SERVICE-ENGAGED EARLY PARENTING WOMEN WHO HAVE PROBLEMATIC SUBSTANCE USE: FACTORS THEY FIND HELPFUL AND HINDERING

by

Cheryl Lynn DuMerton

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

in

THE FACULTY OF GRADUATE AND POSTDOCTORAL STUDIES

(COUNSELLING PSYCHOLOGY)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

October, 2018

© Cheryl Lynn DuMerton, 2018
The following individuals certify that they have read, and recommend to the Faculty of Graduate and Postdoctoral Studies for acceptance, the dissertation entitled:

Service-engaged Early Parenting Women who have Problematic Substance Use: Factors they find Helpful and Hindering

submitted by Cheryl Lynn DuMerton in partial fulfilment of the requirements for the degree of Doctor of Philosophy in The Faculty of Educational Psychology and Special Education (Counselling Psychology)

Examing Committee:

Dr. Norman Amundson
Supervisor

Dr. Marla Buchanan
Supervisory Committee Member

Dr. Alanaise Goodwill
Supervisory Committee Member

Dr. Judith Lynam
University Examiner

Dr. Ishu Ishiyama
University Examiner
Abstract

Women who use and misuse drugs while parenting infants and young children are a growing population which is of concern. Caregiving mothers who use illicit drugs are especially maligned by society which often causes them to isolate and prevents them from seeking help. There is a gap in our knowledge about what women in this population say facilitates or impedes them on their journeys toward change. This research study explored the helpful and hindering factors that were described by early parenting women who struggled with substance use issues. Twenty service-engaged women participated in this qualitative project aimed to present a picture of their recent parental experiences and other psychological phenomena. The Enhanced Critical Incident Technique (ECIT) is a valid and reliable method that was chosen for its practical and flexible features. The comprehensive method used semi-structured interviews and involved probing participants for rich details in order to capture clear and complete descriptions. The results from fourteen major themes that were generated from the data stressed important subjects such as trauma, social issues and systemic concerns. The results provided implications for professionals assisting women that include psychologists, counsellors, integrated program providers and the greater treatment system. Future research could critically engage with important topics that were raised in the study such as the overrepresentation of Indigenous participants.
Lay Summary

There was a gap in our knowledge about at-risk women who are impacted by substance abuse while parenting young children. There was a need to explore parents’ experiences at a deeper level. The Enhanced Critical Incident Technique was a qualitative method that was appropriate for this study. It was important to describe what factors parents were finding helpful and hindering, and what they wished for if it was available. The results provide insights for psychologists and counsellors who work with women in this vulnerable group. They can also inform program developers. In addition, the results might assist professionals in the greater treatment system. For example, the knowledge contribution could be important for social workers who have to balance their mandates to protect children and to provide parents with the extensive resources they need to recover from addiction, and hopefully keep their clients’ families together.
Preface

This dissertation is the original and unpublished work of the author Cheryl Lynn DuMerton. Data collection and data analysis were conducted independently with the approval of the University of British Columbia Behavioural Research Ethics Board (BREB), under certificate number H16-03168.
# Table of Contents

Abstract .......................................................................................................................... iii

Lay Summary .................................................................................................................. iv

Preface ............................................................................................................................ v

Table of Contents .......................................................................................................... vi

List of Tables ................................................................................................................... ix

List of Figures ................................................................................................................ x

Acknowledgements ....................................................................................................... xi

Dedication ....................................................................................................................... xii

Chapter I: Introduction ................................................................................................. 1

  Theoretical Models ........................................................................................................ 2

  Rationale for a Qualitative Study ............................................................................... 3

  Purpose of this Study ................................................................................................. 4

Chapter II: Review of the Literature ........................................................................... 6

  Attachment, Disorganized Attachment and Caregiving .......................................... 6

  Relational-Cultural Theory (RCT) and Integrated Drug Treatment for Women ....... 51

  Attachment-based Interventions in Early Life ......................................................... 70

  Summary of the Literature Review ......................................................................... 85

Chapter III: Methodology ............................................................................................. 89

  Flanagan’s Critical Incident Technique (CIT) Method .............................................. 89

  Philosophical Principles and Theoretical Assumptions ......................................... 92

  Rationale for the ECIT in the Current Study ........................................................... 94

  Researcher’s Beliefs and Assumptions ................................................................... 97
Method for the Current Study ................................................................. 100
Ethical concerns .................................................................................. 101
Sampling criteria .................................................................................. 104
Procedures for participant recruitment ............................................... 107
Description of the sample .................................................................. 113
Procedures for data collection ............................................................. 118
Procedures for data analysis ............................................................... 124
Credibility checks ............................................................................... 126
Representation of Research Findings ................................................... 136
Reflective Stance of the Researcher ....................................................... 136
Chapter IV: Results ............................................................................. 139
Contextual Section Results ................................................................. 139
ECIT Results ....................................................................................... 142
Category 1: Integrated addiction treatment for women that includes their children 144
Category 2: Medical and mental health issues/illness, trauma, and concurrent
addiction treatment ............................................................................. 159
Category 3: Mother’s relationships with their children, and parenting support ..... 168
Category 4: Understanding addiction as a disease ................................. 172
Category 5: Provincial government involvement and assistance ................ 175
Category 6: Support from family and friends ....................................... 180
Category 7: Relationship with oneself, and personal characteristics .......... 184
Category 8: Short-term and long-term practical needs and support .......... 186
Category 9: Spirituality ........................................................................ 190
Category 10: Child care ............................................................................................................. 192

Category 11: Experiences of pregnancy and/or parenthood having used or while using substances ............................................................................................................................... 195

Category 12: Relationships with and support from partners and/or children’s fathers ........................................................................................................................................ 198

Category 13: Upbringing, life circumstances, and critical stressors .............................................. 202

Category 14: Housing and financial issues, and support ................................................................. 205

Chapter Summary ......................................................................................................................... 208

Chapter V: Discussion .................................................................................................................... 210

Discussion of Contextual Results .................................................................................................. 210

Discussion of Critical Incident Results .......................................................................................... 211

Overall Discussion of Results ....................................................................................................... 230

Considerations for Integrated Program and Treatment Providers .............................................. 237

Implications for Psychologists and Counsellors ........................................................................... 239

Broader Implications for Integrated Programs and the Treatment System................................. 242

Limitations of the Study ............................................................................................................... 246

Implications for Future Research .................................................................................................. 250

Conclusions .................................................................................................................................. 254

References .................................................................................................................................... 256

Appendices ................................................................................................................................... 286
List of Tables

Table 1: Basic Demographics ........................................................................................................ 114
Table 2: Parental Status and Household Composition.................................................................. 115
Table 3: Exhaustiveness Log ........................................................................................................... 130
Table 4: Critical Incident and Wish List Categories...................................................................... 143
Table 5: Incidents that Helped Early Parenting Women with Substance Use Problems ...... 145
Table 6: Incidents that Hindered Early Parenting Women with Substance Use Problems... 146
Table 7: The Wish List items of Early Parenting Women with Substance Use Problems ... 147
List of Figures

Figure 1: Continuum of Desired Service-engagement Diversity…………………………108
Acknowledgements

The topics of addictions and parenting are not in his research wheelhouse. So I will be forever grateful to my supervisor Norm Amundson. You raised your hand for me in that committee meeting in 2013 because you felt that my research proposal was worthy. Thanks to my committee members Marla Buchanan and Alanaise Goodwill for your knowledge, input, feedback, and encouragement. Alanaise, you told me that I would love my data and you were right.

To my transcriptionist Joanne Desrosiers. You’re awesome.

I offer my gratitude to Mark DuMerton for supporting me and cheering me on for all these years. Thanks for your love, for all the listening, and for putting up with me.

I have my extended family and friends to be thankful for. Kids, you have been so patient, understanding, and proud which has made this journey easier. To my friends, thanks for raising my spirits when I needed it and hanging in there when I was too busy.

This research project became possible because of twenty valiant and big-hearted participants.

I was inspired by your openness and honesty. I am indebted to each of you and I have hope for you and your families.

Finally, and respectfully, I acknowledge the traditional, ancestral, and unceded territory of the Musqueam people on whose lands the University of British Columbia resides.
I dedicate this work to all of the women similar to my participants who are stigmatized by society for having issues with addiction when they are pregnant and early parenting. You are not the cause of your problems with substance use. I know you love your kids as much as I love mine.
Chapter I: Introduction

Drug use and misuse during pregnancy and while parenting is a growing problem. In the United States approximately four million infants are born every year with some type of exposure to substances (Centre for Substance Abuse Treatment, 2005). As the opioid crisis has emerged in the United States the incidence of neonatal abstinence syndrome has increased from 1.20 per 1,000 hospital births in 2000 to 5.80 in 2012 (Substance Abuse and Mental Health Services Administration, 2016). In Canada, rates of substance use in women are on the rise (Ahmad, Poole, & Dell, 2007). Of Canadian childbearing women overall between the ages of 15-44 years 76.7% reported consuming alcohol during the past year, 11% used cannabis and 2.1% used illicit drugs such as hallucinogens, heroin, ecstasy, speed and cocaine (Health Canada, 2012). It is difficult to quantify the drug use of pregnant women and mothers because of limited data and because women likely under-report due to fears of disclosure. Therefore, there is a good chance the numbers are even higher.

Regarding pregnant women 10.5% of women participating in the Canadian Maternal Experiences Survey reported drinking alcohol in pregnancy and 1% admitted continuing to use street drugs after discovering their pregnancies (Public Health Agency of Canada, 2009). In the Canadian Perinatal Health Report 11% of pregnant women reported past-month alcohol consumption and 5% of pregnant women reported using other drugs (Public Health Agency of Canada, 2008). Younger women and women from low income households were more likely to use street drugs during pregnancy than other women.

Over the past few decades researchers in the field of substance use have come to understand that the way women develop substance problems and experience them is different than men. This is partly explainable by the psychology of women and that women often
identify in terms of their relationships with others and their relational obligations to others including their children (Berger & Grant-Savela, 2015). Women in this population that are pregnant and parenting while experiencing substance use problems are often isolated and stigmatized. Pepler et al. (2014) described women with chronic substance use problems as socially marginalized and experiencing difficulties in accessing support. In addition, they often have become disconnected in relationships and from their communities.

**Theoretical Models**

Key researchers in attachment theory have demonstrated that women who are struggling with substance use while pregnant and parenting, and their children are at greater risk for the development of disorganized attachment and caregiving (Solomon & George, 2011). Disorganized attachment refers to the strategies of infants or children and disorganized caregiving refers to the insensitive maternal behaviour of the parents. Both co-exist in bi-directional relationships and provide evidence for disorganized caregiving systems. In addition, the literature now clearly demonstrates the negative sequelae of disorganized attachment (Groh, Fearon, van IJzendoorn, Bakermans-Kranenburg, & Roisman, 2017). Interventions are still considered relatively new, but demonstrate that the disorganized attachment and caregiving system can be changed. There is evidence that treatment that improves a woman’s reflective functioning can help make her a more sensitive mother to her child via increased ability to understand and empathize. This is related to the likelihood that she can decrease substance use (Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2005; Berger & Grant-Sevela, 2015; Suchman et al., 2017).

Substance use treatment designed specifically for women came out of the literature of relational-cultural theory (RCT) (Jordan, 2010; Miller, 1976). Relational-cultural theorists
Posited that a definition of health for women and men should revolve around relational, not individual and separated selves. Connections with others are fundamental for growth and healing, and people should each be considered within their unique circumstances and cultures. Using RCT to develop substance use treatment for women would imply that women will heal through healthy, mutual relationships. Treatment would focus not only on the problems of addictive behaviour, but also on the quality of women’s lives, with particular focus on their relationships with others and with their children (Belt et al., 2012).

**Rationale for a Qualitative Study**

A qualitative method was used because it could get at the context of women’s problems and help me to more fully comprehend their experiences. Qualitative research is a way of understanding at the social level and gets at the core of an experience such as problematic substance use while parenting. Most of the research that is currently being done in this area is still relatively new from the last two decades and uses mostly quantitative methods. There is still much to be learned. A qualitative study could provide additive information to the existing literature by presenting a picture of how service-engaged women who are dealing with substance use problems and early parenting are experiencing their situation. They spoke for themselves in terms of what they found helpful or not helpful, and what they said they needed or wished for.

The Enhanced Critical Incident Technique (ECIT) method was used in the study. It was deemed suitable because: a) it is semi-structured and sensitively engages participants who might be nervous by letting them control what they choose to talk about; b) the structure and repetition provides flow to the interviews and helps interviewers keep participants on track with the research question without being dominant or leading; and c) the elicitation of
helpful factors and wish list items tend to be positively focused and participants might feel empowered by that. A sample of 20 participants were interviewed between 80 and 170 minutes with an average of 109 minutes. All 20 interviews were audio-recorded and transcribed. The factors that participants found helpful and hindering relating to their experiences of substance use problems and early parenting were coded and analyzed using qualitative data analysis software. A total of 14 categories were created from the data. Throughout the data collection and analysis phases an extensive series of nine credibility checks were conducted to ensure rigour.

**Purpose of This Study**

There was a need to explore at a deeper level the experiences of at-risk women in this difficult to reach and marginalized population. Judgments and assumptions are made in society about how early parenting women should be treated for their problems with substance use. However, the women themselves revealed different and surprising aspects of their experiences and needs. What is traditionally thought of in addiction treatment for parents might not be what they need most. For example, research on evidence-based interventions demonstrated that targeting sensitive parenting behaviour in the mother-infant dyad and helping mothers experience joy and reward in parenting might be more important than targeting substance use severity (Dubois-Comtois et al., 2017; Suchman & Bers, 2015).

In this study women elaborated on aspects of the programs they were involved in that worked for them or did not. They also described their concerns and hopes about what would happen after programming ended. Participants described their experiences in abstinence-based transitional housing programs and residential alcohol and drug treatment centres together with their children. That information and more was useful to achieve the purpose of
the enhanced critical incident study which was to present a description of how service-engaged women were experiencing: a) substance use problems; and b) parenting at least one child between the ages of birth and six years. The research question that informed the study was “What factors help or hinder service-engaged women dealing with substance use problems while early parenting?”

Counselling psychologists and other practitioners will hopefully benefit from the provision of these research results on what helps and hinders substance using parents. It adds to the existing knowledge and provides insights for psychologists and counsellors that want to work with people in this vulnerable group. The information can be used to create strategies that reduce stigma and judgment. This could increase the chances that women in this population will engage in services earlier.

Findings from this study will be disseminated through presentations and publications. The results will be formatted as a type of needs assessment to inform program developers who are starting new programs or improving existing ones. The results might also assist government and other professionals in the greater treatment system. The knowledge contribution could be important for those who finely balance their mandates to protect children in our society and provide parents with addiction the extensive resources they need to recover, increase their parenting capacities and remain together with their families.
Chapter II: Review of the Literature

A literature review was conducted on three areas foundational to this study. They are: (1) attachment theory (Bowlby, 1969) and how it pertains to disorganized attachment and caregiving; (2) relational-cultural theory (Miller, 1976) that serves as the backdrop to integrated treatment for women who are parenting with addictions; and (3) research on attachment-based interventions that address insecure and disorganized attachment and caregiving.

Attachment, Disorganized Attachment, and Caregiving

The first sub-section below provides an overview of attachment theory including an introduction to disorganized attachment. Next, summaries are given of three of the major longitudinal studies that provided confirmation of the importance of early attachments in foretelling later outcomes for children. Developmental outcomes of insecure and disorganized attachment in children are reported next, from a series of meta-analytic studies that were completed over 10 years. Following the outcomes sub-section is a review of the research on the etiology of disorganized attachment. There was some debate in this area as to exactly what type of parental behaviour might be the cause of disorganized attachment behaviour in infants. A sub-section follows with a review of research on epigenetics as it is helping explain the intergenerational transmission of attachment from parent to infant. Finally, the attachment theory section ends by briefly highlighting the missing fathers in attachment research with a description of some studies that included fathers.

Attachment theory. The life course literature in developmental science, as it pertains to the domain of the emotional and social development in infancy, is undergirded by attachment theory. John Bowlby (1984) was influenced by Darwin’s baby biographies in
developing an evolutionary attachment theory. Guided by the premise that in order to survive and pass along their genes to the next generation, humans go through a process of attaching to caregivers within the sensitive period of the first few years of life. Bowlby’s early work on attachment theory in London, together with Mary Ainsworth who also conducted naturalistic research in Uganda, resulted in the ABC classification of attachment which is discussed in further detail below. Ainsworth and Wittig (1969) expanded on Bowlby’s emerging theory by providing a framework for assessing an infant’s attachment and exploratory behaviour. This set the stage for almost five decades of accumulating empirical evidence for attachment theory. The purpose of this section is to review the literature on attachment theory as it pertains specifically to disorganized attachment in infancy and its relationship to maternal caregiving.

**Individual differences in attachment.** Weinfield, Sroufe, Egeland, and Carlson (2008) suggested that in general, individual differences in attachment in infancy predict attachment security later in infancy. In other words, infants come to expect what they got before. Infants develop internal working models based on past experiences. The internal working models get carried forward regarding their expectations concerning the self, and for later relationships with others. Individual differences in attachment security are also predictive of brain development at a neuronal level. They predict how an infant learns self-regulation. Disorganized attachment – Type D, predicts an absence of emotional strategies that could be used and thereby predicts poorly managed emotions. Individual differences in attachment security also predict behavioural regulation or synchrony (interactions with social partners). Finally, individual differences in attachment security predict internal
representations. According to Weinfield et al., insecurely attached infants grow up to see the world as unpredictable and insensitive.

**The stability of attachment security.** Directly related to the topic of internal representations mentioned above, Fraley (2002) highlighted a major feature of attachment theory. Adult attachment represents earlier attachment based on infants’ earliest interactions. Fraley conducted a meta-analysis of research on attachment stability from infancy to adulthood. Echoing Bowlby (1969), Fraley likened individual differences in attachment security to a personality variable reflective of the original attachment system. It provided a way of understanding personality formed out of earliest relationships and how earliest relationships affect the rest of relationships. Furthermore, Fraley contended that personalities tend to stay the same relative to forks in the road that development entails.

Others, however, hold the opposite view. Fraley (2002) highlighted the prototype and the revisionist as two differing perspectives in how they conceptualize the malleability of early representations. Each perspective leads to dramatically different predictions regarding the stability of attachment. The results of Fraley’s meta-analysis supported the prototype perspective. This indicated that early representations tend to remain stable; people create or seek out environments consistent with the interpersonal dynamics of their pasts. In this perspective, attachment security is moderately stable across the first 19 years of life.

Weinfield et al. (2008) also confirmed the stability of attachment security. They explained Bowlby’s (1969) pathway model from the developmental perspective. It indicates that individual differences in the attachment behaviour of infancy represent different ways of adaptation. While not totally determined, infants will interact in their current environments according to their established patterns. It is possible that their representations can be
transformed, but at the same time their histories are never erased. Therefore, regarding change, Weinfield et al. suggested that while it is possible to change expectations that were formed early in life, such change is always constrained by infants’ prior adaptations.

The topic of the stability of attachment security is important for two reasons. First, it is important to acknowledge that there is another body of research that endorses a revisionist perspective and raises the question of whether early representations and interaction patterns may or may not be stable. Second, most of the research reviewed for this chapter is in accordance with the prototype perspective. It informs treatment interventions with a goal to change or prevent insecure and disorganized attachment.

**Measuring attachment security.** The Strange Situation Procedure (SSP) became and remained the gold standard for categorizing infants according to the quality of attachment to caregivers (Ainsworth, Blehar, Waters, & Wall, 1978). The principle of the SSP is that interactions between caregivers and infants under stressful conditions provide the indication of infants’ attachment. It is also understood that caregivers’ interaction styles are usually representative of their earlier attachment experiences in life. In a laboratory setting, trained raters observed 12 to 20-month-old infants. Observers studied infants’ reactions to increasing stress induced by two brief separations from their caregivers, followed by two reunions. How the infants behaved when reunited with their caregivers became the particular focus of the assessor’s attention.

The three classes of attachment security postulated by Ainsworth and colleagues from the SSP were described by van Rosmalen, van IJzendoorn, and Bakermans-Kranenburg (2014). Securely attached Type B infants were upset when caregivers left and showed their distress briefly when they returned. However, after seeking proximity for a short while,
infants played independently again, indicating the balance of assurance seeking and exploration, the hallmark of secure attachment. Type A infants were classified as insecure-avoidant, displaying a lack of emotion or desire for closeness upon the return of caregivers. From prior experience, it was likely that Type A – avoidant infants’ negative emotions – were not responded to as sensitively as to positive emotions. This resulted in an embodied sense of rejection. Last, the second kind of insecure classification was Type C – insecure-ambivalent. The opposite of Type A, these infants made it clear when caregivers returned that they were upset and wanted to be close. However, they vacillated between proximity seeking and pushing caregivers away. Type C – ambivalent infants – may have already experienced ambivalence in caregivers’ unreliability and unavailability to them in the past.

*The introduction of disorganized attachment.* After 1982, Ainsworth found it difficult to classify some infants given her existing framework. Ainsworth asked her graduate students to investigate (Weinfield et al., 2008). Main and Solomon (1986) eventually announced the discovery of disorganized infant attachment, adding Type D to the classification system. Later, Main and Solomon (1990) outlined the procedures to identify infant Type D in the Strange Situation Procedure (SSP). The addition resulted in a revised ABC + D theory of attachment.

According to Main and Solomon (1986, 1990), Type D stood for a unique type of attachment named Disorganized/Disoriented. Type D was predicated on infants’ fear of their caregivers. Put in an unsolvable situation, infants were afraid of their caregivers at the same time the infants had to rely on them for safety and comfort. This often resulted in infants’ contradictory or disorganized strategies for interacting. For example, in the SSP, an infant classified as Type D may have acted in contradictory ways such as approaching its caregiver
and then turning around. The infant’s expressions or actions could have looked either directly apprehensive of the caregiver or looked indirectly afraid. Examples of indirect fearful actions of an infant were freezing, stilling or slowing its movements. Other movements of the infant appeared to be disoriented or misdirected and included anomalous postures. After almost 40 years the SSP remains the primary assessment of individual differences in the security of attachment for infants (van Rosmalen et al., 2014). It is still in use today in much the same way it was when Ainsworth created it.

**Major longitudinal attachment studies.** Inspired by Ainsworth, a rich legacy of longitudinal research over four decades has clearly demonstrated the link between early development and future outcomes. Grossman, Grossman, and Waters (2005) explained that Bowlby always intended to study typically and atypically developing infants in two pillars. Bowlby proposed that attachment theory cut across both pillars that represented evidence from individual development and from developmental psychopathology (Bowlby, 1988). As a psychoanalyst, Bowlby hoped that attachment research would lead to prevention and clinical applications. Grossman, Grossman, and Waters (2005) edited the first book *Attachment from Infancy to Adulthood* that reported the results of the major prospective studies on attachment that began in the early 1970’s. Several of the seminal prospective studies are described below.

**Bielefeld and Regensburg Longitudinal Study.** Grossman, Grossman and Kindler (2005) studied 100 low-risk, low-stressed, middle-class infants and their families in Germany over 22 years in two different projects. The Bielefeld project started in 1976 with 49 families and the Regensburg project started in 1980 with 51 families. The purpose was to examine the cross-cultural generality of Ainsworth’s findings in the United States. The pivotal issue in
their research was how the capacity to make affectional bonds develops. For Grossman, Grossman, and Kindler, five sets of findings stood out from both of the projects:

1. Attachment security in childhood and adolescence predicted attachment and partnership representation at age 22. This finding implied that an adult partner’s ability to reflect on close relationships, and to be a secure base and safe haven for the other, was learned or not learned early in life in his or her family of origin.

2. A child’s attachment to both its mother and father, separately and taken together, strongly predicted the internal working model of close relationships in young adulthood.

3. Parents’ support in sensitive and cooperative joint play with their children also predicted representation of close relationships in adulthood. In other words, parents’ respect for children’s desires to explore promoted their sense of competence. A sense of competence would influence children’s capacities to extend their relationships with other peers and other adults.

4. Unlike the other major longitudinal studies, infant attachment measured at 12 to 18 months using the Strange Situation Procedure (SSP) did not correlate with adult attachment or partner representation. Fortunately in their case, Grossman, Grossman, and Kindler used additional measures of attachment beyond infancy in order to successfully report important correlations.

5. The findings from the Bielefeld project demonstrated the complexity of developmental pathways past infancy.
It is of interest to point out more recent evidence that has been amassed in support of the first major finding described above in relation to romantic adult attachment. Zeifman and Hazan (2016) summarized research that has tested Bowlby’s theoretical claim that attachment behaviour is a vital part of human existence across the lifespan. Empirical data on relationships has indicated that pair bonds are similar to caregiver-infant bonds. Zeifman and Hazan confirmed that four decades of research now supports Bowlby’s (1979) original hypothesis that healthy pair bonds in adulthood meet the defining features of attachment: (1) proximity maintenance; (2) separation distress; (3) safe haven; and (4) secure base.

Grossman, Grossman, and Kindler (2005) described several study factors that might explain why infant attachment assessed in the SSP at 12 and 18 months did not correlate with partnership representation and adult attachment measures. First, from the second year of the study of infants’ lives going forward, researchers observed their behaviour in their natural environments. This was at the time when instruments to assess developmental transformations of infants’ attachment had not yet been developed and validated. Bowlby (1982) had cautioned researchers against relying on only one measure of attachment after the first year of infancy. It is possible that in the Bielefeld Longitudinal Study, the SSP did not adequately measure the diversity of infants’ attachment strategies in the second year of life. Recently, Solomon and George (2016) outlined the existing instruments that measure attachment security in toddlers and preschool children. Several measures created in the 1980s and 1990s are still in use today, some more than others (Cassidy & Marvin, 1992; Crittenden, 1992, 1994; Main & Cassidy, 1988). Solomon and George claimed there have been no major advances made in the assessment of attachment in young children over the past 10 years.
However, investigators continue to use and adapt older instruments that Solomon and George refer to as “good enough” for their purposes (2016, p. 387).

Second, the reason that infant attachment security and adult attachment and partner representation were not correlated in the Bielefeld study could have been due to significant intervening events in participants’ lives. Compared to the other longitudinal studies described here, there would likely have been more partnership-oriented interactions in the Bielefeld study considering it included low-risk, less stressed, two-parent families. Grossman, Grossman, and Kindler (2005) suggested that experiences with both parents early in life exert powerful influences on adult attachment and partnership representation. The researchers listed several important factors that study participants experienced: (a) participants experienced various levels of supportive and unsupportive parenting in later years of the study; (b) some participants experienced rejecting parents and parental divorce; and (c) participants experienced various degrees of play sensitivity from both their fathers and their mothers. The importance of play sensitivity is described below. In the Bielefeld study, it was not infant attachment but measures of the quality of parental-child interactions and behaviour in childhood that predicted adult attachment and partner representation.

Unique in the Bielefeld/Regensburg Longitudinal Study were two things. First, Grossman, Grossman, and Kindler (2005) stressed the important role of fathers in the development of children’s attachments. Second, they studied parental sensitivity during children’s play. Parental sensitivity was described as respecting and supporting children’s desires to explore. Grossman, Grossman, and Kindler suggested that their findings supported an important developmental premise. The evidence suggested that parents’ responses to children’s desires for exploration and children’s resulting behaviour was equally as important.
as parents’ responses to children’s desires for attachment security and children’s subsequent behaviour.

**The London Parent-Child Project.** Steele and Steele (2005) conducted longitudinal attachment research at the University College of London starting in 1988. They performed 200 Adult Attachment Interviews (AAI) on 100 expectant mothers and their partners. The pregnant participants were expecting their first-born children in traditional mother-father-child homes. The study was conducted in four phases over 17 years. The researchers were able to examine the distinctive contributions made by mothers and fathers to children’s emotional and social development. Steele and Steeles’ study provided the first prospective link between pregnant women based on the AAI and their infants’ attachments to them at age one. Their research demonstrated that even before birth, intergenerational transmission of attachment was evident in both mothers and fathers.

**The Minnesota Longitudinal Study.** Gauthier (2011) lauded the Minnesota Longitudinal Study as the most revealing of the major longitudinal studies for several reasons (Sroufe, Egeland, Carlson, & Collins, 2005). The three reasons were: (a) the population researched was young, high-risk mothers and their infants; (b) multiple observations were made over 26 years; and (c) reported evidence was strong based on the quality of instruments used and the multiplicity of informants. Sroufe et al. conducted comprehensive assessments of the attachment and caregiving behaviour within mother-child dyads for 26 years. Across the years, they measured correlations between infant attachment security at age 12 and 18 months and romantic relationship quality and parenting effectiveness in adulthood.

Sroufe et al. reported their major findings: (a) the quality of caregiving received in the earliest years was the most important factor in development; (b) attachment history interacted
with other life experiences in a cumulative way, and early experiences were never erased despite remarkable changes; (c) each case was one of developmental complexity in which dichotomies such as nature versus nurture were usually false; and (d) psychopathology was not inherent, but the result of a developmental process, as were protective factors such as resiliency. With reference to resiliency in other words, it derived from early environments of positive care and competence. That prepared children to manage well in the face of future distress. Sroufe et al.’s conclusion was strikingly different at the time from the widely accepted belief that resiliency was a unique personality trait.

**Outcomes of secure, insecure and disorganized attachment.** An international team was made up of developmental and developmental psychopathology researchers. They provided the most comprehensive set of four quantitative reviews of approximately 50 years of attachment research. They collaborated on four meta-analytic studies of the predictive significance of early childhood experiences with primary caregivers on developmental adaptation or maladaptation. The goal of each study was to discover the links between attachment and externalizing problems, internalizing symptoms, children’s social competence with peers, and children’s temperament. As they proceeded over the past decade, the researchers also compared the strength of the associations found in each study with the strength of the associations found in the others. They recently summarized the results of the four meta-analyses in light of claims made by attachment theory (Groh, Fearon, et al., 2017). The next sub-sections describe each of the meta-analyses in chronological order of when they were conducted, followed by a description of the researchers’ summary.

**Insecure and disorganized attachment and externalizing behaviour.** Fearon and colleagues highlighted, for the first time, the link between infant attachment security and
externalizing behaviour (Fearon, Bakermans-Kranenburg, van IJzendoorn, Lapsley, & Roisman, 2010). The researchers conducted a meta-analytic review of 69 independent studies that included approximately 6000 infants and children. The majority of the studies were longitudinal, with measures taken two years apart on average. Studies that assessed disorganized attachment were incorporated into the insecure group. The relationship between attachment insecurity and externalizing problems was significant. The researchers found a combined effect size of $d = 0.31$, modest but robust. Several potential moderators were investigated. Socioeconomic status did not moderate the relationship between attachment insecurity and externalizing behaviour, as expected. However, the effect sizes were larger for boys than for girls, as hypothesized, $d = 0.35$.

In 34 of the studies that included 3,778 participants, disorganized attachment had been assessed and reported. Children coded as disorganized versus other insecure types were at elevated risk for the development of externalizing problems, as predicted, $d = 0.34$. Again, male gender moderated the relationship between disorganized attachment and externalizing behaviour, $d = 0.35$. Fearon et al. discussed three interesting points, among others, in connection with the results of the meta-analytic study of attachment security and externalizing behaviour in childhood.

First, the meta-analysis did not include any father-child studies. Only one in 70 studies that initially met the criteria for inclusion analyzed father-child attachment security, so it was excluded. Possible reasons for the dearth of attachment research that includes fathers is discussed in the final section of this chapter. Second, the researchers recapped the limitations of correlational results to explain causal mechanisms of externalizing behaviour in children. Fearon et al. (2010) pondered the possibility that certain parenting characteristics
might be the cause of both attachment insecurity/disorganization and externalizing behaviour in children. The researchers suggested that intervention studies in the future could powerfully address the understanding of causation. Third, Fearon et al. considered reasons why male gender moderated the relationship between insecure/disorganized attachment and externalizing behaviour. They speculated that attachment insecurity/disorganization might be related to externalizing behaviour for both genders. However, girls’ versus boys’ expressions of aggression are different. Girls typically display more relationally versus physically aggressive behaviour. In addition, girls display more covert versus overt antisocial behaviour. Fearon and colleagues surmised that if outcome measures were more sensitive to gender differences in the expressions of aggression, the results of the meta-analytic review may have been different. Alternatively, they also wondered if, like gender and the development of psychopathology in general, attachment insecurity/disorganization might be related to girls’ internalizing versus externalizing behaviour. This was investigated in a companion study.

*Insecure and disorganized attachment and internalizing symptoms.* Fearon and colleagues’ companion study was the second of four meta-analytic reviews. It investigated the link between infant attachment and internalizing symptomatology in children (Groh, Roisman, van IJzendoorn, Bakermans-Kranenburg, & Fearon, 2012). In addition, the meta-analytic review study also compared the strength of those associations to what they had already discovered regarding externalizing symptoms. Groh et al. analyzed 42 studies that included just over 4,600 participants. The researchers discovered a small but significant relationship between internalizing behaviour in children and insecure attachment, $d = 0.15$. However, they did not discover a significant relationship between disorganized attachment and later measures of internalizing symptoms in children. Furthermore, the effects of
insecure and disorganized attachment on externalizing symptoms that were discovered by Fearon et al. (2010) were larger than the modest effects of insecure attachment on internalizing symptoms.

Groh et al. (2012) discussed why insecurity and disorganization better predicted externalizing versus internalizing symptoms in children. They provided one potential theoretical and one potential methodological explanation. The theoretical explanation regarded children’s failures to learn emotional regulation from their caregivers. Unable to manage distressful emotions, insecure and disorganized children may use impulsive emotion regulation strategies (Ainsworth et al., 1978; Main & Solomon, 1986, 1990). Impulsive strategies have been shown to lead to more heightened risk of externalizing versus internalizing behaviour in children (Eisenberg et al., 2001). The methodological explanation referred to the validity of maternal reports using the Child Behaviour Check List (CBCL) for assessing internalizing versus externalizing behaviour in children. Groh et al. (2012) suggested that parents might find it more difficult to observe and report less public internalizing symptoms of children compared to the more obvious externalizing symptoms.

Groh et al. (2012) included a small number of father-child studies in the meta-analytic review that were available and met the criteria. The researchers hypothesized that father-child attachment, similar to mother-child attachment, would be significantly related to the development of internalizing behaviour in children. However, the findings for father-child attachment were not significant, $d = 0.01$. Groh et al. cautioned readers to interpret the results in light of the small number of studies, and to keep in mind that future research with father-child attachment measures is needed.
Attachment security and children’s social competence. The third companion of four, in the series of meta-analyses on early attachment, was of 80 independent studies of 4441 participants. Researchers looked for a relationship between attachment security and children’s social competence with peers (Groh et al., 2014). The study examined the relationship between early attachment security and social competence during childhood. Peer competence was assessed as children’s social skills, the quality of children’s relationships with their peers, and children’s social status.

Researchers found that attachment during the early life course was significantly related to social competence in childhood. The combined effect size was $d = 0.39$. In addition, the relationship was not moderated by the age that children were assessed for peer competence. Avoidant attachment $d = 0.17$, resistant attachment $d = 0.29$ and disorganized attachment $d = 0.25$ were all significantly related to lower levels of social competence in childhood. The effect sizes were comparable, suggesting that there was no particular insecure type or Type D that was worse than another with regard to lower levels of social competence. The combined effect size was compared to the results of the two earlier meta-analytic studies. The relationship between attachment security and social competence $d = 0.39$ was significantly stronger than the relationship between attachment security and internalizing problems $d = 0.15$ (Groh et al., 2012). However, it was not significantly stronger than the relationship between attachment and externalizing problems $d = 0.31$ (Fearon et al., 2010).

Attachment security and children’s temperament in early life. The fourth companion of four reviews was a meta-analysis of 109 independent studies including 11,440 participants. Researchers looked for a relationship between attachment in early life and temperament measures in childhood (Groh, Narayan, et al., 2017). Negative emotional
reactivity and regulation is one factor of children’s personalities that was thought to
determine attachment security status. Therefore, as represented in the temperament literature,
some believed that reunion behaviour displayed in the Strange Situation Procedure (SSP)
 might be a better measure of an infant’s temperament than of its attachment security (Kagan,
attachment security measured at 1 to 5 years of age and lower levels of negative temperament
assessed at birth to 12 years of age, d = 0.14.

Groh, Narayan, et al. discussed that although the relationship between attachment and
temperament was significant, the effect size of d = 0.14 was well below d = 0.20, which is
considered statistically small. Furthermore, the significance was almost entirely due to
resistant attachment type versus avoidant and disorganized types. There was a modest
relationship found between resistant attachment and higher levels of negative temperament, d
= 0.30. However, the associations of avoidant, d = 0.10, and disorganized attachment, d =
0.11 and negative temperament were not significant. Overall, Groh, Narayan, et al. concluded
that temperament and attachment security are diverse and ineffectually related constructs,
with one exception. Based on the findings, the authors suggested that there may be a genetic
basis for resistant attachment that could be explained by negative temperament. However,
there could be rival explanations for the nature of the relationship as well.

Summary of meta-analytic support for the role of attachment in socioemotional
development. Their recent article summarized the evidence from the series of four meta-
analyses on early attachment (Groh, Fearon, et al., 2017):

Our meta-analyses, comprising the most comprehensive set of quantitative reviews of
the literature on the developmental significance of early attachment, provided
evidence that early attachment security is only weakly associated with infant temperament, has enduring significance for children’s socioemotional (mal)adjustment, and is more strongly involved in social competence and externalizing problems than internalizing problems. (p. 73)

Groh, Fearon, et al. (2017) contended that the findings from over 50 years of research supported the proposals made by attachment theory. However, they listed two caveats. First, even the largest of the associations found in the four meta-analytic reviews were modest in size, indicating that attachment theory is limited for updating the models of how psychopathology and mal(adjustment) develop. Second, the evidence did not support the attachment theory claim of differential significance; the differential significance claim that was not supported was the hypothesis that insecure avoidant type would predict externalizing problems more strongly, insecure ambivalent type would predict internalizing problems more strongly, and disorganized attachment would predict general psychological problems more strongly.

Groh, Fearon, et al. (2017) emphasized that the meta-analyses provided evidence that early attachment influences development over the early life course and does not diminish. Among their suggestions for future research, they called for large-scale longitudinal intervention studies. Intervention studies could investigate various potential mediating and moderating mechanisms at the same time. For example, possible mediating mechanisms between attachment in early childhood and later emotional and behavioural outcomes could be (a) internal working models, (b) social information processing, and (c) emotional reactivity and regulation. If found to be significant, mediating processes could strengthen the relationships between attachment type and outcomes. They suggested testing:
a cascade model in which associations between early attachment and competencies in subsequently developing domains of socioemotional development arise from the spreading effect of (in)security on functioning across many levels (including cognitive, emotional, and neurobiological) that may or may not depend on the ongoing quality of caregiving. (p. 75)

Groh, Fearon, et al. (2017) conveyed that large-scale longitudinal intervention studies are necessary to tease apart how attachment type affects development in some circumstances, but not in others. Ultimately, this line of research could inform the development and improvement of attachment interventions that should work more effectively than existing ones.

**Disorganized attachment.** Via the pathways model that Bowlby first formulated, pathology in relation to attachment is not inherent. Pathology can occur as a process due to a lack of support in early childhood experiences or in times of crisis. In the past 20 years epigenetic researchers have contributed new understandings in the area of the transmission of attachment which may contribute to children’s maladjustments to life. Insights from epigenetic research are described in the next sub-section. van Rosmalen et al. (2014) outlined five different and non-exclusive pathways to disorganized attachment that could be taken by children from families with social risk. The first pathway is parental accumulation of multiple risk factors associated with the development of Type D. The risk factors include low income, single mother status, young mother status, low education, ethnic minority, and substance abuse. The second pathway is the association between disorganized attachment and child maltreatment or neglect. The third passageway that children from families with social risk may develop disorganized attachment is from the trauma of being exposed to violence.
The final two pathways to developing disorganized attachment are via behavioural mechanisms of parents, according to van Rosmalen et al., (2014). The concept of “fright without solution” generated studies regarding what type of parental behaviour predicted infant disorganization. On one hand, van Rosmalen et al. argued that the literature is clear that the *expressed fright of caregivers* toward infants can lead to disorganized attachment. On the other hand, the literature is less clear about what particular form of parent-infant communication *frightens the infant* which may also lead to disorganized attachment (Solomon & George, 2008). The question of which type of parent-infant communication frightens the infant at risk of developing Type D formed the centre of an active debate. Both sides of the debate are described below.

**Etiology of Type D: Frightened and frightening maternal behaviour.** One side of the debate mentioned above regarding the etiology of disorganized attachment is based on the Berkeley longitudinal research of Mary Main and colleagues (Main & Hesse, 1990). They hypothesized that mothers with unresolved states of mind on the Adult Attachment Interview (AAI) behaved in frightened and frightening ways toward their infants. Main and Goldwyn (1995) developed the coding system based on the AAI. They labelled adult states of mind Type D for dismissing, Type E for preoccupied, and Type F for autonomous or secure. Hesse (1996) added a “cannot classify (CC)” category that signified adults’ unresolved or disorganized states of minds. The CC category also indicated adults’ dissociative behaviour that was usually related to previous trauma and loss.

The addition of the CC classification allowed the ABC + D categories of infant attachment to line up neatly with the DEF + CC categories of adult attachment. Parents classified as the unresolved or CC type often displayed frightened or frightening behaviour.
This provoked conflict within infants as parents were both the “source of and solution to its alarm” (Main & Hesse, 1990, p. 163). According to Main and Hesse, there existed a paradox of fearing the figures you must also approach for comfort, in times of stress. That could bring about risk factors in the family that influenced the development of disorganized attachment.

Main and Hesse (1992, 1998) created detailed descriptions of frightened and frightening parental behaviour. They labeled them FR behaviour and included a coding system for assessing them. FR parental behaviour included: (a) threatening postures, expressions and movements; (b) frightening behaviour such as inexplicably backing away from the infant; (c) dissociative indicators such as speaking in a haunted tone or freezing as if in a trance; (d) timid or deferential behaviour that appeared as though the parent was being submissive to the infant; (e) spousal or romantic behaviour toward the infant that was excessively intimate or sexualized; and (f) disorganized behaviour similar to the disorganized/disoriented behaviour displayed in infant strategies for attachment. Hesse and Main (2000, 2006) hoped that further research on frightened and frightening parental behaviour would illuminate the behavioural processes that increased the risk factors in families for the development of Type D.

_Etiology of Type D: Disrupted and contradictory forms of affective communication._

On the other side of the deliberation regarding the origin of disorganized attachment was Lyons-Ruth and colleagues. Their prospective longitudinal research was named the Family Pathways Project (https://www.challiance.org/academic/family-pathways-project). The project based at Harvard University represents several phases over almost 30 years. Researchers were and are investigating the long-term developmental outcomes of infants and children born in adverse environments into families at social risk. The group studies the links
between disorganized attachment and the development of psychopathology from infancy through young adulthood.

In the first phase, Lyons-Ruth and colleagues reported that maternal depression and disorganized infant attachment predicted child aggression by school age. See the lab website for the entire list of research publications (https://www.challiance.org/academic/family-studies-lab). In the second phase of the Family Pathways Project researchers concentrated on the nature versus nurture consideration concerning the origins of disorganized attachment. Researchers demonstrated that disorganized attachment was associated with parental caretaking factors and was not associated with child temperament. By the next phase of research, the Family Pathway’s dataset ranged from the first year of life to age 20. Researchers associated the troubled dyadic interactions of the first two years of children’s lives with long-term implications for their mental health, measured in young adulthood. The probability was raised that the first two years of life represent an early sensitive period for infants to develop the ability to regulate emotions efficiently.

Disorganized attachment and caregiver trauma. In an early phase of the Family Pathways Project, Lyons-Ruth and Block (1996) reported the interrelations of maternal childhood experiences of trauma, adult trauma symptoms, adult caregiving behaviour and infant attachment. The investigators measured maternal behaviour and child affect when the infants were 18 months old, followed by infant attachment classifications shortly thereafter. Seven and eight years later, the mothers were assessed using the Adult Attachment Interview, a trauma questionnaire, and post-traumatic/dissociative symptoms inventories. The major finding was that infants of mothers who had been exposed to trauma had disorganized
attachment strategies compared to infants of mothers who had benign or neglectful childhood experiences and exhibited insecure-avoidant attachment strategies.

For the first time, Lyons-Ruth and Block (1996) proposed an expansion of Main and Hesse’s (1990) concept of maternal frightened and frightening behaviour. According to Lyons-Ruth and Block (1996), mothers might display frightened behaviour, but might not. Some mothers display an adaptation to fear. They exhibit a profound disruption of responsiveness to infants that may either be unresponsive withdrawal or unresponsive hostile-intrusiveness. What infants experience as frightening, therefore, is the lack of appropriate protection in the system. Despite the limitations of correlational data, the contribution to the literature was important. It clarified a nuanced pathway to infant disorganized attachment.

Lyons-Ruth, Bronfman, and Parsons (1999) hypothesized that it is not only caregivers’ frightening behaviour that leads to disorganization, it is parents’ disrupted and contradictory forms of affective communication around infants’ need for comfort. These parents exhibited extremely insensitive behaviour toward their infants. The researchers developed and refined the Atypical Maternal Behaviour Instrument for Assessment and Classification (AMBIANCE) tool to measure disrupted behaviour of caregivers (Bronfman, Madigan, & Lyons-Ruth, 2009-2014; Bronfman, Parsons, & Lyons-Ruth, 1992-2008).

The AMBIANCE included the six sub-scales of frightened/frightening (FR) behaviour from Main and Hesse’s (1992) first version. In addition, the AMBIANCE (Bronfman et al., 1992-2008) included five indices of disrupted parental affective communication with infants: (a) negative-intrusive behaviour that represented a hostile attitude toward infants such as mocking or teasing; (b) role confusion behaviour such as
parents requesting affection from infants when infants were distressed; (c) disorientation behavior that was odd from an emotional standpoint, such as when parents used a different pitch or intonation to their voices; (d) affective communicative errors which were failures to appropriately respond to and comfort infants; and (e) withdrawal behaviour that communicated parent’s hesitancy to interact with infants. Disrupted parental behaviour may be representative of a hostile state of mind, or alternately, a helpless and withdrawing state of mind. Therefore, children from at-risk families could also develop fright without solution from parents’ disrupted forms of affective communication. Bronfman et al. (1992-2008) confirmed this was another conceivable pathway to Type D.

**Research on parental disrupted behaviour.** Holmes and Lyons-Ruth (2006) introduced the addition of a profoundly-distrustful style to an existing dimensional self-report assessment of adult attachment types. They stressed the need for more efficient prenatal measures of maternal attachment and adapted an existing dimensional measure, the Relationship Questionnaire (RQ) (Bartholomew & Horowitz, 1991). Holmes and Lyons-Ruth (2006) added a potential dimension to the RQ that, if endorsed to a high degree, might correlate with the atypical maternal behaviour that the AMBIANCE measured, and predict disorganized attachment. The revised Relationship Questionnaire – Clinical Version (RQ-CV) included the profoundly-distrustful dimension represented by one additional item, and the statement, “I think it’s a mistake to trust other people. Everyone’s looking out for themselves, so the sooner you learn not to expect anything from anybody else the better” (p. 310).

Twenty years into the Family Pathways Project, Holmes and Lyons-Ruth (2006) used the RQ-CV to assess 44 mothers who were still available and were 48-years-old (63% of the
original sample). The AMBIANCE was used to measure maternal disrupted affective communication. The results indicated that the extreme attitude of the profoundly distrustful adult attachment style was related to three separate measures of the quality of maternal interactions with the infant, assessed twenty years earlier. The authors noted limitations, chief among them the methodological weakness related to longitudinal research in general. The attrition of the original sample was 37% of the participants. Nevertheless, they contended that although further research using the RQ-CV was required, it was important to discover that a more extreme relational characteristic predicted troubled interactions with infants.

A correlational study used the AMBIANCE with the same longitudinal sample from the Family Pathways Project (Yoon, Kelso, Lock, & Lyons-Ruth, 2014). They studied the relationships between mother-infant joint attention and sharing, disorganized attachment, and maternal disrupted communication. Sharing attention was described as the communicative looks that infants give or the sounds that they make to orientate toward their caregivers. Visually or vocally referencing the caregiver usually starts between the ages of 9 to 12 months. The caregiver-infant interactions predict the development of theory of mind, language learning, and social learning. Dysfunction in parent-infant interactions could affect bids for joint attention and therefore also affect important child developments.

Yoon et al. found that mothers who were disrupted according to AMBIANCE scores initiated fewer bids for joint attention with their infants. An additional finding of note was that infants with disorganized attachment, unlike their caregivers, were just as likely at 18 months of age to respond to maternal bids for joint attention as their lower risk complements. Yoon et al. surmised that the tendency to share attention with others is already vigorous in
infancy but might depend on the caregiver’s initiation. They recommended interventions that help at-risk parents to initiate joint attention episodes with their children through play.

**Emerging frontiers in the study of disorganized attachment.** Lyons-Ruth and Jacobvitz (2016) reviewed current research on the associations between disorganized attachment in infancy and mental health outcomes from infancy through adulthood. One frontier of research regards the neurobiological and genetic correlates of disorganized attachment. Another frontier of research has branched off of the prospective studies that continue to examine data from longitudinal investigations. Lyons-Ruth and Jacobvitz contended that the evidence is clear that infant disorganization predicts some long-term outcomes of maladaptation. However, prospective studies are now examining whether parental frightened and frightening behaviour or disrupted forms of parent-child communication, in their own right, predict adult psychopathology. The results could indicate that severely troubled parent-child communication by itself in the first two years of life could start negative developmental trajectories. This line of research has potentially important implications regarding societal costs and the need for preventative and early attachment-based interventions. Lyons-Ruth and Jacobvitz highlighted the fact that experimental interventions that target dyadic interactions have caused reductions in disorganized behaviour. Nevertheless, little is known about the mechanisms of change. Researchers want to know what it was about changed parent-child interactions that was working.

**Potential mechanism of change between intervention and attachment outcome.**

Tereno et al. (2017) stated that several randomized controlled trials (RCTs) have now demonstrated that attachment-based interventions reduce disorganized behaviour. Furthermore, some studies have examined potential mechanisms of change such as increased
maternal sensitivity. Tereno and colleagues conducted a randomized controlled intervention trial in France. The intervention was an intense, large-scale home-visiting program for at-risk women during pregnancy and throughout the first year of life. Unique in the features of the intervention were that it was conducted entirely by psychologists and it included a focus on the mental health of children in families. France established a mother-child support and prevention network after WWII at the same time they started to provide free nation-wide mental health services for families. Video feedback was provided in participants’ homes to compare examples of less than ideal parenting behaviour with subsequent sensitive interactions.

The researchers assessed whether reduced disrupted maternal communication, as measured by the Atypical Maternal Behaviour Instrument for Assessment and Classification (AMBIANCE), was a mechanism of change between the treatment and disorganized attachment behaviour. The results showed that the home-visiting intervention resulted in significant reductions to both infant disorganization and disrupted maternal communication compared to the control group. Regarding the mechanism of change, reductions in disrupted maternal communication partially mediated the relationship between the intervention and reductions in infant disorganization.

Tereno et al. stressed that the results indicated that high-risk individual children and their families benefitted from early prevention and intervention. In addition, the researchers suggested that societies as a whole will also benefit from early investment in disadvantaged families. Tereno et al. (2017) quoted Nobel Memorial prize winner in economics, James Heckman. “The best investment is in quality early childhood development from birth to five for disadvantaged children and their families” (Heckman, 2012, p. 1). Tereno et al. cited
evidence of cost-savings from early prevention and intervention in at-risk families. The savings are due to reductions in emergency room visits, special education, child protection services, and other social services (Reynolds, Rolnick, Englund, & Temple, 2010).

Brief measure of disrupted parental communication. The evidence continues to point to non-optimal parenting in the earliest years of infancy as detrimental to long-term development. It is critically important for not only researchers but also clinicians to continue to recognize and assess the distinct parental behaviours that signify disrupted caregiving. For this reason, a team of researchers are working at developing a brief screening measure for disrupted maternal communication (Haltigan et al., 2017). The AMBIANCE, which was described earlier, is used internationally to measure disrupted maternal behaviour (Bronfman et al., 2009-2014). However, using the AMBIANCE in applied settings could be cost and time prohibitive. Clinicians face extensive requirements for qualification to observe and evaluate from video recordings approximately 150 discrete AMBIANCE behaviours along 15 dimensions. Haltigan et al. (2017) used item response models to derive the 45 most salient behavioural indicators of disrupted caregiving. With promising psychometric properties of the 45 items, the way has been cleared for the development of a brief measure.

Haltigan et al. (2017) stated that efficient assessment is crucial given recent research that conceptualizes early adversity as aspects of childhood deprivation (or emotional abuse and neglect) and threat (physical communications) (Teicher, Samson, Anderson, & Ohashi, 2016). Haltigan et al. (2017) suggested that parental withdrawal and parental intrusiveness, two of the 15 latent dimensions of the AMBIANCE, “may be thought of as downward extensions of concepts of deprivation and threat to infancy and early childhood” (p. 15). A
brief measure of disrupted parental communication could become part of the way that research on developmental psychopathology translates to practice over the next years.

*Long-term effects of early maltreatment and neglect on brain development.*

Researchers from the Harvard Medical School that use the AMBIANCE in their investigations summarized the current state of knowledge about the effects of childhood maltreatment on brain structure and function (Teicher et al., 2016). As mentioned above, they conceptualized deprivation as emotional abuse, and physically and emotionally neglecting caregiving contexts. These forms of childhood deprivation, along with childhood physical and sexual abuse, are linked to altered trajectories of brain development and adult psychopathology.

Some key points by Teicher et al. were: (a) the type and timing of exposure to childhood maltreatment results in specific changes. These changes affect areas of the brain that are related to disadvantages in health and psychological development; (b) early maltreatment reduces the volume in structures of the brain such as the hippocampus and various cortices and increases the volume of the left amygdala. Maltreatment affects the development of major fiber tracks in the brain such as the corpus callosum, among others. Early maltreatment affects the functioning of the brain in areas that process stressful experiences. Maltreatment amplifies and diminishes connectivity in brain regions related to threat and reward respectively. It also weakens connectivity between prefrontal regions of the brain and the amygdala; and (c) there are resilient individuals who experienced early life stress (ELS) and showed similar brain changes to other maltreated individuals but who did not have psychiatric consequences in the future. The researchers defined resiliency as the ability to endure the strains in life, plus trauma, and preserve or quickly regain physical and
mental well-being. The researchers hypothesized that maltreated resilient individuals likely developed brain adaptations to compensate for the alterations to their brains due to ELS. Teicher et al. forecasted that future studies could reveal new ways to increase resilience for those affected by ELS.

Researchers at The Family Pathways Project at Harvard have studied the effects of social risk on children’s development for approximately 30 years. There were 33 young adult participants from the longitudinal study that were 29 years old and available for a brain imaging investigation (Lyons-Ruth, Pechtel, Yoon, Anderson, & Teicher, 2016). After screening, 18 participants who were originally assessed with attachment disorganization met the criteria for inclusion. The Strange Situation Procedure (SSP) and the Atypical Maternal Behaviour Instrument for Assessment and Classification (AMBIANCE) were used to measure attachment security and parental behaviour in infancy, respectively. Brain imaging was used to measure the volume of the amygdala of adult participants. A 33-item checklist was used to measure adult limbic irritability (Teicher, Glod, Surrey, & Swett Jr., 1993). After almost 30 years, disorganized attachment in infancy predicted limbic irritability in adulthood and greater left amygdala volume mediated the prediction (Lyons-Ruth et al., 2016). Interestingly, maltreatment that occurred later in childhood and attachment disturbances measured in adolescence did not correlate with amygdala volume.

The human results replicated results from rodent studies. In developmental research, sensitive-period analysis is a statistical procedure. The analysis is used to discover which age brackets, after exposure to maltreatment, exert the most influence on outcomes. Based on that analysis, Lyons-Ruth et al. (2016) suggested that the first two years of life may be an early sensitive period for human amygdala development. Therefore, parenting interventions could
be especially important during the first two years to prevent negative outcomes in child development.

**Epigenetic research.** The understanding of the effects of relational experiences on the developing brain and mind has been an important contribution to developmental science. Siegel (2012a) said, "The question isn’t ‘Is it heredity or experience?’ but ‘How do heredity, epigenetic changes, and experience interact in the development of an individual?’" (p. 31). The field of molecular genetics has provided the means to search for the genetic makeup of humans that is related to secure, insecure, or disorganized attachment styles. Bakermans-Kranenburg and van IJzendoorn (2016) declared that almost no clues for finding “attachment genes” have materialized (p. 173). They suggested that molecular genetics studies over the next 10 years will likely focus on complex gene pathways related to attachment, such as the dopamine system. This section starts with an introduction to the notion of a gap that exists in research to explain the intergenerational transmission of attachment. Next, the process of epigenesis is described as it specifically relates to emotional regulation, which depends on infants’ early interactions with their caregivers. Experimental research with animals is described next. Causal claims can be made from animal parenting studies with regard to the effects of epigenetic changes on the outcomes measured. Last, human research studies of epigenetics are described. The final paragraph circles back to describe a new point of view that researchers are taking on the old issue of the intergenerational transmission gap.

**The intergenerational transmission gap between parent and child attachment.** For almost 25 years, attachment researchers have hypothesized regarding what factor or factors mediated the observed continuity of parent to child attachment security. Simply put, researchers have wondered how attachment security is passed on to the next generation (van
IJzendoorn, 1995). The findings from primate research have highlighted that mother monkeys pass on their attachment styles to their daughter monkeys (Suomi, 2016). The monkey daughters mirror their mothers’ parenting behaviour when they become mothers themselves.

Siegel (2012b) outlined the way human stress and trauma which influence attachment relationships are passed on to the next generation. The way grandparents and parents experience stress causes changes in epigenetic control mechanisms and those alterations are passed on via the sperm and the egg from which the next generation is formed. By now it is clear that the transmission gap in the continuity of attachment cannot be bridged by either heredity (genetic endowment) or environmental (parental sensitivity) input alone (Bakermans-Kranenburg & van IJzendoorn, 2016). Correlational and experimental studies have provided evidence that an interplay of gene and environmental interactions are likely most suitable to explain the gap.

**The process of epigenesis.** Siegel (2012b) described epigenesis as the process of life experience influencing regulation of the expression of genes. He used the metaphor of a library to simplify the understanding of experience, genetics, and epigenetics. Life experience does not alter the letters and words in books (DNA of chromosomes). However, life experience influences the librarians that control the release of the books from the library (regulatory molecules along the chromosomes such as methyl groups that control gene expression) (p. 8:7).

Methylation is a widely studied mechanism of epigenetics (Bakermans-Kranenburg & van IJzendoorn, 2016). Methylation blocks gene expression. Methyl is one type, among others, of molecule along a chromosome that regulates how and when genes are expressed
and ultimately how and when the brain’s structure responds to experience. A methyl molecule attaches to cytosine which is one of the bases in a gene promoting area of the brain, thus blocking gene expression. Bakermans-Kranenburg and van IJzendoorn said, “Methylation might be loosely compared to a cork on a bottle of champagne, down-regulating the escape of bubbles” (p. 163).

Genes always express themselves in a particular infant’s brain in a particular environment of caregiving and interactions. In a traumatic or neglectful caregiving environment, the process of methylation can alter the expression of genes in the infant’s brain. One potential change is to the genes responsible for the neural circuits that manage stress. Methylation patterns can down-regulate the hypothalamic-pituitary-adrenocortical (HPA) axis or lessen its controls.

Siegel (2012a) explained that in the case of neglect and abuse, the stress is responded to by the child’s HPA axis. This causes the child’s neuroendocrine system to release the stress hormone cortisol. When higher levels of cortisol are sustained over time, the result is toxic to the child’s developing brain because the child’s regulatory capacities depend on neural integration. The result is physiological changes in the child’s response to stress. Small stressors can lead to large hormonal responses. The child maintains a hypervigilant response to stress over time. Thus, the HPA axis has become less adaptive to self-regulating emotion. The child’s ability to manage stressful situations in the future is impaired. Furthermore, the negative effects from being less able to manage emotional distress can last forever. Siegel (2012a) summarized, “The essential take-home message here is that early experience shapes the regulation of synaptic growth and survival, the regulation of response to stress, and even
the regulation of gene expression. Experience directly shapes regulation” (p. 22). Siegel clarified how relationships and the embodied brain are part of one system.

**Non-human epigenetics attachment research.** Cassidy and Shaver (2016) stated that Bowlby was ahead of his time in at least two ways. The first way was emphasizing the cognitive construct titled the “internal working model (IWM)” of relationships. The second futuristic way that Bowlby theorized about attachment was borrowing from the evolutionary and ethological approaches to animal research. Randomized controlled trials (RCTs) that compare sensitive caregiving to abusive or rejecting caregiving are not possible in research with humans. Therefore, highly controlled RCTs with socially active primates have provided compelling evidence that would not be otherwise available regarding how early life experiences influence gene expression. Primate researcher Stephen Suomi (2016) reviewed his own and others’ nonhuman investigations that have contributed to Bowlby’s foundation of the biological basis for attachment. Suomi highlighted research studies of epigenetic changes occurring as a result of variations in the caregiving environments of Macaques.

Suomi stated that several types of environments have been created for studies of the effects of early adverse experiences on rhesus monkeys. Furthermore, numerous genes have been identified that influence the trajectories of their development. However, it is neither genes nor environments that function alone to affect development. Suomi contended that the evidence clearly shows that gene (G) by environmental (E) interactions, or epigenetics, were partially responsible for the developmental trajectories of primates.

Primate studies have produced evidence for a “maternal buffering effect” according to Suomi. Neonatal neurobehavioural outcome measures were poor for monkeys who were reared in a laboratory and had a genetic risk factor related to serotonergic function.
Conversely, effective mother-rearing and secure attachment buffered monkeys with the same genetic risk from the same potentially negative outcomes. The evidence for a maternal buffering effect was strengthened by a replication study with juvenile monkeys.

Suomi described his research using a model with primates who had the same genetic variations as humans that indicate risk for impulsiveness and alcohol abuse. The developmental outcomes varied depending on whether the infant monkeys were raised by their biological mothers who passed on the genetic risk or by highly nurturing foster mothers. Once again, the maternal buffering pattern was found in these studies as well as in other animal studies that were testing other candidate genes.

Primate research has also indicated that a gene may at one time represent a risk factor to a monkey reared in adverse conditions. Another time the same gene represents a protective factor for a monkey reared in nurturing, secure conditions. Put another way, some monkeys are genetically sensitive to the effects of their early rearing histories. Belsky’s (1997) notion “that children might differ in their openness to parenting influences in a for better and for worse manner” is at the centre of contemporary attachment research (Bakermans-Kranenburg & van IJzendoorn, 2016, p. 173). The principle is called genetic differential susceptibility and is described in more detail in the next section as it pertains to human research on early childhood adversity, attachment, and interventions.

In a longitudinal investigation, Suomi and colleagues studied genome wide epigenetic changes in rhesus monkeys who were differentially reared in childhood (until 6 to 7 months) and then kept in identical conditions until adulthood (8 years of age) (Provencal et al., 2012). The researchers used a monkey model of maternal separation and analyzed the data when the monkeys were adults. They concluded that the study, among others, has shown that
“Suboptimal maternal care can induce broad transcriptional and epigenetic changes in the brain as well as in the immune system. . . . strengthening the hypothesis that the response of the epigenome to early adversity is an adaptation to the actual environment” (p. 182).

In a second longitudinal study, Suomi’s team used the same monkeys to address the question of whether the massive epigenetic changes brought on by early maternal deprivation would fade with time or persist over the lifetime (Provencal, Massart, Nemoda, & Suomi, 2016). In other words, they wanted to know if the different epigenetic changes due to early adversity were transient or long-lasting. Provencal et al. found that most of the epigenetic changes due to early life stress were transient and faded with time after one year when the experimental conditions were reversed. However, 18% of the epigenetic changes appeared after the first year indicating long-lasting effects of early life stress on the monkeys’ phenotypes. Future cross-fostering experiments were called for to untangle and prevent the long-lasting alterations that were brought on by early life adversity.

Blaze and Roth (2017) used a rodent model of early-life caregiving maltreatment. It addressed the search for the underlying mechanism of the relationship between early adversity and adult measures of brain function and behaviour. Results showed that as opposed to male rats, the expression of one particular gene in the prefrontal cortex (PFC) was altered in female rats that experienced early caregiving maltreatment compared to controls. Blaze and Roth suggested that the maltreatment of rodents early in life caused consequential outcomes for both brain structure and behaviour. They stated that early maltreatment has the capacity to cause epigenetic changes that in turn alter PFC neuronal function. Regarding the sex-specific results, Blaze and Roth surmised that male rodents would also have epigenetic changes as a result of early adversity. They presumed that epigenetic changes in male rodents
would likely occur in other gene loci of the brain that were not tested in the reported study. Blaze and Roth concluded that the evidence is clear that negative effects of early maltreatment are not limited to female rodents.

**The differential susceptibility principle (DSP).** An explanation of the diathesis-stress model (DSM) may be helpful as a precursor to describing the DSP. The diathesis-stress model proposes that genetic vulnerabilities predispose some children to develop differently than other children when they are exposed to early environmental adversity such as insensitive parenting and stress (Zuckerman, 1999). The DSM implies that certain genotypes would be called “risky genes.” The differential susceptibility principle (DSP) is fundamentally different. Belsky (1997) predicted that the child with a genetic marker of susceptibility who also experiences environmental adversity will do very poorly in life. The child will have worse outcomes than the child without the genetic marker. However, the same child with a genetic susceptibility marker could also benefit proportionally more from supportive contexts that induce secure attachment.

The DSP suggests the child’s plasticity or openness to the effects of supportive contexts or to the effects of negative environments, for better or for worse. The DSP is evolutionary. Bakermans-Kranenburg and van IJzendoorn (2016) stated, “The evolutionary foundation implies that certain genotypes must be called ‘susceptibility’ genes instead of ‘risk’ genes” (p. 170). Research based on the DSP is highlighting that genetics moderates the efficacy of interventions.

**Differential susceptibility as a moderator of the effects of interventions.** There are a myriad of interventions that target improvements to parental sensitivity and reductions to insecure and disorganized attachment (Berlin, Zeanah, & Lieberman, 2016). The
interventions are costly and time consuming, yet reports of the efficacy of the interventions have only been modest. The question of what interventions work for whom is still unanswered because the efficacy of interventions might be hidden by gene (G) by environment (E) interactions (Bakermans-Kranenburg & van IJzendoorn, 2016).

Bakermans-Kranenburg and van IJzendoorn (2016) claimed that at this point there is still insufficient evidence reported in attachment literature regarding studies that test the potential moderating effects of genetic susceptibility on intervention effectiveness. They highlighted their meta-analysis of 22 gene (G) by environment (E) RCTs. (Bakermans-Kranenburg & van IJzendoorn, 2015). The requirement to include a study in the meta-analysis was that genetic variation of the participants would be a fixed factor and variations in the environment would be randomized. In total, the 22 RCTs represented 3,257 participants, 1,228 of whom were carriers of susceptibility genes and 2,029 of whom did not carry susceptibility genes. The intervention studies that were available for meta-analysis included several levels of experimental design. The interventions that were outlined in the included studies targeted externalizing problems including alcohol abuse, internalizing problems, aggression, cognitive development, and child abuse and neglect.

Bakermans-Kranenburg and van IJzendoorn (2015) reported the combined effect size of intervention efficacy in the genetically susceptible group was significant, a Pearson $r = 0.33$. The combined effect size of the intervention efficacy in the genetically non-susceptible group was not significant, $r = 0.08$. The effects of interventions on participants with susceptible genotypes from 22 RCTs were much stronger than the effects on participants without them. The difference between the two overall effect sizes was significant ($p < 0.01$).
Bakermans-Kranenburg and van IJzendoorn concluded that the evidence from the meta-analysis has implications for the way that intervention experiments are designed in the future.

If the effects of an intervention are summarized across both susceptible and non-susceptible groups of individuals, researchers may be powerfully underestimating the efficacy of the intervention. For example, if the majority of participants in a sample do not carry the susceptibility gene marker, the effect of the intervention on outcomes may be modest at most. The modest effect size might be hiding the large effect of the intervention on the minority of individuals in the sample that did carry the susceptibility gene. Bakermans-Kranenburg and van IJzendoorn contended that the reason for overestimating or underestimating effects is that the efficacy of interventions depends on the proportion of genetically susceptible participants in the sample. The susceptibility genetic marker moderates the effect of the intervention on the outcome. The authors concluded that further gene (G) by environment (E) intervention experiments in the next decade will hopefully reveal what types of interventions work best for whom based on critical genetic moderators.

**A new view of the missing gap in the intergenerational transmission of attachment.**

Bakermans-Kranenburg and van IJzendoorn (2016) construed that the gap in the transmission of attachment from parent to child can most likely be bridged by gene by environment interactions. Research that incorporates epigenetics will continue to provide a framework for examining the back-and-forth between genes and environment in attachment. They specifically pointed out the differential susceptibility principle as key for a new viewpoint on the long-standing issue of the transmission gap, “... genetic makeup might make some children vulnerable to the development of insecure attachments in less supportive
environments, whereas the same genetic endowment enables children to profit more from supportive environments (i.e., sensitive parenting)” (p. 173).

Suomi (2016) offered an interesting insight from primate research with respect to the continuity of human attachment security from parent to child. Suomi’s and other animal research has provided clear evidence for the biological basis of the continuity of attachment. Suomi contended that monkeys do not have internal working models (IWM) and yet animal research, like human research, has clearly confirmed the same developmental outcomes from early adverse experiences. Suomi recapped that the IWM is a uniquely human cognitive process. It can be changed by experiences and insights during the time period of adolescence through adulthood. Otherwise speaking, Suomi was describing the notion of “earned security.” Suomi was suggesting that the development of secure attachment in humans later in life is possible via altering the IWM. He said this cognitive process is not only a uniquely human luxury. The IWM is also a non-genetic means of passing on the adaptive features of the maternal buffering effect that he and others discovered in studies of rhesus monkeys.

Throughout the series of four meta-analytic reviews summarized earlier, the research team noted the absence of attachment research that included father-child relationships. The next section highlights the scarcity of attachment research including fathers and suggests possible reasons for it. It also describes some attachment-oriented studies and interventions that focused directly on fathers or included them as co-parents.

**Missing fathers in attachment, parental caregiving, and addiction literatures.**

This dissertation study focused on mothers who were early parenting and struggling with substance use issues. The majority of the literature reviewed for this chapter centred on maternal attachment and caregiving, and integrated addiction treatment for women that
includes their children. However, it is important to provide a brief focus on the considerable absence of research that includes fathers in the literatures of attachment theory and parenting interventions. Until recently, in the extant literature on parent-child relations, maternal caregiving was the central focus of studies (Cowan, Cowan, Pruett, & Pruett, 2017). Exceptions of research in the attachment literature that included fathers were described earlier in this chapter. They were two of the seminal longitudinal studies by Karin and Klaus Grossmann (Grossman, Grossman, & Kindler, 2005) and Miriam and Howard Steele (Steele & Steele, 2005).

In a global review of over 700 parenting intervention studies only a small portion included fathers or obtained information about them (Panter-Brick et al., 2015). There are several potential explanations that could partly account for the scarcity of paternal attachment and caregiving found in the literature. From the earliest stages, a psychoanalytic backdrop for attachment theory focused on mother-infant dyads, resulting in a disproportionate amount of research that includes mothers (van Rosmalen et al., 2014). In addition, lack of accessibility to fathers might have been an issue. Cowan et al. (2017) addressed the issue of fathers from families that are at-risk for child maltreatment. They contended that more often fathers are the perpetrators of violence in relationships and may be incarcerated. Therefore, more often mothers would be granted custody of the children. This could exclude fathers from participation in research.

Suchman, Pajulo, and Mayes (2013) edited the first book that included researchers and clinicians who were attempting to connect the silos of addiction research and developmental science. Yet, the book *Parenting and Substance Abuse: Developmental Approaches to Intervention* devotes only 2 of 24 chapters exclusively to fathers. Suchman,
Pajulo, et al. acknowledged the immense need for research on fathers, parenting, and addiction. However, they admitted that at present, mothers remain the primary caregivers in families with parental addiction. Most developmental interventions still focus on mothers.

McMahon (2013a, 2013b) recognized how little research exists on fathering in the context of substance abuse. He lamented the dearth of research, especially given that in the past two decades the role of fathering in western society has changed substantially. The three sub-sections that follow contain descriptions of a portion of the limited research that regards paternal attachment relationships, paternal caregiving, and fathering in the context of substance abuse.

**Father-infant interactions, and paternal caregiving and attachment.** A study in the United Kingdom investigated the relationship of father-infant interactions at three months of age and child behaviour problems at age one (Ramchandani et al., 2013). The study was prompted by research focusing on an early sensitive period for the impact of parenting behaviour on infants. Participants were 192 families that came from two maternity units in hospitals. Observations of fathers’ interactions with infants were made in their homes, and nine months later child behaviour problems were assessed by maternal report. The results showed that fathers with the most disengaged and aloof style of relating with infants at three months predicted early externalizing behaviour problems at age one. Ramchandani et al. concluded that it could be important in the future for preventive parenting interventions to be introduced very early in the lives of children. They proposed that the benefits might be not only for the parents and children, but also for potentially reducing the societal costs involved with families at-risk.
Research in Canada explored the relationships between paternal unresolved states of mind (Type U) regarding attachment, atypical paternal caregiving behavior, and disorganized infant-father attachment (Madigan, Benoit, & Boucher, 2011). The authors stressed the importance of learning more about these relationships given the shift in father involvement in child rearing over the past 20 years. It would be important to understand how fathers with unresolved memories of past abuse and loss behave as parents with their infants that can in turn lead to disorganized attachment.

The data for the study had been collected 20 years earlier as part of a larger investigation of the development of parent-child relationships. Both paternal and maternal attachment states of mind were assessed through the Adult Attachment Interview (AAI) (George, Kaplan, & Main, 1996). Infant attachment was assessed in the Strange Situation Procedure (SSP) (Ainsworth et al., 1978). Both paternal and maternal behaviour was measured during certain episodes of the SSP using the Atypical Maternal Behaviour Instrument for Assessment and Classification (AMBIANCE) (Bronfman et al., 1992-2008).

Madigan et al.’s (2011) results provided evidence for links between maternal Type U states of mind, atypical maternal parenting behaviour, and infant-mother disorganized attachment. However, the association for fathers was not significant. The researchers discussed two reasons why the findings in the study were not significant for infant-father disorganization. First, they claimed that using the SSP to assess father-infant attachment might be inappropriate considering that Ainsworth designed it to measure mother-infant dyads. Furthermore, the SSP was originally created when all mothers observed in the lab and at home were the primary caregivers of their children. Madigan et al. suggested that it could be more suitable to assess father-infant dyads during play time. Second, the authors surmised
that the AMBIANCE might have to be adapted for fathers in order to measure atypical paternal parenting behaviour.

Two interesting speculations about what else might be related to infant-father disorganized attachment were provided. First, Madigan et al. surmised that atypical parenting behaviour might be “dose-dependent” (p. 299). That is to say the longer an infant is subjected to atypical parenting behavior, the more negative the disorganized relationship with that parent could become. Second, Madigan et al. referred to Grossmann, Grossmann, Kindler, and Zimmermann (2008) who proposed that parental sensitivity might have less to do with infant-father attachment than with paternal attitudes toward parenting and family.

*Paternal caregiving and substance abuse.* McMahon (2013a) explained that what constitutes good or bad fathers is a social construction. Furthermore, since there is little research on fatherhood in the context of substance abuse to suggest otherwise, the stereotypes of bad fathers continue to exist. These are “stereotypes that assume they are reproducing indiscriminately, woefully neglectful, psychologically incapable, and potentially dangerous” (p. 157). McMahon (2013a) stated that the limited research that is available is mostly in relation to paternal alcoholism as a risk factor of children’s development. It is not about the parenting behavior and capacities of men who abuse drugs and alcohol. Regardless, the author explained that the limited amount of research on fathers with substance abuse compared to fathers without substance abuse has shown the following: (a) compromise of family environments; (b) parental stress; (c) dissatisfaction with parenting; and (d) poor developmental outcomes in children (p. 162). In addition, paternal substance abuse is related to lower involvement with children and difficult co-parenting relationships. There is less cooperation and more frequent aggression toward the mothers of the fathers’ youngest
children. This sometimes occurs regardless of whether the fathers live in the family home or not. What is more, there is higher risk for intimate aggression and partner violence. The author suggested that men receiving alcohol and drug treatment also need help as parents, and family-oriented interventions could address that.

Fathers Too! is the name of an individual psychotherapy intervention that was designed for fathers to be delivered in conjunction with methadone maintenance treatment (McMahon, 2013b). McMahon described Fathers Too! as a psychosocial versus behavioural intervention that focused on fathers’ dyadic and triadic relationships in the family. The goal of therapy was for a father to improve his relationship with one target child between the ages of 1 to 21 while he reduced his substance use. An early evaluation of the pilot study indicated promising results (McMahon, 2009). Participant fathers who received the Fathers Too! intervention together with methadone maintenance treatment had reductions in substance use and decreased high-risk parenting behaviour.

**Combining attachment and family systems theories with fathers included.** Just over 20 years ago, Cowan (1997) issued a plea for a family systems attitude toward attachment theory research. Cowan was concerned that the “pervasive focus on mothers has serious negative consequences both for attachment theory and for what is conveyed by researchers to the general public” (p. 602). Cowan and Cowan of Cowen et al. (2017) spent decades developing an evidence-based, father-inclusive group for parenting young children (Cowan et al., 2017). The original parenting intervention was founded on family systems theory. Thus, the researchers assumed that improvements in the couple relationship and in co-parenting would benefit the entire family system. As the intervention evolved over decades, the developers incorporated many concepts from attachment theory. The most recent version
of the couples group was called Supporting Father Involvement and was considered to be an attachment-based intervention. The authors contended that retaining a family systems approach would connect other important resources and outcomes to attachment-based interventions for the benefit of both parents and children.

The Supporting Father Involvement intervention is group therapy for low-income couples that meet for two hours per week for 16 weeks. The five-pronged model that informed the curricula included: (1) the psychological status of each parent, assessed separately; (2) both the intimate and the co-parenting relationships of the couple; (3) the characteristics of each parent’s connections with their children; (4) the problems related to the transmission of insensitive caregiving in three generations; and (5) the challenges of negotiating negative influences in the environment such as life stress and lack of social supports that impact family life.

Considering a summary of five trials of group couples therapy over many years, Cowan et al. (2017) discussed the domains that were positively affected by the intervention: (a) mothers and fathers experienced positive outcomes individually such as reductions in depression scores; (b) there was stable marital satisfaction and less violent problem solving over long periods of time; (c) focusing on co-parenting versus paternal parenting had value-added benefits such as reduced parenting stress; and (d) the potential for reductions in child behaviour problems was reinforced when both parents attended group couples therapy led by trained clinicians. In addition, the benefits were sustained even though uncontrollable life stress and sources of support in the community remained the same. The evidence indicated the promising potential from taking a family systems-oriented approach to attachment-based
interventions. Targeting couples and co-parenting relationships may have value-added benefits compared to targeting individual parents.

**Summary of attachment, disorganized attachment and caregiving.** A wealth of evidence based on Bowlby’s (1969) attachment theory and extensions of Ainsworth et al.’s (1978) empirical basis for the theory has accumulated from almost five decades of research. While the populations studied were varied, the major longitudinal studies demonstrated the importance of primary attachment in foretelling later outcomes for children (Grossman, Grossman, & Kindler, 2005; Sroufe et al., 2005; Steele & Steele, 2005).

Disorganized attachment was identified as a key factor related to the development of externalizing behaviour in children (Fearon et al., 2010). Conversely, only insecure, but not disorganized attachment style, was related to internalizing behaviour in children (Groh et al., 2012). The literature has captured the deleterious effects of disorganized attachment and caregiving (Solomon & George, 2008; van Rosmalen et al., 2014). There is an ongoing debate regarding the exact etiology of disorganized attachment as it pertains to caregiving behaviour. However, there is consensus that fear without solution (i.e., caused by parental frightened and frightening behaviour or other anomalous parental behaviour) is one underlying cause of disorganized attachment in infants (Holmes & Lyons-Ruth, 2006; Lyons-Ruth & Block, 1996; Lyons-Ruth et al., 1999; Main & Hesse, 1990; Solomon & George, 2008).

**Relational-cultural theory (RCT) and Integrated Drug Treatment for Women**

In preparation for this study, literature was reviewed that explored relational approaches for helping people, and especially for helping women in the population who are pregnant and post-natal parents who have substance use problems. Jean Baker Miller (1976)
was credited as being one of the first feminists who theorized that healthy development should not be focused on separation and independence but on making and enhancing connections with others. Advocates of RCT were the first to outline that substance use problems do not occur within persons but result from interpersonal disconnection (Finkelstein, 1994).

Sword et al., (2012) defined integrated programs as “substance abuse treatment programs that provide comprehensive services that address substance abuse as well as maternal and child well-being through prenatal services, parenting programs, child care, or other child-centred services in a centralized setting” (p. 310). Some of the literature reviewed here consisted of explanations of the philosophical foundations and practical aspects of integrated programs. There were several experimental studies that demonstrated how integrated programs are working in different ways and in different treatment settings. Many terms are used within the literature to label drug and alcohol behaviour and issues. Therefore, the terms for women who “use,” “misuse,” “abuse” drugs or “women who experience substance use problems,” and others, are used interchangeably. Authors’ specific terminology is used when reporting their findings. Women are not referred to as addicts or alcoholics in this study. Those terms used as nouns are considered pejorative and would be inconsistent with relational-cultural theory.

**Background: Relational-cultural theory (RCT).** In the 1970’s, Miller (1976) and colleagues from the Stone Centre at Wellesley College introduced a broad feminist theory regarding women’s psychological development. Miller posited that development occurs within connection to others. Taking the focus off of separation and independence as hallmarks of healthy development, Miller conjectured that women’s sense of personhood is
grounded in a motivation to make and enhance relationships. Furthermore, women’s sense of worth is derived from connection with others. The Stone Centre theorists were joined by Carol Gilligan (1982) who critiqued Kohlberg’s model of moral development, and by trauma expert Judith Herman (1992) who ran a victims of violence group. Together these prominent feminists and others gathered to hold bi-annual conferences at Harvard University for thousands of participants. Their purpose was for women to learn from other women via sharing their knowledge and understandings.

Jordan (2010) explained that before it evolved over the years, RCT was founded as self-in-relation theory (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Surrey, 1991). The way RCT had expanded was in the way it considered the contexts (including the sociopolitical, economic, cultural, racial and sexual) of both women’s and men’s lives (Jordan, 1997). For 20 years, the Jean Baker Miller Training Institute has been conducting RCT-inspired training, workshops, and research forums. Jordan (2010) noted RCT’s prominent place in contemporary culture as Robb (2006) had pronounced that the field of psychology was undergoing a relational revolution.

From a psychodynamic context Jordan (2010) contended that RCT is grounded by “talk therapy” (p. 13) and the concept of relational images that were differentiated from transference. Relational images are derived from interactions from the past that set up expectations for relating to others in the present. However, unlike traditional psychoanalytic theory, RCT stated that our primary drive as humans is relationship-seeking, and the main task of psychotherapy is to move into relationship. Mutual empathy is the keystone of RCT. It was described as one of the activities of mutuality, a way of relating with each other and a condition for growth. Through the lens of RCT, a person’s capacity for relationships that
grow in complexity is when both people in the relationship see that they matter to and influence each other.

Jordan (2010) suggested the ways that relational-cultural theory (RCT) and advances in brain science are coming together, described below. Jordan contended that humans are indeed hard-wired to connect and pointed to brain research on neuroplasticity (Cozolino, 2006) that confirmed that relationships change the brain. Jordan (2010) summarized:

What still marks RCT as special, different, and even perhaps revolutionary is its integration and appreciation of the centrality of relationship, the pain of isolation, the importance of power stratifications in creating disconnections and significant distress, and the ways in which our brains are programmed for connection. (p. 22)

Our current culture with its focus on self-sufficiency and independence was lamented by Jordan. She stressed that such a culture is a barrier for humans to grow through connections, as their brains and bodies were meant to do.

**Relationships, the developing mind, and the brain.** The focus on relationships is linked to research and findings from neurobiology. Siegel (2012a) contributed an interdisciplinary and scientific synthesis regarding what it means to be human and about how the mind develops. The last two decades of neuroscientific research has left many concerned that the field of psychiatry has been “losing its mind in favour of the brain” (p. xiv). Siegel opposed the field’s emerging viewpoint that is based on biological determinism. Interpersonal Neurobiology (IPNB) is Siegel’s effort to equate nurture with nature. He claimed that choosing between genetics and experience is unnecessary and prevents clear thinking about a complex topic such as the developing mind.
Siegel (2012a) contended from the field of child development research that what is clear by now is that forms of communication shape a child’s developing brain. A child’s interactions with the environment, especially early relationships, directly shape the brain’s structure and function. Experiences and neuronal firing influence genetic expression in the process called epigenesis and this can occur across the lifespan. The process of epigenesis was described in more detail in an earlier section. IPNB seeks to understand the interconnections between the brain, the mind, and relationships as three aspects of humans’ information and energy flow. In other words, neural processes (brain) and shared processes (relationships) give rise to mental processes (mind) in lifelong development.

According to Interpersonal Neurobiology (IPNB), the concept of the integration of mind, brain, and relationships is an organizing notion and is the heart of wellbeing. For Siegel, a healthy person is someone with a coherent sense of self across past, present and future. Integration can be assessed using the Adult Attachment Interview as it relates to a person’s attachment history. From the IPNB perspective, the opposite of health is via a lack of integration, which is represented by forms of chaos or rigidity. Siegel claimed that forms of chaos or rigidity would be similar to disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders – 5th edition (DSM-5) (American Psychiatric Association, 2013).

In more contemporary research in counselling psychology, Sampaio and Lifter (2014) provided practice and research implications derived from the emerging neuroscientific evidence that infants’ mental health is associated with caregiver-child interactions. The authors suggested that research that informs practice for those working with families to support responsive care of children is what relates attachment theory and attachment-based
interventions to counselling psychology. The authors stated that the traditional research approach is studying the outcomes of interventions on child behaviour and on attachment scores. They recommended that in the future it would also be important to study the outcomes of interventions on the neural correlates of children and their caregivers.

**Integrated relational treatment for women with addictions.** As early as the 1970s and early 1980s, crack babies were a hot topic in society. Researchers acknowledged that the prevailing perspectives on drug dependence were based on the behaviour of men. Treatment organizations were designed with men in mind (Reed, 1987). Feminists promoted specialized addiction treatment for women. However, it took until the next decade for gender-specific treatment to address the barriers that were unique for women (Finkelstein, 1994). Finkelstein contended that women’s problems with drugs and with obtaining treatment should not be based on the medical model. She explained the concept of disconnection borrowed from relational-cultural theory (Jordan et al., 1991; Surrey, 1991). Women’s failure to develop relationships with significant others was a difficulty that could lead to drug and alcohol problems (Finkelstein, 1994). Finkelstein’s seminal article regarding treatment issues for drug and alcohol dependent pregnant and parenting women was considered ground-breaking.

Finkelstein identified stigma, denial and lack of gender-specific treatment services as barriers for women. In addition, she cited the unique socioeconomic and systemic issues that women face. Women as daughters often came from families where one or both of their own parents were substance abusing. Women as partners were often involved in violent relationships; historical and current trauma were realities in their lives. A treatment model for pregnant and parenting women who abuse substances was proposed and became widely adopted by program providers. Based on the settlement houses movement, Finkelstein’s
The proposed model was coordinated, multidimensional, and comprehensive. The template recommended empowerment, a strengths-based and non-pathologizing approach, strong connections with family and community, and specialized services for women.

Kaltenbach (2013) pointed out that there was now approximately 25 years of research on the integrated treatment approach for women that Finkelstein (1994) laid out. A composite profile of these at-risk women’s bio-psychosocial characteristics was derived from the data and much of it confirmed Finkelstein’s original observations (Kaltenbach, 2013). The four risk factors of women in this population were: (1) family history of addiction plus family history of physical, emotional, and sexual abuse. A family history of substance abuse may negatively affect childhood social and/or emotional development. In turn, underdeveloped girls may become parents with limited abilities; (2) psychiatric comorbidity that includes posttraumatic stress disorder (PTSD) and high rates of other diagnoses; (3) caregiving environments that are often chaotic and transient bringing parents to the attention of child protective services; and (4) parenting attitudes that indicate hesitancy about having children and maintaining custody of them, low comprehension of child development, and low capacity for reflective functioning. The multiple risk factors that were identified in the literature are referred to independently but most often they intersect with each other. Each of the four factors is a risk for substance abuse and dysfunctional parenting behaviour, regardless of substance use.

On the topic of family history of abuse Szalavitz (2011) summarized the findings from a retrospective survey study conducted in California called The Adverse Childhood Experiences (ACEs) study. The results from 8,613 adults showed that the higher the amount of ACEs that people had and the greater the sources of what their stressors were, the greater
likelihood they would develop addiction as adults (Dube et al., 2003). Lewis (2015) stated that research has shown that people often use drugs to either rev up their sense of mastery and excitement or to quell their anxiety and distract themselves. Thus, there is a logical connection between early childhood trauma, adult trauma, PTSD and subsequent misuse of substances to medicate the painful effects.

In a meta-analysis of integrated treatment programs for women and their children, Milligan et al. (2010) synthesized the results of 21 quasi-experimental and cohort studies, plus two RCT studies. Integrated treatment for women was defined as providing treatment for addiction combined with services for pregnancy, parenting, and children. Milligan and colleagues concluded that integrated programs were associated with reduced maternal substance use. Several important issues and limitations of their research were discussed. The way that substance use was operationalized was notable. For example, when drug use severity was measured on a continuum, the reduced use was significant. When drug use was based on a binary measure according to urine toxicology, the reduced use from integrated treatment was often non-significant. Therefore, effect sizes were impacted by the way substance use outcomes were measured.

A systematic review of 13 studies was conducted to provide evidence of the effects of integrated programs on child outcomes (Niccols et al., 2012). Integrated programs for women with addictions that provided pregnancy and parenting services were related to positive influences on child development, growth, and emotional and behavioural functioning. Milligan et al. (2010) cited the need for more evaluation research generally and for higher quality studies specifically.
Other research has shown that keeping children together with their primary caregivers, given a tolerable risk level, is preferable to multiple placements in foster care (Kalland & Sinkkonen, 2013). From an attachment perspective, the researchers insisted that foster care is complicated. They asserted that foster care placements only work better than keeping children together with at-risk parents, under specific conditions: (1) when foster parents are highly committed; (2) when foster parents do not have their own adverse childhoods and do have autonomous/secure attachment classifications; and (3) when foster care placements occur only once, preferably, and when children are very young in age (e.g. under 12 months). If not, the effect of foster care on children’s development is worrisome.

Another line of research focused on adolescent and young adult mothers struggling with addiction and compared them to older, more mature mothers (Madgidson, Garber, & Lejuez, 2013). Four results among others that derived from the research seem important to highlight. First, the shame, guilt, and frustration younger mothers feel as parents with chaotic lifestyles often prevents them from seeking help and support. Second, young adult mothers who use substances are less likely to have partner support, especially if their partners also abuse drugs and alcohol. Third, although the support of a positive social network buffers the risk for non-optimal child development, younger parents may be more ambivalent than mature parents about the need to change relationships that are unhealthy. Some young mothers become distressed in the post-partum period when their peer networks change. They have to spend considerably more time raising their infants compared to socializing. There is an increased risk of substance use in the younger group to attempt to fit in with peers or cope with the distress related to feeling left out. Fourth, the need for child care is salient, especially from a familial support network.
Similar to the window-of-opportunity concept, the birth of a baby often inspires a young parent to make longer-term changes. However, changes require a balance between her own identity development and caring for her child. Sadler and Cantrone (1983) called this the dual-development hypothesis. An adolescent or young adult mother could experience a developmental crisis from the clash between the tasks of identity development and forging independence, and the tasks of caregiving. Madgidson et al. (2013) suggested that this situation would call for additional support for the parent including child care, keeping in mind that a younger parent might perceive too much support as a threat to her independence.

**Pregnant and early parenting women with substance use problems.** Relationship-based and integrated programming for women is often mapped against the stages of change process based on the Transtheoretical Model (TTM) (Prochaska, DiClemente, & Norcross, 1992). The TTM is described below including the related topics of motivational interviewing and harm reduction. Next, selected research is presented regarding integrated programs for pregnant and parenting women in Europe and North America.

**Transtheoretical model (TTM) of the stages of change.** Prochaska et al. (1992) described the TTM alleging that change naturally occurs over a period of time and in stages versus all at once. The TTM outlines the process of change and the model is atheoretical about why change takes place. Six stages of change that individuals go through were identified: (1) pre-contemplation, (2) contemplation, (3) preparation, (4) action, (5) maintenance, and (6) termination. In addition, the model normalized the notion of relapse as part of the learning and changing process and suggested that relapse or slip-ups could occur at any stage. The way to help individuals that are in the process of changing a problem behaviour is different, depending on the stage they are in.
Although the TTM was designed to address any type of behaviour change, it was quickly adopted in the addictions field (DiClemente & Prochaska, 1998). Addictive behavioural change is complex and the TTM provided a useful heuristic to understanding it. Addiction workers could plan interventions that matched the stage of clients’ readiness for change. DiClemente and Prochaska recommended that stage-sensitive and brief encounters with clients should occur at each phase. The strengths of the TTM were described as its proactive versus reactive approach, cost effectiveness, and its morale boosting benefit for addiction workers.

**Motivational interviewing.** Motivational interviewing (MI) was described as a useful counselling approach for helping individuals in the early stages of changing addictive behaviour (Miller & Rollnick, 1991). When the stages of change are considered, the topics of motivation for change and MI strategies are natural companions. Miller (2015) proposed that MI strategies can be useful in the precontemplation, contemplation, and preparation stages to increase readiness to change as people at these points are often ambivalent and motivationally challenged.

The MI technique can be particularly helpful for pregnant and parenting women who have substance use issues (Motz, Leslie, Pepler, Moore, & Freeman, 2006; Pepler et al., 2014). It is a client-centred and empathic approach that emphasizes personal autonomy with regard to change. The MI technique underscores self-efficacy and like the TTM acknowledges that relapse is a common part of the change process. Motz et al. endorsed those perspectives plus two additional ones from MI that pertain to programming. First, intrinsic motivation is not a trait but a state of being that is developed via the interactions between counsellor and parent client. Second, a parent’s resistance to changing addictive
behaviour is not seen as a lack of readiness. Resistance is viewed as a sign that the counsellor might be making suggestions that are mismatched with the stage the client is in. From the MI perspective, resistance is reframed as a sign of ambivalence regarding change and is met with reflection rather than confrontation.

Grant and colleagues created the Parent-Child Assistance Program (PCAP) for pregnant and parenting women who live in Washington State and struggle with substance use issues (Ernst, Grant, Streissguth, & Sampson, 1999; Grant, Ernst, Pagalilauan, & Streissguth, 2003; Grant, Ernst, Streissguth, & Stark, 2005). They developed and regularly evaluated the three-year home visitation and case management intervention. Grant and Huggins (2013) reviewed the PCAP. They stated that both the relational emphasis of the PCAP and the use of motivational interviewing (MI) techniques are believed to be two key factors related to the intervention’s successful outcomes. They suggested that the principles of MI compliment relational-cultural theory. The MI approach prioritizes that case workers practice empathy and nonjudgment in their interpersonal relationships with parent clients. It also involves cultivating discrepancy and building capacity for resistance in order for their clients to increase their self-efficacy for change.

Harm reduction. Abstinence from substances is often seen as the ideal goal for addictive behavioural change. However, a harm reduction approach uses interventions that accept alternatives to total abstinence to reduce risk as part of the process of change (Marlatt & Tapert, 1993). A person’s symptoms of substance use severity are viewed on a continuum. Decreasing risk by reducing substance use is viewed as a helpful step on the path to abstinence. When women find out they are pregnant while struggling to stop using substances, they often hesitate to engage in services due to the stigma attached to a “using
parent.” In fact, Howard (2015) distinguished external stigma from internalized stigma. Women who are early parenting with substance use issues are often socially stigmatized in the form of extreme societal disapproval. Two ways women could manage being stigmatized by society would be to isolate themselves or to internalize the stigma and identify with it. Collins et al. (2012) endorsed harm reduction partly for this reason. They declared that harm reduction is an emboldening approach that aims to lessen the stigma and guilt associated with addiction with the goal to reduce substance use.

Similar to motivational interviewing, harm reduction is an approach that is endorsed by integrated treatment programs for women that are scaffolded by relational-cultural theory (Grant & Huggins, 2013; Nathoo et al., 2015; Pepler et al., 2014). Breaking the Cycle (BTC) is a relationship-focused integrated outreach program in Toronto. Program providers there viewed harm reduction as a pragmatic and compassionate approach to assisting pregnant and parenting women who struggle with substance use (Motz et al., 2006; Pepler et al., 2014). They considered that meeting a pregnant or parenting woman non-judgmentally concerning her current substance use would be necessary for engaging with her further. A harm reduction approach seeks to contemplate a person’s substance use in the greater context of their life. For example, drug and alcohol counsellors connected to BTC would attempt to understand how pregnant and parenting women might use substances for coping. Young parents would be viewed within the greater context of poverty, trauma, and mental health problems. More research from BTC is described later in this chapter.

**International research.** Infants of drug dependent caregivers face unique challenges. Velez and Jansson (2008) identified a neurobiological model of mothers with chronic substance abuse problems. Parents who chronically struggle with substance misuse
experience a cycle of caregiving related triggers, craving and relapse. These mothers are often more vulnerable to stress and more reactive to stressors. Infants of mothers on methadone maintenance often experience Neonatal Abstinence Syndrome (NAS) and their disorganized behaviour impairs their basic functions such as feeding and sleeping. In addition, infants’ abilities to stay alert and communicate clear cues to their mothers are also weakened. Alternately, opioid dependent mothers’ physical and psychological well-being is often incapacitated to some degree. This affects their abilities to recognize and react to their infants’ signals. Velez and Jansson stressed that this vulnerable population must be provided with nonpharmacological care in addition to medication, and not as a substitute for it. Care providers should focus on improving the nurturing connections between methadone-maintained mothers and infants experiencing NAS. According to Velez and Jansson, treatment plans should focus on the interactional dyad.

Preliminary data from a feasibility study on an attachment-based parenting intervention for mothers with drug dependency was presented by Suchman, Mayes, Conti, Slade, and Rounsaville (2004). The intervention group consisted of 25 mothers who were referred for drug treatment outpatient assistance and received services for 1.5 hours per week for 12 weeks. The treatment included paying attention to the emotional quality of the parent-child relationship in addition to the parent’s behaviour management skills. Using chart review, the intervention group was compared to 23 mothers who received standard care at the same time. The mothers in the treatment group attended more sessions on average, were retained in the program longer, and were more compliant in following clinical advice. There was no difference between the groups with regard to drug use at discharge.
In Finland for approximately 15 years researchers have been studying how to best serve pre and postnatal women in their country that struggle with drug addiction. Women there who are early parenting and struggling with substance use issues there have pronounced risk factors (Pajulo & Kalland, 2013). They typically have inadequate finances, limited social support, low levels of education, and have a hard time obtaining housing. Some expectant mothers who struggle with addiction may also be ambivalent about parenting because of their current situations. They may be overwhelmed by the amount of changes required in many areas of their lives.

Becoming aware of what constitutes good relationships, and learning how to establish them, is an important target for pregnant and parenting women who are attempting to recover from addiction (Pajulo, Suchman, Kalland, & Mayes, 2006; Pajulo et al., 2012). A residential treatment intervention called Holding Tight for parents with addiction was developed. The name Holding Tight refers to Winnicott’s (1957) concept of the “holding environment.” The concept implies that intensive relational support within a highly structured milieu is best for pregnant women and new parents struggling with addiction issues. The Holding Tight intervention was implemented in six residential treatment houses spread throughout Finland. It is one part of the national child protection mandate and is structured within a larger foundation-based sector. This creative intervention in Finland has shown that strengthening the relationship capacity of women with addiction issues can result in women making the investment in parenting instead of in substance use.

Members of the Holding Tight research group also conducted a study in an outpatient setting. Belt et al. (2012) compared Psychodynamic Mother-infant Group Psychotherapy (PGT) to individualized support for improving the early dyadic interactions of mothers who
misuse drugs and their children. The extensive PGT treatment involved six months of three-hour weekly group therapy sessions as well as three to five months of individual follow-up. The primary purposes of the treatment group were to attach the mothers to treatment so they would stop using drugs, process their past experiences that lead to using drugs, regulate emotions, respond to infants’ cues, and prevent disorganized attachment. The comparison group was provided with an individualized Psychosocial Support Intervention (PSS) that lasted 12 months on average and was tailored around mothers’ schedules. The PSS group included an emphasis on the dyadic relationship as well. However, care providers in the PSS group were experienced in early relationships and substance abuse, but not in psychotherapy.

Belt et al. (2012) indicated that mothers in the psychotherapy group had significantly decreased hostility. Intrusive behaviour was reduced in both groups, although especially in the intervention group. Both groups showed improvements in the quality of mother-infant interaction as assessed by emotional availability scales. Furthermore, both groups also showed mothers’ improvements in sustaining abstinence, being retained in treatment, and reducing depression symptoms. The researchers attributed the success of both interventions to the powerful motivating factor at work in new mothers, enhanced because they were receiving the support they needed.

Belt et al. (2012) discussed why psychodynamic group therapy did not result in significantly more responsive and involved infants in dyadic interactions with their mothers. The intense nature of the group therapy process ended abruptly after six months. At that point, the individual follow-up was implemented. However, attachment behaviour, based on interactions with primary caregivers, continues to develop in the second half-year of life. Therefore, Belt et al. postulated that the benefits from the six-month group therapy
A component may have stopped prematurely. Among a number of methodological limitations reported, the lack of random assignment to groups stood out. In this clinical setting, mothers self-selected the psychotherapy group or individual services based on what suited them best. It is possible, therefore, that psychotherapy group members were previously motivated in unique ways to work on their personal problems.

**Canadian research.** The Breaking the Cycle (BTC) program in Toronto was created over 20 years ago to promote healthy mother-child relationships in substance exposed families (Motz et al., 2006). Two decades of subsequent research and clinical experience convinced BTC developers to take an explicitly relational approach to serving pregnant and early parenting women with problematic substance use. BTC uses relationship-focused interventions that help women foster their own sense of well-being as well as help infants to develop optimally. Pepler et al., (2014) said that one reason among others that early parenting women with addiction issues use drugs and alcohol is due to their complex and challenging lives. This includes poverty and transient housing and those issues are compounded by a lack of social supports. At BTC researchers and program providers have found that even though they lack resources it is common for potential clients to not engage in services at first. They tend to isolate, partly due to fear of child protection involvement.

In one study of high-risk polysubstance-exposed dyads, Espinet et al. (2013) assessed the mother-child relationship using multiple methods including videotaped observation of emotional availability, maternal self-report of parenting stress, and clinical evaluation of parent-infant interaction. The 34 dyads came from the BTC early intervention program. The investigators hypothesized that parent self-reports and more objective clinician ratings of maternal emotional availability and sensitivity would diverge.
The results supported their hypotheses and indicated that maternal ratings emphasized the child factors that contribute to the relationship, while clinician ratings seemed to be more sensitive to the parenting contributions. It was apparent that high-risk mothers in this sample were better at reporting on their children’s behaviour than their own. Espinet et al. (2013) discussed the difficulties of parenting with substance-use problems that may have accounted for the results. The authors concluded that multimodal assessments are important when measuring the transactional nature of high-risk, substance-exposed dyads. Two aspects of the methods stand out. First, the mothers in the sample were already part of the BTC program when the data was collected. They were being taught how to improve maternal reflective functioning capacity despite the consideration of their parenting stress. Therefore, intervention effects may have influenced their scores on numerous assessments. Second, the sample size of 34 dyads was considered small and did not include non-clinical comparisons.

More recently, Breaking the Cycle (BTC) researchers wanted to find out if integrated treatment based specifically on relationship-focused interventions would have significantly better outcomes than integrated treatment as usual (Espinet, Motz, Jeong, Jenkins, & Pepler, 2016; Pepler et al., 2014). In addition, they wanted to explore improved relationship capacity as a mechanism of change associated with lower addiction severity. Results of the comparison study indicated that both groups had reduced addiction severity. However, the relationship-focused approach of BTC also resulted in significantly improved mental health and relationship capacity compared to integrated treatment as usual. Regarding relationship capacity, Espinet et al. concluded that participants’ perceived support from others, perceived ability to be close to others, and the perception that others can be trusted, could be important mechanisms of change.
A study about readiness for change was part of the BTC longitudinal research project (Jeong, Pepler, Motz, DeMarchi, & Espinet, 2015). Unexpectedly, Jeong et al. found that participants’ stage of readiness predicted only their parenting attitudes. Stage of readiness did not predict substance use and parenting outcomes as hypothesized. They discussed the importance of their findings that add to a growing literature. Women’s capacities for caregiving and for other close relationships are being seen as important beyond their substance use problems. Jeong et al. proposed that rather than seeing the caregiving role as a barrier for women’s treatment as in the past, parenting and relationships could be seen as catalysts of treatment outcomes.

**Summary of relational-cultural theory and integrated drug treatment for women.** The value and critical importance of human growth through relational connections emerged as a theme across feminist literature (Gilligan, 1982; Herman, 1992; Jordan, 1997, 2010; Miller, 1976). Siegel (2012a) linked consistent findings in current neuroscientific literature related to brain development with environmental influences, especially attachment relationships. Sampaio and Lifter (2014) spoke to the need for future researchers of caregiving and behavioural child outcomes to include measures of neural correlates as additional evidence of the success of attachment-based interventions. Considerable evidence is mounting that relational, comprehensive, and integrated treatment for pregnant women and mothers who have problems with substance use reduces addiction severity and improves parenting and child outcomes (Belt et al., 2012; Espinet et al., 2016; Jeong et al., 2015; Pepler et al., 2014).
Attachment-based Interventions in Early Life

Gauthier (2011) described an important development based on the major longitudinal studies of attachment theory, described earlier in this chapter. The consequent research set a trend towards starting interventions early in children’s lives and serving both mother and child. Research on narrowly-focused, attachment-based interventions has shown a “less is more” effect (Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2014). An earlier meta-analysis and review by the same researchers had revealed that brief interventions that emphasized sensitive parenting behaviour worked best to decrease children’s attachment insecurity and disorganization (Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2005, 2008). The researchers claimed that intervention experiments that manipulate parental behaviour and relational patterns could shed light on the etiology of disorganized attachment better than correlational studies. There is also an accruing evidence base for long-term psychotherapeutic interventions for parents and very young children. For example, Child-Parent Psychotherapy (CPP), which is described next, uses a relational approach that improves parent-child interactions. In one study CPP significantly increased secure attachment in children of depressed mothers (Toth, Rogosch, Manly, & Cicchetti, 2006).

Most of the interventions described next are expensive and time-consuming to implement. Efforts have been slower to design more practical attachment-based interventions (Cassidy et al., 2017). Cassidy and colleagues reported on the Circle of Security – Parenting (COS-P) intervention. It was developed to meet the need for attachment-based programs that are large-scale and can be implemented in community settings. This section is divided into two parts: (1) long-term and short-term psychotherapeutic interventions aimed at parental
internal working models and reflective functioning; and (2) evidence-based interventions that use video-feedback to drive potential improvements in sensitive parenting behaviour.

**Long-term and short-term psychotherapeutic interventions.** The three attachment-based psychotherapeutic interventions described below have similarities and differences. They are all intensive therapies, prioritize therapeutic alliance, and include parents together with children. Improvements in parental behaviour are not targeted directly. Child-Parent Psychotherapy (CPP) targets parents’ internal working models of attachment and children’s mental health. Minding the Baby (MTB) and Mothering from the Inside Out (MIO) both target parental reflective functioning. However, MIO is the only brief intervention and was based on special considerations for parenting women who are in treatment for addiction. The MIO intervention was designed to address the demands of parenting and addiction recovery concomitantly.

**Child-Parent Psychotherapy (CPP).** CPP is psychodynamic and attachment-informed and was created as a dyadic relational intervention (Lieberman & Van Horn, 2004, 2008). The origin of CPP was Infant-Parent Psychotherapy (IPP) which Fraiberg (1980) and colleagues designed for mothers who experienced abuse and neglect in the past. Fraiberg referred to “ghosts in the nursery” who represented parents’ unresolved conflicts from childhood that impacted their children. Lieberman and Van Horn (2005, 2008) increased the scope of IPP using a manualized, one-year model for CPP. It included traumatized children from birth to five years of age and their traumatized parents. Compared to other interventions described below, CPP is long-term, and requires extensive resources.

Berlin et al. (2016) explained that CPP targets parenting behaviour and sensitivities that derive from two sources. The first source is internal working models of parenthood that
have been impaired from adults’ own histories of being parented. The second source of behaviour is the current relationships parents have with their own children. The intervention also targets children’s mental health and therapists provide CPP weekly in the family home. Therapists do not seek to change parenting behaviour directly. Rather, therapeutic points of entry are discovered within parent-child interactions, child’s play, mental representations of absent parents, and other issues that present themselves (Van Horn & Reyes, 2014). Similar to other trauma therapies CPP is delivered in stages and relationships are prioritized between therapist and parent, and between therapist and the dyad. The efficacy of CPP has been supported by at least five RCTs and the intervention has been disseminated worldwide (Berlin et al., 2016).

Recently, researchers reported on a longitudinal study of CPP for toddlers and their mothers suffering from depression. The effects of the intervention were associated with the children’s relationships with peers measured at the age of nine (Guild, Toth, Handley, Rogosch, & Cicchetti, 2017). Maternal depression has a negative impact on healthy child-rearing environments. That poses a risk factor for young children for insecure attachment which relates to the ability to make friends later in childhood.

Guild et al. described the four main goals of CPP: (1) to increase the capacity of a parent to respond to their child in developmentally appropriate ways; (2) to alter the potentially maladaptive or inaccurate perceptions of each other for both the parent and child; (3) to restore a sense of trust to a child in order for them to experience their parent as a safe haven that is capable of meeting their needs; and (4) to support the parent in their ability to balance their child’s need for autonomy with their own needs. The results of the study supported the hypothesis that attachment security would mediate the relationship between
CPP and children’s peer relationships at age nine. The researchers suggested that a relational
treatment such as CPP could be used with depressed parents and their children in
combination with parents’ individual treatments for depression.

**Minding the Baby (MTB).** The MTB home-visiting intervention prioritizes the
psychological and cognitive enhancement of maternal reflective functioning (Fonagy, Steele,
(RF) as psychological abilities that underlie one’s capacity to mentalize. When people are
psychologically aroused, the therapy model suggests practicing specific, guided
mentalization strategies. As a result RF enables a person to understand another’s mental
states and behaviour as meaningful and predictable.

Slade (2005) introduced parental RF as a parent’s capacity to represent and
understand the breadth of their child’s internal experience. Put another way, parental RF is an
ability to hold oneself and one’s child in mind as two distinct persons. A highly reflective
parent understands their child’s feelings which makes it possible to behave sensitively with
their child. Slade suggested that maternal RF could derive directly from a mother’s capacity
for reflecting on her current experience with her child and from her own experience as a
parent. This would be preferable to maternal RF achieved indirectly from a mother’s
descriptions of her relationship as a child with her own parents. It was once proposed that
maternal RF might mend the gap in research as a mediator of the intergenerational
transmission of attachment (Slade, Grienenberger, Bernbach, Levy, & Locker, 2005).

At its foundation, the Minding the Baby (MTB) program design was based on the
combination of two existing evidence-based programs (Sadler et al., 2013). The first
conceptual base for the program development was the Nurse-Family Partnership (NFP).
Nurse home-visitors had access to the target population and brought expertise to their physical and maternal health concerns. However, the NFP program was less able to meet mental health concerns and demonstrate changes to mothers’ attachments to their infants.

The second evidence-based approach that was adapted for the Minding the Baby (MTB) program was Infant-Parent Psychotherapy (IPP) (Fraiberg, 1980; Heinicke et al., 1999; Lieberman, Weston, & Pawl, 1991). Results of the home-based IPP were improved rates of secure attachment and the development of strong parent-child relationships. However, IPP did not primarily focus on the health concerns of families. This was seen as a significant gap. Ordway et al. (2014) described three unique aspects of MTB. The first unique feature is that MTB aims to enhance mothers’ reflective functioning more than to teach them specific parenting skills. The second unique aspect of MTB is the intensive, long-term (27 months in the RCT), and interdisciplinary nature of the intervention for helping high-risk families. The third distinct aspect of MTB is a contemporary view of the relational approach to both problems and interventions. The MTB program “requires a clinician to view the parent-child relationship as the patient” (p. 11).

Sadler et al. (2013) reported the results from the pilot-phased RCT of the MTB program. Health-related outcomes indicated that intervention families were less likely to be referred to child protection, were on schedule with immunizations at one year, and mothers’ rapid subsequent childbearing was reduced. For teenage mothers their children’s behaviour was less disrupted at four months. At one year of age, infants were more likely to be securely attached and less likely to exhibit disorganized attachment strategies. A major finding at follow-up was that significantly fewer parents reported child externalizing behaviour. The researchers were encouraged by the results although reflective functioning did not mediate
the relationship between parents’ and children’s attachment behaviour as expected (Ordway et al., 2014).

**Mothering from the Inside Out (MIO).** Suchman and colleagues created a brief 12-session, intensive individual therapy intervention that targets parental reflective functioning. The intervention was first named the Mothers and Toddlers Program (Suchman et al., 2010). They later reported positive outcomes of the pilot project measured at the six-week follow-up (Suchman, DeCoste, McMahon, Rounsaville, & Mayes, 2011). The foundation of MIO is attachment theory and mentalization theory. In addition, MIO is grounded in evidence from the neuroscientific findings related to parenting and addiction (Rutherford, Potenza, & Mayes, 2013). Rutherford et al. listed three psychological deficits related to chronic substance use and ineffective parenting. They are impulsivity, emotional reactivity, and a reduced ability to tolerate distress. Parents who struggle with substance abuse are more triggered by the difficulties of parenting than parents who do not have substance use issues. Examples of caregiving related triggers that can lead to cravings and relapse are: (1) high levels of negative affect such as stress and anxiety that effect responses to infant distress; (2) infant crying and irritability; and (3) stress related to insufficient resources. A neural pathway explanation outlines the effects of stress that impacts the striatum of the brain, that impacts craving and drug-seeking, which can lead to relapse.

Suchman, Pajulo, Kalland, DeCoste and Mayes (2012) described the premise that drug abuse co-opts the same neural pathways where dopamine normally sensitizes women to experience the parenting role as rewarding. Therefore, many women do not experience the caregiving role as rewarding compared to mothers who do not abuse substances. During pregnancy and postnatal, mothers in this condition may tend to think of their infants as
merely extensions of themselves. The MIO was designed to address a non-traditional clinical concept regarding addiction and early parenting that focuses on the parent-infant relationship. The concept emphasizes helping mothers as early in post-partum as possible to experience caregiving as enjoyable. Theoretically, this would re-set the dopaminergic reward pathway in parents’ brains. The implication is that mothers who are rewarded by the caregiving experience would be powerfully motivated to reduce substance abuse.

The MIO intervention was designed to be implemented for mothers at the same time they are being treated for addiction. However, the intervention is also for their children. One MIO tenet is about the need for developmentally-informed child care for this population of at-risk parents with substance use issues (Suchman & Bers, 2015; Suchman, DeCoste, Ordway, & Bers, 2013). The intervention developers discussed the need for guiding child care workers and training them in assessing the development of children. The child assessments are meant to be conducted during the time while the children attend addiction treatment together with their mothers.

Suchman et al. (2017) reported on a second RCT of the MIO intervention. The RCT tested brief mentalization-based individual therapy for 87 mothers in treatment for addiction. At 3-month follow-up, but not at posttreatment, MIO mothers had significantly greater capacity for maternal reflective functioning (RF). At posttreatment and 3-month follow-up, MIO mothers had significantly more intelligible mental representations of their caregiving relationships and of themselves as parents. The MIO mothers’ scores for mental representations at 3 months approached a benchmark score that denotes average. That score signifies sufficient parental RF to be aware of and differentiate between own and infants’ mental experiences, especially affective experiences. The researchers stressed the importance
of interventions such as MIO that aim to treat the psychological deficits of parents who abuse substances before interventions can be expected to teach them sensitive parenting behaviour:

The results bring to mind the oxygen mask metaphor where airline staff instruct a parent to place their oxygen mask first on themselves before fixing their child's mask. Children's unmet needs cannot be addressed without first meeting the needs of their primary caregivers, who are, most typically, their mothers. (p. 635)

**Use of video in attachment-based interventions.** Since attachment theory has been fully endorsed Juffer and Steele (2014) suggested that efforts have turned to translating theory into practice. They reflected on that 25-year period of time that many interventions used video-feedback. Juffer and Steele stated that interventions that use video-feedback are effective and rich for the following reasons: (1) the observations are indisputable; (2) a therapist can speak for the child; (3) positive moments can be watched, re-watched and reinforced; and (4) video-feedback permits a way that parents can see and reflect on their parenting behaviour. Two evidence-based interventions that use video-feedback to promote attachment security and sensitive parenting are described next.

**Circle of Security (COS).** The COS was originally developed for children ages birth to five years to prevent mental disorders and attachment insecurity and disorganization (Hoffman, Marvin, Cooper, & Powell, 2006). More recently, developers created a Circle of Security–Parent (COS-P) version of the program (Woodhouse, Powell, Cooper, Hoffman, & Cassidy, 2015). The original COS and the COS-P will be described in order. The COS was originally clinic-based, did not include children, and was delivered in 20 weekly group sessions to between six and eight mothers at a time. Group leaders completed a 10-day, in-person training and were required to pass the certification exam (Hoffman et al., 2006). The
COS intervention used video reviews of dyads that were recorded in the initial interview.

The COS program is based on attachment theory and object relations theory. Intervenors seek to prevent insecure and disorganized attachment along with their negative sequela for children. The COS is also influenced by affective neuroscience (Vu, Hustedt, Pinder, & Han, 2015). Berlin et al. (2016) highlighted that the COS program attends to “the intimate and often delicate nature of attachment intervention work” (p. 747). Like other interventions described in this section, the program places a specific emphasis on the relationship between intervenor and mother in early sessions.

The Circle of Security (COS) intervention has been described in detail (Zanetti, Powell, Cooper, & Hoffman, 2011). It has three unique features that help parents understand the academic basis of attachment and object relations theories. First, regarding attachment theory, the COS graphic depicts the safe haven and secure base concepts that help participants learn that children have needs for both safety and autonomy respectively. The picture also includes illustrations of parents’ appropriate behaviour to respond to each of those needs. Group members are taught that disorganized attachment can result from three forms of disturbed caregiving. Disturbed caregiving is when the child experiences the caregiving as mean, as weak, or as “gone,” or dissociated. The abdication of the parenting role might be a consequence of constant disturbed caregiving over time. The COS formula for parenting is to “always be Bigger, Stronger, Wiser, and Kind. Whenever possible, follow your child’s need. Whenever necessary take charge” (p. 322).

Second, regarding object relations theory, the COS developers created the unique concept referred to as “shark music.” Zanetti et al. contended that some mothers get triggered by their own painful childhood memories. They tend to act in habitual ways that have to do
with their central concerns regarding the mother-child relationship. The COS participants are
taught to be aware of their own “shark music” when they feel threatened, and to understand
its connection to responding negatively. The third unique feature of COS also involves object
relations theory. The COS program includes a unique consideration of parents’ “core
sensitivities.” When designing the original curriculum, the developers were informed by
Masterson and Klein (1995) with reference to the psychological defensive strategies that
parents use. Some mothers are separation-sensitive meaning that encouraging children’s
explorations would be equivalent to abandoning them. Therefore, these mothers might
discourage exploration. Other mothers are esteem-sensitive and hide their vulnerabilities. By
projecting a veneer of success, these mothers interfere with their own abilities to empathize
with their children. Last, some mothers are safety-sensitive and experience danger in close
relationships. They tend to remain distant and dampen children’s expressed emotions to the
degree that is comfortable for them. Understanding participants’ core sensitivities is meant to
guide COS intervenors with respect to behaviour coaching.

The Circle of Security–Parent (COS-P) is shorter in duration at eight weeks, focusses
on parental sensitive responding only during times of distress, and uses stock videos instead
of individualized parent-child videos (Woodhouse et al., 2015). This revision of the original
COS was manualized and specifically designed with broad implementation in mind, for real
world settings, and for at-risk families. Cassidy et al. (2017) recently conducted a RCT of
just under 200 participants that received the COS-P intervention as part of a Head Start
program. The journal article was part of a special issue in the Development and
Psychopathology Journal, entitled, Attachment in the context of atypical caregiving:
Harnessing insights from a developmental psychopathology perspective. Cassidy and
The researchers also included child cognitive measures. The results indicated that COS-P mothers reported significantly fewer unsupportive responses than control mothers. Furthermore, children in the COS-P group had significantly higher inhibitory control which was one dimension of executive functioning that was measured. This study is one example of research on attachment-based interventions that is starting to provide evidence for improving children’s cognitive development. Interestingly, the brief COS-P intervention had null effects for both attachment and child behaviour measures. In the editorial of the special issue, Roisman and Cicchetti (2017) commented that the 200 participants in the study comprised a relatively large RCT in terms of attachment research. They suggested that larger scale RCTs of attachment interventions will be needed in the future. Maternal depression was one of the moderators of the effects of the COS-P intervention on the child outcomes. Cassidy et al. (2017) discussed several potential reasons for the null results relating to attachment and behaviour outcomes: (a) fidelity to the manualized delivery of the relatively new COS-P may not have been achieved; (b) the brief intervention may have not been efficacious for some of the participants compared to others. They pointed to the need for researchers to continue to tease out which attachment-based interventions work best for whom; and (c) if follow-up measures were used the results might have shown a delayed effect from the intervention.

An effort was made to address a gap in the research on attachment-based interventions (Huber, McMahon, and Sweller 2015). It is well-known that young children’s problems originate in relationships. However, the researchers argued that there is still not
tremendous support in the literature that improving attachment security and reducing attachment disorganization will have indirect and positive effects on children’s behaviour. Their study results indicated that the 20-week Circle of Security (COS) intervention was effective in improving the externalizing and internalizing behaviour of children ages one through seven years, of 83 parents. Huber et al. discussed that retention in the study was high despite families having moderate to high psychosocial and demographic risk. Moreover, children with the most severe difficulties had the most improvement. Success in engaging hard to reach families was believed to be most likely due to the COS emphasis on relationship.

Changes in maternal reflective functioning (RF) were described by Page and Koren-Karie (2013) in a case study derived from a COS intervention. The researchers outlined the signs of improving maternal RF as the capacity of the case mother to think of her child’s motives, take the child’s perspective, consider the child to be a complex person, and understand their behaviour appropriately. Page and Koren-Karie’s understanding of the mechanism of change due to the COS intervention is notable. They believed that change occurred in the case mother when she experienced an empathic shift via repeated exposure to video images of her child in need.

**Attachment and Biobehavioural Catch-up (ABC).** The ABC intervention was designed to help children who experience early adversity in high-risk families that puts them at risk for further child maltreatment. Bernard et al. (2012) alleged that targeting not only maternal insensitivity, but also maternal frightening and atypical behavior was required to reduce disorganized attachment in children. In a review of attachment-based interventions, programs like ABC that focus on parental sensitive behaviour were promoted from meta-
analysis as more effective than programs that target mental representations of parents (Juffer et al., 2014). The ABC program was based on both attachment theory and stress neurobiology theory (Dozier, Meade, & Bernard, 2014). Stress neurobiology theory outlines how stress affects a child’s emotional regulation abilities. In an earlier study of high-risk households, researchers discovered the result from stress of disruptions to the daily pattern of children’s cortisol production, the end product of the Hypothalamic-Pituitary-Adrenal (HPA) axis system (Bernard, Butzin-Dozier, Rittenhouse, & Dozier, 2010). Dozier et al. (2014) believed that the two foundational theories of ABC merge together well because high-risk parenting that includes neglect or intrusive behaviour is connected to dysregulation of the neuroendocrine system.

The ABC program is evidence-based, brief (10 sessions), manualized, and home-based. Parents are treated together with their children using in-the-moment video feedback. The program targets three main issues. First, when children are distressed parents should soothe, comfort, and nurture them. Second, when they are not in distress parents should follow their children’s leads. Last, parents should never indicate their fright or display frightening or subtly intrusive or threatening behaviour to their children. Bernard et al. (2012) reported the results from a RCT of a foster-care diversion program. Disorganized attachment was assessed after the intervention and was reduced in the intervention group compared to the control group, 32% of the group in total compared to 57% of the group, respectively. In addition, the researchers found it remarkable that children in the intervention group had a normative cortisol pattern measured over two days. Bernard et al. insisted that the short-term targeted approach that focused on parent behaviour in-the-moment was the reason the program was effective.
Canadian researchers developed Attachment, Video-feedback Intervention (AVI), a short-term, 8-week program for maltreating parents and their children (Moss et al., 2011). The AVI is primarily based on the Attachment and Biobehavioural Catch-up (ABC) intervention. Enhancing parental sensitivity was the major aim of the study. Sixty-seven participant dyads were randomly assigned to the intervention and control groups. The results of the RCT revealed that disorganized attachment in the intervention group was transformed to organized at posttest. In the program implementation article Moss et al., (2014) stated that despite the exciting results, further research was needed to: (1) determine if the short-term effects on attachment security that were discovered in the study could have positive long-term sequelae; and (2) find out if stressed and unstable parents can maintain sensitive parenting after a short-term intervention and after the intervenors are gone.

A recent follow-up study by the same Canadian research team was the first of its kind to test the effectiveness of a short-term, attachment-based intervention on the cognitive and motor development of neglected and at high-risk infants and toddlers (Dubois-Comtois et al., 2017). A second purpose of the study was to assess whether parents’ subjective experiences of stress were reduced as a result of the intervention. Some of the 41 parent/child participants were recruited from the team’s original longitudinal study of families at-risk for maltreatment of children. The rest of the participant dyads were recruited through child protective services and were included if the children were assessed as neglected and at-risk for maltreatment.

The Attachment Video-feedback Intervention (AVI) was used during eight at-home sessions in which intervenors guided mothers through feedback toward more sensitive parenting behaviour. The quantity and quality of in-the-moment comments made by parenting coaches of the related Attachment and Biobehavioural Catch-up (ABC) were being
proposed as a mechanism of change of the intervention on attachment outcomes (Berlin et al., 2016). Hence, because the AVI was based on the ABC, it implied that intervenor-parent interactions would be crucially important for its success. Parental sensitivity and child mental and motor development scores were higher in the intervention group, although not significantly. This result is most likely due to the small sample size, n = 41. Still, Roisman and Cicchetti (2017) included the “proof of concept” report in a special issue on attachment and atypical caregiving, denoting the hopeful and practical potential of the AVI.

Dubois-Comtois et al. (2017) provided an informative discussion concerning parental stress. There are clearly many stressful events and interactions in high-risk homes. In spite of this, subjective parental reports of stress are not always equivalent. The AVI did not affect parent participants’ subjective experiences of stress according to their self-reports. The researchers speculated that parents from high-risk homes may under-report stress because of social desirability and defensiveness. On top of that parenting is hard, and parents who have high-risk infants might have been challenged by the demands of the intervention. Dubois-Comtois suggested that there may have to be more support added before and after interventions such as the AVI that target parental stress. The interventions may place burdens on parents that they are not used to.

**Summary of attachment-based interventions in early life.** The interventions reviewed in this section represent the translation of the past 20 years of attachment research into practice. The interventions also embody a diversity of approaches and duration. For example, the long-term psychotherapeutic interventions, child-parent psychotherapy (CPP) and minding the baby (MTB), target parental reflective functioning over a period of 12 to 18 months. The video-based interventions reviewed here are the Circle of Security (COS),
Attachment and Biobehavioural Catch-up (ABC), and shorter versions of them both, Circle of Security–Parent (COS-P), and Attachment Video-feedback Intervention (AVI) respectively. Video-feedback interventions target child attachment security and parental-sensitive behaviour and sessions last between 8 to 20 weeks. Berlin et al. (2016) noted that the CPP, COS and ABC have built up the strongest evidence bases.

Summary of the Literature Review

Attachment literature has clearly shown that early attachment security has lasting significance for children’s socioemotional (mal)adjustment, and is modestly related to social competence, externalizing problems, internalizing problems, and only weakly related to infant temperament (Groh et al., 2012; Groh et al., 2014; Groh, Fearon, et al., 2017; Groh, Narayan, et al., 2017; Fearon et al., 2010). In particular, the disorganized attachment literature has unambiguously shown that severely troubled parent-child interactions in the first two years of life are significantly related to negative developmental trajectories that continue into adulthood (Lyons-Ruth & Jacobvitz, 2016). Neuroscientific developmental research is now revealing the deleterious effects of the type and timing of early childhood maltreatment including neglect, and infant disorganization, on brain development (Lyons-Ruth et al., 2016; Teicher et al., 2016). This literature has revealed there is a pressing need for intervention in parent-child interactions and caregiving environments very early in the lives of children with disorganized attachment.

Epigenetic researchers are providing important evidence that gene x environment interactions at least partly explain the intergenerational transmission gap between parent and infant attachment (Bakermans-Kranenburg & van IJzendoorn, 2016). Primate research was reviewed in this study: (1) experimentally altering caregiving environments has provided
evidence for a maternal buffering effect on monkeys with risky genes (Suomi, 2016); and (2) longitudinal studies showed that the worst maternal care, in and of itself, produced broad epigenome responses in offspring that were an adaptation to the early caregiving environment (Provencal et al., 2012; Provencal et al., 2016). This research demonstrated the mechanism by which early rejecting and neglectful caregiving relationships caused alterations in healthy brain development.

According to the relational literature, connections are how women in particular establish their identities (Gilligan, 1982; Herman, 1992; Jordan, 1997, 2010; Miller, 1976). This has implications for women who seek treatment for drug and alcohol addiction, due to the importance of relationships and all of the relational roles they occupy (Finkelstein, 1994). Considerable evidence is mounting that relational, comprehensive, and integrated treatment for pregnant and parenting women who have problematic substance use reduces addiction severity and improves numerous other parenting and child outcomes (Belt et al., 2012; Espinet et al., 2016; Milligan et al., 2010; Niccols et al., 2012; Pepler et al., 2014). The risk factors of this population are now well known (Kaltenbach, 2013). However, much less is known about the potentially protective factors of women in this population.

The intervention literature reviewed in this chapter indicates modestly effective but promising results for women at psychosocial risk who are early parenting and struggling with addiction. The evidence-based interventions that are making a difference and were reviewed: Child and Parent Psychotherapy (Guild et al., 2017; Lieberman & Van Horn, 2004, 2008; Van Horn & Reyes, 2014); Mothering from the Inside Out (Suchman et al., 2010, 2011, 2017); Circle of Security (Cassidy et al., 2017; Hoffman et al., 2006; Huber et al., 2015); and Attachment and Biobehavioural Catch-up (Bernard et al., 2012). In addition, although not yet
evidence-based, the Attachment Video-feedback Intervention was also described in this chapter for its hopeful potential (Dubois-Comtois et al., 2017; Moss et al., 2011).

Advances in our knowledge of epigenetics including the differential susceptibility principle have led to new avenues of intervention research. Only fairly recently has meta-analytic evidence indicated that the effects of the interventions listed above, targeting maternal sensitivity and the mother-infant dyad, appears to depend on the proportion of genetically susceptible participants (Bakermans-Kranenburg & van Ijzendoorn, 2015, 2016). These attachment-based and mentalization-based interventions were derived from psychodynamic theories and continue to be researched predominantly with experimental and quasi-experimental designs. One of the goals for research over the next decade is to discover what interventions will be most effective for individual at-risk parent-infant dyads. There is much left to be learned. However, what is certain from the research is that it helps to improve the caregiving environments of infants at-risk of insecure or disorganized attachment. Furthermore, the positive effects from sensitive caregiving might be even greater for those infants with genetic vulnerabilities.

There is less known about other factors that may be influencing women who struggle with substance use issues while early parenting, and who are already actively engaged with integrated treatment programs, together with their children. Jeong (2015) suggested there is a gap in our knowledge related to what the key factors are for early parenting women that are moving along in a process of recovering from substance abuse. Jeong proposed that future research should test whether the caregiving role, within a supportive environment, could itself be a catalyst of change to reduce substance use severity. If so, it would be important to know in these supportive environments what factors in particular were parents finding
helpful. What factors would have been helpful if they were available, and what factors were making it harder for them as parents with substance use issues. There is no known qualitative research that explored the helpful and hindering factors that women might describe of their experiences of early parenting while struggling with substance use issues. Therefore, this study was conducted to ask such questions of women and was focused on the research question: “What factors have been helpful or hindering for service-engaged, early parenting women who have problematic substance use, and what do they wish for that might help if they had access to it?”
Chapter III: Methodology

This chapter describes the framework of the study. First, the history of the Critical Incident Technique (CIT) is described followed by how the CIT evolved within counselling psychology into the Enhanced Critical Incident Technique (ECIT). This is followed by the rationale presented for using the ECIT method in the present study. After outlining the philosophical and theoretical assumptions that undergird the study, the researcher’s beliefs and assumptions are presented.

The remainder of the chapter explains in detail how the ECIT method was followed in the current study. This includes ethical concerns, the description of the sample, procedures for participant recruitment, and the procedures for data collection and analysis. Finally, there is an explanation of the series of steps taken after the data was analyzed to ensure its credibility and trustworthiness. The chapter concludes with a summary of how I represented the findings and practiced reflexivity as the primary researcher.

Flanagan’s Critical Incident Technique (CIT) Method

Flanagan’s (1954) Critical Incident Technique (CIT) method was developed during and after World War II. Its origins are in organizational and industrial psychology. The CIT was a functional tool that Flanagan used to objectively observe, analyze, and describe a task. Flanagan’s findings about the critical job functions of airmen were published in 1954 and the seminal article described the method and introduces its name. Flanagan’s CIT method has five steps: (a) determine the aim of the activity being studied; (b) set the plans, specifications, and criteria; (c) collect the data; (d) analyze the data; and (e) report the findings.

In the early stages of using the CIT method, Andersson and Nilsson (1964) studied the job of grocery store managers in Sweden according to the behavioural tasks related to
their training. University students were used to independently confirm the categorical system that was created by the investigators. The authors provided important support for the CIT as they concluded from their extensive study that the information collected when using the method was reliable and valid.

**CIT research at the University of British Columbia (UBC).** Starting in the 1970s and 1980s, the CIT approach has been used extensively as a qualitative research method at UBC. UBC researchers are chiefly responsible for the evolutions of the method for research in counselling psychology (W. A. Borgen, personal communication, February 21, 2017). Borgen and Amundson (1984) used the CIT for their research on the dynamics of unemployment. Woolsey (1986) made an important contribution and explained the CIT method in further detail, using examples from her own research.

Woolsey (1986) was the first person at UBC to make use of the CIT within the field of counselling psychology research. Instead of using the CIT to study only activities and behaviours, Woolsey suggested using it to also study research subjects’ perceptions and experiences. Woolsey used the CIT to explore her participants’ psychological phenomenon. Building on these contributions, many masters and doctoral students at UBC began to use this approach in a variety of research studies. For example, Wong (2000) utilized the CIT to explore the process of cross-cultural supervision for her dissertation research.

Butterfield, Borgen, Amundson, and Maglio (2005) conducted a 50-year review of the CIT literature. The authors detailed the extensive use of the CIT in a wide variety of disciplines including counselling psychology, as described above. Their follow-up article (Butterfield, Borgen, Maglio, & Amundson, 2009) described revisions to the CIT method for use in research. They provided detailed instructions about how to use the method, including a
comprehensive structure for checking reliability. The authors expanded the CIT method with two additions. The first addition was within the CIT interview, which included an introductory section that focuses on participants’ contexts. The second add-on was a new set of questions in the interview in order for participants to report their wish lists. With these added elements, the authors suggested that the name “Enhanced Critical Incident Technique (ECIT)” be used for the method.

Butterfield, Borgen, Amundson, and Erlebach (2010) used the ECIT in their research to explore what helped and hindered workers who believed they managed workplace change well. Their study was unique in that it approached their research questions from the strength-based perspective of positive psychology. Their study painted a picture of workers who self-described as doing well, according to the positive strategies they employed, in the face of uncertainty and change.

More recently Amundson, Borgen, and Butterfield (2013) suggested two things for fine tuning the ECIT method. Incorporating them would serve the purpose of being able to conduct more interviews and thus collect more data after tracking exhaustiveness in a cost-effective way. First, they introduced a summary process to use within the interview after each of the three major ECIT sections. The authors suggested that this formalized addition also serves as a type of internal credibility check. Second, they described how the summarizations can be used for targeted transcriptions. After exhaustiveness is discovered, researchers can still interview more participants if it would lend to the credibility of the study, but would only transcribe the summaries. The Enhanced Critical Incident Technique (ECIT) is “a method that is growing into a methodology” (W. A. Borgen, personal communication, February 21, 2017). The major advancements and evolutions of the ECIT, specifically within
the counselling psychology discipline, have been described above. The major contributors have provided a clear breakdown of how ECIT research should progress (Borgen, Amundson, & Butterfield, 2008).

**Philosophical Principles and Theoretical Assumptions**

Cresswell and Poth (2018) advocated for beginning qualitative researchers to make the philosophical and interpretive frameworks behind their research explicit. The Critical Incident Technique (CIT), as a method, was originally designed by Flanagan (1954) as a scientific tool for investigating observable activities. In the 1950s, the positivist paradigm dominated scientific inquiry. In its evolutions since that time, variants of the CIT can be applied within several theoretical perspectives (Chell, 2004).

The postpositivist paradigm is the theoretical worldview that provided the structure for this study. Postpositivist assumptions are undergirded by the realist ontology and the objectivism epistemology (Crotty, 1998). First, the realist ontology lines up with essentialism asserting that reality exists apart from the human mind. Therefore, the purpose of science is to discover the existence of reality and express it. Second, objectivism as epistemology asserts that meaning already exists within objects independently of the subjects studying them. This assumption of the postpositivist worldview means that what is possible for humankind to know must be revealed. Knowledge, according to the postpositive paradigm, is to be discovered. Claiming to know anything is thought of as the best understanding of something at a given point in time. When positivism was challenged in the 1960s, postpositivists argued that there are multiple truths (Guba & Lincoln, 1994). Postpositivism opened the doors for the use of both quantitative and qualitative research methods.
Within a postpositivist framework for this study, I had confidence that the experiences that participants recalled were actual events. In addition, I accepted as true that the meanings the participants conveyed to their experiences were their own. From a postpositivist perspective, my job as primary researcher was not to co-create meaning with a participant, but to discover it (Moon & Blackman, 2014). The postpositivist worldview offers one approach to research in counselling psychology that is appropriate for both naturalistic designs and qualitative methods such as in-depth, face-to-face interviews. Both quantitative and qualitative interpretive research are conducted from within a postpositivist paradigm (Bhattacharya, 2012). Some notions of the interpretive theory of knowledge were also assumed in this study. Interpretation is derived from a relationship in which the researcher and the researched have dynamic interaction. My values, assumptions, and lived experiences were never divorced from the research process.

Domenici (2008) reviewed the relevant issues of non-dualism, historicity and the interpersonal nature of interpretation as three central features of qualitative research. First, as humans we are engaged knowers, embodied and embedded participants in the real world and not separate from it as dualism suggests. Second, we exist in a particular context of time and culture. Third, our history affects our present experiences and interpretations of them. This in turn affects our future interactions and interpretations in a circular fashion. These three features outline the subjective nature of my role as a qualitative researcher in this study.

The Enhanced Critical Incident Technique (ECIT) itself continues to be regarded by many researchers as a functional method scaffolded by the philosophical and conceptual assumptions of the postpositivist paradigm (W. A. Borgen, personal communication, February 21, 2017). Furthermore, postpositivism can be justified as an appropriate paradigm
from which the ECIT method is used. For a qualitative research method, there is a substantial focus on counting and numbers when analyzing data using the ECIT. For example, a sample size is not the number of participants in the study. The sample size is the number of critical incidents and wish list items extracted from transcribed interviews. In addition, the created categories with higher participation rates and more critical incidents are understood to represent important areas of the domain being studied. This emphasis on counting and numbers with the ECIT method adds more support for its use within a postpositivist paradigm.

**Rationale for the ECIT in the Current Study**

A practical and flexible qualitative method such as the Enhanced Critical Incident Technique (ECIT) was appropriate for an exploratory study that focused explicitly on parents. As stated earlier, the notion of the contextualizing portion of the interview was introduced by Butterfield, Borgen, Maglio, et al. (2009) as one of the enhancements of the ECIT. In this study the contextual section of each interview took place during the first 10 – 15 minutes, and was basically unstructured. This was to allow participants to briefly start telling their stories of the past 12-18 months. This open-ended space was suitable for helping participants calm their nerves, and at the same time focus their attention on the timely events they would later be asked about in more detail. Less structure at the beginning of the interview did not frame participants in, but gave them the choice of what they wanted to divulge first, and with how much detail.

Dell (2007) reviewed the research landscape in Canada specific to women and substance use from a feminist perspective. She endorsed qualitative approaches to gather data and create knowledge separate from quantitative research. Regarding specific investigative
techniques, Dell stated that, “The interview takes women’s own accounts as the starting point for making sense of women’s experiences, providing an opportunity to glimpse the richness and complexity of the human side of a story” (p. 501).

Dell would likely have recommended using an unstructured interview in the present study, which would align with a feminist approach. However, as primary researcher and feminist, I found the semi-structured interview had unique advantages and worked well with the vulnerable participants in the study. The semi-structured style of the interviews, after the contextual component, was suitable for gathering rich and detailed aspects of the participants’ experiences. Utilizing the ECIT in this study enabled me to be sensitive toward a group of parents with self-identified substance use issues, many of whom had experienced stigmatization. The use of the ECIT method was appropriate for the present study in five ways that are described next.

First, the Enhanced Critical Incident Technique (ECIT) method sensitively engaged the participants. Although it is a semi-structured interview style, it still gave participants a fair amount of control. They could be in charge of what incidents they chose to recount in terms of how important the experiences were to them. Depending on their comfort level, participants could move through the interview in an organized fashion, from helping to hindering factors, and then to wish list items. Alternatively, they could jump around from helping to hindering as incidents came to mind, and I would follow. In guiding them through the interview by following the protocol, a helpful structure was provided, especially to put nervous or reticent participants at ease. As the ECIT method requires, the probing questions around critical incidents helped to draw out the necessary details from the participants.
Second, the semi-structured interview helped me to control the interviews in helpful ways. Chell (2004) used the Critical Incident Technique in organizational research. She contended that probes keep participants attentive and focused on the research question. The interaction that develops between the interviewer’s queries and the interviewee’s descriptions serves to create a relaxed flow to the interview. The questions and probes also serve to steer participants away from monologues to more focused dialogues. The benefits described above, from the structure of the interview and the style of conducting it, were experienced in this study. I was able to guide participants without being dominant or asking leading questions. The repetitive questions helped participants continue to reflect on the research question which was, “What factors have been helpful or hindering for service-engaged, early parenting women who have problematic substance use, and what do they wish for that might help if they had access to it?” Using the structure of the ECIT interview, I was consistent within each interview and between 20 interviews.

Third, the focus on helpful factors and wish list items might have contributed to participants’ feelings of empowerment and recognitions of strengths. The positive focus could have helped participants realize they have a voice, they can contribute to others, and they can gain new perspectives of themselves. Pre-test and post-test interview measures were used in a previous study using the Enhanced Critical Incident Technique (ECIT). The results showed that even taking part in the interview itself can have a positive impact on people (Butterfield, Borgen, & Amundson, 2009).

Fourth, the elicitation of unhelpful factors during the interview is sandwiched between the relatively positive discussions of helpful factors and wish list items. The discussion of wish list items near the end of the interview might have been positive and
uplifting for participants. By naming what could have helped if it had been available, participants might have felt hopeful for others in the future that might benefit from those things.

Last, the ECIT method was suitable for this research topic because it has already been found to be valid and reliable. Nine credibility checks were introduced by Butterfield, Borgen, Maglio, et al. (2009) to make the method as rigorous as it has come to be known. The credibility checks are described in detail later in this chapter. Using them increases confidence that the data analysis and the results reported are an accurate interpretation of the participants’ experiences.

**Researcher’s Beliefs and Assumptions**

I expected that my pre-existing beliefs and assumptions would influence how I collected, analyzed and interpreted the data from this study. For example, my orientation as a Registered Clinical Counsellor is informed by theories connected to the relational psychodynamic approach. This undergirds my belief in the primacy of relationships as the basis of understanding mental health and illness, and the basis of how to heal problems. Upon reflection, I recognized the following beliefs and a priori assumptions I brought to the research project:

1. The abnormalities and problems that humans face are not merely individual in nature. Rather, particular contexts of clients’ struggles and problems are just as important as their intrapersonal factors.

2. When asked, women would likely reflect on and recall more helpful and hindering relational experiences versus other types of non-relational experiences. The basis of this assumption is self-in-relation theory that calls attention to
women’s interpersonal development of the self (Miller, 1991; Surrey, 1991). In light of its current version called relational-cultural theory, it made sense that the important experiences that participants recalled would be about connections or lack of connections with others (Jordan, 2010).

3. By “service-engaged,” I assumed that women were accessing social supports and seeking to build helping relationships. I was not assuming, however, that women who were not engaged in services were not help-seeking.

4. From what I learned in the literature, I believed that women in the population that I was studying would manage better with social supports than without them.

Having stated my philosophical stance, theoretical worldview and assumptions, I also acknowledge that due to the subjective viewpoint I brought, a different researcher might have examined the same data and arrived at different interpretations.

**Situating the researcher.** Throughout the project, as the primary researcher, I had to navigate several different positions. I was a graduate student in a doctoral program for the duration of the study. As a foreigner to the population I was studying, I am middle-aged, Caucasian, highly educated with high socioeconomic status, and from a middle-class neighbourhood. This contrasted starkly with the participants in the study. All participants were younger than me, many were Indigenous women, all reported low incomes, and many came from impoverished neighbourhoods such as the Downtown Eastside (DTES). As survivors of trauma struggling with addiction, the participants in the study were considered highly vulnerable.

As a middle-aged Caucasian woman I was concerned about interviewing young, Indigenous participants. They could perceive me as a person with power, someone with the
potential to oppress them further. For that reason, I intentionally sought the counsel of one of my dissertation committee members who is also an Indigenous woman. Over several meetings before the data collection phase began, the professor educated me further about the 550 year intergenerational history of colonialism and trauma experienced by Canada’s Indigenous people.

In a practical sense, my committee member emphasized the ways that Indigenous women have been affected throughout the generations. This was meant to better prepare me to encounter Indigenous participants with more knowledge, without judgment, and as the ally I believed I was. The professor also provided helpful suggestions such as how to engage Indigenous participants who might be initially reticent, using the concepts of food and story-telling. She encouraged me to practice reflexivity by tracking my reactions to participants which could tap into any internal biases I might have. The responses to those reactions, she said, could be worked through during different phases of the study and beyond.

From a different position, I have worked with women from the sample population as a Registered Clinical Counsellor. In addition, I could express my passion about parenting to the participants who were also parenting. I have personally experienced the challenges of parenting over decades of life experience. I have studied parenting at the graduate level and could not only share my interest in parenting, but also my desire to disseminate the results from the study in the form of a needs assessment which could benefit parents like these in the future. Furthermore, I have professional experience counselling, advocating for, and coaching parents.

Based on a research professor’s recommendation, I volunteered for one semester at a transitional housing program in the Downtown Eastside (DTES) that offered to assist with
recruitment. Through volunteer hours, I became somewhat more familiar with the population of people and issues I was studying about at that time. Encountering and connecting with clients of the transitional housing program was helpful. The encounters provided one way to prepare me for meeting similar women that would be participants in the study. I accompanied clients to their appointments, participated in groups, lead groups, and connected with individual parents and their infants. Having situated myself as the primary researcher, the rest of this chapter outlines the way I proceeded.

**Method for the Current Study**

The research question for the study was: What factors have been helpful or hindering for service-engaged, early parenting women who have problematic substance use, and what do they wish for that might help if they had access to it? Early parenting, in this study, was defined as having at least one child between the ages of birth to six years. Women’s service-engagement was deemed to be a protective factor. Engagement meant that participants were accessing and involved with at least one service provider in their communities. Examples of services they might have been accessing included residential alcohol and drug treatment centres, shelters, stabilization/supervised housing programs, and second stage housing programs.

Other service providers could have been community-based harm reduction outreach programs and after-care programs that women transitioned from treatment to, such as government subsidized or other transitional housing programs. There were numerous ethical concerns relating to the study. They are described briefly below. Addressing ethical concerns regarding the study was necessary before the recruitment process began.
Ethical concerns. Potential participants’ vulnerability was rated as high in this study based on the population that the sample was drawn from. The participants were women who were early parenting and had substance use problems. They had a history of substance use issues, among many other problems and barriers. The potential participants’ experiences included trauma and other difficulties such as discrimination.

A sizeable proportion of participants were Indigenous women, who together with other women, were residing in the Downtown Eastside (DTES) of Vancouver. Many women were dealing with poverty, violence in relationships, and child welfare issues. The combination of those factors qualified the participants’ vulnerability as high. To mitigate risk, a “staff spotter” was designated at a transitional housing program that committed to assisting with recruitment and with advertising the study.

The designation of a “staff spotter.” Before assisting with recruitment and assessing the suitability of their clients for potential participation, the organization was provided with an information sheet for facilitating recruitment (see Appendix A). The purpose of the document was to explain the study in detail and to insist that their clients would not perceive coercion to participate. In addition, the document insisted that their clients would not be denied access to programming or be discriminated against if they decided not to participate in the study.

The staff spotter, a registered social worker, assessed their clients’ suitability for participation and monitored their well-being. It was expected that the staff spotter, being familiar with clients’ current situations, would provide fair-minded assessments of substance use severity symptoms that could impede women’s abilities to participate in the study. There was a slight chance of a difference of opinion between the staff spotter’s assessment and a
potential participant’s desire to be involved in the study. If that situation arose, the Principal Investigator (PI) would become involved and the PI would make the final decision.

On several occasions at the transitional housing program, the staff spotter postponed interview appointments. The staff spotter also delayed presenting the recruitment poster to clients based on her opinion of their vulnerability, or did not recommend participation at all. One potential participant at the same program initially provided informed consent. Later, when the staff spotter followed up with her to schedule the interview, she had changed her mind about participating.

I anticipated that staff spotters might be assigned at two residential treatment centres where I interviewed 16 of the 20 participants. However, no formal staff spotter positions were established due to lack of personnel. In both treatment centres, the executive directors informally assisted in recruitment efforts which were informed by their perceptions and knowledge of their client’s vulnerability. The assistance of the staff spotter and executive directors was invaluable as I continued to discover the complexities and vulnerabilities of women in the population that I was studying.

At one of the alcohol and drug treatment centres, four women initially provided informed consent to participate. They were scheduled for the first interview, but did not follow through. In one case, a woman changed her mind and withdrew before the first interview. By her account, the potential participant stated that she felt emotionally triggered when the potential risks of participating were explained to her in advance. In three cases, women were discharged from the treatment centre for violating program rules before their first interviews were conducted. However, at another alcohol and drug treatment centre, all
four women who originally consented to participate in the study followed through with their first interviews.

Concerns about the Downtown Eastside (DTES). There were other ethical concerns about research in the DTES due to the high turnover of the population, payments for participating in the study, and potential disclosures by participants that might implicate child protection services. Salmon, Browne, and Pederson (2010) described the turnover of women residing in the DTES due to their disjointed living situations and issues of survival. It was suspected that transiency might affect my ability to track down participants for cross-checking purposes after the initial interviews.

Regarding the DTES, Salmon et al. contended that the experience of some of the front-line workers and of the women who use drugs is that they are already “researched to death” (p. 340). Despite generating a lot of research, the authors stated that there are few community programs that follow from it. Furthermore, word tends to get out that people will be paid honoraria in exchange for their participation. In this study, it was possible that women would actively seek out participation by sharing their stories in exchange for money, without considering risk to themselves. The response to this concern is discussed in the participant recruitment section.

As primary researcher, I acknowledged a potential problem of balancing ethical and legal issues in the study, and conducting research with women from the DTES. On one hand, there might have been a duty to report participants’ disclosures of harm or potential harm to appropriate agencies. On the other hand, there was the major task of the study which was to interview women in depth about their experiences of problematic drug use while early parenting. This dilemma required consultation with committee members, other researchers,
and community service providers. It was decided that on the consent form, which was presented at a pre-interview discussion, potential participants would be apprised for the first time concerning the legal limits to confidentiality. More details about how the legal limits to confidentiality were handled are discussed in the section outlining the informed consent process.

Given these challenges, it was important to follow Polkinghorne’s (2005) advice regarding the production of qualitative data. With ideas and support from the dissertation committee and others, I planned to make the well-being of the participants a primary concern. As Polkinghorne suggested, I proceeded with integrity regarding the research, and with sensitivity around the participants’ needs and desires.

**Sampling criteria.** There were criteria to include and exclude potential participants in and from the study. An explanation of a particular exclusion was provided. In addition, the definition of problematic substance use was outlined.

**Criteria for inclusion.** Inclusion criteria for the present study included the following:

- Women. In addition, participants were also asked to identify their gender. All 20 participants replied that their gender identification was female.
- Were of minimum age 19 years.
- Engaged with at least one service provider in their communities, as described above, at the time of their participation.
- Early parenting with at least one child between the ages of birth and six years. Women may or may not have had legal custody of their child or children, or visitation rights, at the time of their participation. However, for those parents who were not together with their children at the time of their participation, they were
required to confirm their parenting goals. Potential participants were asked about their goals for potential custody of their children and family reunification, in whatever way they were defining those goals, alone or together with their service providers.

- Willing to self-identify, when screened for the study, that their substance use was problematic for them as a parent. The definition of problematic substance use that was used in the study is provided below.

- Could understand written and spoken English.

**Definition of problematic substance use.** The term substance use, as it was defined in the study, encompassed the participants’ self-reported current use of substances. If they were abstinent, potential participants were asked if they had used substances within the past year that had been problematic for them as a parent. At screening time, when two potential participants indicated that they had been clean and/or sober for longer than one year, they were excluded from the study. In this study, it was parents’ relatively current experiences and viewpoints about problematic substance use and parenting (from the past 12 to 18 months) that were being sought.

The types of substances used meant any from the classes of licit and illicit drugs, including but not limited to, alcohol, cannabis, hallucinogens, inhalants, opioids, stimulants, or a combination of them. The participants’ admissions of problematic substance use during the past year, while pregnant or early parenting, was sufficient for inclusion based on the criterion. Although some of them may have met the diagnostic criteria for a substance use disorder according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013), a diagnosis was not required for participation.
**Criteria for exclusion.** Neither fathers, nor other non-biologically related partners, nor teenage mothers under the age of majority in British Columbia were included in this study. While these groups would have made important contributions to this complex topic, they were beyond the scope of this doctoral research project. Therefore, exclusion criteria for the present study included the following:

- Men.
- Teenage mothers under age 19.
- Not service-engaged with at least one service provider at the time of recruitment for participation.
- Not early parenting one or more children between the ages of birth and six years.
- Not self-identifying with a current substance use problem or problematic substance use within the past year, as defined above.
- Not understanding written and spoken English. I conducted the interviews in English which is my only language. Participants were required to read and understand the consent form before signing it, and language translation was not a possibility in the study.

No exclusions were made on the basis of socioeconomic status or cultural background.

- Self-describing, or knowledgeable others reporting, current or recent substance use symptoms in a severe range. Severity included the potential participant’s reported symptoms of impaired control, social impairment, risky use, tolerance, and withdrawal.
Excluding a participant based on symptoms of substance use severity. In addition to increased vulnerability, functional impairment due to symptoms of substance use severity might have prohibited a woman from being able to participate in one long interview (2 + hours), and one shorter interview, and be fully cognizant. The decision to exclude a person from possible participation on the basis of their vulnerability and substance use severity symptoms was my responsibility. I planned to consult with the principal investigator about these decisions, but it was not necessary.

**Procedures for participant recruitment.** Numerous attempts were made over a period of three months to recruit participants from across the Lower Mainland and one large city in the interior of British Columbia. Including the transitional housing program, a total of 14 organizations that provided services to women in the sample population, were contacted and agreed to advertise the study.

The original goal was to recruit a diversity of participants who were accessing services from a continuum of abstinence-based and harm-reduction based providers. At one end of the spectrum, the goal was to interview women who had already completed, or were completing, abstinence-based alcohol and drug treatment. At the other end of the spectrum, the hope was to talk to women who were accessing services such as the ones they could receive at harm-reduction based drop-in centres. See Figure 1 for a graphic of the diversity of service providers that were being sought to advertise the study.

The advertising process that was used for recruiting a diverse sample is described below. However, at the time of their participation, 17 of the 20 participants came from three abstinence-based, residential alcohol and drug treatment centres. Therefore, the participants
Figure 1: Continuum of Desired Service-engagement Diversity
were engaged with a narrower variety of service providers than we had hoped for. This is discussed as a limitation of the study and includes recommendations for future research. The types of organizations and the process followed is described in detail below.

Assistance and referrals from the community, including non-profit organizations and government funded establishments. Several years before the study was conducted, the management team from a transitional housing program that was being piloted in the Downtown Eastside (DTES) expressed their support to recruit participants. They offered not only to advertise the study to their clients, but also to refer the study to other organizations. Their program provides bridged housing and 24-hour supervision for 15 single women and for up to six additional women, together with their infants. The mothers would have given birth within the past year, and were dealing with substance use issues.

When the recruitment phase started, the manager of the transitional housing program was provided with a Study Guideline (see Appendix B). The guideline clarified the stages of the study and the steps that would be taken within each stage, from the recruitment process through to the second and final interview. To assist with further recruitment beyond their own housing program, the manager made seven introductions to other service providers. They work in various partnerships with these organizations in the Downtown Eastside (DTES), elsewhere in the Lower Mainland, and in the interior of the province. First, the manager made an email introduction to a harm reduction-based drop-in program in the DTES that serves high-risk pregnant and early parenting women who are dealing with drug and alcohol issues. In addition, they made three introductions to residential drug and alcohol treatment centres.
The second and third introductions were made to integrated treatment centres. Integrated means that residential treatment is for mothers together with their infants and young children whenever possible. The rural centre is a government-funded residential drug and alcohol recovery program that treats women for approximately 10 weeks. Clients live together with their infants or young children over three months of age while receiving treatment. Other women are treated at the centre without their children. Situations vary depending on whether women voluntarily leave their children in the care of others, or are under supervision or other orders by provincial child protection services.

The urban alcohol and drug treatment centre is operated by a charitable organization, and while similar in many ways to the rural centre, their clients are also seeking recovery from sexual exploitation and trafficking. In addition, the urban centre offers advanced programming and transitional housing support for their clients. Mothers who are treated in this centre, together with their children, are required to make a minimum one year commitment. The fourth introduction was to a residential alcohol and drug treatment centre. It operates in a rural community in the Lower Mainland and treats adult women only.

Fifth, an introduction was made to a project for high risk pregnant and early parenting women. This community health centre in a Vancouver suburb provides services in partnership with a provincial health authority, and with the Ministry for Children and Family Development (MCFD). They have a wide range of health and social supports for women who are pregnant or who have young children, and who are impacted by substance use and/or violence and abuse. Sixth, an email introduction was made to a supportive housing program in a large city in the Okanagan Valley of BC. It is operated by a charitable organization for pregnant and parenting women recovering from chemical dependency. Seventh, an email
introduction was made to a charitable organization in the Downtown Eastside that provides supported housing for women-led families.

*Networking with other professionals.* In addition to the eight organizations described above, six separate attempts were made to recruit participants through professional connections I already had or through new information I learned about and followed up on.

First, in seeking a diverse sample, I connected with a MCFD regional mental health consultant. The hope was to recruit participants by advertising the study among their early childhood programs. For example, the MCFD provides Parent and Child Interaction Therapy at child and youth mental health counselling offices in two regions that the consultant oversees. Second, and also for the purpose of recruiting a diverse sample, I met with the director of young families’ programs which are part of the services offered by a charitable organization. Services include an outreach oriented drop-in program for young mothers in a large suburb of Vancouver.

Third, I was introduced by a colleague via email to the executive director of a private residential drug and alcohol treatment facility on a gulf island of BC. Fourth, the study was introduced by an acquaintance to the staff of a residential alcohol and drug treatment centre in a large city in the Lower Mainland. Fifth, through a personal relationship, the study was introduced at their workplace, one of Vancouver’s largest and most diversified non-profit organizations. Their services are focused on helping to lift women and their children out of poverty. Last, through one of the contacts mentioned above, a referral was made to the manager of a subsidized housing program in the Downtown Eastside.

In addition to the transitional housing program that was already committed, the 13 organizations described above initially expressed interest in the study and in advertising it.
Each of the managers or directors received further information by email that included two study documents. The first document was titled Information Sheet for Organizations to Advertise a Study (see Appendix C). The purpose of this document was threefold. First, it was for the directors of the treatment centres and other programs to understand in detail what the study was about and what would be required of their clients if they participated. Second, it provided contact information for both me and the principal investigator of the study. Third, the document informed directors that their participation in advertising the study was voluntary. The second document was an electronic copy of the recruitment poster (see Appendix D).

The result of the recruiting efforts described above was gaining the assistance of nine out of 14 organizations. Five of them did not advertise the study, despite their initial interest, for a few reasons. Regarding two organizations, the process to obtain permission to advertise the study to their clients was either too onerous or getting the final approval was overly difficult. At three organizations, the directors were either extremely busy in their positions and/or under significant stress. After making contact in these cases, the directors were initially willing but later unable to follow through and advertise the study.

**Poster recruitment.** Laminated, paper, and electronic copies of the recruitment poster were delivered, with permission, to the Lower Mainland contacts described above that offered to advertise the study to their clients. The wording of the poster was sensitive due to the stigmatization that mothers in the population face. A Facebook advertisement was also prepared (see Appendix E). However, advertising on social media was unnecessary.

**Snowball sampling.** At the end of the first interviews, participants were asked if they knew another woman or women who would potentially meet the inclusion criteria and who
might be interested in the study. If they did, paper copies of the recruitment poster were
given to the participants to pass on.

**Description of the sample.** Twenty service-engaged, early parenting women were
selected to participate in the study. They ranged in age between 21 to 41 years with an
average age of 32 years. See Tables 1 and 2 for summaries of the demographic data that was
collected. All women met the inclusion criteria outlined later in this chapter. Education levels
of the participants varied between some high school (8:40%); high school (8:40%); some
university (3:15%); and university degree (1:5%). Four of the participants indicated an
annual income between $20,000 - $40,000 dollars. The sizeable majority (16:80%) reported
incomes between $0 - $20,000 dollars per year. Participants were asked what their cultural
background was, and 11 (55%) responded Caucasian while 9 (45%) answered that they were
from an Indigenous background.

When asked their drug of choice, 3 women (15%) indicated alcohol alone and 2
women (10%) specified stimulants alone. Out of 20 participants, 15 (75%) replied that when
they were not abstinent, they were poly-substance users. Almost all of those participants (13
of 15) reported using a depressant such as alcohol or heroin, combined with a stimulant such
as cocaine or methamphetamine. In this group, 18 (90%) of the participants indicated a
personal and/or family history of addiction. As part of the demographic questions,
participants were asked three questions about their family and parental status: (a) regarding
their household composition, they were asked how their immediate families were organized
or, in other words, who they lived with; (b) they were asked if they had a supportive intimate
relationship; and (c) participants were asked to indicate the gender and age of their children.
Table 2 provides the summary of this demographic information.
Table 1

**Basic Demographics**

<table>
<thead>
<tr>
<th>Part #</th>
<th>Age</th>
<th>Gender</th>
<th>Education</th>
<th>Annual Income</th>
<th>Cultural Background</th>
<th>Drug of Choice</th>
<th>History of Addictions</th>
<th>History of Trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>32</td>
<td>F</td>
<td>High school</td>
<td>$20-$40,000</td>
<td>Caucasian</td>
<td>Poly-drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>41</td>
<td>F</td>
<td>Some university</td>
<td>$0-$20,000</td>
<td>Caucasian</td>
<td>Alcohol</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>3</td>
<td>33</td>
<td>F</td>
<td>Some high school</td>
<td>$0-$20,000</td>
<td>Caucasian</td>
<td>Poly-drugs</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>4</td>
<td>32</td>
<td>F</td>
<td>Some high school</td>
<td>$0-$20,000</td>
<td>Indigenous</td>
<td>Poly-drugs</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>5</td>
<td>22</td>
<td>F</td>
<td>High school</td>
<td>$0-$20,000</td>
<td>Indigenous</td>
<td>Poly-drugs</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>6</td>
<td>24</td>
<td>F</td>
<td>Some high school</td>
<td>$0-$20,000</td>
<td>Caucasian</td>
<td>Poly-drugs</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>7</td>
<td>34</td>
<td>F</td>
<td>High school</td>
<td>$0-$20,000</td>
<td>Indigenous</td>
<td>Stimulants</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>8</td>
<td>37</td>
<td>F</td>
<td>High school</td>
<td>$20-$40,000</td>
<td>Caucasian</td>
<td>Poly-drugs</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>9</td>
<td>32</td>
<td>F</td>
<td>High school</td>
<td>$0-$20,000</td>
<td>Indigenous</td>
<td>Poly-drugs</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>10</td>
<td>37</td>
<td>F</td>
<td>High school</td>
<td>$0-$20,000</td>
<td>Indigenous</td>
<td>Alcohol</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>11</td>
<td>30</td>
<td>F</td>
<td>Some high school</td>
<td>$0-$20,000</td>
<td>Caucasian</td>
<td>Poly-drugs</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>12</td>
<td>22</td>
<td>F</td>
<td>Some high school</td>
<td>$0-$20,000</td>
<td>Caucasian</td>
<td>Poly-drugs</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>13</td>
<td>38</td>
<td>F</td>
<td>Some high school</td>
<td>$0-$20,000</td>
<td>Indigenous</td>
<td>Poly-drugs</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>14</td>
<td>38</td>
<td>F</td>
<td>University degree</td>
<td>$0-$20,000</td>
<td>Caucasian</td>
<td>Poly-drugs</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>15</td>
<td>28</td>
<td>F</td>
<td>Some high school</td>
<td>$0-$20,000</td>
<td>Indigenous</td>
<td>Poly-drugs</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>16</td>
<td>35</td>
<td>F</td>
<td>High school</td>
<td>$0-$20,000</td>
<td>Indigenous</td>
<td>Stimulants</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>17</td>
<td>33</td>
<td>F</td>
<td>Some high school</td>
<td>$0-$20,000</td>
<td>Indigenous</td>
<td>Alcohol</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>18</td>
<td>29</td>
<td>F</td>
<td>High school</td>
<td>$20-$40,000</td>
<td>Caucasian</td>
<td>Poly-drugs</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>19</td>
<td>30</td>
<td>F</td>
<td>Some university</td>
<td>$0-$20,000</td>
<td>Caucasian</td>
<td>Poly-drugs</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>20</td>
<td>36</td>
<td>F</td>
<td>Some university</td>
<td>$20-$40,000</td>
<td>Caucasian</td>
<td>Poly-drugs</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
Table 2

*Parental Status and Household Composition*

<table>
<thead>
<tr>
<th>Part. #</th>
<th># of children</th>
<th>Gender of child</th>
<th>Age of child</th>
<th>Supportive intimate relationship Y or N</th>
<th>Living with partner, other adult(s) or living on own</th>
<th>Living with no children, some, or all children</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Female</td>
<td>1</td>
<td>Yes</td>
<td>With partner</td>
<td>All children</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>Male</td>
<td>8</td>
<td>Yes</td>
<td>With partner part-time</td>
<td>All children</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>Male</td>
<td>Infant</td>
<td>No</td>
<td>On own</td>
<td>All children</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>Male</td>
<td>13</td>
<td>No</td>
<td>On own</td>
<td>Some children</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>Female</td>
<td>3</td>
<td>No</td>
<td>On own</td>
<td>All children</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>Male</td>
<td>3</td>
<td>No</td>
<td>Other adults -parents</td>
<td>No children</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>Male</td>
<td>10</td>
<td>No</td>
<td>On own</td>
<td>Some children part-time</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>Female</td>
<td>16 Infant</td>
<td>Don’t know</td>
<td>On own</td>
<td>Some children</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>Female</td>
<td>10 5</td>
<td>No</td>
<td>Other adult - brother</td>
<td>No children</td>
</tr>
<tr>
<td>10</td>
<td>4</td>
<td>Female</td>
<td>18 14 9 3</td>
<td>No</td>
<td>On own</td>
<td>No children</td>
</tr>
<tr>
<td>11</td>
<td>2</td>
<td>Male</td>
<td>8 2</td>
<td>Yes</td>
<td>On own</td>
<td>All children</td>
</tr>
<tr>
<td>12</td>
<td>1</td>
<td>Male</td>
<td>Infant</td>
<td>No</td>
<td>On own</td>
<td>All children</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>Male</td>
<td>4</td>
<td>Yes</td>
<td>On own</td>
<td>No children</td>
</tr>
<tr>
<td>14</td>
<td>2</td>
<td>Female</td>
<td>1 Infant</td>
<td>No</td>
<td>On own</td>
<td>Some children</td>
</tr>
<tr>
<td>15</td>
<td>1</td>
<td>Female</td>
<td>2</td>
<td>No</td>
<td>On own</td>
<td>All children</td>
</tr>
<tr>
<td>16</td>
<td>3</td>
<td>Male</td>
<td>14 9 4</td>
<td>No</td>
<td>On own</td>
<td>No children</td>
</tr>
<tr>
<td>17</td>
<td>2</td>
<td>Female</td>
<td>10 Infant</td>
<td>No</td>
<td>On own</td>
<td>Some children</td>
</tr>
<tr>
<td>18</td>
<td>1</td>
<td>Female</td>
<td>Infant</td>
<td>No</td>
<td>On own</td>
<td>No children</td>
</tr>
<tr>
<td>19</td>
<td>1</td>
<td>Male</td>
<td>1</td>
<td>Yes</td>
<td>With partner</td>
<td>All children</td>
</tr>
<tr>
<td>20</td>
<td>2</td>
<td>Male</td>
<td>8 6</td>
<td>Yes</td>
<td>With partner, other adult - mother</td>
<td>All children</td>
</tr>
</tbody>
</table>
**Pre-screening.** Interested participants were instructed to respond using the telephone number or email address provided on the recruitment poster. Four participants responded using their cell phones to make direct contact. They were pre-screened according to the study criteria. Telephone or email response process turned out to be difficult for the majority of the potential participants. In residential treatment centres, women’s phone and internet time was extremely limited. When they did have the allotted time, women reported having other priorities for the telephone, or long wait lines. Directors and counsellors at two treatment centres, where 16 participants came from, made the initial telephone or email contact at a woman’s request and on her behalf. As a result, the pre-screening was put on hold until I met potential participants in person at the pre-interview discussion. These potential participants’ privacy was compromised after directors and counsellors contacted me on their behalf. This issue was later made clear to each of the potential participants before they agreed to provide informed consent.

**Pre-interview discussions.** After potential participants were pre-screened over the telephone or in person, brief in-person, pre-interview discussions were scheduled. The purpose of the 15 minute pre-interview discussion was multifold. First, the formal screening process was conducted according to the inclusion and exclusion criteria. Second, the study was then described in general terms. This included what was meant by helpful and hindering experiences and other factors that they were being invited to recall and talk about in the future interview. Goodwill and McCormick (2012) suggested that conducting pre-interview discussions in-person provides opportunities to start building rapport with potential participants who might need additional encouragement or reassurance. Obtaining participants’ consent was the third purpose of the pre-interview discussions.
Informed consent. The Informed Consent Form (see Appendix F) was presented section by section and explained with considerable detail. Any questions or concerns women had about participating in the study were addressed. Confidentiality and privacy issues were discussed thoroughly. There was a possibility, considered remote, that participants in the study could incriminate themselves. This could happen if they disclosed their own or others’ behaviours or actions where there are legal limits to confidentiality. To reduce the chance of self-incrimination, the consent form contained a detailed statement regarding legal limits to confidentiality and the duty to report to appropriate agencies. The legal limits to confidentiality were separated into their own section of the consent form. This made it clear to the participants that there were, in fact, limits to confidentiality in the study. In addition to being highlighted on the consent form, the same legal limits to confidentiality were specifically pointed out and explained. Finally, I asked the potential participants to verbally confirm their understanding of the legal limits to confidentiality.

Regarding privacy, it was explained to women that the protection of their identities as research participants was already compromised when staff persons made initial contact with me. In addition, they were told that their identities as research participants could not be protected if interviews took place in offices at treatment centres when child care was provided at the same time. In every case, women indicated that they understood the breaches of privacy. They each claimed to have no concerns if staff persons or other clients knew that they were participating in the study. When they continued to express interest in participating in the study, their written signatures on the consent forms were obtained. The fourth purpose of the pre-interview discussions was to distribute and explain other important study documents.
**Priming and supporting the participants.** In addition to receiving a copy of the signed consent form, participants were given two other documents. The first document was a Timeline Exercise (see Appendix G). This worksheet was meant to prime participants’ memories by completing it in advance of the first interview and bringing it with them to the interview. It was designed to help them recall and contemplate important experiences in advance of the interview. The second document was information about free community counselling and other support services (see Appendix G). The counselling resource list was distributed at the pre-interview discussions in the event that participants felt the need for emotional support during, or after, finishing the timeline exercise. Participants were also encouraged to let someone know if they became emotionally upset at any stage of participation in the study and to seek support. Next, an interview date and safe, private space was scheduled at a minimum of three days after the pre-interview discussions. Three days allowed women to mentally prepare for the interviews, reflect on their informed consent, and to consider the benefits and risks of participating. It also gave them time to change their minds about participating, if they wanted to, for any reason.

**Procedures for data collection.** The interview guide was piloted twice. The first pilot interview was conducted on a staff person at the transitional housing program providing the assistance in recruitment. The interviewee was approached by the staff spotter because she had past experience with substance use issues and parenting. The pilot interviewee provided helpful feedback about my interviewing style and about the instructions to the timeline exercise, which she found wordy and somewhat confusing. The exercise was amended based on her feedback. The interview with the first participant was the second pilot interview. I asked for and received helpful feedback from the first participant at the end of the interview. As the interview had gone well, it was included in the data collection.
The first interviews were arranged according to the participants’ availability. All but one of the 20 interviews were conducted in the safe, quiet offices of their service providers. This worked well because participants’ day-programming and child care was provided at the same locations. With permission, one interview was conducted in the living room of the participant’s home at a subsidized housing program. Light snacks were provided at the start of the interviews, along with pre-ordered beverages of their choice.

Care was taken to remind participants that interviews could last more than two hours and break times were recommended and planned for. Participants were reminded about the conditions of ongoing consent and all agreed to continue. Their attention was drawn to the legal limits to confidentiality that were briefly explained once more, similarly to the pre-interview discussion. The interviews ranged between 80 and 170 minutes (average of 109 minutes).

**Reimbursement for participants.** A committee member provided advice in advance of this study about reimbursement for participants, given the ethical concern of undue inducement. The goal was to balance the committee’s desire to acknowledge their contributions and cover women’s costs, without making the reimbursement so high that participants would ignore potential risks. As a result, participants were given a choice of one $25 gift card from a variety of businesses. The gift cards were handed out before the first interview commenced to acknowledge and thank them for their time. In addition, they could be reimbursed for public transportation (up to $11 round trip) and limited child care costs (maximum $20) if necessary in order for them to participate. Since 19 of the interviews took place within their treatment centres and housing programs, child care was included and transportation was unnecessary. One participant was reimbursed for child care in order to participate in the first interview.
**Interview 1 process.** At the beginning of the first interviews, the purpose of the study was stated. An Interview Guide (see Appendix I) was closely followed and included ample space for note-taking and for adding other field notes. The guide provided a helpful protocol that facilitated me to follow a participant, and depending on their style of expression, jot down reminders if they jumped around from place to place during an interview. Asking for details, and making note of them, facilitated participants’ recall and full expression of important events and factors.

**Contextual questions.** The purpose of asking participants the initial contextual questions was to provide background information about them, to establish rapport, and to put them at ease with the audiotaping procedure (Butterfield et al., 2005). The expectation was that using the timeline exercises they were given prior to the interview, participants would tell a short story about themselves by describing events of the past year they identified as important. However, only two or three participants arrived with their completed timeline exercise sheet or other prepared notes. The majority of participants said they had either misplaced the exercise or forgot about it given their busy schedules and hectic pace. Women were reassured about proceeding without their homework and blank exercise sheets were available to remind participants what they were being asked to think and talk about. The contextual questions were asked as follows:

- Let’s take about 10 minutes for you to tell me a little bit about your significant experiences during the past year. What events or moments occurred that had an impact on you? Tell me how you came to arrive here?

Probing questions were used to obtain a fuller description of those events. Participants were asked how those events turned out, what they learned about themselves, and if other experiences were coming to mind.
Potential Critical Incident Technique (ECIT) questions. The initial statements and questions for the ECIT portion of the interview were as follows:

- You have been thinking about your experiences of the past year and in the present. Now focus on those and more.
- What has helped you as a parent who has struggled with a substance use problem?
- What has not been helpful for you (or what has made it harder for you) as a parent who has struggled with a substance use problem?

Other probing questions were used to follow up:

- What exactly was it about that experience that makes it helpful/unhelpful?
- What went on before or after?
- How did it turn out?
- How did you feel about it?
- What did that incident mean to you?
- Can you give me a specific example of when it helped/didn’t help?
- What were you thinking?
- Can you tell me more about that?

The process outlined above continued until the participant indicated they could not think of any other critical incidents.

Wish list questions. Butterfield, Borgen, Maglio, et al. (2009) enhanced the Critical Incident Technique by adding wish list (WL) questions after critical incidents have been described in as much detail as the participant is able to provide. Knowing what participants hoped for in the future or wished they had when it was not available to them provides another source of rich information regarding their needs. The WL questions I asked were:
• Can you think of other things that would have helped in the past that were not available to you, or can you think of things that will help you now or in the future if they become available?

Participants were asked to provide demographic information at the end of the interview (see Appendix H – demographic questions are near the end of the interview guide). Participants were also asked to provide contact information for the next interview. At that time, I also checked in with participants and asked them how they were doing emotionally. Most said that although they felt emotional at times, their overall experience of the interview was positive.

For those participants that expressed mild upset, they were reminded of the free counselling and telephone support resource list they were given at the pre-interview discussion. Copies were available if required. In addition, because many of the participants were located in treatment centres, I encouraged them to speak with their assigned counsellors if they felt the need for immediate in-person support.

*Interview summaries and targeted transcription.* I planned to employ both of the recently recommended innovations to the ECIT (Amundson, Borgen & Butterfield, 2013). They were proposed to assist researchers using the ECIT method to expand the interview data and increase the number of participants that could be interviewed in a timely and cost effective way. First, while interviews were being conducted and as each of the three ECIT sections seemed to be coming to a close, I summarized back to the participants the critical incidents or wish list items that had thus far been described (see Appendix H). Summarizing their statements back to the participants near the end of each section of the interview served as a type of internal check. It gave the participants a chance to clarify or amend the
information provided to that point. In some cases, the summarization also served to cue their memories of other events or wishes.

Second, the audio recordings of the summaries would have permitted me to use targeted transcription on every interview beyond the point of exhaustiveness (Amundson et al., 2013). Therefore, beyond the point that no new categories were emerging from the data, I would have been able to transcribe and code from the summaries only, versus transcribing the entire interviews. Less time and less transcription costs were expected, if needed, to help increase the number of participants in the study which could enhance the level of confidence in the reported results.

A decision was made with my supervisor early in the data collection stage to continue to conduct all interviews possible while the recruitment process was going extremely well. Twenty interviews were scheduled in advance and conducted in less than 60 days. There was a waitlist of five potential participants that were not required at the end. Coding and data analysis was started after all 20 interviews had been done and was completed in a relatively short period of time in one continuous process. Electing to analyze the data all at once and not in batches over a longer period of time, prevented me from determining the point of exhaustiveness earlier in a data analysis process. For practical purposes, I elected in advance to have all 20 interviews fully transcribed. Although they were never needed for targeted transcription, using the three summarizations in each interview was helpful for data collection and analysis.

**Interview 2: Participant cross-checking process.** Cross-checking with participants is one of the nine credibility checks in the Enhanced Critical Incident Technique (ECIT) method (Butterfield et al., 2005). In this study, the participant cross-check was referred to as Interview 2. After the data was analyzed, participants were contacted by email or telephone
and plans were made for the second interview. At the second interview, participants first considered the accuracy of the critical incidents (CIs) and wish list (WL) items that were extracted from their interviews. Next, they were asked to confirm if their CIs and WL items belonged in the categories they were placed in. The results of the second interviews and more details are described later in this chapter.

**Procedures for data analysis.** The three steps of data analysis in the ECIT method were followed in the traditional stages that Flanagan (1954) laid out. The first step was determining the frame of reference. Using the ECIT, the frame of reference generally means determining the audience that the results of the study are intended for (Butterfield et al., 2005). In this study, the themes derived from the data represented what parents who struggle with substance use problems said about their recent experiences and needs. I intended that the study results would be reported to counselling professionals. I hoped they might be additive with reference to the complexities and long-term implications of counselling with women in this population. I also planned to report the results to program providers, program developers, and to stakeholders as a form of needs assessment. Flanagan’s (1954) second and third steps for data analysis are to create the categories and determine the level of specificity or generality for reporting them.

**Organizing the raw data.** While the 20 interviews were being conducted, the audiotapes were being transcribed during the same time period and by the same person. The transcriptionist was given a key that provided formatting instructions and other guidelines (see Appendix J). The transcriptionist was apprised of confidentiality issues including access to, and security and transfer of the electronic files. Transcription of all 20 interviews was practical in order to extract direct quotations of the participants and be able to incorporate
them as part of the results. Furthermore, transcriptions later provided easy access to the content of the original interviews for the purpose of participant cross-checking.

Twenty copies were made of the 20 original transcripts. The next step taken in organizing the raw data was to listen to the audio recording of each interview and simultaneously edit the second copy of the transcript. This process served two purposes: (a) to become more familiar with the data that would be analyzed and interpreted later; and (b) to correct typing errors and attempt to clear up small segments in the transcripts from audiotape that was unclear to the transcriptionist.

The third step taken to organize the data for analysis was to import 20 edited transcripts into the software program. Atlas.ti (Version 8) (2017) was the qualitative data analysis and research software that was used in the study. It was helpful to keep track of a large volume of textual data electronically. Atlas.ti had the necessary tools for arranging and managing 20 lengthy transcripts, coding them and reassembling codes into code groups that later became the categories from the data. The software was used mainly for organization of the data and not for interpreting it.

**Identifying the critical incidents and wish list items.** Short phrases in participants’ own words were extricated and coded from 90% of the transcripts which were analyzed in random order. Each coded helping or hindering critical incident and wish list item was supported by what the participant said about their importance and by an outcome or example. I also chose to code particular quotations by the participants that were profound, in my opinion, and could be used in reporting the results. Therefore, at the end of this process there were at least three or four codes for every helping, hindering or wish list item, resulting in over 1,800 coded segments.
Creating and specifying the categories. Using inductive reasoning, I created tentative categories for all of the critical incidents (CIs) and wish list items (WL) from 18 transcripts. Participation rates and the number of CIs and WL items in each tentative category were being considered during this time. The level of specificity or generality of the categories is often a practical consideration (Butterfield, Borgen, Maglio, et al., 2009). Considering how the results would be reported to the intended audience, the tentative scheme was comprised of 14 categories.

Next, the category titles and operational definitions were written. The remaining task of the data analysis was to extract and code the CIs and WLs items from the final 10% of the interviews (Butterfield et al., 2005). Later, each of those CIs and WL items was placed into the existing categories, providing an indication that the scheme was comprehensive. The data and the proposed categories were then subjected to a series of reliability and validity checks described in the next section.

Credibility checks. In addition to placing a greater focus on contextual factors, as Butterfield et al. (2005) and Butterfield, Borgen, Maglio, et al. (2009) suggested, this study also utilized the nine recommended credibility checks. The description of the credibility checks follows:

Audiotaping interviews. Butterfield et al. (2005) recommend working directly from audiotapes and transcripts that enable researchers to make interpretations that closely reflect participants’ own words. It was possible that not all of the participants in this study would be comfortable with the audiotaping procedure. However, audiotaping interviews is compulsory when using the Enhanced Critical Incident Technique (ECIT) method (L. D. Butterfield, personal communication, February 22, 2017). Therefore, on the Informed Consent Form it
was explained to participants that by signing the form they were giving permission for the interview to be recorded.

**Interview fidelity.** Cresswell and Poth (2018) discussed how a good qualitative study employs a rigorous method that uses systematic procedures for data collection. Applying that directive to the ECIT, it is important to conduct each semi-structured interview in a consistent manner to ensure that the method is being followed. The interviewer must follow the script as closely as possible in order to make sure they capture the details that are required for a complete critical incident. In addition, the interviewer must refrain from asking leading questions or prompting the respondent. For researchers using the ECIT, it has become conventional to have the first, followed by every third or fourth interview, listened to by an expert in the method or by someone outside of the research team who knows it (Butterfield et al., 2005).

Doctoral students who were trained in the ECIT method or who were familiar with it listened to interviews 1, 5, 8, and 12. They listened to the audiotapes soon after each of the interviews in order to provide feedback that could be implemented before the next one, ensuring ongoing consistency. They were asked to advise me regarding my interviewing style, and if they observed a consistent approach to the method through the use of the guide. Feedback after the first interview was positive, with the exception of a potentially missed opportunity to follow up with the interviewee regarding a helping incident. Reactions from the next three interviews were encouraging, as they commented about my thorough and consistent approach to the method. Feedback regarding my interviewing style contained references to three occasions when I was coming close to leading the participant, or I did lead them, and then caught myself.
**Independent extraction of critical incidents.** This credibility check was to confirm the decisions of the primary researcher about what constituted critical incidents. It was conducted in two parts with another doctoral student who is a trained and experienced coder and familiar with the Enhanced Critical Incident Technique (ECIT). First, the person independently extracted what they believed were the critical incidents and wish list items from 5 of the 20 (25%) randomly chosen transcripts. The purpose was to see if their coding procedure resulted in any new incidents or any transfers of incidents from one type to another. The initial percentage of agreement between the researcher and the independent extractor was 78%. The reason for approximately one-third of the discrepancy was that the independent extractor did not extract and code critical incidents from the contextual section of the interviews as well as from the ECIT section. This resulted in nine missed critical incidents or wish list items by the independent extractor.

Second, a discussion ensued and the independent examiner was directed to each of nine previously coded incidents in the contextual section of the interviews. He agreed that they were all valid incidents as long as the researcher could follow them up during the cross-checks for verification by the participants and for additional details where necessary. After further discussion between the researcher and the independent extractor, 100% concordance was reached. What resulted from the credibility check was seven new critical incidents or wish list items, and two changes from one type of coded incident (helping, hindering, or wish list) to another.

**Exhaustiveness.** This reliability and validity check was conducted to ensure that there was adequate coverage of the domain being studied. Flanagan (1954) suggested that redundancy occurs when no new categories arise from the data. With the intention of tracking the point at which exhaustiveness was achieved, I kept a running log of the
interviews conducted on a table (see Table 3). The headings used were as follows: (a) date the interview transcription was coded for the withdrawal of critical incidents (CI’s) and wish list (WL) items; (b) participant number; (c) date the CI’s and WL items were categorized; and (d) whether or not new categories emerged from that interview (Butterfield, Borgen, Maglio, et al., 2009).
Table 3

*Exhaustiveness Log*

<table>
<thead>
<tr>
<th>Participant #</th>
<th>Date coded</th>
<th>Date categorized</th>
<th># of new categories emerging?</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>July 27, 2017</td>
<td>August 23, 2017</td>
<td>21 new categories</td>
</tr>
<tr>
<td>10</td>
<td>July 28, 2017</td>
<td>August 24, 2017</td>
<td>7 new categories</td>
</tr>
<tr>
<td>8</td>
<td>August 2, 2017</td>
<td>August 24, 2017</td>
<td>10 new categories</td>
</tr>
<tr>
<td>4</td>
<td>August 4, 2017</td>
<td>August 24, 2017</td>
<td>4 new categories</td>
</tr>
<tr>
<td>5</td>
<td>August 9, 2017</td>
<td>September 6, 2017</td>
<td>1 new category</td>
</tr>
<tr>
<td>15</td>
<td>August 10, 2017</td>
<td>September 7, 2017</td>
<td>No new categories</td>
</tr>
<tr>
<td>14</td>
<td>August 14, 2017</td>
<td>September 8, 2017</td>
<td>No new categories</td>
</tr>
<tr>
<td>3</td>
<td>August 14, 2017</td>
<td>September 8, 2017</td>
<td>No new categories</td>
</tr>
<tr>
<td>12</td>
<td>August 14, 2017</td>
<td>September 8, 2017</td>
<td>No new categories</td>
</tr>
<tr>
<td>9</td>
<td>August 15, 2017</td>
<td>September 8, 2017</td>
<td>No new categories</td>
</tr>
<tr>
<td>17</td>
<td>August 15, 2017</td>
<td>September 11, 2017</td>
<td>No new categories</td>
</tr>
<tr>
<td>6</td>
<td>August 16, 2017</td>
<td>September 11, 2017</td>
<td>No new categories</td>
</tr>
<tr>
<td>2</td>
<td>August 17, 2017</td>
<td>September 11, 2017</td>
<td>No new categories</td>
</tr>
<tr>
<td>16</td>
<td>August 17, 2017</td>
<td>September 11, 2017</td>
<td>No new categories</td>
</tr>
<tr>
<td>13</td>
<td>August 17, 2017</td>
<td>September 11, 2017</td>
<td>No new categories</td>
</tr>
<tr>
<td>18</td>
<td>August 18, 2017</td>
<td>September 11, 2017</td>
<td>No new categories</td>
</tr>
<tr>
<td>11</td>
<td>August 18, 2017</td>
<td>September 11, 2017</td>
<td>No new categories</td>
</tr>
<tr>
<td>19</td>
<td>August 18, 2017</td>
<td>September 11, 2017</td>
<td>No new categories</td>
</tr>
<tr>
<td>7</td>
<td>September 14, 2017</td>
<td>September 14, 2017</td>
<td>No new categories</td>
</tr>
<tr>
<td>1</td>
<td>September 18, 2017</td>
<td>September 18, 2017</td>
<td>No new categories</td>
</tr>
</tbody>
</table>
Exhaustiveness was reached by the 5th interview. However, interviewing had already continued beyond that point for two main reasons. First, the intended audience to present the results of the study to was not only from the counselling profession, but also from the non-profit and government sector and major stakeholders that provide programs. Therefore, a suggestion was made by the research supervisor and principal investigator at the proposal stage of the study to conduct and analyze 20 interviews if possible. The supervisor believed that the results from 20 participants would lend more credibility to the target audiences of the study. Second, interviewing beyond the point of exhaustiveness added richness and complexity to the data being collected, even when no new categories arose from them.

**Participation rates.** Butterfield et al. (2005) and Butterfield, Borgen, Maglio, et al. (2009) suggested that a category is considered valid if a minimum proportion (usually around 25%) of participants endorse it. I kept track of participant numbers for all of the helping or hindering critical incidents, and wish list items that were being placed in the same tentative categories. I was able to determine the participation rate by simply dividing the number of participants within the same tentative category by the total number of participants (N = 20). This procedure was also useful in determining the relative strength of a category compared to others for reporting purposes. Four tables are presented in the next chapter (see Tables 4, 5, 6 & 7). The first table summarizes the participation rates that met the 25% test under at least one or more of the helping, hindering, and wish list headings. The following three tables present the 14 categories in descending order by participation rate as viewed through the three different lenses of helping, hindering, and wish list.

**Independent judge.** Butterfield et al. (2005) indicate that an independent judge provides a reliability check when they assign the same critical incidents (CI’s) and wish list (WL) items to the same categories that the primary researcher did, at a high rate. The aim is a
final result of 80% concordance or higher, indicating that the categories are sound (Andersson & Nilsson, 1964). For this purpose, a doctoral student in the role of independent judge was sent 25% of randomly selected direct quotations of the participants that were coded for the CI’s and WL items from each of the 14 categories. The list of category titles with their operational definitions was included to assist the judge to understand them thoroughly.

The independent judge placed 118 from a total of 477 CI’s and WL items into the tentatively formed categories where she believed they belonged. After comparison with the researcher’s own placement, the initial agreement was 74%. In the discussion that followed, the transcripts were used to explain to the independent judge the context from which the quotations were extracted. After providing those details, the outcome was 100% concordance. The credibility check resulted in moving two CI’s to different categories. In addition, to reduce any perceived crossover, eight of the category titles or their operational definitions were marginally amended.

**Cross-checking of participants.** Morrow (2005) claimed that, among other things, the credibility in qualitative research could be partly achieved by using participant cross-checking. This credibility check is meant to provide interpretative validity. Participants are able to add, delete, or revise their own information to ensure that the results of their first interview and their overall experiences are represented correctly. It is also an opportunity for the researcher to follow up and get any important details they may have missed in the first interviews (Butterfield et al., 2005; Butterfield, Borgen, Maglio, et al., 2009). Approximately six months after the first interviews, attempts were made to connect with the 20 participants using the contact information they had provided.
Efforts were taken to include all of the participants and 11 of them fully completed cross-checking interviews. Of the remaining nine participants, six never responded to the two or three attempts that were made to reach them approximately six months after the first interview. The reasons the six participants never responded to the invitations are unknown. The final three of the remaining nine participants were reached by telephone or email and initially agreed to complete the second interview. They were sent the summary documents of their data by email, but did not respond to subsequent requests for the follow-up conversations. Of those three, I received a reason from two of them about not participating. One of the participants was sick on the day of the scheduled cross-checking interview and did not attend. Another participant indicated during the first contact that she was extremely busy with work and family, and did not reply to email invitations for the follow-up interview.

For the 11 women that followed through, the participant cross-check took place as a 30-minute second interview and was conducted in-person, by email, by telephone, or a combination. Participants viewed two documents. The first document was a summary sheet of their direct quotations that were extracted from their transcripts and coded as critical incidents (CIs) and wish list (WL) items. The CIs and WL items were listed in the order of helping, hindering, and wish list. Following the approach that Butterfield, Borgen, Maglio, et al. (2009) recommend, the participants were asked four questions:

1. Are the helping/hindering CIs and WL items correct?
2. Is anything missing?
3. Is there anything that needs revising?
4. Do you have any other comments?

The second document contained a list of the specific categories, their definitions, and the participant’s CIs and WL items that had been placed in them. After reviewing the
document, the participants were asked three questions (Butterfield, Borgen, Maglio, et al., 2009):

1. Do the category headings make sense to you?
2. Do the category headings capture your experience and the meaning that the incident or factor had for you?
3. Are there any incidents in the categories that do not appear to fit from your perspective? If so, where do you think they belong?

The participant cross-check process resulted in one additional helping incident. Participants added two hindering incidents and deleted one during the cross-check interviews. Finally, four WL items were added and four CIs and WL items were moved from one category to another. In addition, I was able to gather necessary details for a number of CIs or WL items in order to better and more completely understand what the participants meant in their original discussions about them.

**Expert opinions.** The category scheme was presented to two experts in professional disciplines related to this study. It was not necessary that they were experts in the Enhanced Critical Incident Technique method, but rather that they had extensive experience in their related field. They were consulted to provide their opinions as to the usefulness of the categories based on their experience and knowledge of the associated research. Dr. Mary Motz is a clinical psychologist and adjunct professor in Toronto. She works with and conducts research on infants, children, and mothers who are affected by maternal substance use, trauma, mental health issues, violence in relationships, and poverty. Dr. Ron Abrahams is the Medical Director of Perinatal Addictions at BC Women’s Hospital. Approximately 25 years ago, the doctor founded a combined care unit that keeps substance-dependent women and their substance-exposed infants together. The program was the first of its kind in Canada.
Butterfield, Borgen, Maglio, et al. (2009) suggested that after they reviewed the category titles and their operational definitions, the experts be asked (a) if they found the categories to be useful, (b) if they were surprised by any of the categories, and (c) if they thought there was anything missing based on their experience.

Both experts confirmed that the categories were useful and that there were no surprises according to their experience and their knowledge of the research. Dr. Motz stated that the categories were certainly comprehensive and would provide a useful context of understanding for people who would read about the work. She went on to name a few additional factors or constructs from related research and how she saw them all covered within the operational definitions she was reviewing. Dr. Motz offered for me to incorporate any of her words as a component of various operational definitions if it would be helpful. Therefore, the operational definition to the category Relationships with Oneself and Personal Characteristics was enhanced with the expert’s words about self-esteem, self-worth, and self-efficacy (M. Motz, personal communication, October 26, 2017).

Dr. Abrahams (personal communication, October 24, 2017) suggested that what was missing, in his opinion, was more precise references to trauma in the category titles and operational definitions. Although trauma was described in many incidents, the decision was made to make it more overt by adding words or phrases such as trauma, trauma-informed, traumatic events, and traumatic experiences to four of the category titles or operational definitions.

**Theoretical agreement.** The 14 categories that emerged in the study were examined with reference to the existing relevant scholarly literature. It took place in two parts. In the first part, I found support in the literature for the assumptions underlying the study. In the
second part, I compared the categories against the existing literature and found support for those.

**Representation of the Research Findings**

Participants’ voices were spotlighted in this study. First, their own words were used to code the critical incidents and wish list items that were placed into the categories of the study. Second, researchers using the Enhanced Critical Incident Technique (ECIT) include direct quotations of the participants when reporting the results. The quotations aid in describing the contents of a category and provide vivid, interesting highlights from participants’ stories. As in all aspects of this study, I took the necessary precautions to ensure the confidentiality of participants when directly quoting them as part of the results.

**Reflective Stance of the Researcher**

It was important to engage in reflexivity throughout the duration of the study. One of the committee members described reflexivity as “in-dwelling in my own knowledge construction” (M. Buchanan, personal communication, March, 2017). However, this study was conducted within a postpositivist paradigm, and reflexivity is generally adapted in a postmodern approach to qualitative research. Yet, from a postpositivist paradigm, a researcher acknowledges a subjective slant towards data collection and data analysis. Therefore, taking a reflective stance in this study was appropriate. Hsiung (2010) states that qualitative researchers not only search themselves for revelations of bias, but also be able to answer to them.

Searching myself included checking what I was curious about, why the research was important to me, where I was coming from with regard to the research, and whether I brought a personal agenda to the project. Practicing reflexivity means more than reflecting on the research process, the research relationship, and on oneself as the researcher. It involves
talking about what is discovered with committee members or others. For this study, I engaged in six reflective practices. The first practice was to reflect in advance on any impinging issues that might create a problem within the research design. The second practice I engaged in was conducting two pilot interviews. The purpose of this was to identify and change areas in the script and in the handouts that were too wordy or complex for participants to understand.

The third reflective practice was using field notes for journaling. The last page of the interview guide was created as a self-summary of the interviewer (see Appendix I). Immediately following each interview after the participant was gone, I wrote down my thoughts, reactions, and any biases that I was aware of. This practice helped to monitor, for example, interviews that felt more difficult to conduct than others, and to ask myself what the contributing factors might be. The note-taking provided an informative process for reflection, and issues that came up could be kept in mind before the following interview.

The fourth reflective practice I engaged in was having regular appointments with an Enhanced Critical Incident Technique (ECIT) consultant throughout the duration of the study. I acknowledged perceived biases when I became aware of them, and the consultant asked me questions and challenged me. For example, in our society people tend to be biased about how they believe parents should behave. People may judge parents when they encounter them parenting differently than their biased viewpoints. It was essential for me to be aware of, and set aside, my own parenting biases or judgments.

The fifth reflective practice was to go back to the participants after all of the interviews and data analysis was conducted. The advantages of the cross-checking interviews were to provide another chance to honour the participants as the experts of their lived experiences, for participants to have a final say over the presentation of their data, and to
maintain rapport and trust. The sixth reflective practice I engaged in started with posting a message on the computer during the data analysis phase. I asked myself questions about my audience that included the participants. I continually asked if the reductions of their data into codes and code groups would make sense to the participants, and if the categories created honoured their contributions.

The purpose of this chapter was to describe the philosophical and theoretical framework of the study and to present the rationale for using the Enhanced Critical Incident Technique (ECIT) method. Next, the purpose was to detail how the steps of the ECIT method were followed to conduct the study. The next chapter is a presentation of the results of the study. It consists of the descriptions of participants’ helpful and hindering experiences, and wishes as parents who struggle with substance use issues. To honour their voices as the participants in the study, direct quotations are woven throughout the chapter.
Chapter IV: Results

This chapter is a presentation of the results of the study derived from the research question: “What factors have been helpful or hindering for service-engaged, early parenting women who have problematic substance use, and what do they wish for that might help if they had access to it?” The first section is a summarization of the results from the contextual portion of the Enhanced Critical Incident Technique (ECIT) interview. Next is the description of the critical incidents and wish list items derived from the ECIT interviews according to the 14 categories they were placed in. Along with descriptions of the results in each category, four separate tables are presented early in this chapter that highlight the numerical contents of each category. Table 4 is presented first and numerically summarizes the total of 477 critical incidents and wish list items in their respective categories. Tables 5, 6, and 7 are presented next and report the numbers separately, headed by each of the helping, hindering, and wish list results. At the end of the chapter is a brief summary.

Contextual Section Results

The purpose of asking participants the initial contextual questions was to gather background information about them, to establish a connection with them, and to help them feel comfortable with two audio recorders in front of them. Participants shared impactful experiences over the past 12 to 18 months, the outcomes of some of those experiences, and what they learned about themselves during that time. They also explained how they had come to arrive at the residential treatment centres and other programs they were engaged in. In the next section I will be describing the contextual results. There was no specific thematic analysis done, but I will highlight the general observations and themes that I observed.

Observations and summaries. I perceived that four participants were guarded or reserved during the contextual portion of the interviews. The other 16 participants were open
and talkative, and disclosed intimate and personal details. There were times when participants wanted to share experiences such as childhood trauma or other events and problems that had occurred more than one or two years prior. At those times, participants were gently guided back to recalling their more recent pasts as this was the focus of the study. My observations of the participants’ stories during the contextual section of the interview are organized and described below.

**Discoveries of pregnancy while using substances.** Women talked about discovering their pregnancies, often later in the pregnancies, while in active or full-blown addiction. For some, the pregnancy was a motivating factor to seek treatment. For others, especially if they could not find help initially, the experiences of pregnancy and early parenting were not enough to help them get clean and stay clean. Participants reported having many ups and downs while attempting to get clean while pregnant and while trying to get their other children back in their care. Experiences of shame and guilt regarding their drug use while pregnant or parenting were common. When participants could not find timely help and support, they said they often relapsed. Some recounted perceiving that they could not handle their pregnancies while managing their own lives under stressful conditions.

**Declines in functioning that led to interventions.** Participants conveyed that they found themselves going downhill physically, mentally and emotionally during the year before they joined the study. Most of the women were single and were not receiving parenting breaks in order for self-care. They described feeling trapped and alone. Some participants related that they found the initial experiences of parenting an infant or young children to be isolating and overwhelming. For some of the participants, their substance use escalated at the same time they faced unstable situations. As more crises occurred in their lives, women recounted interventions that were made to steer them to treatment by child
protection services, their families, and workplaces.

**Incidents with partners and family members.** A few participants spoke of supportive experiences with their partners and family members during the 12 to 18 months prior to participating in the study. When their secrets were out in the open or they felt they could not carry on, those participants conveyed receiving non-judgmental help and support. The great majority of the participants described negative experiences with their partners in the past and in the present. The partners they depicted were often drug users and drug dealers. Details were provided regarding violence in relationships that often led to child protection concerns and distressing break-ups or abandonments. Some women spoke of toxic relationships with other family members.

**Issues with medical and mental health.** Participants described some of their experiences of medical and mental health issues prior to participating in the study. Some stated having serious medical health problems that required hospitalization. Other participants shared stories about not being able to accept that they had mental illnesses and about not being willing to pursue treatment. A few participants talked about anxiety, depression, post-partum depression, and the negative effects that mental illness had on bonding with and parenting their infants and children.

**Experiences with service providers.** Women told stories of many obstacles they faced to get treatment before they eventually received services. The majority of the participants described the positive experiences they were having at a variety of programs. For example, they explained encouraging events such as helpful referrals to programs and treatment centres. In addition, participants spoke of appreciating help to transition from one program to another. These were encouraging events. Some women described the programs they were currently in as being new homes for themselves and their children. Others identified their
clean time and highlighted how the programming they were receiving was already making a positive difference for them. Many of the participants’ experiences were later reported in more detail as critical incidents. They are presented in this chapter as part of the results.

**ECIT Results**

Before the participant cross-checking interviews, there was a total of 470 critical incidents (CIs) and wish list (WL) items extracted from 20 interviews. As reported earlier, after the cross-checking interviews, participants added one helping incident, two hindering incidents, deleted one hindering incident, and added five WL items. In addition, participants requested that four CIs and WL items be placed in different categories. Therefore, the final number after the cross-checking interviews was 477 CIs and WL items broken down as follows: 210 (44%) helping critical incidents; 159 (33%) hindering critical incidents; and 108 (23%) wish list items.

Each of the 477 critical incidents and wish list items was placed into one of the 14 categories generated from the data. A category is considered feasible as long as 25% of the participants in the study contribute a critical incident or wish list item to it (Borgen & Amundson, 1984). The participant rates were tracked accordingly, and the 14 categories met the 25% criterion within at least one of the helping, hindering, or wish list sections. The categories were given titles and definitions that were carefully drafted with the hope of reflecting the spirit of what the participants contributed.

Table 4 presents a summation of the 14 categories divided into the helping, hindering, and wish list components. The number of critical incidents and wish list items, the number of participants that contributed them, and the participation rates calculated as a percentage are included. The 14 categories on Table 4 were listed in descending order according to the participation rates for each, under the helping column.
Table 4

Critical Incident and Wish List Categories

<table>
<thead>
<tr>
<th>Categories</th>
<th>Helping Critical Incidents (N = 210)</th>
<th>Hindering Critical Incidents (N = 159)</th>
<th>Wish List Items (N = 108)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participants (N = 20)</td>
<td>Participants (N = 20)</td>
<td>Participants (N = 20)</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>% PR</td>
<td>n</td>
</tr>
<tr>
<td>1. Integrated Addiction Treatment for Women that Includes their Children</td>
<td>16</td>
<td>80</td>
<td>45</td>
</tr>
<tr>
<td>2. Medical and Mental Health Issues/Illness, Trauma, and Concurrent</td>
<td>16</td>
<td>80</td>
<td>23</td>
</tr>
<tr>
<td>Addiction Treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Mother’s Relationships with Their Children, and Parenting Support</td>
<td>15</td>
<td>75</td>
<td>20</td>
</tr>
<tr>
<td>4. Understanding Addiction as a Disease</td>
<td>12</td>
<td>60</td>
<td>17</td>
</tr>
<tr>
<td>5. Provincial Government Involvement and Assistance</td>
<td>11</td>
<td>55</td>
<td>20</td>
</tr>
<tr>
<td>6. Support from Family and Friends</td>
<td>11</td>
<td>55</td>
<td>16</td>
</tr>
<tr>
<td>7. Relationships with Oneself and Personal Characteristics</td>
<td>9</td>
<td>45</td>
<td>14</td>
</tr>
<tr>
<td>9. Spirituality</td>
<td>9</td>
<td>45</td>
<td>11</td>
</tr>
<tr>
<td>10. Childcare</td>
<td>8</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>11. Experiences of Pregnancy and Parenthood Having Used or While</td>
<td>6</td>
<td>30</td>
<td>6</td>
</tr>
<tr>
<td>Using Substances</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Relationships with and Support from Partners and/or Children’s Fathers</td>
<td>6</td>
<td>30</td>
<td>6</td>
</tr>
<tr>
<td>13. Upbringing, Life Circumstances, and Critical Stressors</td>
<td>5</td>
<td>25</td>
<td>5</td>
</tr>
<tr>
<td>14. Housing and Financial Issues and Support</td>
<td>4</td>
<td>20</td>
<td>4</td>
</tr>
</tbody>
</table>

PR: Percentage Representation
Reporting the results separately on tables under the headings of incidents that helped, incidents that hindered, and wish list items is a common practice when using the ECIT method (see Tables 5, 6, and 7). Each table emphasizes the 14 categories thematically according to each of the three topic areas. Within each table, the 14 categories are ordered uniquely according to participation rates. The hope is that the reader might see at a glance what seemed to be the most and least important to participants within each of the three areas of focus.

Butterfield’s (2006) format was followed for introducing each category by breaking down its contents. Following that, each category is described in its entirety in the order of the helping and hindering critical incidents, and finally the wish list items. Many of the participants’ verbatim quotations are woven throughout the rest of the chapter. The goal was to describe the categories but also to highlight the richness of the data by presenting part of it in the participants’ own words. In this chapter, pseudonyms are used for humanizing the voices of the participants, while protecting their anonymity. Some of the grammatical errors from direct quotations were corrected. However, some incorrect grammar and slang within participants’ quotations was intentionally left as is. The goal was to present the participants’ voices as respectfully and realistically as possible.

**Category 1: Integrated addiction treatment for women that includes their children.** At the time of their participation, 19 of 20 women in the study were residing at an integrated treatment centre or at an integrated transitional housing program. Therefore, the participants’ feedback about treatment and programs gave this category the highest number of critical incidents (CIs) and wish list (WL) items. This category had a total of 76 CIs and WL items, with a classification as follows: 45 (59%) were helping incidents with a
## Table 5

*Incidents that Helped Early Parenting Women with Substance Use Problems*

<table>
<thead>
<tr>
<th>Categorical Emphasis on Helping Incidents</th>
<th>Number of Participants (percentage of total)</th>
<th>Number of Incidents (percentage of total)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>N = 20</em></td>
<td><em>210 Helping Incidents</em></td>
</tr>
<tr>
<td>1. Integrated Addiction Treatment for Women that Includes their Children</td>
<td>16 (80%)</td>
<td>45 (21%)</td>
</tr>
<tr>
<td>2. Medical and Mental Health Issues/Illnesses, Trauma, and Concurrent Addiction Treatment</td>
<td>16 (80%)</td>
<td>23 (11%)</td>
</tr>
<tr>
<td>3. Mothers’ Relationships with Their Children, and Parenting Support</td>
<td>15 (75%)</td>
<td>20 (10%)</td>
</tr>
<tr>
<td>4. Understanding Addiction as a Disease</td>
<td>12 (60%)</td>
<td>17 (8%)</td>
</tr>
<tr>
<td>5. Provincial Government Involvement and Assistance</td>
<td>11 (55%)</td>
<td>20 (10%)</td>
</tr>
<tr>
<td>6. Support from Family and Friends</td>
<td>11 (55%)</td>
<td>16 (8%)</td>
</tr>
<tr>
<td>7. Relationships with Oneself and Personal Characteristics</td>
<td>9 (45%)</td>
<td>14 (7%)</td>
</tr>
<tr>
<td>8. Short-term and Long-term Practical Needs and Support</td>
<td>9 (45%)</td>
<td>13 (6%)</td>
</tr>
<tr>
<td>9. Spirituality</td>
<td>9 (45%)</td>
<td>11 (5%)</td>
</tr>
<tr>
<td>10. Childcare</td>
<td>8 (40%)</td>
<td>10 (5%)</td>
</tr>
<tr>
<td>11. Experiences of Pregnancy and/or Parenthood Having Used or While Using Substances</td>
<td>6 (30%)</td>
<td>6 (3%)</td>
</tr>
<tr>
<td>12. Relationships and Support from Partners and/or Children’s Fathers</td>
<td>6 (30%)</td>
<td>6 (3%)</td>
</tr>
<tr>
<td>13. Upbringing, Life Circumstances, and Critical Stressors</td>
<td>5 (25%)</td>
<td>5 (2%)</td>
</tr>
<tr>
<td>14. Housing and Financial Issues and Support</td>
<td>4 (20%)</td>
<td>4 (1%)</td>
</tr>
<tr>
<td>Categorical Emphasis on Hindering Incidents</td>
<td>Number of Participants (percentage of total)</td>
<td>Number of Incidents (percentage of total)</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---------------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>( N = 20 )</td>
<td>159 Hindering Incidents</td>
</tr>
<tr>
<td>1. Experiences of Pregnancy and Parenthood Having Used or While Using Substances</td>
<td>14 (70%)</td>
<td>32 (20%)</td>
</tr>
<tr>
<td>2. Relationships and Support from Partners and/or Children’s Fathers</td>
<td>14 (70%)</td>
<td>17 (11%)</td>
</tr>
<tr>
<td>3. Provincial Government Involvement and Assistance</td>
<td>12 (60%)</td>
<td>17 (11%)</td>
</tr>
<tr>
<td>4. Medical and Mental Health Issues/Illnesses, Trauma and Concurrent Addiction Treatment</td>
<td>12 (60%)</td>
<td>14 (9%)</td>
</tr>
<tr>
<td>5. Integrated Addiction Treatment for Women that Includes their Children</td>
<td>9 (45%)</td>
<td>16 (10%)</td>
</tr>
<tr>
<td>6. Relationships with Oneself and Personal Characteristics</td>
<td>9 (45%)</td>
<td>13 (8%)</td>
</tr>
<tr>
<td>7. Upbringing, Life Circumstances, and Critical Stressors</td>
<td>8 (40%)</td>
<td>14 (9%)</td>
</tr>
<tr>
<td>8. Understanding Addiction as a Disease</td>
<td>8 (40%)</td>
<td>11 (7%)</td>
</tr>
<tr>
<td>9. Childcare</td>
<td>5 (25%)</td>
<td>5 (3%)</td>
</tr>
<tr>
<td>10. Mother’s Relationships with Their Children, and Parenting Support</td>
<td>5 (25%)</td>
<td>5 (3%)</td>
</tr>
<tr>
<td>11. Support from Family and Friends</td>
<td>5 (25%)</td>
<td>5 (3%)</td>
</tr>
<tr>
<td>12. Short-term and Long-term Practical Needs and Support</td>
<td>4 (20%)</td>
<td>6 (3%)</td>
</tr>
<tr>
<td>13. Housing and Financial Issues and Support</td>
<td>4 (20%)</td>
<td>4 (3%)</td>
</tr>
<tr>
<td>14. Spirituality</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 7

*The Wish List items of Early Parenting Women with Substance Use Problems*

<table>
<thead>
<tr>
<th>Categorical Emphasis on Wish List Items</th>
<th>Number of Participants (percentage of total)</th>
<th>Number of Incidents (percentage of total)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>N = 20</em></td>
<td><em>108 Wish List Items</em></td>
</tr>
<tr>
<td>1. Short-term and Long-term Practical Needs</td>
<td>13 (65%)</td>
<td>20 (19%)</td>
</tr>
<tr>
<td>2. Housing and Financial Issues and Support for Them</td>
<td>11 (55%)</td>
<td>22 (20%)</td>
</tr>
<tr>
<td>3. Integrated Addiction Treatment for Women that Includes their Children</td>
<td>9 (45%)</td>
<td>15 (14%)</td>
</tr>
<tr>
<td>4. Medical and Mental Health Issues/Illnesses, Trauma, and Concurrent Addiction Treatment</td>
<td>8 (40%)</td>
<td>8 (7%)</td>
</tr>
<tr>
<td>5. Provincial Government Involvement and Assistance</td>
<td>6 (30%)</td>
<td>9 (8%)</td>
</tr>
<tr>
<td>6. Childcare</td>
<td>6 (30%)</td>
<td>8 (7%)</td>
</tr>
<tr>
<td>7. Upbringing, Life Circumstances, and Critical Stressors</td>
<td>5 (25%)</td>
<td>8 (7%)</td>
</tr>
<tr>
<td>8. Mother’s Relationships with Their Children, and Parenting Support</td>
<td>5 (25%)</td>
<td>5 (5%)</td>
</tr>
<tr>
<td>9. Relationships and Support from Partners and/or Children’s Fathers</td>
<td>3 (15%)</td>
<td>4 (4%)</td>
</tr>
<tr>
<td>10. Experiences of Pregnancy and Parenthood Having Used or While Using Substances</td>
<td>2 (10%)</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>11. Spirituality</td>
<td>2 (10%)</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>12. Support from Family and Friends</td>
<td>2 (10%)</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>13. Understanding Addiction as Disease</td>
<td>1 (5%)</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>14. Relationships with Oneself and Personal Characteristics</td>
<td>1 (5%)</td>
<td>1 (1%)</td>
</tr>
</tbody>
</table>
participation rate of 80% provided by 16 participants; 16 (21%) were hindering incidents with a participation rate of 45% contributed by nine participants; and 15 (20%) were wish list items with a participation rate of 45% supplied by nine participants.

Integrated treatment defined in this study was residential treatment centres and other programming for addiction with gender-specific, trauma-informed services for pregnant and parenting women. Integrated treatment services have the goal of keeping a mother and her family together whenever possible. In this study, integrated services included residential drug and alcohol treatment centres, transitional housing programs, and drop-in centres. Women reported what they specifically found helpful and unhelpful about the residential treatment centres and other integrated programs they were in at the time of their participation. They spoke about the quality or lack of quality of relationships they had within integrated centres and programs. This included relationships that participants had with counsellors, with staff members, and with other parenting clients in treatment.

What helped participants at integrated treatment centres and programs?
Participants found the integrated services they were receiving to be very helpful. They discussed in detail the practical, clinical, and relational aspects of the services they were currently receiving. To pick up on the distinctions within this category it was sub-divided into five separate sections: (a) meeting basic needs; (b) including children; (c) providing structure; (d) treating drug and alcohol issues; and (e) creating a community of women.

Meeting basic needs. Participants conveyed the practical ways that the residential treatment centres they were living in were helpful. One participant conveyed the importance of a family feeling. “You don’t feel like you’re in an institution . . . . It’s like you can take a deep breath when you get home. It’s a safe place, it doesn’t have the hard cement walls and
people with clip boards everywhere” (Carey). Another participant said, “The house. The program. The routines of living stable…not homeless” (Ramona). Leah needed somewhere to rest, “I remember not sleeping and just being so irritable and it was just such a bad feeling. Now I sleep every day.” For these participants the residential treatment centre represented a safe, new home.

Including children. Completing drug and alcohol treatment at an integrated centre that included their children made a huge difference for participants. For two of them, being in treatment with their children was the only thing that kept them together. “So had I not registered for this, then I don’t think I would have my daughter today” (Stacey). The other one explained that it would be unbearable if she lost her child because she could not find treatment together with her:

If I didn’t have the [name of integrated hospital program] and [name of integrated drug and alcohol treatment centre], I might not have been able to keep my daughter. I might still be using drugs, and losing my daughter would have just been that much more for me not to want to live, not to want to get clean. I’d probably be right back out there. (Sarina)

One participant shared that being in treatment together with her son was helpful for learning to take care of herself and conscientiously parent him at the same time. Another claimed it was likely she would not have sought treatment if she was forced to leave her toddler at that stage of the child’s life.

Providing structure. Living with strict rules and within the structure that was provided at integrated treatment centres was helpful for participants. After periods of active addiction, irresponsibility and chaos, women stated that they needed to develop
accountability in order to mature as parents. For one participant, a one-year structured treatment plan was crucial, “a few hours after my delivery I looked at him and I just knew something else had to change. . . . I wanted to do more cuz I didn’t want to lose him, I didn’t want to screw this up” (Carey). In structured treatment environments participants found that heavily scheduled days, regular eating and sleeping times, and limited technology were helpful. One participant found it helpful that each day was broken up into short classes, other activities including art, yoga and exercising, and going to meetings. She explained that structure and rules were important for her by providing opportunities to learn more about herself and to make friends.

_Treating drug and alcohol issues._ Regarding this aspect of how integrated care for women with addiction issues was helpful, participants spoke about what the actual treatment was focussed on. In addition, participants voiced their feelings about the quality of relationships they had with their counsellors. They also made connections between the addiction treatment they were receiving and how it affected their parenting.

One participant found the focus on positivity in counselling to be helpful. She appreciated having to make a gratitude list about herself. “They try to make us see all the positive things about ourselves rather than focus on everything wrong in our lives so that there’s a healthy balance of what has happened and what we can work towards” (Leah). One participant at an integrated transitional housing program found it helpful to start to work on co-dependency issues in counselling:

I can start thinking about the stuff I need to work on as my brain is clearing. I can start working with the psychiatrist. . . . One of my goals this week was to start working with her [counsellor] on my issues with relationships. (Emma)
One participant had already made a one-year commitment to reside together with her child at an integrated treatment centre. She described finding treatment for a longer period of time helpful in order to get to the core of herself and her struggle with addiction. “Since October until now [six months] I relapsed four times. I finally started to grasp the idea of recovery and sink deep into myself to the core of why I continue drinking” (Marissa). Listening to Marissa, it seemed that treatment and support over a longer term might be additionally helpful.

Participants found that good relationships with their counsellors at integrated treatment centres and programs were helpful. They recalled helpful aspects of counsellors that included the counsellors’ backgrounds and their counselling styles. One participant claimed that one of the things that helped her grow was relating to a counsellor that had recovered from her own struggles with addiction. “A lot of the staff members [counsellors and other staff] have been in my shoes, they’ve actually sat in this program dealing with things hands on. And for me I can’t ask for anything better than that” (Marissa). Ramona appreciated her counsellor’s listening skills. “We just talk. Feels good to get words of encouragement to help me through my days. Feels good to talk to someone when they’re not drunk and have their mind on something else, and aren’t listening to you.”

Two participants explained how the counselling staff at integrated treatment centres and programs helped them as parents and positively influenced their negative perceptions of themselves as bad mothers. “I thought I was way better than that as a mother. Mothers don’t go to treatment for sure. Like, how pathetic. And it turns out that it’s one of the best things that’s ever happened” (Jacqui). The other participant suggested that her counsellor was credible as a parent because of her past. “She checks in on me and stuff but, it’s just like
mom tips, cuz she’s got two kids who both struggled with addiction problems. She has been clean 30 years so she has a lot of knowledge” (Evelyn). For these two participants the treatment seemed to be addressing the very foundation of themselves as mothers.

Creating a community of women. Participants in this study often communicated the isolation they experienced in early parenting while also struggling with substance use problems. The benefit she received from living with other parents and their children was comradeship for one participant:

The fellowship of the girls here. Counsellors aren’t always available but the women here will find women that they get along with. Once you do find some that you can talk to, if you’re crying, if you’re upset, they’re always there and they’re so understanding, because we’re all here for the same purpose. (Haley)

Participants explained that another key benefit of community at integrated treatment centres was parenting alongside each other. Jacqui said, “It’s comforting to see what I thought was kids misbehaving. It’s just normal two year-old behaviour. Seeing them all here, well, it’s like it’s just normal.” While helpful for children, one participant added that parenting in community was also a way for her as a mother to help other mothers:

I’ll grab [name of child] and I’ll rock with her just so her mom can maybe go on a smoke break, go have seconds to herself. Cuz even just five minutes to yourself can make you a brand new woman. I’m telling you [laughing], just walk right back in and be like ‘okay, I am here to take the challenge’ [chuckle]. (Marissa)

These three participants articulated how helpful it was to be in treatment centres and programs along with other mothers.
What hindered participants at integrated treatment centres and programs?

Approximately one quarter of the critical incidents in this category represent what participants did not find helpful at integrated treatment centres and programs. From an overarching viewpoint of what was not helpful, one participant stated that it was not having sufficient treatment programs and other help available early in pregnancy:

Programs for mothers who are pregnant and trying to get clean, and more help for them. There’s not very many places to go at all…If you aren’t able to get into a program you’re going to lose your child, you’re going to continue using. You could possibly end up dead nowadays because of all the car fentanyl and fentanyl that’s going around out there. Or you could end up losing your child in the womb because of using. (Sarina)

In order to capture and describe the nuances of the unhelpful aspects of integrated treatment programs, this section was divided into four sub-sections: (a) leaving family and children; (b) experiencing challenges from living in community; (c) abbreviating drug and alcohol treatment; and (d) excluding participants’ extended families.

Leaving family and children. Two participants recalled how difficult it was to enter an integrated treatment centre without their children. For one participant, a foster care placement disturbed her deeply because it did not make sense. “They told me that she couldn’t go stay with her grandma in [another province] because it’s not healthy for her not to see me for three months, yet it’s already been a month and I haven’t seen her” (Leah). Another participant described being in treatment without her children as petrifying. She said it led to negative self-talk and catastrophizing. “I left the house thinking I’m better off dead. Am I going to be able to go back into my family life and have a place? . . . I was just terrified that
they were done with me” (Jacqui). For these participants it seemed to be excruciatingly painful to go from being inseparable from their children to being cut off while in treatment.

Experiencing challenges from living in community. Two hindering critical incidents involved difficult interpersonal relations while living in community at integrated treatment centres. One participant found it unhelpful to be judged by other parents. “I feel like they’ve got so much to say about my life and I don’t know if it’s a jealousy thing or what the hell it is but there’s something about my life that is just so interesting to them” (Brooke). Another participant described a domino effect of negativity passed from one parent in community to another:

Like, the gossip, the drama and not remembering why we’re all here. We’re all here because we all have a problem. We all need help and we need to help each other and not knock each other down. . . . And I understand we’re here for ourselves but at the same time you don’t have to make it horrible for others. (Leah)

On a practical note, one participant described two aspects of what she found unhelpful regarding exercise at an integrated residential housing program. The first aspect Emma described was about the limited opportunities for exercise. “One thing we learned at the hospital is that exercise is an imperative part of recovery. They have three times a week where we go to the gym here, but that’s not enough for me having an addictive nature.” In addition, the participant suggested that more exercise at integrated programs should be achieved by walking. “There’s a TED talk saying how it’s beneficial having meetings while you go for walks. People might get more therapeutic value going for a walk and talk and not just sitting.” (Emma)
**Abbreviating drug and alcohol treatment.** In this section, the critical incidents were based on what participants found unhelpful about the specific aspects of the drug and alcohol treatment they were receiving. One participant complained that treatment was too narrowly focussed on clients as individuals in the present moment. She said it was a problem to not provide clients enough accessibility to the outside world while in treatment. Similarly, the participant criticized that treatment did not extend outside of the walls of the centre where clients could take action and learn by practicing different behaviours in public places and with other people.

One participant had been prostituted and recalled a hindering incident when she was triggered at a previous treatment centre. “This program is the only program that focuses on male violence, like aspects of sexual exploitation. People don’t realize how many women in addiction have gone out there and worked on the streets” (Marissa). She believed that staff members at treatment centres need more knowledge about prostitution. Another participant explained how crucial it is to have prompt, properly prescribed methadone for pregnant women in community who are in active addiction and waiting to get into a residential treatment centre, “it could literally be up to a month before you can be stabilized. The chances of someone actually making it to where they’re stabilized, and not using any heroin, is very slim” (Carey).

One participant criticized psychiatrists at treatment centres. She blamed them of failing to provide clients with thorough mental health assessments and for prescribing and monitoring medications without adequate treatment plans. “So they wait for a period of time till you’re clean to see what actually is coming up. But nothing gets done after that, it’s like an experiment. They just treat you like a guinea pig” (Stacey). On a related topic the same
participant condemned what she called a cookie-cutter approach to treatment. She disapproved of an arts-based approach to drug and alcohol treatment:

Basket weaving is not gonna keep me clean. Basket weaving is not gonna fix my mental health issues. It’s not gonna fix my post-traumatic stress disorder. We have the same addictions but we didn’t grow up the same way, we don’t live the same lives. We have similarities, yeah, but everybody handles things differently and copes with things differently. (Stacey)

Citing the complexity of women at treatment centres, the participant suggested diverse treatment plans using a variety of therapeutic approaches and tailored to meet individual needs.

**Excluding participants’ extended families.** One participant found fault with integrated treatment centres that sometimes enforced no contact orders between clients and their families. She said that made it harder for her as a mother because she needed help parenting her child. “Sometimes I get it, family members aren’t healthy, but sometimes they are. If I had my daughter full-time, my daughter wasn’t allowed to go see her grandparents” (Marissa). The participant claimed she suddenly went from absentee or part-time parenting to full-time parenting without the assistance she needed.

A different participant contended that what made it harder for her as a parent in treatment was not addressing the problems in her home and with her partner that she would return to:

I’m just expected to not think about it and separate myself and, in lots of people’s opinion, leave him. . . . I’m not ready to let go. . . so instead of doing it almost like a harm reduction within a relationship, they just expect you to
just cut them out. . . There’s zero about family here. (Stacey)

The participant suggested her partner be able to join her for couples counselling while in treatment.

**What participants wished for concerning integrated treatment centres.** Nine participants contributed wish list items related to the category titled, ‘Integrated treatment centres and programs for women that include their children.’ What participants touched on differed to a degree so the following sub-categories were used to describe what they wished for: (a) improved features at integrated treatment centres and programs; (b) more integrated treatment centres and programs; and (c) more options and specializations within integrated treatment centres and programs.

**Improved features at integrated treatment centres and programs.** Participants suggested various ways that integrated treatment centres and other programs could be improved. Examples of wish list items were for more balanced diet options and nutritional guidance, for more fun activities that included mothers together with their children, and for help to find transitional housing. “If they know about places, if they had access to a housing list that had places available. If they had access to transportation that could transport me, that would be helpful” (Brooke). Cooking, baking, and doing art together were examples of how mothers could have fun and learn together with their children while in treatment. Another participant hoped for more access to the outside world while in treatment. The importance of access to more activities beyond the treatment centre would be an increased sense of support and a decreased sense of being overwhelmed. For example, one participant said she wished there was no wait for telephones when she had to take care of personal business.

The second thing one participant wished for was more treatment activities that
included mother together with her child. She spoke about the practical need for mothers to have more fun together with their children and learn how to act less frustrated around them. She said that cooking, baking, and doing art together were examples of how mothers could learn together with their children while in treatment. Next, participants described what they wished for about the need for more integrated treatment centres and programs.

More integrated treatment centres and programs. Participants espoused that it was critical to have more integrated treatment centres and programs to meet the demands of pregnant and parenting women struggling with substance use issues. Two participants stressed that if treatment programs were localized they could be better integrated as part of the community and make it possible for parents to remain with their children in treatment. One participant wished for cost-saving prevention by the government:

It would cost taxpayers less in the long run taking children away from families into foster care. Paying for women that go into second stage housing, they go into jail, into treatment, that is hundreds of thousands of dollars. Whereas, if you helped support that family when this woman was five years old herself and her mother was 17, I bet you would make a lot more impact. (Jacqui)

Another participant wished for more integrated treatment centres and shorter waitlists. She conveyed her experience, “I felt like I had no reason to live. And when I was trying to get clean and I was told to keep using drugs . . . that was like, ‘really’ ” [Chuckle] (Marissa)?

More options and specializations within integrated treatment centres and programs. Not only did participants wish for more treatment centres and programs for parents, they also hoped that services might be specific to those situations that required additional focus and care. For example, two participants expressed the need for programming for parents that do
not yet suit intensive treatment, and oppositely, for women who have the most severe mental health issues and nowhere to go.

One participant advocated for long-term treatment as a wish list item. She believed long-term treatment could be more effective provided that the parent would be together with their child. Another participant wished there were more options for light programming at integrated housing programs that included options for women to live in a space where they could also attend meetings every week, make friends, be sober, and do sober activities. The participant wished that parents could go to detox together with their infants when appropriate. “If she’s someone who’s just struggling, say someone like me, who needs to be guided in the right way without the ministry coming in and apprehending completely. Like, they work with you, and not against you” (Haley).

Category 2: Medical and mental health issues/illness, trauma, and concurrent addiction treatment. This category had a total of 45 critical incidents and wish list items with a classification as follows: 23 (51%) were helping incidents with a participation rate of 80% provided by 16 participants; 14 (31%) were hindering incidents with a participation rate of 60% contributed by 12 participants; and 8 (18%) were wish list items with a participation rate of 40% supplied by eight participants.

What helped participants regarding medical and mental health issues? What participants said helped them, in this category, made up half of the critical incidents and wish list items. To break it up into different albeit related units, this section has been divided into four sub-sections: (a) methadone; (b) combined care unit at hospitals; (c) daytox and community mental health services; and (d) relationships with medical and mental health professionals.
Methadone. On this topic, participants were for and against methadone medication and the critical incidents are described in that order. One participant thought methadone was helpful for two reasons:

I’ve been in a lot of car accidents and stuff, right. My body gets so sore sometimes. With the methadone it helps with my pain and with my mind…it stops the cravings and the thoughts of using….I never even could believe that medication could stop those thoughts but it actually does. It’s amazing.

(Sarina)

Two participants found it helpful to be off methadone medication when the time was right. “I can go somewhere, you know, without having to worry about, ‘do I have a prescription?’ It just makes it easier to go places cuz I’m not dependent on one thing that’s in one place” (Savannah). The other participant said that she did not like the side effects of methadone for herself and she worried that in the long-term methadone would make it harder for parents to stay clean because of its neurological effects.

Combined care unit at hospital. Four participants in this study were interviewed at treatment centres after giving birth at a hospital combined care unit for pregnant women struggling with substance abuse. They provided critical incidents about their positive experiences:

The maternity hospital program is an amazing program and there’s nothing like it all across Canada that I know of. It helped me realize that without them I couldn’t keep my baby. It helped me come off drugs. It helped me through my post-partum depression. (Brooke)

One participant stated, “The baby had no withdrawal, he was super healthy, he was two
weeks early, he was 38 weeks. Yeah, that place, it just saved my life, it saved my baby’s life” (Carey). She said it took persistence to get admitted to the unit, but once there, she was quickly stabilized and preparing for parenthood.

Two participants who delivered at the combined care unit had been homeless and fleeing domestic violence. They said they found it helpful to be in a secure place that felt like home for a while. Savannah stated, “Somewhere that I can sleep for one, and have my stuff and shower and eat, and there’s locked doors at night time, all the time actually, so no one gets in and no one comes out that isn’t welcome.” This participant also found it helpful after she was discharged that doctors from the combined care unit continued to treat her as an outpatient in the community. One participant transitioned directly from a homeless shelter to the combined care unit:

I got to live there; I got my own room, my own bed, my own TV. I got to rest and be off my feet and not worry about where I’m going to sleep, and how I am gonna go about getting housing and stuff like that, because they were helping me with that. (Ramona)

The same participant also appreciated the help she received at the combined care unit to transition to residential treatment and remain together with her infant. “I guess what was a really big help was them helping me find the [present treatment] place and actually helping me fill out applications which they mostly did themselves” [Laughs] (Ramona). Another participant described her experience of being stabilized and living at the combined care unit for a period of months. She indicated that after dealing with her negative behaviours, staff members carefully set boundaries for her in a helpful way.

*Daytox and community mental health services.* Daytox is medically monitored
withdrawal supervision offered in the community during the daytime. Some people go to
daytox versus inpatient drug and alcohol treatment because they have a safe, stable home,
and find it convenient. Others may not afford to be away from their profession. Yet others
access services at daytox programs before and after they are treated at residential centres.
Participants explained how daytox was or could be helpful for them as parents who had
substance use problems. One participant learned what services daytox could provide such as
acupuncture and yoga classes for when she transitioned home from residential treatment.
“[Daytox helps to] hang on to recovery and hang on to some form of structure in your life for
now till you can do it yourself. It sort of eases you into life I think” (Stacey).

Several participants described what was helpful about mental health resources in their
communities. One participant was able to do several things in community that prepared her
to enter residential treatment: (a) she took a skills course; (b) she regularly met with a drug
and alcohol counsellor; and (c) she applied to appropriate agencies to receive funding for
residential treatment. Participants also found it helpful to receive counselling at community
mental health centres. One participant described a helpful counselling experience in
community. “I found she was really good at digging up stuff and really good at talking to me
I guess about my past. My past, I think, is what kind of has brought me where I am”
(Natalie). Evelyn found the nonjudgmental approach at her community mental health centre
to be helpful. “When I was back home I started seeing a psychiatrist again, I was seeing an
addictions counsellor . . . They’re very supportive, like they listen to what I have to say. They
don’t put me down.”

Relationships with medical and mental health professionals. The quality of
relationships that participants had with medical and mental health care professionals was
important to them. It was not what the professionals did that was as important as how they related to the participants. Stacey said, “She looks past the fact that I’m an addict. I don’t think there’s enough doctors out there that understand. They look down on you I find.”

Another participant commented on the helpfulness of the staff at the combined care unit at the hospital. “I don’t know, it takes a real special breed of women to work there, that’s for sure. They’re very patient and tolerant and they put up with a lot of shit from us women [Laughs]. I guess they’re just well trained, they care” (Savannah). A third participant spoke about the helpfulness of a counsellor:

She helps me so much and she helps me understand myself and how I process things and we do a lot of PTSD work. Just having those genuine people makes so much of a difference. It makes it so much easier for me to continue doing what I’m doing. Like, she will go out of her way, she even bought me a book.

(Carey)

**What was unhelpful regarding participants’ medical and mental health issues?**

Twelve participants provided hindering critical incidents about the unhelpful aspects of mental and medical health issues and illnesses, and trauma. Since there were nuances to their descriptions, this section has been divided into three sub-sections: (a) mental illness including postpartum depression; (b) effects of trauma; and (c) barriers and stigma.

*Mental illness including postpartum depression.* Six participants spoke about their challenges with mental illness and struggling with substance use issues while early parenting. It became clear that their mental health issues were long-term and complex. In addition to postpartum depression, women described struggling with other mental illnesses such as borderline personality disorder, bipolar disorder, major depressive disorder, generalized
anxiety, obsessive compulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD), eating disorders, post-traumatic stress disorder (PTSD) and psychosis including paranoia, caused by active addiction. One participant summed up her thoughts regarding mental illness, “I just want to go away. It’s like a really annoying friend, frenemy, [chuckles] and you want it to go away and it won’t go away. I’m pretty sure I have to learn to accept it” (Jacqui). Like Jacqui, participants seemed to have a difficult time admitting they had mental illnesses and accessing treatment for themselves.

One participant painted a clear picture of the experience of living with untreated bipolar disorder. “It was like being on a roller coaster without the seatbelt. Like you’re hanging on for dear life and you’re just swinging all over the place” (Audrey). She spoke of her pregnancy with bipolar disorder describing agitation, irritability, and at times interpersonal violence. The participant said she eventually convinced herself that she could parent, “It turned out to be that having a baby doesn’t solve your issues, you still have all of them, and you just have a baby then” (Audrey).

For one participant, experiencing postpartum depression but not understanding it led her to binge drinking. Another participant also described not understanding postpartum depression when she first experienced it in the hospital after giving birth. In this hindering critical incident the participant explained how postpartum depression affected her ability to bond with her infant:

I didn’t love him. I didn’t know I didn’t love him, I didn’t realize what was happening. But postpartum depression is real and I had it and then about a month in I finally looked at him one day and I was like ‘oh my God, I love you, I’m so sorry.’ and I just kissed him. (Brooke)
It was after these participants were diagnosed that they could look back with understanding and recall how horrendous their experiences of postpartum depression were.

**Effects of trauma.** Many experiences of childhood, adulthood, and intergenerational traumatization were described by participants. Within this category, one critical incident came from a participant that did not find group counselling at a daytox program helpful due to group members’ disclosures of traumatic experiences. The participant recalled being triggered by listening to other stories of trauma and relapsing shortly after. One participant in residential drug and alcohol treatment said she was trying to understand the causes of the issues she was dealing with as a parent with substance use problems. “I believe trauma caused my mental illness. I believe I was maybe predisposed to it but my environment and how I was brought up really blew it up . . . it’s like I was a sitting duck” (Jacqui). Jacqui described this hindrance concerning trauma after learning about the contributions of nature and nurture to her present condition.

**Barriers and stigma.** In this sub-section, participants described hindering critical incidents related to obstacles and long waitlists to get into treatment. One participant described facing numerous hurdles when she was pregnant and motivated to receive treatment as soon as possible. For example, being required to make daily phone calls, being required to access a community counsellor for referral to treatment, and waiting longer yet while the workplace addressed numerous employment issues. The participant stated that other parents in the same situation might not patiently persevere in order to successfully navigate those hurdles.

Another participant described long waitlists for the treatment of pregnant and parenting women as a barrier. She explained that waitlists are unhelpful because they keep
women in a cycle of eagerness, followed by discouragement, which is followed by repeated drug use. The participant described that one additional day in the cycle could result in death from overdose, given the current fentanyl crisis. One participant described the shame she experienced from the stigma attached to being a young parent struggling with borderline personality disorder:

When I was in the hospital I had one of the nurses look at me like I wasn’t a full human…. He was saying ‘so, you gonna hurt yourself today? You gonna kill anyone today? You gonna jump off any buildings?’ It was humiliating, and he looked at me like he’s better than me. (Audrey)

On a related topic, another participant complained that doctors who do not listen are unhelpful as regards mental health treatment. She said she perceived judgment while under the care of a doctor. “I felt like he was sitting up there on his high doctor pedestal and talking to just some lowly junkies, like we’re all the same” (Kaitlin). The participant protested that she and other parents in residential treatment were viewed by the doctor as basically alike, and were given the same diagnoses and medications.

What participants wished for with regard to medical and mental health issues.

When participants talked about their wishes in this category, their wish list items were split between the topics of themselves personally and the broader system that affects medical and mental health care. Therefore, this section was separated into two parts: (a) provision of medical/mental health support, and motivation to seek it; and (b) removal of barriers to medical/mental healthcare access.

Provision of medical/mental health support, and motivation to seek it. Participants shared their wish list items based on personal experiences with medical and mental health
care. Examples were the desire for a family doctor and dentist to provide proper and timely health and dental care for the family, and the wish to have seen a psychiatrist sooner. That participant thought that seeing a psychiatrist for support might have been helpful to motivate herself to go to treatment sooner. Another participant shared a similar wish that she would have started talking to a professional sooner after her child was born, versus isolating and feeling sorry for herself:

Cuz I think I got post-partum, but not the type like where you hate your child but I started getting very depressed after I had her. I was very emotional, I was not in a good frame of mind. They gave you pamphlets at the hospital and they talked so much about postpartum after you have your child. I wish that I took up the advice that they were giving me, right, and I didn’t. (Leah)

Another participant wished “for more doctors that understand addiction, that really understand it as a disease and not as a lifestyle (Stacey).” Stacey believed that more doctors that understand addiction as a disease would be less pejorative and more able to support women in recovery.

*Removal of barriers to medical/mental healthcare access.* In this segment, the majority of wish list items concerned changes to the system and how they would help if they were available. One participant wished for a bed earlier at the combined care unit at the hospital. “I would have been able to start the whole process a lot earlier, if I would have got in, in June, when I first called. I could have had much more clean time while he was still in my tummy, right? (Carey). Another participant wished that filling methadone prescriptions would be easier suggesting it might save pregnant women from using other drugs while they wait for treatment. One participant wished there was more advertising of assistance for
women who are pregnant or early parenting and struggling with substance use problems:

Just getting it out there, like, that it’s a common thing. If I went to the drop-in mental health [and addictions centre] and there were signs all over, ‘Are you a mother struggling?’ those would make me a lot more comfortable in admitting it. (Chelsea)

The participant recommended something as simple as poster advertising in liquor stores and government offices that could encourage women to open up about their substance use problems.

**Category 3: Mother’s relationships with their children, and parenting support.**

This category had a total of 30 critical incidents and wish list items, with a classification as follows: 20 (66%) were helping incidents with a participation rate of 75% provided by 15 participants; 5 (17%) were hindering incidents with a participation rate of 25% contributed by five participants; and 5 (17%) were wish list items with a participation rate of 25% supplied by five participants.

**How relationships with their children and parenting supports helped participants.**

The overall participation rate in this category was high at 75%. In this section, 11 women contributed helping critical incidents regarding their relationships with their infants and children, and regarding parenting support. It appeared that pregnancy and early parenting were times that many participants perceived a window of opportunity to make positive changes in their lives. One participant described that receiving her children’s love and desiring to meet their needs helped her as a parent with substance use issues. “My daughter, she’s so attached to me . . . I think that if I were to ever lose her, I don’t know if I’d even want to live. . . . I just couldn’t imagine my life without her” (Natalie). Participants described
other ways that relationships with their children and parenting support helped them. The rest of this section has been organized into three parts: (a) motivation to embark on a recovery journey; (b) a reason to change beyond themselves; and (c) the provision of genuine care and support for acquiring parenting skills.

Motivation to embark on a recovery journey. The birth of their infants and the joy they got from early parenting provided helpful incentives for two participant to abstain from substances. “I just wouldn’t be able to use and parent him at the same time…. I just don’t see that right now cuz I am just so in love with parenting right now [Chuckle]” (Ramona), and, “she helped me just by [me] wanting to be better and get clean” (Chelsea). For a different participant whose child had been removed from her care, the child helped by providing the desire to recover from addiction. “Well, it gives me hope that I just have to do what I need to do. . . . He definitely does need me because nobody can give him the kind of love that I can” (Audrey).

A reason to change beyond themselves. Two participants expressed dismay for not loving and respecting themselves enough to get clean and sober:

I was never enough, and I’m working on why in my steps and through some of the classes here, but he [the child] gave me that reason that I needed. . . .

My family says, ‘he brought you back to us.’ He brought me back to life.

Yeah, he’s so special [Chuckle], he has no idea yet just what he’s done.

(Carey)

The other participant’s comment represents a similar helping incident:

I was trying to get sober for a really long time but I never really had the, whatever it was that I needed to be able to do it. So now I actually have
someone to do it for besides myself. For a long time myself wasn’t enough.

(Savannah)

The provision of genuine care and support for acquiring parenting skills. Six participants contributed helping incidents regarding parenting classes and programs, facilitated groups, and the professionals who ran them. One participant described the help she was receiving for her child at a behavioural program:

We do a lot of play therapy, and me and my daughter’s bond is like solid now.
Like, she knows at the end of the day, that I’m not going anywhere. ‘I’m here, mommies back on track, mommy’s here.’ You get a one-on-one worker who’s like a counsellor, so she shows me mindful play. We also work on when she’s having a tantrum; we work through it with them and they’re hands-on.

(Marissa)

Another participant shared a helping incident regarding parenting classes after experiencing an extended absence from her child. “Disciplining was really hard because I carried so much guilt, so they really helped me with that part. . . . I realized that all he needed was like, my love and my attention, and to just always be there” (Natalie). Finally, it was not just the provision of a parenting program that one participant expressed appreciation for, but also the care she received from a genuinely caring worker. “She’s [professional worker] doing a lot for me . . . she went out of her way to find a family doctor, not just for my daughter, for me as well” (Marissa).

What was unhelpful about participants’ relationships with their children, and about parenting support? Five participants contributed hindering incidents related to what made it harder for parents concerning their relationships with their children, and parenting
support. One participant added a hindering incident about a lack of specialized classes for parents struggling with substance use problems:

Like, I don’t know how to be a mother to a toddler…. Like they should have a parenting program for when you’re an addict and they should mix in how to be a parent but also how to maintain being clean. . . . When I’m going through a relapse thought, like a using thought, and my daughter’s screaming in my ear, I don’t know how to handle both. (Marissa)

Two participants described attachment issues that hindered them as parents struggling with addiction. One said she found it hard to connect with her child when she struggled with substance use issues. “He was definitely like my glue a bit . . . and it was almost like an excuse when he got taken away, to get worse. . . . and then I just like went off the deep end” (Audrey). The other participant described that emotionally attaching to her spouse and children was difficult while she struggled with substance use issues. She said her desire was to be emotionally connected to her family, but she tended to detach, escape the home environment, and avoid being around her family.

What participants wished for concerning relationships with their children, and regarding parenting support. It was apparent in this category that women wished for more parenting support. One participant wished for combined addiction and parenting courses, “Well, like I said, maybe a program geared towards the children, that parenting class that incorporates your drug addiction or your alcoholism, but is also a parenting class. So those two combined would be really cool” (Marissa). Another participant stated that she was previously exposed to only one type of parenting course that was specifically designed for how to keep one’s child in one’s custody:
Maybe teach them baby care, how to bath your baby, how to change a diaper,
how to cook, how to make a bottle, you know, things like that. And especially
women that are coming off the streets or coming out of drug addictions, it
could be hard for them not knowing. (Sarina)

Sarina was calling for more of a general skill-building type of parenting courses.

**Category 4: Understanding addiction as a disease.** This category had a total of 30
critical incidents and wish list items, with a classification as follows: 17 (57%) were helping
incidents with a participation rate of 60% provided by 12 participants; 11 (37%) were
hindering incidents with a participation rate of 40% contributed by eight participants; and 2
(6%) were wish list items with a participation rate of 5% supplied by one participant.

**What helped participants through understanding addiction as a disease.** Within this
framework, participants were learning about addiction as a chronic illness with genetic and
other causes, and maintaining sobriety as the major goal. Whether they found it helpful or
not, at least 17 of the participants were required to embrace the 12-step process with their
counsellors. While in residential treatment centres and other programs, they were also
attending Alcoholic Anonymous or Narcotics Anonymous (AA/NA) meetings. The
participants’ references to religious or spiritual aspects related to the 12-step process were
placed in the ‘Spirituality’ category. A total of 12 (60%) participants contributed helping
critical incidents about understanding addiction as a disease. Incidents in this category were
divided into three groups that represent the distinct ways participants found the disease
model helpful: (a) learning that addiction is a chronic illness provided clarity; (b) maintaining
sobriety was restoring; and (c) joining the Alcoholics Anonymous/Narcotics Anonymous
(AA/NA) community was supportive.
Learning that addiction is a chronic illness provided clarity. One participant said the disease model helped her gain clarity as she recently realized that her love for her child was not enough to stop using drugs. “I was very dedicated as a mom to her and so for me, the fact that it [unsafe incident with child] happened to me even though I love her this much just shows how powerful this disease is” (Stacey). For another participant the disease model helpfully addressed a false belief. “It wasn’t like I sat down one day and said, ‘I’m gonna choose to go do coke and drink instead of be with my family.’ It just progressed and this is a cunning baffling disease” (Jacqui). A third participant shared how helpful it was to learn that she suffered from alcoholism and was powerless over her illness. For a fourth participant knowing addiction was a disease led to forgiving herself. It seemed that understanding addiction as a disease provided tremendous relief to some participants’ guilt.

Maintaining sobriety was restoring. One participant highlighted the emotional benefit she received from sobriety. “Maybe you know when you use crystal meth for so long you forget what it’s like to laugh, and you’re just so miserable…and it just reminds me about when you don’t do drugs how much happier you are” (Leah). Four other helping incidents from understanding addiction as a disease were about the benefits of embracing abstinence. They were learning how to handle situations without using alcohol, making sober friends in the neighbourhood that kept oneself sober, making important decisions with the money to do necessary things, and saving a child from potential distress.

Joining the Alcoholics Anonymous/Narcotics Anonymous (AA/NA) community was supportive. Seven participants contributed helping incidents about the benefits of attending meetings and the AA/NA community of support. One participant remembered feeling inspired at a meeting after an elderly man took his 50-year cake. “He’s very straight to the
point, like, ‘basically you either do it [sobriety] or you don’t, don’t waste a bed when someone else is out there dying,’ you know? And it really inspires me, its awesome hearing them talk” (Evelyn). Another participant provided a helping incident about how AA/NA meetings were somewhere to gather with other parents who were struggling with the same problems. “We get a babysitter that comes to the house and then all the girls go to the meeting and that kind of makes us feel like a team” (Marissa).

Participants detailed many aspects of AA/NA meetings that they found helpful, as follows: (a) confidentiality; (b) the power of listening to other stories whether they were about success or failure; (c) the power of sharing their own stories; (d) the positive emotions participants felt after attending meetings such as the feeling of belonging; and (e) the sense of being part of a family, especially when their own families were small or fragmented. Participants shared positive outcomes of these incidents. One participant appreciated getting a sponsor and getting help with relapse prevention through the AA/NA community. Another participant remembered how her AA/NA community lovingly adopted her son as part of the family.

**What made it harder for participants with regard to understanding addiction as a disease?** Participants contributed six related hindering incidents about what made it harder for them as parents to remain abstinent. Following the disease model of addiction, participants in treatment centres were being advised to avoid environments in the future that could trigger them and to limit their access to drugs and alcohol. Participants described previous social environments where they might be triggered. The also described living close to liquor stores or living close to locations where they previously bought drugs. One participant explained how being around certain people in active addiction was not helpful:
Because it makes me feel like, when people are using, then it’s, ‘hey, I want to fit in too, I want to use, oh maybe I’ll just try this once,’ and this once is never just once, it will just spiral into more and more and more. (Teresa)

On a different note, two participants claimed they did not find the 12 steps approach and AA/NA meetings helpful. One of them said:

I’ve been to more treatment centres than I can count. And the first step says, we admitted that we are powerless over our addiction, and I totally disagree with it. You aren’t powerless, you choose to be where you are and that’s just my personal view, and I know that I’m different than all the rest of the world. (Brooke)

**What participants wished for with regard to understanding addiction as a disease.**

One participant said she wished for a plan to create a safe, sober environment for her and her children after treatment. For her, that wish included planning to attend AA/NA meetings where she could meet similar people, and stay away from people who use drugs and alcohol.

**Category 5: Provincial government involvement and assistance.** This category had a total of 46 critical incidents and wish list items, with a classification as follows: 20 (43%) were helping incidents with a participation rate of 55% provided by 11 participants; 17 (37%) were hindering incidents with a participation rate of 60% contributed by 12 participants; and 9 (20%) were wish list items with a participation rate of 30% supplied by six participants.

**How the government’s involvement and assistance helped participants.** The helping category included incidents where participants described the involvement of and assistance from divisions of the government including the Ministry of Children and Family Development (MCFD) and its various branches. Participants shared 46 critical incidents and
wish list items so it seemed that this was an important factor to them. For this reason, four sub-categories were created to better represent participants’ thoughts and opinions: (a) resources and financial assistance; (b) child protection; (c) foster care; and (d) social workers.

Resources and financial assistance. Financial assistance was identified as helpful for making residential treatment a possibility, and for paying for school and job re-training. Another helping factor was related to food vouchers and bus passes. “She’s [social worker] kind of giving me my own space but at the same time helping me with childcare. She pays for my bus pass cuz I’m in this program full-time” (Marissa). One participant described a helping incident related to receiving various other supports from the government. “I don’t even particularly like my social worker right now but, I know that there are a lot of resources that I can get if I need them” (Stacey).

Child protection. Five participants appreciated aspects of child protection services of the Ministry of Children and Family Development (MCFD). For example, mandatory urine sampling was described by two participants as helpful. “The drug testing has been a big one. I’ve had the option to stop, they told me I’ve done it long enough if I wanted, and I’ve asked to continue, just keeping me accountable” (Carey). In two helping incidents, apprehension of their children by child protection services was described as a necessary wake-up call for participants. “My son being removed out of my care ensured that he was actually safe, he’s not with anybody who’s using at all, and also it makes me really look at myself like in an honest way” (Audrey).

When child protection services arranged supervised visits with her children, one participant recalled, “It gives you hope. A lot of the times the kids were the only thing that kept me from going down as far as possible” (Kaitlin). Kaitlin claimed to be in a better frame
of mind while in treatment. She stated that her sense of being judged by child protection workers had been reduced.

**Foster care.** One participant recalled a helping incident when foster parents were supportive of her family reunification plan:

They’re [foster parents] obviously there for my child but they’re there for me too in a way. They want us to be together and they’re just there to listen and help with my child’s needs. . . . It doesn’t feel like that they just, they just want my kid for money, they actually care about him. (Haley)

One of the other ways that foster care placements helped participants was at times they were unfit to parent. One participant remembered feeling grateful for foster care when she sensed an inability to bond with her child. Another participant gave an example of feeling desperate shortly after her child’s removal. She described later sensing that the foster parents of her child genuinely cared.

**Social workers.** Family preservation workers and other social workers were described as helpful by four participants. One spoke of one-on-one guidance, “It’s just me and her [social worker]. I have that privacy, that trust, and to talk about just about anything even if I had a crappy day, instead of doing everything in a group setting” (Carey). Another said, “That’s really nice when somebody can understand who you are as a person and actually take the time to get to understand you, especially with a busy, very busy schedule” (Marissa). Marissa said that it was the social worker’s empathy and recognition that was most helpful.

**How the government’s involvement and assistance hindered participants.** Twelve participants recalled unhelpful aspects of government involvement or lack of assistance in their lives. Many described having defensive reactions and some cited a lack of
understanding of what the government’s involvement actually was. This section has been divided into the following four sub-sections to organize what participants said they found unhelpful: (a) lack of support; (b) government professionals; (c) child removals; and (d) restrictive conditions.

**Lack of support.** One participant described a hindering incident as the small proportion for rent that income assistance provides. “You can’t find a place anywhere for $500 a month. When I’m ready to leave here I’m gonna struggle to find a place to live” (Marissa). Income assistance issues were also identified as unhelpful by other participants. One claimed that because some people abuse the system others might not get the amount of financial assistance they need.

**Government professionals.** Some examples of hindering incidents in this sub-section were social workers that lacked empathy, made life harder for a parent, or were impossible to reach. The negative outcomes arising from these examples were as follows: (a) being left with the impression that a social worker did not like a participant, and was against her; (b) having to seek out the social worker rather than the other way around; and (c) having supervised visits with children delayed for unreasonable periods of time. Sensing no “real” support from government workers was described by one participant who recalled discovering her pregnancy and desperately seeking help. “Like you know you want help, you know you want change, but there’s no billboards saying, ‘here’s change,’ right, ‘call this number’” [Chuckle] (Marissa). The participant lamented losing months of potential abstinence due to not receiving appropriate and timely information about treatment options that would include her child.

**Child removals.** One participant recalled two hindering incidents from the devastation
she experienced when her child was removed by child protection services. She said she was
defensive at first. Next, she described how her health deteriorated quickly with no
accountability left as a parent. “I was just so messed up, after he was taken was the worst part
of my whole addiction. Like, I’ve never been so close to death” (Audrey). Two other
participants described hindering incidents about when their children were apprehended by
child protection services. “I had a lot of fear cuz I was fearing that they weren’t gonna give
my boy back to me if I told them that I was into drugs and that I was an addict and that I
went into the psych ward” (Maria). Another participant suspected that her child would have
been confused after her social worker had still not arranged a visit after her first full month at
a residential treatment centre.

RestRICTIVE CONDITIONS. One example of a hindering incident was the resentment felt
by a participant caused by splitting up her family and by not replacing necessary resources in
each household. “I started stealing from Walmart just so that I had food for my children, and
I feel like that kind of brought out another bad side of me. . . . using didn’t seem like too far
away after that” (Natalie). A second example of a hindering incident was the resignation
experienced by one participant:

I kind of felt at a certain point my kids were the only thing standing between
me and taking a swan dive. There is a point when they told me that I wasn’t
allowed to see my child at all and that made it really bad. My addiction really
skyrocketed and my mental well-being and my physical well-being went way
down. (Kaitlin)

A different participant recalled that it was unhelpful to have the Ministry issue a no
contact order with her ex-partner. She suggested that it would prevent the opportunity
to work on healthy boundaries and other family issues.

What participants wished for regarding the government's involvement and assistance. The wish list items in this category represented participants’ descriptions of how government involvement and assistance could offer more support for families and partners. Examples of items were: (a) desiring a separate government worker that would offer time and support for the entire family including the partner; (b) wishing for more services in order to work on co-dependency issues in the family; (c) getting more support to have the right thing done in a custody battle versus having the parent with the most money win; and (d) getting the necessary referrals in a timely fashion to reduce the long delays to get custody of children back.

One participant offered a wish list item which was her desire for a supportive ministry worker although she was not on income assistance:

I feel like you either get help when you’re on welfare or you’re rich. So being in the middle, having a job, there’s not much help for people like me. . . . I can’t access some of the help that other people can. (Maria)

Maria suggested that the importance of having a support worker was for needed help, motivation, and resources.

Category 6: Support from family and friends. This category had a total of 23 critical incidents and wish list items, with a classification as follows: 16 (70%) were helping incidents with a participation rate of 55% provided by 11 participants; 5 (22%) were hindering incidents with a participation rate of 25% contributed by five participants; and 2 (8%) were wish list items with a participation rate of 10% supplied by two participants.

How family members and friends helped participants. The critical incidents in this
category focussed mostly on how participants’ family and friends helped and supported them. To better understand the distinctions between their contributions, this section was divided into three ways that family and friends help: (a) family members and friends understood addiction and mental illness; (b) family members and friends provided emotional support; and (c) family members and friends provided practical support.

*Family members and friends understood addiction and mental illness.* Three participants appreciated their family members and friends for taking the time to learn about addiction. One participant said she noticed that as family members’ understanding of addiction grew, so did her sense of support. Another participant said that after a suicide attempt, “They were just there for me and were supportive and loved me and didn’t give me trouble or make me feel ashamed. . . . like they understand the disease and they understand mental illness it seems. That’s helped a lot” (Chelsea). A third participant noticed benefits to herself as family members learned about her addiction. She sensed a growing bond after being invited back into the family circle.

*Family members and friends provided emotional support.* Experiencing unconditional emotional support from family members or friends was described as important by six participants. An example of a helping incident highlighted two best friends who lovingly cared for a participant at a desperate time.

They just reassured me that I’m a good mom, I’m a good person, like it’s not my fault that I’m an addict. Yeah, that was very helpful. . . . just no shame and I think that that’s my biggest thing, you never want to say that you’re an addict when you’ve got kids. I’m like, so scared to be judged, and to have that shame. (Natalie) The participant explained that if shame had a voice, it told her she was not strong enough to
get better, which kept her from building herself up. For the other five participants, family members gave them a sense of belonging and of always being there for them. Another participant shared a helping incident about her value of family:

I’ve been so fortunate that through all the turmoil, cuz I’ve put my family through a lot [Chuckle], that they’re still there for me….it’s being part of the family again, and family is something that’s really important to me. (Carey)

A different participant said that family support meant not being strangers to each other. She described a helping incident about the lifesaving support of a brother who detoxed her in his home and later transported her to a residential treatment centre.

*Family members and friends provided practical support.* One participant found that friends in the neighbourhood and family members that hosted sober functions were helpful for her as a parent:

I said, ‘we need to do that more often. We have to, you know, maybe two or three times a week just meet up with the family, even at their house, just to spend one hour together is all we need,’ that helped a lot. (Ashley)

Other examples of helping critical incidents centred on various kinds of practical support from friends, parents, and grandparents. One of the ways family members and friends helped participants was relating to them mother to mother. One participant shared how her sister met her practical needs for baby supplies. She said her sister was a parenting role model and taught her how to nurse her infant. For another participant making other friends who were also parents was helpful for sharing parenting tips, sharing vehicles, and babysitting each other’s children.

*How family members and friends hindered participants.* Five participants provided
hindering incidents about family members’ lack of support that was not helpful for them as parents with substance use problems. Three of them stated that coming from families with a history of addiction made it harder for them in the following ways: (1) family members continued to use drugs and alcohol around one participant in a misguided attempt to bond with her; (2) not knowing or trusting extended family members implied restricted visits for the safety of one participant’s child; and (3) family members’ lack of understanding the disease model of addiction, and perceived judgment was unhelpful for one participant as a parent.

One participant described a hindering incident as a difficult experience with her father during a recovery phase, “. . . I remember calling him, three different times I tried to call him and like, I’m at wits end, bawling my eyes out, ‘Can you please help?’ and he said no” (Natalie).

Another participant said she found it unhelpful when close family members resisted change. “Like you think when people change their lives, like when people decide, ‘I’m not gonna use drugs anymore,’ that the people closest to them are gonna be happy. But it’s not necessarily always the case” (Emma). The participant seemed to understand the complexities related to her position within the family system.

*What participants wished for concerning family members and friends.* One participant provided a wish list item to live near her mother. “That would have been helpful just to have her here every day. She’s a great support over the phone but just to have her support on a daily basis would be such a wish and a dream come true [Chuckle] (Carey).” Another participant wished for supervised contact and counselling with family members including ex-partners that she would continue to be in contact with.
Category 7: Relationship with oneself, and personal characteristics. This category had a total of 28 critical incidents and wish list items, with a classification as follows: 14 (50%) were helping incidents with a participation rate of 45% provided by nine participants; 13 (47%) were hindering incidents with a participation rate of 45% contributed by nine participants; and 1 (3%) were wish list items with a participation rate of 5% supplied by one participant.

Aspects of participants’ relationships with themselves that were helpful. Nine participants reported positive feelings and thoughts about themselves that helped them as parents with substance use issues. In particular, women provided helping incidents related to self-esteem, self-worth, and self-efficacy. Increased self-esteem was helpful for two participants. One participant learned to like herself more as a sober person. She conveyed her desire:

I want them to see a healthy relationship, a healthy mom, and a strong woman because I’m raising two boys. . . . They need to see people can change as well and they need to respect women and in order to do that I have to respect myself. (Jacqui)

Another participant shared that higher self-esteem helped her become more socially engaged around sober people in community. Increased self-worth was helpful for three participants:

I’m feeling more comfortable with having more positive self-talk, whereas before when I was in my addiction I believed that I was unworthy of love….I want just to break any kind of cycle from my past so I can be there and my son can be proud. (Teresa)

Another participant said, “I would put affirmations in my room saying I’m worth it, I deserve
to be clean and sober, I deserve to love my son, I deserve to love myself” (Maria). A third example of a helping incident regarding self-worth was a participant’s knowledge that her children would have a healthier mother with the ability to free them of the complicated life that she experienced as a child.

Three participants described their growing sense of self-efficacy, believing in their capacities for change. One described the helpfulness of getting stronger. “Oh yeah, if I put half the amount of energy from being chaotic into being stable, we’re gonna be good” (Jacqui). Another communicated how sobriety and personal enlightenment helped. “I can be a mom, I can be there for them, I can teach them things, I can be happy for them, I don’t know, be a good mother” (Kaitlin). A final participant shared her pride in finishing a treatment program from beginning to end.

Aspects of participants’ relationships with themselves that were hindering.

Participants conveyed the effects of low self-esteem and low self-worth as unhelpful. One participant constantly compared her family to others. She said her frustration often snowballed into self-destructive thoughts. Another participant was angry and bitter towards herself. “Why was I so angry and bitter? It was because I was angry with myself and I was just taking it out on people. And that is not me, like I am a loving, caring person” (Teresa). A third participant was constantly disappointed in herself. She explained that disappointment contributed to low self-esteem which caused her thoughts to spiral downward.

Lack of self-worth prevented one participant from getting help sooner. “Not being enough wasn’t very helpful. At the time like, I wasn’t worth it, worth the effort, worth the embarrassment of going somewhere and saying I was pregnant, I was a heroin addict, and I needed help” (Carey). Participants described the internalized effects of abusive relationships
that made it harder for them as parents. “I used the drugs to fill that hole inside of me . . . and it all came from not loving myself, not trusting myself, being talked down to and allowing it to happen” (Jacqui).

Four participants described being in abusive relationships that they sensed they could not leave. One described the self-loathing she experienced from abusive relationships. “I would always say I was not good enough, I was not a good mom, I was not pretty enough, I was not worthy of love, I was not smart enough to comprehend anything” (Teresa). Teresa explained the progression from low self-esteem leading to low ambition, and finally depression. The only wish list item in this category was a participant’s desire for personal motivation to be in treatment sooner.

**Category 8: Short-term and long-term practical needs and support.** This category had a total of 39 critical incidents and wish list items, with a classification as follows: 13 (33%) were helping incidents with a participation rate of 45% provided by nine participants; 6 (16%) were hindering incidents with a participation rate of 20% contributed by four participants; and 20 (51%) were wish list items with a participation rate of 65% supplied by 13 participants.

*What helped participants with regard to short-term and long-term practical needs?* One example of what helped participants in this category was having jobs to return to after residential drug and alcohol treatment. For these two participants, the significance of secured employment reduced panic pertaining to the future, increased a sense of purpose for their lives, and fulfilled their personal work values. One described medical and dental insurance, and support for illness were other practical benefits of employment.

Practical supports in the community were described as helpful to three participants.
The helping incidents included the local food bank, legal aid, and organizations that give away baby supplies, “if you are giving it your all and doing what needs to be done to make the changes in your life, then I don’t think there’s anything wrong with accepting help like that” (Carey). Participants contributed helping incidents about the value of fellowship, long-term supports in communities, and actively working with community resources. One participant gave examples of AA/NA meetings in the community, activity groups, church, and sponsorship activities that she said were helpful for her as a parent. Another participant described the helpfulness of building connections, “So it’s like I’m starting to learn to work on my issues with people in the community, so that I’ll have these good resources when I get out of the treatment” (Emma).

Participants described the helpfulness of keeping busy with their children in their communities. Examples of helping incidents were obtaining free swimming passes, supervised activities for children, and having hobbies such as knitting, drawing, and reading. The positive results from these examples were described as staying active in public, bonding with their children, offering their families joy and excitement, and having peace of mind. One participant described that living close to nature helped her, “I wasn’t drinking at all. I was keeping busy, taking them exploring, teaching them how to fish and watching them catch their first fish. It was better than being drunk [Chuckle], it was an experience” (Ashley).

What hindered participants with regard to short-term and long-term practical needs? Not having vehicles and other transportation problems were described as unhelpful by participants. Without transportation, participants said they were less self-reliant, less able to access resources, and more easily frustrated. One participant described an unhelpful lack
of resources in a remote community:

There was nowhere to go, we couldn’t meet friends, couldn’t go for coffee. . . but if there was a mall or something, a gym you know, yoga with babies, something where you could take your babies to, like ‘mom and tot times.’ There was absolutely nothing so I became bored and drinking became my new best friend. (Ashley)

Other examples of hindering incidents were not being engaged in the community and not staying busy with jobs. One participant explained that it was challenging to find employment that would work for a single parent with school-aged children.

*What participants wished for with regard to short-term and long-term practical needs.* Just over 50% of the factors in this category were wish list items about participants’ short-term and long-term practical needs. What they wished for was divided into the following four sub-sections: (a) education and work opportunities; (b) transportation options; (c) personal and family activities; and (d) community support and connection.

*Education and work opportunities.* Four participants expressed a desire for more education in the future. They described the importance of education as something fun to do, something that would provide purpose, and something that could contribute to higher incomes in the future. One of them wished for quality education for her child in order for her child’s future security and independence. Three participants wished for career related support. One participant desired more work programs that help parents who have struggled with substance use issues. “Maybe more programs to get women out there to work in the industry, to find a career, to even do service work or give them a boost in the right direction, to be financially stable, and to have security” (Teresa). Another participant wished for suitable job prospects for single parents with school-aged children.
Transportation options. To own a vehicle for practical reasons was a wish that was expressed by two participants, “having a vehicle, like transportation even, so I can get to and from doctor appointments and be able to drive my kids places, you know” (Kaitlin), and for a sense of security and normality, “I would like to have a vehicle. I’ve had my license for nine years and just imagining getting out of treatment and not being able to drive my two children around is a little scary” (Natalie). Participants wished for other types of transportation. Examples of wish list items were a neighbourhood vehicle co-op, and increased bus services for parents and children in urban and rural communities. Participants said the importance of accessible transportation would be to empower parents to move forward in their lives.

Personal and family activities. Participants had a variety of wishes about the types of activities and programs they hoped for in their communities. One participant wished for affordable and readily available children’s programs in her community, “access to programs like dance, or arts and crafts, like affordable things that I can do for them or with them” (Kaitlin). Other examples of wish list items were cooking classes for parents and swimming lessons for children. One participant suggested that cooking classes would be important to teach her healthy eating and proper nutrition for herself and for her children. Another participant suggested that swimming is a life skill that could provide her child with future opportunities. A third participant described a wish to show love through traveling together with her child.

Community support and connection. One participant wished for a life coach that could guide her concerning nutrition, parenting, career, and relationships, “get to know you first obviously, what’s happened to you . . . and just to be able to guide you to where you need to be. A lot of us are . . . emotionally retarded or stunted, or whatever” (Stacey).
Another participant described a similar wish for support. “To have a one-to-one worker who can kind of bring us back into society by doing fun things, sober things where we wouldn’t have to use. It would be like having an adult big brother, big sister program” (Marissa). As parents, participants also wished for close ties to their communities in the future. One participant described her hope for people to be close, supportive, and to get along. Another participant said that involvement in her community could provide positive activities that would get her and her children out meeting people.

**Category 9: Spirituality.** This category had a total of 13 critical incidents and wish list items, with a classification as follows: 11 (85%) were helping incidents with a participation rate of 45% provided by nine participants; no hindering incidents were placed in this category; and 2 (15%) were wish list items with a participation rate of 10% supplied by two participants.

*How spirituality helped participants struggling with substance use*

*Issues.* Nine participants in residential treatment centres suggested finding it helpful to develop spiritual relationships with a Higher Power. The ‘Spirituality’ category included incidents in which participants discussed that acknowledging a Higher Power helped them give up attempts to be in control and to just do their best. “I believe in a Higher Power now, not necessarily God, but something. I really tried to run things and that’s cuz I’m afraid. I don’t think anybody else can do it” (Stacey). Another example of a helping incident was a participant’s combined belief in a Higher Power with aspects of Buddhism that kept her grounded and calm. “Having a Higher Power keeps me humble and makes me less like, ‘everything’s about me.’ It puts me in my place kind of, I’m just one little part of this big universe” (Kaitlin).
A different example of a helping incident was described as experiencing a dependable, intimate relationship with a Higher Power. The participant described honest talks with God and the satisfaction of being listened to. She explained the outcome. “It’s having something to believe in, having something to turn to. The intimacy there is just so comforting. It takes away so much of my stress” (Carey).

To participate in meaningful spiritual practices was described as helpful for participants. Examples of helping incidents were baptism, healing classes, prayer, and Aboriginal practices. The importance of spiritual practices for one participant was to help her exit the drug life. For another participant, the Aboriginal practices of smudging and prayer helped her with anger, negativity, and forgiveness. “It removes any negative energy and after smudging you pray to the grandmothers and grandfathers a prayer that is heartfelt. It just makes you calm, relaxed and relieved. Like, it feels like everything’s been lifted off of you” (Teresa).

Participants shared that spirituality was helpful because they joined communities of supportive, likewise believers. Examples of helping incidents were as follows: (a) the experience of being “part of” from attending an Aboriginal friendship centre and All Nations healing centre; (b) the experience of greater hope, greater faith, and less judgment from meeting with church people; and (c) the experience of a wholesome environment from attending church. “It’s just the community, being around healthier people. It’s not necessarily that everyone’s healthy there, but just to be positive around positive, influential people as opposed to having been hung over [Chuckle]” (Chelsea).

**What participants wished for in connection with spirituality.** A participant described wishing for broader religious perspectives at residential drug and alcohol treatment centres.
She claimed to not relate well to the traditional religious material she was provided with. Another participant wished she would have trusted in a Higher Power to take over the reins of her life earlier. “Now I know that there’s something else out there that will not let me down. So I will put my faith and my trust in it and I wish I’d found that sooner” (Leah). This participant expressed that a relationship with a Higher Power could have buoyed her during experiences of isolation and loneliness while in active addiction.

**Category 10: Childcare.** The childcare category had a total of 23 critical incidents and wish list items, with a classification as follows: 10 (44%) were helping incidents with a participation rate of 40% provided by eight participants; 5 (21%) were hindering incidents with a participation rate of 25% contributed by five participants; and 8 (35%) were wish list items with a participation rate of 30% supplied by six participants.

*How childcare helped participants.* The helping incidents were those where participants described the supportive care of their children. They included childcare provided by professionals, family members, partners, friends, and government day care centres. Participants reported on the childcare support they received both before and after they arrived at residential treatment centres and other programs. Participants in residential treatment centres appreciated the provision of day care that enabled them to be in treatment that included their children. One participant spoke about the credentials of the day care staff members. “They have their Early Childhood Education so that’s good, I know that they’re educated. They’re certified to take care of these kids, they’re not just some random people” (Evelyn). Another participant added that it was helpful knowing her child was safe at day care and that it was beneficial for her child to play and interact with others.

Participants explained the importance of day care at treatment centres was to get
needed breaks for working on themselves. “When I’m doing my program, when I’m doing my step work, it just gives me that little bit of a break to be able to breathe and think about my recovery” (Sarina). Another participant said, “With me taking my baby to a meeting, like sometimes they’re fussy or something and you end up missing part of the meeting” (Emma). A third participant provided a helping incident about leaving her child in the care of her family while in residential treatment. She said the importance of family members caring for her child was the assurance of safety and the avoidance of a foster care placement.

Participants claimed that family members and the government were a helpful and important source of childcare in the following ways: (a) to go to appointments and run errands alone; (b) to have needed breaks from children to work on recovery issues and attend AA/NA meetings; and (c) to receive parenting assistance through the creation of safe environments with appropriate use of discipline for their children.

**How childcare hindered participants.** The hindering incidents were those where participants said that they needed more affordable and dependable childcare options. An example of two hindering incidents was not having childcare in order for self-care and for when in crisis. “Just a drop-in [childcare centre], that you don’t have to pre-book for a certain date, because you don’t plan ahead when you relapse” (Natalie). One participant shared that it hindered her as a single parent when close family members often reneged on their offers of childcare. Another participant described that it was hard for her as a parent to find time for self-care at a residential treatment centre with no childcare on the weekends.

Two different examples of hindering incidents about lack of childcare were an inability to attend personal appointments with counsellors or doctors and an inability to return to work. A single parent described the potential outcome of returning to work without
affordable childcare. “It’s gonna be all my money just to feed us and get the day care taken care of. It’s gonna be crazy” (Brooke).

**What types of childcare participants wished for.** The wish list items were those where participants described what kind of childcare they wanted while in residential treatment centres and other programs. One was a desire for day care that was closer to treatment centres for parents not in custody of their children. The participant said she believed it would reduce the need to consider foster care placement. One participant wished that childcare at a transitional housing program was provided by designated staff members rather than by volunteers. She said the importance for her was to do things on her own without her infant and not feel guilty for asking for help. Another participant wished that integrated residential treatment centres would increase their overall capacities. “They could have a bigger day care, where they can accommodate more mothers, so that the mothers can form more relationships with people” (Stacey).

Other items were those where participants wished for more supportive childcare after they left treatment centres and other programs. Examples included a wish for childcare during the day and a wish for appropriate, safe day care centres in the community. Participants indicated that more childcare options would be helpful for rejoining society. They said it would also help them get back into the routines of their lives that might include education and work. One item was a desire for the provision of childcare at more AA/NA meetings, “like, just for about one hour, there’s some meetings like that, but not that many have childcare at them” (Evelyn). One participant wished there was more funded day care spots in the province. “I wouldn’t have this issue of having to have a live-in day care. Maybe I could have a subsidy somewhere along the way because I’m a single mom” (Brooke). She
anticipated that if she received financial assistance for day care from the government, it would leave more of her earnings for other needs.

**Category 11: Experiences of pregnancy and/or parenthood having used or while using substances.** This category had a total of 40 critical incidents and wish list items, with a classification as follows: 6 (15%) were helping incidents with a participation rate of 30% provided by six participants; 32 (80%) were hindering incidents with a participation rate of 70% contributed by 14 participants; and 2 (5%) were wish list items with a participation rate of 10% supplied by two participants.

*How experiences of pregnancy and/or parenthood having used or while using substances helped participants.* Three participants shared that having a child while struggling with substance issues use issues was a helpful eye-opener. One participant described that the guilt of using drugs while pregnant provided motivation to make it up to her infant. Another participant described the experience of being without her child at a residential treatment centre as partly helpful. “Now I know what I have to lose if I use. It is a good reminder that if I use drugs and alcohol, if I slip into denial about my mental health, I could lose it all again” (Jacqui). The helping category also included incidents where participants described the routines of raising children as helpful for them as parents. In addition, one participant said that less socializing as a parent helped her avoid temptations around friends that use drugs.

*How experiences of pregnancy and/or parenthood having used or while using substances hindered participants.* Participants spoke of negative factors affecting parenthood including secrecy, shame, fear and loneliness. Other factors included the challenges of single parenting and participants’ tendencies to isolate themselves. Women
spoke of other experiences of early parenthood such as being abandoned, stigmatized, and judged by others. To capture the nuances of many hindering incidents this section was split into four parts as follows: (a) secrecy, isolation, and abandonment; (b) stigma and judgement; (c) parenting challenges; and (d) issues and consequences from using while pregnant and/or parenting.

Secrecy, isolation, and abandonment. Participants described unhelpful experiences of loneliness and seclusion during early parenting while struggling with substance use. The outcomes of isolating were described as taking their children out less and losing their social skills. Participants provided accounts such as “I’ve been so withdrawn and I’ve been alone for so long that I don’t even know how to talk to people anymore” (Ashley) and, “I would spend lots of money at the casino and the shame and the guilt feelings, and then to get those feelings to go away I would just do more drugs” (Leah). One participant described how keeping drug use a secret affected her. “You don’t get the help you need if you can’t be honest about what you need it for, right?” (Carey). Another participant said, “Feeling like a bad mother because I wasn’t doing anything really, and just sitting around, I was feeling like I wasn’t giving him [the child] a very good life” (Audrey). For Audrey the experience of alienation resulted in disconnections from her child and spouse.

Stigma and judgement. One participant described that the stigma of a “using mother” was shaming and caused self-induced pressure for her to be perfect. “That judgement makes me feel like the thoughts are out there and that I’m a bad mom. And I definitely wasn’t a good mom, but I’m not a bad person and I’m working on it, so that’s hard” (Jacqui). Another participant explained that stigmatization by health professionals made her feel trapped. “She doesn’t get it at all. It made me cut her off and put a wall up with her. So then, there goes me
right back to falling into a toxic cycle with addiction and sex trade working” (Marissa).

A third participant provided a hindering incident about being judged and shamed by other members of society. “It made me question myself, my own parenting, like, made me think that maybe I shouldn’t be trying to be a parent to them” (Kaitlin). A fourth participant shared how being judged as a mother resulted in bringing her down further emotionally. “It just doesn’t help. Like, they think maybe they’re helping by telling you to get it together, but really they’re just making you feel worse, like a piece of crap” (Audrey).

Parenting challenges. Examples of hindering incidents were about the challenges of single parenting or parenting with a mostly absentee partner. Participants described feeling stressed and impatient without help. The outcomes participants recalled were often increased substance use to provide motivation for parenting or to reduce loneliness. One participant described the experience of parenting with a substance use problem as driven by perfectionism. “My happy family split up . . . I’m very family oriented and it’s probably cuz that’s how I viewed my grandparents, that was the perfect life. So, I wanted it, and when I didn’t have it, I felt like relapsing” (Natalie). One participant described feeling terrified to become a parent without a sense of self. She said that she continued to use drugs as a parent and found it impossible to discipline her child as a result of shame and guilt.

Issues and consequences from using while pregnant and/or parenting. Four participants described unhelpful consequences of using substances while early parenting. One participant described consequences when she was delayed from entering treatment. “I’m trying to take the steps and there’s nothing I can do in the meantime, so I might as well just keep using, right? And in that time I couldn’t see my kids either” (Kaitlin). For another participant, a consequence of parenting an infant while struggling with substance use
problems was attachment related. “I couldn’t even bond with him at first because I was in my addiction and he ends up going to foster care. Like, what kind of parent is that” (Evelyn)?

Two participants recalled believing that their pregnancies and the birth of their children would be enough to abstain from drugs and alcohol. Yet, one participant described having no idea how to get the help. “I was like hitting a brick wall everywhere I went. And it really sucked because I knew I wanted change, I know that I deserved it and my daughter deserved it” (Marissa). Another participant described her dismay when her addiction issues remained after her child was born. “Like, I know I’m smart and I know I’m capable of so much more but my substance abuse was really holding me back from being a good mom, from just taking care of myself, being independent” (Audrey). Participants described outcomes of long delays for treatment being continued drug use and additional declines in functioning.

What participants wished for. Examples of two wish list items in this category were desiring a parenting advocate and wishing to have asked for help sooner. One participant described the way an encouraging advocate could have helped her. “I wish I could have divulged that [need for support] to somebody and they could have found me resources . . . I’m a really shy person and I don’t like asking for help” (Natalie). Another participant claimed that getting help sooner could have permitted her to maintain custody of her child and bring the child with her to a residential treatment centre.

Category 12: Relationships with and support from partners and/or children’s fathers. This category had a total of 27 critical incidents and wish list items, with a classification as follows: 6 (22%) were helping incidents with a participation rate of 30% provided by six participants; 17 (63%) were hindering incidents with a participation rate of
70% contributed by 14 participants; and 4 (15%) were wish list items with a participation rate of 15% supplied by three participants.

**How partners and/or children’s fathers helped participants.** Participants generated six helping incidents about their partners and/or the biological fathers of their children. Four helping incidents were related to the support provided by partners and other positive aspects of the relationships. One participant said, “I have a lot of faith in him and knowing that I’m loved really helps and seeing that he’s really family oriented, like I feed off of that, and I want to be family oriented” (Natalie). The participant described an outcome as experiencing her partner’s love and comfort and being grateful for the way he accepted her addiction and did not look down at her. Another example was from a participant who found her relationship with a sober partner to be helpful. “He didn’t drink like I did, so I didn’t have a partner in crime [chuckle]….I didn’t want him to see me like that either, it was embarrassing” (Ashley).

Two helping incidents were provided by participants who claimed that abusive relationships turned out to be helpful in a way. “I’m sad for my child that his dad isn’t there, but at the same time his dad wasn’t healthy. . . . And yeah, the fact that he’s not around, I’m able to solely focus on my recovery and my son” (Carey). The other participant remembered being pregnant and abused by her partner. Both participants said that when child protection services got involved, it helped them move forward and get into treatment.

**Unhelpful factors related to partners and/or children’s fathers.** A total of 17 critical incidents or 63% of factors were about negative and traumatic aspects of participants’ relationships with their partners and/or the biological fathers of their children. It seemed that the parents in this study reflected more on unhealthy intimate relationships than healthy. This section was divided into four sub-sections to capture the distinctions of the hindering
incidents: (a) emotional abuse; (b) violence in relationships; (c) negative consequences of participants’ childhood abuse on future partnerships; and (d) partners’ addiction issues.

Emotional abuse. The hindering incidents about partners included factors related to negativity, misunderstandings, and emotional suffering. One participant remembered a hurtful and verbally abusive partner. “When he did message me he was calling me down. Like, ‘you’re just a piece of crap mom who has her newborn baby in a recovery house, why don’t you just leave me and your son alone’ ” (Sarina). One hindering incident was related to an ex-partner’s criticism of a participant’s parenting, “blaming it all on me, everything that has happened throughout the two years, it’s all me” (Judy). Another participant explained unhelpful misunderstandings with her partner, about addiction, and about whether residential treatment was necessary. She recalled the outcome was being put down by her partner and feeling defeated as a parent.

Violence in relationships. Domestic violence was the topic of four hindering incidents related to partners. “He was just as much of an addict, he became physically, mentally abusing in front of the kids. So yeah, that was definitely not helpful” (Kaitlin). One participant explained something both helpful and hindering about surviving physical abuse. “Like I said how it helped, it opened a file with the Ministry and pushed me in the direction to come here. What didn’t help was getting beaten up, it’s not fun” (Ramona). A third participant provided a hindering incident about her children witnessing years of physical abuse by her partner. She said what made it harder for her as a parent was the potentially harmful long-term effects on her children.

Negative consequences of participants’ childhood abuse on future partnerships. One participant shared a hindering incident about internalized inequality with men based on
adverse childhood experiences. She claimed that the outcome was a pattern of relationships with partners that abused her. Another participant provided a hindering incident about rushing into relationships early in sobriety:

Anybody that I would choose right now in early recovery is probably just as broken, if not more, than I am . . . when you get into relationship with somebody that’s in recovery, it sounds great in theory, but what happens when one of them goes out. That’s the hardest part. (Stacey)

This participant described an outcome of strained and broken relationships with ex-partners and others that were not helpful for her as a parent.

Partners’ addiction issues. Although the number is likely to be higher, 13 participants in this study spoke about past and current relationships with partners who abused illicit drugs and alcohol. One participant’s partner was incarcerated due to drug problems. “I don’t want my child thinking, ‘oh daddy’s in jail, it’s okay,’ and that is a concern for me . . . that’s not really the upbringing, or the family environment I want for my child” (Evelyn). Another participant explained that an outcome of using drugs together as a couple was impaired parenting and increased risk to her children.

Three participants offered hindering incidents regarding being triggered by their partners’ drug use. One said, “I felt really abandoned by him . . . I really started thinking, ‘well, if he’s drinking then maybe I should be using.’ And seeing that he was backing off from parenting, then I wanted to back off from parenting” (Natalie). Another participant in a relationship with a partner who was in active addiction experienced something similar. “I was in there doing all this work on myself, going to groups and having this baby in the oven, [Laughing] and he was out there still able to drink and get messed up” (Carey). The third
participant’s hindering incident was about a partner’s drug issues and mental illness. She said she found it hard as a parent because of the constant distractions while working on her recovery.

*What did participants wish for about partners and/or children’s fathers?* Three participants wished for more capable fathers for their children. “I think he wanted to be a dad but he couldn’t give up the alcohol…the extra help, the sense of family which is so important to me, my child having a dad” (Carey). One participant described a wish that her infant’s father was prepared and willing to be a helpful co-parent. She stated its importance for her child to know his father and to have a sense of family. Another participant shared a wish that her child’s father was not incarcerated. She described the lack of financial support and her partner’s intermittent presence as making it harder for her as a parent.

*Category 13: Upbringing, life circumstances, and critical stressors.* This category had a total of 27 critical incidents and wish list items, with a classification as follows: 5 (19%) were helping incidents with a participation rate of 25% provided by five participants; 14 (52%) were hindering incidents with a participation rate of 40% contributed by eight participants; and 8 (29%) were wish list items with a participation rate of 25% supplied by five participants.

*What was helpful from upbringing, life circumstances and critical stressors?* The helping section of this category included incidents where two participants related harsh life circumstances but with positive outcomes. Two examples were being raised by parents with addictions, “it’s just knowing what I’ve been through and stuff, I don’t want that for my kid. . . . I don’t want him to have to go through the same shit I went through as a result of my parent’s addictions”
In addition, surviving a suicide attempt, “So without taking that sort of step [suicide attempt], I don’t know if I would have been here, I probably would have been dead. But I survived it and, it’s helped a lot, cuz the timing has been perfect” (Jacqui). The importance of these incidents was expressed as helping the participant’s parenting capacity and motivating the participant to seek treatment, respectively.

**What was not helpful from upbringing, life circumstances and critical stressors?**

The hindering section of this category contained incidents related to the environments participants were raised in including the way they were parented. This section also included traumatic experiences from both their past and present lives. The hindering section was divided into two areas to better organize the participants’ experiences: (a) participants’ experiences in early family environments; and (b) participants’ experiences of trauma.

**Participants’ experiences in early family environments.** Hindering incidents concerned participants’ experiences of being raised by parents with addiction issues and mental illnesses. One participant described experiencing poor parental role modelling. “I thought to myself, hey, my mom did drugs when I was little, why can’t I? Like monkey see, monkey do” (Teresa). Another participant described childhood adversities. “I was extra sensitive towards those situations and, I don’t know, I guess there was just lots of stuff like that going on [in childhood] that I never dealt with that, and then becoming a mom out of nowhere…it was very tough for me (Leah).

**Participants’ experiences of trauma.** Participants relayed hindering incidents regarding traumatic childhood events that made it harder for them as parents. They said that as parents in the present, they often used drugs to cope with emotional pain from the past as one quotation reflects. “I can’t keep on living in the past or thinking about the people that
have harmed me because I will not be able to move forward in my life” (Teresa). One participant explained the impact of childhood abuse, “the trauma I experienced came from a man, and most of the esteem things I suffered came from my dad. And the esteem things that I suffered also came from me watching my mom be a victim” (Jacqui). Another participant shared her negative experiences as a child receiving counselling for abuse. “When I would open up to counsellors, like, that my trauma was so intense… it would almost be like they didn’t believe me. It really discouraged me from counsellors” (Marissa). Marissa said it made it harder for her as a parent because she did not trust professionals and needed trauma counselling at the present time. Three different examples of hindering incidents were about pregnancy and homelessness, “just you know having no money and more stress because I had to go find some food, you know, find somewhere to sleep, yeah” (Ramona). The outcomes described were stress and further traumatization.

What participants wished for related to their upbringings, life circumstances, and critical stressors. Participants mourned their early lives. In addition, they wished for better conditions in their present lives. This section has been divided into two parts, as follows: (a) to change the past and (b) to change life circumstances.

To change the past. Examples of what participants wished for were to never have been abused, “I blame a lot of my [low] self-esteem and a lot of my not thinking I’m worth it and not liking myself, on my dad” (Carey), and to have had parents who had really listened, “by grade 9 I was failing every class and hanging out in the smoke pit. To me as a parent I would notice a drastic change and I would have done something more about it” (Jacqui). Jacqui suggested that a better outcome would have been receiving the attention and balanced discipline from her parents that she needed as a teenager. Finally, two participants wished
that they had never become addicted to drugs to cope with the effects of abuse.

To change life circumstances. Three examples of wish list items were for financial and other supports. One participant wished for money. “A million dollars. [Laughing] literally. Since he’s been born, I wouldn’t have had to use those resources and would have just felt capable, able to take care of him, and find whatever he needs” (Carey). Another participant provided a wish list item related to more support when in crisis, “…maybe not even necessarily just the funding cuz I probably just would have spent money on dope but [Laughing] just like the resources, by having a place to go, a spare change of clothes. I had no shoes” (Savannah). The third participant imagined what it would be like to be the recipient of the Make a Wish Foundation. The participants stated that what they wished for was important for providing security, shelter, and recognition in the role of a single parent in recovery.

Category 14: Housing and financial issues, and support. This category had a total of 30 critical incidents and wish list items, with a classification as follows: 4 (13%) were helping incidents with a participation rate of 20% provided by four participants; 4 (13%) were hindering incidents with a participation rate of 20% contributed by four participants; and 22 (73%) were wish list items with a participation rate of 55% supplied by 11 participants.

What helped participants pertaining to housing and financial issues? Four participants described aspects of housing and finances that they found helpful as parents with substance use problems. One participant described having timely support available to apply for income assistance and child tax credits. Another participant explained the helpfulness of using gift cards instead of cash in order to manage her money well. As a single parent
struggling with mental health issues and addiction, a third participant recalled the helpfulness of secure, second stage housing. She recounted the advocacy and support she received from staff members for working on goals and relationships.

**What hindered participants pertaining to housing and financial issues?** Four participants described aspects of housing and finances that they found hindering. One participant provided a hindering incident concerning the lack of second stage housing for mothers recovering from addiction and abuse. “There are second stage houses, but there’s only a few that take children. That is a big problem, and for the ones that are available, there’s huge waitlists” (Stacey). Other hindering incidents concerned running out of money every month, experiencing financial problems when employment income from maternity leave ended, and an inability to budget. The outcomes described were about the stress participants experienced as parents when they were unable to manage their financial affairs and to afford basic necessities.

**What participants wished for pertaining to housing and financial issues.** Over half (55%) of the factors in the housing and financial issues and support category were wish list items. This section has been divided into two main areas in which participants expressed their desires: (a) financial resources and assistance; and (b) safe, secure, and affordable housing.

**Financial resources and assistance.** Participants described a desire for more money to finance their children’s education, “a college fund for my child, and just more security and stability for him when he grows up” (Teresa), to be able to afford extra food and activities, and to spend on self-improvement. One participant described that having more money would help her worry less. “I wouldn’t have to worry about anything, the bills and rent, and would
not worry about where the next meal is gonna come from” (Haley). Participants provided examples such as more money for better school lunches, having snacks in the park, taking children to the gym and to dance lessons, and taking children on vacations. For participants in the study, it seemed that wishing for more money represented a desire to provide for their children the same things most parents hope to provide. Participants also wished to have assistance with managing their money. One participant wished for help filing tax returns, “because you’re juggling a lot of things and your mind is in a lot of different places when you’re getting prepared to have a baby. You can’t think properly” (Sarina). Another participant wished for help to amalgamate loans.

*Safe, secure, and affordable housing.* For three participants, the wish for housing seemed to represent security to them. “If I owned my own house then all I would have to do is pay the bills. I wouldn’t have to pay for anything else, right . . . It would help us out tremendously, and we wouldn’t have to worry so much” (Ashley). Two other examples were a participant’s wish for safe transitional housing without waitlists, and finding housing in the future that a participant’s children could call “home.” This participant expressed that creating a home would be a sign of getting their lives back on track.

Three participants described wishes that were related to the affordability of housing. Examples of wish list items were subsidized housing for single parents on disability, low-income housing for single parents in remote towns where prices are exorbitant, and low-income housing with no waitlists for single parents. The anticipated outcomes of the participants’ desires regarding housing were to rent bigger spaces, reduce cramped conditions, and free up more finances for food and practical services.
Several quotations follow that illustrate the desperation for housing support, “Where are you gonna find a place for $500 a month? And that’s for a person with a child, right? That could possibly send her back into the sex trade, you know” (Sarina), and a desire for more income assistance to be allocated to housing, “there was hardly anything left for groceries…you can’t just have a roof over your head. You need to be able to pay your bills” (Audrey). Another participant provided a wish for assistance to find housing that would satisfy a social worker’s expectation of her before she would send her to treatment. “So when I did all my applications, and I sent them all away, they said there was no way I was going to get into those places when I left here” (Natalie). Natalie explained that a realistic demand by the social worker could only be met by more alternatives for housing when parents leave residential treatment centres with their children.

**Chapter Summary**

The purpose of this chapter was to present the results from 20 interviews in which participants described what helped, what hindered, and what they wished for while early parenting and struggling with substance use problems. In the first section of this chapter the results from the contextual component of the interview were summarized. The remainder of the chapter presented the results derived from the specific Enhanced Critical Incident Technique (ECIT) component of the interview. The results were presented one by one, in order of the 14 categories that had been created. Direct quotations were woven throughout this chapter to illustrate critical incidents and wish list items. In addition, quotations were used to show respect to the participants for their contributions to the study by presenting many of them in their own voices. Each of the 14 categories that comprise the results are
considered in light of the prevailing literature in the next chapter.
Chapter V: Discussion

In the beginning of this chapter, the results from the contextual component of the study are discussed. In the next section I discuss the results and provide theoretical agreement for each of the 14 categories with references to the existing relevant scholarly literature. Next, an overall discussion of the results that integrates the categories within three topical areas is presented. Following this, considerations and broader implications for integrated program providers and treatment systems will be delineated. Next, implications for psychologists and counsellors will be outlined. The chapter will end with limitations of the study, implications for future research, and a brief conclusion.

Discussion of Contextual Results

The contextual section was at the beginning of the interviews and lasted between 10 to 20 minutes. At first, I found it surprising but also encouraging that participants were talkative about their experiences and forthcoming with personal and painful details. I expected that participants would be guarded and more suspicious of me as a researcher, especially at the start of the interviews. However, professionals who work with early parenting women struggling with substance use issues told me otherwise. They said participants would likely want to dialogue about their situations. Dr. Ron Abrahams from the combined care unit at Women’s Hospital was not surprised by the high level of engagement. He claimed that his patients want respect in order for their experiences to be heard, and after that they want to be of help to others (R. Abrahams, personal communication, October 24, 2017).

In the contextual section of the interviews, participants briefly shared retrospective reports of the past 12 to 18 months. They re-counted isolation, shame and guilt, and their
parenting struggles. They also provided descriptions of difficult issues with partners and with mental illness that led them to engage in services. Aspects of their accounts provided anecdotal correspondence with a bio-psychosocial profile that was reviewed for this study (Kaltenbach, 2013). The participants’ statements hinted at what they would share later that hindered them as parents who were struggling with substance use issues. Some findings from the contextual section represented positive experiences participants were starting to have while in treatment for addiction, together with their children. These anecdotes might have been a token of their subsequent descriptions of helping critical incidents with reference to integrated treatment for parents with addiction.

Discussion of Critical Incident Results

Facilitating the emergence and subsequent discussion of the 14 categories was the primary goal of the study based on the research question: “What factors have been helpful or hindering for service-engaged, early parenting women who have problematic substance use, and what do they wish for that might help if they had access to it?” During the second interviews participants substantiated the validity of the category titles and operational definitions. They also confirmed whether or not the contents of each category that included their unique data made sense to them. Face validity of the categories was assessed by two experts in the field of parenting and substance abuse. They also confirmed that the category titles and their operational definitions appeared to be relevant. In the following section I attempt to validate the importance of the 14 categories with an interpretation of each relative to the existing scholarly literatures.

Integrated addiction treatment for women that includes their children/ Medical and mental health issues/illnesses, trauma, and concurrent addiction treatment/
**Provincial government involvement and assistance.** A pattern was detected in these three categories. In connection with participation rates, their relative placements were either very high or high within each of the respective helping, hindering, and wish list columns. This was an indication that it is likely that the categories hit on what participants thought was important. Within each category there were substantial numbers of both helping and hindering critical incidents that also translated into what parents wished for. This suggested that the factors making up these categories might need addressing by program providers or within greater treatment systems. Participants conveyed that there was already helpful supports in place, effective drug and alcohol treatment, the formation of supportive and nonjudgmental relationships with professionals, and healthy connections with other mothers. The participants obviously found these factors helpful and wished for more. The results were not surprising given that 85% of the participants were service-engaged in residential treatment.

The participants’ emphases on the helpfulness of treatment for concurrent disorders, interpersonal connections, and necessary supports all while remaining together with their infants was clearly supported in the maternal caregiving and addiction literature. There is very strong evidence that supports these categories and has shown the necessity of a multi-tiered, relational and comprehensive approach to integrated treatment for women in this at-risk population (Espinet et al., 2016; Finkelstein, 1994; Grant & Huggins, 2013; Motz et al., 2006; Pepler et al., 2014; Suchman, DeCoste, et al., 2013).

Participants spoke of equally as many factors regarding the absence of supports, the lack of timely treatment, or the lack of healthy connections that made it harder for them as parents. I made an observation over the course of 20 interviews when participants spoke
about two things. The first was barriers to getting the help they needed when they sought it. The second was having their children removed from their care. I noticed the connection between those experiences and participants’ reports of more severe drug use. These negative experiences related to a lack of timely treatment that would permit the participants to remain with their children has important implications regarding the prevention of disorganized attachment.

As described in chapter two, frightened and frightening behaviour and other atypical parental behaviour are pathways to disorganized attachment (Lyons-Ruth, Bronfman & Parsons, 1999; Main & Hesse, 1990). When parents are perceived as unresponsive and frightening children may grow up to believe they are unworthy of care and love (Weinfield et al., 2008). These potential outcomes are what makes intensive and early intervention so crucial. Brief, behavioural attachment-based interventions, including those that use video feedback, that focus on the dyad, on a mother’s sensitivity, and help her become a secure base for her infant are most effective (Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2005; Moss et al., 2011). The interventions would include discussions that educate mothers about attachment theory so that they learn to help their children feel safe. And these interventions are meant to happen in the very early stages of parenthood, and are suitable for women in treatment for addiction. Unfortunately, some participants lacked both timely referrals to treatment with their children, and did not receive the type of attachment-based interventions described above. In addition, some participants seemed to carry an additional burden that currently does not have much support in the literature. Given the current fentanyl crisis some participants feared for their lives if they continued in a toxic cycle that included drug abuse.
I was moved by participants’ stories of the desire to be effective parents and by the amount of positive energy they were putting into their recovery journeys. Therefore, I was not surprised when I contacted 11 of them six to eight months after the first interviews and all of them were still working hard to recover and to get or maintain custody of their children. From the literature I learned that the participants are in a class of people that are judged as lowly citizens and are societal outcasts in a way. Yet listening to their stories I found I could closely relate to them as a parent who would never want to be without her children. I experienced the participants as more alike than different from me in that regard. I hope that through the dissemination of the results of this study the intended audience will get a unique sense of my experience of equality with the participants.

Participants spoke of child removals and foster care arrangements as helpful only when they realized they were not fit to parent and their children required safety. Otherwise, participants were hindered by being in treatment centres without their children. This makes sense in light of attachment theory. Keeping mothers in treatment centres together with their infants will give children a much better chance of developing a secure working model of attachment. As Bowlby (1969, 1972) indicated long ago, proximity seeking to one’s primary caregiver is biological. Most importantly, these unconscious representations of relationships are carried forward throughout life (Fraley, 2002). And, they are based on infants’ earliest interactions with their caregivers, even before one year of age (Ainsworth & Wittig, 1969). How crucial it is then to support women to be in treatment for addiction and include their children in their care at the same time.

The integrated treatment literature also supports the participants’ concerns. Research has clearly shown that mothers with addiction issues who are the primary caregivers of their
children often hesitate or fail to engage in services for substance abuse because they will not leave their children (Finkelstein, 1994; Kaltenbach, 2013; Pepler et al., 2014). The desire for addiction treatment while they remained together with their children is also supported by foster care research that has shown that keeping children together with their primary caregivers is preferable given a tolerable risk level (Kalland & Sinkkonen, 2013). In keeping with the same literature participants found that foster care was either helpful or hindering depending on the quality of the placements.

A particular issue for participants that made it harder for them as parents was struggling with substance use issues, mental illnesses, and the effects of trauma. There is plenty of support for this finding in the literature and the topic of trauma is also discussed independently later in this chapter. Importantly here, disorganized attachment in children or Type D is the most common attachment classification related to the interactions of parents and children suffering from trauma. This includes parents’ complex trauma from their own child abuse, and interpersonal violence (Alexander, 2015; Main & Solomon, 1986, 1990). Without intensive supports the participants’ children would be at risk of developing disorganized attachment.

The related categories about integrated treatment that keeps children together with their primary caregivers and about medical/mental health and illness, and concurrent addiction treatment speak to a serious need. Children impacted by Type D are most significantly related to the further risk of the intergenerational transmission of trauma. This makes the prevention of Type D via the urgent and concurrent treatment of their parents for addictions and trauma such a critical issue.
Also of note in these categories was participants’ identification of hindering incidents with regard to relationships. A large percentage of the hindering incidents identified negative and inauthentic relationships with medical and mental health professionals, social workers and especially child protection workers. Participants spoke of defensive and resentful reactions toward child protection workers who in their opinions forced removals unfairly and imposed overly restrictive conditions. It was almost as if participants who had already been traumatized in life were signaling that they were being re-traumatized on account of unhelpful relationships within the system.

The participants’ emphasis on personal and professional relationships certainly lined up with the maternal caregiving and addiction literature (Espinet et al., 2016; Pajulo & Kalland, 2013; Pepler et al., 2014; Suchman, DeCoste, et al., 2013). There is potential for women in this population to have contentious relationships with government professionals. Some integrated program providers are addressing this issue. For example, the expansive relational goals of the Breaking the Cycle (BTC) program in Toronto include respectful and productive connections between the program providers and other professionals in the treatment system. Researcher Dr. Mary Motz said that when BTC clients observe staff modeling healthy relationships with child protection service personnel, they become more willing to give up their fights with the system and focus on more positive hopeful directions (M. Motz, personal communication, October 26, 2017). It seems that an intentional, intensive focus on healthy relationships is definitely one important way to provide hope for parents in this population.

Barriers to treatment was a hindering theme that was noticed in these categories that also turned into wish list items. Like trauma, barriers that include stigma are discussed
separately later in this chapter within the broader topic of social issues. One important aspect that seemed to be missing in integrated treatment programs was more interventions like the ones described above that are designed specifically for parent-child dyads. The participants’ wishes correspond with the literature on the early parent-infant relationships of women with addiction issues (Dubois-Comtois et al., 2017; Suchman et al., 2017). This research has shown the importance of keeping mothers and their children together and intervening with the dyad as early as possible.

**Mothers’ relationships with their children, and parenting support.** The high participation rate ranked this category third under the helping column. Half of the participants provided touching descriptions of the ways that their children helped them by providing them with a reason to change. One of them called her infant her “miracle baby.” The participants’ descriptions were related to the concept of a “window-of-opportunity” for change which has been observed elsewhere (Espinet et al., 2016). Participants echoed ambivalence regarding change when they described hindering incidents such as unplanned pregnancies, attachment issues, and problems bonding with their children. This resonated with literature on parenting and substance abuse (Pajulo & Kalland, 2013).

Participants found compassionate, caring support for parenting helpful. What made it harder for them was not having parenting classes that were specialized for dealing with caregiving and addiction issues together, and their wish lists called for more. The models for what the participants wanted come from the burgeoning literature on interventions for this population. Those studies suggested that the early parent-infant relationship context is very important for developmental outcomes (Dubois-Comtois et al. 2017; Suchman et al., 2017). The participants in this study were struggling with substance use issues in the early stages of
parenting their infants. They would likely benefit substantially from the type of parenting interventions reviewed earlier.

Some participants had little experience with full-time parenting when they arrived at residential treatment centres together with their children. Some admitted feeling grateful to be there but also overwhelmed from suddenly being thrust into that challenging role. This was observed in studies that recommended that relationship-based parenting support for women with addictions is provided with sensitivity to the demands it places on mothers (Dubois-Comtois et al., 2017). Other research has contended that early parenting is inherently stressful and that stress contributes to craving, drug-seeking and the potential for relapse (Rutherford et al., 2013). Participants demonstrated this risk when they talked about times in treatment centres when caregiving was difficult and they experienced subsequent “relapse thoughts.” The results from this category confirm that in order to reduce stress parents in this population need more support both before and after relationship-based interventions are introduced.

Understanding addiction as a disease/ Spirituality. The creation of these categories was unusual but can probably be explained because of the nature of the sample. The participants were coming from residential treatment programs and were influenced by the tenets of those programs. Since these unexpected categories go beyond the scope of what was reviewed for this study some of the citations below are new. Furthermore, spiritual factors could have been incorporated within the Addiction as a Disease category due to the emphasis on religion in the 12-step process. However, spiritual resources seemed to stand out on their own. So although the two categories are closely related some aspects of each are discussed separately below to better convey the deeper meanings of the participants.
Addiction as a chronic, relapsing brain disease is currently the front runner of addiction models (Lewis, 2015). The founders of Alcoholics Anonymous (AA) described two important features of addiction from their perspective: (1) addiction was characterized as a sickness and people have physical sensitivities to alcohol or drugs, similar to allergies; and (2) addiction was also seen as a spiritual malady of people who were struggling with life (Alcoholics Anonymous, 1939). Over 50 years later in the 1990’s decade of the brain, scientists started explaining the neurobiology of addiction. Drugs changed the brain systems that anticipate rewards. During the decade of the brain Leshner (1997) coined the phrase that drugs hijack the brain. The biological features from AA and the scientific advances in neurobiology are clearly two distinct developments pertaining to a medical model of addiction. However, the AA lifestyle intervention remains central in residential treatment facilities.

The participants in this study seemed ready to embrace abstinence and AA meetings for social, emotional, and practical reasons. Lewis (2015) stated that one of the major benefits of calling addiction a disease is that it facilitates treatment and mitigates stigma, intense shame, and guilt. The disease model is definitely better than denigrating people with addictions for their lack of will power and moral decrepitude. These benefits were underscored by participants when they spoke of being able to forgive themselves from understanding that the disease was not their fault and when they spoke of not being able to fight addiction on their own. They could do something about it. In this study 90% of participants had a family history of addictions. Hence, learning about their genetic predispositions to drug abuse seemed to help participants lessen the weight of full responsibility.
Participants found the 12 steps helpful even if they had no choice about participating in the process. They confirmed that the premise of powerlessness was helpful. For some participants their love for their children was not enough to stop abusing substances. Another AA tenet involved the need to avoid environmental triggers and access to substances in order to remain abstinent. Participants demonstrated this notion when they talked about triggers they would face if they returned to old neighbourhoods, workplaces, and former partners after treatment.

The AA prescribed way of life encouraged reliance on a Higher Power but emphasized religion more than that and was sometimes criticized as religious exhortation (Loder, 2009). It seemed important to create two separate categories for two reasons. First, as Maté (2008) suggested, the Higher Power concept within the 12-step process does not necessarily require a belief in God or another deity. It can be one’s sense of a Higher Power with or without religious meaning. In addition, “turning one’s life over to the care of God as we understood him” (Alcoholics Anonymous, 1939) can be replaced with trusting in universal truths and higher values. The way that participants identified spirituality did not resemble either of these descriptions. Second, what stood out to me was that participants talked about actual relationships with a Higher Power in addition to the helpfulness of spiritual practices and gatherings.

Religious thinking about dependence on a personal God corresponds with attachment theory and with research on the relationship between religion and mental health (Granqvist, 2014; Granqvist and Kirkpatrick 2016). Researchers contended that humans have perceived connections with unseen figures such as God that meet the defining criteria of attachment relationships. For example, one defining feature of an attachment relationship is God as a
secure base for exploration. Granqvist and Kirkpatrick stated, “It is easy to imagine how an attachment figure who is simultaneously omnipresent, omniscient, and omnipotent can provide the most secure of secure bases” (p. 921). Participants indicated this when they talked about being guided down a path by God and about staying out of the drug life through a relationship with God. Contextual factors such as stress, low social assistance, and the absence of attachment figures represent times of trouble that actually strengthen the link between religion and mental well-being. Participants identified extremely difficult experiences, the threat of child removals, isolation and constant distress. The participants’ situations support the notion that aspects of religion would likely be more beneficial to them than to others who were not in such adverse circumstances.

Support from family and friends/ Child care. These two categories had plenty of support in the literature but slight differences were observed. Only 35% of the participants were 30 years of age or younger (average age 32 years), only 45% were primiparous (just less than half had borne their first child), and 80% were single parents. The results of both of these categories are limited to the people who participated in the study. However, the two categories are connected in the sense that the results may have been substantially different if the sample was younger in age and from a more diverse source of service-engagement. If that was the case the results of both categories might have been more pronounced as the literature on adolescent and young adult mothers suggests (Madgidson, 2013).

Participants contributed twice as many helping critical incidents about how family members helped them compared to friends. At first this finding appeared unusual. However, it could be expected given that almost all of the participants were in treatment, that many of them were experiencing renewed, supportive relationships with extended family members.
The participants illuminated the relationship-building skills they were developing while in treatment and demonstrated the need for connection and comfort. These findings were consistent with intervention literature in which an important target is helping parents increase their capacities for interpersonal relationships (Espinet et al., 2016; Pajulo et al., 2006).

This category left an impression that corresponds with an attachment and family systems viewpoint (Cowan, 1997; Cowan et al., 2017). Women in this population themselves as children likely had limited or poor experiences of sensitive caregiving. In therapy they might reflect back on their own relationships with their parents and family patterns that did not serve them well. This could help them make conscious efforts to shift their own parenting behaviour. Participants in the study demonstrated this concept when they spoke of alcoholic family patterns and growing up in negative environments. Their past experiences of being parented made it harder for them as parents in the present.

In most cases the participants were not ambivalent about the need to change harmful relationships. They demonstrated this when they spoke of the need to cut off relationships with family members that could not be trusted around their children. It is not known how different the results of this category might have been if participants were younger in age or if the sample was from a more diverse source of service engagement. Ambivalence about ending negative relationships might have been more prominent as the literature indicates (Madgidson, 2013).

Participants spoke of a basic and important need for child care. Their wish list items called for more help with child care during treatment and more affordable child care after treatment from safe and qualified sources. Participants’ identification of child care issues is bolstered by the literature on integrated drug treatment for women (Finkelstein, 1994;
Milligan et al., 2010; Reed, 1987) and by intervention research (Suchman et al., 2017; Suchman, DeCoste, et al., 2013). Daycare centres were crucial in order for participants to be in residential treatment together with their children and avoid foster care placements. What participants said about the need for child care was also supported by research on adolescent and young adult parents (Madgidson et al., 2013; Sadler & Cantrone, 1983). The participants demonstrated the dual-development hypothesis. First, some talked about the desire to develop their identities by re-joining society. Participants expressed visions for their futures and goals regarding education and career. Second, their wish list items conveyed the need for child care in order to pursue those goals as parents. The child care category was already the sixth highest under the wish list column. It is probable that child care needs would have been even more evident if the sample was in the 18-25 years of age group.

**Experiences of pregnancy and parenthood having used and/or while using substances/ Relationships and support from partners and/or children’s fathers/ Relationships with oneself and personal characteristics.** The pattern that was noticed in these three categories was that they were dominated by hindering incidents. Relatively speaking, they were extremely high or quite high relating to the negative experiences that participants spoke about (1st, 2nd, and 6th place of 14 categories in the hindering column respectively) and low with regard to what they wished for (10th, 9th, and 14th place of 14 categories in the wish list column respectively). This is an indication that factors the participants identified as unhelpful for them as parents would need to be addressed in treatment for addiction and in mental health counselling. I was warned by one program provider to expect that participants would portray negative relationships with partners. Nonetheless, I was surprised and alarmed by the extent of the problems that participants
described in that category and in the other two. There is strong evidence in the literature for each of the categories which are discussed below.

The results of the Experiences of Pregnancy and Parenthood category represent participants’ experiences of distress associated with addiction issues in pregnancy and parenting, especially caregiving in the first months postpartum. The participants’ identification of distress is supported by the findings from two areas: (1) addiction science and attachment (Rutherford et al., 2013); and (2) from the research on developmentally informed interventions that target distress (Dubois-Comtois et al., 2017; Suchman et al., 2010, 2011, 2017). The participants’ hindering incidents demonstrated the cycle of caregiving related triggers, craving and relapse that has been observed elsewhere in the literature (Velez & Jansson, 2008). They talked about delays in getting treatment, inability to find support, bonding and attachment problems, fear, guilt, and high levels of stress. Many participants also spoke about the connection between those negative experiences and drug use. One participant used the words “falling into a toxic cycle with addiction.” The participants pinpointed that experiencing stigma and judgment was hindering for them as parents with substance use issues which is discussed as one of several social issues later in this chapter.

In the Relationships and Support from Partners category a small number of participants demonstrated healthy partnerships. They discussed things such as partners’ love, care, comfort, nonjudgmental acceptance of their substance use issues, and commitment. Their descriptions resembled pair bond attachment from the adult attachment literature (Zeifman & Hazen, 2016). However, those relationships were clearly exceptions. The results in this category regarding romantic relationships mostly illustrated the opposite of healthy
adult attachment. Only 20% of the participants lived with partners full-time or part-time and also described those relationships as supportive and intimate. Of the 80% of the participants that were single mothers, only two of them described having supportive and intimate relationships with partners not living in the same household.

The participants’ identification of mostly troubled relationships with partners is consistent with the literature on parenting and substance abuse (Madgidson, 2013) and the literature specific to paternal substance abuse and parenting (McMahon, 2009; 2013a; 2013b). The participants made associations with the literature when they spoke about lack of support, emotional abuse, violence in relationships, and their partners’ addiction issues. Some participants perceived an inability to leave destructive relationships. Other participants talked about what they felt were the negative consequences of early life adversity on future problematic partnerships. These results are supported with evidence from attachment literature that showed that early attachment security predicts adult attachment and partnership representations (Grossman, Grossman, & Kindler, 2005; Sroufe et al., 2005; Steele and Steele, 2005). Adult attachment assessments were not used in the study but this topic might warrant additional investigation. If the study was repeated with another sample it could include assessments of adult attachment and representations of self in romantic relationships. The results could provide more important information for a category such as Relationships and Support from Partners.

In the Relationship with Oneself category some participants reported having increased self-esteem, self-efficacy, and self-worth. This is likely not a novel finding because of the makeup of the sample. It is reasonable to expect that as inpatient clients receiving counselling and adequate support the participants would start to feel more optimistic and
develop more supportive views of themselves. Their relationships with themselves were improving as they moved out of isolation and into relationships while in treatment.

Dr. Mary Motz is one of the evaluation researchers at Breaking the Cycle (BTC) in Toronto and has observed the same thing in outpatient clients of that program (personal communication, October 26, 2017). Motz said that self-esteem and self-efficacy are two constructs that arise frequently at BTC. They see women’s beliefs in their capacities to make change, as well as beliefs that they are worthy of positive outcomes in their lives such as having healthy children and having good relationships.

Half of the Relationship with Oneself category was comprised of hindering incidents about participants’ low self-esteem and low self-worth related to parenting and addiction. Self-loathing and low self-esteem were at least partly the internalized effects of participants’ maltreatment in childhood and interpersonal violence in adulthood. It is clear as it pertained to this category that the participants’ self-worth was influenced by relationships for both the good and the bad.

**Short-term and long-term practical needs and support/Housing and financial issues, and support.** An aspect of these two categories was intriguing. I considered their relative placements within each of the helping, hindering, and wish list columns based firstly on participation rates and secondly on the number of critical incidents. Generally speaking, participants did not cite issues in either category as being helpful to them as parents or hindering. Yet, these categories placed 1st and 2nd respectively out of 14 under the wish list column and contained approximately 40% of 108 wish list items combined. This suggests that more research might be needed on these categories about factors that help or hinder women who are early parenting with substance use issues. Besides the fact that both
categories were wish-list dominant they seem to be connected in several other ways. The results in both categories appeared to be affected by the nature of the sample in which 85% of the participants were completing residential treatment. In addition, the wish-list items in both categories were predominantly future-oriented and seemed to signify participants’ desires for self-efficacy and empowerment.

Participants indicated that personal and family activities, transportation options, employment opportunities, and community supports were helpful for them as parents. Supports are imperative considering the links discovered in research between lack of support, lack of engagement in services, stress, and chronic addictive behaviour for parents from at-risk families (Dubois-Comtois et al., 2017; Madgidson et al., 2013; Rutherford et al., 2013; Suchman et al., 2017). Participants resembled mothers who were likely socially underdeveloped since childhood. This was similar to what was reported as part of the biopsychosocial profile of women in this population (Kaltenbach, 2013). In total, 80% of the participants only completed some high school or high school.

The participants were not asked directly about employment. However, only two of 20 participants discussed having a job or having their expenses at residential treatment or transitional housing covered by employment benefits. It became clear that the participants would need substantial support in the areas of obtaining further education and exploring careers. The participants demonstrated the potential risk for relapse in the future when they provided hindering incidents such as the lack of transportation that made them feel less self-reliant. In addition, they said lack of employment led to boredom and lack of engagement in their communities left them isolated.
The participants indicated their struggles as parents experiencing poverty and a lack of housing. A total of 16 (80%) of participants reported annual incomes of $0 - $20,000. Most were on income assistance and most had no firm mailing addresses. It is not surprising that the participants would wish for affordable and available housing and for help with their financial problems. Their attention was on the recovery process, but they were also clearly thinking about their next steps as demonstrated by the wish lists. Housing would potentially meet emotional needs by providing security and by the ability to create “homes” for their families. Safe and affordable housing was also needed to meet child protection standards.

In the form of their wish lists the participants demonstrated a desire as parents to break the cycle of alcohol and drug abuse and dysfunctional parenting. They called for a lot of support in order to have that chance. The practical short-term and long-term supports that participants wished for also represented a desire for healthy connections. They seemed to be mentally preparing for life after treatment. One participant said relational support would help “bring us back into society by doing fun things, sober things.” The types of supports wished for signified the agency and empowerment that participants seemed to be seeking. I perceived they would likely need long-term and substantial support in order to be the effective parents they desired to be. When I asked him, Dr. Abrahams said this of his patients in the combined-care unit of the hospital, “They are on a lifelong journey that will require support. They will need support for the rest of their lives” (personal communication, October 24, 2017). The participants in this study also symbolized parents that would likely need a lifetime of support. Through the provision of extensive supports such as what was indicated by the participants, their environments could be changed significantly. Kaltenbach (2013) stressed the importance of discovering the mediators that strengthen the interrelationships
between the multiple risk factors for substance abuse and dysfunctional parenting. Perhaps the lack of sufficient social supports is one of them. It is possible then that the provision of abundant resources could be one mechanism of change for women who are early parenting with substance use problems.

**Upbringing, life circumstances, and critical stressors.** Participants disclosed almost nothing that was helpful about their upbringings, current life circumstances, or critical stressors as parents with substance use issues. Hindering incidents and wish list items comprised over 80% of this category. I expected those results considering the participants’ backgrounds. Most of the participants seemed to fit the bio-psychosocial profile of women in this population (Kaltenbach, 2013). First, 90% of the participants claimed to have both a family history of addiction and a personal or family history of trauma. Second, although they did not use the exact words, participants demonstrated that they fit the composite profile when they indicated hindering incidents about the risk factors such as early childhood adversity and parents who also abused substances. While interpreting the data from the study I realized through the participants’ stories that the pattern I was noticing amongst them reminded me of the intergenerational transmission of attachment. The results of this Upbringing category generated part of that impression I was getting as a researcher.

One might wonder why this category did not rank even higher in the hindering and wish list columns if almost all of the participants’ upbringings included trauma and familial addiction. One reason could be that the interview protocol called for participants to reflect on their experiences of parenthood and addiction issues over the past 12 to 18 months. A portion of the participants may have reflected on how negative experiences from the past affected them as parents in the present. A larger proportion of participants were likely focusing on
what was making it harder for them as parents in the present. The fact that trauma from the participants’ upbringings did not stand out more prominently in the results of this category and the study overall surprised me at first. I discuss trauma separately later in this chapter.

**Overall Discussion of Results**

Having discussed the categories in light of the literature to this point the results seem to raise several issues. The categories were pooled into three groups based on their overall thematic content. They are discussed below under the broader topical areas of trauma, social issues, and systemic concerns.

**Trauma.** Traumatic experiences and the effects of trauma clearly come out in the following four categories: Upbringing, Life Circumstances, and Critical Stressors; Relationships and Support from Partners and/or Children’s Fathers; Relationships with Oneself and Personal Characteristics; and Mothers’ Relationships with Their Children, and Parenting Support. The critical incidents and wish list items and these categories they were placed in were especially imbued with participants’ accounts of trauma. Experts proposed models of addiction in which early life trauma is central (Lewis, 2015; Mate, 2008). The neuroscientist Lewis (2015) eschewed models of addiction as being less helpful when they do not consider addictive behaviour as a deeply learned habit in response to developmental trauma and adversity. Lewis called addiction a complex condition, a “house with many doors” (Loc. 2546). He believed the self-medication model of addiction goes together well with a learning model because people use addictive behaviour to soothe the pain created by trauma. Furthermore, Maté (2008) pointed to the clear link between early traumatic adversity, neural development and addiction. These viewpoints generally, and Dr. Abraham’s
comments specifically, made me question why I did not interpret a Trauma category from the data.

Psychologists and physicians might say that trauma is at the root of the participants’ issues. However, upon considering his experiences with hundreds of hardcore drug users in the Downtown Eastside of Vancouver Maté stated that his patients lack the awareness of trauma in their lives and therefore do not know how to talk about it (Lavitt, 2016):

They didn’t know they were traumatized. No doctor had ever pointed it out to them. They thought they were just fuck-ups. . . . They didn’t realize that they were using the addiction to soothe a deep pain that was rooted in trauma (January 6, 2016).

Some of the findings in these categories provide support for Maté’s insights about the relationship between early traumatic experiences and addiction. Similar to what Maté explained about his patients, the participants in the study did not seem to understand trauma in such a way as to describe it using those exact words. In this sense, the fact that a Trauma category did not emerge from the data is not necessarily surprising. Perhaps the participants did not consciously understand they were traumatized as much as the fact that trauma was simply their realities. Alternatively, if they did understand the impact of trauma in their lives the participants did not acknowledge it in the same way professionals do. The participants likely needed more psychoeducation regarding trauma and the connection to addictive behaviour in order to have articulated it differently. According to Maté many health professionals lack that education as well.

I did not have addictions expertise as the primary researcher when this study was conducted. The participants’ accounts made me curious about their motives, as parents, for using substances as coping mechanisms. The demographics indicated that 75% of the
participants had been poly-drug users. Of the poly-drug users, 87% used a combination of depressants (alcohol or opioids) and stimulants (cocaine or methamphetamine). Although further information was not directly solicited, I noted throughout 20 interviews the numerous reasons that participants gave for substance use that are broadly grouped together in alphabetical order: anxiety; boredom; comfort; effects of trauma; emotional pain; fatigue; loneliness; relational problems; and stress. As Lewis (2015) suggested, it is likely that the participants were using a combination of illicit drugs partly to distract or medicate themselves from pain.

The findings in these categories regarding trauma are consistent with research on the connection between trauma and illicit drug abuse. Exposing parents struggling with addiction to alternatives to the disease model of addiction might help them better conceptualize the connection between trauma and substance abuse. The participants might have embraced features from a variety of models that could have helped them make those connections in more self-compassionate and hopeful ways.

Although this study did not critically investigate the role of race in early parenting experiences, it is imperative to highlight that there are historical differences between Indigenous women and non-Indigenous women when considering the effects of trauma on their substance use behaviour and parenting capacities (A. Goodwill, personal communication, July 13, 2018). Trauma experienced for the Indigenous women in the study can be sourced inter-generationally. Whereas, in other countries citizens could experience trauma such as war but afterwards have long periods of reprieve. However, for Indigenous people in Canada trauma has been continuous. The manifestations from the theft of their lands, children during the residential school era, and child welfare policies shows up as
overrepresentation in the court and prison systems, in child welfare, and in their coping with substances (Royal Commission on Aboriginal Peoples, 1996).

Intergenerational trauma was generated by racist policies that operated from the premises of separating mothers and children (Blackstock, Trocme, and Bennett, 2004). This is what is different for Indigenous women compared to non-Indigenous women. According to Goodwill, Indigenous mothers have to recover from the effects of attachment traumas that were intentionally inflicted on their families before the mothers were even born. This “invisible” trauma has very real implications on early parenting practices for Indigenous women who struggle with self-medication and addiction as well as with the right to parent. This insight also has implications for future research which is suggested later in this chapter.

**Social issues.** There are some social issues that emerged from the following categories: Experiences of Pregnancy and Parenthood; Short-term and Long-term Practical Supports; Understanding Addiction as a Disease; Housing and Financial Issues; and Support from Family and Friends. Participants identified barriers such as stigma and a lack of nonjudgmental support. It is clear in the addiction literature that stigma and judgment play a powerful role in preventing women to seek treatment sooner and in blocking their caregiving ambitions (Finkelstein, 1994; Howard, 2015). Being shamed by society in general and being blamed by former partners, parents, and professionals led some participants to perceive themselves as bad mothers and question their own parenting capacities. Researchers contended that struggling parents in this population should be met without judgment in order to engage them, and counselled without judgment thereafter (Collins et al, 2012; Grant & Huggins, 2013; Nathoo et al. 2015; Pepler et al., 2014).
Dr. Abrahams, one expert referenced in this study, stated that addiction is the result of social fall-out. Current society and culture create trauma and anxiety, which leads to addictive behaviour, and results in parents with very high needs. Advocates of the social determinants of health perspective contend that social change in society improves health status most, including recovery from addiction. Participants were offered the disease model of addiction and many found it helpful. However, while the disease model may be the front-runner of addiction models it does not address the depth and breadth of social issues the participants faced. In addition, along their recovery journeys participants started benefitting from improvements in their relationships with family and friends. Similar to Hari (2015), I observed that participants’ experiences were signs that human connections, not only sobriety, are contrary to addiction. Furthermore, those types of connections are needed at all levels of society.

Finally, in relation to social supports, it was interesting to note that 87% of 108 wish list items were future-oriented. The concepts of empowerment and self-efficacy might explain the participants’ future emphases with reference to their fervent desires for social supports such as housing, income, and education. Once the participants were engaged in services that supported their roles as parents they were gaining a hopeful vision for the future and asking for what they needed. Espinet et al. (2016) found that Breaking the Cycle (BTC) clients had a higher capacity for relationships and greater perceived support. In fact, the perception of support was at times as good as the provision of real resources. I agree with the BTC developers who recommended that providers of support should focus more on women’s agency as parents and less on their victimization.
**Systemic concerns.** There was an obvious need for more systemic supports that surfaced in the following categories: Provincial Government Involvement and Assistance; Medical and Mental Health Issues/Illnesses, Trauma, and Concurrent Addiction Treatment; Integrated Addiction Treatment for Women that Includes Their Children; and Child Care. The duty of child protection services is to protect infants from harm which often results in apprehensions and foster-care placements. It sometimes appears in our society that this responsibility to the children is not balanced with the obligation we bear to their parents. What is desperately needed is to support at-risk women such as the participants in this study with treatment and with the extensive resources they require to become what Winnicott (1957) called “good enough” parents for their children. A total of 75% of 108 wish list items formed six categories at the top of the wish list column and all were related to the wider system. It was as if the participants were screaming for systemic supports.

A fair number of participants conveyed that they recognized their pregnancies as windows of opportunity for change. However, a pattern that I observed amongst the participants was that they were seeking help much sooner than they were able to be engaged in services. For a number of them there was a lack of information and timely support and referrals for treatment. Some could not find help because they lacked the basic information to locate it. A number of them needed help urgently and said it was alarming to be put on waitlists and be told to keep using heroin or their fetus’ lives would be endangered. Most of the participants had been traumatized in life. They should not be re-traumatized within the system. Timing and social scaffolding are critical for treating women in this population. That requires less barriers, faster entry into integrated and concurrent services, and adequate social supports.
There are some government and not-for-profit programs that operate from a different perspective. The first two described below were not originally reviewed for this study but are worth mentioning. Reach out Recovery (ROR) (https://reachoutrecovery.com) partners with The Recovery Research Institute at Harvard University (https://www.recoveryanswers.org) that translates the latest addiction research for public consumption. The ROR non-profit organization is a non-biased online portal for consumers that targets their treatment readiness and gets them the help they need exactly when they are ready for change. It also links them to a Recovery Guidance website of a for-profit organization that advertises treatment providers in consumers’ geographical areas. The objective of the ROR model, which could be adopted by cities, is to lift the stigma of addiction and normalize the journey of recovery.

Health authorities could implement the type of systems “makeover” of what was formerly called South Shore Health in Nova Scotia. They provided a model of integrated, client-centred, concomitant care for mental health and addiction. The model was written about in Leader’s (2016) book, *It’s Not About Us: The Secret to Transforming the Mental Health and Addiction System in Canada*. Leader is a social worker who outlined how mental health and addiction services partnered and collaborated with other major service providers. Together, they completely overhauled the way the system-centred model was previously working. On the one hand consumers in Nova Scotia were saying, “It’s not about us!” This meant consumers had too many barriers, not enough supports for mental health and addiction treatment that they could get fast enough, and in a coordinated fashion. On the other hand, while the re-vamped model was being implemented, service providers were often reminded, “It’s not about us!” This was meant to prompt treatment system professionals to be client-centred instead of system-centred.
It could also be beneficial for the broader treatment system in British Columbia to learn more about the pioneering work that has been done to create relationship-based interventions for at-risk parents in this population such as: (a) the outreach program Breaking the Cycle in Toronto (Espinet et al., 2016); and (b) the residential treatment intervention Holding Tight for parents with addiction in Finland (Pajulo et al., 2006; Pajulo et al., 2012).

**Considerations for Integrated Program and Treatment Providers**

What follows are 10 reflections and tentative suggestions based on the findings from the study. The implications are geared toward residential treatment and transitional housing program providers due to the nature of the sample:

1. The results implied a need for more psychoeducation for clients and staff regarding the bio-psychosocial basis of addiction. Clients and staff might benefit from more instruction about the developmental pathway from traumatic experiences to their impacts on anxiety and subsequent addictive behaviour.

2. The participants’ stories indicated the need for more comprehensive treatment for PTSD and other comorbid mental illnesses concomitantly with treatment for addiction.

3. Parent participants in one-year programs confirmed the value of longer-term residential treatment. Treatment providers could investigate and consider the optimal length of time for residential drug and alcohol treatment that would be most beneficial.

4. Many participants experienced barriers to receiving well-timed support. Program providers could develop unique ways to further educate and
collaborate with Ministry of Children and Family Development (MCFD) professionals. Strengthening an alliance with the MCFD could boost the urgency for child protection workers and other social workers to make timelier and earlier referrals.

5. Stress around a lack of social support was a risk factor for relapse for participants in the study. Parent-clients would likely benefit from more assistance and time within programming to help secure financial assistance, affordable housing, and job opportunities.

6. Participants indicated a need for more interventions that include their children. Program providers might incorporate interventions that target specific issues such as sensitive caregiving interactions, parenting stress and its association with craving and drug-seeking, and joint-activities that promote fun for parent-child dyads.

7. Programs of various types could improve by strengthening organization-wide, relationship-focused approaches to service provision. This includes the prioritization of intentional, healthy interpersonal connections at all levels: between children and their mothers; mothers and the counsellors/staff; and counsellors/staff and other government and agency professionals.

8. As some participants identified, there is potential for some biological or social fathers or partners to be effective co-parents. Program providers could develop creative and flexible strategies that include partners deemed to be appropriate. Including partners in aspects of programming might benefit clients’ family systems.
9. Some findings in the study stressed the importance of physical and nutritional needs of clients. Service provision could include nutritional counselling and other aspects of enhanced programming based on clients’ previous experiences, stages of recovery, and levels of abilities.

10. Some participants indicated their struggles as full-time parents for the first time while in treatment. Finding creative ways to augment child care services while in treatment centres and other programs, especially on weekends, might allow clients to benefit from additional breaks.

**Implications for Psychologists and Counsellors**

Gathering data from the participants on what helps and hinders them as parents provides insights for professional psychologists and counsellors that want to work with people in this vulnerable population. For example, the study offers insights from women’s perceptions of, and actual experiences with, stigmatization and judgment. That information can lead to effective approaches that counsellors could use to connect with this relatively suspicious, non-trusting population. The two sub-sections below offer implications for psychology professionals that work in outpatient or inpatient settings.

**Outpatient services of psychologists and counsellors.** The results of the study reinforced that parents in this population will need services for addiction issues concurrent with treatment of mental illness and trauma. Psychologists and counsellors that are interested in working with clients who are early parenting should be educated about the complexities and unique difficulties related to caregiving while struggling with addiction issues. In addition, professionals should be aware of the crucial issue of timing with regard to the need for intensive supports for women as early in their parenting careers as possible. Therefore,
professionals should be prepared to refer clients to and collaborate with other program providers that are set up to address their complex issues.

Counsellors should use evidence-based long-term and short-term therapies that have been designed specifically for women in this population to manage distress in the parent-child dyad. These therapies do not address parenting behaviour directly but aim to treat maternal reflective functioning first. For example, a mentalization-based individual therapy such as Mothering from the Inside-Out would be advised for use in an outpatient format. This intervention and other evidence-based therapies mentioned in this paper can be learned by Masters and Ph. D. level therapists but require a certain level of knowledge and skill, special training, opportunities for practice, and supervision (Suchman et al., 2012). Furthermore, it is recommended to use assessments such as the Atypical Maternal Behaviour Instrument for Assessment and Classification (AMBIANCE) instrument (Bronfman, Madigan & Lyons-Ruth, 2009-2014; Bronfman, Parsons & Lyons-Ruth, 1992-2008). To use the AMBIANCE in clinical and research settings to measure atypical maternal behavior also requires special training and supervision. Therefore, working to help women from this vulnerable at-risk population would require considerable specialization.

Indigenous parents comprised 45% of the sample. Their overrepresentation in the study has implications for the practice of psychologists who aim to provide parental capacity assessments (PCAs) that inform child welfare cases. The apprehension of Indigenous children to be placed in government care by child protection services is on the rise. Journalists have been covering the situation which has become a Canadian concern (Hunter, 2018). Currently there are no standardized guidelines in social work practice for determining what “good enough” parenting is (Choate & Engstrom, 2014) let alone what that means for
Indigenous parents (Lindstrom & Choate, 2017; Morgan, 2018). The settler culture defines “good enough.” The proportion of the study sample based on ethnic heritage was unanticipated. Since the child welfare literature was not reviewed for this study the articles cited here are new.

The Canadian Psychological Association (CPA) responded to the Truth and Reconciliation Commission of Canada Report (Canadian Psychological Association, 2018). In their reply, the CPA task force stated that the situation involving a lack of culturally appropriate assessment processes was dire. The task force called for psychologists to engage in PCAs of Indigenous women that are no longer biased toward child apprehension. On that note, PCAs could be undertaken in part with the use of a brief version of the Atypical Maternal Behaviour Instrument for Assessment and Classification (AMBIANCE) tool that was described earlier in the literature review (Haltigan et al., 2017). This tool has encouraging implications for the treatment planning and progress assessments for Indigenous women precariously parenting their children or trying to regain access to them.

**Inpatient services of addiction counsellors at residential treatment centres.** The results indicated that parenting clients who receive counselling at residential facilities could benefit if addiction counsellors consider and/or implement the following suggestions:

1. An integrative theoretical orientation informed by attachment theory and family systems theory could enhance counsellors’ perspectives.

2. To potentially help clients engage in counselling faster, counsellors could be alerted to stigma and use stigma reduction strategies. Helpful information about stigmatizing language can be found in the Addictionary at Harvard’s
Recovery Research Institute, retrieved from
https://www.recoveryanswers.org/addiction-ary/

3. The results of this study implied that more thorough assessments of clients and their children could be beneficial. This could include measures of mental health, trauma, adult attachment, and parenting capacity.

4. Ensure clients have options for spiritual searching and consider providing a variety of religious perspectives.

5. Consider teaching clients different models of addiction in addition to the disease model. This could augment clients’ understandings and permit them to select one model or combine aspects of several that resonate in helpful ways.

6. Parent-clients would likely profit from being coached about how to recover in environments with so many triggers around them. They might need more instruction on how to manage triggers and prevent relapse in a variety of real-world settings beyond the counselling office.

**Broader Implications for Integrated Programs and the Treatment System**

This is the first qualitative study to use the ECIT method to investigate aspects that help and hinder women who are early parenting and struggling with substance use issues. The results of the study provided an opportunity for me to speak to other topics that are related to integrated programs and influenced by various branches of the government that impact treatment of this highly vulnerable and at-risk population. The categories were supported in the existing literature. There was a correspondence between what the participants said they needed and innovative programs and interventions that were reviewed. However, there are gaps in service across the healthcare spectrum that are needed to support
these women. At the time of this work there were only three integrated residential treatment centres for women that included their children in Canada. Therefore, this study offered implications that could be translated into improvements to existing programs and the development of new ones.

The Integrated Treatment category and the Relationships with Children and Parenting Support category contained participants’ calls for greater access and more specialized interventions that included their children and targeted their complex parenting issues. The Government Involvement category along with the Medical and Mental Health category included helping and hindering incidents that highlighted the need for better multi-sectoral partnerships. Research has been cited earlier in this paper that refers to these concomitant services as the “one-stop shop” approach needed for women in this population. Yet, the participants signaled ongoing barriers to effective and timely concurrent services, when pregnant or parenting, and disadvantaged. The Housing and Financial Issues category pointed to a greater need for available, subsidized social housing for women–led families. The wish list items in the Short-term and Long-term Practical Supports category emphasized employment, job security, and education that had been unavailable to participants in the past. It is clear that participants needed equal access to services related to the social determinants of health in our society. As outlined above, this is linked to the categories created from the data.

It would be prudent to reinforce a developmental lens and an Indigenized lens for making decisions about the therapeutic interventions offered at integrated treatment programs. A range of short-term, long-term, individual and group modalities could be considered. The focused therapies that were described in chapter two do not target substance
use directly. They were designed to be delivered in pregnancy and in the early post-partum time period. They are meant to increase motivation to parent and provide help for parenting that in turn would be a strong motivator to reduce substance use. The evidence-based interventions to improve dyadic interactions and reduce insecure and disorganized attachment are Child-Parent Psychotherapy, Mothering from the Inside-Out (MIO), Circle of Security (COS), and Attachment and Bio-behavioural Catch-up (ABC). Short-term therapies taking 8 to 12 weeks such as MIO, COS, and ABC are as effective as some longer-term therapies and could be delivered at residential treatment centres.

Program providers should be aware of the risk of stereotyping parents with addiction issues based on the findings from 30 years of research regarding what they have in common. Women in this population may share multiple risk factors on both substance abuse and on dysfunctional parenting behaviour. However, they have different genetic factors, different trauma histories, and different stressors. They arrive in treatment having had different environmental influences. A parent’s caregiving capability partly depends on those factors. As our knowledge of epigenetics (gene x environment interactions) and the role it plays in the intergenerational transmission of attachment increases, our understanding of how to prevent disorganized attachment also develops.

The differential susceptibility principle forecasts that the effectiveness of parental sensitivity interventions depends on whether or not infants carry susceptible genes. There may come a time in the future that information regarding parents’ and their infants’ genotypes will be accessible. At present an at-risk dyad made up of a parent with an unresolved state of mind concerning attachment and a highly sensitive infant could be prioritized for immediate and intense intervention. The early caregiving environment is the
major factor in which program providers can intervene. Using the interventions discussed above can strengthen sensitive caregiving and attachment concomitant with addiction treatment. That could provide better opportunities to break the cycle of the intergenerational transmission of insecure and disorganized attachment.

There is often cynicism in the addiction treatment field that the aims of harm reduction and abstinence can coexist. Dr. Gabor Maté (2008) said, “There is also no contradiction between harm reduction and abstinence. The two objectives are incompatible only if we imagine that we can set the agenda for someone else’s life regardless of what he or she may choose. We cannot” (p. 317). The results demonstrated that harm reduction and abstinence-based programming can and are working together.

At one stage of their journeys some participants found the harm reduction approach beneficial. It was helpful to be given the choice to reduce their substance use severity and be stabilized at the harm reduction-based combined care unit at the hospital. It helped participants to be accepted and treated nonjudgmentally by medical professionals while preparing for the birth of their infants and while considering treatment alternatives. Shortly after, at the next stage of their journeys, the same participants were embracing abstinence while in residential treatment centres. Many participants insisted that abstinence for them was necessary for effective parenting. Furthermore, while in abstinence-based programs many participants were prescribed methadone which is a specific harm reduction practice. It seemed that the objective to reduce harm for many participants in the study was working the way it should. Harm reduction was meant to be a foundational piece of a broader plan for their recovery journeys.
While completing this study I was reminded of what Johann Hari (2015) concluded in the book, *Chasing the Scream: The First and Last Days of the War on Drugs*. He contended, “The opposite of addiction isn’t sobriety. It’s connection. . . . If you are alone, you cannot escape addiction. If you are loved, you have a chance” (p. 293). Approximately 70% of the hindering incidents in the data were placed in six categories that were either directly relationship-oriented (i.e. Relationships and Support from Partners; Relationship with Oneself and Personal Characteristics) or contained high levels of relationship-oriented content (i.e. Integrated Addiction Treatment for Women that Includes their Children). The six relationship-oriented categories ranked highest in terms of participation rates under the hindering section. This indicated that problematic relationships or lack of supportive relationships made it harder for participants to parent their children at the same time they were struggling with substance use issues. An implication for the treatment system from the study is to reinforce the primacy of loving, supportive relationships as the context for recovery for at-risk parents with substance use issues.

**Limitations of the Study**

The Enhanced Critical Incident Technique (ECIT) is meant for conducting a broad exploration of a novel topic. Therefore, as an ECIT researcher I sought a diverse source of participation to represent the exploration. However, the participants in the study were engaged with a narrower variety of service providers than hoped for. I attempted to recruit participants from a broad spectrum of 14 separate organizations with harm reduction-based drop-in centres at one end of the continuum and abstinence-based residential drug and alcohol treatment centres at the other.
Initially, for organizational administrative reasons, there were delays in advertising the study at one harm reduction-based drop-in centre and at one woman-led family housing program. Both are harm reduction-based. At the same time, a very high level of interest in participation was generated at three residential drug and alcohol treatment centres and at one supervised transitional housing program. All of those organizations are abstinence-based. In the end 19 of 20 participants came from those four organizations where they were engaged in more advanced stages of treatment for addiction than other potential participants might have been. Therefore, it is important to denote that the results of the study largely reflect participants that were abstinent and actively engaged in treatment for alcohol and drug addiction.

It is possible that the results of the study may have been different in interesting ways if the sample had been more homogenous vis-à-vis the inclusion criteria. Women who were pregnant at the time of the study were excluded for the purpose of homogeneity. The early parenting inclusion criteria stated that participants had to be a minimum of 19 years of age (with no age cap) and had to be parenting at least one child between the ages of birth and six years (not, for example, parenting their first child between the ages of birth and six years). The age range of participants was 22 to 41, the average age was 32, and the average number of children was 1.85. A total of 75% of the participants were age 30 and above which was older than expected.

Research has indicated that adolescent and young adult mothers have different risk factors and environmental influences than more mature mothers. This implies younger mothers struggling with addiction might have relatively different opinions about what helps and hinders them and what they wish for. In addition, the concept that their children present a
window-of-opportunity for change might be more salient for adolescent and young adult mothers. For example, if the sample for this study was more homogenous, it might have been made up of primiparous mothers between the ages of 19-26 years. The results from those mothers may have conveyed a greater sense of urgency to program providers and to the treatment system who are the intended audience of the results of the study.

Not all of the 20 participants completed the second interview as a credibility check. Therefore, the non-completers did not verify that the data extraction from their first interviews was correct, that the category titles and operational definitions made sense to them, and that the extracted critical incidents and wish list items were placed in the appropriate categories. The second interviews were conducted in a reasonable time period between six and eight months after the initial interviews. However, changing contact information and multiple transitions in housing are expected from women in this population. While residing at treatment centres many participants had multiple email addresses, no fixed residential addresses and no workplace contacts for follow-up. This made it particularly difficult to contact them again. It is notable however, that of the 11 participants that completed the credibility check, none contested any of the 14 category titles or operational definitions with the exception of one who asked for the word “and” in one category title be changed to “and/or.”

The findings from this qualitative study are from a relatively small sample of 20 participants and are not generalizable to the greater population of women who are early parenting with substance use issues. The experiences and needs of the 20 participants are meant to provide valuable information to the intended audience, but this limitation necessitates that I present the findings tentatively.
The ECIT is a pragmatic, strategies-focused method. A limitation of the method is that it is not set up for critical engagement with issues such as the overrepresentation of Indigenous participants in the study. The ECIT reveals psychological and behavioural events that participants can recall. It does not ask critical questions or interrogate the source of experiences, nor does it ask the participants to do that work.

The ECIT is also limited for contextual analyses which some see as essential given the vulnerable population that the participants were drawn from. Contextual analyses consider experiences together with broader societal states of affair and how they function (Bourdieu et al., 1999). These types of analyses highlight social structures, dominant discourses, and policies that shape how minority groups interact with main-stream society. Often minority groups are marginalized without even a conscious acknowledgment by the persons within the minority group or by the dominant group.

Using a local example of contextual analysis, researchers came to reflect on how the poverty and disadvantage suffered by the Indigenous minority group was multiplied by colonial policies such as residential schools and the “60s scoop” (Lynam, Grant, and Staden, 2012). Policies that have displaced Indigenous people have created their lack of belonging which in turn has assigned them to the margins of society. Dominant discourses such as Indigenous deviance have created a bias towards the apprehension of children by the government, robbing Indigenous women of their parenting rights. Lynam and Cowley (2007) considered marginalization, defined as a social determinant of health, to be a context for health inequity. Since the ECIT method focused primarily on the experiences of participants and not on their marginalization as a social structure, a contextual analysis from a critical
perspective was not possible. However, both limitations of the ECIT described here can also be seen as strengths in terms of how to proceed with the findings in future research.

**Implications for Future Research**

This ECIT study explored the factors that participants found helpful and hindering and the things they wished for as women struggling with substance use issues while parenting young children. The research questions necessitated that during the interviews I steered participants in the direction of recalling important experiences from the previous 12 to 18 months. There was valuable data related to the participants’ backgrounds and life stories that they seemed ready to talk about and I was unable to collect. A study using a narrative method with this population or an ECIT study with an added narrative component could generate additional important information. A research team at the University of British Columbia in the department of counselling psychology combined the narrative method together with the ECIT method. They are investigating both the stories of career decision making and what helps and hinders immigrant and Indigenous youth to make career decisions well (Borgen, Ishiyama, Mathew & Becker, 2018).

An area that would benefit from further investigation would be to conduct a longitudinal study of women who are recovering from substance use issues, parenting young children, and self-report that they are doing well. Six to eight months after the initial interviews, at the time of the second interviews, 11 of the participants reported to me that they were moving ahead in their lives as parents. It was tremendously heartening to hear that they were doing well on their recovery journeys, remaining abstinent relating to substance use, and were continuing to make progress in the direction of their parenting goals.
Jeong et al. (2015) from Breaking the Cycle in Toronto wondered if focusing primarily on substance use problems was less important to the women they studied than increasing their capacity for parenting and other close relationships. I wondered how the participants in this study were finding reward and delight in parenting again, how they were balancing the demands of parenting with recovery activities, what relationships and social supports were helping them, and what were still missing? A longitudinal study that takes a positive psychology approach could be used to find out: (a) what was going right for the participants; (b) what gave them hope; (c) what factors made them optimistic about their futures; and (d) what impacted their growing resilience.

It would be informative if an ECIT study like this was replicated to ask one-third of participants about helping critical incidents (CIs) first, one-third of participants about hindering CIs first, and one-third of participants about wish list (WL) items first. The semi-structured interview guide used in ECIT studies asks participants to describe in order, what helps them, what hinders them, and what they wish for. Often the total numbers of critical incidents (CIs) and wish list (WL) items collected in a data set reflects a descending proportion according to the order the questions were asked. If it was changed up, researchers could observe if the proportions of CIs and WL items are different compared to studies that ask questions in the conventional order.

I suggest this because I was somewhat surprised that participants in this study recalled from a total of 477 more helping critical incidents (210) than hindering critical incidents (159) or wish list items (108). I expected that as parents of young children and struggling with substance use issues, the participants would describe more things that made it harder for them. One possible explanation for the final proportions is that participants were in
recovery programs at the time of the interviews and were actually more positive and more focused on what was helping them. Another possible explanation is that the average length of 20 interviews was 109 minutes, just under two hours. I was told to expect and later observed that many participants were experiencing fatigue by the time they were asked about what hindered them and what they wished for. Therefore, varying the order that the ECIT questions were asked might have produced a different proportion of results.

Neglected in the addiction and parenting literature is the issue of the role of men and their roles as biological or social fathers. As men present themselves for addiction services there may be more demand to address their roles as fathers given societal changes in the past 20 years. An ECIT study on what men who are engaged in services for addiction say would help and hinder them as parents would be informative. The results could be used for gender comparisons and they could provide a needs assessment for program providers that work specifically with men.

A study may be warranted using participants from the same population which focusses explicitly on short-term and long-term practical supports and on housing and financial needs. In both of those categories, the participants said very little about what made it harder for them as parents. However, there were a very high number of wish list items in each. A possible explanation for that situation comes from the ECIT protocol. Participants were not asked specific questions about systemic supports. Instead, participants always decided for themselves whatever factors came to mind that seemed most important to them at the time of the interview. Therefore, given how low the categories ranked under the hindering column and how high the categories ranked under the wish list column, it is possible that valuable information about systemic supports is missing.
Future research could critically engage with the elevated numbers of Indigenous women found in this study who were struggling with substance use and parenting. There was no secondary data analysis of group differences by race which I could have addressed more explicitly. However, I did conduct a secondary data analysis that led to a discussion of the results across participants in the broader topical areas of trauma, social issues, and systemic concerns. Perhaps the omission concerning race comparisons was for this reason. In addition, the original research design did not include an intention to make group comparisons on any variables.

Having said that, there may be incongruity between the Indigenous and non-Indigenous participant groups that could provide valuable insight pertaining to the reported categories and broader themes. For example, systemic issues showed up in the findings with reference to the social determinants of health. The Indigenous and non-Indigenous groups could be compared with regard to traumatic antecedents, attachment indices, access to services, experiences with child protection agencies, and with parenting capacity assessments, among other factors. There might well be other significant differences found in the results between the Indigenous and non-Indigenous groups that deserve further exploration. Future work in critical research could take into account the oppression and difficulties experienced by both and highlight the services that could meet the needs of both groups.

The final implication for future research described here is in response to the limitation of using the ECIT method for contextual analyses. A study could be done of similar at-risk parents from the Bourdieu et al. (1999) perspective related to the entrenched societal conditions that marginalize them. In the first phase parents’ experiences of the system could
be described. Through a critical lens in the second phase the processes in the broader system that shaped the participants’ experiences could be examined (Lynam & Cowley, 2007). The benefit of conducting a contextual analysis of the vulnerable population of women who are early parenting and impacted by substance use would be to produce insights for potentially mobilizing change at the systemic level.

Conclusions

This study offered a peek into the complex and distressing issues that 20 women who were early parenting faced while they also struggled with substance use issues. The results emphasize the need to break the intergenerational transmission of insecure and disorganized attachment that is common in this at-risk population. Participants identified with all of the known factors related to their children’s risk of disorganized attachment. The quality of caregiving they provide to their children is something that could be changed for the better to promote secure attachment and reduce the risk of insecure and disorganized attachment. I hope to share these study results with my intended audience which is primarily program providers for at-risk mothers who struggle with addiction and for the professionals that work with them. My wish is that the results contribute to a type of needs assessment for new program development and for existing program improvements.

Almost all of the participants in this study were somewhere in the process of residential treatment for addiction that included their children. The data from the interviews was enriched by their openness and emotion, likely due to the fact that they were receiving supportive counselling during the same time period. The participants were future-oriented and optimistic about parenting. As Lewis (2015) described, because they were on a recovery
journey, the participants may have been imagining their futures spreading out ahead of them rather than just reiterations of their present struggles with addictive behaviour.

The participants seemed to want badly to be the authors and agents of their own lives. This included their roles as caregivers of their young children at the same time they as parents were on a recovery journey from addiction. I plan to share these results through presentations and publications. I hope the results will contribute to making a difference in helping mothers such as the participants in this study to recover from addiction, remain together with their children, and achieve their parenting goals. In addition, potentially successful new or improved programs for mothers in this at-risk population should be rigorously evaluated using comparison groups. The results of such program evaluation studies could shed more light on the potential cost-effective benefits from early and concentrated interventions. It is my hope that our society will make an intensive, preventative investment in young parents’ lives when they struggle with addiction at the same time their hearts’ desires are to be loving and effective parents.
References


(Original work published 1969)

Cohler, & S. H. Weissman (Eds.), Parenthood: A psychodynamic perspective (pp.

145, 1-10.

instrument for assessment and classification (AMBIANCE): Manual for coding
disrupted affective communication (2nd ed.). Unpublished manuscript, Harvard
Medical School, Cambridge, MA.

instrument for assessment and classification (AMBIANCE): Manual for coding
disrupted affective communication (1st ed.). Unpublished manuscript, Harvard
Medical School, Cambridge, MA.

strategies help and hinder? Unpublished doctoral dissertation, University of British
Columbia, Vancouver, British Columbia.

research interview on workers’ views of their situation. Canadian Journal of
Counselling, (43)2, 120-130.


understanding mental states: The reflective self in parent and child and its significance for security of attachment. Infant Mental Health Journal, 12, 200-216.


Grant, T., Ernst, C. C., Pagalilauan, G., & Streissguth, A. (2003). Post-program follow-up effects of paraprofessional intervention with high-risk women who abused alcohol


Groh, A. M., Roisman, G. I., van IJzendoorn, M. H., Bakermans-Kranenburg, M. J., &


doi:10.1017/S0954579417001778


holocaust-disease-trauma-recovery


Retrieved from http://ebookcentral.proquest.com


doi: 10.1002/imhj.20297


Main, M., & Solomon, J. (1986). Discovery of an insecure, disorganized/disoriented attachment pattern: Procedures, findings, and implications for the classification of behaviour. In M. Yogman & T. B. Brazelton (Eds.), *Affective development in infancy*
Main, M., & Solomon, J. (1990). Procedures for identifying infants as
disorganized/disoriented during the Ainsworth Strange Situation. In M. T. Greenberg,
D. Cicchetti, & E. M. Cummings (Eds.), Attachment in the preschool years: Theory,
research, and intervention (pp. 121-182). Chicago, IL: University of Chicago Press.

behaviours. In J. S. Baer, G. A. Marlatt, & R. McMahon (Eds.), Addictive behavior

Masterson approach. New York: Brunner/Mazel.

Maté, G. (2008). In the realm of hungry ghosts: Close encounters with addiction. Toronto,
ON: Alfred A. Knopf Canada.

N. E. Suchman (Chair), Interventions for Parents with Substance Use Disorders: New
Findings from Clinical Research. Workshop presented at the annual meeting of the
College on Problems of Drug Dependence, Reno, NV.

Suchman, M. Pajulo, & L. C. Mayes (Eds). Parenting and substance abuse:
Developmental approaches to intervention (pp. 156-182). New York, NY: Oxford
University Press.

men. In N. E. Suchman, M. Pajulo, & L. C. Mayes (Eds). Parenting and substance
abuse: Developmental approaches to intervention (pp. 447-468). New York, NY:
Oxford University Press.


doi:10.1017/S0954579417000013


(Eds.), *Disorganized attachment and caregiving* (pp. 3-24). New York: Guilford Press.


Basic Books.


Appendix A

Information Sheet for Facilitating Recruitment

UNIVERSITY OF BRITISH COLUMBIA

Service-engaged Early Parenting Women Who Have Problematic Substance Use: Factors They Find Helpful and Hindering

Principal Investigator

Dr. Norm Amundson, Ph.D., University of British Columbia, Department of Educational & Counselling Psychology, and Special Education, (604) 822-6757

Co-Investigators

Lynn DuMerton, MA, Doctoral Student, University of British Columbia, Department of Educational & Counselling Psychology, and Special Education

Marla Buchanan, Ph.D., University of British Columbia, Department of Educational & Counselling Psychology, and Special Education, (604) 822-4625

Alanaise Goodwill, Ph.D., University of British Columbia, Department of Educational & Counselling Psychology, and Special Education, (604) 827-0627

Purpose of the study

You are being invited to help recruit participants as part of a qualitative research study. We are looking for 20 service-engaged women who are early parenting (they have a child or children between the ages of birth to six) and they self-identify as having a substance use problem. Your role will be to assist with recruitment and serve in the role of a staff spotter, as it is described in detail below. We want to interview the women and have them describe what helps and hinders them, and what they wish would be available to them that has not been in the past, from their own perspectives.

Study procedures

Here is how we will do the study with the women we interview. All together it will take between 2-3 hours of the participants’ time:

Pre-Interview meeting

The in-person meeting will be for the participant to meet the primary researcher Lynn and will last about 15 minutes. Lynn will go over the procedures for the study in detail and can answer any of their questions. In addition, if they agree to participate Lynn will obtain their written consent. Lastly, Lynn will leave them with a timeline worksheet to help them reflect on what they will be asked about during the first interview, and a list of free counselling and other helpful services in their communities should they feel the need for additional support during their involvement in the study.
Interview 1
This interview could last between 1.5 to 2 hours. The primary researcher Lynn will ask them questions for them to remember and describe what has helped or has not helped them as an early parent who has substance use problems. Lynn will also ask them what they think could have helped if it was available at the time. The interview will be audio recorded, with the participant’s permission, and transcribed.

Interview 2
All participants will be asked to do a follow up interview that will last about 30 minutes. The primary researcher Lynn will ask them to review the key information that came out of the first interview. Lynn will check with them to see if the categories she created from the first interview match with how they experienced it. The procedure for the second interview can also be done by email/telephone if the participant cannot or chooses not to meet again in person.

We will be asking you to assist us to recruit and assess the suitability of potential participants at your organization according to the inclusion and exclusion criteria. As deemed appropriate, you will tell them about the study, and give them the recruitment poster, providing them with instructions about how to contact the primary researcher. Depending on the circumstances, you could act in the role of liaison between the primary researcher and the participant during their involvement in the study.

It is expected that because you have a relationship with your clients you might see them regularly and will be asked to pay attention to whether or not you notice any negative effects from their participation. If appropriate you might be able to encourage them to seek the counselling or other assistance using the information they were provided with at the beginning of the study. It is unknown exactly how much of your time will be taken up in the study because it would depend on how many potential participants you talk to and interact with, and whether or not they decide to become involved. You could expect to spend anywhere between five minutes to 1-2 hours per participant, depending on their decisions.

Study results
The results of this study will be reported in a graduate thesis and may also be published in journal articles and books. The participants can check the box at the end of their consent form and provide their mailing address if they would like to receive a summary of what we find out. You could receive the information as well by request.

For mental health researchers and practitioners, the report of the participants’ needs may assist them in designing future research, and in the use and development of counselling techniques and interventions. The study could inform needs assessment for those who propose enhancements to existing programs, and new programs. This project could inform the need for more intensive and sustainable supports for women dealing with these issues. In addition, it is hoped that through the dissemination of the results of the study, policy makers and other stakeholders will be more aware of the needs of this population.
Is there any way being in this study could be bad for the participants?

Participants might find that taking two to three hours of their time is inconvenient or costly for them, especially if they are taking care of and nursing a baby, or taking care of their other children. If needed, their public transit to and from an interview and some childcare costs can be covered. That is explained in more detail below. If a 1.5 – 2-hour interview seems too long, the primary researcher Lynn can plan to take a break for a snack and for them to nurse their baby if required.

We do not think there is anything in this study that could harm participants. Some of the questions the primary researcher Lynn will ask them might seem sensitive, or might upset them. They do not have to answer any questions if they do not want to. They can be reminded to let Lynn know if they have any concerns and she can stop the interview for a break, or re-schedule the interview if necessary. In addition, at the first meeting, a list of free resources in their community to see a counsellor, or to get support over the telephone, will be given to them. They can use that list to get support in a confidential way if they still have any uncomfortable feelings during or after the study.

We do not think there is anything in this study that could harm you as a staff spotter. It is unlikely but possible that some of your clients might be upset at you if they felt pressured to participate but didn’t want to. They could feel disturbed emotionally from their participation and attempt to hold you responsible for that if you recruited them originally. In addition, you might feel inconvenienced on occasion if the time you spend assisting with the study gets in the way of your regular tasks.

Will being in this study help participants in any way?

We are not sure that taking part in this study will help the participants directly. However, in the future, other women and their families may benefit from what we learn in this study. Talking about themselves in an interview could be a positive experience for them. They might learn more about their strengths and worth as a person. They might feel proud knowing that what they say can help other women like them, and their families. As a staff spotter, you might feel content knowing that your help made the study successful, and you might feel hopeful that the results of the study could impact positive change in the future.

How will participants’ identity be protected?

Participants’ identity will be confidential within the limits of the study and within the limits of the law. This means that:

1. It is possible that others will know when someone is participating in the study. For example, if the participant is a client of a housing program and a staff spotter told them about the study, and the program is providing childcare during their interview,
those staff persons will be aware that they are participating in the study.

2. Participants’ names will be removed, and they will be given a code number for all of the written and digital documents that come from their interviews. The list that matches their name with their code number will be stored in a fireproof safe by the primary researcher Lynn DuMerton, separate from their documents file. All documents in their file will be identified only by the code number, and the files will be stored in a locked filing cabinet by Lynn.

3. Only the primary researcher Lynn and the research team listed on the top of this form will have access to the identifiable written or recorded data. A small group of additional study team members will have access to limited portions of the data. They will be other UBC doctoral students, under the supervision of the primary researcher Lynn, and will assist her in checking the data but only after it is coded with a participant number and the identifying information for participants is removed.

4. After the study is over the audio recordings will be destroyed and only the de-identified documents will be kept. The de-identified data will be kept indefinitely for research and educational purposes.

5. Your identity as a staff spotter will not be protected within the limits of the study because your role will be to recruit potential participants at your organization. However, in any report of the study results, your name will not be used, and you will be referred to as a staff spotter.

Legal Limit to Confidentiality in the Study

Everything that participants say during the study will be confidential. However, there are legal limits to confidentiality that are important for them to know. If they say that they intend to harm themselves or hurt someone else, or that a child or youth is being abused or neglected, or is at risk of abuse or neglect, the primary researcher Lynn must, by law, report this information to the appropriate agencies.

Will participants be paid for their time?

A $25 gift card will be given to participants at the beginning of the first interview to thank them for their time. In addition, we will pay the costs of their childcare or public transportation if required and within limits. Unless it can be arranged for no cost, childcare costs could be paid at $10 per hour for up to two hours or $20 total. Bus and sky train costs could be paid in the range of $2.75 - $5.50 for one-way, to a maximum of $11 for a one-time return trip, depending on the number of zones they have to travel.

A $50 gift card will be given to a staff spotter at the beginning of the study to acknowledge the additional time and energy required to assist with recruiting participants at the same time they are doing their regular job.
Who can you contact if you have questions about the study?

If you have any questions or would like more information about this study, you may contact Lynn DuMerton (Primary Researcher) or Norm Amundson (Principal Investigator) at 604-822-6757.

Who can you contact if you have complaints or concerns about the study?

If you have any concerns or complaints about your rights as a recruitment facilitator and/or your experiences while assisting in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

Consent by Study Participants

Taking part in this study is entirely up to the participants. They have the right to refuse to participate. If they decide to take part, they may choose to withdraw at any time without giving a reason and without any penalty.

As a facilitator of recruitment you will ensure that the program will not deny access to program support or discriminate against a prospective participant who might decline to participate.

Recruitment Facilitator’s Right to Withdraw

Helping recruit participants for this study is entirely up to you and your organization. You have the right to refuse to participate. If you decide to take part, you may choose to withdraw at any time without giving a reason.
Appendix B
Study Guideline

Two sources for participants:

A. PP Non-Sanctuary program sees poster
   - Contacts PR by phone/email

B. PP is in Sanctuary program
   1. SS assesses suitability (per inclusion/exclusion criteria)
   2. SS provides recruitment poster
   3. PP in Sanctuary Program contacts PR by phone/email directly

Initial contact between PP and PR by email or phone
1. PR assesses suitability of all PPs per inclusion/exclusion criteria
2. PR pre-screens PP’s and sets up pre-interview discussion

Pre-interview discussion, in-person
1. PR conducts screening process
2. Informed consent obtained
3. Timeline given, counselling resources given (see Appendix E in Box 9.7)
4. Wait minimum three days to give participant time to decide

Interview 1 – ECIT, in-person
1. PR reminds P of rights
2. PR connects P with resources

Interview 2 – Participant checking, in-person, by email, or telephone
1. PR reminds P of rights
2. PR connects P with resources
Appendix C

Information Sheet for Organizations to Advertise a Study

UNIVERSITY OF BRITISH COLUMBIA

Information Sheet for Organizations to Advertise a Study

Service-engaged Early Parenting Women Who Have Problematic Substance Use: Factors They Find Helpful and Hindering

Purpose and potential contributions of the study

You are being invited to advertise a qualitative research study because we are looking for 20 service-engaged women who are early parenting (they have a child or children between the ages of birth to six) and they self-identify as having a substance use problem. We want to interview them and have them describe what helps and hinders them, and what they wish would be available to them that has not been in the past, from their own perspectives. The findings of the study will be reported in the primary researcher’s graduate thesis and possibly published in journal articles or book chapters.

For mental health researchers and practitioners, the report of the participants’ needs may assist them in designing future research, and in the use and development of counselling techniques and interventions. The study could inform needs assessment for those who propose enhancements to existing programs, and new programs. This project could inform the need for more intensive and sustainable supports for women dealing with these issues. In addition, it is hoped that through the dissemination of the results of the study, policy makers and other stakeholders will be more aware of the needs of this population.

Study procedures

If they agree to participate in the study here is how it will be conducted. All together it will take between 2-3 hours of their time:

Pre-Interview meeting
The in-person meeting will be for the participant to meet the primary researcher Lynn DuMerton and will last about 15 minutes. Lynn will go over the procedures for the study in detail and can answer any of their questions. If they agree to participate Lynn will obtain their written consent, and will leave them with a timeline worksheet to help them reflect on what they will be asked about during the first interview. In addition, participants will be given a list of free counselling and other helping resources in their community should they feel the need to seek support while involved in the study.
**Interview 1**
This interview could last between 1.5 to 2 hours. The primary researcher Lynn will ask some questions in order for them to remember and describe what has helped or has not helped them as an early parent who has substance use problems. Lynn will also ask them what they think might have helped if it was available at the time. The interview will be audio recorded and transcribed.

**Interview 2**
Participants will be asked to do a follow up interview that will last about 30 minutes. The primary researcher Lynn will ask them to review the key information that came out of the first interview. Lynn will check with them to see if the categories she created from the first interview match with how they experienced it. The procedure for the second interview can also be done by email/telephone if the participant cannot or chooses not to meet again in person.

**Recruitment of participants**

We will be asking you to use our recruitment poster to advertise and promote the study on your premises and directly to your clients. If you are interested, and are able to, it may help to assign one of your staff persons to the role of assessing the potential participants for suitability in advance, and connecting them with the primary researcher by presenting them with the recruitment poster.

**Reimbursement for participation**

A $25 gift card will be given to the participant at the beginning of the first interview to thank them for their time. In addition, we will pay the costs of their childcare and/or public transportation if required and within limits. Childcare cost will be paid at $10 per hour for up to two hours or $20 total. Bus and sky train costs will be paid in the range of $2.75 - $5.50 for one-way, to a maximum of $11 for a one-time return trip, depending on the number of zones they have to travel.

**Who can you contact if you have questions about the study?**

If you have any questions or would like more information about this study, you may contact Lynn DuMerton (Primary Researcher, UBC doctoral student); or Dr. Norm Amundson (Principal Investigator) at 604-822-6757.

**Right to withdraw**

Assisting with recruitment is entirely up to you and your organization. You have the right to refuse to advertise the study. Alternatively, if you decide to help, you may change your mind at any time.
Participants Needed for a Research Study!

Are you a woman who is early parenting and has a substance use problem?

Then you might be able to participate in a study that describes what you and other women find helpful and unhelpful in your lives.

Lynn DuMerton, Ph.D. Candidate, is doing this research project as part of her doctoral studies at UBC. Dr. Norm Amundson is supervising this study (604) 822-6757.

We would like to hear from you if you are:

- A woman who is 19 years of age or older
- Parenting at least one child between the ages of birth to six years
- Self-identifying as having a substance use problem
- Willing to talk about factors you have found helpful and not helpful in your life, and what else would have been helpful, in a confidential interview

Contact information:

Contact Lynn if you would like to participate or if you need more information:

Phone:

Email:

Research participants will receive a $25 gift card to thank them for their time and help. If required, they can also be paid for regular transit fare (between $2.75 - $5.50 each direction) and limited childcare costs (up to $20) for participating in the study.
Appendix E
Facebook Advertisement

UNIVERSITY OF BRITISH COLUMBIA

Are you a woman who is early parenting and has a substance use problem?

Then you might be able to participate in a study

Lynn DuMerton, Ph.D. Candidate, is doing this research project as part of her doctoral studies at UBC. Dr. Norm Amundson is supervising this study (604) 822-6757.

We would like to hear from you if you are:

- A woman who is 19 years of age or older
- Parenting at least one child between the ages of birth to six years
- Self-identifying as having a substance use problem
- Willing to talk about factors you have found helpful and not helpful in your life, and what else would have been helpful, in a confidential interview

Contact Lynn for more information: Phone: Email:

| Research participants will receive a $25 gift card to thank them for their time and help. If required, they can also be paid for regular transit fare (between $2.75 - $5.50 each direction) and limited childcare costs (up to $20) for participating in the study. |
Appendix F
Consent Form

UNIVERSITY OF BRITISH COLUMBIA

Service-engaged Early Parenting Women Who Have Problematic Substance Use: Factors They Find Helpful and Hindering

Principal Investigator

Dr. Norm Amundson, Ph.D., University of British Columbia, Department of Educational & Counselling Psychology, and Special Education, (604) 822-6757

Co-Investigators

Lynn DuMerton, MA, Doctoral Student, University of British Columbia, Department of Educational & Counselling Psychology, and Special Education, phone number

Marla Buchanan, Ph.D., University of British Columbia, Department of Educational & Counselling Psychology, and Special Education, (604) 822-4625

Alanaise Goodwill, Ph.D., University of British Columbia, Department of Educational & Counselling Psychology, and Special Education, (604) 827-0627

Why are we doing this study?

You are being invited to take part in this research study because you are a woman who is early parenting and self-identifies as having a substance use problem. We want to learn more about how to help women like you by describing what you say has helped you or not helped you, from your own perspective. We are looking for 20 women to be interviewed.

How is the study done?

Here is how we will do the study. All together it will take between 2-3 hours of your time:

Pre-Interview meeting
The meeting will be for you to meet the primary researcher Lynn and will last about 15 minutes. Lynn will go over the procedures for the study in detail and can answer any of your questions. After obtaining your consent, Lynn will leave you with a timeline worksheet to help you reflect on what you will be asked about during the first interview.
Interview 1
This interview could last between 1.5 to 2 hours. The primary researcher Lynn will ask some questions for you to remember and describe what has helped or has not helped you as an early parent who has substance use problems. Lynn will also ask you what you think could have helped if it was available at the time. The interview will be audio recorded. By signing this consent you are giving permission for the interview to be recorded. Every effort will be taken to do the interviews in private spaces to protect your identity. For example, if they are on-site, interviews could be done in rooms that are in low traffic areas and secure parts of a building that are not commonly used by other clients. If they are off-site, interviews could be done in a private room of a community centre or library. Participants are asked to please remember to bring the time-line exercise with them to the first interview.

Interview 2
You will be asked to do a follow up interview that will last about 30 minutes. The primary researcher Lynn will ask you to review the key information that came out of your first interview. Lynn will check with you to see if the categories she created from the first interview match with how you experienced it. It will be preferable to do this interview in-person, if possible. However, this second interview could also be done over the telephone or by email. Your contact information (for example, your telephone number and email address) will be stored by the primary researcher in a locked safe separate from the other study data. Email interviews will be conducted by the primary researcher using a UBC–hosted email address, for added security.

Study results
The results of this study will be reported in a graduate thesis and may also be published in journal articles and books. You can check the box at the end of this form and provide your mailing address if you would like to receive a summary of what we find out.

Is there any way being in this study could be bad for you?
You might find that taking two to three hours of your time is inconvenient or costly for you, especially if you are taking care of and nursing a baby, or taking care of your other children. If needed, your public transit to and from an interview and some childcare costs can be covered. That is explained in more detail below. If a 1.5 – 2-hour interview seems too long, the primary researcher Lynn can plan to take a break for a snack and for you to nurse your baby if required.

We do not think there is anything in this study that could harm you or be bad for you. Some of the questions the primary researcher Lynn will ask you might seem sensitive, or might upset you. You don’t have to answer any questions if you don’t want to. Please let Lynn know if you have any concerns and she can stop the interview for a break, or re-schedule the interview if necessary. In addition, at the first meeting, a list of free resources in your community to see a counsellor, or to get support over the telephone, will be given to you.
You can use that list to get support privately if you still have any uncomfortable feelings during or after the study.

**Will being in this study help you in any way?**

We are not sure that taking part in this study will help you. However, in the future, other women and their families may benefit from what we learn in this study. Talking about yourself in an interview could be a positive experience for you. You might learn more about your strengths and worth as a person. You might feel proud knowing that what you say can help other women like you, and their families.

**How will your identity be protected?**

Your identity will be confidential within the limits of the study and within the limits of the law. This means that:

1. It is possible that others will know you are participating in the study. For example, if you are involved with a housing program and they told you about the study, and are providing childcare during your interview, those staff persons will be aware that you are participating in the study.

2. Your name will be removed, and you will be given a code number for all of the written and digital documents that come from your interviews. The list that matches your name with your code number will be stored in a fireproof safe by the primary researcher Lynn DuMerton, separate from your documents file. All documents in your file will be identified only by the code number, and the files will be stored in a locked filing cabinet by Lynn.

3. Only the primary researcher Lynn and the research team listed on the top of this form will have access to the identifiable written or recorded data. A small group of additional study team members will have access to limited portions of the data. They will be other UBC doctoral students, under the supervision of the primary researcher Lynn, and will assist her in checking the data but only after it is coded with a participant number and all of the identifying information for you is removed.

4. After the study is over the audio recordings will be destroyed and only the de-identified documents will be kept. The de-identified data will be kept indefinitely for research and educational purposes.

**What are the legal limits to confidentiality?**

Everything that you say during the study will be confidential. However, there are legal limits to confidentiality that are important for you to know. If you say that you intend to harm yourself or hurt someone else, or that a child or youth is being abused or neglected, or is at risk of abuse or neglect, the primary researcher Lynn must, by law, report this information to the appropriate agencies.
Will you be paid for your time?

A $25 gift card will be given to you at the beginning of the first interview to thank you for your time. In addition, we will pay the costs of your childcare or public transportation if required and within limits. Childcare cost will be paid at $10 per hour for up to two hours or $20 total. Bus and sky train costs will be paid in the range of $2.75 - $5.50 for one-way, to a maximum of $11 for a return trip, depending on the number of zones you have to travel.

Who can you contact if you have questions about the study?

If you have any questions or would like more information about this study, you may contact Lynn DuMerton (Primary Researcher) at phone number: or Norm Amundson (Principal Investigator) at 604-822-6757.

Who can you contact if you have complaints or concerns about the study?

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

Consent

Taking part in this study is entirely up to you. You have the right to refuse to participate. If you decide to take part, you may choose to withdraw at any time without giving a reason and without any penalty. If you decide not to participate you will not be denied access to any program supports or be discriminated against in any way. The program or organization you are connected to will not receive any of the study data. The program or community service will not receive copies of your interview recordings or transcripts but may receive copies of the summary report.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study. You do not waive any of your legal rights by signing this form.

<table>
<thead>
<tr>
<th>Participant signature</th>
<th>Date</th>
</tr>
</thead>
</table>

Printed name of the participant signing above

Check the box below if you would like to receive a copy of the summary report of the results of this study.

☐ Mailing address including postal code:

____________________________________
____________________________________
Appendix G  
Timeline Exercise

UNIVERSITY OF BRITISH COLUMBIA

The arrow below represents time. This can help you think about things before the interview:

1. Mark an X on the timeline where you are now. Then think about how things are now and in the recent past (in the last year).

2. Think about your experiences as a parent with substance use problems. It can include experiences before the baby was born too. Besides things that happened to you, it can also be about your relationships, thoughts, and feelings.

3. What things stand out the most? Mark them down on the time-line too. They might be helping you on your journey or they might not be helping you. You’ll be asked questions about both. You can use the space underneath to add details.

4. Add more items below or on the back of this page as you remember more.

5. If you feel upset at any time when you do this, it might help to let someone know and get support.

---

(This timeline above represents the past 1-2 years)

<table>
<thead>
<tr>
<th>Things that have helped</th>
<th>Things that have not helped</th>
</tr>
</thead>
<tbody>
<tr>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>
Appendix H

Free Community Counselling and Other Support Services

UNIVERSITY OF BRITISH COLUMBIA

1. Vancouver Women’s Health Collective – General Counselling – 604-736-5262, can self-refer, offers counselling every Thursday from 12:00 – 4:00 pm, sometimes a wait for services (for example, 2 weeks before an appointment is available). www.womenshealthcollective.ca

2. Watari Counselling – Addictions Counselling - (604) 254-6995, can self-refer, clients have an intake appointment first and then are assigned a counsellor. There is a short waitlist at times and when that happens the intake worker can support clients who are waiting. www.watari.ca


Telephone and Chat Support

4. Vancouver Crisis Centre Distress Phone Services– 604-872-3311- Toll free (866) 661-3311. People can call 24 hours/7 days per week. This is not just for suicidal calls but also for people wanting emotional support. During busy times people might be asked to leave a first name and phone number to be called back. Chatting online is an option to talking on the telephone:

Online Chat Service for Youth up to and including age 24 • www.YouthinBC.com

Online Chat Service for Adults age 25+ • www.CrisisCentreChat.ca

Chat services are provided seven days of the week from noon until 1:00 am. When busy, people might be placed in line and have to wait for a short period of time.


Other counselling options may be available. Check with the program or organization you are connected to.
Appendix I
Interview Guide (short form)

UNIVERSITY OF BRITISH COLUMBIA

Interview Guide

[This is a condensed version of a 14-page guide. The complete version of the guide leaves ample spaces on each table and under each heading to keep detailed notes]

Service-engaged early parenting women who have problematic substance use: Factors they find helpful and hindering

Participant #: ________________ Date: ________________

Interview Start Time: ________________

The guide contains directions (in brackets) and otherwise instructions to read out loud.

Purpose of the Study

[Welcome the participant to the study. Invite them to enjoy a drink and a snack. Explain that this interview could take approximately 1.5 hours and that there is a short break planned in approximately one hour]

Our purpose in this study is to understand and describe what has helped and hindered service-engaged women who have experienced substance use problems and they are early parenting.

[Review consent form, answer any questions about consenting, obtain written consent if participant agrees]

[Provide the list of free counselling and telephone support resources. Let the participant know they should seek support if they have any emotional concerns after the interview]
Part One: Contextual Component

Purpose of Contextual Questions
[To ask contextual questions with participants in order to provide background information about them, to establish rapport, and to put them at ease with regard to the audiotaping procedure. The participant will tell a short story about herself by describing the events of the past year that she has identified as important on the timeline exercise she was given prior to the first interview, but in more detail. If the participant arrives without the exercise sheet or not having completed the exercise previously, the primary researcher will produce a blank timeline exercise sheet to elicit her answers].

Contextual Protocol
[After the participant produces the timeline exercise the contextual questions will begin. All participants will be asked to describe the experiences they identified on the timeline].

To prepare for today you were looking at the timeline exercise I gave you. Later in the interview we are going to explore in detail the factors that have helped or have not helped you. But first we want to take 15-20 minutes for you to tell me a little bit about your significant experiences during the past year.

We would like you to remember and describe the significant events or moments that occurred over the past year that may have affected you.

Beginning with the first event that you indicated on the timeline, please tell me more about it.

[Possible probes to obtain a fuller description of events]

What does that event mean to you?
What did you learn about yourself?
As you recall the past year, do any new experiences come to mind?
Part Two: Enhanced Critical Incident Interview

[Preamble:] You have been looking at the timeline and thinking about the things you wrote down. Now focus on them and more.

I am going to be asking you to think about the specific experiences or other factors over the past year and now in the present that have either helped you or not helped you. I am going to ask you to tell me about them in detail and I will have follow-up questions for you so that I can make sure I clearly understand what you are telling me.

Near the end of the interview I will ask you if there was anything that you wish you would have had if it was available to you at the time in the past year and now.

A. What has helped you as a parent who has struggled with a substance use problem? (Probes: What was the incident/factor? How did it impact you? How is it helping? Can you give me a specific example where it helped?)

<table>
<thead>
<tr>
<th>Helpful Factor &amp; What it Means to Participant</th>
<th>Importance (How did it help? Tell me what it was about...that you find helpful.)</th>
<th>Example (What led up to it? Incident. Outcome of incident.)</th>
</tr>
</thead>
</table>

Before we move on to the next set of questions about what was not helpful for you, I would like to make sure I have not missed anything you have said up to this point. [Summarize helping items].

B. What has not been helpful for you as a parent who has struggled with a substance use problem? (Alternative question: Describe something significant to you that made it harder for you as a mother?)
<table>
<thead>
<tr>
<th>Hindering Factor &amp; What it Means to Participant (What do you mean by ..?)</th>
<th>Importance (How did it hinder? Tell me what it was about... that you find unhelpful.)</th>
<th>Example (What led up to it? Incident. Outcome of incident.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Before we move on to the next set of questions, I would like to make sure I have not missed anything you have said up to this point. [Summarize hindering items]

C. We’ve talked about what’s helped you as a parent with a substance use problem (name them), and some things that have not helped you (name them). Can you think of other things that would have helped in the past that were not available to you, or things that will help you now or in the future if they become available? (Alternative question: I wonder what else might be helpful to you that you haven’t had access to.)

<table>
<thead>
<tr>
<th>Wish List Item &amp; What it Means to Participant (What do you mean by ..?)</th>
<th>Importance (How would it help? Tell me what it is about... that you would find helpful.)</th>
<th>Example (In what circumstances might this be helpful?)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thank you. Before we move on to the final set of questions, I want to make sure I didn’t miss anything [summarize items regarding what would have helped and what would potentially help].
Part Three: Demographic Information

This is the last part of the interview. I will ask you a few questions to gather demographic information. This information will not be used to identify you in any report of the study.

1. Age: ______

2. Gender: □ Male  □ Female  □ Other

3. Where did you grow up? ____________________________________________

4. Income level: □ $0 - $20,000  □ $20,001 - $40,000  □ $40,001 +

5. Education level: □ Some High School  □ High School
   □ Some University/College  □ University/College Degree
   □ Other ________________

6. Cultural background: ____________________________

7. Family status (household composition) / parental status:
   a. How is your household and immediate family organized? Who do you live with?
      _________________________________________________________

   b. Are you in a supportive intimate relationship? □ Yes  □ No

c. Please indicate the gender and age of each of your children:
   1. □ Male  □ Female  Age: _____
   2. □ Male  □ Female  Age: _____
   3. □ Male  □ Female  Age: _____
   4. □ Male  □ Female  Age: _____

8. What has been your preferred drug?
   □ Alcohol  □ Opioids (e.g. heroin)
   □ Marijuana  □ Stimulants (e.g. cocaine, methamphetamine)
   □ Hallucinogens  □ Tobacco
   □ Inhalants  □ Poly/Multiple Drugs ____________________________

9. Is there a family history of addictions? □ Yes  □ No

10. Is there a family or personal history of trauma? □ Yes  □ No
Debriefing:

This is the end of the formal part of the interview. I want to take some time if you have any other questions or concerns about participating in the study.

I would like to meet with you again after this interview is transcribed and analyzed. It is a way to check that I understood what you said correctly. I will show you the parts of your interview that seemed to be the most significant incidents and the categories that I will create to put each incident in. I could also send the information to you by email and discuss it over the phone or by email with you.

[If the participant has been emotional during the interview or has expressed concern about their emotional state, remind them of the list of counselling resources they were given at the beginning of the interview.]

Interview Start/End Time: ______________

Length of interview: ______________

Interview location: ______________________________________

Interviewer’s Self-Summary

[Immediately following interview and after participant is gone, write own thoughts/reactions below]
Appendix J
Transcription Key

UNIVERSITY OF BRITISH COLUMBIA

Formatting guidelines:

- Use plain, simple text
- No underlining
- No centring
- No bullets
- No italics
- Single spaced within paragraphs
- Double spaced between paragraphs
- Use titles Interviewer (I) and Respondent (R), no bolding

Other guidelines:

- For long pauses or silences within and between turns use (Pause)
- For transcription difficulties enclose within parentheses and mark the time on the audiotape, for example (Unclear; 45:12)
- Anonymity of people, places and programs is required. Replace participants’ personal, program, or city names with (participant’s name), (program name), and (city name)
- Use …if sentence trails off
- Omit small talk at the beginning and end of interviews, however transcribe the introductions and relevant closing statements