) rarely have women been supported to develop studies that determine their own health needs in relation to the interconnection of women’s social, political and health determinants. To potentiate this kind of involvement Participatory Action Research methods were utilized so that women living in the DTES were effectively supported to set their own research agendas, develop research questions, collect data, analyze data and generally
guide the research process. Findings in the subsequent research report “Me, I’m Living it”: The Primary Health Care Experiences of Women who use Drugs in Vancouver’s Downtown Eastside were collated into two sections: the first referred to women’s experiences and use of primary health care and the second discussed how primary health care could be better integrated into the community through collaboration of DTES women, care providers governmental policy makers.

Interviews from the VANDU Women CARE Team (2009) study reported that women using substances in the DTES did worry about the effects drug use had on their health noting concern regarding dental health, HIV and Hepatitis C infections, effects on pregnancy and risks of overdose with “17% of women reporting an overdose in the past year” (p. 7). These same women reported a range of reasons for using drugs including: Alleviation of emotional pain and trauma from depression, violence, loss, stress as well as physical pain from injuries. Using drugs helped women cope with circumstances of daily life, provided pleasure and were used as part of a harm reduction strategy to improve their health. In terms of health care providers: those who were seen most positively used holistic approaches that were caring and provided information in a manner that was useful. “Nurses, in particular, were singled out as being helpful in this way” (p.8). As one women named Brandy Rose in this study described street nurses: “They’re kind and gentle, they’re understanding, they’re compassionate. They give us knowledge . . . they take their time on letting us know where to go and how to get there. Instead of being just pushed aside” (p. 8, italics in original). Feeling respected was very important to the
women in this study and occurred for them when they felt safe, listened to and spoken to in a courteous manner. However, respectful treatment was not generally reported by women respondents of the VANDU Women CARE Team study. Instead women felt they were made to wait for assistance, neglected and labelled derogatorily as drug addicts or “junkies” (p. 9).

The findings of VANDU Women CARE Team (2009) project demonstrate the effective contributions that women who use drugs can make in collaboration with “researchers, health care providers and administrators, community-based organizations and policy makers at all levels of government, in identifying opportunities to advocate for and implement meaningful changes and improvements in quality health care” (p. 27). It is noted in this PAR study with women who use drugs in DTES Vancouver that these circumstances pervade women’s lives throughout the Canadian health care system and that they might be more effectively addressed through similar research projects involving women at all stages of community-based or participatory research.

**Truthful Self-Nurturing as a Theory of Women’s Addiction Recovery**

Kearney (1998) notes, that although substantial research regarding women’s readiness for addiction treatment has occurred and that it has included factors to predict long term success; the relapse rate for women within the first year following treatment remains significant. To address the high rate of relapse for women seeking addiction treatment Kearney determined that a synthesis of previous research findings regarding this issue might provide successful recovery strategies. With this in mind, Kearney reviewed ten qualitative research reports from ethnographic, grounded theory and
phenomenological conventions to identify indicators of treatment readiness as well as predictors of recovery sustainability. Kearney noted that although qualitative researchers individually studied women’s experiences of addiction recovery from an array of cultural and social perspectives, none of the research findings were applicable in more generalizable manner.

Kearney’s (1998) research synthesis analyzed ten research reports regarding women’s addiction recovery to establish a theoretical basis for women’s addiction treatment that could be utilized across diverse contexts. Kearney’s subsequent modeling of the recovery process was intended for wide use by health professionals in multiple contexts but was to remain attentive to women’s individual needs and unique circumstances. “The model reflects the essential elements of the recovery process, grounded in data from women of two nations and many cultures and social groups, as a response to a basic problem crossing many women’s families and lives” (Kearney, 1998, p. 500).

Kearney (1998) proposed that women’s addiction and recovery were both established through common processes of self-nurturing. Addiction resulted from destructive self-nurturing and recovery from self-nurturing that was health promoting and truthful. Kearney (1998, p. 500) states that destructive self-nurturing was medicating oneself with substances to cope with “psychic pain from early abuse or neglect, social exclusion, or cultural disenfranchisement.” However, it was noted that use of substances did not alleviate pain but rather potentiated it because when women were sober they had to attend to not only engrained pain from earlier experiences but also from the physical and psychological symptoms of withdrawal from drugs or alcohol addiction.
Conversely, Kearney outlined how truthful self-nurturing occurred as women were able to become more knowledgeable and understanding about themselves and their lives while simultaneously moving toward healthy self-care and affirming relationships.

The truthful self-nurturing process was not rigidly defined in this study but included processes that might be self-guided by a woman or carried out with supervision in a treatment program or by a professional. Kearney does note that formal treatment was least used by women who were socially and culturally outside of the mainstream: “The farther, a woman’s sociocultural milieu from mainstream social institutions and traditions, the less likely she was to use formal treatment programs” (Kearney, 1998, p. 501). The first step in the process toward truthful self-nurturing occurred when women experienced a painful shift in their awareness and the recognition of substances as problematic in their lives. Each subsequent step in the recovery process involved another shift in awareness sometimes a result of other people such as friends or professionals and at other times through personal examination. As women became increasingly aware they had greater insight into where their problems originally came from and how they might address these problems. As Kearney notes after the initial painful awareness of problems associated with substances women later had “deeply meaningful insights into the origins of their problems and the work needed to address them. These included awareness of childhood abuse or other early experiences and their impact on selfhood, adult relationship issues, cultural and community issues” (Kearney, 1998, p. 503).
According to the Kearney's (1998) study the work of women's recovery encompassed three areas: Firstly was abstinence work which might be motivated by external factors such as retaining employment or avoiding incarceration, physical rewards of becoming healthier and identity rewards such as keeping custody of children or feeling a greater sense of self respect. Secondly women's recovery included work on self incorporating components of truthful self-appraisal and "vulnerability to past harms and present threats and facing how little one knew about oneself as an adult woman" (Kearney, 1998, p. 505) as well as self-nurturing. The self-nurturing component included women identifying and attending to their own needs by taking responsibility and actively caring for themselves. Lastly, once women were able to know that they could responsibly care for themselves they were able to change how they related to their families, networks and the community at large. Boundaries were established gradually at first within treatment settings or with other people in recovery and later within their connections to social networks. Healthy relationships and expression of feelings occurred as "women saw their roles in human society differently, and they began to find mutually beneficial ways of interacting rather than always protecting themselves out of vulnerability, anger, and fear" (Kearney, 1998, p. 506). From these healthy connections a sense of safety in community was established as was a sense of meaningfulness in relationships with others.
National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances

The Government of Canada (2005) *National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances* has a vision that “all people in Canada live in a society free of the harms associated with alcohol and other drugs and substances.” A major principle of this framework includes involvement by those most affected by problematic substance use. However, this document does not consider the impacts of gender on all facets of substance addiction. Although the Canadian Centre on Substance Abuse (2008, p. 7) summary report of the second forum on the *National Framework for Action* includes “trauma, abuse and family violence (related to addictions)” as emerging priorities, the inclusion of the specific needs of women in relation to substance use are not visible. However, in response to the lack of gender focus within the national framework for action, an accompanying worksheet was developed by Dell and Poole (2009) which attends to specific gender and diversity perspectives. This worksheet broadens the scope of the framework and applies gender and diversity lenses to each of the priorities for service. The inclusion of Dell and Poole’s worksheet is important to service provision for women at a more local level as national priorities filter down to provincial and regional levels. An area of this worksheet that is particularly relevant to women is that it has laid the groundwork for “how to better reduce stigma, monitor needs and gaps, [and] improve the continuum of care” (Dell & Poole, 2009, p. 3) from a woman’s and diversity point of view.
BC Ministry of Health Planning Framework: Every Door is the Right Door

The British Columbia Ministry of Health Services (2004) plan for substance addiction *Every Door is the Right Door* suggests further research in the social sciences and that which is community-based are both required in BC. This plan states that:

Regular, well-conducted research and evaluation is an essential foundation for action. It provides the evidence needed to formulate sound policies and practices, allocate resources efficiently and effectively, and support decision making at all levels to address problematic substance use and mental health problems. (BCMHS, 2004, p. 56)

The BCMHS (2004) framework is expected to address downstream harm reduction and treatment services and also upstream prevention and self-management. It is an effective tool for professional service providers and, unlike many frameworks, also includes grassroots and community initiatives. There is an understanding in the BC framework that the social problems caused by substance use and associated mental health issues cannot be alleviated by the availability of unlimited financial resources. As Stringer (1999) has stated: “the billions of dollars invested in social programs have failed to stem the tide of alienation and disaffection that characterizes social life in modern industrial nations” (p. 2). Ideally, the BC framework proposes strategic placement of funding to not only build ‘bricks and mortar’ residential treatment centres but to also build alongside these, compatible and sustainable community capacity. However, this mandate to build community capacity is actually taken up far more ably in larger urban centres than it is in smaller urban or rural communities.
Funding for Women’s Treatment Services in BC

Availability of treatment programs for women that attend to needs for both residential and day treatment programs are determined by diminishing funding levels. Many provinces in Canada have tried to address funding shortfalls through structured business models and by promoting regionalized health services (Hartrick Doane & Varcoe, 2005; Storch, 2006). This is often defined as a neoliberal approach or one in which business models override social justice models. As Stanford (2008) notes:

The main goals of neoliberalism . . . include controlling inflation; disciplining labour; downsizing and focusing government; and reinforcing business leadership. . . . The broadest but perhaps most important goal is . . . ratcheting down popular expectations. There has been a deliberate and multidimensional effort since the early 1980s to construct a whole new cultural mindset, in which people stop demanding much from the economy, and accept insecurity and vulnerability as permanent, “natural” features of life. (p. 48)

An implication of a business model for health care, at the local level, is that the value of cost efficiencies and bottom lines by regional health authorities, although important, may override the equally important values of social justice toward citizens in communities. As Kenny (2003) suggests, the “notion of health care as a public good is intimately connected to fairness. A central issue in health reform is whether or not we will affirm this belief. Will health reform preserve a concept of justice that protects the ‘have-nots’ or which privileges the ‘haves?’” (p. 165). Many health services, for example addiction services, have been
absorbed into cost effective centers in larger communities leaving smaller communities in have-not positions.

The British Columbia strategy for women’s health is an example of how smaller community health services can be absorbed into larger centers. The BC health strategy for girls and women is partnered with BC Women’s Hospital & Health Centre [BCWHHC] and the British Columbia Centre of Excellence for Women’s Health [BCCEWH] both located in Vancouver, BC which is a large urban centre. The women’s health strategy discusses access to health services, “barriers to access … [and] addresses issues beyond traditional medical interventions, placing health in its broad social context” (BCWHHC & BCCEWH, 2004, p. 18). Although this strategy notes the interrelationship between “mental health and addictions” (p. 27) and suggests that, “multi-disciplinary research must be conducted on the sources of women’s mental health services and the effectiveness of intervention strategies” (BCWHHC & BCCEWH, 2004, p. 27) there is little in this plan for communities within the interior of BC. Instead, access to comprehensive addiction health services is more readily available to women who live in the Vancouver region or to those in more distant locations who are able and willing to travel.

Areas outside of the Vancouver, BC region are losing services for women because of funding shortages. For example, the House of Ruth, in Kamloops, BC has discontinued residential treatment programs for women and the Kiwanis House for men and women has changed to a more expensive private facility as a result of provincial government funding cuts within the previous five years. Residential treatment services for women with substance use problems have become eroded in the Kamloops area. Local treatment programs particularly for women have markedly
decreased over the past decade. For example, both the Women’s Emergency Bed and Breakfast (WEBB House) with six beds for street-involved women and the House of Ruth with ten beds for residential treatment and women’s programs, are either closed or are redirected to non-treatment services (TRUE Consulting Group, July 2003).

**The Aurora Centre at BC Women’s Hospital and Health Centre**

The Aurora Centre, now part of Children’s and Women’s Health Centre of BC (2001), was preceded by a smaller 12-client program located in Vancouver called Aurora House. Philosophically the Aurora House was founded on principles which were feminist oriented and approaches to treatment that were holistic with an understanding “that women’s addiction to alcohol and drugs is inseparable from the struggles women face in every day life” (The Women’s Addiction Foundation, 1998, p. 2). Healing at the Aurora House included emotional and spiritual dimensions that aimed to build women’s self-esteem through journaling, self-affirmations and self-determination, so that each woman could find personal meaning and purpose in her life. As well, overall well-being was promoted through group therapy, twelve-step meetings for women only, nutrition, vocational planning and follow-up discharge planning.

The Aurora House relocated in 1995 to the Children’s and Women’s Health Centre of British Columbia in Vancouver, BC and was renamed the Aurora Center. The Aurora Centre as a provincial treatment centre for women with chemical dependency provides twenty-five beds for residential treatment as well as a ten women day treatment program and a pre-treatment stabilization program (Poole, 2007). The Aurora Centre continues providing holistic services
with an understanding “that women’s addiction to alcohol and drugs is inseparable from the struggles women face in every day life” (The Women’s Addiction Foundation, 1998, p. 2).

A Framework for Action: Four-Pillar Approach in Vancouver, BC

A Framework for Action is a four-pillar approach to drug problems in Vancouver, BC developed in 2001. It is a comprehensive plan designed to encourage regional development of services including prevention, treatment, law enforcement and harm reduction keeping in mind national and international contexts (MacPherson, 2001). The Framework for Action was developed with community input and local attention to the drug problems in Vancouver but was also intended to be taken up by the rest of Canada to address increasing rates of addiction. Alexander (2008) states that some of the positive attributes of Vancouver’s Four-Pillar approach are that it evolved through an open consultation process in the community and that: “It engenders enthusiasm in the local media, compassion among the public, and financial support in legislatures” (p. 13). Alexander does however note that this approach remains limited in that it does not address the root causes of addiction. One of the major areas that was focused on in the Framework for Action was the down town east side (DTES) of Vancouver, an area of approximately ten square blocks that has a “high incidences of poverty, drug addiction, violent crime, and prostitution” (The Downtown Eastside, n.d.).

Despite all of the difficulties associated with the DTES political activism has occurred over the years and brought with it a sense of community. Some of the activist groups include: The Vancouver Area Network of Drug Users (VANDU) and the associated women’s research group called VANDU Women
Clinic Action Research for Empowerment (CARE) team. VANDU has also been involved in community building by contributions to the Canadian HIV/AIDS Legal Network’s paper on meaningful involvement of individuals in the community using illegal drugs called: “Nothing About Us Without Us” (Jurgens, 2005). This kind of grassroots activism and community development is progressive and while supported by federal agencies like the Public Health Agency of Canada (2003), encounter difficulties at the local service level. At the local level through program development and what McKnight (1995) calls ‘client making,’ community activism and empowerment are sidelined. As Roe (2009/2010) writes, harm reduction services while expanded to reach the population in the DTES have changed the social structure and diminished the autonomy of residents.

New services . . . changed the scene from a community of residents to a therapeutic community in which residents became clients” and rather than being seen as independent community members were now viewed as unhealthy people requiring professional assistance. (Roe, 2009/2010, p. 80).

**The Phoenix Centre in Kamloops, BC**

The Phoenix Centre is the primary resource for tertiary care providing withdrawal management of drug and alcohol-related addictions in Kamloops, BC. Residential treatment services include detoxification programs for men and women. The five top drugs of choice requiring detoxification in this population for the year of 2003 were: Alcohol – 38.21%; Cocaine – 35.67%; Opiates – 8.74%; Cannabis – 6.91% and Benzodiazepines – 3.76% (Phoenix Center Detoxification Services Statistics, January 1, 2003 – December 31, 2003, p. 1).
The Phoenix Centre provided a combination of residential treatment as well as community counselling for both men and women with substance use addictions until March of 2004, when counselling moved under the umbrella of Mental Health Services. Statistics prior to this division of services in 2004 indicate that in a twelve month period 341 of the 984 individual clients or 34.65% of clients admitted for detoxification to the Phoenix centre were women (Phoenix Center Detoxification Services, January 1, 2003 – December 31, 2003, p. 2). In a similar twelve month period, 414 of 869 clients or 47.64% of the clients accessing community counselling were women (Phoenix Center Counselling Service, April 1, 2003 – March 31, 2004, p. 1). It is interesting to note that a greater percentage of women accessed counselling services than detoxification services. One reason for this might be that detoxification requires in-house treatment whereas counselling is available on an out-patient basis. Services that remove women from their socially expected care-giving roles, particularly in relation to partners and children, can make it difficult for them to access treatment (Varcoe & Hartrick Doane, 2007). To address some of these gender specific barriers to substance use treatment initiatives for marginalized women are occurring to address needs for community support in the Kamloops region at the local level.

It’s All ‘Bout You’ Women’s Conference

Carriere (2004a), a Street Outreach Nurse Educator, conducted a local health assessment of ninety marginalized women living in Kamloops, BC. The rational for this survey was that current health initiatives are inadequate because they are not gender specific and create barriers that exclude women from health
care. Carriere (2004a) notes in a subsequent proposal that a “generic approach is inadequate for understanding the health needs of women...because women experience health, illness and health care in different ways than men. “Findings indicated that forty-six percent of the women use illicit drugs, of those 74% use daily and ... 38% [state that] their coping skills are inadequate with substance use being their main coping strategy” (Carriere, 2004b, p. 3). As follow up to this assessment a conference was organized with the women from the survey identifying priorities for health information. The most highly rated topics of interest were: “How to Stay Sane in an Insane World” and “Lady Beware Safety Techniques” (Carriere, 2004c).

The intention of the It’s All ‘Bout You’ Women’s Conference was to provide “a day of self-discovery, self-empowerment, and self-advocacy” for one hundred Kamloops women who were identified as vulnerable (Letter of invitation to community leaders from Gayle Carriere - Street Outreach Nurse, August 16, 2004). This conference promoted action, empowerment and choice best expressed in its mandate to:

Assist women by enhancing the understanding of health practices and the skills of self-care, self-help, and self-advocacy as they relate to health and wellness. ‘It’s All ‘Bout You’ will empower women to identify the choices in planning actions that will positively influence their mental, spiritual, emotional and physical being. (Public Health Street Outreach Services, 2004, p. 1, All capitals in text altered to capitals plus lower case, italics in original).
Approximately one hundred women participated in the *It’s All ‘Bout You’ Women’s Conference*. Each of the women could attend larger sessions as well as smaller presentations of their choice. The conference program included opening and closing keynote speakers, concurrent session speakers as well as volunteers from different backgrounds covering topics such as “Nutrition on a Food Bank Budget … Gathering Your Spirit – Yoga for Centering and Stress Relief … Lady Beware, Lady Be Safe … ‘What are My Rights in All This Chaos?’ Ask A Lawyer … Speaking Loud and Clear for Your Rights … Road Maps to Help You Navigate the Employment Roadways” (Public Health Street Outreach Services, 2004, p. 5). As well, approximately thirty displays and booths offered information on a range of topics some of which included addiction, Aboriginal services, legal and police services and child care programs. The women received a conference package, many door prizes, an honorarium for attending, nutritious and tasty refreshments and childcare as required.

The *It’s All ‘Bout You’ Women’s Conference* was an excellent example of program development that was gender sensitive and specific to women’s self-identified needs. Nurses within the health care system effectively reached out in an inclusive manner to marginalized women who are most often excluded or “peripheralized” (Meleis & Im, 1999, p. 95). This conference sent a message of caring and liberation to marginalized women who often live desperate lives oppressed and controlled by social systems that do not notice or acknowledge them in positive ways.
The Roles of Nurses Supporting Women in Recovery from Problematic Substance Use in Kamloops, BC

The roles of nurses supporting women in recovery from substance use within the Kamloops, BC community are multifaceted including tertiary care, residential care and street nursing. Nurses in these diverse contexts provide professional care in more traditional settings including the Royal Inland Hospital (RIH) and the Phoenix Centre both of which provide nurse managed client detoxification or withdrawal from substances. Less formal care is provided by street nurses as well as by public health nurses who utilize a population approach that is client centred with the intention of fostering increased “capacity within clients, health and social service providers, and the community at large” (Carriere, 2008, p. 209). Additionally, nurses assisting women with problematic substance use issues practice in non-traditional roles in non-governmental non-profit organizations including the New Life Mission and Salvation Army and private for-profit residential care services; for example the Sage Centre.

Summary

This chapter reviewed the relevant literature from a Canadian context in terms of the research question: How do women with a history of substance misuse negotiate barriers and find paths to recovery? A wide range of literature sources pertaining to women’s substance addiction were reviewed broadly and then more specifically from provincial, regional and local landscapes. The wide scope of review was completed to better understand what is known about the nature of women’s lives both in addiction and as they recover. This review of
the literature was carried out with an emancipatory mindset intended to clarify how women recovering from substance use experienced power and control within hegemonic systems. Although the deleterious effects of drug and alcohol use on women were noted to be statistically significant it was also determined that there was a lack of research information specifically focused on women’s personal experiences of recovery. However, the literature did address related issues for women using substances including those who were pregnant, parenting or had mental health concerns.

There was a small portion of the literature that did explicitly outline the unique influences on women’s addiction and recovery experiences which included: Specific biological, psychological and social parameters, gender differences and women’s exclusive life events. This present critical feminist study seeks to contribute to the body of knowledge related to women’s unique circumstances, social conditions and experiences and to uncover from their individual perspectives what helped and did not help them on their recovery journeys.
CHAPTER THREE: THEORETICAL FRAMEWORK AND METHODOLOGY

The following chapter reveals the foundations that have underpinned the theoretical framework for this critical feminist study. The fundamental components of both critical and feminist theories are discussed in terms of their commonalities and how these are intertwined within a critical feminist theoretical framework. The rationale for the choice of this structure over competing frameworks is presented as well as how and why I have, as the researcher, been immersed in all components of the study. Following this, my work as a nurse researcher in emancipatory community practice is demonstrated through three exemplars that clearly show the nature of this work at a community level. These exemplars demonstrate that a critical feminist methodology is congruent with my own world view and preferred practice framework. Lastly, this chapter outlines the methodological composition of gendered interviews which have been integral to this critical feminist study.

Choosing a Theoretical Framework

The theoretical framework selected for this study is derived from my own ontological stance and necessarily informs both the research methodology and epistemology (Crotty, 2007). Ontology is an expression of one’s sense of ‘being’ in the world or as Walter, Glass and Davis (2001) suggest: “the way one acts in the world; for example, the way one ‘walks one’s talk’” (p. 266). Denzin and Lincoln (2005) propose that ontological perspectives differ according to individual world views and beliefs framing such questions as: “What kind of being is the human being? What is the nature of reality?” (p. 22). Methodology
based upon one’s ontological perspective regarding reality “guides how a researcher frames the research question, and decides on the process and methods to use” (Grant & Giddings, 2002, p. 12). How a person comes to know about the world is an epistemological endeavor or “theory of knowledge” that determines “how we know what we know” (Crotty, 2007, p. 3). For example, Doucet and Mauthner (2008) pose epistemological questions asking “what can be known and how?” (p. 399). By addressing each of these questions I was able to choose a framework appropriate to my research question as well as to my own preferred stance and a framework therefore that was methodologically possible and epistemologically attainable.

The choice of an appropriate theoretical framework required an in-depth understanding of the many commonalities and differences between a range of interpretive, critical, feminist and post modern paradigms. Central to this study of women’s experiences of recovery from substance use was my position that women’s life narratives, although evolving and changing, could be understood and interpreted. Interpretive paradigms did permit understanding of women’s stories but viewed them as static and unchanging whereas postmodern paradigms were adverse to the idea of common self narratives viewing individuals completely dissimilar and constantly changing. These positions were demonstrated by Lather (2007, p. 165) using a graphic called “major interpretive paradigms” developed by Wanda Pillow and Annel Medina. In this graphic an interpretive paradigm presented one’s ‘self’ as constant and unchanging whereas the post-modern paradigm construed individuals as continuously reconstructing themselves with no position as constant. Unlike
interpretive and postmodern paradigms critical feminism was more compatible with this particular study because it endorsed the concept of emancipatory change. A critical feminist framework was most congruent with this research because it promoted transformative change through augmentation of people’s self-awareness, ideological critique and emancipatory action.

An additional factor that was considered when choosing a methodological framework was how differently interpretive, postmodern and critical feminist perspectives viewed social reality. From a poststructuralist viewpoint social reality is specifically created through language (Hartrick Doane & Varcoe, 2005). This perspective differs from Doucet and Mauthner (2008) who argue that although social reality is experienced through language or discourse it is also experienced within multiple relational contexts. As Smith (2004) discusses women’s lived experiences exist beyond the postmodernist barriers that would deny “the validity and originality of speaking from experience and insisting on a solipsistic confinement to discourse” (p. 24). In agreement with Doucet and Mauthner as well as Smith, I believe that individuals are composed of much more than their words or narratives and that they are constituted in a social world by the multiplicity of their relationships. After considering both interpretive and post-modern or poststructuralist perspectives I ultimately determined that the best fit with my personal philosophy regarding women’s selfhood, social reality and their potential for emancipatory change was a critical feminist framework.
The Fundamentals of Critical Theory

The original development of critical theory is most often associated with the Frankfurt School which was established in Germany in 1924. At the Frankfurt School, critical theorists advanced critique of positivist paradigms and developed lines of thought that were Marxist based (Fontana, 2004). Crotty (2007) presents Jürgen Habermas as a second-generation critical theorist who believed that critical theory was a socially based construct that was purposed to address discontent within society. “As to its origin, a critical theory is clearly rooted in concrete social experience, for it is one which is explicitly conceived with the practical intention of overcoming felt dissatisfaction” (Habermas, 1972/2002, p. 109). According to Oliga (1996) the overall aims of Habermas’ work were to free individuals from societal oppression and potentiate their emancipation. Critical theory capably met Habermas’ aims by encouraging critique and awareness of social domination and subsequent actions of empowerment. It was through this process of enlightenment and empowerment that control was transformed into emancipatory action and day to day personal liberty (Oliga, 1996).

Ideology Paired With Power Produces Control

Discussion of the concepts of ideology, power and control and comprehending how these concepts contribute to oppression in the lives of women with substance use history is an effective first step toward understanding women’s realities. As Oliga (1996) states, “it is through the “media of power and ideology that control is exercised, leading to domination” (p. 291). Knowledge related to these concepts supports a critical feminist research project
that examines what forces have controlled the lives of women with a history of substance use and may have also contributed to their marginalization. Through the media of liberatory research there is the possibility for women to collectively and individually develop awareness of oppression and in the process become enlightened, empowered and transformed.

Ideology is the taken-for-granted workings of the world that one lives in. It is the belief system that articulates and organizes all aspects of everyday life (Kincheloe & McLaren, 2005). Powerful forces shape individuals and social groups so that they unconsciously support constraining and dominant systems. As Brookfield (2005, p. 68) notes ideology is the:

System of beliefs, values, and practices that reflects and reproduces existing social structures, systems, and relations. Ideology maintains the power of a dominant group or class by portraying as universally true beliefs that serve the interests mainly of this dominant group.

Identifying ideology in relation to dominant power structures in society is well supported in the literature (Crotty, 2007; Kincheloe & McLaren, 2005; Marger, 2002; Oliga, 1996). Crotty (2007) suggests that ideology as a value and belief system unconsciously causes people to see the world as they expect to see it rather than the way it really is. Marger (2002) considers ideology as more than unconscious expectation and suggests that when it is paired with hegemony becomes ideological hegemony. Ideological hegemony is demonstrated when dominance and the status quo are legitimizes by all of society’s social systems. Individual and communal views of the world or worldviews are determined by beliefs and values that rationalizes a society’s structure of power and privilege
(Marger, 2002, p. 227). McDonald (2006) discusses ideology, in relation to gender and states that it is "a powerful and authoritative voice in society that tells us who we are and how we are to behave" (p. 336).

Paradoxically, legitimation of dominant ideologies and maintenance of the status quo, are embraced not only by those who benefit from power and privilege, but also by those who do not. Stanford (2008) in consideration of economic outcomes suggests that even though some groups in society are known to exert power and influence in their own interests others in society willingly tolerate it. As Stanford (2008) states:

Different economic actors use their political influence and power to advance their respective economic interests. The extent to which groups of people tolerate economic outcomes (even unfavourable ones) also depends on political factors: such as whether or not they believe those outcomes are "natural" or "inevitable," and whether or not they feel they have any power to bring about change. (pp. 24-25)

Marger (2002) suggests that even while people with little power or wealth may acknowledge the inequality of the system they still see it as fundamentally fair and the best that is possible. As Kincheloe and McLaren (2005) note people have "limited exposure to competing definitions of the sociopolitical world. The hegemonic field, with its bounded sociopsychological horizons, garners consent to an inequitable power matrix – a set of social relations that are legitimated by their depiction as natural and inevitable" (p. 309). As well, individuals often look for experts to have the solutions devaluing their own knowledge, expertise and power (Ife & Tesoriero, 2006). Ideology is thus maintained and supported by
those who are privileged and also by those who are oppressed. However, Kincheloe and McLaren also pose the idea that this depiction of ideological legitimation is not always accepted without challenge but rather that it is frequently contested by oppressed groups who, as they become increasingly aware and knowledgeable about inequitable power distributions, question that which is normalized or taken for granted in our society.

The definition of power is derived from the Latin word “potere” which means having “the ability to choose” (Kuokkanen & Leino-Kilpi, 2000; Rodwell, 1996). Within this definition power may be conceptualized narrowly as individual capacity for choice or spread more broadly to include the communal preferences of society. Gilbert (1995) discusses two competing paradigms to define power; a psychological model denoting that it is a personal attribute which expands to increase personal efficacy versus a political model that results in distribution of resources as people and communities collaborate synergistically. Brookfield (2005) expands this notion of power in terms of resource allocation by posing the politically and economically weighted question “how is it that these resources are differentially distributed and tapped?” (p. 49). Querying how resources are distributed is a thought provoking question even though the answer is not easily determined. However, it does seem reasonable to posit that those who do receive the most resources are indeed imbued with more power than those who are less privileged. Beyond equating power with possession of external resources and opportunities Brookfield also relates power to biologic energy and intelligence with the implication that having the means to power might simply be the ‘luck of the
draw’ for many people particularly in relation to genetic endowment. However, McGibbon, Etowa and McPherson (2008) suggest that even when taking biology and genetics into consideration specific groups of people have diminished health outcomes related to inequitable distribution of resources.

**Hegemony and ‘Power Over’**

Chinn and Kramer (2008) suggest that hegemony is dominance of one set of ideologies, beliefs and values over other viewpoints and that these are “taken for granted as fact” (p. 79). Brookfield (2005) writes: “the networks of community associations through which we all move, all serve to convince people that the way they live is a natural, preordained state that works in their best interests” (p. 97). People live within these circumstances having limited power and may even recognize the presence of social inequality yet still view the system as basically fair and ‘normal’ (Marger, 2002). The outcome of these legitimized social relations is general acceptance of dominance or ‘power over’ relationships.

Chinn (2008) refers to power over others as hierarchical and oppressive. “Defined in hierarchical cultures, power is the capacity to impose one’s will on others, accompanied by a willingness to apply sanctions against those who oppose that will” (p. 17). Graveline (1998) also defines the position of power over in terms of hierarchy within bureaucratic systems and suggests this affects all who are connected to these systems including both those who provide services as well as those receiving them. Fontana and Frey (2005) consider hierarchical power as subordination of one individual or group to another while others (Habermas, 1984; Kasl, 1992) take this a step further and attribute
oppression to dominant systemic power and also as the root cause of
dysfunction and impairment of people’s engagement, communication and
participation within society. Dominant power structures perpetuate dysfunction
through the control of people’s discourses regarding what knowledge might be
considered legitimate and reliable (Brookfield, 2005, p. 136).

A commonly recognized statement: ‘knowledge is power’ presupposes
that as knowledge is gained so is power (DePoy, Hartman & Haslett, 1999;
Freeman, 2001; Morris, 2002). Within mainstream society knowledge
construction is generally considered the purview of socially constructed systems
of higher education or research institutes and not that of the common person
(Kirby, Greaves & Reid, 2006). These systems, given the authority to decide
what is or is not credible knowledge, become more powerful than knowledge
itself and in turn perpetuate the authority of some over that of others within
society. As Brookfield (2005) suggests “whoever is in a position of power is
able to create knowledge supporting that power relationship. Whatever a society
accepts as knowledge or truth inevitably ends up strengthening the power of
some and limiting the power of others” (p. 136). Brown and Strega (2005)
concur with the idea that knowledge serves a hegemonic function particularly
when it privileges dominant views of reality over less dominant views.

**Liberatory Social Power**

Although advancement of power may have negative connotations, it is
important to remember that societal power also contains productive and
liberatory qualities. For example the liberatory dimensions of power are
demonstrated, particularly by those outside the mainstream, when individuals
become actively engaged in democratic processes of sociopolitical critique and other related empowerment-based activities (Kincheloe & McLaren, 2005). These kinds of engagement are also demonstrated within the community-building principles of “PEACE” power; an acronym for praxis, empowerment, awareness, cooperation, and evolvement (Chinn, 2008, p. 10). Chinn defines praxis as living one’s values in action where knowing and doing are synchronous. Empowerment as “growth of personal strength, power, and ability to enact one’s own will and love for self in the context of love and respect for others” (p. 10). Awareness is of the present moment in which knowledge grows of oneself and others, cooperation values people’s diversity and cohesiveness while evolvement commits to deliberate transformation. As Chinn notes the process of community building, when integrating these principles, respects the individuality and voice of each person yet develops community in a way that ensures equality and is supportive of non-oppressive ideology.

Another form of liberatory power is that described by Vanderplaat (2002) as mutual empowerment. This is a type of cooperative power in which individuals come together with varying abilities, attributes and experiences and communally share these for the benefit of others; it is an altruistic endeavor in that what is shared becomes greater than the sum of individual contributions. Through this respectful process of mutual empowerment relationships are built and all participants experience change. “In a mutual approach to empowerment, everyone involved, regardless of position of power and privilege, recognizes that she or he is both agent and subject . . . in a truly empowering process everyone changes” (Vanderplaat, 2002, p. 94).
Critical Perspectives of Oppression and Liberation

Oliga (1996) views social conflict and struggles for dominance or control from a critical perspective viewing control as a social phenomenon that is “not only pervasive but is perhaps the most powerful and ideological concept in human and social relations” (p. 3). Oliga argues that through ideology and power, control is established leading to social domination or oppression. Oppression is based on differences between people and groups such as difference in gender and race occurring when more dominant groups are considered the norm and less dominant groups inferior. As Reid (2004b) states: “Dominant group’s experience and culture are universalized and established as the norm. ‘Other’ groups are brought under the measure of dominant norms and are constructed as non-adherent, deviant, and inferior” (p. 27). Furthermore, those in power are the touchstone for how people are to behave. As McDonald (2006) notes, ideologies are “not merely ideas, but a powerful and authoritative voice in society that tells us who we are and how we are to behave” (p. 336).

Within this definition of ideology power is equated with authority but as Kabeer (1999) suggests, power may also mean the ability to choose. Kabeer (1999) equates power to personal choice in relation to accessing resources, experiencing personal agency and the opportunity to successfully achieve goals. Control, justified by ideology, includes the power that social systems exert in general as well as the capacity that individual people have to express power within their own lifeworlds (Oliga, 1996).
Control as an Outcome of Established Ideology and Power Bases

Control may be defined and theorized broadly as power that is mediated socially but also may be connected to individual perspectives or personal control (Brooks & Goldstein, 2003; Oliga, 1996). Brooks and Goldstein equate personal control with a healthy mindset suggesting that “a sense of personal control plays a major role in emotional and physical well-being” (p. 10). Raphael (2009) also discusses individual control in terms of well-being suggesting that it occurs as people exercise their choices or lack of choices for healthier lifestyles. It is interesting that the primary health care model promoting healthy lifestyle choices in Canadian society is based on the assumption that people actually have control of their lifestyles. As Raphael proposes:

The logic of promoting healthy lifestyle choices rests on the belief that people have considerable control over their everyday activities, their grocery bill, and organizing the possibility of time for a safe place to walk. Since control over one’s life circumstances rests heavily on one’s economic circumstances, the logic and efficacy of lifestyle approaches to health promotion increasingly disintegrate as one descends the socio-economic gradient. (p. 328)

Oliga (1996) considers control as an outcome of the effects of ideology and power resulting in social order and also notes that the concept of individual control within social systems may be conceptualized as originating from internal or external sources. Oliga (1996, pp. 141-142) suggests that although there are many different definitions of control “the problem of maintaining social order in the face of actual
or potential conflicts and contradictions” underlies all of these views. This is further conceptualized within the parameters of a critical view whereby social order is defined in terms of resolution of conflicts that arise because of domination within the societal structure. As people begin to comprehend the reality of social domination within their communities and visualize the potential for action they are able to change their beliefs about the rightness of the prevailing social order. As Oliga (1996) states, there is a change in their perspectives from “resigned acceptance of the existing coercive social order to one of transformative action to redeem human freedom and collective autonomy” (p. 142).

**Enlightenment/Awareness through Empowerment and Transformation**

The most basic meaning of enlightenment is to become knowledgeable or aware of information that has previously been unconscious or unknown. For example, it is to become conscious of how ideology affects one at social, political and economic levels and then to envision how change might occur (Freire, 1993). Gutiérrez and Lewis (1999) suggest that, “consciousness will only lead to social action if individuals believe that the system is unfair” (p. 7). The known world in terms of social justice is dependent upon individual perspectives and knowledge gained from each person’s lived experience. Increased consciousness and subsequent transformation is established when the system is critically examined “creating transformative tension within the social system itself” (Hesse-Biber & Leavy, 2006, p. 32). As Kincheloe and McLaren (2005) propose people do not passively permit their own victimization nor do they accept the status quo unquestioningly. Rather, people choose empowering options as they become aware and are able to discern meaning within their circumstances.
**Personal Empowerment**

For those who struggle with day to day oppression the idea of having the power or freedom to make personal life choices might seem impossible. Empowering someone else is frequently seen as a noble gesture, yet empowerment is not a ‘gift for giving’ by more powerful people rather, empowerment is encouraged when people come together and share resources and strengths in the hope of building strong and supportive communities (Hooks, 2003). Sharing of knowledge and resources does not in itself impart empowerment. Empowerment occurs when people uncover the deeper parts of themselves through personal insights and self-discovery. As well, it occurs when individuals develop their own support and credibility within sustainable and life enhancing community networks. When empowerment is located in this manner the possibilities of a civil and just society are potentiated whereby the personal becomes political and people become more free-thinking and independent with intrinsic power to consciously transform oppression into liberty (Habermas, 1972/2002).

**The Fundamentals of Feminist Theory**

Feminist theories are framed by multiple standpoints or feminisms, which incorporate varied forms of scholarship and perspectives. Although diverse forms of feminist inquiry demonstrate fundamental differences regarding core beliefs and assumptions all feminist theory examines gender-based issues and how these might be addressed to improve the lives of women (Dell, 2007; Maguire, 2002; Reid, 2004a, 2004b). Gender-based issues regarding societal oppression that are commonly identified by feminist theory include: the power of women’s voice and personal agency (Hesse-Biber & Leavy, 2007; Doucet & Mauthner, 2008) as well
as individual and group perceptions and experiences of being an insider versus an outsider within society (Buch & Staller, 2007; Hesse-Biber, 2007a; Reid, 2004b). Overall, critical feminist inquiry addresses ideological issues of power and control related to social domination and seeks increased awareness, empowerment and transformation as components of emancipatory action within the research process (Oliga, 1996).

**Feminist Perspectives of Oppression and Liberation**

Dell (2007) notes two of the central themes of feminist theory include women’s emancipation and a progressive mandate for social change. Feminist theory informs gender-based studies and helps to clarify the interrelationships of ideology, power and control with enlightenment, empowerment and transformation and how these are embedded within women’s experiences of social domination and of emancipation within society. Maguire (2002, p. 60) proposes that critical feminist research draws from feminist theory and becomes most progressive and transformative when it foregrounds feminist perspectives with a focus on women in terms of their “oppression, devaluation and exploitation” yet also challenges the many locations of oppression within our society. Maguire contends that societal oppression of any kind needs to be challenged so that we can politically move forward toward personal, social and structural transformation. Furthermore by embracing a feminist mindset Maguire (2002) suggests we demonstrate “a commitment to expose and challenge the web of forces that cause and sustain all and any forms of oppression for both our sisters and brothers, our daughters and sons” (p. 60).
Women as Insiders and Outsiders

Women live within socially constructed communities in which the intersections of “race, class, geography, ability, gender identity, and sexuality” (Varcoe, Hankivsky & Morrow, 2007, p. 12) influence where they are positioned within their worlds. Social location is dependent upon where a woman stands within these intersections and determines if she is considered a group member or insider or whether she is excluded as an outsider. There are no hard and fast rules regarding who might be in or out of a group and in actual lived experience social locations may be permeable, changing or altered depending on surrounding influences (Hesse-Biber & Leavy, 2007). However, some social locations are less permeable than others. Women who experience social exclusion are more likely to be static in terms of access to resources and participation in their communities. As Raphael (2007, p. 106) notes:

Social exclusion is a process by which people are denied the opportunity to participate in civil society; are denied an acceptable supply of goods or services; are unable to contribute to society; and are unable to acquire the normal commodities expected of citizens.

Marginalization of Women

Marginalization is a concept that defines how an individual or group is disconnected from the mainstream. Margins may be identified concretely as a distinct person, group or place or more abstractly as a process of people’s social exclusion as they are moved to the periphery of mainstream society (Vasas, 2005). For Meleis and Im (1999) marginalization is “the process through which persons are peripheralized on the basis of their identities, associations,
experiences and environments” (p. 95). Individuals and groups who experience peripheralization are pushed to the edges of mainstream society and are thus marginalized. Vasas (2005) writes marginalization occurs when people are relegated outside of specific physical or psychological margins in relation to a centre point. As individual and group characteristics are contrasted to those that are prevalent within the center point, people who do not fit within these parameters are then marginalized or excluded in some manner. From this perspective the powerful center determines who meets its criteria for inclusion and who does not. As a result Vasas states that those who are marginalized or distanced from the center become less visible and go unnoticed by the powerful mainstream.

The selection of who do or do not fit within certain boundaries varies within the social context that a person is situated within. In complex mainstream society marginality is tied to the concepts of power and control and related to not ‘fitting’ within the dominant ideologies of a culture or community. Therefore, as Alperin & Richie (2001) posit, it is possible for anyone to be marginalized in some fashion at one time or another. No one individual always ‘fits’ into mainstream society in every way. However, there are groups of individuals who are consistently excluded and treated unjustly by mainstream society. For example, women and their families who live in poverty and those living with substance use issues often are marginalized over long periods of time.
Reid (2004b, p. 27) theorizes, in relation to women and poverty, that dominant groups in a society normalize their own experiences and stereotype less dominant groups as ‘Other’ who thus become “on the margins or excluded altogether from the social fabric.” Reid (2004b) suggests that mainstream dominance is therefore substantiated as the norm through the process of ‘Othering’ and exclusion. A consequence of this dynamic is that poor and marginalized women experience negative health impacts. “The explication of cultural, institutional, and material exclusion elucidates how the processes that create and perpetuate poor women as the Other influence their health” (Reid, 2004b, p. 27). According to Varcoe (2004) ‘Othering’ as an act of exclusion is an ethical issue whereby those who form the majority, particularly within health care settings, designate difference to those they do not want to identify with. As well, Boyd (2004) suggests that the system works to categorize pregnant and mothering women who use substances as they fall under the gaze of social agencies.

Attempts to categorize and separate women who come to the attention of social services, the medical profession, and the criminal justice system from conventional society disregard the near universality of drug use and the diversity of illicit drug users. Categorization of this kind encourages one to see certain groups of people as Other. (Boyd, 2004, p. 36)

For women who are made to be the ‘Other’ in society Vaszas (2005) proposes, that the chances of being further disadvantaged and subsequently socially excluded from mainstream society altogether increase substantially with each intersecting difference a person experiences. For example intersecting
factors that people live with that classify them as different or atypical are those who live in poverty as well as those living in unsafe physical and psychological environments where they are subjected to varying measures of “physical, emotional, or mental violence and abuse” (Vasas, 2005, p. 198). In these situations people are unable to contribute to society meaningfully and most focus on meeting basic needs such as food, shelter, and clothing (Raphael, 2007).

In terms of working with individuals or groups who have been defined as “Other,” Fine (1994) in Working the Hyphens describes the hyphen as a place where Self and Other meet; a place tangled by social identities and contextual constructions of reality. To work the hyphen is to collaborate with people rather than simply collecting their stories/contributions and writing about them.

Despite denials, qualitative researchers are always implicated at the hyphen. When we opt, as has been the tradition, simply to write about those who have been Othered, we deny the hyphen. Slipping into a contradictory discourse of individualism, personologic theorizing, and decontextualization, we inscribe the Other, strain to white out Self, and refuse to engage the contradictions that litter our texts. (Fine, 1994, p. 72, italics in original)

It is at the place of face to face meeting that one is able to take the liberty to perhaps ameliorate some of the oppressive/control aspects of the research process through interactions that optimize opportunities for mutual sharing and which then open possibilities for new political and personal insights (Kirby, Greaves & Reid, 2006, p. 141). In that space where one is able to sit openly and
transparently as one person communing with another there is freedom to disclose/not disclose who we are as people. This space and moment in time is a location where people can share with one other and experience a sense of safety and trust. It is a relational place where “Self and Other reside on opposite sides of the same door” (Fine, 1994, p. 72).

For researchers who choose to work alongside those who are marginal social and academic barriers are erected by the mainstream. Collaborative grassroots research and knowledge construction attending to issues causing marginality such as poverty, violence and unsafe or unhealthy environments is often not valued or legitimized by traditional institutions. Through delegitimation the researcher and participants then experience a form of academic marginalization. Brown and Strega (2005) propose that through legitimation of specific kinds of knowledge production and by determining who might produce it, knowledge and those who construct it can effectively become marginalized.

Knowledge production has long been organized, as have assessments of the ways producing knowledge can be “legitimate,” so that only certain information, generated by certain people in certain ways, is accepted or can qualify as “truth.” Historically, this has meant that those on the margins have been the objects but rarely the authors of research, and the discomfort that those on the margins feel about adopting traditional research processes and knowledge creation has been interpreted as their personal inability or failings. (Brown and Strega, 2005, p. 7)
One of the ways that marginalization of research and knowledge production may effectively be addressed is when professionals, including nurses, are able to work within the bureaucracy and complexity of mainstream systems yet willing to also step outside of them to notice and make visible the issues that exist in society.

**Lifeworld Colonization**

Oliga (1996) describes colonization broadly as a process whereby the mediums of money and bureaucratic power systemically control socialization. Thus complex bureaucracies including a myriad of organizational management systems alienate citizens and result in what Habermas (1984, p. 305) calls “colonization” of the lifeworld. Colonization of the lifeworld which includes one’s culture, relationships and self-identity are controlled through dominant and oppressive social structures (see Figure 1). Defined more narrowly colonization occurs whenever one body dominants another or as Cowling, Chinn and Hagedorn (2003) propose when one person’s point of view is imposed on another. Common to each of these viewpoints is that the product of colonization in society results from unequal power distribution segmenting those who have power, voice and agency and those who do not.
Figure 1: Schema of Lifeworld Colonization

Women's Liberation: Awareness + Empowerment = Transformation

Lifeworld Colonization

A Woman's Lifeworld
Culture: Traditions
Society: Relationships
Person: Identity

Women with a history of substance use

Women within oppressive social systems

Women's Oppression: Ideology + Power = Control

(Habermas, 1984; Oliga, 1996)
**Women’s Voice and Agency**

Women’s voice from a feminist viewpoint concerns being ‘heard’ by those in close relationships as well as by the larger sphere of community regarding women’s day to day experiences. Having voice denotes not only being visible but also being supported to improve quality of life (Hesse-Biber & Leavy, 2007). The connotation of voice suggests a shared community commitment to address inequity; a promotion of choice and agentic power and control. Doucet and Mauthner (2008) discuss agentic research participants as those who “act with intentionality and agency” (p. 407). Agency is the autonomy a person independently holds to make decisions that shape one’s life (Kincheloe & McLaren, 2005). The intention of collaborative and inclusive research is to bring people’s autonomy and voice to the foreground so that they are able to control and “connect the articulated, contextualized personal with the often hidden or invisible structural and social institutions that define and shape our lives” (Reid, 2004b, p. 36).

**Women’s Lifeworlds and Social Systems**

The life world also phrased as lifeworld is composed of unconscious assumptions about daily life which each person takes for granted and which are situated with established social structures (Brookfield, 2005; Holstein & Gubrium, 2005; Lipp, 2003). Life experiences that are taken for granted are also equated by Hartrick Doane and Varcoe (2005, p. 65) with “ideologies” that shape how everyday relational experiences are interpreted. Brookfield (2005) proposes that the lifeworld is composed of “the clusters of preconscious understandings that structure how we see the world and communicate our understanding to others” (p. 220). Kemmis (2002) derives from Habermas’ conceptualizations that the lifeworld is
composed of a matrix of “culture, society and person” (p. 94) or cultural knowledge, interpersonal relationships and personal identity and that all of these are situated within complex social systems.

From a narrow viewpoint culture is represented as a group’s behavioural patterns and the “beliefs, knowledge, and ideas people use as they live” (Cohen & Cameron, 2005, p. 157). Edmunds and Kinnaird Iler (2012) note that culture is all encompassing in one’s life; that it is shared with others, learned and changing so that “what we have learned to value represents our assumptions about how to perceive, think, and behave in acceptable, appropriate, and meaningful ways” (p. 126). Hartrick Doane and Varcoe (2005) suggest that culture be more broadly defined as a process that is not necessarily situated within a group but rather one that is created and “lived between groups and people” (p. 306, italics in original) and also that culture is developed and redeveloped within powerful Western societal structures. Furthermore, it is proposed that the impact of these powerful structures on individuals in our society is such that social issues such as poverty and unemployment become signs of people’s choices rather than circumstances of life.

Identities are developed within powerful social structures and result in how people perceive themselves within the world. As Coburn (2010) suggests:

Personal identity is a product of one’s upbringing within a specific societal culture during a particular historical time. Social structures or society comes first, then our own subjectivities, identities, or “selves.” We do not create the societies or institutions within which we find ourselves; we reproduce, modify, or transform already existing structures. Our own most unique ideas and beliefs
are somehow based on the fact that we were born, brought up, and socialized in a specific family, group, area, society, and civilization. (Coburn 2010, p. 66)

Hartrick (2002) writes of relationships in the global sense that nothing in one’s reality exists independently in its relationship to something else. This of course is viewing relationships in a universal manner in terms of all facets of one’s experiences of being in the world. This research was specifically interested in the experiences of women in relationship to others – not barring the idea that global interests do affect these relationships. Within interpersonal relationships this study endeavored to move beyond traditional constructs derived from linear models of communication skills and behaviours. It valued the more personal connectedness of one being deeply in relation to another as an act of resistance to an objectifying system (Hartrick, 2002). This type of relational process acknowledges the interdependence of human beings as they connect and relate to one another in the world. As Hartrick Doane and Varcoe (2005) write: “Because relating and relationships are so central to our lives, to assume that we function independently (that is, that we function separately from each other and from our world) is to miss all the ways we are connected and relating” (p. 175).

Empowerment

Ife and Tesoriero (2006) offer a simple working definition of empowerment stating that it “aims to increase the power of the disadvantaged” (p. 65, italics in original) while Cameron (2002) and Vollman, Anderson and McFarlane (2004) define empowerment more complexly as both a process of ongoing knowledge and skill development within individuals/communities as well as an endpoint in which people assert themselves, participate in community
life and actively resist dominant power structures. Barriers to empowerment are noted to include people not feeling influential, having disparity in social status to those with ‘power over’ as well as experiences of inaction and resistance to change. These barriers are alleviated when people develop community concern, experience working with others in tandem with good conflict resolution and have availability of resources (Vollman, Anderson & McFarlane).

In traditional nursing practice, particularly in relation to health care strategies, the discourse regarding empowerment is one of the professional nurse empowering clients or patients through motivating change in health behaviours. Vanderplaat (2002) suggests that presently nursing practice continues to view empowerment as transmitted from nurse to client and the traditional attitude of “you will be better because we know better” prevails (McKnight, 1995, p. xi). For example, Wittmann-Price (2004) writes: “empowerment is a positive process [in which] . . . some type of power is shared or transmitted to patients” (p. 441). Vanderplaat considers currently accepted indicators of client empowerment as little more than examples of individual’s compliance to professional requests for behavioural change. Powers (2003) also proposes that in health care adherence or compliance to professionally recommended health strategies is not a measurement of empowerment but rather indicates external coercion and control. When treated coercively people are disempowered and controlled. Christians (2005) writes: “The dominant understanding of power is grounded in nonmutuality; it is interventionist power, exercised competitively and seeking control” (p. 155).
Vanderplaat (2002) suggests that when emancipatory approaches are embraced one can neither empower others, share power nor develop conditions whereby people can be empowered. If, for example a nurse researcher, can empower others by these methods then power can also be removed, not given or controlled by the more powerful nurse. In essence these methods of empowerment are only simulacra of the real thing. In truly empowering emancipatory work Vanderplaat describes a relational approach whereby all involved are both givers and takers of empowerment; this is called “mutuality” (p. 94) and entails involvement by all in the process.

Mutuality demands that we as academics and professionals place ourselves firmly in the center of the empowerment process—not instead of program participants but with them. Mutuality requires that those of us with privilege recognize this power and take responsibility for the systems and social structures that contribute to people’s disempowerment, and which we help to maintain. A commitment to mutual empowerment opens the way for program participants to teach us about the realities of their lives so that we, in turn, can base our practices on these experiences.

(Vanderplaat, 2002, p. 94, italics in original)

Emancipatory research methods are effective tools available to the nurse researcher interested in mutual growth and equity amongst those who would build empowered communities. With this approach people are offered opportunity and mechanisms to become invested in their communities, to work collaboratively in progressive group processes and learn of how one might access needed resources. The range of grassroots empowerment strategies may
comprehensively mobilize whole communities (Kretzmann & McKnight, 1993), develop liberatory processes in smaller groups (Chinn, 2008) or address individual rights (Ife & Tesoriero, 2006).

Kretzmann and McKnight (1993) work with those in the community by first determining individual, small group, and community assets followed by engaging in relationship building and information sharing so that they are able to work within the community alongside others to strengthen and build from the inside outwards. In this kind of empowering process there is a focus on people’s strengths and what they can do rather than on their deficits. As Vanderplaat (2002) notes regarding this kind of empowerment: The focus is not on objectifying people “as being needy, passive, incapable of action, and deficit driven” (p. 95) but rather as active and empowered participants.

Chinn (2008) also encourages the aims of mutual empowerment and meaningful change through the processes outlined in Peace and Power. Commitment to the feminist values in this process are actualized through permitting all voices to be heard, supporting equal power between participants, addressing each person’s interests and concerns and conveying respect for every person involved. The process and resulting knowledge generation are of equal importance and both have the potential to catalyze empowerment and meaningful change as group participants become conscious of oppression and bring it to light for discussion.

Ife and Tesoriero (2006) in their discussion of power query “what sort of power is involved in the term empowerment?” (p. 71, italics in original). They suggest that particular kinds of influence such as exploitive power are
disempowering and that in contrast there are eight ways power can be constituted in a more positive manner in the community. Interestingly these kinds of power are phrased ‘power over’ but not in the manner previously discussed in this work in terms of dominant power in hierarchical systems. Ife and Tesoriero state that the power that is part of empowerment is power over: personal choices and life chances, assertion of human rights, definition of need, ideas, institutions, resources, economic activity and reproduction.

Power over personal choices and life chances includes the ability to choose one’s own life course as well as choices regarding health and lifestyle. Ife and Tesoriero (2006) state that: “An empowerment strategy . . . would seek to maximize people’s effective choices, in order to increase their power over decisions involving their personal futures” (p. 71). Assertion of human rights by those who are oppressed and marginalized within a dominant society claims power. Defining one’s needs from personal experience and through seeking appropriate knowledge and expertise rather than being informed by others such as professionals regarding what is needed is empowering. Being able to challenge dominant world views and have personal knowing or ideas is liberating. To counteract the disempowerment of social institutions:

An empowerment strategy would aim to increase people’s power over these institutions and their effects, by equipping people to have an impact on them and, more fundamentally, by changing these institutions to make them more accessible, responsive and accountable to all people. (Ife & Tesoriero, 2006, p. 72)
One may have power or be empowered over economic activity by having even a modicum of control over societal mechanisms of the economic system. Lastly people may be empowered in terms of reproduction and as Ife and Tesoriero (2006) note, it is more than a woman’s control over reproductive biologic functions but also relates to control over raising, educating and socializing children or “all the mechanisms by which the social, economic and political order is reproduced in succeeding generations” (p. 73). As individuals and groups become aware and seek empowerment this may lead to transformation or change.

**Transformation**

Transformation is the process of change and may be experienced by both individuals as well as larger and smaller groups within society. Gaventa and Cornwall (2002) suggest that an important component of change is increased consciousness of one’s reality and that when consciousness is combined with knowledge then transformative action may occur. Oliga (1996) defines and contrasts morphostatic versus morphogenic processes in relation to social reality and change. A morphostatic view of reality in social environments supports existing social structures and is unchanging whereas morphogenic processes are dynamic and transformative (p. 126). Transformative change that starts from the community and is inclusive to those who stand outside the mainstream is possible when people come together collaboratively at the community level and work from the bottom up (Ife & Tesoriero, 2006).
A Critical Feminist Theoretical Framework

Critical feminist theoretical frameworks support research that promotes emancipatory knowledge construction and potentiates participant liberation by ensuring that all voices are heard (Speziale & Carpenter, 2003). In a critical feminist framework Hartrick Doane and Varcoe (2005) propose that feminist views inform the critical perspective of the gendered nature of power and “conversely, a critical lens brings to a feminist perspective a concern with how gender relations are socially produced” (p. 66). The overarching gaze within a critical feminist framework is on the social production of gendered relationships as well as on the resultant development and maintenance of epistemologically based power structures within society (Hartrick Doane & Varcoe, 2005). A critical feminist study explores how gender influences the development of social relationships and voice within society asking the question: Whose knowledge or power, within the community, is valued and considered legitimate?

This study from a critical feminist perspective explored the question: How do women with a history of substance misuse negotiate barriers and find paths to recovery? Central to an understanding of this inquiry was the belief that people are capable of developing a powerful inner voice or self-concept that relates to and influences others within the community and larger society. As well it was understood within this context that one’s voice may be narrated and interpreted to some degree by oneself as well as by others (Doucet, 2008). As Meyers (2010) notes: “stories can include the many voices within us and the many relationships we have experienced . . . and they presuppose a core capacity to describe and reflect on one’s experience.”
Researcher immersion within the research process is possible when egalitarianism and reciprocity between the researcher and participants are an ideal that is manifested within the research framework. This is the case within critical feminist research which seeks to restructure “societal roles and relationships to create equal rights and power” (Hartrick Doane & Varcoe, 2005, p. 66). Fine (1994, p. 14) suggests those facilitators of the research process are not neutral but are indeed participants as well. “We are…shapers of the very context we study, coparticipants in our interviews, interpreters of others’ stories and narrators of our own.” Furthermore, critical feminist research encourages researcher reflexivity as a means of noticing one’s personal attitudes and values and how these are brought to and influence the research process. Hesse-Biber and Leavy (2007) suggest that critical reflexivity of one’s own reality and lived experiences are helpful to the researcher and research process. Reflexivity is potentiated by considering the following questions:

How does your own biography affect the research process; what shapes the questions you chose to study and your approach to studying them?

How does the specific social, economic, and political context in which you reside affect the research process at all levels? Reflexivity is the process through which a researcher recognizes, examines, and understands how his or her own social background and assumptions can intervene in the research process. Like the researched...the researcher is a product of his or her society’s social structures and institutions. Our beliefs, backgrounds, and feelings are part of the process of knowledge construction.

(Hesse-Biber, 2007b, p. 129)
Situated Within a Critical Feminist Framework:
Three Perspectives

Doucet (2008) proposes that there are three viewpoints from which one may relate to a study. Firstly, there is looking within oneself to understand what motivated the research to begin with or what has driven one’s personal ontological and epistemological choices and theoretical perspectives (Crotty, 2007). Secondly, there is an understanding of the relationship between oneself and participants and lastly the relationship between oneself and her audience or epistemic community. By situating myself at selected points in the research process I was better able to clarify my positioning in relation to both process and participants; as Hesse-Biber (2007a) proposes positionality breaks “down the idea that research is a ‘view from nowhere’” (p. 16).

Viewing Oneself

Doucet (2008) states that although there are:

Large webs of complex personal, political, theoretical and institutional rationales for particular research agendas, perhaps the most important consideration, when we consider the relationship between our projects and our selves, is to reflect on and dissect the personal or political motivations that matter in how we come to our research topics. (p. 75, italics in original)

Most often the work I do within the community is directly related to the oppressions that were so ‘normal’ for me in my earliest years. In remembrance of the past it has always been my intention and hope that my work would significantly impact and alleviate social injustice within society. To this end I
am committed to social activism and political causes that improve “the life chances of women and girls” (Hesse-Biber & Leavy, 2006, p. 27). Overall, I have a sincere desire to make a difference in society by working closely with those who have the least of life opportunities and are therefore most vulnerable (Pederson, Raphael & Johnson, 2010).

*Oneself and Seven Women: Positions of Power-sharing*

Hesse-Biber (2007b) notes that traditional research has emphasized the distance and objective scientific stance research must take to provide credible results in contrast to more recent critical feminist research that values immersion and transparency within the research process. From a critical feminist perspective I planned to situate myself within the research involving women with a history of substance use by foreshadowing my own experiences or “subjectivities into the process of interpretation from the start by identifying, exploring, and making explicit...thoughts and feelings about, and associations with, the narrative(s) being analyzed” (Gilligan et. al., 2006, p. 257). This transparency was intended to demonstrate power-sharing and to impart a sense of openness, respect, equality and trust toward participants.

*Oneself and Epistemic Community*

Doucet (2008, p. 81) discusses the theoretical lenses through which she views her work and how research is structured within “epistemic or epistemological communities” that determine how social reality might be defined through development of shared references and expectations. Furthermore, Doucet (2008) suggests that epistemic communities which are formed by those who read and engage with work that has been generated, for
example from research, both enable and constrain one's scholarship and that this is the tension when one is involved with research that has an explicit emancipatory intent. For example, those employed and entrenched within existing social systems although enabling community scholarship by provision of funding and ethics boards also constrain it by resistance to power sharing and knowledge exchange at the grassroots level. The epistemic community that influences me the most are those individuals and groups who while able to work within mainstream systems including universities, government and health care prefer to step outside of these hierarchical structures so that their experience, influence and power might collaboratively be shared. "Power is shared, not reluctantly but generously, so that community is built and lives are open to common purposes....connections are made and relationships established" (Bade, 2009, p. 2). With this discussion in mind, I the researcher will outline a statement of beliefs, an overview of my own story and perspectives as a nurse and researcher located within the community.

Self Narrative

It is my perception that I did not choose a critical feminist perspective at a singular point in time but that it evolved over the years as a result of personal and professional lived experiences. The manner in which I lead both my private and public life fits within the philosophical beliefs of a critical feminist mindset or as a colleague/supervisor commented at different times, "you live your research" (Robyn Ogle, personal communication, 2010/2011). I do authentically live the principles of critical feminism in that, unlike a positivistic-leaning mainstream society centered on measurable factors, I trust in the immeasurable
life-story that in its telling contributes to foundational knowledge for communities and society in general. I believe that all people, by making sense of lived experiences, capably theorize and effectively construct useful knowledge (Bade, 2009). I value the diversity of experiential knowledge that when recognized potentiates independent thought and the ability to transgress the oppression of socialized knowledge so that it becomes possible to build strong and hopeful communities (Hooks, 1994).

It is my contention that everyone, regardless of their present or historical social/political strata, is of equal value. I inherently expect the best of those I encounter and in turn most often receive the best each person has to offer. I also believe in a paradigm of abundance and not of scarcity, which bodes well for embracing empowerment over disempowerment within daily life (Kendall, 1992). Abundance, in my belief system, relates to simplicity and quality of life rather than quantity of ‘things.’ This is congruent with what Hooks (2000) calls “communitarian values” or “the call to live simply” (p. 48). Living simply and sharing resources with those who have less is adverse to consumerist societal values in which “money is the measure of value, where it is believed that everything and everybody can be bought” (Hooks, 2000, p. 47). However, in support of communitarian values it has been my experience that valuing people over ‘things’ is incredibly powerful and results in a much healthier and peaceful coexistence with others.

Presently, I live a life of privilege with plenty of material resources and a degree of influence within my community. I am middle-class in terms of income and identify as a white woman; it is important to note that I assume my
white identity with limited knowledge regarding my ancestry. How I express myself as a woman in both personal and professional dimensions is embedded within my own story and is the reason that I am impassioned regarding a liberatory study involving women. What makes this particular study so important to me is situated within my own history in which my family of origin lived a marginal life impacted by poverty, societal neglect and abuse in its many forms. The sense of hopelessness and helplessness within this environment always overshadowed times of happiness. Later in my teen years, apart from this family and in foster care, I experienced material privilege far beyond what I had known but somehow retained the despair and despondency from earlier years. It is on this grounding that I have grown into the person I am today and is the reason why I have a deep desire to make a local contribution into the lives of women with a history of substance use. It has always been my hope that the process and outcome of all of the work that I do would provide transformative windows of opportunity for those who have been touched by it in some manner.

A major component of my nursing career has been working in critical care in tertiary hospitals including Intensive Care, Coronary Care, Neuro-Services and Post-anesthetic Recovery Room. In the latter half of my career, which has spanned thirty-seven years, I have worked as an educator with baccalaureate nursing students and have immersed myself in personal undergraduate and graduate studies. Over time these studies have shifted my views regarding what knowledge entails and who might be a ‘knower.’ Rather than viewing knowledge from a mainstream perspective or a socially prescribed construction I presently see it as a construct of collaborative exchange; the result of one
person understanding the life-stories and experiences of another. Foundational to all endeavors including service to non-profit organizations, research projects and community development has been a vision of the possibilities that exist when liberatory and transformative action is exercised within society.

Two examples of non profit organizations that showcase my community involvement are the New Life Mission and the Food Action Centre both located in Kamloops, BC. As a New Life Mission Board Member and the Director of Recovery Program Accreditation for men and women’s programs I was able to integrate theory and models of addiction treatment programs into policy used for accreditation by the BC Ministry of Children and Families Addiction Services. As the result of this accreditation the House of RUTH (Refuge Under Times of Hardship) was established as an eight bed residential treatment centre for women. Following this work and as a board member of the Kamloops Food Bank and Food Action Centre, I established a health promotion committee which received funding for the Tiny Bundles program to provide weekly food supplies and additional support for pregnant women and their children, up to one year of age.

My involvement in the local community led to research that continued to evolve as an outcome of my continued communication with disenfranchised women. For example, collaboration with women post-incarceration resulted in the Women Moving Beyond Bars: Building Community participatory research project. This work, funded by the BC Women’s Health Research Network, initially engaged with women situated within the criminal justice system to identify their issues and to encourage them to drive the knowledge generating
process as an alternative to mainstream research/knowledge production. Building on this work, several women from this initiative collaborated with other groups such as the Elizabeth Fry Society to initiate a process to address identified issues related to food security, housing, education and employment.

The Discipline of Nursing and Emancipatory Practice

First steps toward addressing societal oppression is what Freire (1993, p. 17, italics in original) calls “conscientização” or consciousness of the deeply felt disharmony between daily life and mainstream society. It is well discussed in the literature that overcoming this disharmony is a matter of becoming aware of and then responding to the disempowerment that has been born out of a colonized society (Cowling, Chinn & Hagedorn, 2003; Habermas, 1984; Oliga, 1996). As a nurse and as one increasingly conscious of this reality as well as dissatisfied with injustice and inequity (Cowling, Chinn & Hagedorn, 2003), I have the power to choose alternatives. As well, as a nurse with a degree of socially mandated power, I also have the ability and means to work within the system alongside those who are entrenched as oppressors as well as alongside those who are oppressed. Indeed Freire would suggest that it is necessary for all of society, the oppressed as well as those who dominate, to critically examine their lives and become aware of inequities. Furthermore it is the work of the oppressed, rather than those with power, to initiate change by becoming conscious of social injustice and to push toward societal transformation. “Who are better prepared than the oppressed to understand the terrible significance of an oppressive society? Who suffer the effects of oppression more than the oppressed? Who can better understand liberation?” (Freire, 1993, p. 27).
Beyond internal consciousness, as a means of liberation Fontana (2004) also presents the Habermasian ideal of external critique of dominant social structures with the intent of exposing mainstream society’s perpetuation of power and domination.

Similarly, Chinn and Kramer (2008) address internal and external social critique through the emancipatory pattern of knowing. To address social and political contexts of nursing practice emancipatory knowing is conceptualized by Chinn and Kramer as both an inward relationship to nursing knowledge and practice and “an outward view that examines social and political practices” (p. 10). Inherent to this process of emancipatory knowing is individual and collective praxis or “synchronous critical reflection/action that is directed toward transforming social conditions toward full human health and well-being for all” (Chinn & Kramer, 2008, p. 16). Cowling, Chinn and Hagedorn (2003) “believe that nurses are particularly attuned to the needs for social justice . . . given their connection to humans in times of personal change and challenge” and suggest that this work ideally begins once self-healing and wholeness have been established within one’s own heart. As one understands the relationship of personal knowing encompassing all forms of defined knowledge construction the idea of embracing emancipatory knowing as action in support of women’s health becomes possible. Chinn and Kramer’s (2008) processes of emancipatory knowing within nursing practice are ideally suited for nurses attending to the determinants of health for woman living with histories of substance addiction.
Emancipatory knowing makes social and structural change possible. It is the human ability to recognize social and political problems of injustice or inequity, to realize things could be different, and to piece together complex elements of experience and context in order to change a situation as it is, to a situation that improves people’s lives. (Chinn & Kramer, 2008, p. 77)

Emancipatory knowing is the ability to not only notice social injustice but to look more deeply and examine why it exists in the first place. Nursing practice that deeply analyzes social injustice is then empowered to engage with others who are like-minded to challenge the status quo. In this manner transformation can occur as liberatory action. “It is the human capacity for emancipatory knowing that gives rise to a realization that there is something wrong with the way things are, and that it is possible to change for the better” (Chinn & Kramer, 2008, p. 79). Vanderplaat (2002, p. 94) describes these activities as “emancipatory politics” and suggests that unless nurses actively work alongside those seeking empowerment to address social, political, and economic issues by challenging the status quo; people instead end up supporting and perpetuating it. Canadian Community Health Nursing Standards of Practice [CCHNSP] (2012) equate socio-political knowledge and emancipatory knowing as one and the same describing them both as going beyond personal knowing and placing the nurse “within the broader social, political and economic context . . . It equips the nurse to question the status quo and structures of domination in society that affect the health of individuals and communities” (p. 496).
To promote the well being of others through activism is often perceived as seeking social change through more overt and visible activities (Brookfield, 2005; Shragge, 2003). Although much activism is practiced within the public domain many nurses, particularly those participating in grassroots activism, slide under the radar as they develop communities of subtle yet profound resistance. Both kinds of activism have their place and one is not necessarily superior to the other. However, overt and covert activism do have similarities too, both have the common purpose and drive to seek social justice within society. As well, nurses with emancipatory intentions, consciously take personal moral inventories with the purpose of increasing understanding of self and others through mutual growth and dedication to building healthier communities. This is exemplified by Chinn and Kramer’s (2008) artful nursing which is preceded by knowing oneself well for as Hartrick Doane and Varcoe (2005) share “as we open to knowing ourselves more fully, we simultaneously expand our knowing of others” (p. 92).

Within the local Kamloops, BC community and surrounding regions progress at the grassroots level is occurring. There is growing activism that seeks the basics of health care for all and remediation of inequality and inequity in the community. However, the dearth of community based health promoting initiatives is prevalent Canada wide and as Raphael (2009) notes demonstrates the non-achievement of the community-based participatory goals of primary health care.

Hospitals have been renamed ‘health centres,’ while the real work of bringing participatory health care to the neighbourhoods and streets of communities is undertaken largely by not-for-profit community agencies
across the country. . . . the participatory goals of the Alma-Ata have been muted by an increasingly corporate model of health care delivery.

(Raphael, 2009, p. 328)

Meanwhile, as the formal health care system demonstrates local ineffectiveness, many individuals including nurses walk quietly alongside those who are most disenfranchised in their communities to promote healthier lifestyles through participatory and community driven initiatives. Three of these initiatives follow as exemplars of community driven activities that I have been involved with which have improved health at the local level but for the most part have remained hidden and unnoticed by the mainstream community.

Exemplars of Emancipatory Nursing Practice

Exemplar 1
Voice: Challenging the stigma of addiction; a nursing perspective (2008)

This project began with a network of nurses who met at least monthly to discuss the barriers posed to women who were marginalized for various reasons within the Kamloops, BC region. Some of the women who were most invisible to mainstream community experienced extreme poverty, physical and mental health challenges and all had experience with a range of addictions. The main question posed by the nurses was how could they partner in some way to speak to women directly about their perspectives, share these perspectives at an international conference but not speak for them? Different nurses met at a variety of formal and informal settings with women living in this small urban centre who because of their exclusion from mainstream society did not have the opportunity to be heard. For example actual art work developed in community settings was deemed a more
formal method of collaborating with woman and less formal methods included one
to one conversations about the Voice project both at the street level and at other
venues where women gathered.

For the formal art work one of the nurses met weekly with women at a local
agency where there was co-creation of art projects including mask making, collages
and painting. The less formal generation of women’s contributions were generally
poems and narratives although some pieces of art work were also submitted to the
nurses who spoke with contributors. Paramount to interactions with women who
participated was being trustworthy and respectful and listening to what they wanted
to share in the way they wanted to share it. Gender sensitivity, inclusivity, trust,
equality and respect were vital to the success of this process.

A selection of the women’s art was presented at several venues, including
an International Conference on Drug Related Harm, a Nursing Conference and a
local art gallery. The positive community response to the women’s work
contributed to feelings of great pride and enhanced the women’s confidence in
their ability to express themselves. Throughout this process, women had the
opportunity to develop social networks and to become aware of the value their
creative knowledge had to their community. (Paivinen & Bade, 2008, p. 214).

By valuing women’s contributions to this project and then sharing their
work with the community the affects of stigmatization were decreased. This
became apparent through write-ups in local newspapers and responsive writing
in a communication book stationed with the women’s work that was on display
for eight weeks at the open art gallery. Youds (2006) writes:
The viewer (of the show) is moved to sense the humanity beyond the stigma of addiction. This is more than a simple matter of perception. That stigma—the demonization of drug abuse—is the usual stumbling block preventing social acceptance of harm reduction, a proven approach to treating addiction. (p. A12)

In response to newspaper coverage of the art gallery presentation one of the women contributors wrote:

I read the articles about voice in the newspapers and was VERY impressed! Hopefully, they will bring lots of people down to see the show.

I really believe that this kind of thing will help mend the broken connections between people who have been victims of drug abuse and those who would benefit by improving their understanding of us... p.s.

My Mum wants to see the show! Can you believe it? (Personal communication cited in Paivinen & Bade, 2008)

**Exemplar 2**

*Women moving beyond bars: Building equity in community partnerships*

Presentation at the 21st Canadian Bioethics Society Annual Conference (2010)

By: Gayle Carriere, R.N. and Sherrie Bade, R.N.

Engaging with women situated within the criminal justice system regarding their issues and encouraging women to drive the knowledge generating process presents an alternative to mainstream research/knowledge production. Initially our research team, with funding from the Women’s Health Research Network, connected and established relationships with women living in the Kamloops, BC community who had experienced past conflict with the
law. Some women were on parole and others were post-parole. Safe spaces were established including physical locations for community meetings and development of beginning research questions based upon the women's experiences. Areas of exploration determined by the women included the importance of employment, food security, shelter and adequate income to successfully integrate into the community and find meaningful and healthy relationships. The knowledge and experiences that women shared were foundational to the second and third phases of this work which promoted gender sensitive community action research (CAR) as outlined by Stringer (2004). Knowledge dissemination included presentations at provincial and Canadian conferences, a one-day workshop for local women facilitated by a peer researcher, associated with a program called Women Into Healing, from the University of British Columbia, as well as a published commentary (Bade, 2009).

The second step of the Women Moving Beyond Bars initiative drew upon the diverse expertise the research team shared: for example proposals were written with input from all three team members, health related connections were made by the two Registered Nurses (RNs) and links to the corrections services by a third member of the team who intimately understood this system having been previously incarcerated. Written proposals were distributed to known contacts by the experiential team member: locally in person and to federal agencies electronically with the intention of connecting at both levels. Although important links to the federal corrections system were effectively established including consent to form Stride Circles which are: Women-directed, woman-centred grassroots mentor/ally
networks of support established for women prior to leaving federal prison which are continued post-incarceration (Community Justice Initiatives, n.d.).

Although the proposal for Stride Circles were approved by federal corrections these were not endorsed by local justice systems. There was no memory in the Kamloops agencies of anyone receiving the proposal from our experiential team member and instead the intentions of the Women Moving Beyond Bars initiative were questioned. Communication at the local level was irretrievable despite multiple efforts and the project was impeded from moving forward.

Knowledge dissemination throughout this time frame included a presentation at the 21st Canadian Bioethics Society Annual Conference: *Voices of Community* in 2010 and submission of proposals for further funding from the Women’s Health Research Network and Paolo Pertica Fellowship from the International Harm Reduction Association.

There was much knowledge shared throughout the Women Moving Beyond Bars initiative as well as multiple lessons for the research team. Upon my own reflection as an academic involved in community based research (CBR) the questions that require more clarity involve: who defines what knowledge is, who can be a ‘knower’ and how does CBR show participants the value of sharing their experiential knowledge? Also, how can power and credibility of position be shared with community partners in a manner that provides support but also promotes self-development of one’s own resources, ability and credibility within the community? Lastly, how might a collaborative research team most effectively ensure communication at all levels of the research process and with all stakeholders?
Exemplar 3
A ‘hands-off’ approach to community partnerships: a critical perspective:
Posted paper prior to presentation at the 14th International Critical &
Feminist Perspectives in Nursing Conference (2007)

By: Barb Smith, co-founder of Prostitutes Empowerment and Education
Resource Society (PEERS) and Sherrie Bade, R.N.

Knowledge and theorizing are important concepts to community
development. One’s worldview directly shapes how these concepts are
understood. If knowledge is only viewed as valid if it originates within
academia and from those who are professional, people who are experiential and
marginal within community are not recognized as having knowledge
development capabilities. However, if those who have grassroots experience
within the community are valued as a source of theory and knowledge the
picture changes significantly. A participant at the Other Voices Forum in
response to the question, “what is the value of the experiential voice?” states:
“The knowledge that we have as experiential people can’t be found in books
because it comes from our hearts and souls” (Other Voices, 2006, p. 8).

Theorizing or making sense of the world is not an activity restricted to
those who are engaged in academic research or only to those who work in the
academy. Rather it is described by Brookfield (2005) as a natural activity of
daily life that has not been adequately recognized by the social systems within
our communities. The experiential voice values those who have lived
experience in many areas in which people have increasingly become marginal
including “poverty, homelessness, sex-work, addictions, low literacy and mental
health issues” (Other Voices, 2006). An experiential person is one “who has
intimate, day-to-day lived experience of an issue, either currently or in the past” (Other Voices, 2006). Those who are experiential resist a system that would silence them and are organizing into visible and influential communities (Jurgens, 2005; Kerr, Small, Peeace, Douglas, Pierre & Wood, 2006; Rabinovitch & Lewis, 2001; Rans, 2005).

A critical perspective lends itself to critique and alteration of systems that, through their complexity, have peripheralized (Meleis & Im, 1999) or marginalized the social experiences of citizens. A purpose of critical theory and corresponding critical research is to initiate social change by understanding power and oppression and how these play out in the everyday experiences of people in community (Kincheloe & McLaren, 2005). Fay (1975) suggests critical theory is located within the experiences of those for whom it speaks.

Those in places of privilege and power play an important role in community development and the potential empowerment associated with it as long as this role does not mask oppression and dominance. Community partnerships are most effective and mutual when the professional person or facilitator takes a “hands-off approach” (Smith, 2006) to community development. Partnerships that are not formed in this manner “pull community organizations into relationships that hide power and interest” (Shragge, 2003, p. 114). Professional individuals may avoid self interest and oppressive use of power by bringing “skills, knowledge, and a useful status to a group or a struggle, but at the same time … build a true democracy in which people can have control and a voice” (Shragge, 2003, pp. 15-16). Smith (2006) in Voices from the Margins suggests that meaningful grassroots development requires a two-pronged approach. One prong includes the professional
facilitator taking a hands-off approach by encouraging decision making to rest within the community. The second prong, equally as important as the first, is composed of those individuals who come from a place of experience within the community and are willing to share this knowledge with others at some level. These kinds of partnerships result in an interdependence between those who might work together to develop and sustain truly caring communities (McKnight, 1995).

The development of the Prostitutes Empowerment and Education Resource Society (PEERS) in Victoria, BC is an example of the effectiveness of community partnerships built on mutuality. PEERS was established by ex-prostitutes and community supporters “to be a voice to speak out publicly against the abuse and stigmatization of prostitutes and ... [create] more sensitive public policies and programs” (PEERS, n.d.). Rabinovitch and Lewis (2001) note that collaboration between a community facilitator and women with a history in the sex trade resulted in co-development of priorities for PEERS to offer outreach, education, programs and a drop-in for women in the sex-trade as well as those exiting from it.

Community partnerships developed collaboratively between those who are experiential in the community and professionals, including academics, hold much promise of success if a hands-off approach is taken. A critical perspective as well as a return of caring to the community effectively exposes underlying power and oppression within bureaucratic systems such as health care. Respect is given to all by recognizing that knowledge and theorizing are everyday activities of citizens in our communities and is the way in which we make sense of the world in which we live. PEERS is an organization that demonstrates how those who are experiential
can hold power and be expert when supported and mentored by community professionals taking a hands-off approach to community development.

The previous three exemplars have attempted to demonstrate that meaningful activism is not always obvious or visible. What makes work, such as that outlined in the previous three exemplars, meaningful is the respectful collaboration that was co-created by women in the margins and nurses when we proved our credibility to the women, not through taking charge and ownership of our work but through sharing, caring and walking alongside women who are often excluded and disempowered. By working in this manner with women who have struggled mightily to be heard and supporting them in the work that they do in their communities; at the end of the day their accomplishments were valued and modeled success. The spirit within these thoughts is best expressed by Lao Tsu:

Go to the people
Work with them
Learn from them
Respect them
Start with what they know
Build with what they have
And when the work is done
The task completed
The people will say,
We have done this ourselves

(Lao Tsu, China, 700 B.C. cited in Freeman, 2001, p. 448)
Critical Feminist Methodology

Critical feminist methodologies use contextual and relational methods of critique to reveal social domination or oppression and to initiate transformative emancipatory action (Fontana, 2004; Hartrick Doane & Varcoe, 2005). Grant and Giddings (2002) consider critical and feminist theories as radical in the sense that they share the same roots or foundations. As well, both have common “assumptions and values. We live in an unjust world in which inequalities are configured along predictable social lines ... we can and must do something to address the injustices we observe around us” (Grant & Giddings, 2002, p. 18). The critical feminist methodological perspective of this research is best exemplified by Chinn and Kramer’s (2008) description of emancipatory knowing. Emancipatory knowing is attuned to critical examination of the status quo and how it develops. From this perspective, social and political inequity are identified and tied to emancipatory action through an understanding of the relationship between power and knowledge. Chinn and Kramer suggest that “emancipatory knowledge grows out of critical analysis of the status quo and visions of the changes that are needed to create change toward equitable and just conditions that support all humans in reaching their full potential” (p. 5).

Critical Feminist Methodology and the Gendered Interview

Fontana and Frey (2005) suggest that traditional interviews are hierarchical and that within this hierarchy respondents or participants are subordinate to interviewers. Researchers who are informed by critical feminist perspectives resist
participant subordination and its resultant objectification and disempowerment by developing interviews that are less hierarchical. For example, gender sensitive interviews or gendered interviewing is a non-traditional approach that encourages closer egalitarian dialogue as well as personal relationships among those involved in the research. “Researchers are attempting to minimize status differences and are doing away with the traditional hierarchical situation in interviewing. Interviewers can show their human side and can answer questions and express feelings” (Fontana & Frey, 2005, p. 711). To avoid dominance, or a power over situations Chinn (2008) recommends non-hierarchal relationships between the researcher and participants. This is accomplished through previously discussed principles of PEACE power which advocate egalitarian relationships and respectful communication. Rubin and Rubin (2005) propose that a feminist research methodology includes an egalitarian interview process whereby an interviewer and interviewee share the responsibility for locating words and concepts that can express the participant’s lived experiences. It is stated that feminist researchers believe that:

A more open, loosely structured research methodology is necessary to learn about women, to capture their words, their concepts, and the importance they place on the events in their world. An interview should not involve applying a sterile instrument to a passive object, but should resemble normal conversation in which the interviewee influences the exchanges. Further, in the course of time, the researcher may become a friend to the interviewee. (Rubin & Rubin, 2005, p. 26)
Capturing individual women’s words or voice within oppressive social systems provides the opportunity for understanding what these words may mean to them. As Beauboeuf-Lafontant (2008) states: “While privileging the standpoint of the oppressed, voice-centeredness builds analysis by attending to the meaning-making of individuals (p. 406).

Summary

The previous discussion of the theoretical framework and methodology has examined the fundamentals of critical and feminist theory and how these are interrelated within a critical feminist study. The particulars of gendered interviews have also been explored in terms of their coherence with a critical feminist research methodology. Planning of a critical feminist research project has required that I as the researcher reflect on my own lived experiences and beliefs both of which influence the research process. Indeed my own history and past location within society are intertwined with my present circumstances and shape the questions I choose to ask and how I seek to answer them. My own sense of self in relation to others determines the kinds of relationships established. Within these relationships, specifically with participants, a critical feminist framework encourages reciprocity and trust as well as a sense of openness and transparency. In terms of relationships it is also important to consider the epistemic community who will review this project and determine its usefulness. The challenge of this critical feminist project is to creatively utilize methods that are capable of bridging the knowledge generation of participants on their journeys of recovery from substance use with the scholarly expectations of the epistemic community.
CHAPTER FOUR: METHODS FOR A CRITICAL FEMINIST STUDY

The following chapter outlines ethical considerations and the selection criteria that were utilized for this Critical Feminist study involving seven women having a history of substance use. It describes the process of data collection including gendered interviews through to data analysis. This section outlines how analytic methods changed by necessity from a less substantial and more preliminary thematic analysis to a much deeper analysis utilizing the Listening Guide. The steps of the Listening Guide method are outlined to demonstrate how it effectively uncovers layers of complexity within the participants’ narratives. As well, this chapter also relates how the reflexivity of participants and myself were incorporated into this work to ensure trustworthiness of the data and subsequent meaningfulness of findings.

Ethical Considerations

The primary ethical consideration in this study, because of purposive sampling, was the potential for coercion because all of the participants were known to me through living in the same community and belonging to the same women’s health networks. Women were asked privately if they would like to receive a mailed invitation to participate in the project. Coercion was avoided by not accepting expressions of interest from potential participants when they were first asked regarding their participation in the research. If they did want to participate in the research an information package including a statement of interest along with a pre-addressed and stamped envelope and my contact telephone number were mailed. Informed consent was ensured through
discussion of all aspects of the research project with participants including informing them that consent could be withdrawn at any time throughout the project and if this were to occur any information obtained, concerning them, would not be used.

Although it was not anticipated that the level of risk or stress to participants of the research project would be high it was an additional ethical consideration because self-disclosure of sensitive topics did have the potential to cause emotional distress. The risk of emotional distress was decreased as I have expertise in debriefing and working with individuals having difficulty in this respect. As well, it was noted in the Plain Language Statement and explained at the first interview that referral to expert help, at no cost, was available to all participants. To protect participants’ anonymity women were not identified by name on data or records maintained by me except on separately stored consent forms. All information provided by participants was treated as confidential. As well, the interviews were transcribed by me and pseudonyms were used in transcripts and written material and confidential material emailed to the supervisory team was sent with security codes. Approval to conduct the study was granted by the Deakin University Human Research Ethics Committee in Australia (see Appendix A) and in accordance with the requirements of the Canadian Tri-Council Policy Statement by Thompson Rivers University Research Ethics Human Subjects Committee in Canada (see Appendix B).
Recruitment of Participants: Purposive Sampling

I contacted women through an extensive network developed through my involvement in diverse community projects and activities related to recovering women. All seven of the potential participants who were approached regarding participation in this research requested the invitation. Each woman was mailed a stamped envelope with a return mailing address on it, the Plain Language Statement (PLS) [see Appendix C] and Statement of Interest (SOI) [see Appendix D]. The Plain Language Statement contained the particulars of the study in sufficient detail so that each potential participant was fully informed of what participation in the research entailed. A contact telephone number was on the Plain Language Statement for more information or questions that women might have prior to deciding to participate. Five women mailed the Statement of Interest and two women telephoned to indicate interest in being research participants. The women were then contacted to clarify any matters and to arrange a meeting to review and sign the consent form (see Appendix E) as well as to obtain participant profiles. The location for interviews was jointly decided by the participant and I based on requirements for convenience, confidentiality and privacy. Seven women were recruited to this study. The criteria for women’s involvement included:

1. Participants were to be 19 years of age or over and legally and cognitively able to represent themselves

2. Participants were to be able to communicate verbally, in English, so that data could be recorded through both audio and digital taping and transcribed.

3. Participants had to have experienced one full year of recovery from substance addiction at some point in their lives
4. Participants were to be in self-reported recovery but not in residential treatment programs at the time of the interviews.

The seven women who requested invitations to participate in this research ranged from twenty-six to sixty-two years of age. One woman was Aboriginal (First Nations) and a second Métis with the remaining five women identifying as Caucasian. As requested all women had experienced one year of self-defined recovery from substance use at some point in time and were in self-reported recovery at the time of the interviews. Additional demographic information included length of longest recovery period; educational achievements and age when first using substances (see Figure 2).
### Figure 2: Participant Demographics

**Participant Demographics**

<table>
<thead>
<tr>
<th>Participant # and Pseudonym</th>
<th>Age at time of interview (years)</th>
<th>I am:</th>
<th>Education (Highest Level Achieved)</th>
<th>Started Using Substances (age)</th>
<th>Longest continuous period of recovery from substance misuse (years or months)</th>
<th>Presently in recovery from substance misuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>P#1: Sarah</td>
<td>44</td>
<td>Caucasian</td>
<td>• Grade 12</td>
<td>12</td>
<td>6.5 years</td>
<td>Yes</td>
</tr>
<tr>
<td>P#2: Lee</td>
<td>52</td>
<td>Caucasian</td>
<td>• Grade 12</td>
<td>12</td>
<td>31 years</td>
<td>Yes</td>
</tr>
<tr>
<td>P#3: Judy</td>
<td>27</td>
<td>Metis</td>
<td>• Grade 12</td>
<td>12</td>
<td>13 months</td>
<td>Yes</td>
</tr>
<tr>
<td>P#4: Tess</td>
<td>62</td>
<td>Caucasian</td>
<td>Master of Science (MSc)</td>
<td>12</td>
<td>12 years</td>
<td>Yes</td>
</tr>
<tr>
<td>P#5: Darby</td>
<td>44</td>
<td>Aboriginal</td>
<td>• Grade 12</td>
<td>19</td>
<td>8 years</td>
<td>Yes</td>
</tr>
<tr>
<td>P#6: Michelle</td>
<td>41</td>
<td>Caucasian</td>
<td>• *GED Certificate (Grade 12 Equivalency)</td>
<td>11</td>
<td>3.5 years</td>
<td>Yes</td>
</tr>
<tr>
<td>P#7: Lisa</td>
<td>26</td>
<td>Caucasian</td>
<td>• Community College Certification</td>
<td>12</td>
<td>1 year</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*GED: General Education Development
Data Collection

While gendered interviewing was the chosen manner in which women were encouraged to share their stories with me, data collection remained within a semi-structured format. This was in the sense that opening interview questions and their general order of discussion were similar for all participants (see Appendix F). However, to ensure that participants shared in the manner they wished there was maximum flexibility regarding the directions that their narrations took as well as the length of time the women wished to speak about various experiences. Fourteen one-on-one interviews occurred; two for each of seven participants using the identified research question and sub-questions based on the aims of the research study. The women participants were invited to tell their stories or talk about their experiences regarding journeys of recovery from substance use and negotiation of barriers to recovery. The interview process was very fluid and moved in the directions that women chose lasting between one to two hours.

All interviews were both audio and digitally taped with participant permission and transcribed by me. I also kept reflective memos or notes during and following the interviews with the purpose of noting such things as mood, conversation nuance and reactions, and these notes were integrated into the findings as data. These memos also encouraged my reflection and ensured processes for an equal researcher-participant relationship were in place and documented (Marshall & Rossman, 2006). Reflexive processes were also encouraged by participants by sharing transcripts of first interviews for their feedback which were included as data and formed the basis for the second interview.
Reflexivity and Trustworthiness within the Critical Feminist Project

The aims of the study and the particular research question were integral to all aspects of the research and embedded within it. Always in mind was the idea of exploring and understanding areas of social life that have not been seen in exactly this manner before our insights, knowledge and discoveries were unearthed. Also, the process in itself was one of learning about power sharing, transparency and meaning-making. This research incorporated methods that promoted participant and researcher reflexivity and also addressed issues of trustworthiness. Tess’ written reflection of her first interview transcript demonstrates how she worked through what she perceived as the researcher’s lack of understanding:

An interesting spot where I became irritated after the fact was when you said that (my sister) had a harder time than I did. When you said it I initially let it slide but afterward I interpreted it that you didn’t understand.

(Tess, personal communication, February 20, 2008)

Following Tess’ second interview I reflect: It was insensitive of me to make this statement regarding Tess’ experiences. It is true that I do not understand her life nor her relationships. I am happy she was able to share her feelings with me.

Badger (2000) suggests that in qualitative research reflexivity is one way to increase the credibility of the work as it encourages consideration of how my “own actions, beliefs and values have affected the situation and its interpretation” (p. 204). It is important that I be cognizant of personal assumptions, perspectives and views of the world which will affect the research at all points of the process. As Reid (2004b) notes, “what knowledge we are
able to observe and reveal is directly related to our vantage point, to where we stand in the world” (p. 76). As well, “at its core, reflexivity is about reflecting on power – a researcher’s power to perceive, interpret, and communicate about Others” (Reid, 2004b, p. 76). Trustworthiness of the data from this research project was potentiated through engagement over two separate interviews and checking with each of the women regarding the accuracy of first interview transcripts as a starting place for second interviews. As Lee writes upon reflection of her first interview and prior to a second interview:

I really painted a dark picture for you and yet what I really want you to understand is that I’m okay with who I am, and who I am has been built by the experiences in my life – good or bad – the end outcome is good, you know God good. . . . Sherrie, thank-you for your understanding and care in this. I appreciate it as do I appreciate you. (Lee, personal communication, August 31, 2007)

Finally, the meaningfulness of findings to other contexts apart from this research would suggest credibility of the work. Stringer (1999) proposes that this is achieved “through thickly detailed descriptions that [might enable] other audiences to see themselves and/or their situations in the accounts presented” (pp. 176-177).

Preliminary Analytic Methods

Preliminary analytic methods included more traditional thematic analysis including clustering common groups of data for each of the participants into a semi-structured framework (Reid, Brief & LeDrew, 2009). Common points on women’s path-finding journeys were grouped together and included: Early into substance use, entering recovery and further along the journey. Each of these
locations were pictorially represented through a winter scene for early into substance use, a spring/summer scene for entering recovery and an autumn scene as women progressed in their recovery journeys. The clusters of data were then superimposed as a schematic onto the scenes going from more chaotic clusters to ones that were more organized to represent the journey from the chaos of addiction to the sanity of recovery (see Appendices G – O). These preliminary analytic methods functioned well initially but it quickly became apparent that they did not represent the complex and multilayered nature of women’s unique journeys. As well, these methods portrayed linear movements on similar pathways whilst women’s actual recovery journeys were non-linear and quite distinctive. To represent the complexity of women’s path-finding journeys an emerging relational method of analysis called the Listening Guide was utilized. The use of the steps of the Listening Guide deepened and contextualized the narratives of women’s personal experiences and assured their voices were central to the research process.

**Emerging Analytic Methods**

The ideal methods for this study were those that were consistent with a critical feminist theoretical framework, had flexibility and were amenable to change. It was important that methods might draw on traditional ideas yet not be bound by them. More traditional semi-structured interviews for example were useful if one could, in a non-traditional manner, actively participate in the interview alongside the participant by role modeling power sharing and transparency. Reid (2004b) proposes that one on one interviews, even those that are semi-structured, are contextually based interactions between two people.
Furthermore, knowledge generation as an outcome of these social dynamics occurs within the interview interactions as much as it does from hard data gathered in transcripts. As well, the depth of interactions in one to one interviews was enhanced through purposive sample selection because this permitted a depth of interaction with known participants that would have been unlikely with strangers. Analytic processes that moved beyond the mainstream and existed at the boundaries were exemplified in the Listening Guide as an emergent method: “To work with an emergent method may require the researcher to engage at the borders of traditional methods... Emergent methods disrupt traditional ways of knowing... in order to create rich new meanings” (Hesse-Biber & Leavy, 2006, p. xii).

The Listening Guide as an Emergent Method: The Multiple Layers of Women’s Narratives

Gilligan, Spenser, Weinberg and Bertsch (2006) write that “The Listening Guide method offers a way of illuminating the complex and multilayered nature of the expression of human experience and the interplay between self and relationship, psyche and culture” (p. 268, italics in original). It is premised on the assumption that human development is grounded within relationships and is inextricable from the surrounding culture in society. As well, meaning of the participant’s stories is socially constructed rather than located or found (McLean Taylor, Gilligan & Sullivan, 1995). The Listening Guide as an emerging relational method of data analysis is particularly suitable for critical feminist research which attempts to foreground participant’s voices in the research process and through this process examine “the interplay of societal
representations of gender with the actual experiences of individuals” (Beaupre-Lafontant, 2008, p. 395). As Gilligan et al. propose the Listening Guide innovatively uncovers the inner world of another person:

Because every person has a voice or a way of speaking or communicating that renders the silent and invisible inner world audible or visible to another, the method is universal in application. The collectivity of different voices that compose the voice of any given person…is always embodied, in culture, and in relationship with oneself and with others.

(p. 268)

Gilligan et al. suggest that this emerging method addresses the concerns that feminist researchers have previously had regarding the researcher’s voice being privileged over that of participants. This concern is alleviated through the Listening Guide whereby one person such as the researcher is able to uncover “the polyphonic voice of another person” (Gilligan et al., 2006, p. 254).

My ability to access the polyphonic voice of another depends on how I as the researcher relate with participants and how I intend to uncover their “complex and multilayered individual experiences and the relational and cultural contexts within which they occur” (Gilligan et al., 2006, p. 267).

Through this relationship participant’s experiences are fore-grounded and the research questions and intentions are back-grounded. Doucet and Mauthner (2008) suggest that the Listening Guide method uncovers the many dimensions of participant narratives so that one truly “can come to know” (p. 407) research participants.
While utilizing the Listening Guide to analyze large amounts of data obtained from fourteen interviews with seven women the integral place of reflexivity and relational knowing became apparent. These were not extraneous to the research but central to it and contributed to the knowledge construction that occurred. The Listening Guide, as an analytic method, addressed researcher concerns that the multiplicity of women’s voice and subjectivities might be lost within the narrow structure of research data transcripts. By presenting data from varying participant positions and within layers of narrative the potential for relaying authentic participant accounts of women’s perspectives was enhanced. I was able to give structure to the analysis by aligning research questions answered by participants and recorded in transcripts with a blend of four readings or steps suggested by several authors which will be outlined below (Gilligan, Spencer, Weinberg, & Bertsch, 2006; Doucet & Mauthner, 2008).

**Reading 1: Central Story Lines and Reflexivity**

Initially a table was developed based upon the first step suggested by Gilligan et al. (2006) to frame the analysis in terms of participant’s stories and researcher responses. The first part of the table was developed by reading through the transcripts multiple times to get a sense of what Gilligan et al. (2006) describes as the plot of the story being told. The reader then attends to multiple contexts within the story by asking what is happening, as well as when, where, with whom and why this might be happening and also listening to oneself in terms of perceived images, metaphors and dominant themes (Gilligan et al., 2006). The social context of the story is also attended to broadly at first in terms of where the story was located and
more specifically regarding the particular social and cultural context in which the researcher and participant have met. As well, it was also important for the listener to be aware and note their own social location, relationship with the participant and emotional responses to the interview. As Gilligan et al. (2006, p. 257) suggests: As we listen we attend to our “own responses to the narrative, explicitly bringing our own subjectivities into the process of interpretation from the start by identifying, exploring, and making explicit our own thoughts and feelings about, and associations with, the narrative being analyzed.”

**Reading 2: ‘I’ Poems: Participants Perceptions of Self**

A second step or reading of the transcript revolved around ‘I Poems,’ which included drawing on transcripts to identify the narrator’s use of ‘I’ and the supporting words that accompany each ‘I’ that in themselves tell a story (Doucet & Mauthner, 2008). The process of developing ‘I Poems’ required reading different passages from the transcripts and listening for the women’s “first-person voice” (Gilligan et al., 2006, p. 259). Two locations in the transcripts were drawn from: one where a woman was actively using substances and another during a period where she considered herself in recovery. Every first-person ‘I’ in each of the passages was kept in sequence and underlined including accompanying words chosen by the person constructing the ‘I Poem,’ in this case myself. Gilligan et al. suggests that:

> Selecting several different passages throughout the interview to focus on in this step and examining them in relation to one another can facilitate hearing potential variations in the first-person voice that may include a range of themes, harmonies, dissonances and shifts. (p. 262)
This step placed the voice of the participant front and centre and revealed how women spoke about themselves as Doucet and Mauthner (2008) suggest this step provides “subjects with identities, and allow them to speak about who they believe they are” (p. 406, italics in original).

**Reading 3: Social Networks and Intimate Relationships**

Thirdly, using the Listening Guide as outlined by Doucet and Mauthner (2008) the analytic method proceeded by viewing the women as “relational narrated subjects” (p. 406) situated within social networks of relationships. This reading acknowledged that the women were more than their narratives or words and were defined by their relationships to others as well. As Doucet and Mauthner propose one reads “for social networks, and close and intimate relations. It is informed by feminist theoretical critiques of individualist conceptions of agency, and their replacement with relational concepts of subjects” (p. 406, bold in original).

**Reading 4: Micro-level Narratives and Macro-level Processes**

Gilligan et al. (2006) indicate that the final reading determines what has been learned about the participants related to the research question with a focus on “structured power relations and dominant ideologies that frame narratives. This reflects a concern to link micro-level narratives with macro-level processes and structures” (Doucet & Mauthner, 2008, p. 406). Participants are once again seen as greater than their narratives alone and viewed in relation to larger social structures and powerful ideologies. As Gilligan et al. proposes:
Although listening for one voice at a time in the earlier steps can illuminate different aspects of a person’s experience as expressed in an interview, these separate listenings must be brought back into relationship with one another to not reduce or lose the complexity of a person’s expressed experience” (p. 267).

This method of data analysis used the steps of the Listening Guide to painstakingly deconstruct women’s narratives and identify dominant themes or metaphors and women’s first-person voices. It then reconstructed and contextualized women’s narratives into surrounding social milieus so that their personal experiential knowledge became accessible and useful as research findings. The Listening Guide method gave thick descriptions of participant’s multi-layered and multi-dimensional experiences all of which contributed to deeper understandings and a rich analysis.

**Summary**

This study was first and foremost concerned with ethical issues involving women participants with substance use history. Ethical concerns regarding possibilities for coercion, potential for emotional harm as well as participant confidentiality were thoroughly addressed in research planning prior to any involvement of women participants. This study informed by a critical feminist perspective explored the social production of gendered relationships by asking the question: How do women with a history of substance misuse negotiate barriers and find paths to recovery? Critical feminist methods of interviews consistent with the philosophical framework were utilized and provided the process for research with an emancipatory and liberatory intention.
This study utilized semi-structured interviews for data gathering and the Listening Guide as an analytic method to uncover multiple perspectives of both the researcher and the participants. The research process itself became a relational method of discovery and demonstrated the meaningfulness of research situated ‘outside the box’ of mainstream knowledge production. Through the Listening Guide method women’s narratives were at first deconstructed and then reconstructed and contextualized so that women’s experiential knowledge became available as research findings.
CHAPTER 5: FINDINGS

*Our dilemma is that all our major concepts, our way of seeing reality, our willingness to accept proof, have been shaped by one dimension... In order to truly understand our universe, we must create a vantage point that allows us to observe it both for what it is and what it is not.* (Eichler, 2004, p. 47, italicized)

This chapter presents the findings of the study which were the result of a detailed analytic process. The initial development of schemas for three of the participants denote early findings followed by subsequent and individual ‘I Poems’ which preface each of the seven women’s personal narratives. The individual narratives are offered as personal odysseys representing women’s path-finding, discovery and transformation. The trajectory of participants’ journeys toward substance use and the significant harm that was caused by addiction is then relayed. Specific circumstances regarding parenting women and those with concurrent disorders are then noted and a composite of the seven participant’s common layers of understanding and ways of knowing are outlined.

This presentation of research findings forms a vantage point from which women’s narratives may be viewed from their multiple dimensions. One can only reflect on the narratives and cannot expect that they accurately represent all dimensions of the women who are located within diverse webs or “networks of relations” (Doucet & Mauthner, 2008, p. 406). Doucet and Mauthner suggest that it is easy to assume that participant narratives give authentic accounts of personal experiences and lives however one wonders if this is ever possible. As Doucet (2008) posits: “rather than claiming access to knowing subjects, all we can know is their narratives or their narrated subjectivities” (p. 84).
The analysis of the transcripts began with development of schemas that demonstrated three points in women’s path-finding journeys: Early into substance use, entering recovery and further along the journey. From transcripts words and phrases were clustered to give an idea of how women perceived their experiences at these points in time. Each schema was back-grounded by pictures; a winter scene for beginning substance use, a spring/summer scene for recovery and an autumn picture for further along the journey. Examples for three of the participants are given (see Appendices G - O). These schemas did provide a starting place for more in depth analysis but did not demonstrate the intersections and divergences of women’s experiences. As well, I thought that the pictures might denote a linear and sequential pathway to recovery which was not the real world experience of most women in recovery from substance use. To address the uniqueness of each of the seven women’s journeys yet show areas that were common the analysis proceeded from schemas to the use of the Listening Guide method.

Within this research individual narratives were framed within larger societal forces and processes also termed “structured power relations and dominant ideologies” (Doucet & Mauthner, 2008, p. 406) with the use of the Listening Guide method (Gilligan et al., 2006). The women’s narratives were viewed in terms of individual understandings as well as within differing contexts and societal structures. The Listening Guide analysis of women’s stories was understood to be one of many possible representations or interpretations; one of many possible vantage points that may exist at different
places in time and space; all of which are embedded within diverse webs of relationships (Gilligan et al., 2006).

Each woman’s individual journey or odyssey of recovery is preceded by an ‘I Poem’ that has been distilled from individual transcripts of personal narratives. The divergence of socioeconomic effects on recovery and the intersection of education are then explored. Lastly, composites are drawn which overviews pathways of addiction and pathways of recovery for all seven participants.

**Odysseys of Seven Women: Path-finding – Discovery and Transformation**

“Today an odyssey means a long, often exhausting, exhilarating and/or excruciating transformative journey” (Ban Breathnach, 1995, italics added). The ‘I poems’ preceding each women’s analysis have been compiled with the intention of effectively show-casing the depth and complexity of seven women’s odysseys of path-finding, discovery and transformation. These poems place the voice or ‘I’ of research participants front and centre and reveal how women speak about themselves within their social worlds (Doucet & Mauthner, 2008). The analysis following each woman’s ‘I Poem’ uses the listening guide as a voice-centred relational method (Gilligan et al., 2006). The Listening Guide method explores women’s insights and understandings with the intention of producing useful knowledge to demonstrate the essence of critical feminism as an emancipatory and transformative act.
I feel that there were two things that sort of changed the course of my life; One of them being something that lowers your self worth I think. I was being sexually abused, I was between the age of eight and eleven. I never told anybody. Then when I was at the end of grade ten I would have been fifteen I think. What I heard was we’re leaving... at the end of the summer. Leaving the neighborhood, leaving everything that was familiar to me. I think because I’d had sort of a taste of being high on pot and drinking a little bit, I found it really easy to use that as a way to stuff the hurt and anger I was feeling that stemmed from this decision that was made. So that’s actually how I ended up becoming a daily user. I was pretty depressed and down. So, I went out and I saw this guy... and he was cute. I was 364 days clean at that point. He asked me if I wanted a Budwiser... I said sure. I started drinking with him. I would drink with him but wouldn’t use cocaine. And then I started using cocaine again. I would use cocaine and would use alcohol.

I confronted. I gave them back what was theirs. I guess. I felt responsible. I let go. I felt a lot better. I have a solid connection to a God of my understanding. I depend upon that source. I need to get through situations. I live my life with spiritual principles. I don’t steal and lie and cheat. I don’t. I don’t live like I would have if I was trying to use. I feel strongest in helping. I work. I feel strong in my position. I have a good reputation.
Sarah’s Odyssey

Sarah was raised in privilege and affluence and other than early teen experimentation with soft drugs such as marijuana did not use drugs or alcohol until she was seventeen years old. Living in privilege did not exempt Sarah from experiences of sexual abuse that occurred from the time she was eight years old until she was eleven. Sarah notes that sexual abuse caused her to have a sense of low self worth which in turn made her “more susceptible to trying to find a way to feel better about [her]self” (Sarah, personal communication, July 5, 2007). Even though sexual abuse did affect Sarah’s sense of worth it did not singularly propel her into a lifestyle of drug and alcohol use. In her mid to late teens a pivotal point for Sarah occurred when her family moved from a small city in BC to a larger city in another province. The move completely disrupted Sarah’s sense of security by separating her from life-long community ties and friendships. However, what caused the most hurt and anger for Sarah was that she had no say or voice in the decisions made by her parents to relocate. She states: “I became very rebellious at my parents for moving me out of my comfort zone and felt that I wasn’t important. . . . to me it felt like I wasn’t a part of the decision and my feelings weren’t acknowledged” (Sarah, personal communication, July 5, 2007).

From seventeen years of age until her late thirties Sarah became a high-end user and dealer of drugs. Throughout this time she had periods of sobriety and attempts at recovery from substances none of which lasted for any length of time. Sarah attributed her lack of success at recovery to the attitudes she held regarding
a drug free life. She notes: “in my other attempts at recovery the things that kept me from actually recovering was a real willingness to work the program the way it was meant to be worked not the way Sarah feels that she can slip and slide around it” (Sarah, personal communication, July 5, 2007). As well, because she had been addicted to drugs and alcohol her entire adult life there was a perception of joylessness associated with a drug free lifestyle. Sarah states: “as far as I was concerned that to start with when I was first trying to get clean is that I’m just gonna you know drink coffee and wait to die sort of thing. Like my life’s over now right? . . . Because I had to be high to do everything” (Sarah, personal communication, July 5, 2007). A second reason that Sarah had difficulty maintaining a drug free lifestyle was related to the relationships she held with male partners. These relationships functioned in a manner that was similar to the highs she experienced from drugs. She relates:

Another thing that kept me from recovery was the fact that when I stopped using substances I would use men to stuff my emotions. And so I would get into relationships and of course either him or I would end up loaded again. But I wasn’t willing to stay abstinent long enough to get a sense of myself and a foundation with myself by myself so I wasn’t depending on him to keep me clean. And he wasn’t depending on me. And so really I always say, and I share this quite often, is that I need to abstain from all drugs in order to recover and that [includes men who] were a drug too. Men were a way for me to get outside of myself. (Sarah, personal communication, July 5, 2007).
Sarah most often formed codependent or care-taking relationships with men in which she was a “mother figure” (Sarah, personal communication, July 5, 2007) or teacher regarding living in the mainstream world as opposed to institutional living for example in prison. “He was very, very institutionalized he’d been in seven years and so he went in when he was sixteen he was out when he was twenty-three. And I’d just met him on the day he’d got out. So he had very much the jailhouse mentality in that he thought the only way he could get through life was to do rip-offs and that kind of thing. So I taught him I guess a little bit” (Sarah, personal communication, July 5, 2007). Another frequent component of Sarah’s partner relationships was physical, sexual and emotional abuse and underlying all relationships a sense that men were replicates of her father who had “never been close” (Sarah, personal communication, July 5, 2007).

Throughout most of her adult life as a high-end user and also into early recovery Sarah perceived the skills that she had learned from the drug-dealing community as positively influencing her life. She felt cared for and respected in this environment until the end-point of her addiction history when she became a bottom-end user:

And when I entered active addiction there was honor amongst thieves. . . . when I started I was taught like I say from these big guys that had this multimillion dollar business how to act, how to speak, when to speak, when not to speak, how to dress and how to survive, do well and get a good reputation. And so, I went into my, into my adulthood with those skills as well. Which have been hugely beneficial to me in recovery by the
way. But, but by the time I left I was a bottom end user. I wasn’t dealing I
was just only buying. The disease had progressed to the point where I was
an end user now. ... I didn’t know, couldn’t trust what would happen next.
I could’ve gone further down. (Sarah, personal communication, July 5,
2007)

At the point where Sarah and her child were placed at risk of violence
because of her lifestyle her parents set an ultimatum: Either get clean and live a
non-using life or give her child up for adoption and prepare for her own funeral.
The impact of this tough love by Sarah’s parents was a pivotal point in her
decision to stop using drugs and alcohol. She was at a very insecure place in her
life; physically unwell and emotionally fragile. Previous counseling for
childhood sexual abuse helped Sarah understand that much of her low
self-esteem and lack of self-value or faith in her abilities resulted in a need to
medicate with drugs and alcohol (Sarah, personal communication, July 5, 2007).
She was able to reclaim herself by giving back responsibility for being abused
to the abusers and not hiding or protecting them by keeping these activities
secret. As well, Sarah was able to progress in recovery from substance use
because of her dedication and resolve to attend and wholly participate in
residential supportive recovery programs which were crucial to her moving
forward in a healthy lifestyle.

I made the decision that this was it for me. I was either going to die or I
was going to get clean and raise my [child] ... And I lived or stayed
there six weeks. I worked the program. ... I really worked a lot of balance
into my life while I was there. And, tried to incorporate everything I
would need to do at home into my program there so that when I got out I could just continue with it. And not be feeling so overwhelmed by the new things that were added to my plate. . . . Anyway I, I did every aspect of that program. I just knew that it was, it was the end of the line for me. That my life was never, could, could, would never be repaired if I didn’t stop then. So I’ve been clean since that day. (Sarah, personal communication, July 5, 2007)

Factors that supported Sarah’s journey of recovery included living by spiritual principles as well as physical detoxification from drugs and alcohol; substances that once helped numb “loss and grief” (Sarah, personal communication, July 5, 2007). Supported by these principles Sarah was able to move more strongly into a lifestyle that included both great pain and the counter measure of great joy. Life became more meaningful and Sarah experienced a sense of value and contribution to others around her in the community. Sarah recounts:

What recovery from active addiction . . . means, is that I have a solid connection to, to a God of my understanding. That I depend upon that source to give me guidance and to give me the strength I need to get through the situations that may become triggers to me. It means that I live my life with spiritual principles. It means that I don’t steal and lie and cheat and that I don’t, I don’t live like I would have if I was trying to use substances and running out all the time. You tend to use anything that you never thought you would do in order to obtain your substances. And now so for me to continue to lie or be dishonest or cheat or steal would mean I
would likely end up back at substances. The ultimate shame would lead me back there. So in order to stay abstinent and stay in recovery from active addiction to me means, living a good, a good honest life. To somehow be giving back to the community that you live in or somehow back to a program that you’re involved with or an organization that you’re involved with or something. Anything that you choose, that you do of your own free will and expect nothing in return. I believe that’s a huge part of your recovery. I believe that having a willingness to look within myself. To, to do the work when things come up.

Further along in her recovery Sarah now spent much less personal time with groups and individuals with histories of substance use but did work in the recovery field as a support worker. In this position she describes herself as not being a decision maker and feeling comfortable letting those in administration make the decisions while she works with clients.

Just kind of go with the flow. Nothing’s ever written in stone. So just, to be able to, sorta go with the flow and see where it ends up. I know that it’ll always be okay. I always have been. And, to not to worry about things that are beyond my control sort of. I don’t have enough energy for all that I do and all the people in my life as well as to worry about things I don’t have control over. So I just make the choice most of the time not to worry about those things and let the higher ups figure it out and let me know what’s going on. (Sarah, personal communication, Feb. 17, 2008)

As well, in her personal life Sarah has aligned herself in a more mainstream way. She views herself as a citizen in the way she contributes to the
community that she lives in and is afforded respect along with support; “listened to” and “heard” (Sarah, personal communication, Feb. 17, 2008). Feeling listened to or heard results in also feeling respected. Sarah goes on to describe what being a citizen in community means to her: “A citizen in a community means that I do my part. It means that I have a place, I’m not trying to find a place to be. That you already are; you are a citizen. . . . And that you show up and do your part. And contribute in community no matter what kind of community it is” (Sarah, personal communication, Feb. 17, 2008).
I believe that it was always there
I always was needy
I always felt less than
I remember always waiting, always
waiting in line and never being
number one
I was always like, where do I fit?
I went into school
I just didn’t fit.
I didn’t fit.
I just went nuts.
I just lost my marbles.
I just fought like a crazy woman.
I have scars all over.
I, I drank like, like there was no
tomorrow.
And I don’t understand how
I did all of that and
I drugged like crazy and
didn’t anybody know?

When I am hurt
I am feeling betrayed
I’m feeling abandoned
I’m feeling like who is gonna even
know?
I really feel like there’s somebody
really wonderful in me
That I could give to different
people but now,
Now I won’t.
So I can live this life;
I can live it in joy;
I can love in it;
I can do all those things.
I will, but they don’t get me:
And I don’t let her come out.
Lee’s Odyssey

Lee believes that she experiences personal inadequacy and insignificance and predisposition to addiction as a result of an abuse-filled childhood. She states: “I believe that it was always there. I always was needy. I always felt less than. I remember always waiting, always waiting in line and never being number one…. And so I was always like, where do I fit?” (Lee, personal communication, July 9, 2007). From this difficult childhood Lee became distrustful of others not knowing what to expect day-by-day; moment-by-moment. She describes home-life as one of extremes; a rage-filled aggressive atmosphere one moment and a happy and giving environment the next. She reflects: “you never knew what you could trust or couldn’t trust… Everything was to the extreme” (Lee, personal communication, July 9, 2007). Lee describes herself as always being wounded and not understanding who she was or the rationale for her behavior. She reveals: I was “just being wounded all the time, you’re always wounded. You’re always, you can never quite find out who you are or figure out what you’re doing or why you’re doing it” (Lee, personal communication, July 9, 2007). By adolescence Lee discovered that she could obtain peer approval and significance by becoming physically violent toward others. She progressed very quickly into gang type activities that included physical aggression often compounded by drug and alcohol and recounts:

And then I went into school and I just didn’t fit. I didn’t fit. And then I beat up somebody really bad and everybody cheered me on. Then I, then I really, that’s when everything happened. Man I just went nuts. I just lost my marbles. I just fought like a crazy woman. I have scars all over. I, I
drank like, like there was no tomorrow. And I don’t understand how I did all of that and I drugged like crazy and didn’t anybody know? I was somebody when I was out; when I was with friends. (Lee, personal communication, July 9, 2007)

As a recovered adult Lee has times when she has difficulty staying clean. She recounts that even presently there are times she experiences flashbacks to previous drug-induced experiences.

And I understand cravings and I understand liking it and wanting it and, and how good it makes you feel. And we do drugs not because they’re bad we do them because they’re so darn good. And I know that craving, and I’ve been: I can close my eyes and go back to a lot of my highs. (Lee, personal communication, July 9, 2007)

Other times it is in relationships that Lee feels a sense of being wounded and abandoned all of which take her back to childhood feelings of inferiority, inadequacy and insignificance. She reflects: “when I am affected, when I am hurt by somebody it really takes me to a very unstable place emotionally. I am feeling betrayed, I’m feeling abandoned” (Lee, personal communication, July 9, 2007).

Although Lee had experienced several drug overdoses they had all been non life-threatening. In her late teens to early adulthood she had taken an unknown drug that had resulted in a near-death experience and which left her physically and cognitively impaired. “It’s like you’re looking at a big beam of light and it just keeps getting smaller and smaller. And your radius of sight goes smaller and smaller. I remember seeing, thinking it’s getting smaller...thinking
so this is what it’s like to die” (Lee, personal communication, July 9, 2007). Many months later she was rehabilitated and regained all of her physical capabilities and a majority of her cognitive abilities. Lee reflects:

I couldn’t walk, I couldn’t talk I had no bodily functions, I couldn’t sit up, I couldn’t do anything. It was horrible....you know I know I just wanted to die. Well, you know when I think about my journey I think you know what? Thank you God that I even have the ability to think, to walk the talk, to function and communicate. (Lee, personal communication, July 9, 2007)

Lee attributes her recovery to a choice she made to live rather than to die although she said she has no fear of dying. For her, it was also a maturational factor including meeting a non-using partner who supported her and loved her unconditionally. Lee was able to grow and reflect on the dysfunctional extremes that were embedded in her childhood and to heal from the emotional and physical wounds that had been inflicted upon her. She states: “So I think maturity plays a huge role in recovery. But, you know I, I almost hate to say this but, you just have to make up your mind. You just have to say, that’s it, enough is enough. . . . Well that’s the whole fine line; do you wanna live or don’t you wanna live? If you don’t wanna live man there’s easy ways to get out” (Lee, personal communication, July 9, 2007). An additional factor contributing to Lee’s recovery is altruism or giving to others. Assisting people that are living marginal lives in the community contributes to her personal healing of childhood trauma. Giving to others who suffer meets Lee’s own needs for meaning, significance and purpose in life; the character within that is wonderful.
However, Lee remains cautious and always holds a part back even with those she loves and trusts. This is a life-long struggle and consequence of the life-journey she has experienced. “So I can live this life; I can live it in joy; I can love in it I can do all those things but . . . they don’t get me. And I don’t let her come out” (Lee, personal communication, July 9, 2007).
I just always came back.
I would leave and then he'd
"oh I'm sorry."
Ya I had a part in it;
I'd go back.
But this time I finally had enough
I really did.
I thought:
"I don't love you anymore you make me feel like shit."
I mean just that.
I mean
I think
When I finally left him that was a huge step.
And just a defining thing you know "I've had enough."
And it's funny cause I stood up
and I said:
"I'm done with you treating me like shit."

I walked into the room of the program
I actually felt like oh my gosh
that's what's wrong with me.
I have this in common with all these people
I never felt at peace with myself and my life
and all along I know,
It was because I was an addict.
I was like oh my gosh
I belong somewhere.
Judy’s Odyssey

Judy, who identifies as Métis, describes her childhood family life as very significant and important to her despite the fact she was “raised in a completely dysfunctional alcoholic home” (Judy, personal communication, August 28, 2007). She says the good times outweighed the bad and when her parents, after many separations, finally divorced she was heart broken and devastated believing her family had been torn apart (Judy, personal communication, August 28, 2007). In Judy’s early teen years she moved from one parent to the other because she felt unwanted and replaced by the parent’s new partner and after moving took on an adult role of maintaining a functioning home. At this time she had a peer group of friends and describes herself as the one who initiated activities such as smoking and drinking heavily. Also, at this time, Judy had a boyfriend who introduced her to harder drugs and she progressively misused substances. Judy relates that she: “loved being stoned” for seven or eight hours as a way of “escape” and also that drug use gave her confidence and made her feel beautiful and the world seem beautiful too. “When I was using . . . one of the things that I loved about using was that I, I just always felt normal and accepted” (Judy, personal communication, August 28, 2007).

Judy describes turning to intimate partner relationships to fill the void caused by diminished self-worth and low self-esteem. She states: “And then it really started with men, boyfriends. My first boyfriend was when I was thirteen and I can honestly say this is the first time in my whole entire life I have been single for seven months” (Judy, personal communication, August 28, 2007). Most often Judy chose partners who were abusive in some manner and unless
they were “drinkers and partiers” she did not want to be involved with them (Judy, personal communication, August 28, 2007). At one point for many years Judy did have a partner who was not into drugs or heavy drinking but still found that this relationship was physically and emotionally abusive nonetheless. Judy took many years to extract herself from this relationship but finally determined that she had had enough. “That was a huge step. And just a defining thing you know ‘I’ve had enough.’ And it’s funny cause I stood up and I said, ‘I’m done with you treating me like shit’” (Judy, personal communication, August 28, 2007). Following the dissolution of this relationship Judy reverted back to heavy drug and alcohol use for a period of time before reaching the place where she stepped up and became accountable for her recovery. She believes that recovery is a choice that each person must make and states:

I really truly believe if I ever pick up a drink or drug again it’s my choice. There’s nothing or no one or anything that’s going to make me relapse.

Like, ‘why did you relapse?’ I relapsed because I picked up the drug again. I chose to. It’s a choice. And I am responsible and you know nobody’s gonna force anything down me. (Judy, personal communication, August 28, 2007)

It is noteworthy that Judy’s recovery started in her early teens and occurred for shorter and longer periods throughout her life. While still thirteen she met a counselor that remains as a mentor in adulthood. “I wanted the help, I really opened up to her...And confided in her and said you know I don’t want to be like this. Like...because I knew that, I knew at that point I understood what alcoholic was and I had really gotten myself deep into the acid really bad”
(Judy, personal communication, August 28, 2007). Judy was able to relate to this counselor even from her early teen years because of this woman’s knowledge regarding relationships and their connection to addictions. “She never did have addiction issues but she had the relationship stuff. And she’d grown up in you know an alcoholic home. Her husband had had his own addictions. He actually died from an overdose” (Judy, personal communication, August 28, 2007). Many different recovery methods were attempted by Judy throughout her life with little ongoing success. Finally, one night Judy found herself alone. No one wanted her around and she was totally isolated. She reached out and was planning on going into treatment but prior to going recounts:

I had eight hundred dollars left in my bank account and I blew it all that night. I did it all, just drank and got it all out of my system. . . . I had no place to live; I had no money and really even my friends that I did party with were tired of me. They were like, “Judy you’re just not even fun to party with any more. You’re just, you do it all and you just get stupid and it’s just sick to watch.” Like they wouldn’t even let me come over, just nobody wanted me around. Nobody wanted me around. . . . I felt, you know with that eight hundred dollars I was hoping that I would die. That was the plan. It was like I needed to get as much coke as I can and hopefully I’ll just die. And I won’t even have to go to treatment. And that’s where I believe in a Higher Power. Because the amount of drugs I did...I shouldn’t have lived! Shouldn’t have lived. . . . Well, once I got to treatment then it
was I want my life back; I want to live. (Judy, personal
communication, August 28, 2007)
Residential treatment provided the counseling and tools Judy required to
move forward in her recovery. She was a strong believer in 12 step programs
and small community support groups and attended these faithfully. Judy
recognized that she had always thought something was wrong with her and
could therefore never fit in with others. However, within the recovery
community Judy was able to find a place for herself. She notes:

And it’s not until I walked into the rooms of the program that I actually
felt like oh my gosh that’s what’s wrong with me and I have this in
common with all these people...I never felt at peace with myself and my
life...and all along I know it was because I was an addict... I was like oh
my gosh I belong somewhere. (Judy, personal communication, August 28,
2007)
I was powerfully, powerfully shy.
I was; didn't have any self
confidence at all.
I didn't know; I...
I didn't know how to behave in
society.
I didn't know what family life was
like. Hadn't had any.
And so I think that's what led
(to using).
You know it made me feel
comfortable to socialize.
I mean
I get terrified when I'm going out.

Where will I sit?...
There'll be no
where to sit.
I'll have to sit.
I mean
I know everybody.
I have friends that are extremely
supportive of me. Extremely
supportive of me.
But I don't dump on them.
I tell them where I am; but
I don't dump on them.
I don't want;
I don't want to push them
away.
**Tess’s Odyssey**

Tess’s journey to substance use started with physical abuse at an early age and later, during school years, geographical disconnection from her family. These factors led to what she describes as a “powerfully, powerfully shy” young woman who “didn’t have any self-confidence at all” (Tess, personal communication, November 23, 2007). As an adult, Tess was only able to attend social events comfortably when she was using substances, which increased in frequency of use over time, regardless of whether she was with others or alone. Deep seated insecurity and a sense of rejection by those in her life compelled Tess to continue on this journey of addiction. She states: “They were getting rid of me. . . I always seemed to be sent away” (Tess, personal communication, November 23, 2007). As well Tess reflects: “I didn’t know how to behave in society. I didn’t know what family life was like. Hadn’t had any. And so I think that’s what led (to substance use) you know it made me feel comfortable to socialize” (Tess, personal communication, November 23, 2007). Additionally, Tess engaged in behavioral addictions including workaholism and perfectionism that were tied to earlier fears of rejection: “because if I didn’t measure up then I’d be told to go away” (Tess, personal communication, November 23, 2007). Reflections by Tess of the first interview transcript enlightened her to thoughts she had not concretely understood prior to reading it: “I have read the interview several times and so forth and each time I tell my story it comes down to fear of rejection. It became clear to me that it’s not just rejection of others but also rejection of myself” (Tess, personal communication, February 20, 2008).
Currently Tess walks a path of recovery from substance use but continues to suffer from concomitant anxiety. She states: “I still do have terrible anxiety attacks at times. . . . Sometimes I get so bad I can’t do anything” (Tess, personal communication, November 23, 2007). Tess’s decision to stop using substances was not momentous. She simply states: “I was just tired” (Tess, personal communication, November 23, 2007). First steps included counselling and attending a residential treatment centre both of which helped Tess to understand the underlying factors that resulted in her need for substances. From the residential treatment centre there was a shift in Tess’s feelings of insignificance. She states: “the main feeling I got is being important. And you counted for something. And it was a different way. It was, it wasn’t a submissive place to be. It was an opportune, an opportunistic place to be. You could go where you wanted to go in your head” (Tess, personal communication, November 23, 2007). In her own reflections Tess writes:

My heart soul does not understand even though at times my head does. Mind you, the questioning is all in my head. This leads to a dead heart soul and a confused brain. I am confused because I am a good person but believing it is very difficult. That sounds pretty screwed up but at least now I am aware of this tendency. (Tess, personal communication, February 20, 2008)

Tess further clarifies what she means by this statement.

Well I can tell myself, in my head, all sorts of things. Both things about my history, things about the past and things about the future. Things about me, things about other people, in my head. But I don’t, my soul doesn’t hear them. It doesn’t hear them it’s all, it only sort of puts a black mark on everything. (Tess, personal communication, February 20, 2008)
The research was beneficial to Tess because it opened her eyes to thoughts she had never spoken. “I’d never put it into words before. I’d never seen it as clearly. It wasn’t a great surprise but it was the first time I’d sort of stated it” (Tess, personal communication, February 20, 2008).

Employed work is an important aspect of Tess’s sense of self; work potentiates her feelings of worth and accomplishment. She is diligent in the work place and finds a place of community in this setting. Tess describes a network of supportive friends; people who are honest yet kind work best in her life. She states: My friends are “gentle and straight forward. They’d tell me the truth they wouldn’t nambie pambie around. But they’d be gentle” (Tess, personal communication, November 23, 2007). Tess is adamant that those who are dismissive or try to dominate others as well as those who are untruthful cause great distress in her life. Tess clearly states that she feels weakened by “people who try and dominate me. Dishonest people who think they’re better than you are. I can’t stand dishonest people” (Tess, personal communication, November 23, 2007). Tess values the friendships she has developed over time and has determined that they are an important part of her recovery journey yet is wary of losing friends if she needs them too greatly.

There are friends that have been part of the journey with me but . . . I don’t like to burden them. . . . But you know, I have friends that are extremely supportive of me. Extremely supportive of me. But I don’t dump on them. I tell them where I am but I don’t dump on them. . . . I don’t want to push them away. (Tess, personal communication, November 23, 2007)
Darby

I was
I guess you could say;
I was a real miserable drunk.
I can admit it now you know;
powerless over alcohol.
I mean you know
I blacked out so much.
I can sit here and talk about it now.
But then, when I was still out there using;
I was ashamed to talk about what I did.

After I got out
I was right back out there again.
I was released.
I mean six weeks doing my recovery
I got out
I got released.
Two weeks down the line and I was back out;
I relapsed...
You know I didn’t like who I was.
I didn’t like who I was you know?
I finally figured, I said;
“Well I gotta get help.”
I reached out again.
I need help bad this time.

I say “well whatever it takes.”
I started working on myself.
I chose to go.
I loved it . . .
I wanted to explore something different.
I enjoyed . . .
I felt part of the family.

I cherish my days one day at a time
I am very grateful.
I don’t know,
I did a lot;
I did my own speech in front of my own community.
And till this day people, back home,
acknowledge my sobriety.
I was kind of scared;
I was kinda scared about it you know?
I’ve gotta tell these guys what kind of lush and drunk I used to be.
I gotta lot of people coming up and you know telling me their stories.
I was a good inspiration to one First Nations woman
I tried to help.
**Darby’s Odyssey**

Darby, who identifies as First Nations, was born in a small BC community of 2,324 people with six surrounding indigenous bands having a combined population of 3,972 (Statistics Canada, 2010). Darby states that as an infant and young child she knows she was cared for by an aunt and was in the Residential School system from nine to thirteen years of age but has no memory of these years. Her first memories start at the age of thirteen when she went to live with her father. She recounts an activity in a residential treatment program in Kamloops: “When I did my timeline (for recall of memories) in The House of Ruth the first 13 beads were black and I told everyone these are the years that I remember nothing” (Darby, personal communication, February 6, 2007).

Darby describes her father as a strong man who taught her to pull her own weight at work and to stand up for herself and although they lived in poverty, believes life was good while living with him. On her nineteenth birthday Darby’s father took her to the bar to celebrate becoming of legal drinking age. In her early twenties, he told her to travel: “He told me to go. Got to explore the world there daughter” (Darby, Personal Communication, February 6, 2007) so she moved to live with cousins in a small interior BC city where she says the parties with alcohol and cocaine were almost continuous. At this time, Darby started her first relationship with a “Caucasian male” (Darby, Personal Communication, February 6, 2007) followed by several other relationships all of which were abusive and included use of drugs and alcohol. Eventually Darby moved back to her home town where abusive relationships and alcohol use continued. Darby states that by this time she had become “powerless over
alcohol" and was a very angry and "miserable drunk" (Darby, Personal Communication, February 6, 2007).

I was a real miserable drunk: Angry drunk all the time. A lot of anger built up inside me and ah . . . . powerless over alcohol. And alcohol took over my life. And ah I mean you know like I blacked out so much, times....like you don’t know who you woke up beside and you don’t know...where you’re camped out at. And you know you just don’t know where you’re at half the time and that’s what really bothered me. (Darby, Personal Communication, February 6, 2007).

By the time Darby was in her early thirties she had serious liver disease and physical breakdown and yet continued drinking alcohol. She states:

When I you know all that misusing the coke and the drinking and you know waking up beside a toilet. My liver was just about ready to be shot and then they caught it. But I mean like that still did not stop, did not stop me. I still went out and got drunk all the time. You know...you know throwing up and you know massive hangovers. When I would drink, when I was out there drinking sure I ya know like you know I’d, I’d eat but still doesn’t help though. I was a very nauseous hangover drunk. I, I couldn’t even keep nothing down when I, when I was hung over. (Darby, Personal Communication, February 6, 2007)

The physical changes that resulted from alcoholism were profound and left Darby feeling self-hatred as she reached “rock bottom” and at this time realized that she needed help. She states:
My face was getting all puffy. Big and puffy . . . and my, my lining of my neck would be all red from getting all sick and all that dry heaving and all that. And you know, like you know I hated that. You know I didn’t like who I was. I didn’t like who I was you know? I finally figured, I said, ‘well, I gotta get help.’ (Darby, Personal Communication, February 6, 2007)

Although Darby had previously attended a six week Aboriginal residential treatment program she had quickly relapsed once it had been completed. With the assistance of a counselor and supported by her family network she made a decision to go to The House of Ruth residential treatment centre for women in Kamloops, BC. This was a huge step for Darby as it was completely outside of the Aboriginal community and was a foreign environment for her. Women relatives went with her on admission and although she was very frightened she chose to stay. Darby relates:

And then they brought me over and this was the scary part. I didn’t want to leave, my grandmother, my auntie…my mom all came with me to bring me to the House of Ruth. And when I got let go, I got released into the staff’s hands I bawled my eyes out . . . Ya cause you know like I told her I said, “this is scary. You know it’s a big step for me to take.” (Darby, Personal Communication, February 6, 2007)

Darby successfully completed the three month program at The House of Ruth and made additional decisions to support her recovery including participating in anonymous support groups (Alcoholics Anonymous; 12 steps),
traditional Aboriginal hand drumming circles and had determination to live a sober life “one day at a time” (Darby, personal communication, February 6, 2007).

As Darby moved further along in her healing journey away from addiction she aligned herself more closely with her community and wanted to contribute back to it. She had a wide network of support and was able to use her own healing as a way to inspire others. She states: “people acknowledge my sobriety” and “I was a good inspiration…I tried to help” (Darby, personal communication, February 6, 2007). At the time of the research interviews Darby had eight years of sobriety and was a strong, caring and altruistic Aboriginal woman. The attributes she used to encourage others were the ability to talk comfortably about her past and an open, honest and helpful demeanor. As well, Darby had a ‘joie de vivre’ or as she states “I enjoy my life the way it is now” (Darby, personal communication, February 6, 2007). For all of this Darby was grateful and determined to continue to grow and learn; to stay on the path of recovery. She said, “I’m still on that healing track and I’m staying there” (Darby, personal communication, February 6, 2007).
I did...
I did a lot of things that
I wasn't proud of.
I was one of the tougher
individuals.
I ended up doing a lot
I can't apologize (for).
I'm sorry,
I mean ya I did my own crime,
I did my own time,
I caused my own problems in
society.
And now; I'm trying to fix that.

I was sexually abused.
I was young
I think twelve.
I'd grown up...
I was troubled.
I was...
I was sticking at the fringe.
I mean...it stands to reason;
I have a problem with authority!
Michelle’s Odyssey

Michelle describes herself in her youth and teen years as an outsider or as a young woman “sticking to the fringes” (Michelle, personal communication, February 8, 2008). During the years that are generally expected to be an age of innocence with time to develop; Michelle instead had to grow up quickly in her full time role doing “women’s work” (Michelle, personal communication, February 8, 2008) for a large family with parents both working and all boys remaining in the home for her to care for. Her experiences with an older brother who mistreated her and adult men in positions of trust who were sexually abusive to Michelle, starting at 12 years of age, overlaid layers of mistrust toward authority figures. Before her sixteenth birthday Michelle had left this abusive environment and was employed in a large Canadian city where she was totally self sufficient and reasonably happy. Later moving across Canada to live in a western province with her sister and newborn nephew she once again assumed adult responsibilities providing care for the new baby as her sister was unwell. To this point use of drugs and alcohol was primarily experimental.

Fast-forward to Michelle at twenty-seven or twenty-eight years of age working in construction full time and drinking heavily nearly every day with her work crew who were for the most part her main social network. Michelle became an alcoholic and because she was arrested for driving while inebriated; she was incarcerated for weekends over several months. This was a transformational period for Michelle where she was “educated” (Michelle, personal communication, February 8, 2008) in a criminal life-style that automatically included the use of substances. From this experience Michelle
developed a new network of friends and associates and became addicted to drugs. To support her drug habit she progressed from selling all of her possessions to minor and then major criminal activity including assault to others. Michelle lived in the Down-town East Side (DTES) of Vancouver, other than the times when she was incarcerated, in what she describes as a “close community” (Michelle, personal communication, February, 8, 2008). In the prison community and the DTES community Michelle felt respected and surely feared particularly at the street level by women (primarily those in the sex-trade) from whom she “collected” drug money (Michelle, personal communication, February, 8, 2008). In all of this Michelle describes herself as a “control freak” even in the worst of times and also as a person who had built layer upon layer of “shame” and “self-loathing” (Michelle, personal communication, February, 8, 2008).

A second transformational time for Michelle occurred on her final admission to a federal penitentiary. During this admission one of the guards frightened her so much that she made a decision to turn her life around so that she would never have to be incarcerated again (Michelle, personal communication, February, 8, 2008). Over her years of addiction Michelle had attended many recovery programs which had exposed deep-lying trauma issues but did not subsequently provide the skills or means to move beyond these. The last program that Michelle attended during her final incarceration was in an Aboriginal healing circle where she was able to effectively address childhood issues of abuse and trauma as well as provide means for healing. As Michelle
states; “there was one trauma program that I took that did everything I needed it to. It went from the very beginning right to the very end. It took me where I needed to go and it sewed up the wounds at the end. And it made it possible for me to get past dealing with the trauma” (Michelle, personal communication, February, 8, 2008).

The barriers to remaining free of drugs, alcohol and criminal behavior once Michelle had worked through trauma issues and was released from a halfway house primarily focused on finding employment and meeting the basic necessities of life (food and housing). Very little help was available for women in this context and it seemed as though the system, instead of giving a hand up to Michelle, attempted to demean her when she required assistance. To Michelle it appeared that mainstream society would give no chances and that it had written her off as an addict and a worthless criminal having no redeeming qualities.

For somebody to say, “no I’m not hiring you. You have a criminal record. I’m not hiring you because you’re an ex-drug addict.” So and then you go into a social service office to go on social assistance. . . . [that is] if you manage to survive your in-house parole and you’re allowed to leave or it’s at the time when they’re kicking you out the door because you only have a couple of months left and you no longer have a mandatory living in the halfway house clause on your parole. You go into a social services office to get social assistance and they beat you down within the first two minutes of your application. And you’re not even seeing a lady or a man
that’s gonna give you your social assistance you’re just dealing with the receptionist at this point and they’ve already got you beaten down to the point where you’ve gotta turn around and walk out the door. (Michelle, personal communication, February, 8, 2008)

Michelle was diligent in her job searching but with little success for as she relates addiction history alone is a major impediment to employment but when combined with a criminal background becomes impossible. It was through the networks that she previously knew but who were now in recovery including others at Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings that once again supported her and provided employment. Since then Michelle has taken educational opportunities and is fully employed in a good job. She states that at one point she almost considered criminal activity just to get the upgrading required to find employment:

Well at one point, I like was looking through funding and stuff like that, I had went to my parole officer and took these two sheets of paper with all these places I had been to and been turned down at. And looked her square in the face and said: “listen, do something. Because if you don’t I’m at the point where I’m going to go and commit crime to further my education.” Not to buy drugs this time around. This time I’m going out to commit crime to make it so that I can go out and get a job and live life. Because there’s no one out there that’s going to help me do it. (Michelle, personal communication, February, 8, 2008)

Michelle’s involvement as a participant in this particular research project as well as other community based research projects has provided a means for
her to articulate the experiential knowledge she holds regarding the barriers women face on their journeys of recovery from substance use. What she has identified as crucial to continued recovery; required in tandem to meeting basic needs, is support and acceptance by the local community. As Michelle relates:

But there's a lot of people out there that are raw. And when you're in that type of fragile state, rejection is something that, rejection and judgment. I think judgment is the bigger one out of the two. Like because it's such a, like you don't know me. You don't know what I've been through, you don't know what's going on in my life. So you don't have the right to judge me or reject me for who I am. I'm trying my best to move forward. I'm trying my best to change. And here I am being slapped in the face by an individual in society that will judge me and reject me because of my past. And give me no room to change or move forward. (Michelle, personal communication, June, 2, 2008)

Michelle is passionate in her desire to help women who have substance use history, are exiting prison and/or are at risk of committing crime. She is a strong advocate for women centered programs and initiatives and believes strongly that what is most appropriate for women does not include the male models currently in use. As Michelle suggests; "they'd better change their outlook, it's a lot different when you're looking at men and women. Like not only do they have to change their outlook they've gotta learn that men and women are two different entities: Their traumas, their reasons, everything. Everything! They're two totally different animals" (Michelle, personal communication, June, 2, 2008).
Michelle recounts that what keeps her moving forward in her recovery from substances is primarily being accepted and respected by those around her for who she is and what she has accomplished. As well, sharing her success with others not as far along the road to recovery is also very encouraging to Michelle as it gives meaning and a way to make amends for past wrongs. As she has been affirmed within the community and by the network of support she has built around herself Michelle has been heard to say in conversation with women beginning their journeys of healing: “You’ll be okay. We’ve got people who’ve got our backs” (Michelle, personal communication, 2010).
I found pot and alcohol and that was

to fit in.

I smoked pot and drank alcohol.

I started to cut every time I drank.

So I got diagnosed with bulimia and
depression.

And that’s where I started my cycle.

I started.

I want more

I want more.

I continued.

I would...

I would lie and use and use and use

and use

Then I would just break.

I’m coping with life just as it is

I don’t use dope

I don’t use alcohol

I don’t...

I’m clean and sober

I can sit in silence

I can enjoy it!

I can enjoy it.

I’m not scared.
Lisa’s Odyssey

Lisa shares that she “grew up in Kamloops in an upper middle class family” with parental alcoholism and was witness to their routine physical violence toward one another (Lisa, personal communication, August 1, 2008). Lisa’s early memories include her own abuse beginning at age five, uncontrolled eating and hoarding of food followed by a later diagnosis of bulimia, depression and self harm (cutting self). Lisa states that she yearned to escape and wondered if she “could kill” herself (Lisa, personal communication, August 1, 2008). As she reached her teen years and was in high school Lisa was an honor role student and was on student council and other clubs so that externally everything looked okay. “I had really, really good grades. At school, I loved school! That was total escape. Like student council and all the clubs and things, right?” (Lisa, personal communication, August 1, 2008).

Lisa, along with high school peers, started using “pot and alcohol and that was to fit in” which by age fifteen had progressed to using cocaine and heroin (Lisa, personal communication, August 1, 2008). She states that cocaine was “the ticket to not feeling and not being, slashing didn’t need to happen, alcohol didn’t need to happen... cocaine was good” (Lisa, personal communication, August 1, 2008). Heroin was Lisa’s drug of choice to come down from the cocaine so that she could return home and sleep. She said it relieved the feelings of “I want more, I want more,” that cocaine gave her (Lisa, personal communication, August 1, 2008). Lisa was able to continue attending high school and maintain appearances of having a typical teenage lifestyle for cycles of six to nine months but then “would just break” (Lisa, personal
communication, August, 1, 2008) and her parents would have her admitted to
the hospital psychiatric ward. It is notable that when Lisa and a friend
progressed from using pot (marijuana) and alcohol to harder drugs they were
ostracized by their peer group “we were the outsiders...we were really popular
before that happened and all of our friends made fun of us all of the time. Like
put us down and stuff for using cocaine” (Lisa, personal communication,
August, 1, 2008).

Following high school graduation Lisa moved to Vancouver, BC where
early on the importance of appearances to her social circle in the Kamloops, BC
community remained significant. For example she married a man who was
bisexual and positive for Human Immunodeficiency Virus (HIV) that she had
met in a treatment centre with the rationale that “if I got married, no one has to
know he’s gay, everyone in Kamloops can know at least I’m married and that
would make everything okay” (Lisa, personal communication, August, 1, 2008).
After approximately a year or so Lisa was at the peak of her drug use and living
in the Downtown East Side (DTES) of Vancouver, BC. She had been
abandoned by her husband and left alone and went into what she describes as
her “first actual full on psychosis ... freaking! Like freaking!” (Lisa, personal
communication, August, 1, 2008).

During the years Lisa lived in the DTES she had poor physical and
mental health and lived a violent life style in the sex trade. While under arrest
she tested positive for pregnancy. Although Lisa continued to use substances
throughout the pregnancy she did access services at Sheway which is a
women’s centre for pregnant and parenting women using substances (Poole,
2007a). Near term with her first pregnancy Lisa returned home to Kamloops and was delivered by a physician she had previously known of a healthy, non-addicted baby. During the following few years Lisa continued using substances and led a chaotic lifestyle. Following delivery of her second child she feared losing her children to social services and decided to turn her life around. Not only was she able to do this but was also able to build strong support networks for both herself and her children.

Presently Lisa and her children live in Kamloops in a safe environment with all of their basic needs met. Lisa is committed to her recovery from substance use and is open to the help of others in the community including friends, support groups and professionals. To Lisa, recovery from the use of substances means that she is “coping with life just as it is and life events without harming (herself)” and that she is “clean and sober” (Lisa, personal communication, August, 1, 2008). She finds the principles of twelve step programs including making amends and having a Higher Power helpful to recovery. Also important to Lisa’s recovery are relationships with other women particularly those who have had substance use history and like her are in recovery. Not only do they understand her experiences and challenges but they also keep her accountable and help her to set healthy boundaries within her life. The most critical factor to Lisa’s maintenance of recovery from substances is her drive to be a good mother to her children and to not have them removed from her care by social services.

Lisa experiences the best of recovery from substance use when she is “totally committed to not using no matter what” and when she feels she is...
“getting serene and healthy and thriving” (Lisa, personal communication, August, 1, 2008). This sense of health is based upon feeling safe and unafraid in her day to day life; having a sense of comfort in her surroundings. Lisa states: “I can stay home alone now... I can sit in silence... and not be uncomfortable” (Lisa, personal communication, August, 1, 2008). Lisa provides leadership and is actively involved in peer driven groups and finds that the relationships with women continue to be important to her recovery. These relationships provide understanding, “unconditional love” and encompass the environment in which she is able to feel “the most love and support” as well as a sense of power, reciprocity and purpose or as Lisa notes: “we exchange power... giving and receiving” (Lisa, personal communication, August, 1, 2008).
Trajectories of Seven Women’s Substance Use

Six women participants reported initially exploring substances as early teenagers and one woman relates that she did not begin drinking until she was the legal age of nineteen however once she had started drinking alcohol she quickly progressed to alcoholism by her early twenties. The six participants who started drinking alcohol between the ages of twelve and thirteen progressed in varying speeds to problematic substance use. For instance Judy, Lee and Lisa all were immersed in the drug culture including gang activities, drug use and illicit drug sales before turning sixteen, Sarah was past sixteen when engaged in similar activities and Michelle, Tess and Darby were adults. It is noteworthy that although not addicted at the beginning of substance use none of the women actually attributed a therapeutic benefit to substances except in terms of fitting in with a peer group or in Tess’ situation to feel more comfortable in social situations.

Harmful health effects did occur to all seven women over time generally being identified within a decade of heavy drinking or regular drug use. At this point in time participants exhibited both physical and psychological dependence in terms of physical cravings and alterations to consciousness. Therefore the women’s substance use could be defined as addiction in terms of persistent and harmful behaviors that continued despite negative consequences for themselves or others. Given all of the women’s experiences of physical, psychological, social and spiritual abuse it would be fair to surmise that they used substances as a way of mitigating emotional or emotional pain. The women’s continued use
of substances was not only problematic to themselves in terms of significant negative health outcomes but also impacted their social networks and society in general.

Although all seven women did use substances their trajectories and stated reasons varied: Tess to feel socially adequate, Sarah from being separated from friends and community, Michelle as a result of incarceration, Darby in celebration with her father, Lee and Judy to fit with a group of high-school friends. The women when actively misusing substances not only affected themselves physically and emotionally but also the community because of illicit drug use. Harm to the community included violence to others, breaking the law by selling drugs and property crimes, sex trade work as well as other detrimental activities that were required by the women to support their addictions.

All seven participants in this study had physical consequences to heavy alcohol consumption and/or use of licit and illicit substances. As well, many of the women had underlying physical health issues that may have been unrelated to substance use. Lee’s experiences following an overdose from an unidentified substance was perhaps the most profound example of physical and cognitive effects of substance misuse. She relates:

But I, I had taken too much of something, I don’t know what it was. All I can think of with the experience I have now it had to be something cut with PCP but I started to freak out. And so I went into my little sister’s room and we slept in the basement and I woke her up and I said, “I, I’m not doing very well and I’m gonna lose myself and I have to go get help
really fast. Cause I, I’m going really fast. So what happened was pieces my sister fills in was that the doctor said that they, that, that I’d lost all of my cognitive abilities and my motor skills and blah, blah, blah and that he didn’t think I would get it back. However, would know more about six months down the road and that he, that I should, that she should put me in some kind of care. . . I, I couldn’t walk, I couldn’t talk I had no bodily functions, I couldn’t sit up, I couldn’t do anything. . . They took me home and my mom and my sister and one friend just twenty-four hours a day just kinda looking after me. Well because in my mind . . . my mind was talking to people. Saying to my sister stuff. And my mouth wouldn’t mouth it. It was saying it and I knew she couldn’t hear me. And my eyes, I just, holy cow I wanted out of there so bad. It was horrible. It was like...ya, ya I, when I think back then . . . I know I just wanted to die. (Lee, personal communication, July 9, 2007)

The remaining six participants also had very serious physical effects from drug and alcohol use: Next to Lee, Darby had the most serious diagnosed problems having substantial liver degeneration associated with hepatitis and alcohol consumption and Sarah too was very unwell but undiagnosed with marked overall physical degeneration. Sarah recounts at one point in her addiction: “I was very very skinny then I was about ninety pounds” and later following a uterine curettage not realizing she was pregnant with twins at the time relates:
So anyways by the time I got to Aurora they had to do another D & C in Women’s Hospital, the Women’s Health Centre. . . . I was still registering pregnant. I registered pregnant the whole time I was in treatment. I couldn’t move faster than a snail or I’d hemorrhage. They actually, and I was ten centimeters dilated the whole time. There was worry about infection or my physical health. (Sarah, personal communication, July 7, 2007)

Another participant, Judy had been diagnosed with Grave’s disease by her physicians following the loss of a planned pregnancy. She recounts:

Now amongst my addiction there is also the Graves disease. A thyroid condition that I’m struggling with. Right? And I still struggle with that like hormonally like. Cause they did, they radioactively removed my thyroid. I don’t have one now so I take thyroid medications. . . . And it’s so significant in our lives! If our thyroid levels are not normal we become completely lacking and psycho and mentally unstable. . . . It’s a medical condition. . . . So I just remember when we were sitting in the office and the doctor said, “you miscarried because of your Graves disease.” . . . I was going to try again and they said okay if you’re going to try and have children again you need to have that taken care of. So I did that right away but we couldn’t try for a year. (Judy, personal communication, January 4, 2008)

Lisa’s health conditions started early as a young teen and included diagnosed mental health problems such as bulimia, depression and self harm including cutting herself which were ameliorated through her use of illicit
substances; all of the preceding factors resulted in undiagnosed physical health challenges as well. Later, when street involved, Lisa would go many days without sleep and because of this experienced further mental and physical health challenges. She states: “We had crack like eleven days up. My first run down there was nineteen days. I stayed awake on like so much cocaine. (Lisa, personal communication, August 1, 2008).

**Participants’ Experiences of Social Harms**

Social harms that women participants experienced included anxiety regarding appropriate social behavior, self-imposed and externally imposed alienation from families and support networks and for one participant a strong dislike of other women overall. Tess speaks about her difficulty in social situations in which she was worried about where she might sit and how she could relate to others as she did not have learned skills in the area of building relationships or of sustaining them. Tess states I “didn’t have any self confidence at all. I didn’t know . . . how to behave in society. I didn’t know what family life was like. Hadn’t had any. And so I think that’s what lead [to drinking] you know it made me feel comfortable and socialize” (personal communication, November 27, 2007). Tess preferred healing groups that incorporated both men and women but felt she was able to work best with male counselors. Michelle left her family of origin prior to her sixteenth birthday and did not call her parents to say where she was for over a year (personal communication, February 8, 2008) whereas in Judy’s situation her friends and family disassociated from her. Judy relates:
I had no money and really even my friends that I did party with were tired of me. They were like, ‘Judy you’re just not even fun to party with any more. You’re just, you do it all and you just get stupid and it’s just sick to watch.’ And my family wouldn’t let me in the house any more. Like they wouldn’t even let me come over, just nobody wanted me around. Nobody wanted me around. (personal communication, August 28, 2007)

Also, while actively misusing substances Judy abhorred women and only felt competition with them. She states: “And like I said I used to hate women. I hated women, I hated them! . . . I think, I think there’s, a lot of my girlfriends always felt like I was a threat to them or I was going to steal their boyfriends or whatever” (Judy, personal communication, August 29, 2007). Conversely, Lisa found women her main support particularly in recovery. She states in terms of remaining in recovery:

Like my women friends are the most important people. Um that’s where we exchange power and the daily trials and tribulations and women are in and out of my house and my life and my work all day long every day. Right? You can’t really isolate from them and that’s where I feel the most love and support. Giving and receiving. And I mean boyfriends are gonna come and go. But the women in my life are solid. Unconditional love with no expectations of anything in return. And that’s who I’ve learned from, right? . . . I’ve learned how to have relationships first with women as friends and once those get strong that’s going to be my gateway into how to have a healthy relationship with a man. It’s a process. (Lisa, personal communication, August 1, 2008)
For Lee and Darby drinking and using illicit drugs was how they socialized both as teenagers and as young adults. Michelle on the other hand was well into her twenties when she socialized with a work crew almost daily in the bars becoming an alcoholic through these social activities. However, it was when Michelle was incarcerated on weekends in a women’s prison for a drinking while driving offense that she became socialized into a criminal lifestyle (Michelle, personal communication, February 8, 2008).

**Women Participants with Concurrent Disorders**

When viewing participants lives in terms of both their substance use histories and in relation to mental health issues it is unclear if one preceded the other or if they both occurred at the same time. It is clear however that both were present in some manner for all seven women as concurrent or dual disorders. Tess and Lisa were the participants who most shared in their interviews about having a combination of substance addiction and mental health challenges. These concurrent disorders occurred in both women throughout their teenage years and continued into adulthood. Tess suffered from social phobias and had great difficulty being in unstructured groups even if the people she was communing with were known to her. Social phobias continued throughout the years Tess used substances and later in her recovery manifested as anxiety: She comments: “I mean I get terrified when I’m going out for a supper or, where will I sit and there’ll be no where to sit and or I’ll have to sit beside. . . . I mean I know everybody has that kind of sort of thing about it but mine goes to the point of gross anxiety [and] I still do have terrible anxiety attacks at times” (Tess, personal communication, November 23, 2007).
Lisa describes cycles of teenage substance use combined with cutting or slashing herself and an eating disorder. She states: “So I got diagnosed with bulimia and depression. They put me on Prozac at that point for the cutting. And threw me in the Psych Ward for a couple of weeks” (Lisa, personal communication, August 1, 2008). As a young adult immersed in the drug culture in the Lower East Side of Vancouver Lisa relates that she and her partner travelled to Vancouver where she used crack cocaine and later:

We ended up down in a Main and Hastings hotel in total psychosis. I remember this psychosis cause it was my first actual full on psychosis. I’d been up for probably, maybe this is my first like four day stint. And he left me down there cause I kept going to turn tricks and not sharing the dope with him. So he left me down there and I found myself near Pigeon Park by myself and I freaked out. I was in this hotel room and I started throwing my body around the room. Freaking! Like freaking! Cause I was like, “where the hell am I? What am I doing?” I would look out the window, I’m at Main and Hastings, like this is insane. Just freaking out.

No money, nothing. (Lisa, personal communication, August 1, 2008)

At the time of the interviews Lisa was in self-reported recovery and had been clear of drugs for just over one year. She continued with feelings of wanting to cut herself and addressed her eating disorder with medications, counselling and attended a twelve step group called Over-eaters Anonymous which she found similar to other twelve step groups she had attended and which supported her very well in her recovery from substances. Lisa recounts:
It's a binge eat at night. It's an escape the same as my drug use. It's at night, the end of the day. And that's when I need to turn to my higher power. So it's applying the same principles to substance use. I can apply the same principles to food now. (personal communication, August 1, 2008)

The concurrent disorders for the remaining five participants, at least as interpreted from the narratives, included eating disorders (over or under-eating), workaholism, post-traumatic stress disorder as well as flashbacks or reliving the experiences of being 'high' and dissociated from present reality. For example, Lee states: "And I understand cravings and I understand liking it and wanting it and, and how good it makes you feel. And we do drugs not because they're bad we do them because they're so darn good. And I know that craving and I've been, I can close my eyes and go back to a lot of my highs" (personal communication, August 31, 2007). All of the women experienced childhood abuse so one might surmise that concurrent disorders resulted from causative factors or perhaps a primary mental disorder such as PTSD as a result of the abuse. However, it is equally possible that there was family history of mental illness and/or addiction which is impossible to ascertain.

**Women Participants as Parents**

Four of the seven women participants Lee, Judy, Lisa and Sarah, had children and three participants did not. As well, Lee had a term pregnancy in which the infant had died at birth and Sarah who had not known she was pregnant aborted twins following a surgical procedure while Tess had two spontaneous abortions. It is noteworthy that the profound grief that the women
experienced following the loss of a child regardless of length of gestation lingered many years following the event. This came out during the interviews with Lee being absolutely resolute to be healthy for a subsequent pregnancy. Sarah was unable to resolve her grief even after having a healthy child until she was able to have a ceremony to find closure while in residential treatment. Tess, who suffered greatly from feelings of rejection, believed that her two spontaneous abortions were just another form of rejection. She states: “I lost two babies when I was in the second trimester. One was twenty-three weeks and one at twenty-two weeks. And um, sometimes I interpret that as rejection too” (Tess, personal communication, November 23, 2007).

The mothering role for each of the four women with children differed depending upon where they were in their recovery journey. Both Lee and Judy were not misusing substances during their pregnancies with Lee in a stable partnered relationship and Judy living as a single mother in a conflicted relationship with the child’s father. Lisa and Sarah were actively misusing substances for the majority of time throughout their pregnancies and also while their children were infants and toddlers. Both women spoke of being grateful that their children were not born with abnormalities nor did their newborns exhibit symptoms of drug withdrawal. However, it is interesting that for these women’s deliveries they did not inform physicians nor the health care providers that they had been misusing substances during pregnancy therefore it is plausible that the system would not have labeled their infants high risk.

Judy remained in recovery throughout her pregnancy and continued in recovery following the birth of her child while both Lisa and Sarah attained
recovery when their children were preschool age. What is notable about all three women is that it was their intense desire to stay with their children that most potentiated continuation of recovery from substances. Judy who as a single parent lived on a fixed income experienced considerable concern that her infants father, who had regular employment and higher income, would attempt to take her child from her. She struggled with issues related to visitation of both the baby’s father and paternal extended family. Judy states: “I started bawling cause I get scared they’re going to take [my baby] from me. And then I had like all my friends from, like all my friends that I’d sobered up with and stuff and they’re saying, “Judy nobody’s taking that baby from you” (personal communication, January 4, 2008).

Sarah tried a range of treatment modalities to achieve recovery from substances including home detoxification, spiritual programs, counselling and residential treatment all without success. It was not until she and her infant child were endangered because of her drug use that she was able to successfully complete a residential treatment program. Sarah had strong support from her parents who, at this time, gave her a heart wrenching ultimatum: “Either I needed to stop using immediately and get help or put my [child] up for adoption. . . . And my mom said, ‘and if you leave this house and use today I’ll start preparing your funeral, what would you like written on your head stone’” (Sarah, personal communication, July 5, 2007). Lisa who was also a single parent worried about losing her children to social services when she was reported to them for continuing to use substances. She was under the mandate of what she describes as “supervision orders” which included weekly counselling
and random urine testing. In order to keep her children Lisa devised methods to circumvent the system checks. She states:

The last time I relapsed, the last time I used, the next day they phoned me for a urine screen. And I had to get my girlfriend to give me her pee, put it in a bottle, put it inside of me, make sure it’s the right temperature . . . and put the pee in a cup. (Lisa, personal communication, August 1, 2008)

After this very close call Lisa was capable of maintaining a drug free lifestyle and able to retain custody of her children.

**Common Layers of Understanding**

Differing vantage points have increased the depth of understanding from which I am able to view varying intersections of seven women’s path-finding, discovery and transformation. Layers of experience have been unwrapped by each of the woman offering insight into their journeys and a deeper understanding of their lives. At times women have had unique life experiences that diverge from those that are common to others but also have many common layers of understanding that become visible as women’s narratives are examined. By discerning differences and commonalities within the women’s experiences a broader and deeper analysis has been possible. For example, all but one of the seven participants had a common experience of significant poverty and a marginal existence at the height of their addiction. Yet, following recovery from substance use women fared differently in terms of their abilities to integrate into the community. Those with a higher socioeconomic background in childhood and teen years had different experiences than women coming from lower socioeconomic groups.
Women from more privileged and affluent backgrounds were more likely to have had opportunities to excel at school and in recreational activities and to experience more positive social support networks than those from lower socioeconomic groups. They had a much different mindset than those raised in a lower socioeconomic environment because they were more knowledgeable about mainstream expectations regarding acceptable social behavior and were able to integrate back into society much more readily. An area that was common to all seven participants was in relation to their education. It is notable that all seven participant’s had achieved grade twelve or grade twelve equivalency and six of the seven women had also completed post-secondary education. Post-secondary included certificates, diplomas, one woman had completed one half of an undergraduate program and another woman had earned a graduate degree. What is significant is that all seven participants demonstrated the intellectual capacity to achieve grade twelve certifications. Education was viewed by the women as challenging at times but an important part of their lives particularly in terms of employment. For example Michelle, while living in the community, had considered committing criminal activities not to buy drugs but to acquire money to upgrade her education so that she would be more employable.

Also, common to each of the seven women, when children or teens, was a disruption of family cohesiveness that included experiences of one or more of physical, psychological, social or spiritual abuse with broken boundaries as a result causing lost innocence and delayed or stunted developmental tasks. The perpetrators of the women’s childhood abuse primarily came from immediate
family members although several of the women were abused by both immediate and extended family members during the same time intervals. Childhood abuse, outside of the family was not recalled by six of the participants. It did not occur from external perpetrators until the women were in their late teen years or when they were young adults with the exception of Michelle who experienced sexual abuse from non-family members during this time. The earliest occurrences of childhood abuse that the seven participants recalled were from as young as three years of age through to pre-teen although one woman had no recall of her childhood memories at all until she was thirteen years old.

Tess recalls being three to four years of age when she was sexually abused by her grandmother and felt hated by her: “I was sexually abused by my grandmother when I was three and four years old. . . . Ummm my grandmother had a real hatred for me” (personal communication, Nov. 23, 2007). Tess goes on to describe how she felt being sent away to boarding school because of her tenuous relationship with her grandmother and shares that while away at school she was further shunned and socially excluded. She recounts:

And, they sent me away to boarding school so I wouldn’t have to deal with grandma . . . I think, I think you know that my parents were, made a lot of mistakes but I think they were initially you know good parents. They wanted to send me away for my protection [even though] it was a terrible place to be. (Tess, personal communication, November 23, 2007)

Unlike Tess with memories as a very young child, Darby had no memories at all until she was thirteen years of age. During the time that Darby resided at the House of Ruth for residential treatment programs she participated in a memory
recall activity with beads and recounts that her “first 13 beads were black and I told everyone these are the years that I remember nothing” (Darby, Personal Communication, February 6, 2007).

Experiences of physical violence in childhood were specifically recounted by both Michelle and Lee. Michelle talks about her parents not being home much because they both worked to support the family so that her main familial authority figures were her siblings. She relates:

It was a crowded lifestyle growing up. I mean both my parents worked. Ah the majority of the time I was left home with my older brother and my older sister. And I mean siblings will be siblings and most of the time it was not a very nice childhood. Laugh. Because you know I can remember getting locked in a closet and you know for, for being reprimanded by an older brother and just stuff that, kids are very cruel to their siblings. They can be very cruel. (Michelle, personal communication, February 8, 2008)

Lee also relates experiences of sibling violence when an older brother who was supposed to look after her while their parents were away, became angry with Lee and locked her into a dirt cellar for three days and forgot about her while he was partying. Lees states that she more or less left her mind and when discovered had to be hospitalized (Lee, personal communication, July 9, 2007). As well as sibling maltreatment, Lee experienced extreme physical and psychological abuse at the hands of her mother whom had been tremendously abused herself. Lee states:

So my mom all I could say was not fully loaded. She was just very hanging on. She had seven kids and didn’t want any kids ever. Thought she had it in her to be somebody great and ended up being raped and that’s how the first,
just went from there. . . And, anyways she had lots of issues. She was not very well emotionally balanced. She used to just completely fly off the handle and have these blackout rages that were just crazy. Then you never quite knew where she was coming from you never knew what you could trust or couldn’t trust. When she was lovely she was really lovely. When she was giving she was extremely giving. Everything was to the extreme. [Lee continues later in her narrative] A jar of jam got knocked off the counter onto the floor and broke. Everybody just kinda went white. My mom come racing out cause someone had dared to make noise. And she used to have migraines really bad. And she’d come racing out. And all, all we heard as she’s coming down the hall was “line up!!!” And you had a cord to an electric fry pan that she used to double. That was what you got…and one time I ran away and I never did it again but I ran away and we had bunk beds in the bedroom. There were five girls in one bedroom. And they were really low to the ground. And I could just, I was just the scrappiest little thing and I went under it. But I went under it with my face out. . . My whole body was in there but my face, this whole side was facing out. So she just got down there and just started swinging this thing. And I couldn’t go to school for a fair while cause it was cut, actually cut my face. So. And she wouldn’t remember . . . and I didn’t really wanna talk about it and was horrified. (Lee, personal communication, July 9, 2007)

Two participants, not including Tess whose sexual abuse has previously been noted, recounted childhood experiences of sexual abuse. Both Sarah and Lisa had been sexually assaulted by their brothers; Sarah between the ages of eight and eleven years old and Lisa from the age of five years old until she
finished primary school at age twelve. Sarah states: “I was being sexually abused by both of my brothers. I was between the age of eight and eleven. They did not know that each other was doing that and I never told anybody” (personal communication, July 5, 2007). And Lisa recounts that:

My brother started molesting me. . . . So he was, it started when I was five, so he would’ve been seven. Touching and that sort of thing. And it was more than like doctor playing, I know that for sure. And that progressed to the point where he would um, at first it was um, I want to say consensual, do you know what I mean like? It started as a playing thing but then it went to like a forceful thing and a violent thing as we were both getting older. And then to the point where he would sneak into my room when I was sleeping to touch me. Right? So then I started sleeping and putting pillows . . . at my door cause I thought that would stop him from coming in. Right? So that progressed and progressed. Same thing over and over and over and over and over again. Right up until grade seven. (Lisa, personal communication, August 1, 2008).

Rather than a sibling Lee was sexually abused by an extended family member and accepted this because she felt a need for people in her life and did not experience this connection at home. She states:

When I was younger, for as much as I can remember just the thought of not having people in my life was the scariest thing in the world. Even if it was an abuser. My brother-in-law sexually abused me when I was a little girl. But I didn’t care . . . you still had to have people in your life. (Lee, personal communication, July 9, 2007)
Michelle was the only one of the seven participants who recounts being sexually abused when a child and teenager from adult men outside the family network. One of the male abusers was a family friend and the other a local provincial police officer involved with youth. Michelle shares:

I was sexually abused by a police officer when I was young [I was] twelve. Um, he was a, a mentor in the community um around young kids. Because where I'd grown up it was a troubled area. It was a troubled area of town and . . . he always, he spoke at school events and stuff like that and, and at that point in time I was a bit of a black sheep I was sticking at the fringes. And he took an interest in me and I guess I might've had a crush on him but I mean he took advantage of that. He was in his thirties. (personal communication, February 8, 2008)

Michelle said that these events regarding sexual abuse by the police officer never came out while it was happening to her but that later this abuser did eventually get charged for sexual abuse of another child and was incarcerated.

**A Composite of Seven Participants’ Internal and External Knowing**

In their late teens and early adulthood women had an altered sense of knowing themselves, which I call internal knowing, that was marred by low self-esteem, diminished self confidence, shame, anxiety, rawness and woundedness. Coping mechanisms relayed by the women that eased their altered sense of self included self harm (slashing), relationship harm including using partner relationships as a drug, substance addiction, a desire to not feel emotions and to die, escape or not exist.

As well as internal difficulties the women also relayed an altered sense of self in relationship with others which I call external knowing. They spoke of
experiencing isolation, not fitting in, feeling abandoned and hurt, having diminished social skills, limited voice and a problem with authority. Coping mechanisms that provided relationships for the women included finding groups outside of the mainstream that offered a sense of community and cohesiveness where they felt respected and included. It is notable that all but one participant recalls one or more individuals, often a woman, who did support them through difficult times. Support persons included relatives, friends or counselors as well as others who were significant in the lives of participants both within their addiction and also within recovery.

Recovery from substance use was possible for the seven women when issues were addressed that related to their altered sense of self/internal knowing and their altered sense of self in relationship to others/external knowing as previously described. Catalysts to internal recovery or reclaiming one’s sense of self included counselors who addressed childhood trauma and abuse issues, addiction treatment programs and communion with a Higher Power of their understanding. Relationship healing occurred as the women were able to connect with a recovery community such as AA and NA, friends, family and develop a healthy support network. Overall, women remained in recovery and continued to grow and heal to the degree they were able to find acceptance, respect, meaningfulness and support.

Once on the recovery pathway, women moved forward most favorably when they discovered their place within the community. Acceptance from others resulted in women valuing themselves and building positive self-esteem. Respect was developed through discovery of personal strength and resilience and meaningfulness was obtained through helping others overcome adversity; helping
others gave purpose to the women and a sense of personal success. Support by a social network provided a place to be heard and a feeling of belonging and inclusion or as Sarah states: Community is “that you have your place; that you belong” (Sarah, personal communication, Feb. 17, 2008).

Summary

The research findings that have been outlined resulted from in-depth analysis of transcript data. Initial analysis of transcripts was detailed in schematics that represented different points of three participants’ path-finding in recovery from substance use. To avoid a linear perspective of women’s journeys the analysis shifted toward the Listening Guide method so that women’s narratives might be viewed from multiple vantage points. The seven participants’ unique narratives were preceded by separate ‘I Poems’ with one poem for each of the women. Similarities and differences between the women were presented as were specific circumstances such as women who were parenting and those having concurrent disorders. Similarities were also noted related to participants’ cognitive abilities as were their histories of childhood abuse. This in-depth analysis of the women’s narratives clarified how these seven women were able to contend with the consequences of addictive lifestyles and move to healthier places.
CHAPTER 6: DISCUSSION OF FINDINGS

This chapter returns to the original question posed by this critical feminist study: How do women with a history of substance misuse negotiate barriers and find paths to recovery? It was the intent of this study to discover what contributed to this remarkable achievement for these seven women and to determine if there were common factors that others might attend to so that they too could follow this pathway. What was discovered was very complex in terms of understanding participants’ relationships with themselves, others and society at large with its formidable social structures which are discussed related to Canadian social hierarchies and class structures. The effects of dislocation, oppression of addiction and liberation of recovery are also presented in terms of social systems of care and local resources for women in recovery from problematic substance use. It is notable that all seven participants experienced social construction of complex barriers that impeded their recovery journeys. Yet, there was also simplicity in their journeys too and what took them toward recovery. Several women simply stated their recovery beginnings were not momentous and that: “I’d just had enough” or “you just have to say no.” This discussion chapter attends to both the complexities and simplicities that are woven throughout participants’ narratives because each contributed to seven women’s successful path-finding to recovery from substance use.

Women’s Path-finding: An Overview

It is interesting that when women participants were most unprotected and open to harm within their addiction journeys it was the system and its bureaucratic structures that they initially accessed. Systemic programs and
health care outreach were often the point of entry for women to begin their healing journeys as this was most often where health care providers including nurses were located. Consider Lisa pregnant and involved in the sex-trade while in Vancouver’s DTES who was referred by a street nurse to Sheway or Michelle who attended an Aboriginal healing circle while incarcerated and Sarah who successfully attended Aurora as her last hope for herself and her child. This was the situation for the other four women as well: Lee with a life-threatening overdose in the health care system, Darby whose family accompanied her to the House of Ruth and both Judy and Tess in healing centres. However, it is notable that the more women healed from past traumas and the healthier they became the less supportive the systemic structures became. As the women declared incremental steps of autonomy and independence from the bureaucratic system, mechanisms within it seemed to impede their growth. The disrespect when seeking financial support, the lack of job opportunities despite many hours of trying to find work and the disparity of the basics of food security, housing and education all became impediments to women’s recovery journeys.

Concurring with Kearney’s (1998) findings the likelihood of women participants in this study accessing initial services directly corresponded to the degree of their disconnection to their own informal social support networks. The positive result of negative circumstances for these seven women was that by accessing the systemic structures their healing journeys from substance addiction could begin. Even though bureaucratic social structures were themselves oppressive in that they had prescribed rules and protocols they still effectively provided beginning places for each of the women’s journey of
recovery and this was an unanticipated finding of this study. Another finding was that as the women learned survival tools including life-skills for coping with everyday circumstances, they were increasingly able to delve into the pain that brought them to addiction.

Sarah recounted that self-discovery was located on two sides of the same coin; without feeling the severe pain on one side of the coin she could not experience the great joy on the other side. As the women participants were able to suffer, so they were able to heal. Exploring much of what had harmed them early on in life, exposed degrees of hurt that were at times incomprehensible. Yet each of the women had the courage to persevere and expose these causative wounds for healing and in this process became able to continue healing from the additional wounds caused by their substance addictions. As Glass and Davis (2004) suggest: “experiencing vulnerability can form part of an opportunity to move forward from a crisis and/or dysfunction and/or negativity. Furthermore, vulnerability can be perceived as mobilizing and a strengthening, not an experience of weakness or failure” (p. 90, italics in original).

**Canadian Social Hierarchies and Class Structures**

Canadian society is composed of various community groupings. There are diverse communities of cultures and heritages, beliefs and values as well as social classes which are most often based upon socioeconomic factors. Hankivsky and Cormier (2009) view Canadian class structure as a product of “economic, and social conditions” (p. 59) and Morris and Bunjun (2007) note that in all economic groups but particularly in those “with less economic power and status, women have even less economic power and status” (p. 18). In polite
conversation, people’s location within this hierarchy is not readily acknowledged although it is one of the taken-for-granted aspects of Canadian society.

In this research, women generally delineated where they perceived that they and their family of origin were situated within the social hierarchy. Both Lisa and Sarah spoke of being upper middle class whereas Judy, Lee and Michelle thought of themselves as working class and Darby and Tess considered themselves poor, Darby more so than Tess. Socioeconomic factors that determined women’s labeling of their status were most often related to the nature of parental employment, income and ability to acquire resources such as housing, recreation and education. For instance Darby relates that she and her three sisters and six brothers lived in “bad poverty especially cause in my childhood life, we lived in a one bedroom, one bedroom shack! . . . Along with one bathroom” (personal communication, February 6, 2008).

Of significance to this study is that regardless of how women designated their social standing in childhood, at the peak of their addictions five of the seven participants were considered poor by Canadian standards. According to Macionis and Gerber (2005) the fifteen to twenty percent of Canadians who are poor are those on welfare or designated working poor with insufficient income for basic food, shelter and clothing. This was the case for five of the seven women participants who, while having social services assistance or minimum wage jobs, sometimes had to resort to sex-trade work, drug dealing or other criminal activities to support themselves, family members and their addiction. The addiction related health implications for being poor in Canada, particularly in British Columbia as the nation’s “most drug- and alcohol-
addicted province” (Alexander, 2008, p. 20) were considerable. Even though two of
the women in this study were not considered poor by Canadian standards, all seven
women when in active addiction experienced common health effects frequently
associated with poverty including malnourishment, depression and anxiety. As well,
experiencing the effects of poverty not only impacted the women’s health but also
influenced the degree of control and self-determination they had within a complex
system in their day to day lives.

Complex and bureaucratic Canadian systems provide services to women
with substance addiction regardless of status designation. However, the greater
citizens depend on these systems for support, the more control systems exert on all
facets of daily life. Collins (2000) states that “bureaucracies, regardless of the
policies they promote, remain dedicated to disciplining and controlling their
workforces and clientele” (p. 281). From a critical feminist perspective it was
apparent in this study that most of the participants, at some point in their addiction,
had to rely on dominant social structures such as social assistance (welfare) for
basic survival but paid a significant price with oppressive system scrutiny of their
personal lives and choices (Boyd, 2004). Boyd suggests that seeking help from the
Ministry of Social Services means women opening their lives to surveillance by
social service agencies, who then judge the fitness of the women to parent. This
causes great concern for women with substance use history who fear losing their
children if social services give an unfavorable report. Of the three women with
children in this study only Lisa was under the surveillance of a child-protection
worker and although she had concerns about losing her children, her experience
with the social worker was positive. She states:
I only happened to go to the hospital because my social worker liked me. I told her, ‘you know I screwed up that last piss test.’ Cause I have a really good relationship with my protection worker now. Even then I was telling her when I relapsed. (Lisa, personal communication, August 1, 2008)

Kasl (1992) considers complex hierarchies as objectifying systems that restrict women’s autonomy by oppressively shaming and excluding them from egalitarian participation in society. This oppression:

- Creates the emptiness and fear that lead toward addictive behavior. The desire to live gets turned into a struggle to survive the pain of our system.
- Instead of affirming life, we are taught to medicate ourselves in order to cope with it. (Kasl, 1992, p. 55)

For instance, in this study, Lisa describes how the use of cocaine effectively helped her cope with day to day living: “And that’s where I started my cycle….got into cocaine. And that was like the ticket to not feeling and not being, slashing didn’t need to happen, alcohol didn’t need to happen. I was totally like, cocaine was good” (personal communication, August 1, 2008). As well, Sarah demonstrates this need for medicating to cope when she relates her initial perceptions of recovery:

- As far as I was concerned that to start with when I was first trying to get clean is that I’m just gonna you know drink coffee and wait to die sort of thing. Like my life’s over now right? … Because I had to be high to do everything. (Sarah, personal communication, July 5, 2007)
McKnight (1995) attributes social turmoil to overpowering systems that remove caring from the community and replace it with professionalized services. Never-ending needs of actual or potential clients/consumers are uncovered to support the requirements for professional care (Illich, 2005). In actuality it is the system itself and the professionals who structure the system who have unmet needs; that is, the need for recipients of their care. As McKnight (2005, p. 74) notes:

In a modernized society where the major business is service, the political reality is that the central ‘need’ is an adequate income for professional servicers and the economic growth they portend. The masks of love and care obscure this reality so that the public cannot recognize the professionalized interests that manufacture needs in order to rationalize a service economy.

Habermas (1984) suggests that as social structures within society become increasingly complex and hierarchical there is separation or differentiation between bureaucratic systems and individuals within the community. This separation results in impaired socialization and communication within modern societies and the use of money and bureaucratic power as “delinguified media of communication” (p. 84). When modern systems, originally structured to benefit citizens, become more complex; they increasingly diminish community support and contribute to individual disengagement as well as overall loss of personal meaning and purpose (Habermas, 1984). Disengagement from oppressive bureaucratic systems was exemplified by Michelle when she went to social services for help and felt alienated and beaten down. She states:
You go into a social services office to get social assistance and they beat you down within the first two minutes of your application. And you’re not even seeing a lady or a man that’s gonna give you your social assistance you’re just dealing with the receptionist at this point and they’ve already got you beaten down to the point where you’ve gotta turn around and walk out the door. (Michelle, personal communication, June 2, 2008)

What is alarming about these experiences are that they have become the norm for disenfranchised women including their children and are not improving over time.

**The Theory of Dislocation**

Within the Canadian health care system there are specific locations where women are referred to for recovery from substance addictions for example residential treatment centres. Women participants in this study did, through various access points, locate themselves within these centres of professionalized service however this was most often as a result of what the women describe as not being wanted by anyone in their lives and being disconnected and dislocated from their community support networks. It is difficult to surmise the cause of this disconnection. Is it a result of the women’s addictive lifestyles that negatively impact society or conversely is it a symptom of people living in a very dysfunctional modern society? The latter cause of disconnection is viewed as the primary cause of citizen’s disaffection within modern society by Maté (2008) who writes from a macro perspective that dislocation is a result of societal modernization within which traditions, extended family and community groups are weakened. Modern day destruction of economic and social connections have “displaced people from homes and
shredded the value systems that secured people’s sense of belonging in the moral and spiritual universe” (Maté, 2008, pp. 261-262). Furthermore, Maté views dislocation as a consequence of fast-paced lives in which communities are destabilized and individuals struggle unsuccessfully to adapt.

Alexander (2008) suggests a more micro or individual viewpoint regarding the theory of dislocation: It occurs when integration of a person’s sense of social belonging and personal autonomy is undeveloped or lost. Social belonging interwoven with personal autonomy or “psychosocial integration . . . enables each person to satisfy simultaneously both individualistic needs and needs for community—to be free and still belong” (Alexander, 2008, p. 59). Lack of psychosocial integration may occur for a variety of reasons over the life span and is expressed as a sense of disempowerment, social exclusion and isolation (Maté, 2008, p. 261). All seven women participants in this research experienced two significant points of dislocation: the first was in childhood in relation to broken boundaries associated with abuse, shame and loss of personal agency. The second point of dislocation was in adulthood when women were actively misusing substances as a remedy or adaptation to deep-seated painful memories and experiences of social exclusion.

**Two Points of Social Dislocation**

The first point of social dislocation that could be identified in participant’s narratives occurred in childhood. Although all seven women had suffered one or more kinds of abuse which were significant factors in impaired psychosocial integration and dislocation (Alexander, 2008) for several women there were additional factors. For example Sarah talks about a geographical
dislocation that negatively impacted her. Poole and Dell (2005) indicate that the act of changing schools or communities is implicated as a risk factor for substance use in girls and young women. In addition to the stress related to moving from her home town to a larger urban centre, Sarah also felt insignificant because the effects on her were not even considered in the decision to relocate. She states:

So you’re moving away from all of your friends and all of the people you’ve gone to school with for eleven years including kindergarten. Leaving the neighborhood, leaving everything that was familiar to me . . . I became very rebellious at my parents for moving me out of my comfort zone and felt that I wasn’t important. That money came before me a lot of things came before me. Of course I was young of course I didn’t understand that money was an important aspect to survival for the entire family but to me it felt like I wasn’t a part of the decision and my feelings weren’t acknowledged. (Sarah, personal communication, July 5, 2007)

For Judy (personal communication, August 28, 2007) a destabilizing and dislocating factor was the separation and divorce of her parents: She states: “I was, and I still am, like I was heart broken. Devastated! Our family was torn apart.” As well, was the subsequent rejection and stigma that Judy suffered at the Catholic school she attended because it was stigmatizing to have divorced parents in this context. Judy relates: “But I went to Catholic School too and there was a huge stigma right? Because I was the divorced [child of divorced parents] and a lot of the parents didn’t want their kids hanging out with me.”
The second significant point of dislocation was in adulthood when participants were actively engaged in substance use. A good deal of the dislocation resulted from the stigma of having addiction particularly if this was combined with child-bearing (Boyd & Marcellus, 2007; Phillips, Thomas, Cox, Ricciardelli, Ogle, Love et al., 2007; Poole, 2003) as well as from societal labeling of women as weak. The traditional overarching belief regarding women is that they are fragile beings who are inherently weak and emotionally labile (Morrow, 2007). With this construction of womanhood it is easy to label them unwell and dysfunctional; requiring substances so that they can cope with life.

Varcoe, Hankivsky and Morrow (2007) ask the question, “who are ‘women’?” (p. 9). At first glance this question would seem almost simplistic; yet, upon reflection one perceives conflicted messages regarding the meaning of ‘woman.’ Modern society, through dichotomous definitions of who women are, creates confusion. As Varcoe and Hartrick Doane (2007) suggest in their discussion of mothering women, “discourses about what constitutes a healthy, mature adult stress the importance of autonomy, differentiation, and separation of the individual from others” (pp. 303-304) yet our Western culture promotes a vision of women being absorbed by others, selfless and self-sacrificing. In actuality, women are defined within socially constructed worlds and communities in which the intersections of “race, class, geography, ability, gender identity, and sexuality” contribute to who they are (Varcoe, Hankivsky & Morrow, 2007, p. 12) and who they might become.
Sarah constructed a vision of herself as unattractive following the birth of her child because of her partner’s disparaging comments yet stayed aligned with him because of her sense of insecurity. “He made lots of sorta really, really rude comments about the baby and about me cause I didn’t look good then. That sort of thing he was very very critical, very chauvinistic. What I saw in him I don’t really know but it was security at the time I felt” (Sarah, personal communication, July 5, 2007). Within this study, all of the participants while actively misusing substances were situated and bound within locations of systemic oppression.

**The Oppression of Addiction**

It is possible to reframe our understanding of addiction by exploring the endemic pathology of the modern system itself and by uncovering the oppressive discourses we have regarding the ‘disease’ of addiction. As Chehade (2011) writes:

> We are a species at odds with itself in a world gone mad, and we can all feel it. And we are duped into believing—through social pressures that create social pathologies—that this is the natural order of things, and that we cannot as socially disenfranchised “citizens” change our external environment. So, we turn to medications to cope. . . . But what we need to realize is that we are not sick; society is (and in turn it has diagnosed individuals as sick). Thus to “feel better” we need to fix society and all its ills.

Alexander (2001) suggests that: “The single underlying cause or precursor of addiction is a person who can find no better way of coping with a
state of sustained, severe dislocation than to adopt an addictive lifestyle” (p. 23). This is borne out in the narratives of participants who used substances as a way to numb the painful feelings of social dislocation and its sequelae. The women were able to cope more effectively with the disabling consequences of childhood trauma by the addictive use of substances. As well, with the confidence substances imparted, women were able to cope better with the boundaries that had been ruptured with childhood abuse and were more capable of developing a semblance of social support and comfort in social settings.

**Broken Boundaries**

Personal boundaries are physical and psychosocial markers that separate an individual’s space or personhood from that of another. Boundaries may be tangible as in one’s physical body or intangible in terms of emotions; all are developed from social interactions starting at birth and onward within the “family of origin….and…society of origin” (Whitfield, 2010, p. 224). However, Maté (2004) proposes that boundary development may not occur at all; if parents have not learned about boundaries in their own childhoods this maladjustment may become intergenerational. “*We can only do what we know*” (p. 276, italics in original). If boundary integrity is successfully constructed a person is able to see themselves as a separate entity from other individuals or as Maté (2008) suggests understand themselves as unique beings in a social world. Boundaries are protective in that they monitor what is permitted in one’s personal space. If these are not developed in a healthy manner, Whitfield (2010) notes, then instead of developing internal coping mechanisms or healthy resources a person may try to alleviate distress through externals such as “people, places, things...anything to lessen the pain” (p.
225). An additional breach of boundaries occurred for both Michelle and Judy when as young teenagers they were expected to completely manage households; Michelle for a larger family and Judy for her father. “In addictive and dysfunctional families, the partners are inappropriately bonded, which most often refers to a child taking on a role with another adult that is most appropriately reserved for one of the adults” (Pletcher & Bartolameolli, 2008, p. 14).

**Abuse of Women and Girls**

The abuse of women and girls is commonly recounted by women when seeking treatment for substance addictions. As Poole (2007b) discusses, related to research findings from the Aurora Centre in Vancouver, BC, “At the time of entering treatment, 63 per cent [sic] of women indicated that, as adults, they had experienced physical violence, and 41 per cent [sic] indicated that they had experienced sexual violence. As children, almost half . . . had experienced physical violence and 46 per cent [sic] had experienced childhood sexual abuse.

What consistently stands out, throughout participants’ narratives, is the invisibility of the abuse that all of them suffered as girls or youth while living within their families of origin and later as adults within their communities. Abuse spanned physical, psychological, sexual and spiritual dimensions. Throughout the analysis of women’s stories it was apparent that singular or multiple kinds of abuse inflicted upon them as girls, despite diverse socioeconomic contexts, synergistically broke protective boundaries and produced personal social dislocation. Michelle speaks about the distrust of authority figures in the community because of sexual abuse she suffered as a pre-teen.
I was sexually abused [when I was 12 years old]. . . . [the abuser] took an interest in me and I guess I might’ve had a crush on him but I mean he took advantage of that. He was in his thirties. So it stands to reason that I have a problem with authority! Laugh. (Michelle, personal communication, June 2, 2011)

As adults, woman abuse continued and increased in prevalence to those who were most vulnerable for example those having the least resources to minimally meet their basic needs. The women’s use of substances was correlated to the degree of abuse they suffered. Poole and Dell (2005) tie the illicit use of substances by women and children to their experiences of violence and victimization. “Violence in the lives of women and children is widespread. Substance use problems, mental health symptoms and physical health problems can all be related to victimization (p. 9). Darby relates her experiences of abuse in which she thought she might die:

So he starts hitting me around and I got up and I hit him back. Like with my little fists. Ya, so as I was trying to escape, you know like he, grabbed a pan. A real big tub about this big, hit me in the back of the head. Ya so ya know like we had it out. Like I literally, literally was fightin for my life and I hadda get outta there. (Darby, personal communication, February 6, 2008)

Wanting to escape from tumultuous circumstances is common among women who have substance use history. Women turn to substances as a way to ease their pain from the past and the present and their fear of the future (Maté, 2008, p. 259). Lisa who was raised in a home with abuse and domestic violence stated that an
eating disorder was a way to hide her feelings. From childhood she had wondered if she could kill herself and “yearned to escape” from her feelings and surroundings (Lisa, personal communication, August 1, 2008). As the Addiction Research Foundation (1996) suggests: “Some women may use alcohol and other drugs to numb their feelings around negative emotions, conflicts and pains over which they feel they have no control” (p. 17). An additional way that participants attempted to escape from the pain of their own lives was through enmeshment and control of the lives of others.

**Enmeshment as Codependency**

Codependency is described by Whitfield (2010, p. 109) as a boundary issue whereby one person is focused outwardly while “trying to fix, rescue, change or control” another person. Enmeshment, as a form of codependency, takes it one step further by not only being focused on another person or people but by also having an intense, persistent and pervasive emotional need to direct another’s action to achieve one’s own sense of personal meaning also called a “false self” (Whitfield, 2010, p. 148). In this situation there is a limited sense of oneself versus the other. Sarah’s partner relationships exemplify the loss of self and enmeshment that she experienced during her many years of substance use.

Another thing that kept me from recovery was the fact that when I stopped using substances I would use men to stuff my emotions. And so I would get into relationships and of course either him or I would end up loaded again. But I wasn’t willing to stay abstinent long enough to get a sense of myself and a foundation with myself by myself so I wasn’t depending on
him to keep me clean. And he wasn’t depending on me. And so really I always say and I share this quite often is that I need to abstain from all drugs in order to recover and that was including men were a drug too. Men were a way for me to get outside of myself. (Sarah, personal communication, July 5, 2007)

Pletcher and Bartolameolli (2008) define the term enmeshment as one of two extremes. Either a person is unable to distinguish their own feelings and needs from someone else or they become totally disconnected and unable to relate in any capacity. Furthermore, “enmeshment or total disconnection occurs whenever addiction is present” (p. 14).

Kasl (1992) refutes the legitimacy of codependency and believes that these traits are developed by women in order to survive within a dominant and oppressive culture. Certainly, for the participants in this study it was an act of survival and adaptation for them given their experiences of child abuse, poverty and exclusion within a hierarchal system. However, this study considers the idea of codependency and enmeshment as more than adaptation but rather views it as a demonstration of women’s marked resilience while living within a complex system. Through phenomenal resilience women participants were able to effectively numb and segregate trauma experiences and develop what Davis (2002) calls “inner resources” so that they could more ably attend to the stressors of everyday life even though these inner resources had negative consequences over time.
Social Exclusion

Social exclusion is being ‘left out’ or not fitting into the mainstream; not being able to belong nor fully participate in the community (Reid, 2004b). As Lee states: “Then I went into school and I just didn’t fit. I didn’t fit” (personal communication, July 9, 2007). In order to fit in Lee participate in gang activities which were violent, dysfunctional and unhealthy but met her need to belong. Michelle attributed lack of fitting in as a factor hindering recovery. When she was asked what might cause her to relapse Michelle states: “Um not being accepted by the community. Not being able, not having anybody there to help you change. And, and help you, they just want you to go away. I don’t fit in anywhere” (Michelle, personal communication, February 8, 2008). If the community excludes women, because of their backgrounds, then their ability to reach out for support is restricted and the community becomes a hindrance rather than a help to recovery. As Michelle notes: Addiction has affected all of the community and by excluding those with substance addiction the community then becomes part of the problem rather than part of the solution:

Every person in society has been affected by drug addiction. Period end of story. . . . Okay now there’s two ways to come out the other side of that. There’s become ignorant and indifferent. Or become part of the solution. . . . You help or you become part of the problem. You help or you become part of the problem because when you ignore it and become indifferent you are part of the problem. Cause then you become one of these people, “not in my backyard! I won’t have a recovery house in my back yard. I won’t have a half way house! (Michelle, personal communication, June 2, 2008)
As well as causing feelings of not fitting in social exclusion perpetuates the sense of isolation girls and women experience particularly when they are situated within locations of family abuse and violence (Erdmans & Black, 2008). When women and girls are isolated they become invisible and in solitude are unable to locate places of healing and comfort in the community even when these resources are available. Women participants in this study confirmed that along with a sense of not fitting in they also had feelings of profound shame which were accompanied, in their words, by anxiety, rawness and woundedness as well as fear of abandonment and experiences of social exclusion and isolation. The reasons for these feelings and experiences were generally not understood by the women; however my interpretation of their narratives indicate that what I have called childhood boundary issues related to abuse and neglect contributed to their use of substances. By using substances women were able to more confidently attend to the effects of isolation through communicating and connecting with others more readily.

Lisa lived in the DTES for several years in her early twenties. She talks about the chaotic life style she endured there including poor physical and mental health as well as the pain and ostracism that came from all quarters. There were many factors at play in Lisa’s life which determined the state of her health and her ability to survive on a day-to-day basis. As the VANDU Women CARE Team (2009) notes: “Persistent inequities in health and social indicators evident among women who use illicit drugs in the DTES...are manifestations of the complex interplay of social, political and economic determinants that influence
health status and access to health care” (p. 3). Lisa recounts how following a violent beating from her partner when the police arrived she recanted her complaint. Often, women do not leave abusive relationships; this may be related to fear of reprisal or a sense of distrusting the system, in this case the police, to protect her. As Cash (2005) notes: “Denial of abuse is not an uncommon situation, especially if the perpetrator is in close proximity. Threats to the woman if she discloses are not uncommon” (p. 236). In Lisa’s situation she does not explain why she withdrew her complaint but does express her frustration with the police who arrested her for an outstanding warrant rather than her violent partner:

Ya about three months in I’d taken his watch off his hand and went and sold it for dope while he was sleeping. And he came and found me and brought me up to our hotel room and just whipped me for like twenty minutes. It’d gone all through my jeans and I had like blood just everywhere. And I called the cops and they came and I said, “oh, he didn’t do anything.” So as they were leaving they said, “oh, can we check your name?” And I was like, “sure.” So they checked my name and of course there’s a fucking warrant out for me. And they took me to jail! (Lisa, personal communication, August 1, 2008)

The pain that Lisa suffered while living in the DTES was as Maté (2008) notes potentiated by the contempt and social ostracism of society toward those who are viewed as unacceptable: sex trade workers, drug addicts, alcoholics, the poor and most disenfranchised individuals in Canada. Maté writes of this pain:
The pain here in the Downtown Eastside reaches out with hands begging for drug money. It stares from eyes cold and hard or downcast with submission and shame. It speaks in cajoling tones or screams aggressively. Behind every look, every word, each violent act or disenchanted gesture is a history of anguish and degradation, a self-writ tale with new chapters added each day and scarcely a happy ending. (p. 17)

In addition to the pain she experienced, Lisa also talks favorably about the DTES when she remembers the street nurse who assisted her and referred her to Sheway, a centre which “provides holistic services to pregnant women with substance use problems, and support to mothers and families until their children are 18 months old” (Poole, 2007a, p. 247). What is relevant to this research though is that even street level comprehensive services like Sheway demonstrated control of women’s actions, most likely with the best of intentions so that women would receive assistance, by having distinct rules for them to follow in order to access resources. Lisa spoke highly about Sheway and what was offered to her there yet it is interesting that during the interview, as she was reminiscing about going there, her demeanor changed and there was a sense of anxiety in her voice as she spoke:

You go in the door, you have to see a doctor first right? And then you have to see the doctor before you can access the food bank there, the clothing exchange or donations or your lunch. Like you have to do it....The floors, the different floors before you can eat. And usually, I mean you get tired and hungry especially when you’re pregnant and you
know you should be eating. Right? But I mean for free food and clothes too [you do it]. (Lisa, personal communication, August 1, 2008)

In recovery from problematic substance use Lisa and her children now live a much different life than they would in the DTES. In Kamloops Lisa has found like-minded women who actively support her. When asked what makes her feel strong and able to stay in recovery she states:

Women in recovery are the most important [people in my life]. Like my women friends are the most important people . . . we exchange power and the daily trials and tribulations . . . and that’s where I feel the most love and support. Giving and receiving. . . . women in my life are solid. [They have] unconditional love with no expectations of anything in return. And that’s who I’ve learned from, right? (Lisa, personal communication, August 1, 2008)

Between incarcerations for a range of crimes, Michelle also lived in the DTES. Although addicted like Lisa, Michelle’s lifestyle was quite different in that she always had money and resources available. She states: “But I always had a roof over my head. My bills were always paid. You know there was always food in the fridge” (Michelle, Personal Communication, February 8, 2008). Michelle acquired some of her income from the ‘work’ she did collecting debts that were owed from women in the DTES. She recounts: “Most of the people that that I had to go collecting money off, they were working girls [sex-trade workers]” (Michelle, Personal Communication, February 8, 2008).

Michelle talks about the guilt she experienced during her DTES days and the small acts of kindness she extended to others that helped alleviate some
of it: “If anything I was bringing strays home from the street to get showered and cleaned up and fed and then, then back out to wherever they wanted to go . . . that took care of some of my guilt. Definitely took care of some of my guilt” (Michelle, Personal Communication, February 8, 2008). In recovery from substance use Michelle has redirected her energies from oppressing women toward passionately supporting and advocating for them in the Kamloops community.

All over they’re cutting back for women and at the same time they’re building more women’s prisons! Laugh. So like tell me, tell me the logic behind that. They’re cutting back the women’s social programs but you’re building another prison to house them. . . . And I’m sorry, I mean ya I did my own crime, I did my own time, I caused my own problems in society and now I’m trying to fix that. But had society became part of the solution instead of scorning me and not in my backyard type of attitude then maybe I might’ve turned around a little bit quicker. (Michelle, Personal Communication, February 8, 2008)

Michelle works tirelessly at the grassroots level to assist women with histories of addiction and incarceration to stabilize in the community and develop support networks. As well, she speaks at different venues, including to those who know her from the street, about the possibilities and opportunities that are available when women are able to help one another.

Lee, one of the four women not discussed so far in terms of early recovery support did not speak about attending any recovery setting and the other three, Tess, Judy and Darby, attended non government organizations (NGOs) or
private settings. Lee following a major overdose and significant health challenges recovered at home under the care of her family. Tess attended the Victoria Life Enrichment (VLES) centre that provided support and counselling which she describes as place where she felt important “and you counted for something” (Tess, personal communication, February 20, 2008). Following a month at this centre Tess continued with private support services. Both Judy and Darby attended NGO women’s residential treatment programs and following discharge from them were actively involved with 12 step programs in the community.

**Systems of Care**

Systems of addiction services exist within Canada at national, provincial and regional levels all of which provide support for women with substance use problems. These mainstream support services provide medical detoxification, residential treatment programs and public health harm reduction at the street level. By accessing available programs and services, ideally at the most local level possible, women can begin their healing processes. The value of all of these services is their ability to stabilize women at their point of access, wherever that might be, and then to work with women to improve not only their health status but also their self awareness. It is important on this journey that service providers collaboratively share power with women to determine what uniquely meets their needs. As Hartrick Doane and Varcoe (2005) suggest “people need to play a central role in their own health promotion and consequently power and expertise need to be shared and mutual” (p. 32). Once women are stable it is important that choices be offered to them regarding paths
they might take. As women move through a continuum of health care self
awareness potentially increases and women are more likely to have opportunity
to connect or reconnect at some level with social networks. The seven women in
this study were in self reported recovery, which to them meant abstinence from
all drugs and alcohol, and had arrived at this location through various means. As
discussed Lee recovered at home under the care of her family; Tess attended an
enrichment centre, Michelle a trauma program in prison and the other four
women (Lisa, Lee, Judy and Darby) residential recovery programs.

Women’s Resources for Recovery in Kamloops, BC

With changes in funding allocations from the provincial government all
funded treatment programs have closed in Kamloops, BC. The closest
residential treatment facility is located approximately one hundred and sixty
kilometers away in Kelowna, BC, at the Cross Roads Treatment Centre. Cross
Roads offers women addiction treatment, withdrawal management and
supportive housing (Cross Roads Treatment Centre Society, 2007). Within
Kamloops, BC, the Phoenix Centre provides adult co-ed detoxification
programs as well as community youth programs, the Mental Health Association
runs short term housing for homeless women and children and Public Health
offers street nurse support and education to women often through other
agencies. Most of the remaining women’s resources in the Kamloops area are
from NGOs including the Y Women’s Emergency Shelter housing women
(children may accompany them) who are experiencing intimate partner violence
(Y Women’s Emergency Shelter, n.d.), the House of Ruth with short and longer
term housing for women with limited income and the Sage Centre for those
having private funds costing $5,600 - $7,600 for a twenty-eight day program [longer programs of up three months are available] (Sage Health Centre, n.d.). Lastly, several very successful organizations and projects have been started in the past five years by women participants in this research. These are grassroots initiatives that offer social support to women and their children who are living with addiction issues. These organizations and projects will not be named to protect the confidentiality of participants.

**The Liberation of Recovery**

The liberation found by women participants on their journeys of recovery from substance use was not a linear process of path-finding but rather a helix of motion backward and forward; up and down and sometimes frozen; no movement at all. Progress and regress walked hand-in-hand on their healing journeys. Every path found and each step taken out of addiction had the possibility of being repeated until women discovered how to negotiate the barriers and experience what would best motivate them to move to healthier places. Thus discovering and knowing themselves more intimately and knowing the depth of others too encouraged autonomy and strength that was required by women to become whole; to become healthy.

**Knowing and Knowledge**

Brookfield (2005) proposes that knowledge is constructed through people’s experiences in day to day life. Other Voices (2006) state that it is not through books that knowledge is acquired but rather from the experiential person’s heart and soul. Hooks (1994) suggests that experiences of suffering produce a particular kind of knowing and knowledge: “There is a particular
knowledge that comes from suffering. It is a way of knowing that is often expressed through the body, what it knows, what has been deeply inscribed on it through experience” (p. 91). Chinn and Kramer (2008) define knowing as perception and understanding of oneself in the world and knowledge as knowing that is expressed to or shared with others. Similarly, this thesis views internal knowing as a subjective process of knowing oneself and external knowing as an outer process of knowing self in relationship to others.

**Personhood: Internal and External Knowing**

As women grew in their knowing of self and as they experienced healing and recovery through what Cowling, Chinn and Hagedorn (2003) call the “reuniting of the inner and outer life, accepting our wholeness and owning our freedom” they were able to move forward. Reclamation of personhood through internal and external knowing was potentiated as women were able to address childhood trauma and abuse through treatment programs and connections with others particularly those who also had experiential knowledge of substance addictions. Support networks such as family, friends and twelve step groups gave women the impetus to remain in recovery by providing acceptance, respect, meaningfulness and support.

**Boundary Integrity: The Unique Self and the Distinct Other**

Boundary integrity was restored when women began to not only recognize physical, psychosocial and spiritual spaces but to respect and value these boundaries. Differentiation occurred whereby women were not enmeshed in the lives of others but were autonomous and in charge or control of their own lives. As Tess states: “I have friends that are extremely supportive of me. Extremely
supportive of me. But I don’t dump on them. I tell them where I am but I don’t
dump on them” (personal communication, November 23, 2007). By being
autonomous women explored their own personhood or uniqueness and understood
that those around them, even those within their own networks, were also unique
and therefore distinctive. As well, with the development of internal and external
knowing women were much less likely to look for external solutions such as
substances to solve their problems. Once boundary integrity was established by
participants, particularly those with children, the opportunity to raise healthier
individuals with good boundaries was potentiated. Pletcher and Bartolomeolli
(2008) suggest: “Appropriate bonds are created between family members when
the necessary boundaries are modeled and taught. Individuals are protected
against enmeshment and/or [a sense of] abandonment” (pp. 31-32).

**Belonging: The ‘I’ and the ‘We’ of Relationships**

As women were able to define themselves in terms of personal boundaries
they more clearly identified where they belonged as autonomous individuals in
relationship to others and to the community. Raphael (2007) writes about three
kinds of belonging: that which is physical, social and community. Physical
belonging is a person’s physical connection to their environment, social
belonging are linkages in the social setting involving “acceptance by intimate
others, family, friends” (p. 271) and community belonging includes how
connected and therefore ably a person can access resources and services. All
three of these sites of belonging were pertinent to the seven participants in this
study. In terms of social belonging, it is noteworthy that at different points
throughout participant’s life spans (women were between twenty-six and sixty-
two of age at the time of the study), supporters had been available. Although occasionally the supporter was a man, most often they were women and included counselors, relatives or friends. As Judy relates:

And that was when I met my mentor...But it was weird because she, and now when we talk about it she said I was one of her quote unquote “unique clients.” I wanted the help, I really opened up to her...And confided in her and said you know I don’t want to be like this. Like...because I knew that, I knew at that point I understood what alcoholic was and I had really gotten myself deep into the acid. (Judy, personal communication, August 28, 2007).

Pletcher and Bartolameolli (2008) suggest that even for those from the most dysfunctional families there are people who imbue in others the drive to heal and to recover. “These are the individuals who...offer us encouragement, acceptance, and love. For some it is a grandparent. For others, it is a teacher, aunt, or neighbor who always made us feel welcome, understood, and safe” (Pletcher & Bartolameolli, 2008, p. 20). Those who align themselves with women having substance use history offer interactions that promote betterment of life and opportunities for ongoing recovery.

Kearney (1998) determined that women with substance addiction practiced destructive self nurturing when they used substance to cope with histories of neglect or early abuse as well as issues related to social exclusion. Truthful self-nurturing was in response to increased self knowledge and potentiated a move toward self-care and healthy relationships. The initial shift from destructive to truthful self-nurturing was when women recognized that
substances were problematic. This step was taken by all seven participants in this study when they spoke about life-threatening health concerns, loss of meaningful relationships or when they were as Tess relayed “just tired” (Tess, personal communication, November 23, 2007). As awareness grew participants had deeper personal insight and became more willing to address often haunting experiences of childhood abuse. Kearney’s (1998) study indicated that there were three stages to women’s recoveries: Abstinence work, honest self appraisal and building of relationships. All seven participants accomplished these three stages of recovery work in various ways.

Women participants were all in self reported recovery at the time of interviews and had experienced a minimum of one year of recovery at some point in their lives. To the seven women recovery meant actual abstinence from drugs or alcohol. However, this research uncovered the idea that abstinence from drugs or alcohol or the downstream part of recovery was simply the first step taken toward recovery and healthier lives. The second was Kearney’s (1998) self appraisal in which women were able to become conscious of how they had been harmed as children and why this made them so shame-filled in the present. Once participants reached this point of understanding themselves they could then identify what they needed to do to self-nurture. This went beyond abstinence to healthy diets, stress reduction and coping strategies. As Judy recounts to be healthy:
I need to make sure I eat in the morning. I need to make sure I take care of my medication and keep myself physically healthy. [I need to be] well fed and all that so that I can take care of myself. (personal communication, January 4, 2008)

Once women had increased knowledge about themselves they were then able to establish healthy boundaries and build supportive networks and relationships. In each woman’s life, depending on the ups and downs that are common to all people, women had various mixes of voice and silence, independence and dependence. However, depending upon how aware women were of themselves within their web of connections and how much they maintained or did not maintain boundary integrity was the degree to which they found voice, independence and joy within their recovery. As Kearney (1998) suggests as women in recovery redefined their roles in society and interacted in a mutually beneficial manner they did not feel threatened nor have to protect themselves from harm.

**Women’s Path-finding: Recovery from Substance Use**

This research began with the underlying assumption that the priority issue for women in recovery from substance use was access to treatment services. At the start of this study I assumed that women’s recovery success was directly correlated to the degree health care programs were funded. I believed that if the system were equitable and provided adequate financial support, particularly to smaller centres like Kamloops, BC, women would then attend treatment services and successfully recover from their substance addictions. Over the course of this work it has become apparent that structured services including
those at the street and provincial levels were accessed by women participants as they were able to locate them. At this point, issues were primarily related to the lack of local mainstream recovery support including limited access to front line nurses and other care providers. Even if street nurses or public health nurses connected with the women delay of further health care access did occur. For example, if women were placed on wait lists to access detoxification in tertiary centres such as Phoenix Centre or the Royal Inland Hospital and later if they were required to travel out of their local communities for residential treatment they were less likely to continue on their recovery journeys.

Following access to mainstream support services, including street nurses and tertiary care centres, women in this study were initially able to heal and recover from identified addictions. As well, when participants learned how to address and cope with everyday life stressors they were not as likely to seek relief of emotional pain through substances. Once recovery from substance use was initiated participants were then more prepared to deal with trauma issues from childhood and adulthood. If addiction treatment and corresponding therapy attended to experiences of abuse women were increasingly able to confront and work through what were most often deeply entrenched emotional barriers to healing which included a sense of shame, woundedness, diminished self worth and feelings of isolation. As women were able to experience the full measure of pain from childhood they were then in adulthood able to feel the full measure of joy. As Sarah expressed: “You can’t experience extreme joy if you’re not able or willing to experience extreme pain” (Sarah, personal communication, July 5, 2007).
Study participants talked about the significant barriers that often delayed the progression of their recovery. They suggested that although system services were very helpful early on; opportunities for them to progress, grow and sustain recovery further along their journeys were not as plentiful. As women became autonomous and self-sufficient they required less service-based treatment but more concrete monetary support for day to day living expenses. The need for concrete supports for women in recovery is substantiated in the study by Postmus, Severson, Berry and Yoo (2009, p. 865) which indicates that women who have endured difficult life trajectories prioritize “tangible supports, such as food, housing, and financial support” over less tangible system services.

As well as tangible supports, participants also valued collaboration and care from peers which promoted personal growth, self-knowledge and self discovery. Women participants indicated that peer support was invaluable and provided opportunity to build positive self concepts, establish healthy boundaries and build supportive and nourishing social networks. This study suggests that following trauma work and addiction services a long term and successful recovery is enhanced if women are able to establish supportive and peer-driven social networks in the community. Several of these networks have been established in the Kamloops region, for example Family Tree and the House of Ruth, with the leadership contributions of academic and community based nurses practicing from emancipatory nursing frameworks (see Figure 3).

In terms of feminist approaches when engaging with women who have experienced oppressive relationships Davis and Taylor (2006) suggest: “facilitating women on a transformative journey by providing a safe, supportive,
caring interpersonal context and the time and ‘space’ that encourages women to tell the whole story will promote best practice when assisting women to recover, sometimes from a lifetime of violence” (p. 207). I believe nurses, particularly those with an emancipatory focus to their practice, are ideally situated to support women seeking recovery from substance use. Certainly that has been exemplified in terms of my own caring, support and interpersonal relationships which have developed over a long career that has been grounded in fundamental patterns of knowing (Chinn & Kramer, 2008; CCHNSP, 2012). By “recognizing truth as experiential and acknowledging practice as a way of both problem solving and constructing new knowledge” (Kagan, Smith, Cowling & Chinn, 2009, p. 77) it has been possible to acknowledge and facilitate the progression of women’s transformative recovery journeys.

Prior to each first interview I was open with women participants regarding my childhood history and my perception of where I had been situated within the social hierarchy. Personal sharing was done as a “strategic disclosure” (DeVault & Gross, 2007, p. 181) to establish rapport. This transparency was neither manipulative nor coercive but was done in a manner that demonstrated power-sharing and openness. By sharing I hoped to impart a sense of respect and trust so that I could establish “common ground with participants” (DeVault & Gross, 2007, p. 179). As I said to Judy: “I think sometimes it’s harder to be vulnerable and real with people that aren’t vulnerable and real themselves.” This approach was very successful and resulted in depths of disclosure from all seven women that I believe would not have been forthcoming or possible otherwise. For example, following reading
the transcript of interview number one (August 28, 2007), Judy reflected on the benefits of participating in this research and talked about the kind of researcher: participant relationships that were most helpful to her such as mutual sharing of stories which gave her comfort in sharing her own history. Judy also indicated that the very act of telling her story and then reading about it in the transcript was healing and gave her hope within her recovery. It was very fulfilling for me to know that the actual research process was beneficial to participants. Judy reflects:

I think one of the most important things to remember or do when helping someone; is to let them know and feel they are equal. There is nothing worse than feeling like you’re different because you’re an addict, or you’re uneducated etcetera. As soon as the interview started you shared a little bit about your experience, strength and hope. It made me feel comfortable and open to sharing my story. As the interview started and I began to tell my story from the very start, I felt a sense of healing begin and a sense of hope. After reading it, I realized if I can get through all that while using I will do just fine especially if I stay clean. (Judy, personal communication, January 4, 2008)

Academic contributions to emancipatory processes, as presented in this critical feminist research, demonstrated emancipatory nursing practice through its efforts to effect change that addressed inequity experienced by women in recovery from substance use within the Kamloops, BC community. The emancipatory nature of this study was founded within ethical, personal, aesthetic and empirical patterns of knowing and also emancipatory knowing
through the process of praxis in which both research participants and I were able to reflect and "see what is unfair and unjust, envision how it could be different, understand how it came to be, and then uncover alternate explanations and possibilities" (Chinn & Kramer, 2008, p. 81) [see Figure 3]. Through discovering new possibilities this research addressed the concern expressed by Chinn and Kramer that there has been limited development of nursing knowledge to address the social context and politically activist spheres of nursing practice.

This study contributed to nursing knowledge development by identifying and defining issues encountered by seven women participants on pathways of recovery from substance use. The research processes encouraged women to share their experiences of recovery and identify what sustained them on these journeys. Building on these understandings by aligning myself closely with the women and also through engaging in ongoing reflection on practice and adjustments permitted accommodation of participants more fully. As well, this process developed a deeper understanding by me regarding how emancipatory nursing actions might best attend to underserved populations. From this work the impetus to move beyond mainstream services that nurses have traditionally provided to the more emancipatory actions entailed in community development and liberatory knowledge construction was gained. Transformation of women's lives, perhaps all citizen's lives, was seen as possible through the critical feminist ideals of "consciousness-raising and community building" (Kagan, Smith, Cowling & Chinn, 2009, p. 78, bold in original).
Figure 3: Emancipatory Nursing Practice

(Chinn & Kramer, 2008)
The Implications of Emancipatory Nursing Practice

The following implications arising from this study are viewed with an emancipatory nursing focus which was inherent to all aspects of this research:

1. Implication: Mainstream Support Followed by Community Support Promotes and Sustains Women’s Recovery, Autonomy and Self-care

   It was important for women to have system support in terms of counselors, particularly to deal with dislocation caused by issues from childhood abuse. At this point of healing women construct a sense of themselves as autonomous individuals. This construction is what Brown (1988) calls “identity formation” or “separation-individuation” (p. 206). The formation of identity undertaken by women at this point in their recovery is similar to that proposed by Davis and Taylor (2006) as inner construction or “reclaiming self and forming a new identity” (p. 202) for women healing from abusive relationships. Once women had developed a sense of ‘I’ or identity it was important for them to find a non-service type of community network within which they could belong and meaningfully contribute. Molyneux (2011) suggests that “in history over and over again...when institutionalized hierarchal forces are withdrawn from a situation people spontaneously organize.” Each of the women did self organize in some manner into interdependent peer groups. However, the degree to which women were individually able to accomplish peer group support appeared inversely proportionate to the extent of system services required. For example less peer group interdependence occurred for women requiring high levels of system services and conversely more peer group interaction occurred as less system services were required.
The women in this study indicated that mainstream service provision was important to their recovery from substance addiction. However, participants also noted that they often had to travel out of their home communities for treatment and felt that in early recovery services were more readily accessed if they were provided locally including at the street level, within community organizations or in a woman’s home. These participants also said that when women with problematic substance use histories are approached by those wishing to support them it is imperative that they be engaged in a nonjudgmental and inclusive manner and given a choice of possible options. For example, a first step toward assisting a woman would be to determine what support would be most valuable and then provide choices to her. This assessment would then determine where within a continuum of care a woman might be able to take further steps toward recovery.

What this study has shown is that initially learning life skills to survive daily pressures as well as discussion with health care professionals to work through childhood trauma issues were very effective supportive measures. The context of these measures was multifaceted including residential treatment centres, counseling centres, agencies and day programs. Once basic coping skills and trauma work were initiated alongside adequate resources women became better prepared and increasingly aware of their self-determined needs. Gradually system support could be decreased as women chose effective recovery pathways and as they built supportive community networks. Diverse paths were chosen by participants and they suggested that it was important that these choices be respected by those within the mainstream system even if they were not completely understood.
2. Implication: Addressing Broad Social Issues Including Abuse, Social Exclusion and Resource Allocation Potentiates Women’s Strength and Capacities

Significant physical and psychological health issues were noted in the literature addressing women’s substance addiction. Indeed participants of this study did report the impact of formidable health issues as sequelae to their substance use. Participants experienced physical effects including blood borne disease for example Hepatitis C as well as cirrhosis, malnutrition and mental health disorders all of which are common in this population of women (BCMHS, 2004; Health Canada, 2005; VANDU Women CARE Team, 2009). However, what was not clearly delineated in the literature but which was also significant in the lives of participants were the broader social issues. Some of the key concerns included girl and woman abuse, social exclusion and lack of resources all of which were clearly identified in this study as factors that often precede and compound addiction-related health issues.

This study argues that women’s traumatic experiences within society in general have caused them to use substances to cope. It is apparent that participants’ coping mechanisms including substance use are reasonable measures for survival given the fundamental lack of options that girls and women experience in dysfunctional and oppressive systems. Understanding the broader societal implications for these seven participants causes one to ask how many women never achieve even one year of sobriety in their lifetimes and therefore would not have met selection criteria for this research. As well, how many women were not available for this work or similar studies because they
have already succumbed to the violent consequences of addictive lifestyles as Darby, Judy, Lisa and Lee almost did?

The implications and loss of contribution by women who have not located paths of recovery from substance addiction are profound for society and for women’s social networks. It is difficult to quantify this loss for although it deeply impacts women’s families and networks it is rarely identified and if identified even more rarely acknowledged or comprehended. This research through qualitative mechanisms has not only uncovered women’s stories of path-finding to recovery but has also acknowledged and potentiated participants’ strengths and capacities. From this new knowledge of women’s experiences health and social action plans may now be articulated to promote the health of girls and women in local communities and broader social systems.

3. Implication: Self Knowledge, Healthy Boundaries and Belonging Promote Women’s Path-finding to Recovery

This study suggests that although each woman’s path-finding to recovery from substance use is unique and individual significant commonalities also exist that might be useful to other women with substance addictions. In this research, for example, all seven women viewed recovery as abstinence from all drugs and alcohol. However, even though this common belief by the seven women participants was integral to their recovery this research uncovered the idea that abstinence from drugs or alcohol although identified as important to them was not the whole of their recovery journey. Just as important and common to each of the women was the knowledge they discovered about themselves in terms of their personhood and about others
within their social networks. In each woman’s life, depending on the ups and downs that are experienced by all people, there were various mixes of voice and silence, independence and dependence. However, depending upon how much they maintained or did not maintain boundary integrity and self awareness within their web of connections was the degree to which they found voice, independence and joy within their recovery.

Women also relayed the importance of being part of something bigger than themselves; contributing back to society and being part of a social network. At times these might be located within smaller, even peripheral groups in the community, at other times it was within the larger mainstream community. Sarah states that being “a citizen in a community means that . . . you have your place that you belong and that you show up and do your part and contribute in community no matter what kind of community it is” (Sarah, personal communication, February 17, 2008). Women chose to address the effects of disrupted and abused childhoods with all of its sequelae by developing sustainable relationships within diverse community groups or networks of support from which they could develop a sense of belonging and meaningfulness.

4. Implication: Women’s Communities of Care; Support Sustainable Recovery from Substance Use

This research suggests that locations of existing networks, even if not mainstream oriented, are the best sites for women to situate themselves so that they can find lasting recovery from problematic substance use. Success is not necessarily integration of women in recovery into the dominant mainstream
society but rather into whichever communities of care are most responsive and helpful to them as individuals. This might be a traditional Aboriginal network as it was for Darby, anonymous support groups such as AA and NA or more mainstream employment communities as was the case for Lee and Sarah. What occurs as women commune is that there are opportunities for sharing both successes and failures in a safe and unconditional space. As well, as groups develop there is potential for impacting the larger system more effectively by contributing grassroots knowledge back to the system so that structural changes regarding policies more accurately reflect the needs and priorities of women with substance use histories. As well, women working together can make a difference to future generations of girls and women by making issues of violence and abuse more visible to the larger society. In other words as women empower themselves and share their experiences their lives can meaningfully impact the lives of others in society. Two places where this potential may be seen are in the prevention of child abuse and in the development of support networks for women living with addiction.

Building on government agency services that are already in place; women’s groups and others as well are currently building communities of care or safety networks for children most at risk of child abuse and for parenting and pregnant women living with addiction. For example, the Boys and Girls Club of Kamloops (2011) offers a program called Power Start for children, affected by poverty, prior to the school day. Children are picked up from home in the morning and driven to school where they receive breakfast and additional hygiene activities before beginning their school day.
In partnership with a local Elementary School we are now offering a new pilot program called Power Start. This program includes transportation to school for children from their home starting at 7:30 am. Once at school children participate in the Breakfast Program, and then join Club program staff in movement, relaxation, grooming and preparation for the school day. When school begins the children go to their classrooms ready to learn with a nutritious snack for recess. The goal of this program is to alleviate any issues that pose barriers for children to reach their full potential. This is achieved by supporting children and families with transportation to school, opportunities for inclusion with peers, fun activities, and nutritional food. (BGCK, 2011)

Another local educational program that in the past has promoted child health while educating single low income mothers regarding healthy parenting was an initiative that was offered between 2004 and 2007 called Magpie Corners Neighbourhood House. Magpie Corners included staff and volunteers to partner with mothers and their preschool children in a supportive environment for a twelve week series of activities. This program was independent of government funding and women accessed it through self referral and also community agency referral. The goal of Magpie Corners was to promote women’s self-sufficiency as well as to promote healthy families by supporting mothers of young children and teaching healthy and nurturing relationships (Magpie Corners Neighbourhood House, 2004). The twelve week series included enriched childcare services while mothers learned about topics such as attachment, communication, nutrition, play, preschool language and
math skills, physical and social/emotional development with the final class on how to proceed with setting up their own groups.

Magpie Corners Neighbourhood House (2004) informed women how they could create their own baby-sitting co-op, how to set up a peer driven community group and how to access affordable community resources. From Magpie Corners two women established a peer driven initiative called ‘Family Tree’ which included programming for pregnant and parenting women who were living with addiction. While Family Tree does address women’s issues it also provides educational and enrichment programs for children many of whom live in poverty (Kamloops Family Resource Society, December, 2008).

Family Tree Family Centre is the culmination of parental and community dedication to providing peer-driven grassroots programs to high priority families in the Kamloops area. The Centre began as a simple weekly playgroup in October 2005 when two young mothers recognized the need for such a service in the downtown core. As parents requested additional services that would be helpful, the centre adapted by providing those services either through peer driven initiatives or by partnering with mainstream agencies to have them offer services on-site. (Kamloops Family Resource Centre, n.d.)

An additional upstream program called It's a Girl Thang! (Bell-Gadsby, Clark & Hunt, 2006) uses a harm reduction model that lends itself well to the support of healthy girls in the community. This all-female youth group addresses violence and abuse of girls. When it is in session weekly meetings are organized and have been offered in Kamloops, BC, and surrounding rural
communities. Bell-Gadsby, Clark, Hunt (2006) write: “The groups provide the girls with the opportunity to explore their experiences of abuse, sexual exploitation, body image and violence as well as their strengths and daily lived realities in a safe and non-threatening environment” (p. 4).

The previous grassroots initiatives are excellent examples of communities of care. They each provide early upstream support that address needs of specific populations including women and children and in the case of Family Tree downstream support as well. Each of these initiatives might be replicated in both urban and rural centres with the potential of healthier children, families and indeed whole communities.

**Recommendations of the Critical Feminist Study:**
*Women’s Path-finding; Recovery from Substance Use*

1. Based on the experience of the nurse researcher that co-creating liberatory knowledge with participants promotes women’s health; engage in further community development to expand peer-driven networks. Increase educational components of emancipatory nursing practice in BScN curriculum. Build on and disseminate findings from this current thesis to provide evidence-based information to health authorities and to professional and lay communities regarding the effectiveness of community based research and peer driven initiatives to collaborate with women in recovery from substance addiction.

2. Based on the findings that treatment services do assist women at the beginning of their journeys toward recovery this study supports and recommends that outreach services be accessible to women wherever they live for example urban versus rural settings. Also, that funding for these services be
allocated based on need not on population. This recommendation could be enacted utilizing existing funding and services; for example, in Vancouver, BC, The Aurora Centre currently provides excellent residential and outreach services that could, with a shift of funding allocation from provincial sources, be expanded into partnerships within smaller communities to augment what is presently being provided for women with substance use issues in these communities. This recommendation is drawing on what is working in larger urban centres and developing outreach portions of programs to intersect with what presently exists at the grassroots level in smaller communities.

3. Based on the findings that women sustain recovery from problematic substance use when they experience a sense of belonging and meaningfulness in communities of care it is recommended that those with resources develop and extend existing networks to neighbouring communities. In these developments diverse community groups or networks of support might be built through grassroots initiatives by including women of all ages and backgrounds who indicate interest. For example in Kamloops, BC these community groups might be enacted through support of existing formal and informal networks including the Family Tree Society, House of Ruth, White Buffalo Society, Boys and Girls Club and Elizabeth Fry Society as well as University Women’s Club, Soroptimist Club and others. However, it would be very important to partner with existing networks in neighbouring communities so that an incoming initiative would not compete with networks that have already been established.

4. Based on the finding that all participants in this study experienced abuse and often social exclusion as pre-teens and youth build on and extend existing
programs that are regularly engaged with these populations. This recommendation might be enacted through ensuring ongoing resources are available to existing groups for example Mothers for Recovery at Family Tree, Power Start and ‘It’s a Girl Thang’ at Kamloops Boys and Girls Club.

**Summary**

Complex and oppressive hierarchies establish barriers to women’s recovery from substance use. Systemic structures that are focused on their own maintenance often do so at the expense of the most disempowered individuals in our society. Canada’s program planning for addiction services at the national, provincial and regional levels is helpful to women, particularly in early recovery, through provision of services such as treatment and counselling to address the impacts of childhood trauma and domestic violence. However, once these issues have been addressed it is then important that women be encouraged to step outside of the system as much as possible and immerse themselves in informal networks of support. Nurses connecting with women at many points in the community are well positioned to engage with them to facilitate journeys of recovery from substance use by offering both upstream prevention and downstream tertiary care initiatives. In this manner, emancipatory nursing practice contributes fully to women’s lives as they further develop their sense of personhood, autonomy, and community involvement and continue on their healing journeys.
CHAPTER SEVEN: FINAL THOUGHTS AND UNDERSTANDINGS

The final chapter of this thesis reflects on what this research has offered to women participants in the Kamloops community. It also relays several challenges and rewards that have been experienced throughout this study. Suffice it to say that challenges and rewards are to be expected with research of this nature. As a nurse researcher I have learned to embrace both difficult and agreeable circumstances equally. I do believe that a rich nursing career ably prepared me for this work and that without nursing as my foundation I would not have produced a thesis such as this. I am satisfied that this work has made an authentic contribution to the nursing discipline and has positively influenced the well-being of others. As Gabor Maté (2008) shares:

In our own hearts most of us know that we experience the greatest satisfaction not when we receive or acquire something but when we make an authentic contribution to the well-being of others or to the social good, or when we create something original and beautiful or just something that represents a labour of love. (p. 391)

Rewards and Challenges

This research has taken a grassroots type of approach with women having history of problematic substance use. By working with participants within an emancipatory nursing practice and engaging with them from a critical feminist perspective it became possible for me to understand causes of their woundedness and shame and where they drew strength from as they moved forward. It also became easier for me to understand the interplay between
knowing self and knowing others and how boundary integrity between the two is so important to healthy living. As well, working so closely with participants provided a better understanding of how women’s consciousness or awareness of themselves as independent individuals contributes to the strength of their voice and relationships with others. This study has attained much in terms of learning about individual women’s experiences although not without some concerns.

One area of concern was that this study was my doctoral research and I therefore had a vested interest in its successful completion as a scholarly work. Even as I sat in interviews with the women I was aware that the merits of this research would be determined by an epistemic community. I realized that this epistemic community would ascribe value and credibility to my work and determine if it makes a significant contribution to nursing’s disciplinary knowledge. The challenge of a critical feminist project has been addressing these scholarly expectations yet facilitating and encouraging women’s sharing. The perception that I have of this work is that it has been scholarly whilst retaining its immersion in relational nursing practice. This has been possible because I have been able to juggle the competencies of a nurse researcher with those of a caring and transparent professional interested in the deep stories of others.

My immersion in the life stories of seven women has truly been enlightening; however, it has also been incredibly difficult at times. There were moments when I was exhilarated believing that this study was exceptional; that
it made a contribution to women’s healing and that it would continue to do so. The study was rewarding in that it offered me the opportunity to be deeply immersed in the research process so that I was able to closely attend to women as they shared their personal stories with me. Yet it was in these same moments of immersion that I despaired on a personal level. Sometimes I felt overwhelmed, burdened and profoundly sad because of the tragedies that women relayed to me. It was in those moments that thankfully I was able to turn to trusted family, friends, colleagues and my supervisory team for much needed support.

With supportive and trusting relationships no difficulty is insurmountable. The importance of authentic relationships was indeed apparent when seven women and I shared with one another through this research: We listened closely and cared deeply as we conversed in safe places. As well, we shed healing tears for wrenching losses. On the other side of incredible fear and pain was enrichment, love and joy and although our conversations were of a most serious nature they were also steeped in laughter. We learned about fragility, stringency and immobility and the countermeasures of strength, resilience and moving forward.
Empathy in Sheer Places

There was enough fear for a mountain,
so we scaled it in words, inch by inch.

You and I, yoked by a fragile rope,
climbing a steep conversation,
way past footholds, we were slipping, dangling
over everything vulnerable within us.
(You wore me like a pendant heavily,
while your shadow moved on my face
like a perishable wonder.)

A cloud pressed us against fossil places in the rock
until we were marked – tattooed –
with truths about each other
that no one had ever cared
to take upon themselves.

Immobile in the wind,
we were braced against the crag
with only the rope while invisibly, geometrically
through conversation being spun, a web
from me toward you, from you toward me
would risk the love that saved us.

(MacCanon Brown, 1976)
Moving Forward

Beyond the helpfulness of this study to the seven participants this research aimed for evidence-based information that would be useful for professional and lay communities in support of women’s recovery overall. I am encouraged that indeed this work has already potentiated better supports for women and girls in the Kamloops community particularly in relation to the prevention of childhood trauma and abuse. For example, the girls group by Bell-Gadsby, Clark and Hunt (2006) that was previously discussed as an upstream measure to address girls’ experiences of sexual exploitation and violence, is currently being offered at the Kamloops Boys and Girls Club for a second time. As well, a fourth year Bachelor of Science in Nursing (BScN) student that I have recently supervised in community practice at the Kamloops Boys and Girls club, helped facilitate the aforementioned girls group and also contributed substantially to a Civic Election Youth Forum involving Kamloops youth in local political issues.

Measures such as these have impacted the community in diverse domains including protection of children, political education of youth and promotion of excellence in nursing practice at the grass roots level. It is also notable that the Executive Director of the Kamloops Boys and Girls Club, Leah Dawson, and I will be collaborating in the near future to establish further community-based initiatives.
Summary

Seven women engaged with me, a nurse embracing emancipatory practice, to share their experiences of recovery from substance use. In this critical feminist study participants actively shared their stories of childhood trauma and relayed how this had subsequently made them more open to problematic substance use as adults. In the process of sharing and being heard women better understood the roots of their woundedness and were also able to applaud the strengths that they possessed to move forward in recovery. For me, it is has now become easier to understand how there is an interplay between knowing self and knowing others and the importance of boundary integrity, having voice and establishing relationships with others. This study has uncovered much about women’s experiences and it has done so in a manner that has been healing and not harmful. This research has achieved its aims to provide Kamloops, BC women with opportunities to share their life stories and experiences of recovery from substance use, explore what slowed their journeys of recovery as well as what potentiated healthier lives. Through the research processes both the participants and I have become more aware of how social structures can impede recovery and how it is possible to circumvent these impediments. Finally, beyond this research, additional questions regarding women’s recovery journeys have been formulated; as have future directions to further support women in our communities as they courageously initiate and sustain their own healing journeys of recovery.
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Appendix A

MEMORANDUM

TO: Prof. Helen Cox

FROM: Executive Officer, Deakin University Human Research Ethics Committee (DU-HREC)

DATE: 30 May 2007

SUBJECT: PROJECT: EC 68-2007 (Please quote this project number in future communication.)
PATH-FINDING BY WOMEN IN RECOVERY FROM SUBSTANCE MISUSE: A CRITICAL AND FEMINIST STUDY

This project was considered by DU-HREC on 2 April 2007.

APPROVAL HAS BEEN GIVEN FOR SHERRIE BADE, UNDER THE SUPERVISION OF EMERITUS PROF HELEN COX, FACULTY OF HEALTH, MEDICINE, NURSING AND BEHAVIOURAL SCIENCES, TO UNDERTAKE THIS PROJECT FOR A THREE YEAR PERIOD FROM 25 MAY 2007.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the approval. It is your responsibility to contact the Secretary immediately should any of the following occur:
- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time.
- Any events which might affect the continuing ethical acceptability of the project.
- The project is discontinued before the expected date of completion.
- Modifications are requested by other HREC's.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

Silvia Rametta
On behalf of DU-HREC
(03) 9251 7123
Appendix B

THOMPSON RIVERS UNIVERSITY

Research Ethics - Human Subjects Committee

Certificate of Approval

PRINCIPLE INVESTIGATOR
Sherrie Bade

DEPARTMENT
Nursing

NUMBER
2006-97/45

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT
Kamloops, BC, Canada

CO-INVESTIGATOR(S)

SPONSORING AGENCIES

TITLE
Path-finding by women in recovery from substance misuse; a critical and feminist study.

APPROVAL DATE
May 24, 2007

TERM
1 Year

AMENDED

SUBSEQUENT CERTIFICATE(S) ISSUED
n/a

TERM
n/a

AMENDED
n/a

CERTIFICATION

The protocol describing the above named project has been reviewed by the Committee and experimental procedures were found to be acceptable on ethical grounds for research involving human subjects.

Signature Redacted by Library

Robin Tapley
Chair, Research Ethics - Human Subjects Committee

This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures.
Appendix C

DEAKIN UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE
PLAIN LANGUAGE STATEMENT

Date:____________________

Dear ____________________:

My name is Sherrie Bade and I am a Registered Nurse enrolled in a Doctor of Philosophy (PhD) in Nursing program through Deakin University, Burwood, Australia. My degree is granted on completion of research that I am undertaking with the supervision of Dr. Helen Cox. I would like to invite you to participate in my research project titled, "Path-finding by Women in Recovery from Substance Misuse: a Critical Feminist Study." The overall question that I am exploring is "how do women with a history of substance misuse negotiate barriers and find a path to recovery?" The aims of this research project are to:

- Provide opportunity for women, living in Kamloops, BC having a history of substance misuse, who are currently in self-reported recovery and have a minimum of one continuous year of recovery at any point in their lifetime, to participate in individual interviews in order to share their knowledge, life experiences and stories regarding journeys of recovery.
- Explore how women with a history of substance misuse negotiate barriers to recovery so that they are able to continue on their recovery journeys.
- Provide the opportunity for women with a history of substance misuse to increase consciousness of their own experiences of social domination.
- Provide evidence-based information to health authorities and the professional and lay communities regarding what most effectively supports women in recovery from substance misuse.

Information will be gathered from individual interviews. You will be asked to attend two interviews each approximately two hours long at a mutually agreed upon time and place. During these interviews, you will be asked to discuss your life experiences in relation to your journey of recovery, self-identified barriers to recovery and how you have negotiated these barriers to continue on your recovery journey. Examples of interview questions include the following:

- Tell me about...
  - What led to your use of substances?
  - What recovery from the use of substances means to you?
  - What made you decide to stop using substances?
  - What keeps you from recovery?
  - How you manage these barriers?
  - What (people/situations/decisions) make you feel strong and able to remain in recovery?
  - What (people/situations/decisions) make you feel weak and unable to remain in recovery?
  - Situations in your life in which you feel in control?
  - Situations in your life in which you do not feel in control?
- What does community mean to you?
- When do you feel supported in community?
- When do you feel unsupported in community?
Prior to the research project there will be a meeting with me at a mutually agreed upon time and place to review all aspects of this project, you will sign consent forms and fill in a participant information sheet at that time. Participation in this project is strictly voluntary. Research interviews will be audio-taped and transcribed by me. You will not be identified in anything written in the study and complete confidentiality will be maintained at all times. All tapes and written material pertaining to the study will be kept locked and will only be accessible to me and my immediate supervisors. As well, material identifying you will be stored separately from data transcripts. Following the project all data will be transferred to Deakin University, Melbourne campus at Burwood to be securely stored for six years after which they will be disposed of. Upon your request, a brief summary of the research findings will be sent to you at a mailing address you have provided.

I do not anticipate that the level of risk or stress will be high, or that it will be any greater than that experienced in day to day living. However, although it is anticipated that discussion with participants about their experiences will not cause undue stress on them, there may be some instances where you do become distressed and in the unlikely event of this happening there will be counselling offered at no cost to you. If you should decide not to participate or to withdraw from the research project there will be no penalty to subsequent contact related to other matters outside the research including any present or future treatment you are involved with. If you decide to discontinue your participation in the research project consent may be withdrawn at any time without penalty and all material related to you will be removed. You may also wish to obtain expert ongoing help, and if this is a desired option you may call (250) 851-7450 during business hours to Mental Health Services located at 519 Columbia St., Kamloops or the After Hours Urgent Response Team at (250) 377- 0088.

If you are interested in being part of this research project please contact me by telephone at (250) 377-6036 or mail the included pre-stamped and addressed letter of interest to me (please refer to the attached statement of interest). I would be pleased to answer any questions you might have. My supervisor, Dr. Helen Cox, is also available to answer questions you might have and can be contacted as follows: Dr. Helen Cox, Professor Emeritus, Deakin University – School of Nursing, Waterfront Campus, Geelong, Australia, telephone number 011 – 613- 9244-6816.

Yours truly,

Sherrie Bade

Should you have any concerns about the conduct of this research project, please contact the Secretary, Ethics Committee, Research Services, Deakin University, 221 Burwood Highway, BURWOOD VIC 3125. Tel (03) 9251 7125 (International +61 3 9251 7125).
Appendix D

Statement of Interest

Research by: Sherrie Bade

Research Title: Path-finding by women in recovery from substance misuse: a critical feminist study.

I am interested in participating in this research project and would like to meet with Sherrie Bade to review the invitation or plain language statement, consent form and participant profile.

My name is: __________________________

The phone number to contact me at is: __________________________

Date: __________________________

If you are interested in participation in this research project choose one of two options to indicate your interest:

Option 1: Telephone Sherrie Bade at (250) 377-6036 and indicate interest to her directly. If she is not there leave a message agreeing to participate as well as your name and telephone contact number.

Option 2: Fill in this paper and mail it in the preaddressed and stamped envelope that is attached.
Appendix E

DEAKIN UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE CONSENT FORM

I hereby consent to be a subject of a human research study to be undertaken by Sherrie Bade.

I understand that the purpose of the research is to provide opportunity for women with a history of substance misuse who live in Kamloops, British Columbia to share their knowledge, life experiences and stories regarding journeys of recovery. The research aims to explore how women with a history of substance misuse negotiate barriers to recovery so that they are able to continue on their recovery journeys. As well, it is anticipated that through the interview process women with a history of substance misuse will have an increased consciousness of their own experiences of social domination. I understand that research findings will be presented in a thesis for examination for the degree of Doctor of Philosophy. In addition, findings will be published in international refereed journals, presented at national and international conferences or discussed at meetings i.e. with local health authority or addictions services. Upon my request, a brief summary of the research findings will be sent to me at a mailing address that I will provide.

I agree to participate in two interviews each approximately two hours long with Sherrie Bade at a mutually agreed upon time and place. These will be audio-taped and transcribed by her and written notes may also be done.

My name will not be used when the audiotapes are transcribed nor in any of the written material. The researcher, Sherrie Bade, will explain all parts of the research to me and will answer any questions or concerns I might have. I understand that there are no personal risks to me in taking part in this research.

I am aware that this project is under the supervision of Dr. Helen Cox at Deakin University, Melbourne, Australia, who may be reached at 011- 613 - 5227 - 8449.

I acknowledge

1. That the aims, methods, and anticipated benefits, and possible risks/hazards of the research study, have been explained to me.

2. That I voluntarily and freely give my consent to my participation in this research study.

3. I understand that aggregated results will be used for research purposes and may be reported in scientific and academic journals, conferences and to community groups.

4. Individual results will not be released to any person except at my request and on my authorisation.

5. That I am free to withdraw my consent at any time during the study, in which event my participation in the research study will immediately cease and any information obtained from me will not be used.

Signature: ________________________ Date: ________________________
Appendix F
Interview Schedule

TITLE: Women's Path-finding; Recovery from Substance Misuse: A Critical Feminist Study

Interview Questions: Interview questions are based on the research question and on the aims of the project. Opening interview questions include the following:

• Tell me about...
  o What led to your use of substances? (Further questions related to narratives)
  o What recovery from the use of substances means to you?
  o What made you decide to stop using substances?
  o What keeps you from recovery (barriers)?
  o How you manage these barriers (note specific ones identified)?
  o What (people/situations/decisions) make you feel strong and able to remain in recovery?
  o What (people/situations/decisions) make you feel weak and unable to remain in recovery?
  o Situations in your life in which you feel in control?
  o Situations in your life in which you do not feel in control?

• What does community mean to you?

• When do you feel supported in community?

• When do you feel unsupported in community?
Appendix G

**Path-finding: The Voice of Judy**

- **Home-life:** "we were raised in a completely dysfunctional alcoholic home"
- **Chaos:** "where's the drama?"
- **Physical Health:** "too busy trying to get loaded...I never went to the doctor, I didn't take my medications properly"
- **Functional:** "I work, I eat, I sleep"
- **Caretaking:** "I was important... [he] needs me"
- **Risk Taking:** "always the initiator... I get addicted to stuff so easily"
- **Escape:** when using "I felt beautiful & confident"
- **Abandoned:** "nobody wanted me around... even my friends that I did party with were tired of me"
- **Low self-esteem:** "I always felt there was something wrong with me"; "I don't belong, I don't belong"
- **Lack of self-respect:** "getting completely loaded...with guys...not respectful of myself"

**RELATIONSHIPS**

- Early into Substance Misuse; I work, I eat, I sleep

Developed by: Sherrie Bade
Appendix H

Path-finding: The Voice of Judy

12 Step Groups: “You need to be working. A step group, you need to have a home group”

Accountability: “Working on yourself and owning your part”

Alcoholics Anonymous (AA): “I belong somewhere”

Higher Power: “I just pray dear Lord... just help me through this moment”

Recovery: “Recovering for me means learning how to think & feel & deal with life”

RELATIONSHIPS

Entering Recovery; I stood up; I went

Self Awareness: “I understand my head now”

Physical Health: “I’ve gotta stay on my health”

Setting Boundaries: “I finally had enough [left an abusive relationship] I really did”; I stood up... I went

Developed by: Sherrie Bade 2010
Appendix I

Path-finding: The Voice of Judy

Knowledge: “I know what I need to do...Just having the information over the years”

Boundaries: “I don’t hang out with people who use alcohol. I hang out with people who are sober”

Social Network: I have “relationships and true, true relationships”

Further Along the Journey; I Live

RELATIONSHIPS

Women: “I used to hate women...[now] I see women...and I’m like, I want, I want to get to know you”

Community: “Just all those networks that pull together”

Higher Power: “Just come to that peace and just know that God has got my back”

Developed by: [Name]
Appendix J

Path-finding: The Voice of Lisa

Home-life: “Both my parents were active alcoholics”

Abuse: “Started when I was five”; “a forceful & violent thing”

“Eating... out of control”; “Hiding food; hoarding food”; “I overate to hide my feelings”

Image to community: “Everything looked okay”

“Yeaming to escape”: “Wondering if I could kill myself”

Family violence: “physical fighting”

Drug use: “Cocaine was good”; “got into heroin”; “I want more, I want more”

Peers: “I found pot & alcohol and that was to fit in”; “throwing up... to lose weight”

Mental Health: “Diagnosed with bulimia and depression”; “Threw me in the Psych ward”; “Prozac for the cutting”

Cycles of recovery & relapse: “I would... use and use and use and use... and then I would just break”

Drug related psychosis: “I remember this psychosis cause it was my first actual full on psychosis... throwing my body around the room. Freaking! Like freaking!”

RELATIONSHIPS

Early Into Substance Misuse; I want more

Developed by: Sherrie Bade
Appendix K

Path-finding: The Voice of Lisa

Recovery: “Recovering from the use of substances means that I’m coping with life just as it is and life events without harming myself”; “I’m clean and sober”

Amends: “I’ve had to make amends to a lot of people”

Narcotics Anonymous (NA) & Overeaters Anonymous (OEA): “I’m doing 12 steps with Overeaters Anonymous”; “I can apply the same (NA) principles to food now”

Commitment: “I’ll do whatever it takes (including) taking suggestions.”

Higher Power: “And that’s when I need to turn to my Higher Power”

Professional Support: “A Street Nurse...I’d really connected with her”; “I do get professional counselling” “I always wanted help”

Children: “I am always trying to stay clean. Since I’ve had kids”

Entering Recovery; I’m Clean and Sober

Relationships that maintain recovery: Other “women (also) in recovery”; “My women friends are the most important people”; “They’re reliable”

Setting Boundaries: My friends have “helped me set up some really good boundaries”; “Three or four sessions (with counselor) just around how to set up boundaries”

Developed by: Sherrie Bade 2010

RELATIONSHIPS
Appendix L

Path-finding: The Voice of Lisa

Being alone: “I can stay home alone now...I can sit in silence...and not be uncomfortable”

Safety: “Staying safe and staying healthy”; “I’m not scared...it’s safe”

A good life: “Getting serene and healthy and thriving”

Commitment: “I totally committed to not using no matter what”

Further Along the Journey; I Can

RELATIONSHIPS

Participation in community: “Peer driven (groups)...moms that are at different stages of either using or recovering”

Women: “The women in my life are solid. Unconditional love”; “We exchange power and the daily trials...that’s where I feel the most love and support. Giving and receiving”

Developed by: Sherrie Bade 2010
Appendix M

Path-finding: The Voice of Darby

Powerless: "powerless over alcohol...and alcohol took over my life"

No memories as a preteen: "I don't remember"

Angry: "A real miserable drunk...A lot of anger"

Decreased self esteem: "I didn't like who I was"

Partying: "I liked partying...[they] were continuously going and going and going"

Ashamed: "I was ashamed to talk about what I did"

Home-life: "Growing up in an alcoholic family"

Physical Health: "I hurt my health"

Control: "When I'm not in control of my life it gets all messed up...I'm confused, I'm lost and emotional...then I isolate myself...don't want to be bothered"

Early Into Substance Misuse; Ashamed to Talk

Developed by: Sherrie Balle 2010
Appendix N

Path-finding: The Voice of Darby

Determination: "there's no such word as can't"

Accountability: "I said enough's enough"; "I admit a lot of people I hurt"; "I hurt...my family"

Making amends: "I had a lot of amends to do"

Alcoholics Anonymous (AA): "I have done 12 steps...Everybody needs AA meetings"; "One day at a time"

Partners: "I stood up for myself in that relationship"; "I fought back"

RELATIONSHIPS

Entering Recovery; Reaching Out

Seeking help: "Recovery means...[finding] courage...strength and the will to seek help"

Recovery program: "Where I can do my recovery, take time to do it. Get to know myself... Learn, pick up some tools"

Developed by: Sherrie Bade 2010
Appendix O

Path-finding: The Voice of Darby

Social Network: "Having a good life and having good friends"; "my community, my family, my friends...my sponsor"

Community: "I did my own speech in front of my own community"; "people acknowledge my sobriety"; "I felt part of the family there"

Ability to talk: "I can talk about it (the past) now because I feel comfortable about it"

Open, honest & helpful: "I was open and honest"; "a lot of people...telling me their stories... I was a good inspiration...and I tried to help"

Further Along the Journey; an Inspiration

RELATIONSHIPS

Enjoyment: "I enjoy My life the way it is now compared to what I used to be like"; "I don't even like going to the bars anymore"

Healing: "I'm still on that healing track and I'm staying there"

Thankful: "I'm very thankful...I cherish my days one day at a time...waking up every day...sober"

Developed by: Sherrie Bade 2010.