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CONSTRUCTING THE SELF AS ADDICT:
NARRATIVES OF RECOVERY AND RESISTANCE
AMONG WOMEN IN DRUG ABUSE TREATMENT

by

HILARY L. SURRETT

A dissertation submitted to the Graduate Faculty in Psychology
in partial fulfillment of the requirements for the degree of
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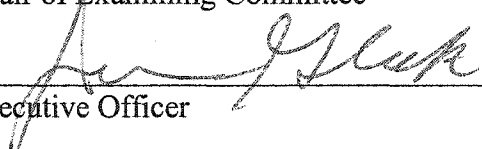
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Abstract

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AMONG WOMEN IN DRUG ABUSE TREATMENT

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The overall goal of this research was to explore the processes of personal identity construction among drug-involved women in Miami, Florida, who were participating in substance abuse treatment with their children. This study traced the development of personal identity within the context of institutional practices common to substance abuse treatment programs. Specifically, this study was concerned with understanding women's active negotiations of authoritative treatment discourses surrounding addiction as a disease, and the processes through which they accepted, resisted, or rejected the construction of an addict identity. Thirty-three participants were recruited from three programs: 12 from a residential substance abuse treatment program for women and children; 9 from a traditional residential substance abuse treatment program for women only; and, 12 from an HIV prevention program for out-of-treatment women drug users. The research plan included two in-depth semi-structured interviews with each participant

over a 3-month period, and naturalistic observations of the treatment programs.

Interviews were audio-recorded and transcribed verbatim, and were coded and analyzed using a standard qualitative analysis package. Clear patterns were evident in the identity trajectories of the participants, particularly as the trajectories were compared across contexts. The majority of participants in the women and children's program negotiated positive, forward-looking "recovery identities" through their participation in this particular system of activity. In contrast, fewer than half of the participants in the "women only" program and the women out-of-treatment displayed any positive developmental change. These findings coincided with more intensive and personal engagement in Twelve Step activities consistently displayed by women in the parental program, as they were more accepting of the self-as-addict label, more actively involved in 12-step storytelling, and more likely to ascribe personal change to their 12-step participation. These developing "recovery identities" were uniquely connected to women's commitments to motherhood, suggesting that recovery became personally meaningful because it afforded the possibility to be a "good" mother. The findings indicate that the interweaving of multiple identity possibilities in a women and children's treatment program affords the construction of more positive developmental trajectories, and argues against the singular focus on "addict identities" so prominent in many substance abuse treatment facilities.

TABLE OF CONTENTS

	<u>Page</u>
Chapter 1: Background and Theoretical Perspective	1
Women, Drug Abuse, and Criminal Justice	3
Treatment Needs of Drug-Involved Women	5
Drug Abuse Treatment Philosophies	8
Drug-Involved Women and Identity Construction	11
Theoretical Perspective	14
 Chapter 2: Research Methods	 34
Study Plan	35
Study Setting	38
Study Procedures	40
Study Participants	42
Data Analysis	43
Initial Transcription and Verification	46
Focused Readings	46
Coding Scheme	50
Interpretive Summaries	52
Implications of Approach	68
 Chapter 3: Study Findings	 71
The Context of Twelve Step Treatment	72
The Addicted Self	73
Rejecting the Addicted Self	78
Resisting the Addicted Self	79
Negotiating the Addicted Self	80
Accepting the Addicted Self	82
Personal Storytelling	83
Passive Compliance	86
Negotiated Performance	87
Active Engagement	89
Self-Change	92
Personal Transformation	93
Personal Inactivity	94
Identity Trajectories	95
Committed Recovery Identity	97
Valerie's Trajectory	97
Shalonda's Trajectory	108
Recovery Identity Found	115
Tolanga's Trajectory	115

TABLE OF CONTENTS (Continued)

	<u>Page</u>
Dea's Trajectory	128
Recovery Identity Lost	134
Yolanda's Trajectory	134
Committed Mother Identity	140
Deanette's Trajectory	140
JoAngela's Trajectory	147
No Identity Trajectory	153
Nicole's Trajectory	153
Ruth's Trajectory	160
Tammy's Trajectory	164
Chapter 4: Discussion and Conclusions	172
Discussion of Results	173
Theoretical Implications	181
Women's Drug Abuse	185
Disease Concept of Addiction and 12-Step Approaches	191
Implications for Future Research	194
Conclusions – Some Personal Thoughts	198
Afterword	201
Appendices	225
Appendix A Informed Consent	225
Appendix B Time 1 Interview Guides	227
Appendix C Time 2 Interview Guides	231
Appendix D Coding Scheme	232
Bibliography	241

LIST OF TABLES

Tables		<u>Page</u>
Table 3.1	Starting Points for Self-As-Addict	75
Table 3.2	Personal Storytelling among Women in Treatment	85
Table 3.3	Personal Storytelling and Initial "Addict Self"	91
Table 3.4	Self-Change among Women in Treatment	95
Table 3.5	Identity Trajectories	169

LIST OF FIGURES AND ILLUSTRATIONS

Figures

Figure 3.1	Valerie's Trajectory	98
Figure 3.2	Shalonda's Trajectory	108
Figure 3.3	Tolanga's Trajectory	116
Figure 3.4	Dea's Trajectory	128
Figure 3.5	Yolanda's Trajectory	134
Figure 3.6	Deanette's Trajectory	141
Figure 3.7	JoAngela's Trajectory	147
Figure 3.8	Nicole's Trajectory	154
Figure 3.9	Ruth's Trajectory	160
Figure 3.10	Tammy's Trajectory	165

Illustrations

Jemeena Photograph One	208
JoAngela Photograph One	210
JoAngela Photograph Two	211
JoAngela Photograph Three	211
JoAngela Photograph Four	212
Vickie Photograph One	214
Vickie Photograph Two	215
Vickie Photograph Three	216
Lucy Photograph One	218
Lucy Photograph Two	219
Lucy Photograph Three	219
Lucy Photograph Four	220
Lucy Photograph Five	221
Tammy Photograph One	223
Tammy Photograph Two	223

CHAPTER 1

BACKGROUND AND THEORETICAL PERSPECTIVE

The overall goal of this dissertation research was to explore the processes of personal identity construction among indigent, criminally-active women in Miami, Florida, who were participating in residential drug abuse treatment together with their children. By tracing women's developing trajectories of self and their relation to social participation within the treatment system, this study broached a fundamental issue in the field of human development, namely, the interconnections of individual and social contributions to personal identity construction. Women's transition into a specialized, family-centered drug abuse treatment program provided a unique opportunity to examine the developmental processes of identity transformation as they emerged and evolved within a particular social system of activity. The process and course of identity development among these women were further contextualized by comparison with two similar cohorts of mothers from the same inner-city Miami neighborhoods located outside of this particular system of activity— those who were in residential drug abuse treatment *without* their children, as well as a cohort who are not currently in treatment. The research plan included two in-depth interviews with each participant and observations of the treatment setting over a six-month period. Data for this qualitative study were gathered through a semi-structured interview guide, and all interviews were audio-recorded and transcribed verbatim. Analysis of the interview transcripts entailed a series of focused readings intersected by detailed passes of descriptive and patterned coding, resulting in the construction of interpretive summaries for each participant.

In this dissertation, a number of themes are addressed in the background sections, including: the increasing numbers of drug-involved women coming to the attention of the

criminal justice system, the treatment needs of drug-involved women, the nature of addiction, and the processes of identity construction. This is followed by a discussion of the theoretical approach of the work, research methods, data analysis techniques, and the presentation and discussion of findings.

Women, Drug Abuse and Criminal Justice

Drug abuse is a significant problem in the United States, affecting some twenty million individuals (Uziel-Miller et al., 1998; Uziel-Miller & Lyons, 2000; Wright, 2004), almost one-third of whom are women (Wright, 2004). Moreover, growing numbers of women have been sentenced to state and federal correctional institutions over the past two decades. At mid-year 2003, for example, 100,102 women were incarcerated in state or federal prisons nationwide, and well over 850,000 female offenders were on probation across the country (Harrison & Karberg, 2004).

The growing number of women involved with the criminal justice system is in many ways a reflection of increasing rates of substance abuse among women, as well as the enactment of tougher drug laws and mandatory sentencing policies as part of the nation's continuing "war on drugs" (Inciardi, 2002). Possession and sale of illicit drugs and other drug-related offenses have contributed significantly to the continuing increases in the female correctional population (Inciardi, 2002; Wilsnack, 1995). Across the nation, moreover, women are more likely than men to be serving sentences for drug-related offenses and to have committed their crimes under influence of drugs, but less likely to be incarcerated for violent crimes (Conly, 1998). In fact, a recent nationwide

survey of women inmates found that nearly 45% were serving time for drug or drug-related charges, up from 15% in 1979 (Bureau of Justice Statistics, 1999). Nearly half reported committing their crimes under the influence of drugs or alcohol and approximately 6 in 10 had used illegal drugs in the month before the offense (Bureau of Justice Statistics, 1997). More recently, studies have indicated even higher levels of drug-involvement among female offenders than male offenders. In a national survey Peugh and Belenko (1999) documented that 79% of male and female prisoners in state correctional institutions had histories of substance abuse problems, but females were more likely to have used drugs in the month before their crimes and more likely to have committed their offenses under the influence of drugs. Going further, Staton and colleagues (2003) found that 85% of female inmates interviewed in Kentucky prisons had used multiple substances in the 30 days prior to their incarceration, a prevalence well beyond that observed for male inmates.

Despite the overwhelming need for treatment among women in criminal justice populations, researchers have estimated that only about 13% receive treatment while incarcerated (Blanchard, 1999; Sheridan, 1996). Among the chief reasons for the paucity of institutionally-based treatment programs is a lack of funding for treatment space and severe shortages of treatment personnel. One approach to providing substance abuse treatment for offenders has been the creation of "drug courts" -- special courts that are given the responsibility for handling criminal cases among drug-involved offenders. Drug courts leverage the coercive power of the criminal justice system to impose judicial supervision, substance abuse treatment, drug testing and case management of drug-involved offenders (Inciardi, McBride & Rivers, 1996). The primary procedure has been

to require the offender, by legislative mandate or court order, to attend substance abuse programs as a form of legal leverage to ensure participation (Shearer, Myers & Ogan, 2001). Drug courts currently operate in all fifty states, and the successful completion of the treatment regimen assigned by the court can result in dismissal of criminal charges, reduced sentences, or lesser penalties for the offender. And with the proliferation of drug courts throughout the United States, treatment populations in many communities are dominated by drug court referrals. This is especially the case in Miami, Florida, the site of this dissertation research, where the entire drug court movement actually began during the late 1980s (Inciardi, McBride & Rivers, 1996). In fact, a significant majority of the women in Miami's community-based drug abuse treatment programs received their placements through the local drug courts.

Treatment Needs of Drug-Involved Women

Historically, treatment programs for drug abuse have been developed for male clients, because men represented the majority of drug abusers and because policymakers have been concerned with reducing violent crimes more commonly associated with men's involvement with drugs. As such, many treatment programs fail to address women's most common needs. Numerous studies of women drug abusers have documented a variety of gender-specific issues and barriers to treatment, including pregnancy and childcare responsibilities, partner violence and abuse, histories of other trauma, resistance from family and friends, stigma associated with women's alcohol and drug use, financial need, conflict between traditional and changing gender roles, and low social support (Grella, 1996; Pottieger & Tressell, 2000). In fact, an analysis of the national Drug Abuse

Treatment Outcome Study data found that women entering substance abuse treatment tend to be younger, less educated, and more often unemployed than their male counterparts, with significantly higher levels of emotional and psychological distress, more depression and anxiety, poorer physical health, more physical and sexual abuse histories, and burdened by more child-related responsibilities (Uziel-Miller & Lyons, 2000; Wechsberg, Craddock & Hubbard, 1998; Wobie et al., 1997). In addition, because substance abuse among pregnant or parenting women is often viewed as more deviant and stigmatizing than drug or alcohol abuse by men, women's sense of shame and guilt related to their drug use may also be heightened (Klee, Jackson & Lewis, 2002; Whiteside-Mansell et al., 1999).

Taken together, these findings clearly demonstrate that substance-abusing women are a highly marginalized and vulnerable population. Frequently situated in a complex of adverse and chaotic social environments, their lives are marked both by intimate partner and community-level violence, poverty, homelessness, disease and mental illness (Baseman, Ross & Williams, 1999; Davis, 2000; Falck et al., 2001; Gilbert et al., 2001; Kettinger, Nair & Schuler, 2000). Chronic drug-using women often inhabit a world of economic deprivation and indigence, where the shifting and precarious nature of their financial resources, health, safety, and fragile social ties often engenders criminal involvement and engagement in sex work as a survival mechanism (Inciardi, 1995). Although these circumstances and conditions appear extreme, they are in fact quite common among drug-involved women encountered in criminal justice and substance abuse treatment settings (Inciardi, Lockwood & Pottieger, 1993).

In response to these research findings, the number of specialized treatment programs for drug-abusing women has begun to increase. In this regard, an analysis of national treatment program data by Grella (1999) found that approximately 19% of the programs surveyed could be classified as “women only” programs. And within the criminal justice system, forty-nine state departments of correction indicated that they had initiatives designed specifically for women, primarily in the areas of parenting, drug abuse treatment, victimization, and life skills (National Institute of Corrections, 1998). Typically, treatment adaptations for gender-appropriate programs include establishing programs staffed by women, changing the nature of staff-client interactions to a more supportive, less confrontational tone, including gender-specific issues in the programming content, and creating safe treatment environments (Kaplan & Sasser, 1996). Although the recognition of difference in treatment needs and the implementation of specialized programs has expanded, detailed descriptions of the services provided under the auspices of such programs and the effectiveness of these treatment approaches are generally absent from the literature.

A remarkably similar situation has evolved surrounding the development and implementation of treatment programs designed to serve parenting women and their children. Historically, there was a strong belief within traditional residential substance abuse treatment programs for women that having children present would be a deterrent to recovery (Dudley-Grant, Williams & Hunt, 2000). It was believed that women needed time away from maternal responsibilities to focus solely on recovery-related issues, and children were alleged to act as barriers to drug-involved women in admitting and confronting their addiction. The problem, however, was precisely that most women could

not enter or complete substance abuse treatment because of childcare responsibilities. Ultimately recognizing this need, providers have more recently established a larger number of residential treatment programs that accommodate women and their young children. Although there is a growing body of literature describing such model substance abuse treatment programs for parenting women, there is little published research on the treatment processes and outcomes related to participation in these programs (Connors et al., 2001). The most consistent finding from this research has been that women will stay in residential treatment longer if they are permitted to have their children with them (Uziel-Miller et al., 1998; Wobie et al., 1997), however, the developmental processes behind this finding have not been described.

Despite the modifications in program content and design implemented in women's substance abuse treatment facilities, most consist of traditional therapeutic approaches: group counseling, psychotherapy, drug education and 12-step programs, such that the fundamental orientation of these programs remains unchanged (Grella, 1996; 1999). In other words, the basic assumptions about the nature of addiction and the goals of treatment persist, unaltered by new patterns of staffing or the expanded purview of treatment to address an array of topics related to substance abuse.

Drug Abuse Treatment Philosophies

Current substance abuse treatment approaches in the United States are committed to the disease concept of addiction - that "addiction is a chronic and relapsing disease" -- although most treatment is not medical (Grella, 1996). This philosophy equates drug addiction and alcoholism with illnesses such as heart disease and cancer, and in this

process recasts behaviors that were historically considered vices as legitimate symptoms of disease (White, Boyle & Loveland, 2002). Although the disease model of addiction was formulated in American medical writings as early as the eighteenth century, it cycled in and out of favor over the years until the repeal of Prohibition, when the concept re-emerged in full force (White, 1998). In fact, the approach continues to flourish, and the language of addiction as chronic disease has fully penetrated professional organizations comprised of substance abuse treatment researchers and practitioners (White, Boyle & Loveland, 2002). The disease model views addiction as a permanent condition necessitating life long abstinence. Because “denial” of disease is considered a symptom of addiction, the recovery process cannot proceed until the individual acknowledges that she has a drug or alcohol problem (Grella, 1996).

One popular medically-based approach that has been widely implemented is the “Minnesota Model” developed in the 1950s to treat chemical dependency. In this regimen, residential treatment takes place in a hospital or independent facility for 28 days, and includes: detoxification, participation in group sessions, including 12-step meetings of Alcoholics Anonymous and Narcotics Anonymous, confrontational therapy, traditional group therapy, peer meetings, individual therapy and relapse prevention education.

Another widely adopted approach to substance abuse treatment is the “social model” genre of recovery program that originated in the 1960s. Although these programs contrast with the medical model by focusing on the environmental context in which substance abuse problems occur, rather than on individual pathology, the concept of addiction as disease nevertheless underlies this perspective. The social view of the etiology of drug and alcohol problems suggests that recovery proceeds through

interactions within the community of recovering individuals rather than through a therapeutic relationship between a professional and a patient (Grella, 1996), yet the central notions of addiction, disease and recovery, for all intents and purposes, go unexamined. As a result, most prominent approaches to substance abuse treatment, both in formal programs and more loosely structured self-help settings, make claims about the nature of addiction that implicate personal identities. Or, as White and colleagues observed, "Chronic disease is culturally viewed as a defect in who you are. The challenge of chronic disease management is to manage the disease without turning the person into a thing and contributing to the social stigma associated with the condition" (2002:113).

In this regard, some researchers have begun to suggest that treating women's substance abuse disorders exclusively as problems of addiction does not ensure successful outcomes (Kaplan & Sasser, 1996). In fact, those approaching the study of addiction from a symbolic interactionist perspective have suggested that participation in, and affiliation with, self-help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) leads to significantly *higher* rates of relapse than does non-participation in such groups (Biernacki, 1986; Cloud & Granfield, 1994; Walters, 1996). Research within this theoretical tradition has frequently explored the social basis of personal identity, that is, personal identity as constituted through interaction with others who define social reality. In this way, groups such as AA and NA, in teaching members that they possess a disease and a life-long addiction to alcohol or drugs, provide a new symbolic framework through which members may undergo dramatic personal transformation. However, Peele and colleagues (1991) argue that these groups may not be effective at stopping addictive behaviors precisely because each subscribes to the

ideology of lifelong addiction. Rigid adherence to a strict philosophy of abstinence may increase, rather than decrease, a person's propensity for relapse (Walters, 1996), in part because of the salience such a philosophy lends to alcohol or drugs in constituting the individual's personal identity.

In this regard, refusal to take on the identity of "addict" has been viewed as therapeutic for *some* drug and alcohol involved individuals. In in-depth interviews with drug and alcohol involved individuals who became sober *without* participating in formal treatment, Cloud and Granfield (1994) found that the vast majority refused to identify themselves as addicts or even as "recovering." Instead, participants were more likely to define their present selves in terms of familial and work-related roles. Similarly, McIntosh and McKeganey (2000; 2001) have argued that the process of recovery is buttressed by the individual's ability to construct a *non-addict* identity for him or herself. McIntosh and McKeganey (2001) propose that identity reconstruction takes place within the person's narrative of recovery and involves the differentiation of the individual's sense of self before drugs became a central part of his or her life, the individual's sense of the person he or she had become as a result of their drug use, and the individual's sense of the person he or she aspires to be. Within the context of these remarks, this research examined the construction and reconstruction of personal identities through the narratives of individual women as they participated in the processes of substance abuse treatment.

Drug-Involved Women and Identity Construction

Borrowing Walters' (1996) definition, the present study treated identity construction as a process that evolves from an ongoing interaction between the individual

and her social environment. Walters (1996) has argued that identity development results from a continuous process that rests on the availability of “identity materials” with which a new identity can be constructed, or an old identity resurrected. Identity materials may consist of social events, relationships, contexts, social positionings, and material practices. For example, in a study of members of Alcoholics Anonymous, Cain (1991) suggested that participants develop a scheme for identity transformation through the telling of personal stories that follow the AA model. She argues that the AA story is a learned, cultural tool that acts to mediate self-understanding for newcomers acquiring the alcoholic identity. In this way, the stories come to guide the members’ present actions and self-understanding, as well as their interpretations of their past behavior. Similarly, Baker (2000) found that women in residential substance abuse treatment did not consistently identify themselves as addicts until they had repeatedly heard the storied accounts of other addicts. In fact, these women gave patterned accounts of *discovering* their addiction and the consequences of that addiction only after they were participating in treatment. Interestingly, construing oneself as a “good” mother also became an important part of the identity that participants in this study constructed in treatment.

Perhaps one of the most salient identities for women in this and many other societies is that of “mother.” In fact, Neuhouser (1998) has argued that in a context of extreme poverty, “mother” is the primary, and often the only, positive identity available to women. Motherhood is an important and highly visible indicator of gender identity. It is widely recognized as an extremely valued role in society, conferring adult status and positive self-image (Edmonds, 2000). One qualitative study of learning disabled women served to highlight extremely well the central role that motherhood can play in identity

construction. In-depth interviews with a group of learning disabled women revealed several key themes, including the importance of the role of mother to the participants, as well as the experience of constant threats to this valued identity, through suggestions of inability and inadequacy from non-learning-disabled others. It appeared that for these women, having an identity as a mother served as an alternative to the enforced primary identity of being learning disabled (Edmonds, 2000), and in this way provided an opportunity to negotiate and resist a devalued personal identity. Similarly, Pursley-Crotteau and Stern's (1996) interviews with pregnant crack-cocaine users in substance abuse treatment delineated the women's struggle to negotiate the development of a valued maternal identity while the treatment program enforced an addict identity. In many instances the women failed to understand these identities as compatible, leading them to contest one of the possibilities for development.

Because of the way in which female identity has become closely associated with women's roles as mothers, and because of the strong social expectations surrounding women's responsibilities as mothers, the designation of 'bad mother' is likely to carry with it not only social stigma, but also a profound threat to the identity of women so labeled (Croghan & Miell, 1998). In fact, substance-abusing mothers have frequently been stigmatized, labeled as unfit, and targeted for disapproval due to their failure to meet cultural standards for mothering (Baker & Carson, 1999). Nevertheless, research with substance abusing women has shown that they are similar to women in general in placing a high value on motherhood, and frequently describe the importance of love between mothers and their children (Sterk, 1999). Despite these intentions, however, there is an ongoing conflict between their roles as mothers and as drug users. Many spend time

hustling to support their habits, and consequently spend more and more time away from their children (Sterk, 1999). Kearney and colleagues (1994) studied the parental attitudes and behaviors of drug dependent mothers finding that women felt a strong responsibility toward their children and were quite proud of them. Studying how these mothers tried, unsuccessfully, to balance their drug use with their parenting responsibilities, they found that "the basic problem crack cocaine presented to mothers was its drain on their attentiveness, their financial resources and their efforts to be appropriate role models for their children" (1994:354).

By providing women with opportunities to develop a coherent discourse on parenting and opportunities to engage in the practices of mothering, residential substance abuse treatment programs for women and their children may afford the construction of a valued, forward-looking maternal identity for drug-involved women. Whether and how individuals actively negotiate this and other identity possibilities within the context of institutional treatment demands for an "addicted self" is a particular interest of this study. Examining the processes through which identities are negotiated, accepted, and resisted may elucidate the implications of social and institutional discourses and practices for identity development, and the ways that individuals labeled with socially problematic personal identities, such as 'drug user,' can actively transform and construct novel personal identities within these institutional contexts.

Theoretical Perspective

Consistent with Kingfisher (1996), identity in this study is viewed as the product of a particular intersection of cultural norms, structural influences and personal

experiences lived by individuals. From this perspective, identities are not constructed independently of societal constraints, material practices, physical and social environments, and biological functioning, but neither are people's identities determined completely by their position in these locations (Neuhouser, 1998). Individuals can therefore be seen to remain agents because they can adopt or resist social and institutional forces in new ways or in new situations. The adoption and resistance of identities can be influenced by the salience of a particular identity in a certain context and the reinforcement of this identity by social others. In this way, identity as a personal phenomenon is nevertheless fundamentally social -- linked to both structural location and social interaction. Beyond this, the study of identity transformation can buttress our understanding of the ways that individuals in context actively negotiate their interaction and participation with social and structural processes.

Theorists and scholars working in the traditions of sociology and social psychology have long argued for a conceptualization of identity based less on individualistic notions, and more on social processes. The work of G.H. Mead presented a distinctly social theory of the self that has served as a foundation for both symbolic interactionist and structuralist accounts of self and identity (Mead, 1934). Mead possessed a vision of self as arising through complex processes of social interactions and role-taking, mediated by shared language structures, meanings, and coordinated activity. For Mead, the solution to the fundamental problem of emerging selfhood lay in the explication of the processes through which an individual becomes an object to himself, which occurs only by taking the attitudes of other individuals toward himself within a shared social environment or context of activity in which self and other are participants.

Although his seminal work clearly implicated a socially situated self, its subsequent application has engendered considerable debate among those adhering to different schools of thought. As a result, scholarly efforts to represent self and identity processes are typically divided by the privileging of either human agency or social structure.

In this regard, Holland (1997) suggests that the opposition between universal and cultural perspectives was the guiding force driving work on the self through the early 1970s. For those who espouse a view of the self as natural and essential, culture is seen as subordinate to the universal properties of human psychology. The self is conceived as comprising natural, species-given structures. In this view, the self possesses an invariant structure, much as the heart or the liver (Holland, 1997). In this tradition, the self is often seen as a cognitive construction (Harter, 1998). The self functions as an organizing system that allows individuals to make meaning of their transactions with the environment, and development is conceptualized in terms of changes in the structure of the self system that allow self-representations to be reorganized conceptually. Cognitive development impacts the self-structure by affecting the level of differentiation and integration that the individual can impart to his or her self-theory (Harter, 1998). With regard to differentiation, emerging cognitive abilities allow the individual to create self-evaluations that differ across various domains of experience. With regard to integration, emerging cognitive abilities allow the individual to construct higher order generalizations about the self in the form of trait labels. In other words, the cognitive perspective focuses on the impact of developing cognitive abilities to impact the self as an object of knowledge (Harter, 1998).

Countervailing sociocultural positions have challenged the notion of the self as entity, developed by an individual's growing cognitive ability (Holland, 1997; Stetsenko and Arieivitch, 1997). Sociocultural perspectives view culturally specific concepts, self-discourses and practices as constituting the self. As such, culture is regarded as a constituent of emerging psychological processes. In this regard, Danziger (1997) has suggested that all phenomena studied by psychology, including the self, are not natural, but historically constituted objects. The self's features cannot be independent of historically changing ways of describing and relating to it.

One interesting approach to the social construction of self has been the analysis of discourse. The view that psychological phenomena, including the self, are created in social discourse fundamentally challenges the essentialist notion of self. In fact, early radical interpretations of this perspective suggested that our language of self is wholly dictated by social forces, that self-knowledge is little more than a mastery of discourse or a simple by-product of people's attempts to relate through discourse (Gergen, 1994; 1997). Many scholars subsequently critiqued this early work for essentially reducing development to the mastery of language and communication (Stetsenko & Arieivitch, 1997; Wertsch, 2000) and failing to recognize the active role of the individual in the development of self and identity. Contemporary discourse approaches are far more complex, casting discourse as a social practice that cannot be understood independently of the social positioning of individuals (Willig, 1999), yet also viewing individuals as agents in their own development. This approach is compatible with socioculturally grounded activity perspectives, which emphasize the role of human activity in the development of the individual (Stetsenko & Arieivitch, 1997).

The present study adopts and blends activity and discourse-based approaches to examine the development of personal identity among women in drug abuse treatment. This study treats self and identity as thoroughly socially situated, yet at the same time, attempts to explore the role of individuals as agents, actively participating in the construction of personal identities. This approach is consistent with emerging theoretical frameworks that emphasize the role of both collective sociocultural and individual psychological processes in any coherent account regarding the self (Jenkins, 2001; Martin & Sugarman, 2001b; Valsiner, 2002; Stetsenko & Arieviditch, 2004). The guiding idea of such an approach is to avoid reductionist tendencies, which depending on the perspective adopted, all but eliminate the individual or sociocultural contributions to the construction of self and identity (see Stetsenko & Arieviditch, 1997).

Theorizing the development of self and identity as an interplay of sociocultural and psychological processes necessitates a conception of human agency that coheres with this approach. There is considerable debate in the literature regarding the individual and sociocultural foundations of human agency (Jenkins, 2001; Ratner, 2000). Although many argue for the privileging of either the individual or the social, there are some who suggest that intra-psychological and inter-psychological processes are equally critical for development (see Valsiner, 2002). From this perspective, self-making involves individuals taking up aspects of the world that pre-exist them, but also transforming this material in the ongoing construction of personal identity (Lawrence & Valsiner, 1993). The difficulty here lies in understanding agency not as a purely individual attribute, but as socially situated. Traditional thinking has tended to characterize agency as a process in which the individual debates his or her commitments within a particular set of

circumstances, or a process of individual choice-making in which the person is free to disregard sociocultural material (Gover & Gavelek, 1996; Ratner, 2000). This approach tends to focus on agency as an isolated mental process, in effect dismissing the notion that agentic activity is always embedded in a sociocultural context.

This study adopts the position that human agency originates in the processes of social interaction and participation in community activity, but recognizes the importance of emergent individual psychological processes in the organization and extension of agency. Holland and colleagues' work is relevant here, particularly as they define human agency:

...the realized capacity of people to act upon their world, and not only to know about or give personal or intersubjective significance to it. That capacity is the power of people to act purposively and reflectively, in complex interrelationships with one another, to reiterate and remake the world in which they live... (1998:42).

In other words, there is a dialectic between the social practices that foster individual agency and the development of individual agency that ultimately has the capacity to go beyond the boundaries of these practices.

In this way, both identity and agency can be said to originate in social processes. Biernacki (1986) has suggested that identity is socially constituted, and argues that as people move from one identity situated in a particular set of relationships to another, a cumulative biographic image of self develops via interactions with others. As such, although individuals typically construe personal identity as based on a unique

combination of personality characteristics and life history items, the entirety of which does not apply to any other single person, others have asserted that even personal identities are replete with socially standardized anticipations and rules regarding the conduct of those occupying certain roles and the behaviors appropriate to particular situations (Becker, 1963; Goffman, 1963; Mead, 1934). Gergen (1971) also shared this view but discussed the phenomenon in terms of role-identification. Role identification occurs when an individual comes to see himself as actually possessing the attributes characterizing his or her role and tends to adopt role-consistent behavior for use in situations where the behavior is not strictly required. In short, the person comes to develop a role-based identity and uses this identity to guide his or her behavior in a wide variety of situations. Although the notion of role-identification is somewhat more simplistic theoretically than the other approaches mentioned in this discussion, it is presented here to demonstrate the wide-ranging support for the view that identity is socially situated.

As outlined in the thinking of these and other authors, identity can be seen as emergent in the interconnections between the individual, social and institutional. For Holland and her colleagues (1998), identity work also entails a merging of the intimate and public venues of social practice. In other words, individuals elaborate their identities on a personal level in the context of social and cultural affordances and constraints, but these identities are constantly worked and re-worked by active individuals in social interactions.

Because our interactions and participation in distinct social domains are constantly in flux, this leads to the idea that identities must be conceived not as fixed

entities, but as mutable process-oriented phenomena. The intertwining of individual, social and institutional constituents in the construction of personal identity suggests an opportunity to approach the study of identity from a community of practice perspective. The uniqueness of the present study lies precisely in the application of this approach to the understanding of identity construction among women entering substance abuse treatment with their children. The use of a community of practice framework allows a focus on the person, not in individual terms, but rather in terms of their changing participation in a network of relations in a particular community (Linehan & McCarthy, 2000). While considerable effort has been made to examine identity development in workplace and educational settings, little is known regarding the processes of identity construction in total institutional settings, such as residential substance abuse treatment. Understanding the capacity of persons to negotiate concepts of personal identity that either correspond to, or conflict with, institutional identity claims in organizations designed to exercise custodial and control functions could potentially inform the development of new approaches to substance abuse treatment.

A community of practice has been characterized by Wenger (1998) as consisting of three primary processes: mutual engagement (people are engaged in actions with one another); joint enterprise (a collective process of negotiation defined by the participants in the process of pursuing it); and, shared repertoire (the joint engagement in situated practices creates shared resources for negotiating meaning, including words, tools, routines, ways of doing things, ways of speaking, stories, gestures, symbols, actions, and discourses). It is therefore the engagement in practices that affords the experience of participation in a particular community, and it is, in turn, what these communities

emphasize and value that reifies individuals as participants. In other words, the experience of identity has its basis in participation in the practices constituting a particular community. Or, as Wenger has so eloquently expressed:

When we come into contact with new practices, we venture into unfamiliar territory. The boundaries of our communities manifest as a lack of competence... We do not know quite how to engage with others. We do not understand the subtleties of the enterprise as the community has defined it. We lack the shared references that participants use. Our non-membership shapes our identities through our confrontation with the unfamiliar (1998:153).

As such, both participation and non-participation in a community of practice can be seen as acting to shape an individual's experience of identity. Or, as Linehan and McCarthy (2000) have noted, identities are created through engaging in practices, but are also defined through practices that are not engaged in. Put another way, actively participating in the practices of a social community and constructing an identity in relation to this community is but one way of engaging in identity work. Equally important are situations of non-participation in which there is resistance to community activities and a rejection of the identity connected with the community of practice. Again, practices can be both explicit and tacit, but must involve aspects of the social and institutional context that structure activities and endow them with particular meanings.

Of particular relevance to the proposed research, Linehan and McCarthy (2000) have emphasized the need for a dialectical approach to understanding self within a community of practice. Clearly, communities constrain the identity possibilities made

salient to members, and yet these possibilities are also influenced by participants' personal histories, previous experiences, and the unique understandings of community practices to which members attach meaning. Packer and Goicoechea (2000) support this approach, suggesting that learning and developing within a community involves participants taking active stances on the culture of the community. Rather than treating identity simply as self-concept, they attend to the dynamic character of identity and its intimate connections to participation and learning in a community. This approach recognizes that people have the potential to participate in communities in many different ways – some by adopting mainstream standards and values, some by rejecting them (Gover, 1999; Packer & Goicoechea, 2000). Regardless, individuals develop identities in which they relate to the prevailing standards in a complex variety of ways, but this does not make the community irrelevant to the construction and reconstruction of identity. Individuals develop and learn as members of communities – communities that define what is valuable, what can be done, and how (Martin & Sugarman, 1997; 2000). This point is particularly critical when studying individuals participating in total institutions (Goffman, 1961;1963). Goffman proposes that participation in a total institution requires that members take institutional claims regarding their identities as a referent from which to construct and present images of self. Regardless of whether individuals accept, reject, or modify the claims organizations make with respect to their identities, the claims themselves are salient for self-making. In other words, the processes of personal identity construction within such settings must be constituted at some level by social, organizational, and institutional structures.

Martin & Sugarman (2001b) extend and re-focus the notion of identity development within particular communities from an emergent, developmental perspective. In this regard, they suggest that reflective human agents can become aware of how they are classified within communities, can experience themselves in different ways as a consequence of these classifications, and importantly, can act in ways that affect their situations. This line of thinking clearly extends critical importance to sociocultural participation, while recognizing the reality of an individual's subjective experience. How then is it possible for an inquiry of the self to attend to both poles of this continuum? Penuel and Wertsch (1995) argue that studying activities or psychological processes as they undergo qualitative transformation is central to a truly developmental approach. In this regard, opportunities for studying the development of self and identity are substantial as individuals enter into new social communities. Studying identity development within social movement organizations, community support groups, or substance abuse treatment programs has the potential to provide insight into the ways that individuals in communities make meaning of novel discourses and practices in order to construct different ways of speaking about themselves and to develop new forms of action (Gover & Gavelek, 1996; Penuel & Wertsch, 1995).

Importantly, these accounts of learning and developing within communities have begun to center on shared activity as a critical process for connecting social contexts with psychological development (Packer & Goicoechea, 2000; Stetsenko & Arieivitch, 2004). Psychologists have traditionally failed to focus on activity, on what people are doing, and how, in the course of these practices, they construct psychological realities (Potter, 2000; Potter & Edwards, 1999). Stetsenko and Arieivitch (1997), however, have argued that

human activity must be the focus of analysis if an understanding of self-processes is to be achieved. In a detailed analysis, they propose that shared social activity is a necessary starting point in the person's gradual appropriation of new knowledge and skills, but suggest that it is the process of subjectivization of a new activity by the person that creates the capacity for human action. In other words, human subjectivity emerges from participation and engagement in dynamic processes of activity, and it is this process that ultimately allows the individual to act upon her world (see Stetsenko & Arieivitch, 2004).

The guiding metaphor that emerges here is the self as an instrument of change (Stetsenko & Arieivitch, 2004). Martin and Sugarman (2001a) support this idea, arguing that the self is most usefully conceived as a particular kind of understanding that discloses and extends a person's relation to and activity in the world. Fundamentally then, the self can be thought of a mechanism through which the individual negotiates activity in the world. People are active in their efforts to understand and engage with the practices of their community, they adopt active stances on the ways they are positioned in a community, and they express this activity by speaking and acting from a commitment to certain goals and ideals (Martin & Sugarman, 2001a; Stetsenko & Arieivitch, 2004).

Conceptualizing the self not as a set of traits or contents, but as a process of reflective, interpretive understanding and interacting with the world, provides a framework to situate the present study of self and identity. Although the concept of the self is a pivotal one for much of contemporary psychology, and talk of self and identity features prominently in professional discourse and practice, there is no agreed upon definition of the self accepted widely by the field (Ashmore, Deaux & McLaughlin-Volpe, 2004; O'Connor & Hallam, 2000). While social identity theories emphasizing

the centrality of social group membership for self have been widely elaborated in the discipline of social psychology (Tajfel, 1978; 1981; Turner et al. 1987), these approaches are fundamentally unconcerned with development, and the processes by which salient personal identities are constructed.

This study views personal identity as continually emerging in the processes of negotiated participation by individuals in a community -- never fully developed, but always developing. It acknowledges the fundamental social penetration of personal identity (Deaux, 1996), while examining the active and creative transformations that individuals bring to bear on social material. Within a community of practice, much of the active work of psychological persons involves attempts by members to penetrate the assumptions, conventions and meanings implicit in the contexts and practices of which they are a part. Although the community defines the modes of appropriation and the kinds of relationships and activities in which recognition can be achieved, human agents push the boundaries of the identities conferred by a community of practice (Martin & Sugarman, 2001a; Packer & Goicoechea, 2000).

Within a residential substance abuse treatment community, many aspects of the program make potentially salient claims on women's personal identities and arguably structure women's experiences in treatment to a great degree. These may include the overarching organizational system of the program and the treatment philosophy, the background, training and beliefs of the treatment staff, formal and informal interactions with other residents, treatment groups, parenting groups, treatment components, handbooks and treatment manuals, program rules and regulations, daily routines, the structure of reward and punishment within the institution, the prevailing metaphors in

program materials and discourse, as well as the social positioning of treatment clients within the program (Harré & van Langenhove, 1999; Linehan & McCarthy, 2000; Willig, 1999). As such, the treatment community can be usefully understood as a “figured world,” that is, a socially constructed location that recognizes particular actors, assigns meaning to particular acts, and values particular outcomes over others (Holland et al. 1998). Within such a context, the treatment institution operates as an official authority, defining the nature and scope of the task at hand as well as the recognized modes of participation in the system of activity. In this capacity, the discourses and practices sanctioned by the institution become authoritative, that is, they are imbued with power to structure the very enterprise of treatment. The ultimate aim of this study is to explore the active processes of identity construction among women within the context of this highly circumscribed figured world. By examining women’s negotiated participation in the treatment process, the present study attempted to explore several key research questions, including:

- In the figured world of treatment, how are women positioned by authoritative institutional discourses surrounding addiction as a disease? In what ways do women accept and/or resist the construction of self-as-addict?
- How do the practices of personal storytelling (autobiography, “sharing”, self-talk) mediate the construction of the addict identity?
- Over time, how does women’s discourse surrounding self-as-addict change? Is there movement from reproduction to personal transformation of institutional discourse? Is there a discernible

developmental process from labeling toward constructing new interpretive frameworks?

- Are the processes of identity negotiation related to self-as-addict different for women who are seeking primary care-taking responsibility for their children than for women who are not? What alternative identity possibilities are considered?
- How does the primacy of the addict identity in the figured world of treatment constrain or facilitate the development of women's personal agency?

This qualitative study of women in substance abuse treatment examined the ongoing, actively negotiated processes of identity development in individual women and their relationship to full, partial or non-participation in the practices of treatment. Within contexts of power, such as substance abuse treatment settings, authoritative discourses and practices afford particular positions to individual members who actively negotiate identities in response to these claims (Holland et al. 1998). This study is fundamentally concerned with understanding the processes by which women initiated the construction of positional identities within the activity system of substance abuse treatment, and the trajectories along which these identities were personally and meaningfully transformed. Borrowing the term "trajectory" from Lave, Wenger, Holland and others, it is used to denote **not** a fixed path toward predetermined outcomes, but an "ongoing flow of reflective moments organized around changing participation in a figured world." In this way, identities develop simultaneously with social participation, as possibilities for

personhood are discarded, maintained or transformed, but always evaluated in relation to the activity system that imbues these possibilities with meaning.

In this regard, a useful framework for the analysis of these identity possibilities has been presented by Wenger (1998). He suggests that as individuals move through a succession of forms of participation, their identities form trajectories. In this sense, identity is constantly negotiated and re-negotiated throughout a person's life. In the context of communities of practice, Wenger has discerned various types of identity trajectories that are useful in the present study, as they correspond in meaningful ways to the processes of identity construction among women in substance abuse treatment:

- Peripheral trajectories - secondary members of a community who do not become full participants, but engagement in community practices still contribute to identity;
- Inbound trajectories - newcomers to a community, identities are vested in future participation;
- Insider trajectories - full membership in a community, identity is re-negotiated to meet new demands;
- Boundary trajectories - members who span the boundaries of and link diverse communities of practice, identity demands from multiple communities; and,
- Outbound trajectories - members who are exiting a particular community, identity work involves seeing oneself in a different way and finding a different position with respect to the community.

In an ideal scenario participation is initially peripheral, but over time the person gradually increases in engagement and complexity with the practices of the community, and moves toward full participation (Lave & Wenger, 1991; Linehan & McCarthy, 2001; Wenger, 1998). As such, learning within communities of practice involves the construction of personal identities that are meaningful within the boundaries of the community. However, there must also be recognition in any analysis that negotiating an identity in a community of practice involves moments of participation, non-participation and interaction (Linehan & McCarthy, 2000). In other words, participants' understanding of community practices can provide a sense of what they "should" do and who they "should" be, yet resistance to these demands is also a very real phenomenon. Non-participation as a dominant activity may lead to marginalization by the community rather than full membership. As such, this study emphasized both processes of engagement *and* non-engagement with the community of practice as women negotiated their identities in substance abuse treatment. In short, a coherent account of identity development must include aspects of social positioning and participation, but must also recognize the ability of people to act agentially as participants in their own development.

Hermans has proposed the notion of the dialogical self as a way to conceptualize these dynamic relations between collective and personal processes of self and identity construction (Hermans, 1999; 2001a; 2001b; 2002). His theorizing rooted in both American psychological and Russian literary traditions, he envisions the self as inhabited by multiple "I-positions." It is the active processes of dialogue between these positions that organizes and comprises the experience of self. According to Hermans, these "I-

positions” are not simply copies of social material, but are active constructions and reconstructions by individuals in the course of development. By theorizing the psychological experience of an individual as a dialogue between multiple voices, he approaches an understanding of the self as a type of interpersonal relationship. Individual speakers here are seen to talk not only as individuals, but in the voices of groups, communities and institutions as well (Hermans, 2002). In this way, individuals may manifest multiple social and personal positions in their self-talk.

The multivoicedness and dialogicality of the self can be addressed by studying the content and organization of an individual’s valuation system (Hermans, 1999). Valuation refers to the active process of giving positive or negative value or meaning to the events in one’s life (Hermans, 2001a). The guiding idea is that a person is able to phrase different self-narratives and formulate different valuations from different “I-positions”.

Hermans typically elicits valuations using open-ended questions inviting participants to talk about important events or circumstances in their past, present, and future. Valuation can refer to anything the person finds to be of importance when talking about her life situation. When an individual is invited to tell her story from the perspective of different positions (in the proposed study, for example, “I as mother” or “I as treatment client”), Hermans theorizes that the speaker will formulate different valuation systems. In other words, an individual may tell different personal histories and evaluate these histories differently depending on the position from which it is told.

The personal position repertoire as a method of inquiry is proposed by Hermans as a way to study the organization and reorganization of a person’s active positioning with attention to the personal meanings that are associated with the different “I-positions”.

Linehan and McCarthy (2000) agree that participants' active engagement in discursive positioning reveals a unique process through which individuals are continually constructing themselves in relation to their community. In everyday life, social positions are typically combined with a particular set of personal positions. For example, a mother (social position) is seen as a good mother (personal position) if she is caring in relation to her children (Hermans, 2001a). Importantly, Hermans believes that by constructing a position repertoire, and bringing salient positions into connection with daily activities, human agents are actively negotiating and re-negotiating their identities.

This point is a crucial one for the present study, given that the methodological approach concentrated on explicating the connections between women's discursive positionings and their participation in the socially shared activity of the treatment community. Drawing on research in a variety of traditions including oral history, discourse analysis, and feminist psychology, the analytic process focused on interpreting women's narratives, in terms of the content and texture of the language they used, as well as the meaning they made of their own experiences. Feminist scholars have suggested that narratives serve as mediators between individual action and social conditions, and as such, they can be usefully interpreted as ongoing negotiations of the self in a specific social context (Morawski, 1997). Going further, Brown (1997) asserts that the impact of social and material location on individual subjectivities requires in-depth qualitative analysis of the language and forms of discourse by people in context. This focus on context also entails that attention be given to the structure of the interview situation itself, and the active role of the interviewer in the production of the narrative (Morawski, 2000).

Many feminist approaches to narrative interpretation and analysis trace their emphasis on discourse and context to the work of Bakhtin. The notion of discourse as inherently interactive and ideologically-infused is a critical thread of Bakhtin's thinking that has been woven into much of contemporary critical feminist scholarship. Discourses are multiple and social in that they can be considered enactments of particular worldviews, some of which are privileged or authoritative, relative to others (Morris, 1994). Following the Bakhtinian argument, it is the transformation of social discourses and into internally persuasive speech that is of critical significance in individual development. Locating women in a milieu of multiple social discourses implies that their narrative texts must be seen not as products of an exclusively private internal domain, but as reflections and evaluations that use categories and concepts derived from a particular social context. In this way, women's narratives can be read as ongoing negotiations of identity as they continually evaluate and re-evaluate themselves in relation to their changing participation in the substance abuse treatment community.

CHAPTER 2
RESEARCH METHODS

Study Plan

This study is fundamentally concerned with the relations between individual development, social participation, and institutional organization. In particular, it asked how engagement and non-engagement with community discourses and practices affected the construction of personal identity among substance abusing women in treatment with their children. Exploring this question required the use of two methods of data collection - in-depth interviewing supplemented by qualitative field observations. Combining the two approaches offered the opportunity to explicate the social and institutional forces that penetrated the personal narrative accounts of the participants, while maintaining a focus on the active work of individual women in making meaning of such forces, as they transformed and integrated them into their personal identity constructions. As such, the study relied heavily on women's interpretive accounts of their everyday lives, as well as observation of treatment practices, reading of institutional documents, the collection of field notes, and informal conversations with treatment staff.

Life history interviews are often regarded as the central method for gaining an understanding of an individual's identity (Plummer, 1990; Denzin, 1989). The life history interviews in the present study were intended to explore how participants organized and interpreted their experiences within and outside of the institution, and to read the connections between such experiences and women's identity development. In order to examine the processes of identity construction among substance abusing women, interviews were conducted with the following: Twelve women in treatment for substance abuse who were residing with their children in a specialized program; nine women in a

“women only” treatment program without their children; and, twelve women substance abusers with children who were not currently participating in substance abuse treatment. The inclusion of women from the “women only” treatment program, as well as women out of treatment was envisioned as a way to contextualize the processes of identity construction among women who were in treatment with their children. Rather than functioning as control groups in the traditional sense, the narratives of these women functioned as material from “cultural insiders” that informed my understanding of the activities and experiences of drug-involved women in differing circumstances. In addition, the comparison of these narratives served to highlight the unique aspects of identity construction as they took place in a specialized women and children’s treatment program.

It is important to recognize and attend to the context in which the women offered their personal stories to me, these private interviews with an “outsider” likely distinct from their everyday treatment experiences in innumerable ways. Although most interviews took place inside the walls of the treatment community, the process was intended as a collaborative enterprise, in contrast to the evaluatory focus of typical treatment interactions with staff. I presented myself as a student and learner interested in women’s issues, and hoped to engage women in a dialogue as equal participants. In this regard, it was anticipated that women’s talk of self in this somewhat unique, less routinized social situation would provide the opportunity to observe the penetration of women’s personal identity narratives by addiction-related discourses and practices in a context where such talk was not mandated.

The interview process served as a tool for understanding the development of identity from the perspective of the women participating in the research. Few research efforts have placed the voices of marginalized individuals at the center of the analysis (Baker, 2000; Peterson-Badali, Ruck, and Koegl, 2001). Attempts were made to interview each woman on two occasions, with initial interviews lasting between sixty and ninety minutes. For both treatment groups, the first interview occurred early in each woman's treatment experience, typically within four weeks after admission into the program. The second interview occurred two to three months later, after substantial exposure to primary treatment in the women and children's program, and typically after completion of the "women only" program. Interviews with the out of treatment group occurred on the same timetable, but coincided with women's entry into an HIV outreach and prevention program, rather than substance abuse treatment.

The interviews were conducted as "guided conversations" that maximized the ability of participants to organize their experiences and insights in the ways they found most salient (Lofland & Lofland, 1995). These semi-structured, in-depth interviews were organized by an interview guide, containing broad questions about key topical areas: the women's experiences of residency in substance abuse treatment (if applicable), history of drug use, previous treatment experiences, experiences of mothering, views of addiction, and views of self in the past, present and future. Rather than a strict interview schedule, the interview guide was viewed as a loosely structured mechanism for eliciting narratives to be organized primarily by the study participants. By beginning the interviews with general, loosely-defined questions, the participants were given the initial opportunity to direct the interview to topics they felt were most salient. In addition, it was expected that

by providing the participants with a space to speak from different positions (treatment client, mother, drug user), the active processes of constructing and re-constructing identity possibilities would emerge. The goal of the longitudinal study design was to understand the ways that women with no or minimal treatment contact initially viewed themselves, and to trace the development of their identities through their participation, or lack of participation, in substance abuse treatment programming with their children.

Study Setting

Both treatment samples were drawn from "The Village," the first residential drug abuse treatment program licensed by the State of Florida (1973), which today is the largest provider of drug abuse treatment services in the state. Located just north of downtown, the Village serves clients primarily from Miami's most economically depressed, high-crime, inner city neighborhoods. The institutional philosophy of the Village is one which views substance abuse as a chronic, complex bio-psycho-social disease, and espouses a treatment approach consisting of comprehensive therapeutic interventions directed toward health, substance abuse, education and social services. The treatment programs are abstinence-based and utilize the 12-step programs of Alcoholics Anonymous, Narcotics Anonymous, and other self-help groups, in conjunction with individual and group counseling and peer support.

The Village operates several substance abuse treatment programs in South Florida for adults and adolescents, including the Families in Transition (FIT) program - a 24-hour residential substance abuse treatment program for women and their children under twelve years of age, and a "women only" Primary Addiction Treatment facility. The various

treatment programs are housed within a compound of twenty-three buildings, covering approximately two square blocks. At any given time, there are nearly fifty women in various phases of the Families in Transition program with their children, and the typical length of stay in primary treatment is approximately six months. The “women only” program is smaller in size and shorter-term, with an average stay of ninety days in the program.

Although the treatment programs are co-located in one sizeable facility, each is assigned separate residential space and treatment staff, and participates in separate therapy groups. Nevertheless, there is significant overlap in programmatic structure and treatment philosophy given the common institutional administration of these programs. There are five general phases of treatment in all of the Village programs, though they may vary in length: Phase 1 (Orientation/retention) - the new resident undergoes extensive medical and psycho-social evaluations, is educated in programmatic communication skills and programmatic rules, and is introduced to the treatment environment; Phase 2 (Primary Treatment) - resident undergoes intensive individual, group and family therapy, participates in 12-step meetings, vocational counseling, and extensive education regarding the nature of addiction; Phase 3 (Re-entry) - resident focuses on building interpersonal and social relationships, goal-setting and planning; Phase 4 (Re-integration) - resident focuses on relapse prevention, obtaining employment and continuing intensive case management; and, Phase 5 (Continuing care) - resident participates in continuing long-term treatment on a non-residential basis as needed. The present research focused on the processes of identity construction among women as they entered and exited the primary treatment phase of the women and children’s program, while for those in the

“women only” program, interviews occurred early in the primary treatment process, and again at program completion (or drop-out).

The out of treatment women were drawn from participants in the “Women Protecting Women” program, a federally-funded HIV/AIDS education program adjacent to the Village treatment facility. This program provides brief HIV/AIDS education, counseling and referrals, specifically for low-income, out of treatment, drug-involved women, and conducts multiple follow-up sessions with clients for some twelve months after enrollment.

Study Procedures

Institutional Review Board approval for the study was obtained from the Graduate School and University Center (see Appendix A for Informed Consent). Potential participants were informed about the opportunity to participate in a study of the life experiences of drug-involved women during my periodic visits to each of the programs. In order to facilitate the interview process, whenever possible these visits were made during periods designated for client “Free Time” so that interference with the treatment regimen was minimized. Participants were informed that participation in the study was voluntary and would not affect their status in the treatment program. The nature of the study was explained in detail and any questions participants had were answered at that time. Participants were asked to read the consent form and sign if they agreed to participate. I conducted the face-to-face interviews on an individual basis in private office space, and audio-recorded each interview for the purposes of transcription. In order to minimize risks to participants, no names or other identifying information were

used on the audiotapes. The initial interviews lasted between sixty and ninety minutes. (see Appendix B for a copy of the time 1 interview guide). Each participant received a small monetary stipend at the completion of the interview.

The ordering of the study procedures was identical for the interviews conducted with the out of treatment women. The out of treatment participants were accessed from the HIV prevention program for active women drug users described earlier. Private interviewing space was made available on-site. As in the treatment setting, I approached potential participants individually to explain the study in detail and secured the informed consent. All of the women approached both in and out of treatment agreed to participate in the study.

Two to three months later follow-up interviews were attempted with all participants. Informed consent and data collection procedures were identical to those at the first contact. The interview covered the same general areas, but with less emphasis on drug use and treatment history. The second interview focused instead on significant events occurring since the first interview, experiences in and out of treatment, and the participants' changing views of self since the first interview (see Appendix C for follow-up interview guide). The follow-up interview typically lasted between forty and sixty minutes.

In order to complement the in-depth interview data collected as the primary source of information in the present study, a number of alternative qualitative strategies were considered. The obstacles to implementation of parallel procedures for the women in treatment and the women out-of-treatment were considerable, given the vast differences in the mobility and living circumstances of these participants. While the circumstances

of the treatment setting afforded ample opportunities for observation of a limited scope of activities, the lack of confines for the out-of-treatment women constrained the logistical possibilities for systematic observation of specific individuals over the multitude of activities and situations in which they participated. As a result, the qualitative fieldwork in the women and children's program focused on bi-monthly observations of treatment groups and parenting groups, and review of relevant institutional documents. Qualitative field notes were composed after each observation period. Qualitative fieldwork with the out of treatment women entailed photographic data collection in order to understand the broader context in which these women constructed their identities. This photographic data collection (described in the *Afterword*) was expected to contextualize the identity narratives of women in treatment as well, by enhancing my understanding of the cultural worlds of drug-involved women.

Study Participants

Out of Treatment Group

Twelve women were interviewed outside of treatment in an outreach and prevention facility. They ranged in age from 20 to 49, with an average age of 37 years. They were an ethnically diverse group, 58.3% were African American, 25% Latina and 16.7% were white. Fifty percent had children age 10 or younger, and fifty percent had been in substance abuse treatment on a prior occasion. Follow-up interviews were conducted with 83% of the women.

“Women Only” Treatment Group

Nine women were interviewed in the “women only” treatment program. They were slightly older than the out of treatment group with an average age of 41 years, and more homogeneous in terms of race/ethnic identification with 89% identifying as African American. Two-thirds had prior treatment experience, and only one-third had children age 10 or younger. Follow-up interviews were conducted with 77.7% of the participants.

Women and Children’s Treatment Group

Twelve women were interviewed in the women and children’s substance abuse treatment program. Overall they were the youngest group, with a mean age of 32 years, and the most ethnically diverse: one third was African American, one third Latina and one third white. All had minor children, and three-quarters had children age 10 or younger. Two-thirds had previously participated in substance abuse treatment. Follow-up interviews were conducted with 83% of the women.

Data Analysis

Analysis of the qualitative data collected in this study emphasized exploration and explication of the interrelations between social participation, institutional discourse, and women’s personal identities. Drawing on research in a variety of traditions including oral history, discourse analysis, narrative psychology and feminist psychology, the core of the analytic process focused on interpreting women’s narratives, in terms of the content and texture of the language they used, as well as the meaning they made of their own

experiences. The goal of the qualitative approach employed in this research was to place the women's understandings of their experiences at the center of the analysis. This was accomplished through systematic analysis of repeated themes in the participants' talk, as well as the patterns of language used in their accounts.

The analysis of personal narratives often proceeds from many theoretical and methodological perspectives, with no single approach or practice predominating in the literature (Baumgartner, 2000; Daiute & Lightfoot, 2004; Lieblich, Tuval-Mashiach, & Zilber, 1998; Ochs & Capps, 1996; Richmond, 2002). Because narrative activity is viewed in this study as mediating an individual's interactions with a particular community, the analytic approach I employed was consistent with the view that narrative comprises a site to examine personal identities and their meanings in specific cultural worlds (Ochs & Capps, 1996). Narrative approaches offer unique opportunities to examine people's lives holistically, and emphasize recognition of the richness and complexity of personal stories (Alexander, 1988; Daiute and Lightfoot, 2004; Lieblich, Tuval-Mashiach, & Zilber, 1998). As such, my concerns throughout the analytic process were two-fold: that my approach would maintain fidelity to the voices of the women who shared their personal accounts with me, yet also provide a systematic and strategic focus to illuminate the core processes of identity development germane to the figured world of treatment. The selection and implementation of particular analytic strategies fundamentally guided and shaped the interpretive decisions that I made throughout this dissertation research, and are discussed in detail in the sections that follow.

The complexities of analyzing personal narratives, as well as my reading of the creative, unique, and intuitive interpretations of narrative material offered in the

published studies of individual researchers, crystallized my understanding that no single reading or interpretation of a text captures all possibilities contained therein. The dimensions and scope of one's analytic focus are clearly powerful determinants of any narrative interpretation, and are guided and justified according to the theoretical bases of the research. As such, narratives can be meaningfully analyzed along myriad dimensions including content, structure, style of speech, and a variety of linguistic and morpho-syntactic forms, depending on the questions one seeks to explore.

More broadly, narrative analysis typically proceeds along two axes: holistic versus categorical approaches, and content versus form approaches (Lieblich, Tuval-Mashiach, & Zilber, 1998). Holistic approaches tend to examine the person's story as a whole, with sections of the text interpreted in the context of other parts of the narrative, whereas categorical approaches often analyze narrative sections in isolation from the entire text. Similarly, content approaches focus on the participants, what is said, both explicitly and implicitly, and the meanings these words suggest. Other analyses focus more heavily on narrative forms, including the plot structure, sequencing and temporal elements, specific metaphors or words, and point of view.

In this dissertation I was fundamentally concerned with understanding the development of individual women's identities as they entered into a unique institutional setting and negotiated membership in the drug abuse treatment community. The approach to narrative analysis that I employed therefore centered on the person-in-community as the unit of analysis. I worked to ensure that the analysis maintained the integrity of the women's accounts by approaching the task of analysis holistically, using

the complete narrative of a particular woman as a referent, even when my analytic focus was directed to separate sections of subtext.

Four primary steps were taken to analyze the textual data elicited in the in-depth interviews. These included: 1) initial verbatim transcription and verification of interview audiotapes; 2) a series of four focused readings of these transcripts; 3) the construction and application of a detailed coding scheme based on analyses of the transcripts; and 4) the construction of an interpretive summary for each participant based on specific patterns of coding and a final reading of the full narrative.

Initial Transcription and Verification

Full transcription of the in-depth interviews was completed as soon as possible following each contact. The transcriptions were entered into standard word-processing files and verified against the audiotapes for accuracy. Five notebooks were compiled from paper copies of each transcript corresponding to each of the intended readings.

Focused Readings

I utilized a method of analysis in the present study based on Brown and Gilligan's (1992) "Listener's Guide." The Listener's Guide as a method entails at least four focused readings of each interview in order to understand who is speaking, from what worldview and in what framework, and what part the listener also plays. Although initially used by Gilligan and colleagues as a way of examining middle class women's sense of morality through connection and relationship with others, and girls loss of voice in adolescence (Brown and Gilligan, 1992; Gilligan, 1993), the Listener's Guide has also been used to

analyze narratives of those whose experience diverges from that of privileged, white, middle-class individuals (see Brown, 1997).

This method was adapted in the present study in order to understand the active processes of identity construction among women with children both in and out of drug abuse treatment, and to explore the primary questions guiding the present research. The analytic process that I engaged in involved examining the turns and patterns in a particular woman's narrative within and across the two interviews, always attending to how these turns corresponded to her changing location in the "figured world" of treatment. Because of this study's focus on understanding narrative in context, this series of readings was undertaken separately for each of the three participant groups (out-of-treatment, in "women only" treatment, in women and children's treatment) at each interview point. Through four focused readings of each transcript, I highlighted the following:

Reading 1: The focus of the initial reading was on the overall narrative in order to get a sense of the unfolding of events; recurrent themes and the way they related to each other; the connections women drew between events in their lives. After my first reading of each transcript, a number of general themes emerged from the women's narratives. These included: reasons for and consequences of drug use; traumatic childhood events; dangers and loss of dignity associated with street life (rape and other violent victimization, homelessness); arrest and incarceration histories; medical/health problems of self and children; loss of relationships with children connected to drug use; social isolation; positive and negative experiences with treatment; addiction and recovery; desire for change, fear of change; goals and future perspective. Salient themes at this point

remained isolated, and subsequent readings explored the connections between these issues.

Reading 2: In line with Brown's approach, the second reading focused on listening for "self" – who the participant believes she is and is not -- in order to understand how the participant locates herself in the story she tells and how she speaks of herself. The self as agent was also a focus here – listening for claims the participant made about whether and how she could act in the world. The second reading brought more specificity to women's personal location within the broad and wide-ranging primary themes identified in the initial reading. I read with particular interest women's discussion of the emerging possibilities for personal change and the meanings of such change within a particular community, as well as the emergent negotiations of personal identity in which women engaged. Consistent themes here clustered around the self as addict, self as mother, self as HIV-positive, self as treatment client, self as subject, self as participant, and self as changing.

Reading 3: The third reading shifted to a focus on institutional discourses and practices that women consistently emphasized in their personal narratives, and was intended to reveal the extent to which an individual narrator referenced and negotiated powerful social material. This reading emphasized women's talk about powerful discourses in the treatment setting (for example, "Addiction as Disease"), their reactions to these worldviews, and moments of accommodation and resistance to these authoritative voices.

Key themes that emerged from this reading included: diagnosis and labeling; medicalization of drug use as addiction; Twelve Step philosophy of change; treatment

program authority; evaluation; compliance; individual responsibility; and personal participation.

Reading 4: Tied to reading 3, the final reading focused on women's use of a "moral language." Berger-Gluck and Patai (1991), as well as Gilligan (1993), stress the importance of understanding a woman's moral self-evaluative statements as an intersection where self is judged in terms of social or institutional norms. Here, I also read for what Berger-Gluck and Patai (1991) refer to as "meta-statements": moments in the interview where women spontaneously stopped, looked back and commented on their own thoughts or assertions. They suggest that these statements can alert the listener to a woman's awareness of a discrepancy between what is expected and what is being said, and can inform us about the categories she uses to evaluate herself. The emergence of a moral language may represent a critical developmental transition for women, who by virtue of their participation in a socially-organized context, begin to transform institutional claims into moral voices by which they evaluate themselves. In essence this reading centered on women's personal application of institutional standards to the self, or the transformation of institutional discourse on addiction and recovery into personally meaningful activity. Themes of acceptance and resistance were critical here, as were descriptions of self-change related to Twelve Step participation, and self in relation to the treatment community. The intersection of recovery and mothering commitments emerged as a particularly salient theme for individuals in the women and children's treatment program. For women outside of treatment, this reading focused on salient sources of personally meaningful activity beyond the world of treatment. Themes that emerged from

the final reading formed the basis of the identity trajectory models described more fully in the sections below.

Coding Scheme

Following this series of readings, a coding scheme was constructed around salient or recurring themes and patterns in the women's narrative accounts of identity construction and/or transformation. The word-processing files were converted into files compatible with the qualitative software package N6, which is designed for the storage, coding, retrieval and analysis of text (Weitzman & Miles, 1995). Analyses of these interview data were based upon identifying categories of language, beliefs and practices relevant to understanding the identity possibilities of women inside and outside of drug abuse treatment. These categories were "operationalized" by key words or phrases that participants used in their own descriptions of self and identity. Each of the categories that emerged in the analyses was identified by a short code. The codes were then inserted into the file to identify appropriate textual passages.

Following the principles of grounded theory (Glaser & Strauss, 1967; Strauss, 1987; Locke, 1996), the development of the coding scheme was an inductive and iterative process, always placing the voices of the participants at the center of the analysis. The premise of this inductive approach is that systematic patterns and relationships among the concepts and themes identified by the participants will emerge, and that the methods of analysis employed must be sufficiently innovative and flexible in order to adjust to new directions that continue to evolve in the research process (Josselson & Lieblich, 2003).

In this regard, coding and analysis were co-occurring, mutually informative activities that proceeded in two ways:

- *Descriptive coding* was initially applied to interview transcripts, based on the series of focused readings described above. The open coding technique produced a series of coding nodes, both “free” and hierarchical, which reflected recurring patterns or themes in the data. These initial nodes were isolated in the sense that no systematic analysis initially linked these categories to one another.
- *Patterned coding* involved intense analysis around selected categories one category at a time. The purpose was to examine the relationships between that concept and other categories and subcategories. For example, during descriptive coding addiction clearly emerged as a recurring theme in the narratives of many women. Similarly, resistance to treatment authority was also revealed as a key theme. Patterned coding looked at the overlap or linkages of key themes so that analyses could explore how they were related to one another in greater detail.

This coding process continued until additional reading and analysis no longer added to the discovery of newly patterned categories or relationships between categories (a summary of the coding scheme appears in Appendix D).

Interpretive Summaries

Following the completion of systematic coding efforts, paper copies of the textual passages identified by descriptive and patterned codes were compiled for each participant. For each individual, a final reading of the coded passages and the full narrative was conducted consecutively, after which an interpretive summary was constructed. Based on the patterns of coding of the thematically identified text passages, and the overall context of the interview, the interpretive summary focused on the identification of systematic patterns and relationships within and across themes and time periods for each woman.

By attending to the entire narrative, and drawing on both observational and archival data from institutional documents, the interpretive summary extended beyond the identification of patterns and themes in the participants' talk. Consistent with discourse analysis, the present study posed questions about how women's talk was an ongoing negotiation of identity within the figured world of treatment, and how aspects of that world simultaneously gave meaning to their language (Gee, 1999). As such, key themes in the narratives were explored in terms of their situated meanings, given the overall context in which the data were collected. This analytic process involved relating the participants' talk to both the explicit and tacit social and institutional discourses, as well as the material practices, that constituted the activity system of treatment.

In this regard, a key interpretive decision in this dissertation analysis entailed focusing on the Twelve Step model of Narcotics Anonymous as the activity system in which women's personal narratives were explored. Because the treatment community explicitly evaluated its members according to "demonstration of the 12-steps," these activities were recognized as particularly salient and powerful components of the treatment experience. As such, the development of personal identity within this specific Twelve Step system became the focus of my interpretive work, and the interpretive summaries that were constructed for each participant.

Twelve Step literature and previous scholarly research provide a framework for understanding the Narcotics Anonymous model as a highly salient activity system for individuals with histories of drug involvement. Emerging as an outgrowth of the Alcoholics Anonymous (AA) program in the early 1950s and modeled on its traditions, Narcotics Anonymous (NA) is described by its own literature as a "nonprofit fellowship or society of men and women for whom drugs had become a major problem," and "whose lives are controlled by drugs" (Narcotics Anonymous World Services, 1991; 1983). In its message to "newcomers" the philosophy and path of recovery in NA is clearly delineated:

The only requirement for membership is the desire to stop using. You don't have to be clean when you get here, but after your first meeting we suggest that you keep coming back and come clean. You don't have to wait for an overdose or jail sentence to get help from NA, nor is addiction a hopeless condition from which there is no recovery. It is possible to overcome the desire to use drugs with the help of the Twelve Step

program of Narcotics Anonymous and the fellowship of recovering addicts. Addiction is a disease that can happen to anyone. Addiction is a progressive disease such as diabetes. We are allergic to drugs. Our ends are always the same: jails, institutions, or death. If life has become unmanageable and you want to live without it being necessary to use drugs, we have found a way (1991;).

Here are the Twelve Steps of Narcotics Anonymous that we use on a daily basis to help us overcome our disease:

- We admitted that we were powerless over our addiction, that our lives had become unmanageable.
- We came to believe that a Power greater than ourselves could restore us to sanity.
- We made a decision to turn our will and our lives over to the care of God as we understood Him.
- We made a searching and fearless moral inventory of ourselves.
- We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
- We were entirely ready to have God remove all these defects of character.
- We humbly asked Him to remove our shortcomings.
- We made a list of all persons we had harmed, and became willing to make amends to them all.
- We made direct amends to such people wherever possible, except when to do so would injure them or others.

- We continued to take personal inventory and when we were wrong promptly admitted it.
- We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
- Having had a spiritual awakening as a result of these steps, we tried to carry this message to addicts, and to practice these principles in all our affairs.

The NA credo is enacted through specific, highly ritualized practices. Although clearly rooted in a disease model of addiction, recovery in NA is a social, rather than medical process. The primary tool of the NA program is attendance and participation in group meetings, as support from fellow members is believed to be a key part of the recovery process. In such meetings, a topic may be selected upon which members are asked to speak. Meetings typically proceed with comments from various members who “tell their stories.” These stories involve describing past experiences with drug use, routes of entry into NA, and depending on the length of their membership, how their lives have changed as a result of Narcotics Anonymous. Essential to these personal stories is the sharing of personal progress and challenges to achieving and maintaining abstinence *through the application of the principles contained within the Twelve Steps of NA*. These principles are asserted to be the core of the Narcotics Anonymous recovery program, and include: admitting there is a problem; seeking help; engaging in a thorough self-examination; confidential self-disclosure; making amends for harm done; and helping other drug addicts who want to recover (Narcotics Anonymous World Services, 1983).

Although these are general guidelines, Cain (1991) suggested that the telling of personal stories in AA involves a process of learning, as these stories are patterned, cultural tools that act to mediate self-understanding for newcomers acquiring the alcoholic identity. The stories come to guide the members' present actions and self-understanding in specific ways that connect to the philosophy of the Twelve Steps. As such, these stories have typical structures and parameters that are considered appropriate (Hoffmann, 2003; McElrath, 1998) and are enforced by senior group members. More experienced members may exert social control over newcomers, correcting "errors" in story presentation should they stray outside the bounds of alcohol or drug use. Appropriate personal narratives typically begin with an explicit labeling of self as addict and reference to "clean time," as recognition of one's illness illustrates the first step in recovery. These are typically followed by disclosures of a downward spiral in one's life due to the tremendous personal consequences of drug use, and some measure of conversion to the NA way of life after "hitting bottom." The telling of personal stories typically invokes the specific language of the Twelve Steps, and is replete with references to powerlessness, humility, and spiritual guidance from one's Higher Power.

Consistent with this understanding of the NA process, I considered and interpreted women's personal narratives as ongoing identity negotiations within the highly circumscribed Twelve Step system. Key elements of women's personal narratives corresponded to what have been identified as key elements of the NA program: labeling the self-as-addict, participation in personal storytelling, and "conversion" or self-change related to program participation. As such, I viewed individual women's ongoing

negotiations of these core program elements as constituents of personal identity trajectories within the Twelve Step activity system.

Throughout this interpretive process, I maintained an approach that focused less on the particular or formal properties of language and more on the meaning women expressed and created through their words (Baumgartner, 2000). In this regard, I borrowed heavily from Alexander's psychobiographical approach to narrative analysis in which he identified several "indicators of salience" that suggest potential importance or meaning in personal stories (Alexander, 1988; Baumgartner, 2001; Courtenay, Merriam, & Reeves, 1998). The principal indicators of salience adopted in this study included: *emphasis* [concept is explicitly embraced]; *negation* [concept is explicitly denied]; *omission* [concept never mentioned]; *frequency* [how often a particular concept is mentioned] *connection/isolation* [concept permeates other domains]; and *consistency/inconsistency* [concept is alternatively emphasized and negated]. These indicators were applied to passages in women's narratives that focused on the core processes of NA (labeling the self-as-addict, participation in personal storytelling, and self-change related to program participation), and guided my decisions for interpreting the data in these particular subtexts of interest. The categories were defined as follows:

Self as Addict Label

Accepting was operationally defined according to the following criteria: **Frequency:** Explicit characterization of self as addict on at least one occasion; **Emphasis:** Addict identity emphasized as central to present and future on at least one occasion; and, **Negation:** no instances where this identity is negated.

Negotiating was operationally defined according to the following criteria: **Inconsistency of Negation and Emphasis:** at least one explicit inconsistency in narrative regarding self as addict; addict identity is negated in one instance and emphasized in at least one other yet there is **explicit recognition and processing** of inconsistency in the narrative.

Resisting was operationally defined according to the following criteria: **Inconsistency of Negation and Emphasis:** at least one explicit inconsistency in narrative regarding self as addict; addict identity is negated in one instance and emphasized in at least one other **without recognition or processing** of inconsistency in the narrative.

Rejecting was operationally defined according to the following criteria: **Omission:** Reference to self as addict completely omitted from narrative, or **Frequency:** explicit rejection of the addict identity on at least one occasion and no instance of **Negation** in any other part of the narrative.

Participation in Personal Storytelling

Active Engagement was operationally defined according to the following criteria: **Frequency:** explicit discussion of active personal participation in treatment groups on at least one occasion; **Emphasis:** explicit mention of participation as positive on at least one occasion; no instance of **Negation** in any other part of the narrative; **Connection:** mentions personal application of 12-steps on at least one occasion.

Negotiated Participation was operationally defined according to the following criteria:

Inconsistency of Negation and Emphasis: at least one explicit inconsistency in narrative regarding personal engagement/disengagement with treatment groups; explicit mention of attempts at positive participation on at least one occasion, yet value of participation is negated in another instance. There is **explicit recognition and processing** of inconsistency in the narrative.

Passive Compliance was operationally defined according to the following criteria:

Omission: Reference to active participation in treatment groups is completely omitted from narrative, or explicit de-valuing of such personal participation on at least one occasion and no instance of **Negation** in any other part of the narrative.

Self-Change – “ Conversion ”

Personal Transformation was operationally defined according to the following criteria:

Emphasis: explicit mention of positive self-change on at least one occasion;
Connection: explicitly describes self-change as connected to recovery activity on at least one occasion, no instance of **Negation** in any other part of the narrative.

Personal Inactivity was operationally defined according to the following criteria:

Omission: Reference to self-change connected to recovery activity is completely omitted from narrative, or **Negation:** explicit rejection of need for personal change as constituent of recovery.

The patterns and connections that arose in women's negotiations of these three specific aspects of the 12-step activity system were used to generate the "personal identity trajectory" paths of individual women that form the core findings of the present study. The term identity, rather than self, is used here to reinforce the notion that identity broadly encompasses an individual's goals and personal commitments, and guides action in accordance with these priorities. Because the treatment facilities explicitly and implicitly privileged the adoption of a 'recovery identity,' the analysis centered on these specific indicators of salience as they pertained to the Twelve Step system. The programs' authority to enforce this identity was not absolute, however, as the women's narratives evidenced uniquely negotiated combinations of this social material that yielded distinct directions of personal identity construction. Nevertheless, women's position within the treatment community constrained the possibilities for personal development. These identity possibilities are presented and defined below.

Personal Identity – Time 1

Recovery Identity was operationally defined according to the following criteria:

Emphasis: Recovery and activities for maintaining recovery identity explicitly emphasized as central to present and future on at least one occasion; **Negation:** no instances where the importance of this activity is negated; **Connection:** explicitly characterizes recovery activities as primary goal and links recovery to another commitment on at least one occasion.

Mother Identity was operationally defined according to the following criteria: **Emphasis:** Motherhood, children and activities related to mothering explicitly emphasized as central to present and future on at least one occasion; **Negation:** no instances where the importance of this activity is negated; **Isolation:** explicitly characterizes mothering activities as primary goal on at least one occasion; no connection of mothering and recovery.

No Identity Trajectory was operationally defined according to the following criteria:

Omission: no explicit reference to commitments, goals or future possibilities for the self; no reference to mothering or recovery activity, or any other domain of activity that guides transactions with the world.

Personal Identity – Time 2

Committed Recovery Identity was operationally defined according to the following criteria: **Emphasis:** Recovery and activities for maintaining recovery identity explicitly emphasized as central to present and future on at least one occasion; **Negation:** no instances where the importance of this activity is negated; **Connection:** explicitly characterizes recovery activities as primary goal and links recovery to another commitment on at least one occasion; **Consistency:** these criteria are met in both time 1 and time 2 interviews.

Recovery Identity Found was operationally defined according to the following criteria:

Emphasis: Recovery and activities for maintaining recovery identity explicitly

emphasized as central to present and future on at least one occasion; **Negation:** no instances where the importance of this activity is negated; **Connection:** explicitly characterizes recovery activities as primary goal and links recovery to another commitment on at least one occasion; **Inconsistency:** these criteria are **not** met at time 1 interview but are at time 2.

Recovery Identity Lost was operationally defined according to the following criteria:

Emphasis: Recovery and activities for maintaining recovery identity explicitly emphasized as central to present and future on at least one occasion; **Negation:** no instances where the importance of this activity is negated; **Connection:** explicitly characterizes recovery activities as primary goal and links recovery to another commitment on at least one occasion; **Inconsistency:** these criteria are met at time 1 interview, but **not** at time 2.

Mother Identity was operationally defined according to the following criteria: **Emphasis:**

Motherhood, children and activities related to mothering explicitly emphasized as central to present and future on at least one occasion; **Negation:** no instances where the importance of this activity is negated; **Isolation:** explicitly characterizes mothering activities as primary goal on at least one occasion; no connection of mothering and recovery; **Consistency:** these criteria are met in both time 1 and time 2 interviews.

No Identity Trajectory was operationally defined according to the following criteria:

Omission: no explicit reference to commitments, goals or future possibilities for the self;

no reference to mothering or recovery activity, or any other domain of activity that guides transactions with the world.

Specific passages from Lisette's narrative from the women and children's treatment program are presented below in order to illustrate the application of the interpretive model to the account of a particular individual, and the grounding of interpretive case summaries according to this same structure. I present and classify several significant utterances in Lisette's talk that relate to the activity system of NA detailed above, followed by a truncated interpretive summary generated from these patterns of coding, as well as the larger context of her narrative.

Self-as-Addict – Accepting

Indicators: Frequency, Emphasis, No instance of Negation

I have a very addictive personality.

All 3 of us were, my brother, my sister and I, we're all 3 from my dad and we're all drug addicts.

I feel that I need to be careful with a lot of things because I have an addictive personality.

I have always known that. And addiction is a disease that I am going to have with me for the rest of my life.

Participation in Personal Storytelling-- Active Engagement

Indicators: Frequency, Emphasis, Connection, No instance of Negation

I have been here 30 days and I have a court hearing next week. I got the program director, which is, seeing my progress, I attend all the groups, you know, I have initiative to do it this time.

I am not in denial anymore. I know what I need to do and I got, I am in the perfect place to do it. And I really thank God that he put this place, I wrote a letter to my program director yesterday, and I thank God everyday for putting me here because I want recovery.

I had been going to NA for years girl, and I had no idea what the 12 steps meant. Now I am actually sitting down listening to it, because I want it. I want it bad. I want to be a normal functioning human being, you know, so that's the way I feel here, that I am going to be able to get everything I need to so I can go out there. So now I am using my time to really focus and listen and let it sink in.

Self-Change—Personal Transformation

Indicators: Emphasis, Connection, No instance of Negation

I see lots of change in myself. I am more humble, I have acceptance, um, I am more anti-social. I was too social before. They say isolation is not good, but I speak to people, I am starting to share in group. I would get cold sweats when I would have to say my name and I'd stutter but now I am a little bit more comfortable. But um, basically now I see I'm sharing more, and taking care of responsibilities, which is a word I haven't heard in a long time.

Personal Identity Time 1-- Recovery Identity

Indicators: Emphasis, Connection, Consistency, No instance of Negation

The most important thing to me right now is recovery. Fear of being out there is why I want to focus so hard on recovery because I don't know how to be any other way but high. So I want to get this right. I set myself goals and that's my main goal.

I started, you know, reading more, I started spending some time in my room, you know, positive time, not isolating. I was reading books and doing assignments, and umm, I got a sponsor and she's giving me assignments, and umm, I'm moving along pretty well through, you know, I noticed that once I, I cut everybody off, and I started focusing on myself, I started enjoying myself and I started thinking positive things.

I'm thirty years old, I haven't raised none of my children, they need me, they love me, and I think it is selfish of me to continue living for me when I have other responsibilities. And I need to start taking care of my responsibilities.

Personal Identity Time 2 – Committed Recovery Identity

Indicators: Emphasis, Connection, Consistency, No instance of Negation

I have a different outlook than when I just got here. I actually thought that, cause I have two years probation, I actually thought that ah, when I finish all this stuff, it's only two years, I can smoke again, I can party again, you know. And um, I've been going to meetings, and I see what recovery has done for other people. And I want that, you know,

so, everything I do, I do so I can stay clean another day. Umm, everything I think about, I try and be a better person, you know. I try not to lie, I try not to deceive, I, I, I try and do everything I need to do, you know. I'm tryin' to do everything I did not do before. Whatever I did back then, I'm doing the complete opposite, you know. Umm, I'm learning how to be a normal human being, I have been using drugs for eighteen years, you know, and umm, I'm practically like halfway through this program, you know, and umm, I feel a lot of accomplishments within me.

I analyze things today, and I see things a little bit more clearly. I have to rebuild my whole life. As if I was born yesterday, but I was born at thirty. I have to learn how to do things without drugging and drinking. I have a clear mind, I can think now. I don't act irrational like before. I'm humble today. I'm open for suggestions, I, I, I do what I'm told, and you know, that's not me. That's not, you know, the old me. I was a rebel, I was a bad ass, I was, you know, breaking all the rules. I, I really didn't care. I never had principles, I never had morals, I never had ethics. I never had nothing, I didn't care. I was a low-down street hoodlum, you know. I'm very grateful to this program because it's changed my life completely. I mean completely. I came in here thinking one way and I'm walking out thinking another.

If I would have done what the judge told me to do last year, I would be fine and dandy with my kids but, you know what, I wasn't ready. I wasn't ready for it, I wasn't ready for recovery, I wasn't ready to stop using. But now I am and I'm hoping she'll work with me.

Interpretive Summary: Lisette's Story

Lisette, a 30-year-old Latina crack user, was mandated to substance abuse treatment as part of a suspended sentence for an aggravated battery conviction. Although court-ordered to enter treatment, she specifically requested placement in the women and children's program in the hope of regaining legal rights to her two youngest children. Cycling in and out of jail and street life during her ten-year span of crack use, she had very limited her contact with all of her four children, leading her to characterize herself as a "bad mother." Admitted to treatment one time previously under the State of Florida's Baker Act, which permits involuntary commitment to treatment under circumstances of crisis, Lisette had stayed only briefly in the program and returned to drug use almost immediately upon leaving. As she compared her current experience in the women and children's program to her earlier episode of treatment she noted a number of differences, both in her personal commitment and engagement with the activities of the treatment system. Though still a relative newcomer to the program with one month in treatment, Lisette was already beginning to evaluate her life according to the standards of the treatment community, formulating goals consistent with the structure of the program, and constructing a personal identity in response to institutional claims. She attributed remarkable changes in herself to her participation in the program, yet at the same time expressed tremendous fear associated with her eventual return to the 'real world'. Her trepidation suggests that the community is scaffolding her 'recovery' in ways that she fears she cannot maintain alone. Fully aware that one can master the language of the 12-step program without achieving meaningful change, she rejected this as a viable path to

'recovery,' choosing instead to actively seek out cultural tools upon which she could continue to scaffold her learning. Two and a half months later I met Lisette again in the women and children's program. She continued to progress in treatment by participating in 12-step activities and doing her 'assignments,' and spoke about significant changes in herself and her outlook on life.

Implications of Approach

The analytic approach that I employed relied heavily on my personal interpretations of the women's narratives, as well as the particular turns and passages that I highlighted for analysis. Because of my primary interest in exploring the connections between individual development, social participation and institutional organization, my bias was consistently toward highlighting passages in which women were negotiating powerful programmatic discourses and practices, in particular those germane to the 12-step system.

Because this dissertation research was exclusively qualitative, it should be noted that the validity of the analyses is grounded in an alternative perspective. Qualitative researchers have argued against construing validity as an indication that an analysis reflects reality in any simple way (Gee, 1999; Mishler, 1990; Morawski, 1997), rejecting the application of positivist conceptions of measurement accuracy to studies of a fundamentally different nature. Similarly, notions of external validity or generalizability are not emphasized in qualitative research (Winter, 2000) as the analysis is situated and localized by design. Because a qualitative analysis is related to the "language plus situation" it is about, and because the analyst interprets his or her data in certain ways,

and highlights some aspects of the data and not others, the interpreted data becomes meaningful in certain ways and not others.

Nevertheless, research becomes meaningful beyond the boundaries of the enterprise itself only through the claims and assertions it makes about a particular phenomenon, and it is therefore critically important that attempts to enhance plausibility and credibility of these claims be considered. Researchers have suggested any number of strategies for increasing the validity of qualitative studies. Most often derived from triangulation approaches, multiple methods of data collection and analysis are purported to enhance the defensibility of qualitative findings as they are based on a broader selection of data sources and/or a more diverse community of data interpreters (Golafshani, 2003; Mason, 1996).

While the present study includes data from a variety of sources, their interpretation was fundamentally grounded in the evaluatory standpoint of a single researcher who engaged in the reflective process of data collection and analysis from a particular social position and ontological perspective. As such, it must be acknowledged that the explanations offered by this study regarding the processes of identity construction among women in drug abuse treatment are only one possible interpretation of the study data. Nevertheless, by making my own research assumptions explicit through detailed descriptions of the methods and analyses employed, the context of the study's arguments and findings becomes more transparent, and the reader is better able to evaluate and assess their plausibility. Because this study was fundamentally concerned with identity development as it occurred within the boundaries of substance abuse treatment, the methods were intended to explicate the relationship of individual, social and institutional

processes in this endeavor, and to understand how these processes were possible in this particular figured world.

CHAPTER 3
STUDY FINDINGS

The Context of Treatment

Current substance abuse treatment approaches in the United States are dominated by the disease concept of addiction -- that "addiction is a chronic and relapsing disease"-- although most treatment is not medical (Grella, 1996). The disease model views addiction as a permanent condition necessitating life long abstinence. Because "denial" of disease is considered a symptom of addiction, particularly in the 12-step tradition, the recovery process cannot proceed until the individual acknowledges that she has a drug or alcohol problem (Grella, 1996).

The disease model of addiction is firmly entrenched in the treatment philosophies of both programs examined in this study, permeating the collection of institutional documents, as well as the structure and content of treatment processes. Although the very structure of the women and children's program imparts value to motherhood, "recovery" is explicitly privileged in both discourse and practice. Or, as the first page of the handbook given to every new resident reads:

...This program is designed to help you and your family to achieve recovery from substance abuse... You will be participating in therapeutic activities all day long. After your children come home from school, they will participate in our day care until 8:00 pm, thus giving you time to work on your recovery.

In addition to mandatory daily participation in Narcotics Anonymous meetings and twice weekly "step groups" (group meetings during which the 12-steps are

discussed), explicitly constructed upon the disease model of addiction, other treatment groups bolster this approach with tacit references to the possibility of “re-infection” through contact with active drug users. Beyond these powerful discourses in therapeutic sessions, the naming of physical program spaces as “Gratitude Hall” and “Serenity Place” and “Recovery Way” reifies the authority of the 12-step philosophy in material ways.

Program handbooks clearly delineate the evaluatory criteria used to assess progress in the program, which include “your overall behavior in the program, completion of therapeutic assignments, and demonstration of the 12-steps that you are working on.” Here, the community explicitly sets the boundaries for successful participation in the activity system of treatment, demanding compliance with rules and authority, as well as participation in 12-step activities. This participation fundamentally demands the acceptance of an “addicted self,” a claim that is answered and negotiated by individual women in a variety of ways. Positioned by a powerful institutional philosophy surrounding addiction and its properties, women are afforded the space and cultural materials related to the construction of an “recovery identity” so valued in the figured world of treatment. And yet, women make use of these tools to varying degrees and with varying results -- often resisting and contesting this privileged identity in unique ways.

The Addicted Self

Commitment to the “addicted self” was evaluated according to whether an individual woman applied the label or reference of “addict” to the self in a manner consistent with the principles of the First Step of Narcotics Anonymous, which entails recognition of the self as powerless, incapable of managing or controlling drug use: “We

admitted that we were powerless over our addiction, that our lives had become unmanageable.” Detailed readings of each woman’s narrative suggested four typical starting points for trajectories of self-as-addict:

- **Accepting** – individual refers to the self as addict often and with certainty, in ways that implicate other aspects of life, integrated with other commitments, such as maternal responsibilities;
- **Negotiating** – individual refers to the self as addict, but reference is cautious or irresolute, may not connect addiction to other aspects of life;
- **Resisting** – individual does not spontaneously refer to self as addict, but may upon questioning; is reluctant to apply this label to the self but remains open to the possibility, struggles to reconcile issues of powerlessness and control;
- **Rejecting** – individual makes no mention of self as addict or openly rejects the label or its implications for the self. May use the word ‘addict’ as synonym for drug user.

<u>Table 3.1 Self-as-Addict Starting Points by Treatment Status</u>			
	Women & Children's Treatment (n=12)	"Women Only" Treatment (n=9)	Out-of-Treatment (n=12)
Accepting	8	3	0
Negotiating	2	1	1
Resisting	1	1	4
Rejecting	1	4	7

Table 3.1 presents summary descriptive information on the distribution of women's initial stances on the self-as-addict at the time of the first interview. Interesting group differences clearly emerged around this topic. Importantly, none of the women interviewed outside of treatment indicated acceptance of the self-as-addict. In fact, they typically refuted this identity possibility in their narratives, either through omission or explicit rejection of the reference and its implication. Yolanda's narrative clearly exemplified the stance. A 36-year-old African-American mother of five, Yolanda had been a powder cocaine user for 15 years when she was first interviewed. Never having participated in a residential program, her perspective on drug use was unique when compared to that of women currently situated in the treatment community. Her experience with periods of abstinence initiated and maintained outside the boundaries of treatment led her to implicate issues of individual responsibility and control related to her drug use, rather than invoking themes of addiction and disease so common to the discourse of women in substance abuse treatment. In fact, her narrative was without a

single reference to the 12-step philosophy that so powerfully positioned women in the context of treatment:

It's basically up to you. Cause you can sit in the room and they can tell you what to do, but you gotta be, you gotta really think about it, if you really want it or if you don't it ain't gonna help you. I know a lot of people that went to treatment and finished, done got their medals, got everything, and they go right back out and they ruin it. They try to fake it, that's how they say, fake it to make it. You can't do it like that. You don't want it, leave it alone. It's basically inside you, if you really want it. Really you've got to be around positive people. Ok? You have to really sit down and think in your mind, get you a Bible and sit down and read it. Once you read that Bible, it's [drug use] gone. But I got a lot of people been in treatment, you know, people I talk to, or whatever, but it's just, I don't look at them different, I'm still the same person, regardless treatment or not treatment. But you be yourself... if you pretend to be somebody else, it never works out.

Importantly, her own lived experiences and interactions with others framed her drug use not as a stable property of an "addicted self" but rather as an activity peripheral to the self that could be abandoned at will. Clearly, Yolanda understood her drug use in a fundamentally different manner than did women engaged in the treatment community.

Beyond the figured world of treatment, the self as addict is not regarded as a highly salient identity possibility. The narratives of women out of treatment, and their lack of reference to addiction, demonstrate that the development of an “addicted self” is not a “natural” trajectory for drug-involved women, but is constructed by individuals situated in unique social and cultural contexts that infuse this identity with meaning.

The activity system of treatment is highly circumscribed, configured by a unique physical space, and bounded by specific discourses and patterned practices. The total organization of the institution can therefore be said to afford the construction of the ‘recovery identity’, yet from a developmental perspective it is of interest that these institutional affordances and supports are not uniformly negotiated by all individuals situated in the treatment community. Rather, individual women actively construct and re-construct their identity in relation to the community according to their changing participation in the program, following unique developmental trajectories in their ongoing negotiations of self. Women approach the task of identity construction from a variety of starting points, and while all respond at some level to powerful institutional discourses, their narratives also reveal self-building as a personally creative process.

Importantly, the two treatment programs studied appear to have differentially impacted women’s constructions of the self-as-addict. Participants in the women and children’s program were generally more likely to label the self as addict than participants in the “women only” program, suggesting that institutional influences on personal identity are not monolithic, but local and situated. In other words, women’s negotiation of personal identity in drug abuse treatment appeared to operate at two levels, influenced on one hand by the very fact of being “institutionalized,” but also developing in a context of

specific, local processes. The presence of children in the parental program exemplified one highly salient local practice that contributed to women's developing identities in unique ways, for many tangibly scaffolding their ongoing participation in treatment and their commitment to a self in 'recovery.'

Following are brief examples from four narratives presented to illustrate the starting points from which women in drug abuse treatment embarked on distinct trajectories of identity construction.

Rejecting the Addicted Self

Paola, a 19-year-old Latina crack and heroin user, did not relate her drug use to an 'addicted self,' but regarded it merely as an activity under her complete control. As a newcomer to the women and children's community with no prior participation in treatment, Paola was as yet unfamiliar with the structure of personal storytelling specific to 12-step approaches. Although she had begun the process of mastering 12-step language as demanded by the program, it appeared to be of little personal salience. At times acknowledging the authoritative claims of the 12-step approach to 'recovery,' she neglected to appropriate the fundamental framework of self as addict upon which the subsequent steps are purported to build:

I wasn't hooked on, I mean I was doing drugs but it, I was never hooked on it like heroin 'cause heroin makes you sick. So the drugs I just quit. And I was a person that I would do drugs like just to do them. I never really had a problem that I needed them. So I just quit and I stayed clean. I didn't even feel sick or anything, just...I was never addicted. The only thing I

was addicted to, and really not addicted, is heroin because I'm addicted to heroin when I do it. If I'm on it but like, right now that I'm clean, I don't want it. I'm only addicted to that when I'm high because I think I'm sick. I feel good now and I'm gonna stay clean. I have a problem that I know my, maybe my, is worse than my drug problem. I have an obsession problem.

Resisting the Addicted Self

While Paola openly rejected institutional claims that positioned her as 'addict,' other women resisted the addict identity, contesting the implication of a de-valued self. Regina, a 40-year-old African American cocaine user, illustrated this stance in her narrative. Although she referred to the self as addict when directly questioned, she gave no indication that this identity served as a point of departure for her transactions with the world. While she was required to attend several NA meetings each week, she remained essentially an observer rather than a full participant:

One of my assignments that my case manager gave me, she tells me, she told me to introduce myself, and she asked me if I had talked at any of the meetings, so I told her one, women's gratitude, and I, she told me, well, that was my homework assignment to share in two meetings, and not the one that I already shared in, but, I don't know, I get afraid, and when the meetings are over I grab my purse and I'm out. I don't know those people, you know, and then I just, I don't want to tell them my business, but I'll sit and listen to them. I was telling my case worker that I hate that, I hate the

way in an NA meeting and you would say Hi I'm R. and I'm an addict. I just, I don't say it. I just say hi, my name is R., and then she said well why can't you say it? Are you an addict? I, I, I guess. I didn't hear you, are you an addict? Stand up and practice it now. I said you guys aren't standing up. Stand up. Hi, I'm R. and I'm an addict. You're R. and you're a who? I'm an addict, but I have a problem with saying I was an addict and ever since because I don't want to say it, and I'm in denial, and I don't want to admit it, but bottom-line I am an addict. It's like some things you just want to keep to yourself. But those people, they get up and they're like "Hi I am so and so, and I am an addict!" Like they will be proud to wear it on a t-shirt. Not me.

Negotiating the Addicted Self

In contrast, Christine, a 22-year-old white cocaine user, appeared to initiate a journey from marginal to more full participation with the system of treatment, as she began to negotiate a personal identity in relation to these activities. As she began to master 12-step discourse and practiced her personal storytelling, she recognized the implicit and explicit demands to revise her understanding of the self as addict. In this way, she began to construct an identity in response to the authoritative claims of NA and program staff regarding her drug use, and the implications for the self:

Even though I was in my addiction, and I did get high, I, some people don't understand it, but I was able to control the high. Um, I was able to control the usage. Me or my husband would get it all the time and

wouldn't have to pay for it so my excuse was if I'm not paying for it, I can't really be an addict. I mean it was, coming in here, the first step is um, honest, the first step has to do with honesty. Actually accepting the fact that you're an addict, being honest with yourself and that took me a while. Before I came here I didn't, I didn't believe it was a disease. I believed it was a cop out, people making excuses. And they explained it that the disease is something... I'm trying to explain it right. It's basically something that you cc-, um, that you know is bad for you that you don't want to have to take, but you keep doing it and you expect, and you keep doing the same thing over and over. And you're expecting something different to happen. And it's something that you can't control. I just thought, well, maybe it's just a cop out, and now being in it, I can understand it more. But it, it's something that it's gonna be with you forever. This whole recovery process, is forever. It doesn't quit when you, you hit forty. It doesn't quit when you go home or uh, when you get off of work. It has to go on forever. You can't go back out there and just try it one more time. And especially you cannot try a different drug. When I first came here, it was like okay, well cocaine was my drug of choice but I'm sure I can go back to marijuana and try it once or twice and it won't hurt me. In here it's made me realize you can't, you can't switch from one drug from another cause it always leads you back. You'll always go back to, you have to really want to live clean with no drugs. You can't switch back and forth. And you have to realize it's forever.

In her self-talk she began to appropriate the addict identity for her own. Candid in her remarks on the topic, she struggled to reconcile her understanding of herself as a controlled user with her identity as an active learner in a community that disputed this possibility.

Accepting the Addicted Self

Most common among participants in the women and children's treatment program was acceptance of and openness to the self as addict. Valerie, a 37-year-old African American crack user, spoke at length about addiction and disease illustrating her examination and reflection on 12-step discourse at a personally meaningful level. Through her transactions with the treatment community she began to transform her personal interpretive framework, creating and attaching specific meaning for the self to the general processes of 12-step practice. Through her intense commitment to this process she began to invest in an identity as addict, which she also related to her identity as mother:

I'm definitely an addict. If I, I, I'm so much an addict to that if I, some things I love, say for instance that candy bar I was eatin'. I eat a candy bar, I gotta have another one. I'm, I'm just that much of an addict. It'll, it'll get out of hand with me. But I'm workin' on that. I have to learn how to get some....I'm learnin' how to get some control over myself. I did things in my addiction that, I mean, ignored my kids. I never would do anything

to just actually just hurt them, you know, physically or anything like that. But mentally I know I hurt them. Um, I know they're, they're hurt. They need therapy too. Um, because they do know about me. They do know what, that somethin' was wrong with mommy. They know mommy wasn't mommy anymore. Um, but they, they really sweet kids. They, they very intelligent kids. All I can do is move on with them, just hold on to them. Ask the Lord to guide me in how to raise them. And they, they precious. They very smart, like I say. They um, they love mommy. They uh, they support mommy. They know what I'm doin'. They know that I'm sick. That I'm here. I'm gettin' well.

Personal Storytelling

While these distinct patterns of initial identity negotiations are meaningful in themselves, from a developmental perspective it is important to understand these constructions as mediated by women's social participation in substance abuse treatment. Within the treatment community, personal storytelling is privileged as a therapeutic enterprise, positioned as the mechanism through which an individual can achieve full membership in the program, and by implication ultimately achieve 'recovery.' Personal storytelling is implicated in all aspects of treatment participation, whether in the obligatory construction of an autobiography to be shared with a therapist, the 'sharing' of one's personal history in treatment groups, or the construction of one's own 12-step story in Narcotics Anonymous. As learners in the treatment community, newcomers are

obliged to display at least minimal participation in the processes of personal storytelling if they wish to 'progress' in the program, yet there is little possibility to mandate active negotiation and transformation of these stories, to examine the ways they are folded into women's developing identities. Viewed as a cultural tool that specifically mediated the construction of an addict identity, differential engagement in these particular instantiations of personal storytelling impacted women's developing addict selves in important ways.

As they narrated their experiences of treatment, women expressed differential engagement and participation in personal storytelling. Individual women differed substantially in their described participation in the practices of personal storytelling germane to the figured world of treatment, namely the construction of an autobiography connected to addiction, and the sharing of personal stories related to addiction crafted using guidelines appropriate to the 12-steps. Detailed readings of each woman's narrative suggested three typical approaches to personal storytelling:

- Active Engagement – the individual fully participates as an active listener and speaker, continues to appropriate cultural material from other community members, creatively expands on cultural material when authoring personal stories.
- Negotiated Performance -- the individual participates in a reserved fashion, some ambivalence regarding the process of personal storytelling, vacillates between moments of engagement and disengagement, not fully committed to the process

yet limited participation may open path to full membership in treatment community

- **Passive Compliance** – the individual participates in a minimal fashion most often in order to avoid negative consequences, de-values process of personal storytelling as mechanism for change.

<u>Table 3.2 Personal Storytelling among Women in Treatment</u>			
	Women & Children's Treatment (n=12)	"Women Only" Treatment (n=9)	Out-of-Treatment (n=12)
Active Engagement	4	1	----
Negotiated Performance	4	6	----
Passive Compliance	4	2	----

Table 3.2 displays summary information on women's engagement in personal storytelling germane to their participation in treatment. As such, the narratives of women out of treatment were not explored in this context. Each form of engagement in personal storytelling was observed in each treatment program, yet the patterns appeared somewhat distinct. Overall, women in the parental program were more actively engaged in storytelling practices than participants in the "women only" treatment, yet there were substantial individual differences within programs with respect to this engagement. Following are brief narrative excerpts illustrating these differential forms of engagement.

Passive Compliance

Nicole, a 33-year-old white heroin user, was a 'volunteer' in the women and children's program. A lack of criminal justice or court involvement afforded her the possibility to openly critique the program in ways less available to women who had compulsory treatment obligations. Perhaps for these reasons Nicole openly expressed little fundamental commitment to participation in many treatment groups and practices. She was particularly frank regarding 12-step activities as they related to her on a personal level. Although quick to recognize the value of AA and NA for others, she displayed no mastery of 12-step discourse in her own talk, and made no reference to the self in the prototypical language of the 12-step program:

I, I, I've been going...I've known about AA for a long time, and NA.
'Cause my mom's in NA, or AA rather. She's got 14 years clean. And it's,
it's, it's ... I don't know. I ... a lot of people, some people go to churches.
Some people go to psychiatrists. And some people go to NA or AA. And
it's okay for some people. For me, it's okay, the NA, I think NA's a little
bit better for me 'cause I'm more into the narcotics. But sometimes people
just sit there and war story and tell...who the hell wants to hear about you
in a gutter shootin' drugs? That, that's when I start want, thinkin' about it.
You know I'd like to, I'd like to take a needle and stick it my arm. Or I'd
like to sniff something. So to me, a lot of it's just bringing up memories. I
like to forget, forget the past. You know, I don't want to, I want to start
clean and fresh. But I do go. And in here it's mandatory you go. But see
for, personally, when they start talking about it and, or, and glorifying it, it

just, it, you know brings up a lot for me. But everybody is different.

Some people, that's what they live for. They live for NA and they live for AA. And that's good if it's keeping 'em clean. It's different for everybody.

Here, Nicole constructs the 12-step model as one among many possible approaches to recovery, raising a fundamental tension in her engagement with the activity system of the treatment environment that privileges the 12-steps as the only path to abstinence.

Negotiated Performance

In contrast to Nicole's open rejection of personal storytelling as prescribed by the treatment program, Barbara struggled to engage in the activities of personal storytelling positioned as integral to 'recovery' in the figured world of treatment. Fully aware of the demands for autobiographical writing and speaking and their interpretation and evaluation as measures of progress in treatment, she nevertheless rejected what she believed to be standard, almost rote, narratives adopted by some of her counterparts. Desiring to construct a meaningful, dynamic personal narrative, she began to appropriate cultural materials from valued community members into her own talk in an effort to scaffold self-change:

A lot of times the same people share all the time. I'm not a big sharer. See I'm real emotional. So when I share, if I'm sharing, it's something inside that I want to share. And I get emotional and I get teary-eyed and my voice breaks up. So it, but, I, I'm not the one that has to raise my hand

every, you know. So I, I'm not a real big sharer in that. Not, you know, I may become one. Who knows. But like I said, I'm... It's very strange. I know that I'm, I'm, I'm, I'm trying to reach a conscience...How, how is it did that guy... We had a guy in NA and I just loved what he said. And now I can't remember it. A con-, conscious conscience with God or something like that. And um, I pray everyday. I pray every morning and I pray at night. And I just pray... I, I don't have a lot of patience so I've been praying a lot for patience. And I see myself a lot more patient. I know every day it's gonna get better and as long as I continue to make the right choice, and they have everything here for you to make those choices, and you know, if you feel bad you know where to run to somebody.

Don't, don't keep it inside and that's when things, that's another thing I see myself changing in. You know because I didn't, you know, I don't want to talk to people. I don't want it. And now I'm starting, you know, like with sharing, you know. I'm not gonna be one that is gonna raise my hand every time. But if now if I have something to say, I raise my hand.

Before I wouldn't. You know, that I'm, I'm beginning to open up. As long as I wake up every day and remember that that day, and I love this, I learned from Mr. L., that that day if I wake up at eight o'clock in the morning, I have eight hours that day. And it's just one day at a time. See because my problem is I try to look ahead too much. And it's, it scares me. It, I, I'll be totally honest with you. Those steps scare the hell out of me. They scare the hell out of me. That one where you have to make all

your amends and all. Oh God, I don't want to do that. And the other thing is, you know, I sit there and think oh God, I've got to be, do this NA shit and drink coffee and smoke cigarettes for the rest of my life. But you know, I, I'm gonna not think of it that way. I'm gonna think of it for today, I'm gonna go to a meeting. You know. And so I'm learning to look at just today. You know. Just for today I'm not gonna use.

Clearly invested in maintaining her sobriety, Barbara continued her active negotiation of self in relation to the program, learning to participate in the practices of treatment through collaborative processes with other members. As a newcomer in the community, Barbara's limited and strained reference to 12-step discourse suggests that, while she is beginning to master the language of the program, she has not yet appropriated it for the self.

Active Engagement

Maggie, a 40-year-old Latina crack user, offered a narrative heavily invested in personal storytelling activities sanctioned by the treatment community, and readily evidenced her acceptance of the self-as-addict:

When we have house meeting in the morning and they have a circle. And we sit, all of us, male, female. If there's a newcomer, each person around

that circle has to stand up and say their name and their drug of choice. And every morning I make sure I'm in that circle because that's what gives me the power to stay clean. When they say what was your drug of choice and they say crack or powder cocaine. So everybody says my name is D. and I'm a crack addict, my name is C. I'm a crack, my name is B. I'm a crack addict. And it goes all around the circle with the same word. And it makes me, not hate it, but assume and look at the situation everyday how the circle grows. And how everyday when the circle doesn't grow, it gets shorter because they die or they go back out to use. And I don't want to be one of those. I want to be the one in the middle to talk, to give them strength not to have that. But our words is saying I'm a drug addict for the rest of my life. I'm a recovering addict for the rest of my life. And I have to accept that for the rest of my life because that's what I did to myself. I have the chance to stay clean for the rest of my life now. Being an addict, is an addict for the rest of your life. Recovering addict. An addict in use is a person that's using drugs everyday or can use drugs today and three months from now again. And go off and on like that on a rollercoaster ride. A recovering addict to me is a person that is exactly in recovery, going to meetings, having a sponsor, going to service. You go to meetings everyday for the rest of your life. There's not an excuse not to go to a meeting. If you can't go in the morning, go in the afternoon. If you don't go in the afternoon, you go at night and if you can't go at night they have a midnight meeting. And recovery is not

about relapsing. A lot of people think, oh I'm in recovery, oh but I relapsed last year, no, no, no. When you're in recovery, you're in recovery. There's no reservation to get high again to go back to recovery. Because if you do, you're not gonna make it.

Table 3.3 graphically illustrates the patterns in women's addict identity starting points and their concomitant engagement in personal storytelling as germane to the figured world of treatment. Clearly there is a dynamic relationship between

Storytelling	Self-as-Addict			
	Accepting (n=11)	Negotiating (n=3)	Resisting (n=2)	Rejecting (n=5)
Active Engagement	4	1	0	0
Negotiated Performance	5	2	1	2
Passive Compliance	2	0	1	3

understanding oneself as "addict" and the depth of engagement in personal storytelling tied to this developing identity. For some, acceptance of the self as addict tended to reinforce participation in the practices that constituted 'recovery,' while for others resistance or rejection of this identity possibility constrained such participation. Yet this connection was far from universal among participants, as some who accepted the addict identity also resisted personal storytelling, and others who rejected claims of the self as addict nevertheless negotiated some level of participation in the practices of storytelling.

In this way, we begin to understand the multiple starting points and dynamic

nature of women's identity trajectories as they are organized and re-organized around their changing participation in the figured world of drug abuse treatment. There are many paths along which women negotiate self in relation to the treatment community, and identity possibilities are re-worked and transformed along the way, but always evaluated in relation to the activity system that imbues these possibilities with meaning.

Self-Change

Within the Twelve Step system, meaningful self-change is afforded by the processes described above, that is, through acceptance of the self-as-addict and active participation in personal storytelling in NA meetings. As such, social participation can be seen as a critical component in women's ongoing negotiations of personhood, as their identities undergo critical moments of reflection and transformation that are intimately tied to the unfolding of their lives and experiences in the figured world of treatment. As they make and re-make themselves and their commitments, their negotiations of self form dynamic trajectories incorporating moments of stability and change. In a very real sense they seek to make meaning of their present and future in light of their past, and to form connections between who they are and who they were. At the same time, the precise nature of drug abuse treatment tasks individuals with separating "problematic" past selves from their present identities, and defines the parameters in which this process takes place. Brief examples from two women's narratives are presented below to illustrate significant moments where self-change emerges, and likewise, where it remains elusive.

Personal Transformation

Maggie elaborated and appropriated the principles of the 12-steps into internally persuasive and meaningful speech, newly re-interpreting her life in these terms. She spoke enthusiastically about a number of important changes she saw in herself during her time in the facility, and appeared genuinely accepting of the 12-step structure as a mechanism to facilitate self-change. In Maggie's talk about the self, she makes repeated reference to 'reservations' and 'surrender' to differentiate her present trajectory from her past. By invoking fundamental principles of the first step of Narcotics Anonymous, she uses language imbued with authority to demonstrate the transformation in her engagement with the treatment system¹:

This time I surrendered. Surrendering means I surrender everything. You know my goods, my bads, the ugly, the happy, the sad, the painful, the resentment, the neglect, the abandonment, the being ashamed, it's all gone.

This time there's no, there's not a reservation. I don't, its, its out. I don't know if it's a demon, I don't know if there is demons, but that little thing, that anxiety, that nervousness, that, it's not in me. And before it was.

This is what I'm recognizing because the more days that I'm here, the more I'm gonna feel, the more I'm gonna be able to see how I'm growing out of this gorilla, out of this monster. I have been clean, and I have um, I have more principles now, I have, you know, morals, and, and, and I'm

¹ Narcotics Anonymous defines reservations as "places in our program that we have reserved for relapse." One example of a reservation is the belief that once a particular goal has been accomplished, the person will be able to control their using. Surrender, defined by Narcotics Anonymous, "happens after we've accepted the First Step as something that is true for us AND have accepted that recovery is the solution."

honest. You know? And a lot of people, like in the facility, have helped me. Before, I was like in a rush and things were like coming so fast for me. Now I can just sit and think about them and not have a reaction that has me thinking, well, I'm gonna have to make amends again, you know, because it's something like so unexplainable. I'm controlling my mood swings when I get upset, you know, I think before I act. Before I would just react and then I would have consequences after that. It's something that is amazing.

Personal Inactivity

Rosa, a 41-year-old African American woman, embraced the material support and opportunities for learning afforded by the women only treatment program, yet lacked any mention of personal self-change in relation to her participation. In contrast to many women, like Maggie, who explicitly broke with her former self through the use of Twelve Step discourses that actively derogated who she was, Rosa's narrative lacked any sense of personal change *salient to the Twelve Step approach*:

I'm looking for everything that I can get out of this program. It's just beautiful. We're fortunate to have a place like this. I mean, three square meals, bed, you know, they help you out with supplies. When you come in, if you don't have anything, people donate clothes and you get to learn – they teach you how to control your anger, how to manage your life. The key things, this uh program, uh, getting a job, getting a place of my own,

getting established back. I want to live nice and comfortable. I want to be productive in society, and I want to live, to work. I'm drug-free.

<u>Table 3.4 Self-Change among Women in Treatment</u>			
	Women & Children's Treatment (n=12)	"Women Only" Treatment (n=9)	Out-of-Treatment (n=12)
Personal Transformation	7	4	----
Personal Inactivity	5	5	----

Table 3.4 displays summary information on the connections women drew between self-change and their participation in treatment. As such, the narratives of women out of treatment were not explored in this context. Again, the patterns across programs appeared unique, with women in the parental program more likely to discuss personal change salient to their participation in the Twelve Steps than participants in the "women only" treatment program. The lack of unanimity in this process within programs suggests that individuals engaged in unique and active negotiations of institutional discourses, yet the discrepancies in group patterns also indicate that local context was a critically important factor that shaped women's personal transformations of 12-step discourses.

Identity Trajectories

Women's narratives over time tended to encompass both continuity and change in the identity possibilities made salient by their location both in and out of treatment. The turns and patterns in women's narratives across the two interviews, particularly with

regard to the personally meaningful transformation of institutional discourses on addiction and recovery, and how these turns corresponded to women's changing participation in the Twelve Step system, formed the basis of the identity trajectories that follow. The development of salient personal identities, namely "recovering addict," and "mother" for those in the parental treatment program, was indicated by women's talk of emerging commitments. In other words, these identities implicated goals, priorities, and commitments that structured women's future ways of life. From this, five essential identity trajectories emerged among women in and out of substance abuse treatment:

Committed Recovery Identity – over time the individual privileges activities related to recovery, and identity as 'recovering addict' above other possibilities; individual organizes or aligns transactions with the world in pursuit of this trajectory; integrates recovery with other commitments.

Recovery Identity Found – over time the individual begins to privilege activities related to recovery, and identity as 'recovering addict' above other possibilities; displays emergent organization of transactions with the world in pursuit of this trajectory.

Recovery Identity Lost – over time the individual declines in commitment to activities related to recovery; identity as 'recovering addict' ceases to organize transactions with the world.

Mother Identity – the individual privileges activities related to mothering, and identity as ‘good mother’ above other possibilities; organizes or aligns transactions with the world in pursuit of this trajectory, not integrated with recovery identity.

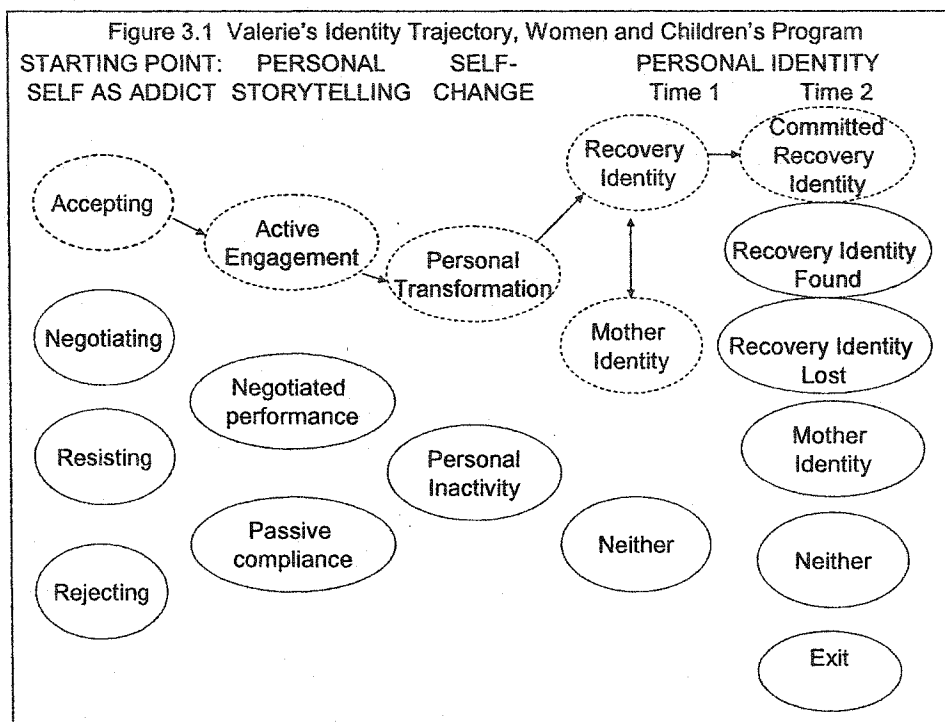
No Identity Trajectory – the individual drifts without purpose; no leading activity guides their transactions with the world.

In the following sections, each of the five distinct trajectories formed by the ongoing negotiations of these salient identity possibilities are presented in graphical form, followed by narrative interpretations charting the unique trajectories of individual women. The figures represent individual women’s paths through the Twelve Step activity system, highlighting their level of engagement with the system’s critical elements: self-as-addict labeling, participation in personal storytelling, and “conversion” or self-change attributed to participation. Women’s negotiations of each of these domains constitute the fundamental developmental processes of personal identity within the 12-step system, as they alternatively embrace, consider, or reject ‘recovery identity’ as a new way of life. From this basis, women’s personal identities are represented at Time 1, along with the patterns of identity change or continuity at Time 2.

Committed Recovery Identity – Valerie’s Trajectory

Valerie, a 37-year-old African American woman, had been a cocaine user for some sixteen years when she entered the women and children’s residential treatment program. Her trajectory is illustrated in Figure 3.1. Valerie’s narrative exemplified a

strong commitment to recovery, as she demonstrated active participation in each of the critical elements of the Twelve Step system pictured below.



Although Valerie's initiation into crack cocaine use took place only a year prior to our interview, she recalled a rapid deterioration in her life at that point that she connected to her chronic and compulsive drug use:

Last year I started smokin' crack cocaine. And this year I'm here. So, that's how I got here because when I started smokin' the crack, that's when my life really got out of control. Not that it was like oh well, you know, right while I was doin' the cocaine - the powder - but it was different. It wasn't as bad as it was when I started using crack. 'Cause I would use cocaine but not everyday. Not even every week all the time. But when I started using crack I had to use it every day. So it just got out of control. It was like, it wasn't like livin' life. It was just, I just lived to

use. I just got high all, every day. Um, I didn't pay bills. I paid no, mm--, not much attention to myself or my child--, children. I just didn't do anything but get high. It's just, it's not livin'. It's like I felt like I was walkin' around dead. Like, 'cause I wasn't doin' nothin' but just gettin' high. And gettin' high just had me feelin' sick. It was sick. It was sickening. I was sick from the drugs but I was still constantly using.

Although she had participated in treatment for cocaine use on several occasions, each entry had been mandated by the Florida Department of Children and Families, where she had an open case concerning her six minor children. Though she complied with these referrals in order to maintain her parental rights, she did not recognize her drug use as problematic at these earlier points and remained by her own admission uncommitted to these programs. Conversely, she entered into the women and children's program voluntarily as she had begun to attribute negative consequences to her use of crack cocaine:

The first three programs I was in, I went because DCF [Department of Children and Families] told me I had to. But I never did complete any other programs they sent me to, I went because they told me I had to go. And I, I guess I just wasn't ready, not yet. So I just wasn't ready to stop usin'. Um, I thought I was, not that I thought I was okay. I knew I wasn't. It wasn't okay. But I, I just didn't realize how bad it was until I started smokin' crack 'cause that, that, that's what really took me to my bottom. I became homeless and all that behind crack. And when I did cocaine I still,

you know, I kinda, I paid my bills. I got a, you know, I got by. But when I started smokin' I just lost everything.

In the program only a short time when we first met, Valerie nevertheless spoke with apparent sincerity about deeply felt transformations of the self. While replete with references to 12-step discourse, as were the narratives of many women in treatment, Valerie's narrative was also comprised by unique moments where she actively appropriated this powerful discourse, going beyond ventriloquation to internalization:

I'm able to see myself better, the way I was. The mess I made out of my life, I'm able to see it. Before I was, I wasn't. I'm able to make a little better decisions. I think more than I used to. When I was out there usin', I didn't think about anything. Just did what I wanted to do. But now I think about everything. I think about every decision before I make it. I assess it. I go through what's gonna happen if I go do it this way, or what's gonna... I think I'm learning to be more responsible for my own, for myself. I feel like I'm growin'. I'm learnin' to be more acceptable. I know that for sure because I wouldn't accept anything from anybody. But now I, I can accept um, other, you know, feedback, whether it's positive or negative. From anybody now. I'm willin' to accept it. Um, before I wasn't. I'm seein' myself more honest. More reliable. Um, but when I was in addiction I wasn't honest about anything. And it didn't take anything for me to lie. I just told a lie to get what I wanted. I would've told a lie just to tell one. You know but it's different now. I don't feel the need to lie

anymore. I don't feel the need to, to hide anything. I have to be honest. It's like the first step is about honesty. If I'm not honest with you, or with, first with myself because to your own self you have to be true first. If I stood up here and deceived myself then guess what I'm gonna do? I'm gonna go smoke dope and die. So I have to be honest with myself. 'Cause I could sit here right now, my sickness will tell me that, 'cause it, a matter a fact a good example... just the other day my sickness, my disease was trying to tell me oh, you can go out and, 'cause another peer did this, went out and used. You can go out and use and come back too. But see, that's why I say I know I'm gettin' better thanks to my higher power. You know. My better mind kicked in and it, you know, if you go get high you not comin' back. See he went and got high and came back. But I'm not gonna come back. I'm gonna be out there tryin' to figure out how to get some more. So that's a example.

Valerie's talk around the 12-steps indicated significant examination and reflection on NA discourse at a personally meaningful level. Through her transactions with the treatment community she had transformed her personal interpretive framework, creating and attaching specific meaning for the self to the general processes of 12-step practice. Through her intense commitment to this process she had constructed an identity as a recovering addict, but at the same time built a stronger sense of self as mother:

I'm definitely an addict. If I, I, I'm so much an addict to that if I, some things I love, say for instance that candy bar I was eatin'. I eat a candy bar, I gotta have another one. I'm, I'm just that much of an addict. It'll, it'll get out of hand with me. But I'm workin' on that. I have to learn how to get some....I'm learnin' how to get some control over myself. I did things in my addiction that, I mean, ignored my kids. I never would do anything to just actually just hurt them, you know, physically or anything like that. But mentally I know I hurt them. Um, I know they're, they're hurt. They need therapy too. Um, because they do know about me. They do know what, that somethin' was wrong with mommy. They know mommy wasn't mommy anymore. Um, but they, they really sweet kids. They, they very intelligent kids. All I can do is move on with them, just hold on to them. Ask the Lord to guide me in how to raise them. And they, they precious. They very smart, like I say. They um, they love mommy. They uh, they support mommy. They know what I'm doin'. They know that I'm sick. That I'm here. I'm gettin' well.

She viewed the trajectory of these two identities as intertwined -- recovery potentiating the self as mother. Growing up for the most part without guardianship due to her mother's heavy drug use and long periods of absence from the family, Valerie appeared to view recovery as important in its own right, but also as a mechanism for achieving meaningful reconciliation with her children. She vividly described the deprivation of her own childhood, culminating in her first pregnancy at age 13. Her youth

and lack of parental role models afforded her a limited understanding of the possibilities for mothering at that time, yet she expressed a strong commitment to altering her trajectory of self as mother:

My mom was a addict. Ever since I was a child I, I, I saw my mom in her addiction. I remember always wantin' my momma. I remember lovin' my mom. And I'd go lookin' for her. Sometimes it'd be, I don't know, I don't care what time it was. I used to walk around lookin' for her 'cause I knew where she'd be hangin' out. I stopped lookin' for her 'cause I started findin' her. And then when I found her I couldn't stand how I'd find her so I stopped looking for her. And my brother, he tried, he, my oldest brother, he, he took care of all of us. We stayed in the house. Scott Projects. We stayed there by ourself. You know, we, my brother always told us not to let nobody know what was goin' on or else, you know, HRS [Health and Rehabilitative Services] would take us. We never said anything but eventually it came out. We lived for, I say how, I maybe was five. It was like maybe when I turned, I was eight goin' on nine when they found out. My oldest brother, he'd been going to jail since he was ten. Tryin' to take care of us. He been gettin' shot at. He was almost killed there and he wasn't but, maybe but eleven years old. Tryin' to break in somebody house to get money to get food to feed us. Now it's strange that I'm not angry at my mom anymore about me. I can't, I don't blame her. I've, I've learned that in order for me to recover I have to accept the

responsibilities for all my actions. So maybe that's why I don't blame her for anything. And it, it probably sound a little weird 'cause it sound a little weird to me but I, I still sometime think about my brother and I get angry at her. 'Cause he never had a life. It's like, she took his life away from him. I definitely don't ever want to be to a point where I have to use something that'll make me, make my kid do somethin' that can get his life taken away from him so I can use. And now that I'm gettin' clean and sober, and I start remembering a lot of things from way back then that I didn't remember I understand it a little more. It, it helps but I'm still, you know, learnin' how to get ov--, gettin' over the pain. I just try to do... I never meant to, to be the way I am. That's the same way my mom was. She got high. Just didn't care. I want to be, I see myself working. Holding down a job. And I plan to live somewhere along this, somewhere along by this water with my kids. Um, as long as I, I'm able to, able to provide for us, I'm, I'm happy. As long as my, long as we be together. Long as I can teach them things and they can teach me things. We could share it. Um, just all, I just want to work towards makin' me a better person, gettin' me more education. Um, work hard on makin' sure my kids get their education. When I was usin', I, I didn't have time for any of it. But now I'm gonna make sure I be there to they schools. I do the things that I need to do to find out how to help my kids grow into responsible adults. 'Cause I want them to be able to take of them, and not have to be like me.

When I met again with Valerie two months later, she maintained her focus on recovery and continued her thoughtful approach to participation in the program. She spoke of significant changes in herself, particularly on the development of her self as an agent capable of reflecting on her actions and mastering her own behavior:

I'm still working on my, myself. I'm changin' my, my way of thinking daily. It gets easier every day. I just, I feel a whole lot better. I can handle my feelings better. Um, well, I realize that I'm gonna have feelings and I'm gonna feel feelings. And it's just a feeling that, recognize them and let, leave 'em alone. Um, um, I'm learning acceptance, how to accept the things I can't change. Accept people for who they are. Accept myself for who I am. The program, it's, it's gave me a lot. I learned a lot about myself being here. I've learned that, um, that I'm not good about, um, authority. I don't like authority. But I'm accepting it, because I know in order for me to live and change I have to accept, um, other people's ideas and not my own. 'Cause all my own ideas are the ideas that had me where I was, you know, doin' drugs, makin' wrong decisions. So now I have to at least be open minded to other people's suggestions and follow the rules of the Village that's, uh, a way of, um, I realize that's a way of gettin' my life structured and back together. I thought I was a really messed up individual. But the only thing that was messed up was my thinkin'. And my reactions to my thinking. I was, I had always, whatever I thought to do, that's what I'd do. If I thought, ok, I'm gonna go smoke, that's what I

did. If I thought ok, I'm gonna go steal, that's what I did. And it, it wasn't a good idea to do those things. I'm learnin' today that it's better for me now to follow, uh, the staff here, their suggestions. I'm still kinda wrestlin' with it 'cause I really sometimes want to go and do what I want to do. But I know if I go do what I want to do, I'll end up back in my addiction. I'm still so far away from, you know, where I know I should be or think I should be before I leave here. It's a matter of me bein', how do you say, persistent. When, when I see myself doin' these things like, just like doin' 'em, you know, not tryin' to do 'em, but just doin' 'em. And bein' ok with it. And goin' out to work, you know, functioning and making good decisions, good sound decisions, and I know every decision I make may not, you know, lead to in-, you may not progress, you know, or lead to something but it'll, I'll learn from it. But as long as I know I'm making better decisions and I'm always willin' to work on it and, and if I have to make another decision aside from the one I made, I'm able to do that. You know, not just sit there and wallow in it if, if I mess up. When I know, I'll know when I'm ready then.

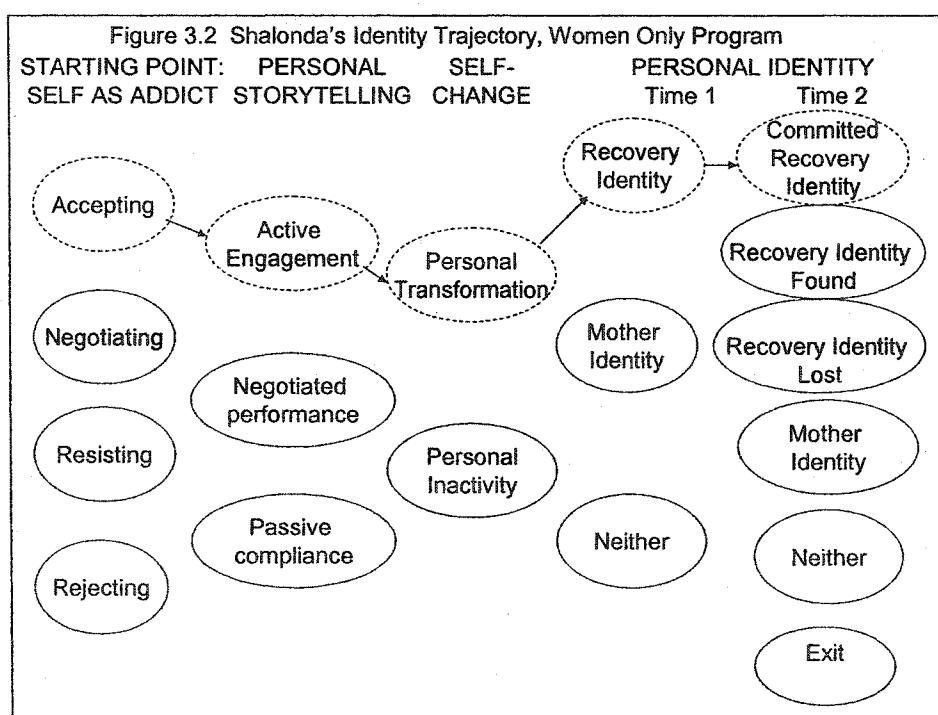
Recognizing the ongoing nature of her self project, Valerie continued to actively negotiate her identity as a recovering addict, all the while anticipating a future where her new positive identity trajectory would be well-established. Though still transitioning toward a desired self, she attributed her successful participation in treatment to the structure of the community and the opportunity to maintain and strengthen ties with her

children, yet clearly viewed these as tools affording the ongoing construction of a valued self – a project which she privileged above all others:

In my recovery it, it's mostly about me 'cause I come first in my recovery. It's very important because in my addiction I didn't come first. You know? I, I didn't come first. I, I didn't even, I, actually I lost myself. So the, that's the reason why it's so important that I keep sight of myself first, now. Because actually I'm now findin' myself. I'm still findin' myself. So if I don't really focus on myself and it's not really about me first, I could easily lose me again. It's, it's definitely the most important thing - priority. It should be in any, any addict's, uh, life of recovery is their, themselves first, in their addiction. I tended to focus on other people. And oh, look at her, she doin' this, and she's doin' that, and I was doin' worse. Look at her drinkin' beer, she's alcoholic, you know, and I was doin' worse. But to keep from lookin' at me, to keep from seein' that I was just as messed up as she was, I focused on her - to keep from lookin' at me. So today, I have to stay lookin' at me. Even when I look at my peers, I have to look at them and, and see what they goin' through and look at it, and say how, now how does this apply to me? What are, you know, if they start, you know, and watchin' other, other, my peers solve their problems and go through their problems, I have to, now how could I have done that? You know it, it always has to go back to me.

Committed Recovery Identity – Shalonda’s Trajectory

While Valerie negotiated an identity as a recovering addict in connection with a mother identity valued in the women and children’s program, Shalonda’s path toward a recovery identity was constructed around full participation in the “women only” treatment program. Her trajectory is presented in Figure 3.2 below.



Shalonda entered the treatment community just two weeks before our first interview. As a 34-year-old African American woman who had been homeless immediately prior to her program admission, Shalonda had lived at the margins of society – trading sex to support her crack use, sleeping on sidewalks and in metro stations, and

existing without proper food and hygiene. Her experiences on the street as an 'invisible' person affected her transition into the treatment program which was remarkable to her for it's affordance of dignity:

You know when I came in the Village and for me to take a bath...you know how great that felt? Because I, I would bathe but it was from a little wet rag and a little, you know those soda bottles. That's how I bathed. But for me to let the shower hit my face, oh God. And actually use soap and have a towel, baby powder, deodorant...Oh my God! I felt like a queen. I felt special. I said these people don't know me. They let me come in here and take a bath. You know? And I got to shower and I went to the room. I got a freakin' bed. 'Cause I was just sleepin' on the concrete. I got a bed. You know, and I, I'm like oh God! And I was like, ya'll know I smoke crack? You know. 'Cause when I walked in the Village, this does not look like a drug treatment program. It looks like a village. Like little different parts of a village, you know. And I'm lookin' around like, these people don't know me. They don't know I smoke crack. And I immediately had a bag. Started putting the soap and everything in that bag. I'm gonna take this with me. But this lady came and she said baby you don't have to take that. It's yours. We gave you that. Nobody's gonna take it from you, you can put it up there. You know I was like, like a whole new world to me. To actually get three meals a day and not have to eat out of the garbage can. And I didn't owe anybody anything. I don't

owe anybody anything for being here. And the people here really love me. You know? This place to me is like it's saving my life. Because it has, it has on this facility they have a person for everything that you need. Before I didn't have that.

Her felt recognition as a legitimate and valued member of the treatment community constituted a significant disruption in Shalonda's life trajectory, as this positioning was incongruous with her previous lived experience. This moment provided her an initial opportunity to begin actively negotiating a positive relationship to the community:

I came here April the 3rd. And I've been here ever since. They say a closed house. I don't care about that. I don't see that. All I see is I am saving my life. You know, it's kinda like here they want you to feel at home. They want you to feel, they prepare you for the world. And that's what I love about the Village. I don't care how long they go on closed house. I don't care if I never have a privilege. As long as I live. You know. As long as I can live healthy and free and able to say what I want to say. That's another thing. You could say what you want to say here. And not be crus-, crucified for it. No finger not bein' pointed. You said this. No. Because they, they, they respect my rights. Freedom of speech. They respect each individual's right to speak and to say whatever they want to say. And I like that. And I don't feel ashamed. I don't need to hold my head down. And another thing that I like about this program, they don't try

to push spirituality on you. Whatever you believe in that's gonna keep you clean, believe in it.

In contrast to other women who expressed resistance to program expectations that interfered with the process of constructing a self-in-relation to the community, Shalonda accepted institutional authority as benign. This allowed her to engage more fully in building a self through the means afforded by the community, a process she appeared firmly committed to pursuing:

There's something inside of me that's telling that it's more. It's not just the drug use that I need to work on. That it's more. And that's what I'm here to find out. 'Cause I could stop using drugs. I want to know what it is that makes me want to use the drugs. See it's not, it just, it's more than just getting, doing drugs, in people's lives that makes them do things. And what they do, they help you look at, look inside of you and figure what it is about you that made me feel bad. What is it about me? And it's like with your attitude, your anger, your ability to accept life on life's terms. To be able to communicate with the um, the inside of you... I have to change everything. My attitude, my anger, everything has to change about me. Okay addicts, I'm gonna be a addict for the rest of my life. But there's a difference. I don't have to be an active, an active addict. I could be a recovering addict. And that's my goal today, to be a recovering addict. To live my life clean and sober.

Her self-talk was clearly scaffolded by valued community discourses surrounding addiction and self. For Shalonda, the discovery and exploration of her “inner self” and her internal motivations for drug use had become her primary activity and the principal mechanism by which she made meaning of her self-in-relation to the program.

Shalonda invited me to her home for the follow-up interview some two and a half months after our first encounter. Her intense focus on maintaining her trajectory of self-in-recovery was evident in the first comments she made about her experiences outside of the treatment program:

It's been a struggle really, you know? Because the neighborhood back that way is where they have all the drugs and everything, so what I do to keep myself away from it, I don't go that way. I just, I basically stay in the house, I go to meetings, I talk to my sponsor, I'm working my steps. I'm doing what I gotta do to survive. I'm doing what I have to do to survive. I'm, I have built a relationship with my kids. 24 hours before I left the Village, I called and made arrangements for everything to be set up for me. So that I know my day when I walked out the Village that I wasn't gonna, I was scared, but I came here to my mom's, I dropped off my clothing, and I went to a meeting with my sponsor. My sponsor picked me up and brought me home and everything. And from that day on, I've been going to meetings, and I've been talking to my sponsor. I've been dealing with life on life's terms.

Although her description of her struggle for survival suggested that her development had in some way been constrained by the boundaries of the self-as-addict identity, she continued to credit treatment for providing her with means of instrumental support, helping her to find a sponsor so that she could continue her 12-step activities, and mostly for “helping her to find herself”:

I got me. I found me in the program. Now, now, I’m a responsible person. Now I’m a mother, something I wasn’t before. Now, um, I’m friends to people. People come to me for advice now. People trust me with their money. People trust me in their houses now. You know, and it feels so good. It makes me know that I’m not a bad person. I just did bad things. And that I’m trustworthy and I’m somebody. You know I see people in the street that I used to drug with, and I tell them, you know, you need to get some help. You may not realize it now, because in the beginning I didn’t realize it. But you really need to get some help and find the inner you. You know, you’ll love that person that’s inside you. You know, and it’s ok to have problems, cause everybody in life has problems. Today I don’t have to use drugs to face my problems. Anything that goes wrong in my life today, all I can do is ask God to grant me serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference. Because I have no control over people, places, and things. I only have control over me.

Significant here was Shalonda's transformation of 12-step discourse into a meaningful instantiation of personal agency realized through her continuing active engagement in "step-work" and sponsorship. By enacting these steps in her everyday transactions with world, she began to experience herself as an instrument through which change could be effected, marking a significant moment in her trajectory of self:

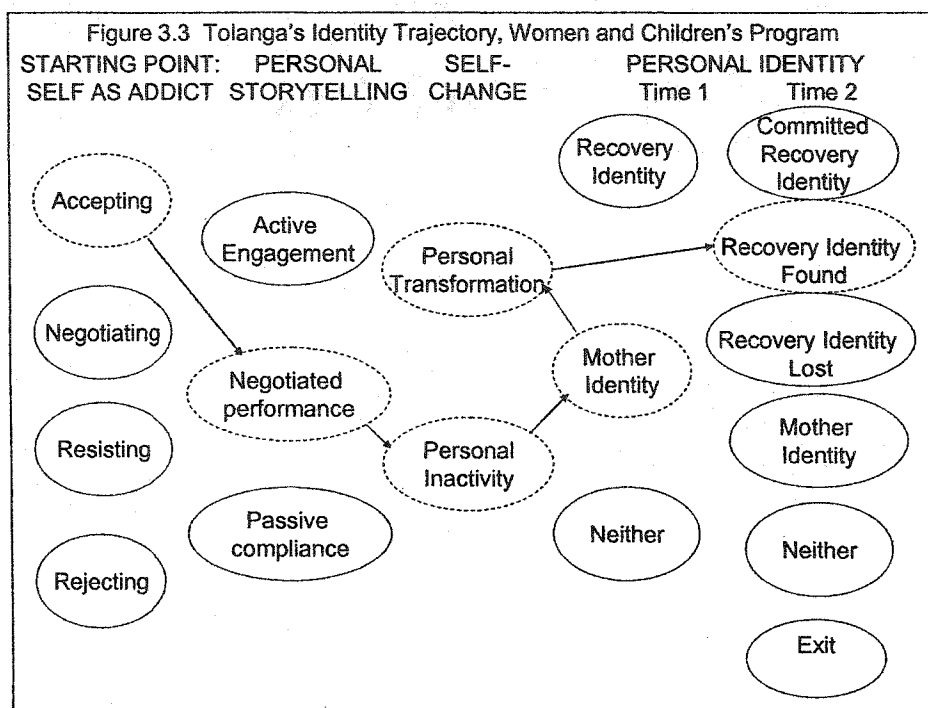
Going to my meetings, talking to my sponsor, and laughing-that's my high now, you know, I had to change people, places, and things. I don't hang around the same people I used to hang around, I don't do the same things I used to, and I don't go to the same places I used to. If I need to go that way to get to Walgreens, I'll go this way, because it's safer for me.

Because I know if I go this way, I'm in danger. So I don't allow myself to go that way. It's a simple program, but we made it complicated for ourselves. Its very simple, its just 3 things that you have to do: go to meetings, stay away from old people, places, and things, and get a sponsor, that's it! And I'm also, I also am getting affordable housing. They said we qualify, so they're gonna find a property to build a house on. Everything is going great for me. I never owned no house, I never paid no rent in no house cause I lived in the street. I never had responsibility, so everything for me is new, you know. I have to learn how to live life all over again, and it's ok. It's ok, the process is ok because I know it's just a process. And I have to go through it. The same way I went at my drugs that's the

same way I'm dealing with things now. I'm determined. I used to be determined, rain, hurricane, whatever, to get my drugs. Now I'm determined to stay clean. It's a fight, but it's a good fight, because I'm fighting for a reason now. Fighting for my life.

Recovery Identity Found – Tolanga's Trajectory

Both Valerie's and Shalonda's narratives illustrated a sustained commitment to recovery over the three month period of the study. In contrast, Tolanga's narrative exemplified a path of increasing commitment to recovery over time, from a secondary to a primary focus of activity. In our second interview, she spoke of meaningful personal transformation that had recently taken place. Tolanga's trajectory is illustrated in Figure 3.3 below.



A 19-year-old African American cocaine user, Tolanga was mandated to the substance abuse treatment program for women and children after the Department of Children and Families investigated a complaint regarding her drug use and removed her 15-month-old daughter from her custody. Eight months pregnant when she entered treatment, her newborn was also removed from her care immediately after birth. The unique set of circumstances surrounding her entry into the program was influential to her transition. She had little opportunity to develop an attachment to her youngest daughter, and had had little meaningful contact with her 15-month-old due to her drug using activities over the prior two years. Yet the very fact of their young ages afforded Tolanga the hope that she could raise her own children and become the mother she would like to be. Since entering the treatment program she had been granted supervised visitation by the court, which positioned her children as highly salient, visible symbols of her recovery.

She organized much of her narrative around the topic of mothering, a 'normal mother' being an identity she highly regarded:

I think I'm doin' good. That I'm doin' great. Um, it's just as long as I do what I'm supposed to do I get my kids back. The most important thing to me today is gaining custody of my kids back. That's, that's, that's my number one goal that I have to achieve. And I can't stand the fact that somebody else will raise them. But by me bein' in the program now, this is my first treatment center. It has really taught me how to deal with life on life's terms without the use of drugs. You know I attend N, NA meetings. And I have a sponsor. And in order for me to be right for my kids I have to get right for myself first, you know. It's, it's the first thing is stayin' clean. Because if I'm not clean, I'm not gonna be able to take care of my kids the way a normal mother would. I'm not gonna be able to keep my self esteem up the way a normal person would. A good mother is someone that's supposed to be there for their kids when, when their kids need them. Their kids depend on them. Um, the second thing is to complete the program. The third thing is to continue outside meetings, and go to my meetings and doin' all the assignments that my sponsor or any, or my therapist, or my case manager require, requires me to do. Um, and just take care of my kids the way a mother should, you know. I have to be there for them. Um, I have to take parenting classes. I have to complete that. I sit down and I play with my oldest daughter now. Before,

I was on drugs I would be out all night and come in in the mornin' and I wanna go to bed. I don't have time to play with her. But now, today, I could play with her with her toys and stuff. And I can let her know what's this color and what's that color. But before when I was on drugs, it was like, fuck what that color is. You know. And it... I look at those things and it hurts to know that I did my daughter the way I did her but, I can't blame it on nobody but myself and the disease - the, the, the craving for cocaine. And it was like, I was like, her cousin or somebody. I wasn't her mother. I was like her cousin because she has seen me here and there, and then I just go away. Like fade away. But now I today, I could buy my baby and my kid some clothes. And I could buy them food. And I could buy them and I could take them to the movies, you know. But before I couldn't do none of it because I was on drugs.

Tolanga appeared to negotiate her identity as mother in response to her own lived experience of growing up motherless. Her explicit disdain for her absent mother and lack of any significant caregiver after her father passed away left her effectively disconnected from others. Certain only that she wished to provide her own children with a different life experience, she attempted to construct an identity in opposition to the "bad mother", evaluating her attributes as a parent by contrasting them against those of her own mother. In this way her possibilities for self were constrained, as she attempted to counter negative images of mothering, but was ultimately limited in her understanding of how to achieve positive self transformation. Although attending weekly parenting classes and

psychological counseling services outside of the treatment program, she continued to struggle with the extensive trauma she had undergone in her adolescence:

I have a really bad anger problem. Maybe cause when I was a child the things that happened when I was a child. I felt not wanted. I felt left out. It's somethin' that grew inside of me, like anger just grew inside of me. My father passed when I was twelve. My mother wasn't there. She left me there with these people, which is my grandmother, but it's still these people. I mean my mother didn't want to be there for me. You know after my father passed like my grandmother didn't really care no more. And I had these anger tantrums too, I would act out and stuff. So I guess they couldn't take it anymore. Um, and they kicked me out the house but it was okay. So I got introduced to the street. At the age of twelve I got kicked out the house. I was strippin' in the strip club at fourteen. That's how I made my money. The reason that I used drugs was to hide up, all those hurtin' feelings that's inside me. But when I came down off the drug, it ain't do nothin' but make it worsen. And that's why I wanted the drug more and more and more. But at victim services I get to relive that, that incident that happened and it's, it's kinda hard but it's had, it has helped me a lot. Because at the age of sixteen I was raped by five boys. And when I got raped, um, I had to take care of myself. It made me feel like that I was nothin'. That I, I didn't matter to nobody. And when I was out there, and nobody, I used to, how you call it? Isolate myself from people.

But now just for today, I know that I am somebody and I got two gifts from God that gonna look up to me and that, that need me. And that depend on me, you know. So I can't, I can't look at, that was just a accident that happened in my life. And then use drugs and just throw it all away and tell my children to kiss my ass. You know, I have to live. Life goes on. My kids these, these, these are my world because if, if I was to have a thought in my mind, I want to go get high, I just think about J. and J. and say no, they need me. So I can't go through that with them. I gotta get them back. Because my, my biological mother is an addict herself. She never was there for me. And I'm not... She choose drugs over me. And I'm not gonna choose drugs over my kids. I can't.

On her own much of her life since the age of 12, Tolanga was far from a typical adolescent. Her identity development was unimaginably constrained during this period of her life, as the void of meaningful or constructive social relationships and frequent experiences of exploitation and victimization altered her expectations regarding transactions with the world. Her self-reliance and expressed unwillingness to communicate openly with others problematized her 'recovery' in the 12-step approach, which relies so heavily on 'fellowship' and 'sharing' among members to construct a community of 'recovering addicts'. Hesitant to share her own story in NA, Tolanga did not fully participate in the 12-step recovery process. Instead, she relied on listening to the

stories of others, using personal storytelling not as a mechanism for appropriating 12-step structures for the self, but as a tool to distance the self from other members:

It gives me a lot of hope to be at outside meetings. It lets me know that I have, other people that been through worse shit than I been through. And practically been through the same thing I went through. I just haven't followed in their footsteps to go to worse. To hit bottom. Um, I learn a lot because I hear other people's stories. And their stories are worser than mine. It, it's like, it scared me. I don't want to be sittin' on no stretcher with my chest open wide, open in the operatin' room. I don't wanna overdose myself and fall out in the middle of the street in front of anybody. You know. It's scary. It really is. It's just scary. People who, that prostitute just hop in a car with a crazy man and he just beat they ass. That never happened to me. They would walk up and down the street. I never did that. I have shared half of my story here. But at, not at outside meetings. I, I feel that I'm not ready for that yet. When the day comes and share it but it's, I have to get, you know, the, the, the courage to do it. I mean every, it, everypp- is a lot of new addicts that come in every other day, you know what I'm sayin'? And it, it's sad. It just sad that I see people how, how bad the disease is. And all of us have a problem. The only problem that we have is addicted, we addicted, you know, we addicts. But we have different addictions, but the disease is just the same. We all here for the same reason. We all have the same problem. And we all here

tryin' to get our kids. Either we got our kids or we tryin' to get our kids. Regain custody of our kids. And some, like they say, some addicts are sicker than others. And that's true. I've noticed that a lot around here. It's true. But, 'cause I have a lot of addicts that's here that's way sicker than I am. It's, it's like this person have more problems that I do. This person's disease kicks up worse than mine do. This person don't know how to handle things the way I do. So that person is sicker than I am.

When I met with Tolanga two and a half months later, in the initial moments of our interview she recounted a recent relapse to cocaine use. Remarking that she was 'put on contract for deviating' when she returned to the program after using, she explained that many of her privileges had been suspended and she was no longer free to leave the community unsupervised. Her position as a deviator, violating core program standards, guided her involvement with the program to a level of greater compliance, while limiting even further a felt sense of engagement with the community:

I've learned to humble myself and I'm coming along great. Um, I'm learnin' to keep my mouth closed. I do all my assignments. Everything these people want me to do I just do it, you know, because I, I, I've learned that they're only here for a minute in my life and, and once I get through this, I don't have to worry about them down in the long run. I go back to court the tw--, um, the 22nd of this month and hopefully, you know, I'll get my overnight and weekends again. And my relapse was really part of my recovery because I don't want to be, I don't want to use no more. I don't,

I, I don't, I can't stand to be locked up in this place like I am now. And I know that I've been doing the right thing. I know that I'm gettin' back on the right track. I know that I'm complying with this program. I'm complying with the courts. I'm kinda, skeptible, skeptical about who I talk to and who I'm around. And, and, and what I let a person, I let people know what I want 'em to know. Usually people here can't, some, mostly, I'm not gonna say everybody but, most people you can't talk to. They will sit and listen, maybe they'll listen, but it goin' through one ear and out the other. And you know, there's a lot of things that I can't share with my therapist because she's not on my level.

On the boundaries of the treatment community, she expressed no collaborative engagement with program staff, even with her primary therapist. Nevertheless, she grew in her commitment to NA since we first spoke, focusing much of her attention on participation in outside meetings that she attended with her sponsor. Her talk was penetrated by 12-step discourse to a much greater extent than was apparent in our first conversation, suggesting perhaps that she was developing a sense of connection through these 12-step meetings that she was unable to achieve in the confines of the treatment program. Her words implied an opening of the self through social participation in a activity system she judged to be benign, as she began to impute personal meaning to the discourse of the 12-steps:

I have to, I had to humble myself and really dig deep down in myself to find out what was really going on with me and, and why I relapsed. I came

to a lot of conclusions 'cause when I first got here, I was here to fight the custody of my kids. I wasn't here for me. I was like, oh shit, I'm gonna get my kids back, let me just do what they want me to do. And I was movin' too fast. I was phasin' too fast. You know, I would go to out-, say on my strength pass that I would go to outside meetings, and I would go somewhere else, you know, deviating and stuff like that. And, and, that's old behaviors. So, you know, it was like, and then I was holdin' a lot of stuff in me that I didn't want to talk about and, I didn't want to feel things, the fact that my kids wasn't here. I didn't want to feel that the fact that I got to go deal with these people, look into these people's faces that raped me and stuff like that. And, you know, I don't, I didn't want to talk about it. And to tell you the truth, for the first three months that I was goin' out on pass, I never went to an outside meeting and I would always go somewhere or other, and I would make it back here at 11 o'clock. I have to talk a, talk about my disease and tell on my disease before, before you pick up that drug. Once you know about Narcotic Anonymous, you will never have fun gettin' high again. I mean it will bother you. You'll feel so guilty, I, I don't even know why I relapsed. 'Cause it felt so, like butterflies in my stomach, it ju-, it just didn't feel right because I know the tools of NA. I know what the disease can do to you and it, it just don't feel right. The f-, the NA fellowship is nice, you know, the outside meetings are great. I mean you have a lot of people that you, you, as an addict, when you first come into the fellowship, you think that you are the

only one that, that has this problem. But once you talk to a lot of people, knowin' that you are not alone in this, and you have a lot of people that's on your side, your side, you have a lot of people that's willing to support you in, in your recovery, you know. And since I've been going to these meetings I know that I'm not alone in this. I'm not the only person that got raped. I'm not the only person that father has died. I'm not the only person that got kicked outta the house at a younger age. I'm not the only person that's going through this thing with DCF [Department of Children and Families] custody tryin' to fight to get back, I mean, it's amazin' how us addicts has these same similar problems. And we all suffer with the disease of addiction. And you know, at first I thought I was the only one with this problem. I know other people that used drugs, but I'm the only one that ain't got no feelings for nobody, you know. When I came here I learned that, you know, I'm not in this alone. And recovery mean to me goin' to outside meetings and workin' the steps and talkin' with your sponsor, and doin' clinical assignments. I mean, findin' a job, gettin' housing, and you know, bein' a productive member of society. That's recovery to me. It's a process thing. You have to, first you have to learn the steps of NA or AA. You got the twelve traditions. You get the big book, the big black book, but you have to work your steps.

Through more central participation she began to re-cast the self as addict, and began a therapeutic process of re-interpreting events in her life through the lenses of 12-

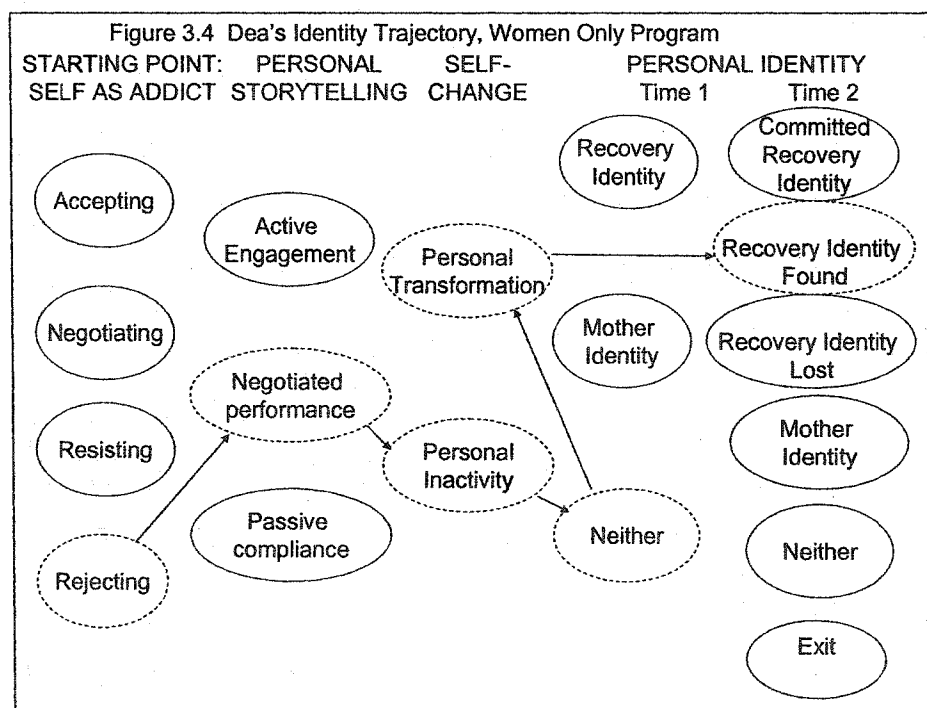
step discourse on addiction. She began to speak of structuring her future life around meaningful participation in 'recovery' activities, although she foregrounded recovery as a means to achieve family-related goals. Importantly, she began to speak of the self in terms that evoked possibilities of development and transformation. Her words regarding motherhood now suggested that the valued identity of "good mother" was achievable through a collaborative process of learning and appropriation scaffolded by others:

My momma was never there for me. And I was kind of upset with my momma about her not bein' here for me, but now that I know the disease of addiction, I could do nothin' but forgive her because at the time, she was in active addiction, and then I didn't know nothin' about this addiction that I have, and, you know, now, now that I think about it and I'm in, in a program, in a drug program learnin' about this disease of addiction, even though our drug of choice's were different, but still, it's still the same disease. And I don't, I don't want to use drugs no more because I don't want my children to look at me how I look at my mom. Because the way I used to look at my mom was like ugh, you ain't my momma, you just had me, you know. And I'm learnin' a lot. I wanna, I'm only nineteen years old. I wanna learn how to be a parent to my, to my child. No one is perfect but I wanna learn how to raise my children without given them a ass-whoopin'. I wanna learn how to punish my child without beatin' them. You know, like, that's why I go to parenting classes. And, you know, I'm learnin' a lot within my parenting classes

because you don't have to punish a child by beatin' that child. You could just punish that child by takin' their privilege and things away. And, or, just putting them on time out or stuff like that. Because I don't want to beat my kids. I got beaten all my life. For me to get off drugs, to get my life back in order, and to become a mother again, I've been a mother, why, because I birthed that child. But, to raise my children I have a chance, you know. And I just want to, for those women that's out there and they got children, I mean give yourself a chance. Give, give your kids a chance in life to have a mother because addicts, drug users, it only leads to jail, or in-, or institution, or death. You know? And, either, or, either way it goes, you don't have a mother. 'Cause you, if you go to jail, how's your mother gonna be there for you? If you're in a institution, how you gonna be there for your child? If you dead, you nn-, you never have a chance to come back around with them, you know? And I'm not dead. I'm in a institution but I still have a chance to be with my child, another chance at life for me and my children. I can be the best mother that I'm, I'm gonna try to be the best mother that I can be. I know that I'll be better than my mom was to me, but I'm gonna be a good, I'm gonna be, try to be the best mom I can. And if I'm a addict, I'm always an addict, but if I'm in active addiction, I'm not gonna be able to do that.

Recovery Identity Found: Dea's Trajectory

Dea's path toward a recovery identity, illustrated in Figure 3.4 below, was similar to Tolanga's for its lack of linearity. Initially disputing the self as addict, Dea grew in her commitment to recovery *after* completing her three-month stay in treatment. She too began to attribute meaningful personal change to her 12-step participation as she continued her affiliation with NA beyond treatment.



A 30-year-old HIV-positive woman with an extensive history of arrest and incarceration, Dea was mandated to the treatment program as part of her one-year suspended sentence. In our first meeting while a novice member of the community, she expressed an active rejection to the self-as-addict label, suggesting that acceptance of such a belief would undermine the possibility of creating a new identity:

When there's a meeting and you raise your hands and say 'my name is such-and-such, I'm an addict'...I don't say that. I, I, I say my name is Dea and I'm blessed. Because if you admit in your head that you're an addict - once an addict, always an addict - of course you're gonna go out and use. Or you're in recovery. No, I'm recovered. To me it's, once you're off of something for a certain amount of time, that's recovered. That's like gettin' it and bein' sick. Oh, I'm sick. I don't feel good. If you're sick, you're sick. When you're done being sick, you're recovered from being sick. You're not recovering...

She spoke at length of her past journeys "in and out of recovery," with brief periods of sobriety surrounding the births of her three children always ending in a return to drug use. She retained no legal rights to her children due to her involvement with the child welfare system and her history of incarceration, leading her to remark that "I can't consider myself a mother." Because she was court-ordered to attend treatment, leaving the program would have serious repercussions for her standing with the criminal justice system. Perhaps for this reason, this episode marked the longest time she had remained in any residential treatment facility.

Although not directly involved in any incidents, Dea was first interviewed under "closed house" conditions due to rule violations by other members of the community. A "closed house" typically involved tightening restrictions on clients' movements and privileges, including the cancellation of outside appointments or meetings, the scheduling of additional groups in the facility, as well as the suspension of some normal program

activities. The practice of “closing the house” tended to position Dea adversarially in relation to the program, in part because it limited her possibilities for development:

What I don't like is this thing with the closed house because me personally, I didn't have anything to do with what the guys were doing up front here. Matter of fact I've never been written up for even a petty thing. And it's stopping me from progressing in my treatment. It's more structured. Which I don't mind the meetings. I don't mind the structuredness. What I do mind is being stopped at a certain point. 'Cause at this point that I'm in here, I'm supposed to be in a different phase and I can't phase.

“Phasing” as a practice represents the culmination of achievements in a particular part of the program, when program staff evaluates a client's progress and confer a recommendation regarding advancement to the next level. Her inability to progress toward an important milestone altered, at least for the moment, her possibilities to construct an identity valued by the treatment community, as well as her personal valuation of continuing her membership in the community. Yet in spite of these feelings, she remained fearful about leaving the community's walls, a fear perhaps grounded in a recognition that her trajectory of self had not yet been meaningfully transformed:

Let me, let me tell you from July um, 2001, to June of 2002 I was incarcerated. And I got out and it's scary when, once you're locked up for so long. A person becomes institutionalized. And being in jail as many times as I have been, and done as much time as I have done, it's a pattern

that I have to look at. And it all stems from my addiction. As far as me leaving here, excuse my language, but hell yeah I'm scared. Yeah I'm scared...but I'm also to the point where I'm ready because of all the garbage that's going on here. I'm, I just started calculating how much time I have left. Because this is madness. I had goals of going into re-entry, which is optional for us. It's a, it's a section in time where once you complete your 90 days, you can go into re-entry and either save up your money if you get a check and go to school, or if you don't get a check, stay in the Village until you save up enough money to get your own place. It's to the point now where I just want to do my 90 days and get out.

At this moment, rather, Dea viewed herself as flawed – curiously an acceptable, even valued position in the figured world of treatment. She had been encouraged to examine how her “anger problem” and “low self-esteem” connected to maintain her drug use and her acceptance of this process appeared genuine:

The key to staying clean is first of all, is the mental thing. You have to want to stay clean. You have to be truly sick and tired, and sick and tired of going to jail and prison. You have to want to stop. You have to want to live. You have to want to deal with the anger and the issues inside of you. 'Cause see I was in denial so strong about my anger, I didn't know I had anger. I'm learning things about myself since I've been here. I used to have very little self-esteem and I used to wear very form fitting clothes. I

made sure I was seen. Um, today I realize I don't have to be seen in order to be accepted and loved. And this program here has taught me that.

Nearly three months later I interviewed Dea while she was living in a half-way house for women. She had completed her 90 days in treatment as mandated by the courts, but was unable to successfully complete all of the program phases. She continued to participate in out-patient treatment and 12-step programs on a daily basis. Looking back on her time in the residential treatment community, she commented on what she had learned:

I learned to be honest. Yeah. I've learned to finally be honest with myself and others. To accept things, to, I've learned that I actually can live life without using drugs. I've always been in and out of the rooms of recovery but never worked the program. Today I'm working the program. I have a sponsor. I work the steps. I do meetings every single day...I just passed six months clean.

Now speaking of herself as a "chronic relapser," or one who cycles through periods of sobriety and drug use, she discussed the importance of attending her 12-step meetings in her present life:

Basically a meeting is a place where addicts or alcoholics meet and one shares their story and we open up the floor for discussion...whatever's going on with their day, if somebody's having a bad day, um, something

going on within their selves, a bad relationship. It could be anything. They open up the floor. ...I shared about two weeks ago up at Little River. I was nervous. There was a bunch of people there. I got a lot of responses. A lot of, I heard a lot of people telling me that they loved my honesty. They respected my honesty and my story and they see the sincerity in wanting to do the right thing. Um, I felt good after the meeting. I felt real good...we share experience, strength, and hope, to help, and it's to help the other addicts to stay clean.

Owing to her daily participation in these activities, her self-talk was infused with the language of Narcotics Anonymous. Although she had prior experience with treatment programs, she nevertheless contrasted her present self-in-recovery with her past self, who although abstinent for a time, “never worked the program before.” In this way, Dea drew a distinction between her previous cyclical pattern of abstinence and use and her present trajectory of self. In contrast to our first meeting, she spoke openly about her recovery as continuing “sometimes one minute at a time,” yet also mentioned her long-term goal of becoming a peer counselor for drug-involved teenagers on several occasions. By all appearances, from Dea’s initial resistance a new understanding of self had emerged – transformed from addict-self as a “foreclosed” identity into an addict-self that potentiated her capacity to work with young people and to share her experiences with them. Or, in Dea’s own words to see that “there’s a life after drugs.”

Recovery Identity Lost – Yolanda’s Trajectory

I never believed in in-patient programs but it does seem to work. If I would've known, I would've been into an in-patient program. I never thought they worked because a lot of people that I know that went into in-patient, they were back out using, so I never thought it worked. But, I was so miserable with the drugs, and I tried everything in my power to try to stop it, and would never, I never could stop. I came here, and since that I've been here I mean, I've learned so much about the virus, about drugs, um, the addiction, how you can actually live a, uh, good life, a real life, ...that this is a, um, a disease. It can be maintained. Uhh, I learned how to keep it going by staying away from people, places, and things. I learned that I have to change my whole lifestyle around. Uhh, you can have fun being sober. There are other people with the virus that look just like me, and even healthier. And, there's life beyond where I just came from. You know, there's hope. And, I'm willing, and I'm ready to go out and see what it's about now. And I don't know, it, it, I'm really glad I came.

Her acceptance of powerful institutional discourses surrounding addiction as a disease appeared nearly absolute, resonating at some level with her personal experience of a chronic and escalating desire to use that she was unable to satisfy:

My addiction, it just, it started driving me crazy, you know, I wasn't out, you know, selling myself. I had men in my life that would supply my habit for me. But, uhh, it was just never enough, I was constantly wanting more and more. So, you know, it was just like an ongoing cycle.

Her willingness to accept authoritative discourses as valid appeared to apply to her construction of self as well. Although initially hesitant, through ongoing interactions with staff she learned to attribute her drug use to a deficiency of self:

It teaches you to learn you about you. And, that's the last person I knew about. I knew about everybody else, but I didn't know who I am. I feel like I really don't, didn't have any problems, other than my addiction, you know. Well, you know, they say people have deep dark secrets and this and that. And, I didn't really feel as though I had any. I didn't have a bad childhood. I wasn't abused. I wasn't neglected. Everything in my life is an open book, but then they're, like, well, there was something that kept you using. Yeah, I was an addict, so, then there was like, what are the, there was some things about myself, and then I did find out I had low self-esteem, you know, and that kind of stuff.

For Yolanda, her struggle was concentrated not on evaluating the veracity of the treatment community's claims, but rather on understanding the possibilities for action afforded to her by these claims. In order to alter what she clearly defined as an undesirable trajectory of self, she actively attempted to engage in co-constructing a positive identity with her therapist:

I went to one of the therapists, and I was talking, and so I asked him, you know, how can you build your self-esteem? And, then, so, he told me, he said start off making a list of your five strong points and five weak points.

I haven't done the assignment yet, this was just the other day, and then they will take the list and then we will go from there, but I actually asked for this one.

Although confident she could effectively participate in this activity while scaffolded by the treatment system, she also displayed significant trepidation at whether and how this process could be sustained beyond the boundaries of the community:

I know for a fact that I would never relapse in here -- behind these walls. I'm just concerned when I go out, if I'm gonna be well-armed, you know, and use the tools that they, you know, like, knowing the triggers, like um, signs, you know, you don't just pick up automatically, there's things that happen and go, moods you go into, the things that you do that starts you or prepares, you know, you're in the relapse mode. At least, you know, I know what to do. Before I didn't know what to do. I tried everything for, I went to church, I, you know, did everything, but I didn't know how evil this disease is. I'll have to make a plan, you know, like structure my life when I get out of here, you know, have a support group, or NA meetings, you know, a home group, aftercare, you know. They were suggesting that I move because I used at the house, but I invested too much in that. I can't just get rid of it. I'm gonna just have to be prepared to deal with it.

Yolanda's recognition of the associated difficulties in maintaining her "inside" identity trajectory in the world outside constituted a significant moment in her narrative.

Here she began to critically examine the value of treatment participation, finding that its benefit lay not only in constructing a recovering self within the walls of treatment, but in establishing ongoing connections to maintain this identity commitment beyond these walls and recognizing that the realities of the outside world do not always afford a singular focus on recovery.

When I spoke with Yolanda again it was nearly five months after our first meeting. She explained that she had been busy at work, having returned to her long-term job one week after completing treatment, and “tending to the children, just trying to maintain, just trying to keep clean.” The demands of her daily life and serious health problems had interfered with her plans to stay involved in 12-step activities after she left treatment:

I kind of slip every now and then, you know, getting a drink or whatever but, um, it is hard. It's real hard. And then by having the virus, working, having a full schedule, which seems like an excuse, but your body is tired. So I don't have the energy to go to the meetings like they say you're supposed to. I come home from work, I eat, and I go right to sleep.

Although she had not waned in her commitment to the self-as-addict, remarking that “it is something that you will always have embedded in your mind, you know, embedded, it does something to the brain,” much of her talk focused on the everyday pressures of meeting financial obligations and maintaining a home for herself and her son. In fact, talk of self in recovery no longer appeared to constitute a meaningful part of

her narrative. She was in fact philosophical about these issues and their connectedness to meaningfully altering one's life trajectory in treatment:

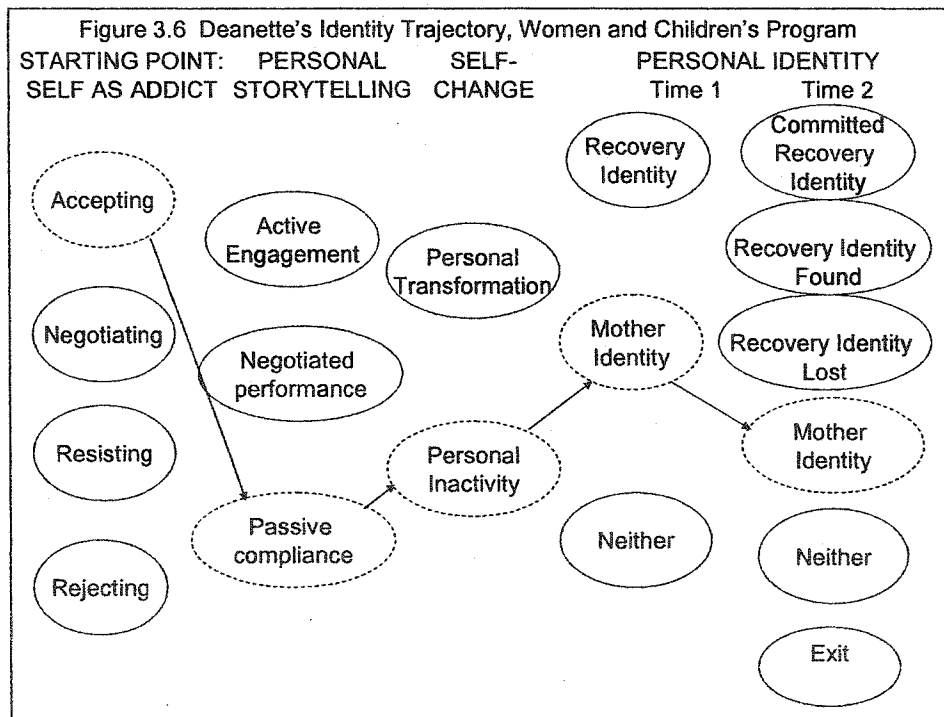
It did help me. It helped me by, um, getting me aware of what drugs, how it affects you, the control it has over you. You're not even aware of what's going on. It teaches you that. Um, what it doesn't teach you is how to maintain when you're out here in the real life, in the real world. The thing is, the program, it keeps you away, it keeps you in safe hands if you want for a period of time where it gives you a chance that you can fight for yourself, you can fend for yourself, but you have to have a made up mind and follow it through. But it doesn't prepare you for when you get out. It doesn't. And I was blessed because I have a job to come to. A lot of people don't have a job, don't have a place to stay, and when you don't have that and then you want, this society is so, it makes you give up. I know a girl now, she doesn't even have a place to stay. She can't get a job. No one will hire her. She has the virus, you know, but she's never had a record. I don't know. Sometimes it's really hard if you don't have nothing to, to, to work with. It'll help, um, a person with a made up mind, it'll give them something to keep fighting for. But when you can't even get started and then, you know, you get worn down by keep trying, and by not having a place to stay it's even worse.

In this moment, she was clearly critical that the valued identity trajectories inside the treatment community are in many cases stunted -- disconnected from the everyday

experiences and practical realities faced by impoverished women as they re-enter the outside world.

Mother Identity – Deanette’s Trajectory

While the previous trajectories illustrated women’s unique negotiations of recovery identities, other women foregrounded the construction of alternative personal identities in their narratives. Although clearly situated by addiction and recovery discourses, Deanette’s trajectory, illustrated in Figure 3.6 below, exemplified the construction of an alternative path with motherhood as its primary focus.



A 29-year-old Latina cocaine user, Deanette was in residential treatment for the second time when we met for our interview. Arrested on serious criminal charges some six years earlier she was mandated to treatment by the Department of Corrections at that

time. She considered this occasion of entry into the women and children's program voluntary although she was involved in a child abandonment case with the Department of Children and Families, facing a termination of her parental rights. She organized much of her narrative around this situation that threatened her relationship with her four-year-old twin boys:

I decided t-, to come here to treatment after six years. I relapsed for two weeks and I was on a two week run and this time I have kids. And now I have, I didn't have kids before, before. 'Cause my mom had to pick up my kids at the sitter's house. And told me if I ever wanted to see my kids again I'll have to go to detox. So I went to detox. But when I went to detox she went to, went to DCF [Dept. of Children and Families] to tell 'em that I had abandoned my kids. So DCF got involved. I didn't want to be here. I was pissed. I wasn't up for it but I knew I had to do it. I, I couldn't, I couldn't leave 'cause I wanted my kids. I was getting further apart from them. I couldn't leave. So each time I went to court it's like a little boost. You know? Each time I go to court it's like, they might set me back a little, but at the same time I know I what I'm fighting for.

She connected her relapse to drug use after six years of sobriety to her separation from her children's father and the stress brought on by managing financial and childcare responsibilities on her own. Citing her failure to keep up with 12-step meetings as the

immediate cause of her relapse, she expressed a renewed commitment to the 'tools' of the 12-steps in her current episode of treatment:

I just stopped once, I just stopped going to meetings. You know cause I just, I couldn't deal with it. I'm a single mom and my children's father had just left me. I couldn't go to no more meetings. I know that sounds horrible, I'm upset why I keep doing these things. And once you stop going to one meeting, you stop going, and you start blocking the pain and eventually it's just gonna hit you. It just takes, it's a matter of time. So instead of talking about it, I went and I used. I have never picked up anything like tools, until like this year, those tools. I know that I got my tools. I know what I have to do for right now for this place and my kids. I got my twelve steps, conditions for 90 days. I have a sponsor, you know, go to meetings, share in the meetings. That's gonna be for the rest of my life. I changed the way that um, I view things now, you know. And I view, the reason why I'm here, 'cause at first you don't want to be here, nobody likes to be told what time to eat, what time to get up, what time to, to do everything. You know. So at first, no I didn't want to be here, but I, I, I started getting used to it, the program and the people who... the staff in here.

In spite of her repeated references to 12-step practices, her words alluded to a self that must accommodate external pressures, which demanded mastery of 12-step discourse, yet not active appropriation by the self. Knowing what 'I have to do for right

now for this place and for my kids' and 'getting used to the program' are but two instances in her talk that implied passivity and submission, or outward compliance in order to achieve an instrumental goal – regaining custody of her children.

Her talk of self as addict was similar in its tone, frequently and forcefully invoked, yet neither considered nor negotiated, nor integrated into a developing trajectory of self. She constructed the self as fundamentally passive and reactive to stimuli in keeping with her understanding of addiction:

It's a mental disease. It's actually in your genes. It, it's in my genes. The gene of addiction. It's passed on. You know, bio-, a bio-, genetic or whatever, to a hed-, heditary, hereditary. An addict should never have goals, but live on a day-to-day basis. Cause once they have goals they have expectations. Once you have expectations, then you feel, if you don't follow through those expectations, it's very hard for an addict. A lot of people here don't know because a lot of people here are not, are just becoming addicts for the first time, like the treatment is their first time. When an addict builds expectations, you're building on something maybe two or three years from now. All I can tell you, all I can promise you, is today. You know? But see, we talk about triggers and a lot of people here have never been clean. But now they stay six months, nine months, but in treatment. Stre--, stress, stress is a trigger. Old friends are a trigger. Old people are triggers, old places are triggers. And you've got money issues, could be a trigger to go back and use. Um, you have, sometimes isolation

can be a trigger. You have all these little triggers but if you don't catch them on time, they'll have you out like this.

Understanding addiction as a genetic disorder implied a permanence and stability to the addicted self to which she was apparently resigned. Though she spoke of 'becoming an addict' in treatment, taken in context her words suggested a finality to this discovery. Addiction foreclosed possibilities for the self in her understanding, rather than opening new trajectories of identity.

In the re-entry phase of the program when we met two months later, Deanette was attending a three-week course to become a nurse's aide, and planned to move into a halfway house when released. Having gained visitation rights, she continued to fight for custody of her children:

They had made so many allegations that it was like really bizarre. I mean I haven't been a perfect mother, but I also have never abused my kids. And (sighs), I was thinking these people don't even know me and automatically, you know, they just want to set my life for me. So I had to learn to accept, you know, and I accepted whatever they wanted. But now my mom and I have, together, we're fighting this hard. And, you know, we're trying to find a private attorney. We're trying to do what we have to do in order to get my kids back because I've always been a mom to my kids. It's been really good, you know, um, I got a sponsor. I'm working my steps. When I get aggravated or agitated I have someone to talk to,

you know. Because not having my kids for a long time has distanced me as a mom - my, my role model as a mother.

Acquiescing to court and program demands out of concern for her children, Deanette appeared resigned to her identity as an addict, yet her talk suggested no personal transformation in her understanding of self since we first met. Constrained by her understanding of addiction as genetic or biological destiny, and by implication her self as addict, she remained unable to gather words to speak about change in herself. Rather she focused on simplifying her life to avoid the seemingly inevitable negative consequences of addiction as she understood them, in essence resisting the possibility of an agentic self. Indeed, even her understanding of self as addict proceeded along a circular trajectory, without potentiating future change:

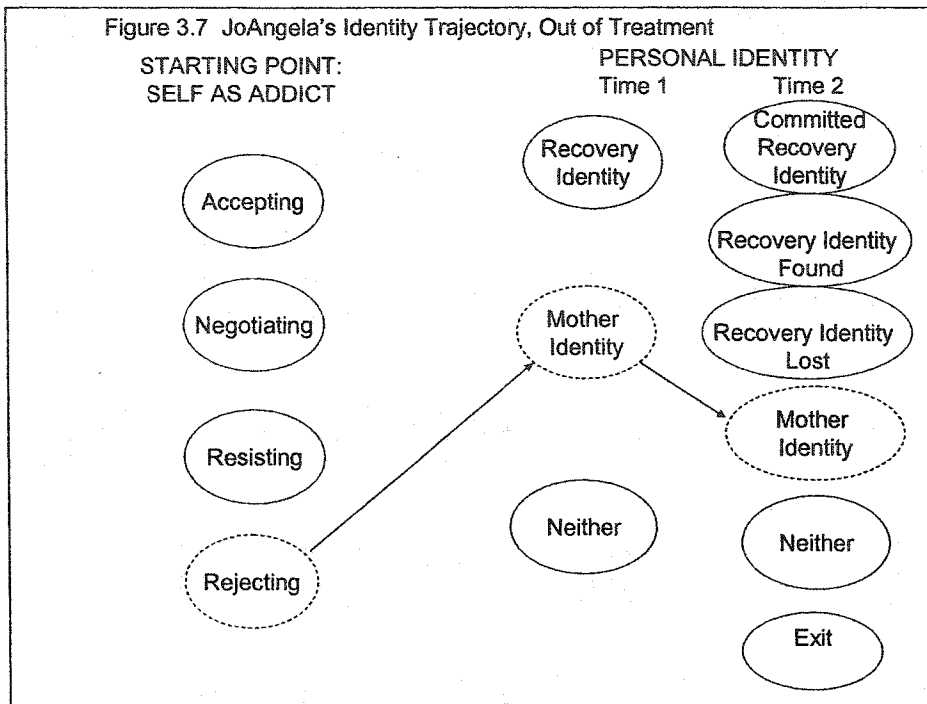
H: Has that changed, how you see yourself or, ...

D: Oh, I have. I will never do this again. I'm sorry I went. You know, if I would've known then what I know now with DCF and everything, I would've never picked up again. Never. That, that would've been, you know what I mean, like, the bottom of my list. And I never want to go through this again. I'm sorry. Ain't no drug good enough that can tell me that my kids are gonna be ok. I can only take it one day at a time. I can't take it a future at a time. Because that'll make me, that'll be making expectations, and I don't make false expectations. Right now, I'm just studying for, for what I can do just for today. Like getting my schooling

for three weeks. Getting my nurse's aide and then going to the Alpha House. That's all I could tell you. I can't tell you anymore. And I don't plan to do anything else. That's just, that's my goal that I know. Those are the goals that I could do. If I build up false expectations, me as an addict, I'm gonna feel like I can't do it. I am an addict. If I didn't, I wouldn't, I wouldn't be doing the footwork because step one says I admitted, I came to, wait, step one is I admitted that I was that I was powerless over my addiction and my life became unmanageable. If I cannot admit it, if I cannot admit that I am powerless and I'm an addict, then I cannot do my steps because why would I if I wasn't an addict?

Mother Identity – JoAngela's Trajectory

In contrast to Deanette's story, JoAngela's narrative exemplified a committed mother identity *outside* the walls of treatment -- one that clearly guided her transactions with the world.



A 26-year-old African American marijuana user, JoAngela was the mother of five young children, ages two to ten. Her children were foregrounded in every aspect of her life narrative, her concern for their welfare threading through seemingly unrelated events. In fact, in her very first comments she attributed her lessening marijuana use to her children:

Ok, the first time I ever used drugs it was um, it was basically only marijuana but it was getting to a point where I was almost in a stage where I was letting it control me. I never went through treatment, I did it, you know, did it on my own. I did it for my kids, that's the most important thing to me. And I feel as though them five or ten, fifteen, you know, twenty dollars that you're using to buy weed, if you have kids, you can take it and do something positive for your kids. That's what really opened

my eyes. And um, before I went there it was like, my kids, I'm sitting up smoking and my kids laying there hungry, you know, and I was like, I had to make a decision whether it's going to be the drugs, or my kids. I am a mother, you know, God gave me these and I got to do what I got to do for them. I feel good for the closeness cause that's what keeps me going. If I couldn't, I don't think not one day if I wouldn't have had kids. Cause I know I probably would have been...They hold me together.

Clearly committed to self as mother, her pursuit of this identity and avoidance of threats to it consistently framed her talk around a complex of issues from drug use and homelessness to relationships and goals. Having recently walked away from an abusive relationship with her youngest child's father, she spoke again about her children as her motivation for action in this regard:

When I got with my little girl's daddy, that just really like, you know, messed me up because I never had a man beat me like he did. It was five years and I felt so down about myself and you know people have a tendency of doing that. They talk down on you and you go to feel it. And the worst experience was to wake up, um, one morning and look at my kid with a purple eye. When he did this (refers to scar) I mean blood was like everywhere, blood was all over my face. And I don't know if they seen it cause I couldn't even see to be honest, you know, and I was like after that, I can't allow my kids to go through that again. You know, I'm getting hurt but I'm not hurting me, I'm hurting my kids, to keep putting them through

that. You know, he was, and my kids were calling him daddy. And when he stood up and he told me, oh, um, stop your kids from calling me daddy, that was the end. That was it. You're not going to like down my kids like that. They don't know nothing, they don't know, you know, they know that you're not their daddy, but they feel like you're their daddy cause you're there, for five years you were there.

Living in a homeless shelter with four of her children at the time of this interview, her precarious circumstances somehow failed to dim her hopes for the future. Her life trajectory was clearly guided by the roles and responsibilities she imputed to self as mother and her activities patterned and prioritized in accordance with this worldview:

The most important things in my life is, one is to go back to school and be a role model, you know what I'm saying, cause how can I push my kids, you know, when I never finished. Like now, being in the shelter, I got all my kids in day care and in school so now it's time to go forward. And I want my kids to have everything that I didn't, not what they want, what they need. Anytime they need something I want them to be able to, you know, get it. Ok, you know, I don't want them to be fed with a golden spoon, you know what I'm saying, but we done went through the struggle and right now we still going through the struggle and I want them to know that the struggle got to be over one day. That's my main purpose for living right now is to do things for them and show them what nobody never showed me. Even though my mom was there, when she never, you

know, like really took the time and did things. I guess when you raise your child, you raise your child the way *you* want, you know, you feel like it's supposed to be. Only worry I have is that, you know, is I'm going to make it? Will I be, um, a faithful and true mother to them cause I don't want nothing to come between me and my kids. I think, I think more for the future for my kids more than I do the present. I live day by day, but my mind goes farther than the day.

With young children in her care, JoAngela's active commitment to their development was evident in her intensely philosophical talk about motherhood. She placed tremendous value on her identity as mother, which provided a focus and purpose for her transactions with the world.

Nearly five months had passed when I caught up with JoAngela again. After leaving the homeless shelter, she and her children had been evicted from their temporary housing and were now staying with a relative. She was concerned about the detrimental effects of this instability and transience on her children, but was equally troubled by the fact that she had become pregnant one month after we first spoke:

I'm four months pregnant. I, I didn't want it at the, you know, at the time. I didn't want to be pregnant because of what I'm going through but, God only do things that, you know, He only, He don't give you too much that you can't handle. You know, it's a challenge right now. It get kind of, it gives me a headache. Just, you know, thinking about being in that

situation. That's what I want to try to, you know, at least have a piece of some job that make the baby comfortable. Cause all the rest of my kids, no matter what, they was comfortable. And that's what I want to do. Make, you know, myself, and my baby comfortable, until I could, you know, really get out there and get a real job. What I want, the goal that I have is to get, for one, get my kids in a stable home and the only way to do that is get a better job, a good, a job, period. But I know I'm gonna have to start from the bottom. But I want to fight my way to the top.

In spite of these challenges, JoAngela continued to maintain a positive outlook. Speaking about important life changes, she was actively engaged in building a self through positive relationships with others:

I'm in, you know, in a situation where I need. And it's got, you know, like, I, I, I just give it to God. He's been blessing me to just put people in my path that has really been helping out and it's really getting me to look at life a whole different way. Most of the people, um, came from my church and my pastor, it's, sometimes it ain't as much, you know, what they're giving you, as a listening ear, somebody to talk to. And then my mom, being that we in the same church, we have built a better relationship with each other cause at one time we didn't have a good relationship. You know, it's like, I felt like I was the black sheep, like I was an outsider. But now I feel closer to the family and our family starting to, you know, get

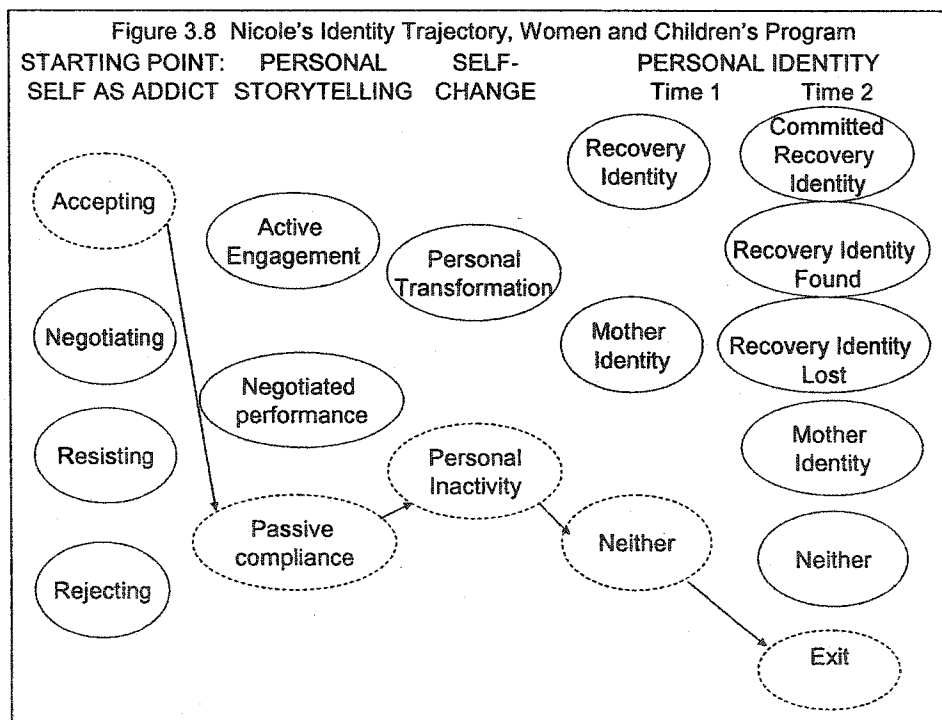
back like it used to be. At one time I used to take life for granted. I was running the streets, I was, you know, turning to drugs, turning to men. But a man and drugs is the farthest thing from my mind right now, you know, I was, I was really neglecting my children and I didn't see it. But now I see it. But I know now I still have a chance. See it was negative people, like my little girl's daddy, telling me I wasn't nothing and I would never, you know what I'm saying, get this. I won't have a man, a good man, you know what I'm saying, helping me with my kids. And most of the people that have been in my path that, they helped me to see it because they done went through what I'm going through. So, and then when I look at people that don't have they kids, or, you know, going through that HRS [Dept. of Health and Rehabilitative Services] thing, it really hits that that could've been me when I was, you know, in my addiction and running out in the streets. Cause I was addicted to the streets. I was addicted to men, I was addicted to, you know, marijuana, but now I'm addicted to the church.

JoAngela's reference to her "path" suggests that she conceived of her life as a journey, capable of evolving in many possible directions. Through her newfound participation in positive social transactions, she began to envision the self as an important actor in this process, implicating personal agency as an impetus of change. Her unique use of the term "addiction" here was of interest as well, primarily in the way it contrasted with its use among women in treatment. It appeared that "addiction" in JoAngela's estimation was an attribute capable of a positive valuation, according to its application.

No Identity Trajectory—Nicole's Trajectory

In contrast to the narratives illustrated previously, a sizeable group of women both in and out of treatment were unable to construct any coherent identity trajectory.

Nicole's trajectory, illustrated in Figure 3.8 below, was unique among participants in the women and children's program for this very reason. Although she accepted the self-as-addict label, she displayed very little engagement with the Twelve Step system.



A 33-year-old white heroin user, Nicole entered the women and children's program almost one month prior to our interview. She enrolled in treatment voluntarily after the recent drug overdose death of her boyfriend. Several years earlier she had participated in another program at the Village that helped her to achieve two years of

sobriety, and she struggled to understand her current placement in the family-centered program:

When I first came in, I was in here seven days I already wanted to leave. I went crazy. Especially you know, I have a son too. I have a ten year old. And you know, everyone's got their kids here and, or they're talking about kids. And my son's not here. He's with his dad. So it kinda, it was very upsetting. You know, I can't have my son anymore. I, I gave up my parental rights to, to his dad. His father has had him since he was five. I had him baby to five and then I hand-, I gave him to his dad. 'Cause I was so bad into drugs. That I, I made the right decision at the time. And at the time whatever my ex-husband did, I would've probably done the same thing. You know? I mean he, he wanted to make sure that I never, you know...you know 'cause look at me now. I, I picked up um, um, you know, I relapsed after almost two years. I stayed clean almost two years 'cause of this program. It helped. So you know, that's the reason why I wanted to come back here. But I also feel that you know, I'm in the wrong program. I think I should be back in Program 10. Not because of the length of time. Because I can get up and leave. I'm here voluntarily. It's the fact that it's not, it's not a parental program and the, the majority of these people are getting their kids back or they're trying to get their kids back. And me and my ex-husband have an agreement, you know. And I signed the papers so, it, it's very hard. You know, you go to groups and

you talk about kids and stuff like that every day. But then I think of it, I'm still a parent so you know, why not learn. Thirty-three. You never know what can happen, right?

Uniquely positioned by her loss of parental rights, Nicole confronted constraints on her full participation in the program that were rooted in the very structure of the institution. Lacking the interactions with her son necessary to scaffold an 'insider trajectory' in a community of families, she inhabited a marginal location on the boundaries of the community that problematized the construction of a valued maternal identity:

I get the most out of, an IC, a one-on-one therapy. Or a group therapy. The rest of 'em, I really could care less about the co-dependency, job development, relapse prevention. As the time goes by, you get, you get comfortable and you know, you don't mind going to groups and you don't mind doing this. And it gets a lot easier. But I would say the first two weeks, it's hard for anybody to, you know, to adjust. It's very hard 'cause you don't know, you know, especially what you're sharing. You don't want them to know your business. And sometimes you feel uncomfortable but like I said, the longer you're here, you get to know the people and you don't even, you know, you know what to tell them, in other words. They have this group at five o'clock and bbb-, which is bonding from five to six. I think it's the most ridiculous thing in the world. They want you to

bond with other people kids. And that's, (laughs), I don't really, I mean, I do 'cause I have to. I, my child's not here. Why, you know, why do I have to play with your child? You know. But that's the rules. I like to be a mother but I w—, I want to be a mother, but I'm not given the chance to. Um, it's, it's, it's, it's probably the, the most precious thing you'll ever have in life. You know when you, it, you know, he came from you, or if you had a dd-, had a daughter she came from you. You just, you can't get the, the bond between having a child, it's amazing.

Her status as a 'volunteer' in the program, without criminal justice or court involvement, combined with the unattainable goal of family reunification, afforded the possibility to critique the program in ways less available to women who had compulsory treatment obligations. Perhaps for these reasons Nicole openly expressed little fundamental commitment to participation in many treatment groups and practices. She was particularly frank regarding 12-step activities as they related to her on a personal level. Although quick to recognize the value of AA and NA for others, she displayed no mastery of 12-step discourse in her own talk, and made no reference to the self in the prototypical language of the 12-step program:

I, I, I've been going...I've known about AA for a long time, and NA.

'Cause my mom's in NA, or AA rather. She's got 14 years clean. And it's, it's, it's ... I don't know. I ... a lot of people, some people go to churches.

Some people go to psychiatrists. And some people go to NA or AA. And

it's okay for some people. For me, it's okay, the NA, I think NA's a little bit better for me 'cause I'm more into the narcotics. But sometimes people just sit there and war story and tell...who the hell wants to hear about you in a gutter shootin' drugs? That, that's when I start want, thinkin' about it. You know I'd like to, I'd like to take a needle and stick it my arm. Or I'd like to sniff something. So to me, a lot of it's just bringing up memories. I like to forget, forget the past. You know, I don't want to, I want to start clean and fresh. But I do go. And in here it's mandatory you go. But see for, personally, when they start talking about it and, or, and glorifying it, it just, it, you know brings up a lot for me. But everybody is different. Some people, that's what they live for. They live for NA and they live for AA. And that's good if it's keeping 'em clean. It's different for everybody. And in my, and I'll do it 'cause if you want it, an answer about a higher power or anything like that. I have a hard time with higher power. 'Cause personally I've never seen God. I'm not an atheist. I could, I'm, uh, I consider myself Jewish. And you know, my God could be my mother. It could my son. It could be my dog. But I've, you know, for me to sit there and tell you that, you know, my, you know, I'm gonna go pray to my higher power. It would be, it's, it's wrong 'cause it's not true. And then they say, you know they want you to get into your higher power of spiritual...it, that annoys the shit out of me.

Here, Nicole constructed the 12-step model as one among many possible approaches to recovery, raising a fundamental tension in her engagement with the activity system of the treatment environment that privileged the 12-steps as the only path to abstinence. Her resistance to the 12-step philosophy, however, did not extend to a rejection of the self as addict. In fact, she readily adopted this identity, constructing it as an almost inevitable outcome of her upbringing and family life. Her divergence from the conventional 12-step path was most obvious in her resistance to authoritative claims surrounding the process for achieving 'recovery.' She rejected the dictate of self as powerless, the foundational 'first step' of AA and NA, instead maintaining a claim to an agentic self capable of acting in the world to achieve recovery 'on her own.'

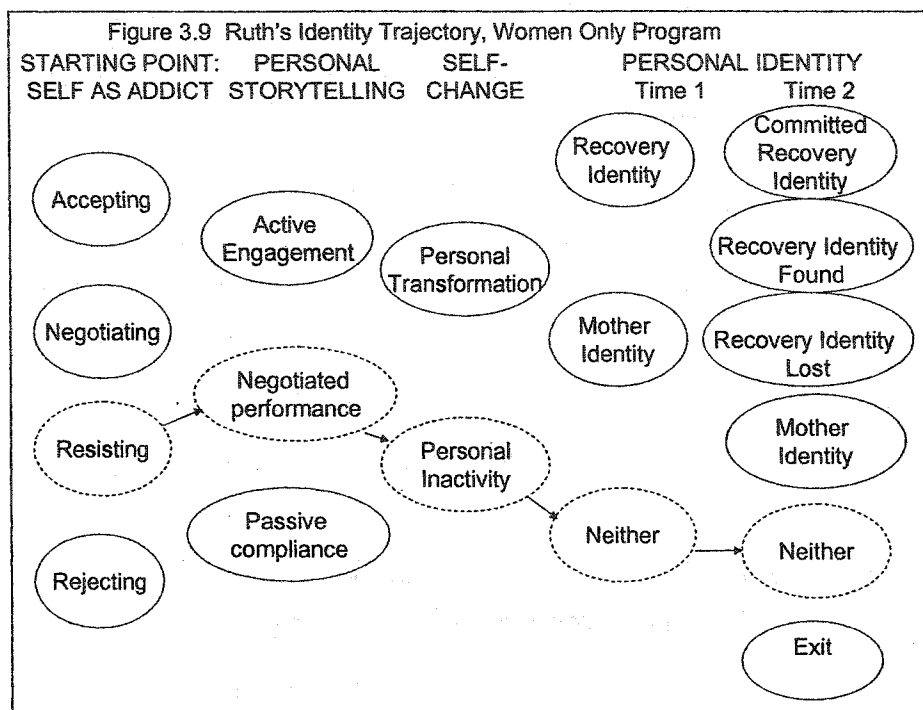
This is how I feel about it, about addiction. Um, as far as, as my, like my mom and my dad were addicts. My aunt was an addict. My grandparents were addicts. Every person in my family was an addict. So, and I'm the youngest. So I was like bb--. I mean they say that's not true. I was bound to pick up. I feel that. You know what I mean? Like that's all I saw my whole life, is drugs and alcohol. So, you know, and I used to, I remember saying when I was young, you know, I don't want to be like them. And I ended up worse than them. For me, that, you know, I know I'm an addict. And, and I, I'm the type of addict where, you know like, I've been with people that they can pick up like every three months and put it down. I can't stop. I'm totally dysfunctional. People get so crazy with me. They're like you're an atheist, and like I'm not an atheist. I'm just not, I'm

not on the ground and I'm not gonna sit there and say yeah, I'm goin' to church and you know. Just 'cause I'm in here. And I'm not gonna change for anybody. I'm gonna, on myself, try to walk out the door.

When I returned to speak with Nicole again two months later she had left the program. Despite repeated attempts to contact her, I was unable to locate her for a follow-up interview.

No Identity Trajectory – Ruth's Trajectory

Uniquely positioned by her loss of parental rights, Nicole was unable to achieve full participation in the women and children's program, thereby constraining her identity possibilities. Similarly, Ruth remained unable to construct a viable identity in the "women only" program in spite of her limited attempts at participation. Ruth's trajectory is presented in Figure 3.9 below.



A 39-year-old African American woman, Ruth entered treatment voluntarily seeking to end her uncontrolled use of crack-cocaine. Sharing her difficulties in constructing a personal narrative valued by the community, she spoke openly about learning the parameters of appropriate “self” storylines from more experienced peers:

When I first came in, it was like, I was like more, I wasn't ready to open up. But, when I like, you know, stayed a little while, I opened up. When I first came in it was like, I'd say, I didn't want to speak on nothing. It took me about a couple of days. 'Cause when I first came, I was feeling like, I felt like I wasn't a part, a part of the, like I was off to the side. I stepped in, you know, introduced myself, who I am, where I come from, and listen to what was going on with them and their lives, and like some of them were like, related to me. Because a lot of things they would talk about were

related to me, a lot of things they would talk about didn't relate to me, and I would speak up on it. When I see someone up there talking, and they go to talking, and they're crying, and it seems like they've been through a lot. Cause everybody tells different stories and I like listening to them. Cause it seems like every night we have a meeting, different people come, and different people talk about different things I never heard before.

Bootstrapping a viable personal narrative by enacting institutional practices and discourses, Ruth was afforded a place of membership in the community. In a life touched early on by violence and trauma, her positive transactions within the boundaries of treatment marked perhaps her first occasion of meaningful participation in a structured system of activity that allowed for the possibility of self-making:

I feel so good about myself, you know? I can't believe it's me. You know, I feel good. I feel like my whole life is turned around. I'm learning how, you know, to open up to people, not getting angry, getting respect. It seems like I'm getting more people to respect me, talking to me nicer, you know, not talking to me like I'm nobody. Making me feel good. 'Cause when I was like out there on the street, seemed like I didn't get no kind of respect from no one. Like they'd talk to you any kind of way. Seems like I'm doing things that I wasn't doing -- in my life, like, taking care of myself.

Despite a palpable feeling of improvement in her quality of life, there was no indication in her talk of an emerging or developing agentic self, capable of acting, transforming and effecting change in the world. She appeared adrift in the program, neither accepting nor resisting institutional claims, carried along solely by the necessity of meeting program demands. In fact, Ruth carried on a negotiation of a much different kind -- an unresolved struggle with the fundamental issues of whether and how she could maintain her survival:

I've been worrying about my life, if I'm gonna keep it up, that's one thing, how is my life gonna continue on, how, how am I gonna keep managing. Sometimes I say to myself and think things, "Gosh, what else do I do now? I done spent half of my life getting high." Sometimes I say to myself, "That's my life. Doing drugs. And I ain't got too much more longer to live. I want to go ahead and live my life without getting high no more. I done wasted half of it."

Ruth had relapsed to crack use a week prior to our follow-up interview. Although she had returned to treatment the day following this incident she continued to stagnate, constructing the program not as therapeutic or educational but as punitive and controlling:

It seems like drugs is like calling me. I try to not to think about drugs, like, based on being here, it feels like I'm being locked up, like I can't do what I want to do in here too much. I like to go out to movies and stuff like that. Everyday I wake up, come to group, go to group, it's like, I don't

have no, not too much activity. Sometimes I'll go to a park, it's like, I feel like I'm being holded, like I'm in jail. And I'm like dealing with that.

Having received sanctions from program staff as a penalty for her relapse, she struggled alternatively between her desire to leave behind the conflict in the program and her fear of doing so because of illness. Motivated by her HIV-positive diagnosis to maintain a healthy lifestyle, she was apprehensive that leaving would result in a return to drug use that would hasten the progression of her disease:

This is the longest I've ever been in a program on the outside. Cause any other time I would've been done left the program. But for some reason, the reason why I'm in this program, staying this long, is because of my illness. And my doctor told me if I ever pick up any kind of drug I will die.

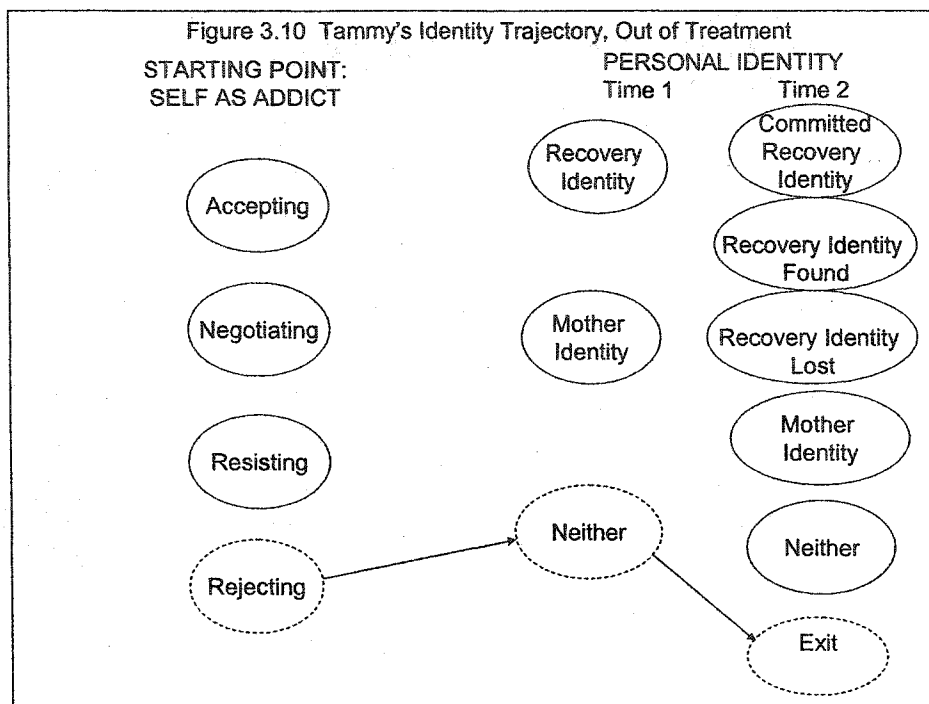
In spite of this powerful influence, the mention of an instrumental rationale for maintaining membership in the treatment community suggests she had undergone little development of self in relation to the program, her discourse lacking any reference to indicate that she had integrated and reorganized her worldview around the 12-step philosophy. Typically characteristic of program newcomers who have not yet engaged in the treatment process, this talk belied her several month tenure in the program. Rather, Ruth appeared to engage in a manner of what Hoffmann (2003) has termed "false confession," or the minimal use of appropriate or valued self-talk in a particular

community in order to avoid criticism or notice by its members. Here she appeared to engage in this practice, speaking superficially on the self as addict:

I know I'm an addict. And it seem like, I tell myself I don't want to be an addict, but I know I am an addict. And it seems like it ain't gonna change, I'm gonna be an addict. I don't feel myself as an addict but I know I am an addict. But, you know, it's like if I pick up, I know I'm an addict. But by me not picking up I know I ain't an addict.

No Identity Trajectory – Tammy's Trajectory

Where Nicole and Ruth were unable to scaffold new identities without meaningful participation in the activity system of treatment, women outside of treatment had even fewer opportunities for self authoring. Tammy's trajectory, illustrated in Figure 3.10 below, exemplified the path of many chronically drug-involved women. Though she rejected the self-as-addict and the idea of treatment, she attributed little meaning to motherhood or any alternative identity possibilities.



A 35-year-old African-American heroin and crack user, Tammy shared a life narrative permeated by utter hopelessness. Having initiated cocaine use at age 14, she recalled a dramatic decline in the quality and stability of her life when she became involved with crack cocaine in her late twenties. The course of her involvement in criminal activity and prostitution had led to the severance of most relationships with her immediate family, including her only daughter, who was residing with a cousin in another part of Miami. Given her present situation, she spoke about the loss of this relationship matter-of-factly:

And my daughter, what I did was, because I used that as an excuse for someone else to take care of my daughter because I already done did, she's fourteen now, I done did all up until she got fourteen, so I told her that I didn't have none of that, I've done been with you and everything and now

I want to be by myself. So that's why I live by myself now. I don't live with her but I do still go and give money, see her, yeah, and call her. I still be with her and what not, even though I'm in my active addiction, but I just, right now she's, you know, I'd rather for her to stay where she's staying at. Every month they issue like out 400 dollars a month for her and I just told her instead of me keeping the money, and knowing that I'm going to spend it and mess it up, I would rather for her to be, I would rather for it to be like that, for her to have money every month. You know I'm not those, some women are, when they do drugs, they selfish, they don't care about their kids, they don't care about their welfare. See I sit down and I think about that. Because when the drugs is gone your daughter, your child is gonna be still there without whatever they need.

Although clearly concerned with her daughter's welfare, Tammy's limited connection to a maternal identity is evidenced by the lack of reference to self as mother throughout her talk, yet she is enmeshed in a life offering few positive alternative possibilities for self-building. She spoke of living an isolated existence, void of meaningful relationships and activities necessary for scaffolding a developing self. A vacancy of self was apparent throughout her narrative, but was particularly poignant as we spoke in the following conversational turn:

H: Is there anything you think that makes you care about yourself, like makes you feel like you're worth taking care of, you know, things that make you feel good about yourself?

T: No, because, I would say my baby, but it really, it really doesn't, beyond that it doesn't. I don't know.

H: You said earlier that it was, that you thought you were doing the right thing for your daughter by having her stay, um...

T: Yeah, because if not she'd be living a miserable life. To me my life is miserable but I won't do anything about it. It makes me like, it's kind of like confusing to me so what I do, I just take it one day at a time.

H: So do you think about your future, like what your life will be like next year?

T: No, because to be honest I always tell myself I'm not promised, you know, I'm not promised, and if I'm not promised I just have to just live it day by day as I said, just take it one day at a time.

Clearly unhappy in her current situation, she was nevertheless constrained by it, unable to either envision or express valued goals or commitments. In this regard, the self can be understood as an agent of change that develops through an individual's interactions within a meaningful system of activity. Without such participation, it can be argued that an agentic self is unlikely to emerge. Tammy spoke briefly of a general

desire to stop using drugs, but at no point implicated a self capable of acting in this regard:

Deep down though, I really do want to stop, but it's like I say, something is holding me back. I know what it takes to get cleaned up. I do know, it's just that something it's like holding me, making me to where I don't want it right now.

In fact, having been in treatment for a short time in the year prior to our meeting, she actively rejected substance abuse treatment as a path to sobriety. Suggesting that her identity trajectory was unaffected by participation in the program, she made no reference to change in her talk of the treatment community. Rather, she vividly recalled her experience in the program as one of resistance, constructing the episode as punitive:

I wanted things my way. I don't know why but I wanted things my way. I didn't want to listen and I, when they tell me to do stuff I used to look at them like they're crazy, and if I didn't feel like doing it I wouldn't do it. And I made excuses so I could stay in the bed asleep, get extra food. And its like, I guess I wasn't ready. I'm, I'm not ready and everybody wants me to be ready and want me to do it, but I'm not going to do it. And over there in that program, I didn't like, I didn't like being over there, I didn't like it, I didn't like the orders that the staff...you couldn't talk to the guys, the men. And half the time women don't want to talk to another woman like that, you know? They want us all to be in one bunch together, you

can't speak with no men, you can't do this. And I just got tired, and I said forget it. I'm not, I don't want to go through no program. I don't like the programs. I didn't like going to the groups. I have to get up, and um, so I can talk to our counselor, our therapist, that's what they called them, you talk to them and you have to tell them everything about you from the time you started using drugs. And everything, you get to talk on a one to one basis with your therapist, and you, you know, you have to, its ok, you know. My therapist, he was a very nice man. He was. He used to try to help me and what not, but he was making it where he didn't want me to be involved with none of my family, he wanted me to do the program.

Summary

Table 3.5 presents summary information on the identity trajectories narrated by women in each of the three study groups.

<u>Table 3.5 Identity Trajectories among Women by Treatment Status</u>			
	Women & Children's Treatment (n=12)	"Women Only" Treatment (n=9)	Out-of-Treatment (n=12)
Committed Recovery	6	1	0
Recovery Found	1	1	0
Recovery Lost	0	2	1
Mother	4	0	5
None	1	5	6

Clear patterns are evident in the identity trajectories of these thirty-three women, particularly as the trajectories are compared across contexts. In this regard, the majority of participants in the women and children's treatment program negotiated positive, forward-looking recovery identities through their participation in this particular system of activity. In contrast, fewer than half of the participants in the "women only" treatment program and the women out-of-treatment displayed any such positive developmental change. These findings coincide with more intensive and personal engagement in the Twelve Step system consistently displayed by women in the parental program, as they were generally more accepting of the self-as-addict, more actively involved in 12-step storytelling, and more likely to ascribe personal change to their 12-step participation.

As alluded to earlier in the presentation of individual women's trajectories, these developing recovery identities were uniquely connected to women's commitments to motherhood, suggesting that recovery became personally meaningful because it afforded the possibility to be a "good" mother. The tremendous value of this connection was also evident over time, as none of the participants in the women and children's treatment program lost their commitment to recovery, while three women in other contexts did so. It appeared that once the personal connection between recovery and mother identities was established, it continued to shape women's development in particular ways and was unlikely to be dismissed. In fact, in the single instance where a participant in the women and children's program had lost legal rights to her only child, she demonstrated little involvement in the recovery activities of the community, and exhibited no positive personal development in relation to the program. This was the typical situation among women in other contexts, as most had no meaningful personal identity guiding their

transactions with the world. The implications of these findings are discussed further in the chapter that follows.

CHAPTER 4

DISCUSSION AND CONCLUSIONS

In this study I highlighted the fundamentally dialectical relationship between the individual and social constituents of personal identity, examining the developmental trajectories of identity among women in and out of drug abuse treatment. I have argued throughout that personal identity emerges through social participation and transactions with particular “figured worlds,” and is constituted by engagement in activity systems that enact particular values or commitments. Clearly these commitments are not freely chosen from among a universe of possibilities, but are embedded in certain social positions and modes of participation within particular contexts in which these values become meaningful. The unique findings of this dissertation research offer support for existing approaches that emphasize the social foundations and mechanisms of personal identity construction, and also highlight the significance of local context in delineating relevant or salient identity possibilities.

Discussion of Results

The tremendous discrepancies observed in women’s patterns of development indicate that social participation in a particular local context is a critically important feature of personal identity construction. Notably, many of the women out of treatment lacked any meaningful social relationships or sense of community membership, as they inhabited marginal spaces on the boundaries of society where concerns for survival and subsistence marked their daily transactions with the world. In this regard, the narratives of these women described lives fashioned in response to outside forces, and an absence of a self capable of effecting change in the world. Or, as one participant poignantly expressed:

I've saw so many, so much bad shit happening to me that it was like irrelevant whether there was a purpose for me here or not because nothing but bad was happening.

Many of these women evidenced a lack of personal identity, drifting without purpose rather than acting from and toward felt commitments in their lives. Interestingly, Archer (2001) characterized homelessness and addiction as “downward spirals” precisely because these circumstances often focus individuals on the pursuit of immediate considerations – the next night or the next “high” – effectively displacing future-oriented commitments to action.

Nevertheless, “mother” was a uniquely salient identity for a substantial proportion of women outside of treatment, particularly those with very young children. In this sense, motherhood afforded the possibility of a positively valued identity around which women were able to organize their lives. As a group, these women described significant challenges, both financial and personal, to the performance of their parental duties. Often they faced threats to their maternal identities due to child welfare, court, or family intervention, which alleged that their drug use impaired their ability to meet their maternal obligations. Although women with young children worked actively to dispute these claims as evidenced by their narratives of care and commitment to their children, the narratives of older women evinced little that meaningfully guided their lives (see the *Afterword* for more detail on women outside of treatment).

Only within the boundaries of drug abuse treatment did recovery identity begin to emerge as the primary path toward personhood. The findings presented earlier

demonstrate that the development of personal identity as a 'recovering addict' is fundamentally grounded in meaningful social participation within an activity system that foregrounds this possibility. Clearly, however, women in the two treatment settings differed in their engagement with and negotiations of this identity. The findings of this research suggest that, for the most part, women's connections to their children reinforced 'recovery identity' as meaningful in tangible, concrete ways. The "women only" program offered no such affordance. In fact, the narratives of women in this program were striking for their lack of focus on motherhood and children. While this was not surprising among the older women that I interviewed in this particular context, women with younger children also failed to discuss motherhood as meaningfully guiding their lives.

Even within the parental program, the importance of social connections in women's construction of recovery identities was belied by the treatment community's persistent focus on recovery as an individual-level process. Treatment staff repeatedly emphasized the idea that "successful" recovery required a period of isolation, when relationships with others were sidelined and "self" held the complete focus of attention. Although participants negotiated these powerful claims in a variety of ways, they were fully aware of the need to align their priorities with those demanded by the treatment program:

Lisette: When they say this is a selfish, you know, recovery should be selfish, it's so true because recovery should be selfish. Because you have to think about yourself first.

Tolanga: They say that it's a selfish program. A selfish program is, it, it means you here for you. Get all you can, don't worry about nobody else.

Jennifer: In our groups, it's like, whenever you say, well I'm here for my kids or I'm here cause of my family, they say you can't be here for your kids or family, you need to be here for yourself and it drives me nuts! You're supposed to put yourself in front of everything.

This separation of self and other was often difficult to achieve, however, particularly among women with young children. In fact, this very focus appears to pose a serious contradiction to the rationale behind the establishment of treatment programs for women with children. For many, it was precisely the felt connection with their children that initiated and maintained their very participation in treatment, and their commitment to motherhood and 'good' mothering that scaffolded a recovery identity trajectory. Constructing these identities as symbiotic was in fact a central feature of the narratives for women most committed to recovery. Christine, a 22-year-old mother in the women and children's program, placed considerable emphasis on this point in our second interview:

The first two weeks I was here, I didn't want to be here and after the first two weeks I realized I have this problem now. I was actually, 'cause I didn't think I had a problem before I came in here. I really didn't. I thought well, I'm not using crack or heroin so I can't be an addict. I didn't think I had a problem then once I found out I did, I was like shit! Now

what am I gonna do? I was like well I started, you know, really listening intensely, and I was like ok, I'm gonna do this for K., my daughter. I came in because of my daughter. And I knew that I had to stay because of her. And I didn't want it for me, I wanted it for her and figured I'll do it for her. But you learn in here, you have to want it for yourself and until I did then, you have to truly want it. I mean, whatever keeps you in here, wonderful. Like she's the reason I stayed in here and that worked. That's what I needed to get by to this point where I can have it for myself and I want it. And it was just gradually throughout, you know. The classes back-to-back everyday, and the counselors and everything that I've heard. And they tell you all the time in there too, you have to want it for you. And I started wanting the better life for me. That way I could give her a better life because if I could do it for me, then I could give it to her. So I mean, that's been a big part too, because I'm, that's what kept me here. Knowing that I am doing this, at first I was doing it for her, but now I'm doing it for me and her. So it's been really a big factor because part of, this, part of me recovering is getting better so I can be with her. I have to put this recovery thing first because if I don't, if I put anything before it, I can't take care of her. That's the most ultimate thing, that I have to know that. And I know I have what it takes to make it in life. But I'm hoping that I can go out there and live my life like I was before. I was working, going to school, being a great mother. And I'm hoping I can do all that again. And not ever have to come back. Not ever have to pick up again.

Here, Christine attempted to balance her future outlook with a focus on recovery and its affordance of other positive identities that she hoped to re-build. In this way, her focus was not on 'recovery' as an end in itself, but on what sobriety allowed her to achieve in other areas of her life. Tying her past experiences to a forward-looking trajectory as a mother, worker and student, she attempted to construct a path for the self that transformed her recovery experience into an opening for acting positively upon the world. The lack of any such positive connection with 'recovery' was notable among virtually all of the women who were in treatment *without* their children.

A primary focus of this dissertation research was to understand women's unique and ongoing negotiations of 'recovery' and the mechanisms through which institutional recovery discourses were personally and creatively transformed. Personal storytelling emerged as a key mechanism of personal change within the Twelve Step system, and was clearly privileged as an activity by the treatment community. Nevertheless, it was clear in the narratives of women in treatment that participation in this activity was an emergent process, and that its skillful performance required social participation. For some, engaging in the processes designed to "uncover" self-knowledge was difficult, as these practices were unfamiliar. In fact, women often claimed that they were initially unable or unwilling to "give testimonies" or to successfully complete autobiographical assignments. In these cases, women frequently suggested that their progress in this regard was intimately connected with listening to other women's stories and hearing other women's experiences. In this way, women learned the parameters of personal storytelling appropriate to the treatment community through interactions with peers and staff, clearly

a social mechanism through which women were able to scaffold the development of recovery identities. In contrast, those disengaged from the practice of storytelling germane to the Twelve Steps were consistently unable to construct personal identities valued in the figured world of treatment.

The present research again indicates that women in the parental treatment program were generally more engaged in each of the critical elements of the Twelve Step system than women in either of the other two contexts. As a group, these women were the most likely to accept the addict label, to participate actively in personal storytelling, and to attribute personal change to this participation. In this way, they were able to construct trajectories as 'recovering' to a greater extent and achieved more full membership in the treatment community than women in treatment alone. I suggest that it is precisely the engagement with one's children that afforded the possibility of this positive personal development. Over time, women in the parental program began to see the tangible benefits of personal participation in recovery activities as they progressed to increased visitations with their children, and ultimately co-residence. As this occurred, women began to interweave recovery and motherhood in their personal narratives, and a sense of personal progress or accomplishment emerged. In this regard, recovery was empowering for women in this context, supporting an emerging sense of personal agency to effect change and to pursue valued commitments.

For other women, however, locating a space for personal agency within the boundaries of treatment was highly problematic. This was especially so in the "women only" program, which afforded few possibilities for positive personal connections with recovery. Measured against powerful institutional claims that endorse the acceptance of

powerlessness as the path to recovery, many women struggled to 'surrender' the self as an agent of change, constructing the task of recovery as an abandonment of will. Rosa, a 41-year-old African American woman in the "women only" program, highlighted her struggle after she was disciplined for a minor rule infraction that threatened her opportunity to attend outside computer classes:

Like I said, when you came into this program, you gave all your will over to somebody else, to the care of somebody else. So I guess, I sort of was trying to take it back yesterday. So I'm supposed to be able to accept and do whatever they tell me to do because their, when you came here you asked for help, so you're supposed to, like, go by all of their suggestions. But I feel, you know, sometimes, it's just to a certain degree, it's like a compromise. I mean whenever, you know, they're not always right, they're human too. And, um, I came to get sober, I didn't come to, you know, I came to leave the drugs alone and everything. I didn't know that when I came here a whole lot of other stuff went along with it. You know, rules and regulations on other aspects of your life. So that's hard for me to grasp cause this is my first time in treatment. So, I'm learning to deal, adapt with it, so, I have no other choice if I want to finish the course. I'm just, I'm very tired of getting knocked down. When I'm trying to do something and go forward and then somebody just pulls it back down, it just seems like, uh, I'm fighting a no win battle. What's the use in me trying, it makes you want to give up. I'm taking computer class since I've

been here so they've nominated me to go the outside classes. So if he puts me back that's gonna interfere with it because I won't be able to go out.

So that'll hurt.

In this moment, Rosa spoke critically on recovery, juxtaposing her desire for agency – to affect her own life course -- against the demands of treatment. Rather than providing a space in which her personal agency could emerge and develop, she maintained the perspective that an agentic self was inherently at odds with recovery as defined by the treatment community.

Theoretical Implications

This research has demonstrated that personal agency emerges in conjunction with developing identities within particular systems of activity. Notably, however, the parameters of a local activity system afford certain individual constructions and imbue identities with distinct meanings. In this regard, the present study illustrated widely disparate meanings of recovery within two spheres of Twelve Step activity. To be “recovering” in the parental program was to open new opportunities for mothering commitments, and to progress toward or achieve goals in this regard, while to be “recovering” in the women only program was simply to abstain from drugs, without constructing alternative commitments. If personal identity is taken as a matter of what we care about in the world, how we prioritize one concern above others (Archer, 2001), and ultimately, I would argue, how we enact these commitments, then the development of identity, agency, and commitment are inextricably intertwined, and cannot proceed in

isolation. In this vein, the present study demonstrated that “recovery identity” was unlikely to emerge as a meaningful trajectory unless linked to possibilities for personal agency.

These findings may inform future studies of drug abuse treatment settings, as research has shown that many types of drug abuse treatment are generally effective in reducing drug use and promoting at least short-term abstinence, yet the processes of engagement and participation through which this occurs are not well understood. This had lead some to refer to treatment as a “black box” (Simpson, 2001), with little understanding of how and why treatment does and does not work. My focus on the processes of identity construction was one such attempt to understand women’s personal development in relation to the figured world of treatment. This study demonstrated that the emergence of personal identity was clearly tied to the women’s particular social location in treatment. Nevertheless, some broad patterns were apparent in the identity negotiations of these 33 women. Although the women who participated in this dissertation research entered the study with accumulated biographies of personal experience, the specifics of which were unique to individuals and provided unique starting points for their identity development, their socially shared position as marginalized women also weaved common threads into their life experiences and trajectories of development.

The breadth of data gathered in this dissertation research clearly provides support for the view that personal identity is a necessary constituent of human functioning, capable of organizing and effecting the focused activity of individuals. That personal identity affords the ability for purposeful transactions with the world was evidenced by

the connections women drew between “recovery” and “mother” identities, and the focused commitments they enacted in this regard, as well as by the “drift” apparent in the narratives of women who lacked a meaningful sense of personal identity. These results resonate with innovative sociocultural perspectives on identity development that posit a fundamental link between identity and agency (Holland, et al., 1998; Martin & Sugarman, 2001a; Stetsenko & Arieviditch, 2004). Importantly, this developmental process is dynamic, as the possibilities for identity and agency are continually re-negotiated in response to an individual’s changing participation in a variety of social contexts, which may reaffirm or challenge existing commitments.

This study of personal identity and agency was carried out as women transitioned into new communities of practice, specifically, drug abuse treatment facilities. These facilities were viewed as “figured worlds” that emphasized particular activities and endowed particular identity materials with meaning (Holland et al., 1998). In this case, the discourses and practices of the Twelve Step system were both prominent and privileged, and these delineated the boundaries along which identity development proceeded. Women’s narratives clearly indicated that the 12-step system of activity constrained the possibilities for personhood made salient to its members, as “recovery identity” constituted the system’s singular focus. Nevertheless, individual women did not uniformly adopt this enforced identity, but displayed varying degrees of resistance to this path. In this way, these narratives of resistance clarified the active contributions of individuals to their own development, indicating that social location does not determine developmental trajectories in any absolute fashion. It is clear, however, that resistance alone did not imply developmental progress. Within the highly circumscribed activity

system of treatment, women who resisted the uniquely salient identity possibility of “recovery” often remained stagnant, as no alternatives for personal development were readily apparent.

Although some scholars have argued that multiple identities such as “mother” and “addict” are incompatible among women in drug abuse treatment (Pursley-Crotteau & Stern, 1996), the findings of the present research indicate precisely that the interweaving of multiple identity possibilities affords the construction of more positive developmental trajectories among women so situated. I suggest that the construction of a broader personal identity, such as “mother,” and the commitments that this identity entails, serves to bolster the individual’s connection to activities relevant beyond the figured world of drug abuse treatment, thereby easing the recovering individual’s transition to the outside world. These results resonate with the recent work of identity theorists who argue that recovery is often supported by the construction of non-addict identities (McIntosh & McKeganey, 2000). As such, these findings argue against the singular focus on abstinence in drug abuse treatment settings, and suggest that a broader, more inclusive approach better enhances women’s potential for positive developmental change.

Within this context, in the remainder of this chapter I discuss a number of themes relevant to the present research approach, as well as implications for the development of future research and drug abuse treatment services. These themes include discussions of the larger sociocultural context that situated the present study of drug dependent women, as well as the philosophy of the drug abuse treatment regimen that structured the process of identity construction among women located within its boundaries. I conclude with a discussion of my personal development as a researcher over the course of this study.

Women's Drug Abuse

Drug abuse and its associated harms continue to affect the lives of increasing numbers of women. These harms include not only a range of physical and mental health problems, but also social marginalization, arrest and incarceration, separations from children and other family members, and homelessness, to name but a few. Rather than viewing these drug-related harms as consequences of individual women's moral failings, drug use is better understood as occurring within the context of other life problems, including the traumatic experiences of early physical and sexual abuse, neglect, psychological abuse, and rape – all of which are often reported by women who use drugs (Bourgois & Dunlap, 1993; Inciardi, Lockwood, & Pottieger, 1993; Mahan, 1996).

In fact, the majority of women who participated in this dissertation research spontaneously recounted prior incidents of abuse and victimization in their childhood and adult lives. Paola's story was a particularly poignant illustration of the violence endemic to many women's lives. A 19-year-old Latina woman, she came to the women and children's program with a substantial history of drug use in spite of her young age. Her early life was fraught with incidents of sexual victimization as she recalled being molested by a family friend, as well as her older brother, before the age of six. Moreover, she was eventually raped by an acquaintance of her boyfriend at age twelve. As a young woman she continued to struggle to understand these experiences as illegitimate acts of violence and to make meaning of these events:

When I was three, I was molested. I mean I had... It wasn't my real uncle.

My grand-, my grandma died and my grandfather got married. He got

married to a woman and she raised me. And her son, when I was three he was like twelve, and he didn't rape me or nothing but he did touch me. And that kinda like, I still remember that like it was yesterday. Plus, I think I was probably three, my brother, my brother did, you know, but, my mom ss-, like I told her. And it's like she ignores me because that's her baby. You know, my brother. He's four years older than me. And maybe it's not rape because we're kids, but when I was little, he was there. He did, he used to tell me that brothers and sisters are supposed to do that. You know, have sex. And he used to do it to me. But then I don't know who told me. I had talked to that, they told me that it's not rape because it doesn't, his, his thing, doesn't get um, hard or nothing like that. But still, that bothered me. And I feel like, feel like just telling him. You know what you did, you know. Don't think I don't remember. But I don't bring it up because I'm embarrassed. And then one day I told my mom and she acted like I didn't, like I never said anything. So those are like the only things that... the guy who I lost my virginity, you know what, I did, I was raped. I think it was rape. There was a, there was, when I was eleven I had met this guy. And he was real cute. I was twelve not eleven. He didn't really like me, 'cause you know, the kind of guy. I'm sure he liked me but all he wanted was to do, was to have sex. And the day I lost my virginity he, he came to my house with a, a friend of his. And I snuck them in my house. 'Cause I would've got busted. And I had sex with him and right after I had sex him...that was me losing my virginity...he tells me

to have sex with his friend. And I didn't want to. I didn't want to have sex, I didn't want to have sex and then, so, so I told him I don't want to. And they told me well, if you don't have sex with him we're gonna hit you. You know, they're gonna beat me up. And I was like you can't do that because my mom. I'll get in trouble. So I did it with the friend. And he, it was, it was bad. And he, he did it... It was like for-, I was forced to have sex. And he didn't just sex, have sex with me. But he also put it in my butt and everything. And it was horrible. And after he did that, they were laughing telling me that I have AIDS. Now that I have AIDS. And that was just a joke, you know, but I was crying. I was devastated.

Personal histories like Paola's are often compounded by low levels of education, extreme poverty, and a lack of social connections and support (Boyd, 1999). Women are more likely than men to undergo serious economic pressures, since they are less likely than men to have adequate job income and employment skills, and in addition, the majority have children to support. This is confirmed by studies demonstrating that women entering drug abuse treatment have inadequate levels of education and job training and extremely high rates of unemployment (Inciardi, Lockwood, & Pottieger, 1993; Wechsberg, Craddock & Hubbard, 1998). Many of these concerns are magnified even further for women from socioeconomically disadvantaged backgrounds or minority communities. Again, these factors had a substantial impact on the participants in the present study, as many experienced periods of homelessness and very few had histories of stable employment.

As such, drug abuse is rarely a woman's sole life problem. Research on drug dependent individuals must acknowledge the context of unstable or resource poor social conditions in which drug use often occurs (Boyd, 1999; Klee, Jackson, & Lewis, 2002). This is not meant to suggest that drug abuse is not a problem in and of itself, but rather, to locate it as one of a myriad of adverse life events that profoundly affect the lives of women -- and for those who are mothers, their children as well. In the present study of women in treatment, their experiences of profound disadvantage and victimization clearly limited the development of their personal identities in important ways. This harkens back to the work of Neuhouser (1998) who argued that in a context of extreme poverty, "mother" is the primary, and often the only, positive identity available to women.

With this in mind, it has been often said that to be a "good mother" in Western society is to meet the cultural expectations for mothering, emphasizing unconditional love, nurturing, and self-sacrifice for one's children (Boyd, 1999). While these idealized notions of motherhood may obscure the realities of daily life for many women who are mothers, drug using mothers may be stigmatized by visible shortfalls in these societal expectations, and often express guilt for failure to meet personal expectations as well. These standards for mothering can be especially difficult to achieve in conditions of extreme poverty, social isolation, and instability (Klee, Jackson, & Lewis, 2002).

In fact, research on women drug users overwhelmingly focuses on their lack of parenting abilities and failure to be responsible or responsive caregivers. Research has indicated that parents with substance abuse problems often exercise less effective discipline than other parents, and may be limited in their ability to attend to their children's emotional and social cues and to respond appropriately (Hans, 1995; Tarter et

al., 1993). As a consequence, drug-involved parents may overreact with harsh discipline or display a severe lack of attention to children leading to higher levels of child abuse and neglect (Blume, 1991; Kumpfer & Bayes, 1995). Despite these suggestions, not all drug-using women abuse or neglect their children, and substance abuse is not directly implicated in all cases of abuse and neglect. Maternal substance use is just one of the many factors that place women at risk for poor parenting, and women who are exposed to a higher number of environmental risks often have more negative parenting attitudes than those with a lower number of risks (Kettinger, Nair, & Schuler, 2000). While women's drug use undoubtedly poses risks for pregnancy complications, fetal damage, and child development, other factors such as poverty, homelessness, poor nutritional status and health care, as well as personal and community-level violence, are but a few of the factors that adversely affect women and their children (Inciardi, Lockwood, & Pottieger, 1993).

In spite of portrayals to the contrary, women drug users express high levels of commitment to their children and value motherhood as a personally meaningful role (Kearney et al., 1994; Sterk; 1999). For many women, children function as a powerful motivating force toward abstinence from drugs, as was the case in this dissertation research. The women were overwhelmingly concerned not only with avoiding the removal of their children from their care, but also with making positive contributions to their development. In fact, achieving an identity as a 'good mother' was a focal point for change in many women, like Alesia, a 38-year-old African American woman:

A mother means everything, a mother is someone that is there for her kids, you know and I'm a mother today. 10 years ago, 15 years ago I was not, I was whatever you wanted me to be but a mother. I did my motherly duties

like when it was time to take them to the hospital or the doctor, yes I did those, but the one where you took time out to watch them grow up to be predictable people in society, I lost a lot of years, cause like I said drugs was everything to me. Anything beyond drugs was irrelevant. And that's a bad deal right there, you know. But I paid the cost, and I am living with it now. Because of the road that I did in my life, somebody thought that it was time for me to start straightening up and start getting myself together, before I could be the mother that I need to be. I found out how much my mother really loves me, and always loved me, even though I felt like she didn't. And I actually realized that she loved me the most when she took on the responsibility for my kids, which she didn't have to. She could've allowed them to go into the system. My kids could've been lost. (Crying) And even today I still love my mama cause if it wasn't for her, I would be a mother without no kids. So my main concern is being able to be a mother, like I need to be. And I'm doing good now, cause for a long time I was not nothing.

Clearly, in her performance of motherly duties and responsibilities, Alesia enacted the self as a "good mother," a highly valued personal identity among many women in this study. In fact, periods of pregnancy and early motherhood are often regarded by drug dependent women, as well as service and treatment providers, as one of the primary opportunities for women to end their use of drugs, as motivation for change is high among women at these times (Klee, Jackson, & Lewis, 2002). This dissertation research

broadened this notion by documenting the developmentally beneficial synergy between commitments to children and mothering and commitments to recovery that supported meaningful engagement with and participation in a drug abuse treatment program.

The Disease Concept of Addiction and 12-Step Approaches

The treatment programs explored in the present study, as well as the majority of substance abuse treatment programs in the United States, are either based on 12-step principles or incorporate 12-step activities into their respective treatment regimens (Moos & Moos, 2004). The wide-ranging use of such self-help groups is evidenced by recent estimates placing national membership in Alcoholics Anonymous and Narcotics Anonymous at 1,160,000 and 185,000, respectively (Humphreys et al., 2004). In a recent review article, a panel of national experts on substance abuse indicated that the body of available research evidence demonstrates that self-help group involvement is associated with reduced substance use and improved psychosocial functioning (Humphreys et al., 2004; Kelly & Moos, 2003). They added, however, that research on a variety of self-help groups, both 12-step and non-12-step based, should be expanded as the mechanisms through which they effect change in members' lives remain unclear.

While longitudinal research studies support the idea that participation in 12-step activities is beneficial to long-term sobriety for many alcohol or drug-involved individuals, increasingly vocal critics have suggested that the philosophical underpinnings of the 12-step approach may actually undermine meaningful life change for others (Morrell, 1996; Peele, Brodsky, & Arnold, 1991). Typically, the controversy centers on the 12-step recovery model that emphasizes the importance of accepting

addiction as a life-long disease, as well as one's powerlessness to overcome the use of drugs. Opponents argue that the disease model of addiction is inherently harmful as it diminishes people's feelings of personal control and encourages intense and frequent contact with other recovering individuals, who may reinforce the salience of alcohol and drug use (Ellis & Velten, 1992; Peele, Brodsky, & Arnold, 1991). While the disease model may lessen the implications of moral responsibility for drug dependence (Trimpey, 1989), at the same time it may serve to stigmatize people as chronically disordered. Similarly, 'surrender' to a higher power may inhibit the development of one's own power and agency. In this way, critics have asserted that the principle of powerlessness stands in opposition to personal autonomy, empowerment, and community participation (see Kurtz and Fisher, 2003), and discourages reintegration with community life and involvement with members of mainstream society. They insist rather, that alcohol or drug dependence can be viewed as a problematic condition without invoking the disease metaphor.

There is recent empirical evidence to support the claim that the 12-step approach to recovery is not effective for a substantial proportion of drug dependent individuals. Kelly and Moos (2003) found that drop-out from 12-step group participation is exceedingly common, reaching 40% in their study, and many participants drop-out before any reductions in substance use are achieved. They demonstrated that less religious individuals are uneasy with the spirituality component of the 12-step program and those less allied with the disease model of addiction are more likely to discontinue their participation in 12-step meetings over time. Nevertheless, Fiorentine and Hillhouse (2003) theorize that the concept of powerlessness is crucial to recovery, suggesting that

participation in treatment and self-help programs promotes abstinence precisely by reinforcing the notion that controlled use is not possible for dependent alcohol and drug users. They argue that the individual's attribution of uncontrolled drug use to a stable property of the self, an addicted self, implies that negative consequences associated with continued substance use are certain and permanent, thereby encouraging abstinence.

While abstinence from drug use is without question a beneficial outcome of participation in 12-step programs, one is left to consider whether it is the *only* valued outcome afforded by such participation. That is, is achieving abstinence a step on a path toward other possibilities, or is abstinence an end in itself? How, for example, does the acceptance of an addicted self impact meaningful change in other areas of life, and what are the implications of powerlessness over drug use for personal agency to effect change?

Morrell (1996) has proposed a similar challenge to our understanding of recovery as a problem of individuals, implicating the disease model of the 12-steps once again in attaching illness and pathology to the person. She argues against what she terms "recovery thought" -- a worldview perpetuated in substance abuse treatment centers and self-help programs which assumes the benevolence of social and economic conditions in general society, therefore placing the full burden for change on the addicted individual. Instead, she suggests an alternative formulation of recovery that involves recognition of the social contributions to drug dependence, and the empowerment of individuals to act. As Morrell correctly points out, many people entering substance abuse treatment facilities and joining recovery groups are from disempowered groups: women, people of color, and often the indigent. When the 12-steps come to these individuals, as they often do, with an

institutional mandate enforced by the courts or social welfare agencies, what are the possibilities for empowering participation?

The present study evidenced women's ongoing negotiations of addiction, focusing on the dynamic moments in women's narratives in which they engaged with or resisted institutional claims regarding the self as addict. Many struggled with issues of powerlessness, remarking on the difficulties of "admitting defeat" and "handing over their will." Almost unanimously, the women spoke of this process as a sacrifice of their albeit limited sense of personal control over their lives, but considered it necessary to achieve "recovery." In this regard, it appeared that "recovery" suffered a fundamental break from agency within the boundaries of treatment. The ability to "stay clean" came only at the cost of other identity possibilities, as abstinence required life-long vigilance and adherence to the Twelve Step program. It was only among participants in the women and children's program that "recovery" identity appeared to be meaningfully connected to the self as mother, raising fundamental questions about the utility of recovery identity and possibility of long-term change. Clearly, many people in Twelve Step programs achieve long-term sobriety and meaningful life change through this participation, but there are many others who do not. The implications of these findings are discussed below.

Implications for Future Research

As drug abuse continues to touch the lives of increasing numbers of women, expanded research in formal treatment settings and self-help venues is urgently needed in order to understand women's experiences of membership in these communities and the

ways that their participation supports or impedes personal change. Because this dissertation research raised fundamental questions about the structure of current treatment practices in the study sites, specifically their ability to scaffold the development of positive, forward-looking personal identities among their women clients, re-thinking the current approaches to the study of drug abuse treatment appears warranted.

In this regard, Reisinger and colleagues (2003) have suggested that traditional substance abuse treatment outcomes, which often focus on discrete measures such as treatment completion, meeting attendance or occasions of drug use, do not fully capture the experiences and engagement of individuals in these programs, and requires instead a focus on the processes of change as they occur during treatment. In this way, unique and varied negotiations of treatment experiences can become meaningful indicators of progress, fundamentally challenging the traditional notions of individual success and failure in social and institutional contexts (Daiute, Stern, & Lelutiu-Weinberger, 2003). Through a different lens, traditional cases of treatment “success” -- women who attend group sessions, comply with program rules and ultimately complete treatment -- may be expanded to include women previously considered “failures,” by recognizing that personally meaningful transformation can be achieved through disagreeing, contesting, “deviating,” or stumbling. Process-oriented research of this type has the potential to unpack the “black box” of treatment, and ultimately to improve the delivery of treatment services to women and their families by refining or re-designing the structure of programs and the meanings of participation in these regimens.

One such fundamental re-design in drug abuse treatment that has occurred over the past decade is the creation and expansion of women and children’s residential

programs. Although the results of the present study indicated that few participants in the “women only” program experienced their participation in treatment as scaffolding positive identity trajectories, participants in the women and children’s program were more likely to understand their recovery and mother identities as intertwined. Several women in this program appeared to be engaged in an active process of bootstrapping ‘recovery’ through commitments to their children, pursuing a valued identity as mother and goals as a parent through participation in the program. Interestingly, while the very creation of a family program privileges women’s engagement with their children, the treatment community’s philosophy purports that successful recovery is accomplished only for oneself and the treatment regimen allows only minimal interaction between women and their children. The inherent contradictions in the treatment system were difficult for many women to understand and negotiate, and many were ultimately obliged to re-align their felt commitments in order to adhere to the path of ‘recovery’ as they understood it.

Virginia’s narration of her personal experience in treatment illustrated this process:

I have to stay clean cause I just love having my family back, you know, and giving my kids and myself 100%. Saving money today instead of making someone else richer cause that money could go towards education and whatever my kids might need or myself, you know. I’m going to give them 100% and, um, and they are my children and I need to be a mother and a parent to them and I can’t do that if I’m getting high. You can’t get clean for anybody else. But then again when I first got clean, when I had B., I did it for my daughter and I looked at it and I said damn I like this and

I pushed B. aside and I held on to recovery, and I stopped doing it for her. I started doing it for myself.

Clearly, women's sense of connection to their children was a powerful part of the "recovery" process in treatment, yet the institutional emphasis on separate, autonomous selves failed to consider the value of this social connectedness, seeing it as a barrier to meaningful change that required removal, rather than a support for developmental transformation. As such, future research in women and children's programs should examine whether and how children are meaningfully integrated into the treatment community as potentially important participants, and the impact of these factors on women's development. From a social policy perspective, in-depth explorations of such programs could lead to improved programming and structured services for drug-involved women and their children.

As a final point, this study captured important moments in women's development in the context of their social participation in particular sites of drug abuse treatment, yet its short-term duration limits our ability to understand how their emerging identity trajectories as mothers and recovering persons will meaningfully connect them to the world beyond treatment. Nevertheless, the findings offer preliminary support for previous research by Stevens and Patton (1998) that demonstrated more positive treatment outcomes for women who resided with their children in treatment. Longitudinal qualitative studies would support the development of further knowledge in this area, as would structured studies in a variety of treatment environments.

Conclusions – Some Personal Thoughts

My personal interest and commitment to research with women and their children has been a consistent focus throughout my graduate education. Yet the approach guiding my study of these individuals has evolved considerably over time as my understanding of human development has grown in new directions. The initial threads of my work were tied to the conduct of my second-year research on the parental belief systems of drug-involved women offenders. In that study I examined the general parenting attitudes and parental attributional tendencies of female inmates as they related to participation in an institutional parenting education program in the Baylor Women's Correctional Institution in New Castle, Delaware. Although one of my primary concerns in this earlier study was the inclusion of women in parenting research who were outside the typical frame of college-educated, middle-class research participants, I relied for the most part on standardized measures to assess women's beliefs and attitudes regarding child-rearing practices, as well as the outcomes of participation in parenting education.

While these data produced interesting results, the selection of this methodological approach did not afford an understanding of how women made meaning of their participation in the parenting program, or fully capture their cultural beliefs regarding motherhood that likely impacted this participation. In this regard, one of the most interesting aspects of my second year research was the finding from women's comments on hypothetical vignettes related to children and their behavior. In their open-ended responses, women consistently referenced themes that differed from middle-class, mainstream values emphasizing individual responsibility and autonomous behavior. Instead the women offered explanations of behavior clearly tied to lived experience in

particular sociocultural contexts. Behaviors were often attributed to external or social factors, rather than internal or mental states. Particularly with regard to depictions of aggression, participants suggested a number of explanations for children's aggressive behaviors that might legitimately be characterized as relational, or positional:

- “she had seen someone else do this”
- “she may have seen violence around her”
- “she probably saw people in the home pushing each other around”
- “maybe someone has treated *him* this way before”
- “ he was bigger and that’s what society teaches - most money, most power then you come first”
- “maybe someone had bullied him around and he thought he could do the same thing”

As women began to invoke explanations for behavior of a fundamentally different sort, it became apparent that their attitudes and beliefs could not be usefully treated as isolated mental properties, but should be considered as fundamentally socially situated. In these moments, I began to re-make my own ideas of how to study developing individuals. Making the transition to my dissertation research, I began to struggle with conceptualizing issues of process as important threads of development rather than rigidly adhering to “outcome” studies, and began to train myself to attend to and recognize the social and contextual constituents of development even when focusing on the words of individuals. The ability to make these transformations was particularly important when exploring issues of identity development in drug abuse treatment, as I began to focus less

on what women's identities are, and more on the sociocultural context and processes through which their identities emerge and change.

The findings of my research enhanced my understanding of personal identity development as an ongoing process whereby individuals actively negotiate and creatively transform social practices germane to a particular system of activity. The negotiated connections of "recovery" and "mother" commitments by many women in this study clearly afforded them a location from which they could achieve meaningful self-change and pursue meaningful action in the figured world of treatment. These findings suggest a number of interesting possibilities for research that builds upon my initial efforts. First, it would be important to examine the extent to which these findings can be replicated in other treatment systems. That is, do the processes of personal identity construction explicated here operate in a similar fashion in other drug abuse treatment environments for women, and what can be learned by the differences or similarities in these processes? Second, the conduct of longitudinal studies to examine women's identity trajectories and their longer-term impact on abstinence, relationships with children, as well as functioning in other domains, could provide important information on women's ongoing personal development *after* treatment, something that the present study could not address. Finally, given the positive developmental trajectories documented among women with young children in this study, an examination of alternative identity possibilities for women without children, or women with older children, appears warranted. Treatment approaches that afford the construction of meaningful personal commitments among this population could potentially engage women more effectively in recovery activities, as specialized women and children's treatment programs appear to do for younger women.

AFTERWORD
Portraits of Women's Lives

As an adjunct to the primary focus of this dissertation research, photographic data collection was undertaken with the women outside of treatment in order to understand the broader context in which these women constructed their identities. This photographic data collection provided an opportunity to examine the ways that women out of treatment made meaning in their lives, and further enhanced my understanding of the cultural worlds of drug-involved women.

Background

Visual research methods have a long history in both anthropology and sociology (Carlsson, 2001; Harper, 1994; Holliday, 2000). The use of photography, in particular, was central to cultural anthropological research in the early part of the twentieth century (see Bateson & Mead, 1942). Rather than conceiving of photographs as materials that simply buttress existing ideas or arguments that the researcher has decided to propose, the Bateson and Mead study marked the clear introduction of photographic images as a separate method of research inquiry. In their book, *Balinese Character*, Bateson and Mead regarded photography as a critical component of culturally informed observation (Harper, 1994). This landmark visual ethnography entailed the cataloguing, study and analysis of more than 25,000 photographic images based on the cultural knowledge of the researchers. Ultimately, the authors composed lengthy explanations of the cultural meanings depicted in their photographic collection.

Parallel developments in the field of sociology have led to the use of photography to study drug cultures, poverty, racism and institutionalization, to name but a few areas

(Adelman, 1972; Clark, 1971; Jackson, 1977). However, visual sociologists such as Howard S. Becker (1974) have argued that the utility of photography in research is clearly linked to cultural knowledge of the subject matter. In other words, photographic fieldwork can be constrained by the researchers' own cultural lenses (Holliday, 2000). To address this potential bias, field researchers have begun to conduct photo-elicitation studies, where images are used to elicit cultural information and meanings are supplied by a cultural insider (Harper, 2000; Smith & Woodward, 1999).

This technique suggests a model for collaboration between researcher and participant in ethnographic fieldwork. Typically, interview inquiry rests on the assumption that the researcher will ask questions that are meaningful to the respondent (Harper, 1994; 2000). Photos used as communicative devices can reduce the asymmetry of power in the interview situation by giving participants more voice in what is discussed (Carlsson, 2001). In the photo-elicitation interview, the discussion is stimulated and guided by images. Although photo-elicitation was first described as a technique in which researchers were to provide the photographic material, participants themselves can also be the photographers, as well as the interpreters of their pictures (Carlsson, 2001; Harper, 1994). In this way, a dialogue is created in which the researcher also becomes a listener.

Photo-elicitation techniques have been used with college students, and adolescent boys and girls in examinations of self-concept and gender identity development (Bach, 2001; Dollinger et al. 1996; Walker, 2000). Typically, participants in visual inquiries are provided with "one-time" (disposable) cameras in order to visually document their experiences. These photographic images provide visual data that are similar to journal entries or field notes. The photographic image is "true" in the sense that it represents a

visual trace of the subject matter at which the camera was pointed, but the point of photo-elicitation is not to determine whether the photograph represents a particular setting accurately (Harper, 1994). Rather, the photographs are used to understand the experiential intent of the maker, and to understand how participants define a situation and their relationship to it.

Methods

In the present research, participation in the photo-elicitation study represented an optional research activity for the out of treatment women, separate from the in-depth interviews. Because the use of photography could potentially entail some loss of privacy for participants, they were given the choice to decline participation in this part of the study. Participants had the opportunity to review all of their photographs and to request that some or all not be used as part of the study analysis.

After the first interview, the participants who consented were given a disposable camera (identified by a numeric code number) loaded with color print film and given verbal instructions on how to use it. Each participant was invited to take twelve to fifteen pictures over approximately two to three weeks that would describe their life and experiences. It was expected that having the participants choose the places and subject matter of the photographs would increase the opportunity for them to express their conception of and relation to their cultural worlds. During the second interview session described earlier, the photographs served as a central point of reference. Participants were asked to discuss their photographs in detail, in particular to describe the importance or meaning of the images in their lives.

Analysis

Analysis of photographic images focused primarily on the narrative interpretation of individual images (Donaldson, 2001) as a supplement to the in-depth interview data for out-of-treatment women. Rather than concentrating on the formal properties of the photographs, the guiding idea of the analysis was to understand how the participants organized and interpreted the context and meaning of the scenes depicted in their photographs, and to understand the daily lives of indigent, drug-using women outside the boundaries of drug abuse treatment. The women's narrative descriptions of their photographs were captured as part of the second in-depth interview. Analysis proceeded in concert with that of the textual data.

Results

Women's photographs were generally of several types: children, self, others, locations, activities and belongings. Beyond this broad categorization, however, the women pictured vivid scenes that evidenced their social location in larger society: homelessness and poverty, marginality and isolation, incarceration and police scrutiny, and a significant burden of disease. Several women's photographs, and their comments on the images, are presented below to provide visual and narrative context to the primary identity trajectories identified among women outside of treatment: *mother identity*, and *no identity*.

The self-as-mother was a uniquely salient identity for a substantial proportion of women out of treatment, particularly those with very young children. In this sense, motherhood afforded the possibility of a positively valued identity around which women

were able to organize their lives. Through the passages and images that follow, Jemeena's and JoAngela's accounts illustrate their strongly held commitments to their children -- commitments that focus the activities in their daily lives.

Jemeena's Portrait. Jemeena, a 26-year-old African American woman, was living with her four young children in southern Dade County at the time of our first meeting. She had moved from Miami Beach several years earlier in order to cut off ties with her drug-using social network and facilitate her cessation of crack use. Successful in this endeavor, she had limited herself to marijuana and occasional powder cocaine use. She maintained a household with her parents and children and was attending courses to become a nursing assistant. She reflected on these accomplishments and her ability to exercise personal control over her drug use:

It depends on, once you get your priorities in order, I guess it depends how far you've been, and how long you've been on drugs. Because I know some people that, you know, they've been on drugs so long they just not even civilized anymore, they don't even belong in society anymore. You know what I am saying? And I feel like I wasn't on drugs long enough or bad enough to be in that situation so it wasn't hard for me to get back to where I had began, you know?

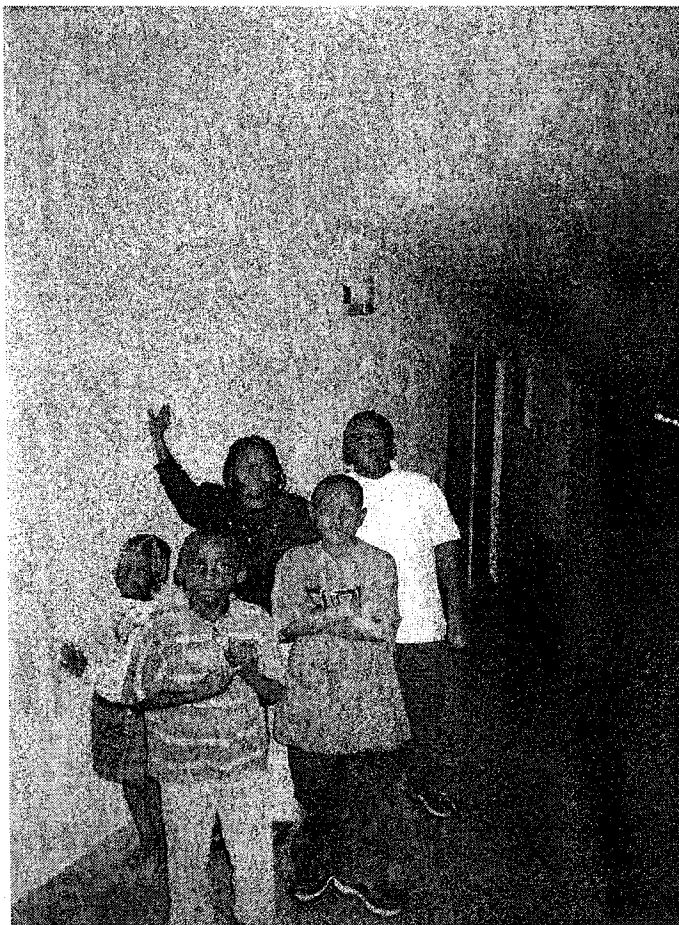
Confronted with a life altering medical diagnosis that had already taken the lives of her brother and sister, she began to transform her understanding of herself as mother:

I have HIV. Both my brother and sister both died from HIV. My sister, when she passed, that changed a lot of things about me, you know, that thought now in the back of my mind is that I lost a brother and a sister, my only thing for the future is just to be here and whatever happens, happens. I just want to be here. I didn't want to be like other parents, you know, who get out there on drugs and then the state take their kids and then they get off drugs and then it take them years to get them back. Some people never get them back, you know, and I didn't want that to happen and then the fact that I found out a couple of years ago that I was myself was sick, I had, I wanted to spend this time with my children and I want to get it all together and I didn't want to die before a could be a mother to them. I notice how that's very hard for a child to grow up without a parent... especially your mother. Especially your mother. You know that's hard and I don't want my kids to be like that. For something to take me away from them just like that and I didn't have a chance to do anything for them.

Jemeena consistently foregrounded her children and their care in her ongoing narrative, and pictured them prominently in her photographs:

(photo 1) This here is my children in, outside my house. In the apartments, right outside the door. This one, that's the eight year-old. He loves to do puzzles. She likes, she wants to be, she always sits around the house and wants to act like she's in the office. This one is 15. That's my niece. That's my sister's daughter that passed. That's my oldest son. They

are very important to me. Those are the most important things in my life,
my children.



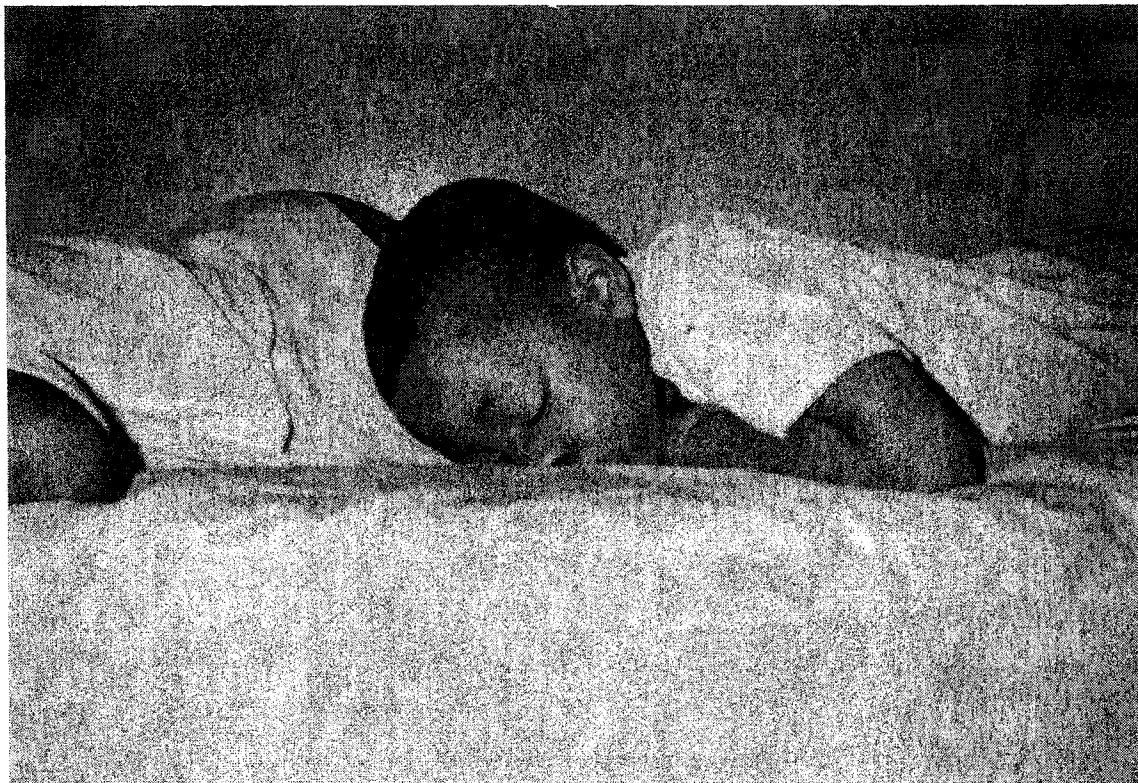
Jemeena Photograph One

JoAngela's Portrait. JoAngela, a 26-year-old African American woman described fully on page 115, expressed a remarkable commitment to her children's welfare in her words and photographs. She placed tremendous value on her identity as mother, which focused many of her transactions with the world, yet she confronted persistent economic obstacles to the performance of her responsibilities in this regard. Living in a homeless shelter with four of her children at the time of our first interview, their present

circumstances and her concerns for the future figured centrally in her photographs of her children:

(photos 1 through 4) This, this is the twins. You can't see both of their faces. But the reason being because these some strong boys. When I say strong, they, they help me. I don't, I know I don't give them, you know what I'm saying, like what I supposed to be giving them. Now this one's gonna make me cry. (crying) Because it's a lot of things that they ask me for that I can't give to them, but they understand. You know, most kids they don't understand. But these two like, they, they understand that mama don't got it right now. They lift my spirits. And they, they just six years old, but at that time they was five. And B. (clearing throat), this my daughter, my second daughter. She's nine. And she helps me, but what scares me with her is that she's in so many ways like I was. And she's trying to, I'm trying to stop her before it get started. And she's trying to live a faster life, cause as you can see, she like to wear the short clothes and the tight clothes. And I'm trying to, you know, let her know that it ain't all about that. You know? I know. I did it. But, be better than me. Ok, this is my baby. There's two pictures with her. This where she's sweeping and that's when she done got the trash. And you can't see him, but this is her father. And, um, she, she love her father. And it hurts me to know that all we been through, me and him, he done been with, you know, we done slept out on the streets while I was pregnant with her. Now he

don't want to be in her life, you know, he want to be there when he want to be there. I put my kids through, like I say, a lot, by taking them from place to place, you know what I'm saying, displacing them.



JoAngela Photograph One



JoAngela Photograph Two



JoAngela Photograph Three



JoAngela Photograph Four

Clearly, Jemeena and JoAngela prioritize and enact their identities as mothers. In fact, their commitments to their children appear ever more steadfast as their personal possibilities for mothering are threatened by serious health and economic concerns that limit their opportunities and abilities to engage fully as parents. Other women, particularly those who had lost relationships with their children, attached little value and meaning to their lives. Typically, they recounted lives lived on the boundaries of society where concerns for survival and subsistence marked their daily transactions with the world. Often, these immediate considerations displaced all other present and future commitments to action. Their photographs often pictured series of unconnected

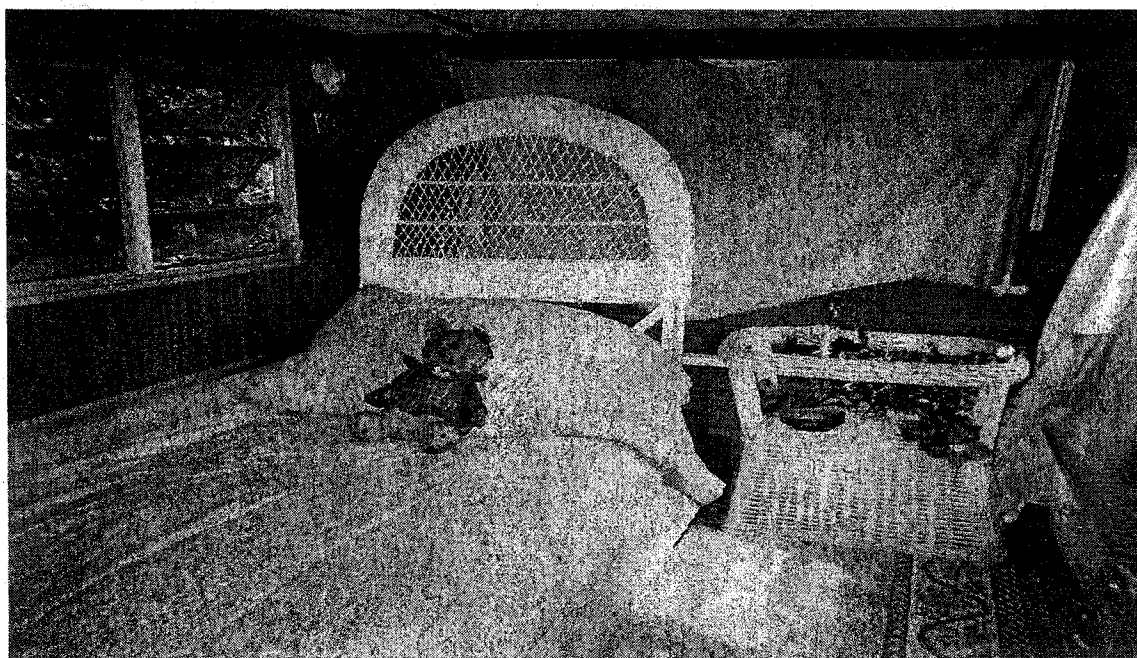
moments, reflecting the lack of a guiding personal identity that organized and focused their activities in the world.

Vickie's Portrait. Vickie, a 49-year-old white crack smoker, spoke candidly about her 35-year history with drug use in our first meeting. Having participated in residential substance abuse treatment programs on numerous occasions over the years, she ultimately returned to drug use each time after varying periods of sobriety. Interestingly, she constructed her drug use alternatively as beneficial and detrimental – providing a mechanism for self to cope with severe childhood physical and sexual abuse, while at the same time instigating the loss of her relationship with her only child:

I was never good to her when she was growing up. I would steal from her, I would lie to her, I would tell her when she was little, that I'm coming over to get you, and she would wait for hours and hours, and I never showed up. Um, as abusive, never, I was never abusive to her. But I just, I lied and conned her, just like I lied and conned everybody else to get what I wanted. Sometimes the drug addiction and alcoholism and the streets overtake things that are most important to you. I gave custody of her to my mother, because I knew my mother was stable. I knew that she would have a stable upbringing. And I did that for a reason, because I was in and out of the street, in and out of jail, out of prison, and she had this secure home life.

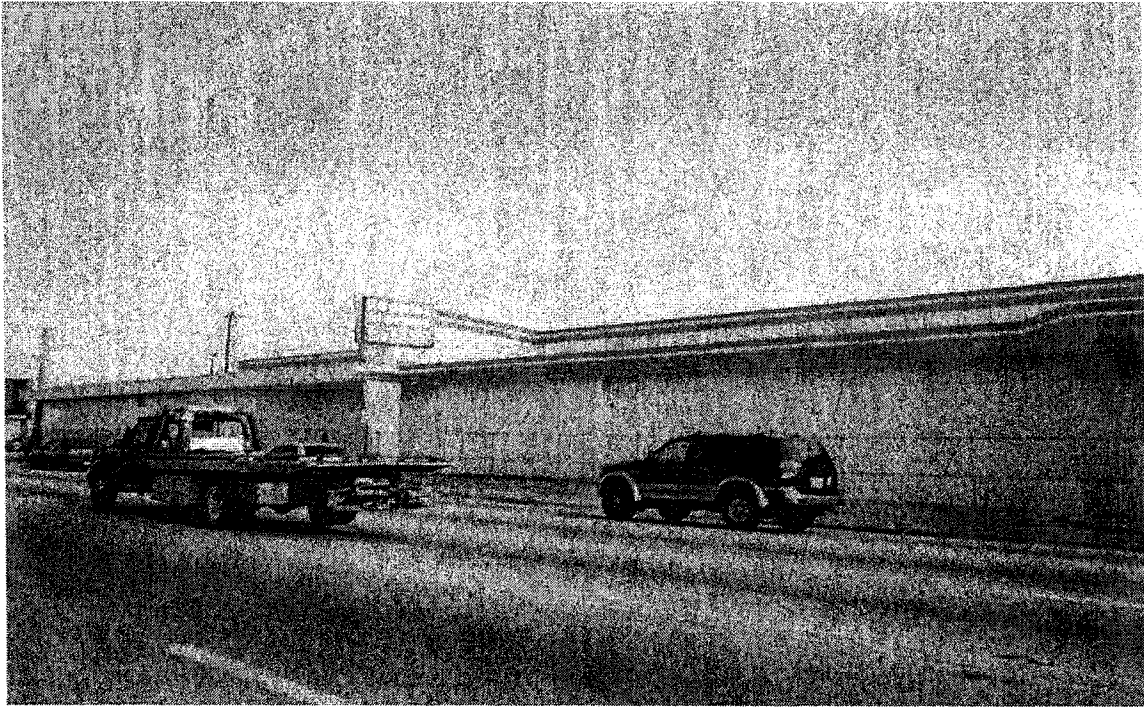
The instability and deprivation of Vickie's early life continued into adulthood, comprised of years spent in prison and "running the streets." Incarcerated for six months shortly after our first interview, Vickie and I spoke about her photographs during a visit I made to the Turner Guilford Knight Correctional Institution.

Interestingly, she pictured in her important photographs locations and activities that connected and stabilized her life in some way, making meaning for the self from connections to her former home:



Vickie Photograph One

(photo 1) This is my home. That's my trailer, but I don't live there no more. The trailer [was important] because I owned it. I never owned anything. This is my bedroom, I went out and found all this in the garbage. Yeah, well I don't have it anymore.



Vickie Photograph Two

former work:

(photo 2) This is the building that my boyfriend and I worked on, and I painted those, I painted these stripes. That was my last job I ever had. I did something, I completed it. You know?



Vickie Photograph Three

And the possibility of treatment:

(photo 3) This is the Village. I took that because it's important to me because two days before I was supposed to go into the Village, I went to jail. I almost was there.

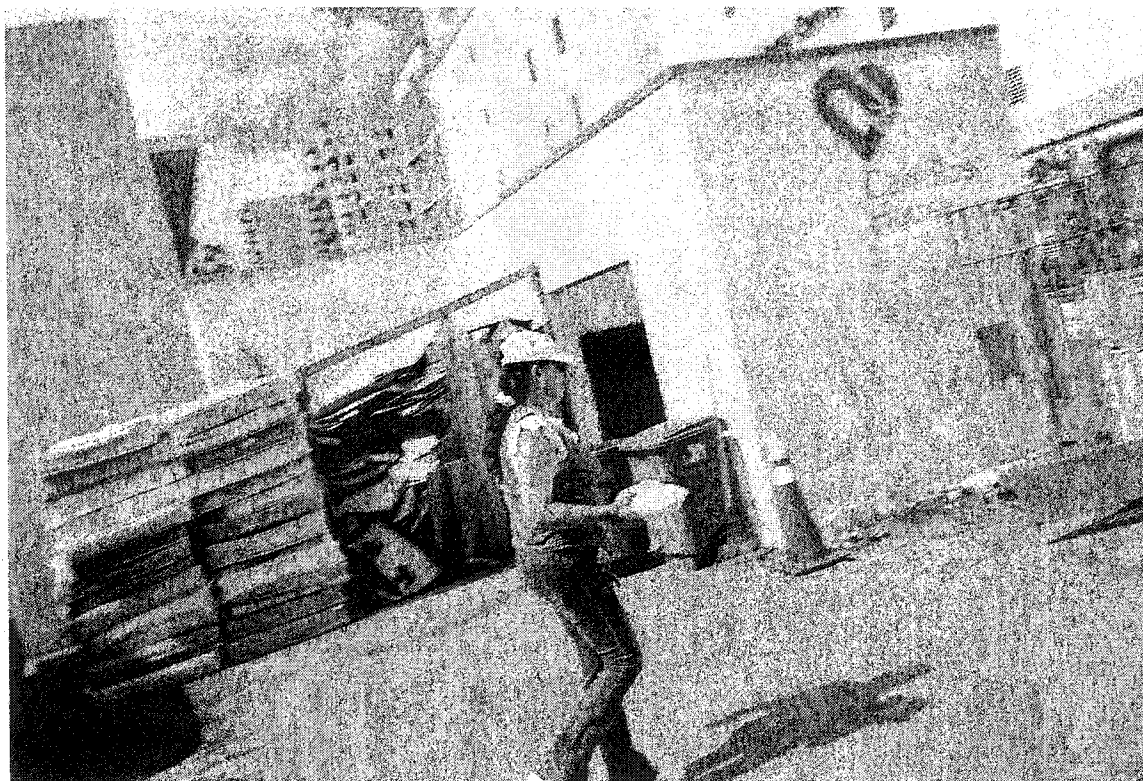
Sadly, however, none of Vickie's images represented actual structuring features of her life; rather her present life was guided by the loss of these meaningful connections of the past: she lost her home to re-possession, she had lost her job, and she had lost the opportunity to enter treatment.

Lucy's Portrait. Lucy, a 38-year-old Cuban mother of four, had been involved with drugs since the age of nine, and was a twenty-year user of crack-cocaine. She had participated in a number of different residential substance abuse programs – eight or nine to her best recollection. She detailed her journey through lengthy periods of sobriety and protracted episodes of drug use, often following stressful life events, in particular the murder of her father. Although she had become homeless at the time of our first interview, she continued nevertheless to assert responsibility for and control over her drug use, tacitly rejecting the notion of “powerlessness” crucial to the 12-step philosophy. Estranged from her children due to her homelessness and chronic drug use, Lucy's desire to achieve some measure of family reunification and connection framed her talk of the future:

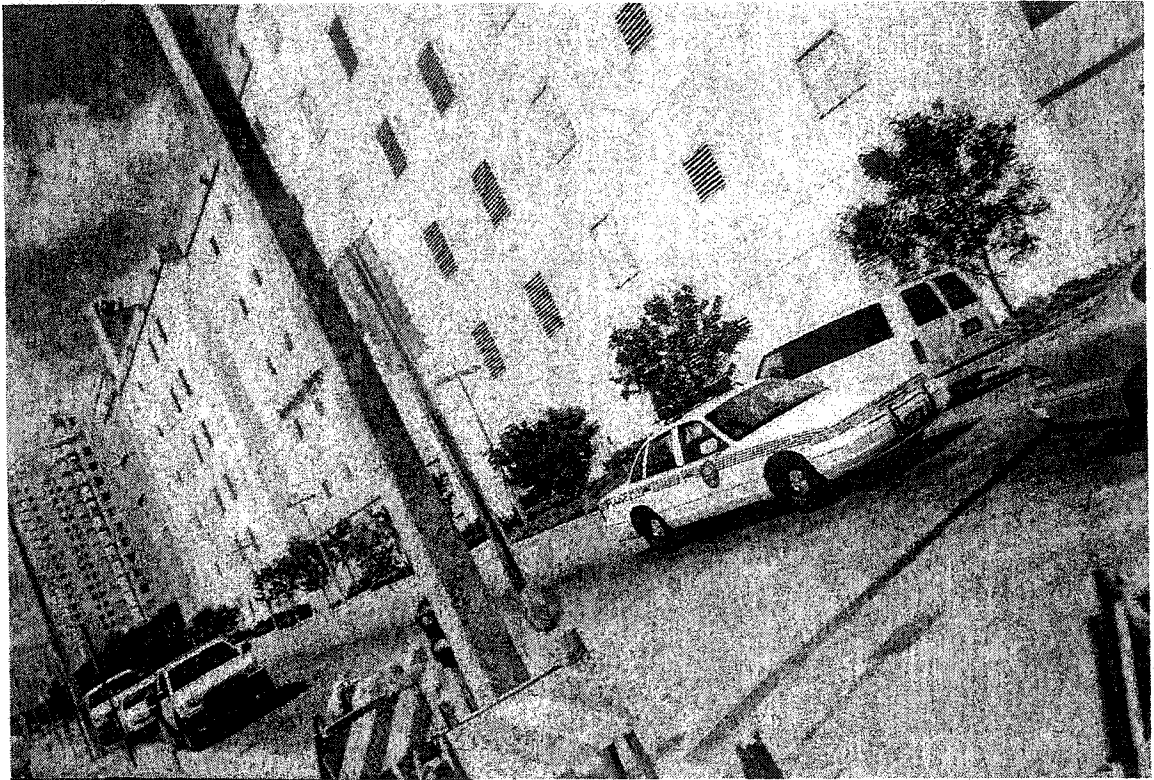
I haven't raised any of my children the way I should have. And uh, it doesn't matter if I have a good job or a bad job. Or if I'm in an efficiency or a two-bedroom apartment or a house, you know, as long as I can be part of their lives. That's the only thing I think about for my future.

Nevertheless, Lucy presented a series of photographs that captured the harsh reality of her life on the streets and her vulnerability as a homeless woman, picturing her existence at the margins of society. These circumstances represented significant obstacles for future change, as she was enmeshed in an environment where concerns for her safety and survival were paramount:

(photos 1 through 5) Most of these pictures were taken around Camillus House. That's where I used to sleep out there on the sidewalk. This police officer used to watch me a lot. It just so happened he rolled by so I took this picture. He didn't know if I was tricking or selling drugs or what I was doing. This is a guy who is mentally unstable. And he used to sleep right there on that spot near Camillus House. He was mentally unstable but he had a lot of sense. He's smart. He's just crazy, but he's smart. He's still there, I saw him there the other day. This is some people sleeping. Um, this old man is a friend of mine, he used to sleep right next to me. You have friends, you have friends. Basically we looked out for each other.



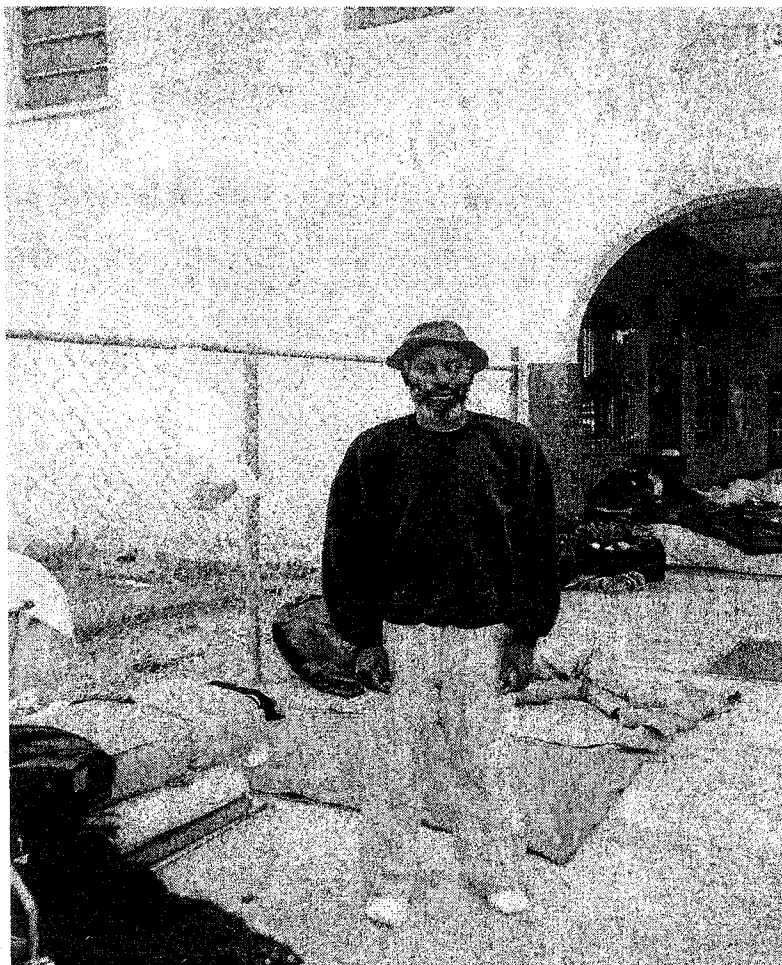
Lucy Photograph One



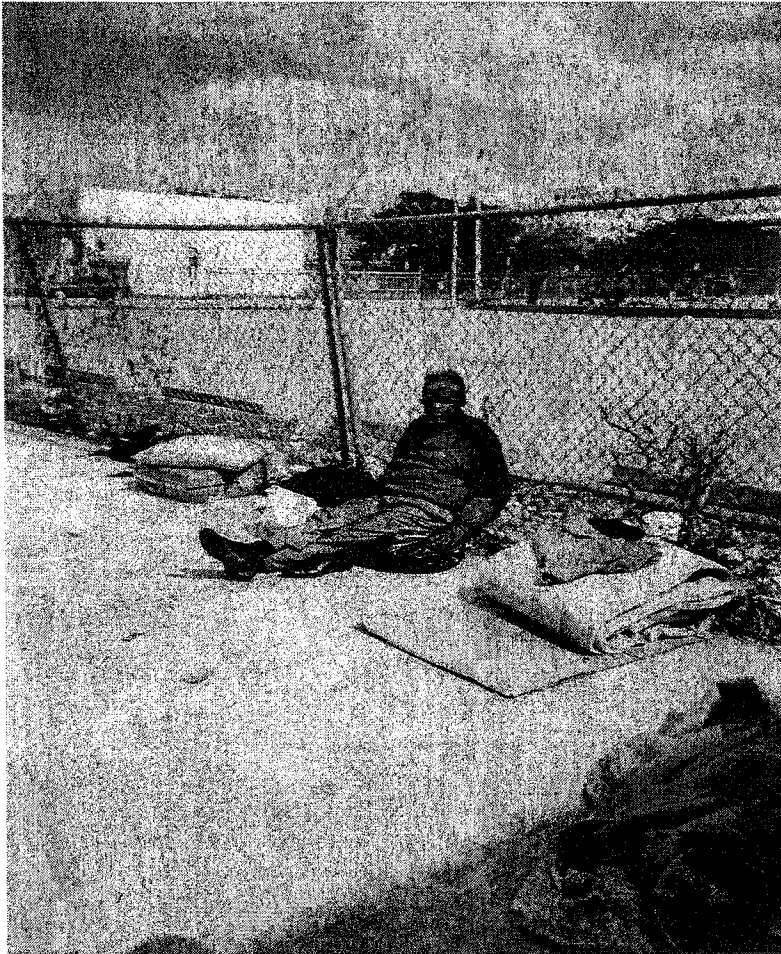
Lucy Photograph Two



Lucy Photograph Three



Lucy Photograph Four

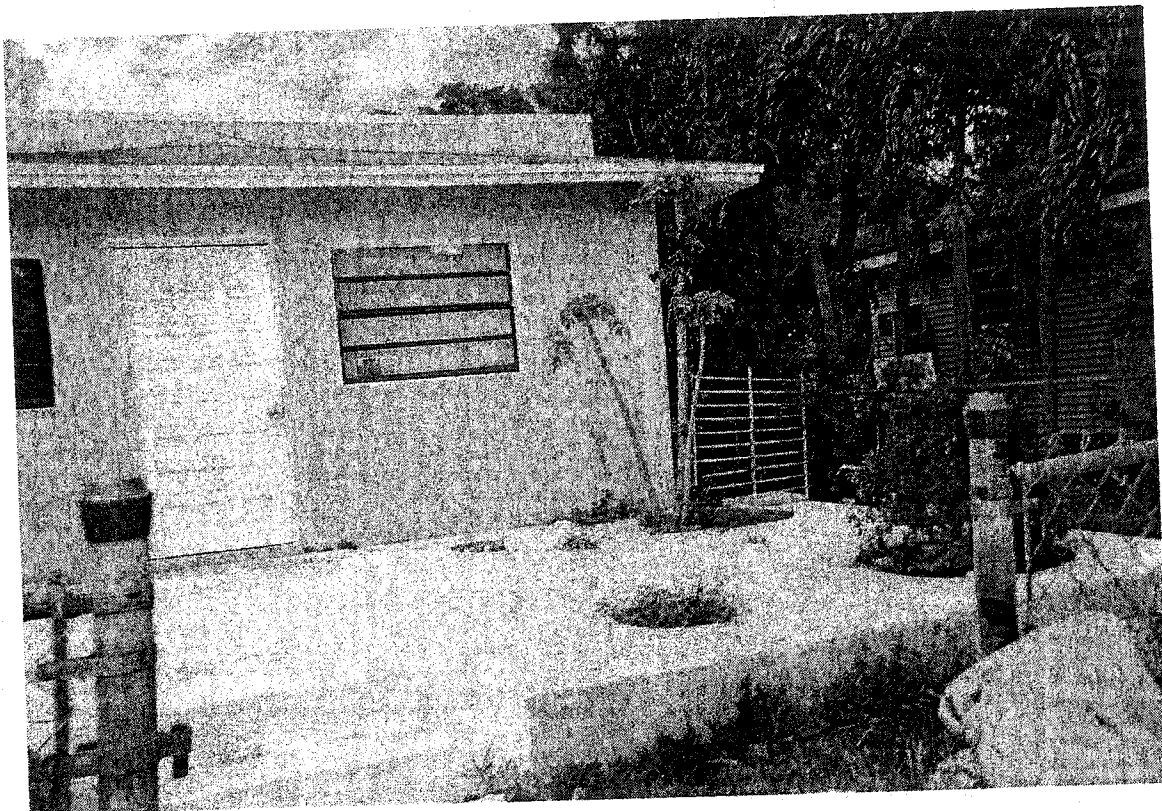


Lucy Photograph Five

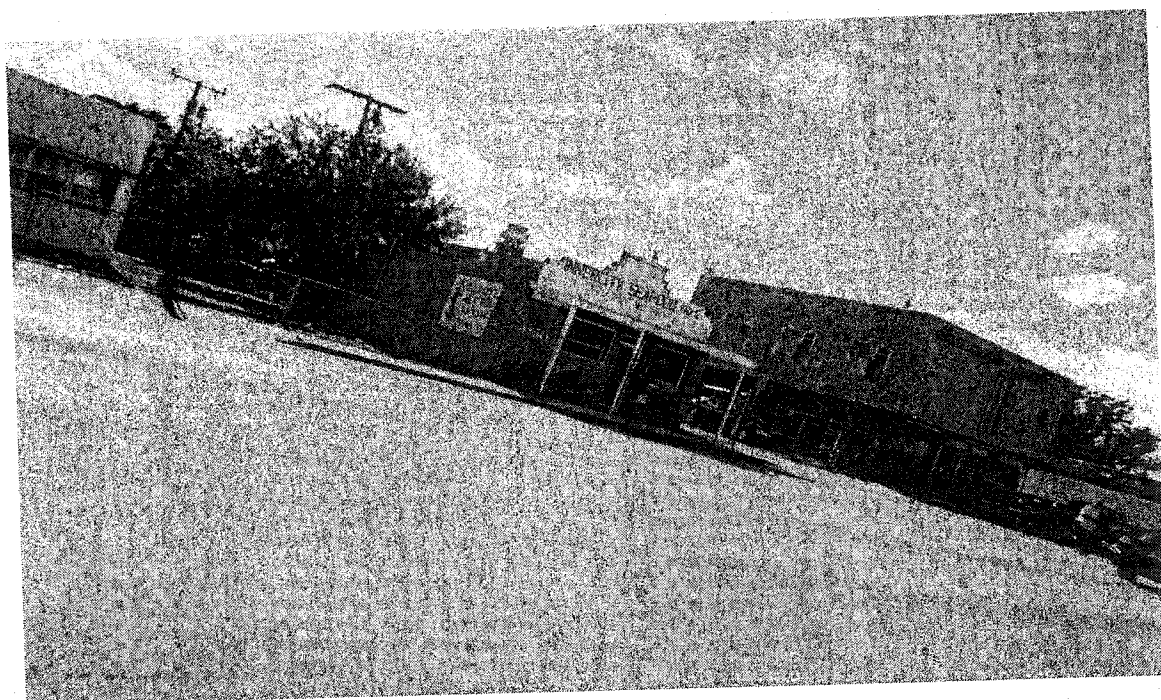
Tammy's Portrait. Tammy, a 35-year-old African-American heroin and crack user described earlier on page 126, spoke with apparent difficulty about her lonely and troubled life. Her chronic drug use and involvement in criminal activity had led to the severance of most relationships with her immediate family, including her only daughter, who was residing with a cousin in another part of Miami. She described an isolated existence, virtually without meaningful relationships, foregrounding instead her concerns for survival and subsistence. A vacancy of self was apparent throughout her narrative, and was evident too as she pictured her life in photographs. Precariously sheltered in a

“rooming house” with several other individuals, she revealed her uneasiness with this arrangement along with her lack of viable alternatives, and regarded the emptiness of her life in general:

(Photos 1 and 2) My housing, that's the most important thing right now. I don't like it up there because I don't trust that area. I'm not from Opa-Locka, I don't know nobody. And I'm afraid of the men, being a woman in a house like that, cause all of them want to try to talk to me. And I don't, I don't want none of them and they gonna realize that, cause they see how, they see how I look at them. I look at them like they're crazy. I don't want them, I don't want to be involved with them, with no one like that. My sister she, she don't want to like help me, like if I go through something, she don't want to help me because she feels that um, she feels that I should be off the drugs and should be able to do this and able to do that. She don't want to have no involvement with me and what not. The other ones, I have two more brothers and they're in jail. I like to go to the fish market and it's a place where you can go and just sit down there, and they sell dinners, fish and conch, and what not. So I go sit there and I talk to the owner and then I go and get high. When I'm using I'm like isolating myself from people. I, I isolate myself. I don't like to be with anybody. I try to be by myself.



Tammy Photograph One



Tammy Photograph Two

Taken together, this compilation of photographic images documents the broader social positioning of impoverished, inner-city women, many of whom are also members of minority communities. That their location in these particular environments shapes and limits the viable possibilities for personhood is undeniable. Already marginalized by their lack of access to economic resources, drug-involvement and the perils of street life often sever women's meaningful personal relationships as well as opportunities for involvement in valued community institutions. Without such meaningful social participation, the development of personal identity is unimaginably constrained. I have argued throughout this dissertation that personal identity is an important constituent of human functioning, capable of organizing and affecting the focused activity of individuals. These photographs offer an important visual record of the cultural worlds of marginalized women, and the personal identities these figured spaces simultaneously afford and inhibit.

Appendix A – Informed Consent

INFORMED CONSENT

Purpose: My name is Hilary Surratt and I am a student in the Psychology Ph.D. Program at the Graduate Center of the City University of New York, and the Principal Investigator of this study. You are one of approximately 30 people being asked to participate in a research study designed to explore the life experiences of women with histories of drug use. The primary purpose of the project is to learn about women's experiences with drug use, drug abuse treatment, motherhood, relationships, and other life events.

Procedures: If you decide to participate, you will be asked today, and on one more occasion in two to three months, to answer questions in a confidential interview. I will ask you about your background characteristics, family characteristics and children, drug use history, life experiences, current and former experiences with substance abuse treatment programs, and feelings about yourself. The interview will take about 90 minutes to complete. With your permission I would like to tape-record the interview. You will not be identified by name on the audiotape. The tape will be identified by code number only, and only I will be able to match your code number with your name. I may also ask you to take about 12 photographs of important things in your life, and to discuss those with me in your second interview. You may choose not to take photographs and still participate in the interviews. If you choose to take photographs, you will be given the opportunity to review them and ask that they not be used as part of the study.

Risks: The goal of this study is to explore women's ideas about their own life experiences. If you participate in this study, there is a small, but unlikely, chance that you may feel distress when asked about your experiences with substance abuse or other life experiences. You may refuse to answer any questions that make you uncomfortable or end the interview at any time. You will be given a list of available counseling services in the community should you wish to speak to a mental health professional.

Benefits: If you participate in the study, you may get some benefit from the experience. You may have the opportunity to learn more about yourself and to talk about your experiences with an interested, non-judgmental interviewer. You may also feel personal satisfaction from participating in a research study designed to better understand women's experiences and needs for substance abuse treatment. The results of this study will also improve the scientific community's understanding of treatment programs designed for women. If you wish, I will be happy to provide you with a copy of the study results once the research is completed.

Compensation: On each of the two occasions of interviewing, you will be paid \$20 for your time.

Confidentiality: Your interview responses will be kept confidential. The interview tapes and photographs will be reviewed only by me and my advisors. As soon as the interview tapes have been transcribed and checked for accuracy, the tapes will be erased. The transcripts and photographs will be identified only by a code number. All records relating to your participation will be kept in a locked file in the Principal Investigator's office. Your records will not be identified as pertaining to you without your expressed written permission and your name will not

appear on any data file or research report. None of the information you discuss in the interview will be made known to the staff of this program, or any other authorities. These procedures are designed to make sure that no unauthorized person will have access to what you tell me, but this protection is not absolute.

Right to Withdraw: You have rights as a research volunteer. Your participation in this study is voluntary and you have the right to withdraw from this study at any time. You will still receive the \$20 payment. If you do not wish to be part of this research study, your status in this program will not be affected in any way. If you wish, you may review the audio-tape of your interview after it is completed, and you may ask that it not be used. You may also review your photographs and ask that they not be used.

If there is any part of this consent form that you do not understand, I will be happy to explain it to you. If you have questions about the study, please call Hilary Surratt, the Principal Investigator, at (305) 529-1911 or hlsny@aol.com, or my advisor Anna Stetsenko at (212) 817-8715 or astetsenko@gc.cuny.edu. Also, if you have any questions about your rights as a research participant, please contact Hilry Fisher, Sponsored Research, City University of New York, at 365 Fifth Avenue, New York, New York, 10016, (212) 817-7523, hfisher@gc.cuny.edu.

Consent: I have read and understood this form (or it has been read to me). The researcher has answered all of my questions to my satisfaction and I agree to participate in the study interview.

I agree that my interview may be tape-recorded [circle one]: YES NO

I agree to participate in the photography portion of this study [circle one]: YES NO

Participant's signature Date

Principal Investigator's signature Date

Appendix B

Interview Guide – Treatment Group

Before we start, please remember that everything you tell me will be kept confidential, and the treatment program will not have access to this information. Also, you have the right to refuse to answer any of the questions I may ask.

Experience of Drug Use

Can you tell me a little about your history with drug use?

How would you describe your life in general when you were using drugs?

Were there times when you stopped using before you came to treatment?

Personal Experience/Identity

Tell me about your life now. How do you spend your time? What do you like to do?

What would you say are the most important things in your life now? What are your biggest concerns and worries?

Is there any person or experience in your past that really has a strong influence on your life today?

What about in the present? Are there any particular people or experiences that exert a strong influence on your life now?

How would you describe yourself as a person?

If you could choose, what would you be doing?

Prior Experiences with Drug Treatment

Is this your first time in a residential drug treatment program?

Could you describe what that program was like in general?

Looking back, what are your feelings about that program now?

Current Treatment Experience

Please tell me about how you came to be in this program? What brought you to this program?

How did you feel about coming into the program?

Can you tell me a little about the program? What is a typical day in the program like?

What do you believe is the most important goal of the program? What do you feel you are getting out of this program?

Experience of Mothering

How many children do you have? How old are they? Could you tell me a little about them?

Tell me about how you see yourself as a mother. What kinds of feelings did you have about becoming a mother? What do you think makes a good mother?

Have you had any experiences as a mother that are particularly important to you?

Future Outlook

When you look ahead to the future, is there anything or anyone that you think will have a major influence on your life?

How do you see your life changing in the future? What will you be doing when you leave here?

What would you say your goals for the future are?

Are there any other experiences that I haven't asked you about that you feel have (or will have) a strong influence on your life, either now or in the future?

Interview Guide – Non-Treatment Group

Before we start, please remember that everything you tell me will be kept confidential. Also, you have the right to refuse to answer any of the questions I may ask.

Experience of Drug Use

Can you tell me a little about your history with drug use?
How would you describe your life in general as a drug user?

Have there been times when you stopped using?

Personal Experience/Identity

Tell me about your life now. How do you spend your time? What do you like to do?

What would you say are the most important things in your life now? What are your biggest concerns and worries?

Is there any person or experience in your past that really has a strong influence on your life today?

What about in the present? Are there any particular people or experiences that exert a strong influence on your life now?

How would you describe yourself as a person?

If you could choose, what would you be doing?

Prior Experiences with Drug Treatment

Have you ever been in a residential drug treatment program?

Could you describe what that program was like in general?

Looking back, what are your feelings about that program now?

Experience of Mothering

How many children do you have? How old are they? Could you tell me a little about them?

Tell me about how you see yourself as a mother. What kinds of feelings did you have about becoming a mother? What do you think makes a good mother?

Have you had any experiences as a mother that are particularly important to you?

Future Outlook

When you look ahead to the future, is there anything or anyone that you think will have a major influence on your life?

How do you see your life changing in the future? What will you be doing when you leave here?

What would you say your goals for the future are?

Are there any other experiences that I haven't asked you about that you feel have (or will have) a strong influence on your life, either now or in the future?

Appendix C
Follow-up Interview Guide – All Groups

Before we start, please remember that everything you tell me will be kept confidential, and the treatment program will not have access to this information. Also, you have the right to refuse to answer any of the questions I may ask.

Since we last talked, how have things been for you?

Have things changed in your life since we last talked? How?

Since we last talked, have you had any experiences that have affected you strongly, or changed the way that you look at your life?

What would you say is most important in your life now? Your major concerns?

What is the program like for you now (in treatment groups)?

Tell me about how you see yourself now.

How do you see your life changing in the future? What would you say your goals for the future are?

Discussion of Photographs (out of treatment group).

Appendix D – Coding Scheme Definitions and Exemplars

Descriptive Codes

1. Addiction-related discourse – participant makes explicit reference in her narrative to addiction related terms, perhaps in a general or descriptive fashion, not necessarily applied to self.

1.1 Addiction/Addict

If you admit in your head that you're an addict - once an addict, always an addict - of course you're gonna go out and use.

1.2 Disease (also illness, sickness)

It is the disease that kills a lot of people, the addiction.

1.3 Clean (sober, sobriety, abstinent)

I'm supposed to stay clean. It's, it's the first thing is stayin' clean.

1.4 Recovery

My recovery, my higher power and my recovery they, they go together. To me it, it means my life. It means mmm, a way of life.

1.5 Relapse

My relapse was really part of my recovery because I don't want to be, I don't want to use no more.

1.6 Drug Use Reasons – participants discussed personal motivations for initiation and continuation of drug use, and applied them to the self.

The reason that I used drugs was to hide up, all those hurtin' feelings that's inside me. And when I used drugs, I didn't feel those feelings.

2. Twelve Step discourse – participant makes explicit reference in her narrative to core concepts of the Twelve Step program, including: Denial, Acceptance, Honesty, Humility, Gratitude, Amends, Higher Power, Just for Today, Powerlessness. Not necessarily applied to self. For example:

Step one is that we admit that we were powerless over our addictions and our lives had become unmanageable.

I have to always acknowledge my higher power. Always talk to him and stay in prayer. You know, always, how do they say it, interact on a daily basis.

One day at a time, um, see yesterday is gone and tomorrow's not promised. You just have today. Just for today. Yesterday I stayed clean. Today I got to try to stay clean. And hopefully tomorrow I won't use.

Those steps scare the hell out of me. That one where you have to make all your amends and all. Oh God, I don't want to do that.

3. Treatment discourse – acceptance: participant's narrative discusses positive or beneficial aspects of treatment for the self; resistance: participant's narrative discusses negative or unhelpful aspects of treatment for the self; process: participant discusses and personally reacts to the institutional process (rules and program structure) and treatment process or frame (personal storytelling)

3.1 Acceptance

I'm the, I'm the type of person that I need things to do. And I need structure. So it all works for me. I go to all my groups 'cause I need to. I like it. Um, it just work for me. I hear things I need to hear.

3.2 Resistance

And then they say, you know they want you to get into your higher power of spiritual...it, that annoys the shit out of me. Excuse me. I'm sorry. I'm not on the ground and I'm not gonna sit there and say yeah, I'm goin' to church and you know. And, just 'cause I'm in here. And I'm not gonna change for anybody.

3.3 Process

3.3.a. Structure/Rules

You have to structure to go the doctor. You gotta structure to go to Walgreens. You gotta structure to go anywhere out of this facility. And you have to have two people sign it, a therapist and one case manager, medical staff, someone has to—, you know you need two signatures. And it's very, very, you know, it's hard 'cause the first thirty days you're here you have to take somebody with you.

3.3.b. Sharing/Personal Storytelling

I opened up. I started telling my story. And a lot of other people could relate.

I'm not a big sharer. See I'm real emotional. So when I share, if I'm sharing, it's something inside that I want to share. And I get emotional and I get teary-eyed and my voice breaks up. So it, but, I, I'm not the one that has to raise my hand every, you know.

4. Motherhood discourse

4.1 Motherhood: idealized: participant's narrative discusses motherhood as a concept, the 'shoulds' or 'oughts' ascribed to mother as a category; goal-oriented: discusses achievement of 'good mother' status as personally motivating; valued:

discusses personal positive feelings or aspects of motherhood; ambivalent: participant references personal ambivalent feelings about motherhood.

4.1.a. Idealized

Motherhood, motherhood -- I think that comes natural. It's supposed to -- something that you, you gotta carry the egg around and be it grows into a human being nine months and then you give birth and you go through all that. That should be a part of you. So, it's always supposed to be a bond, I think. Loving and caring. You should, if I laid my head on a grain of sand, I should share that with my kids. If I have a piece of bread, my kid have to eat before I do.

4.1.b. Goal-oriented

If I'm not clean, I'm not gonna be able to take care of my kids the way a normal mother would.

4.1.c. Valued

When I got pregnant, like the twins and my baby, I really was doing it because of me, you know what I'm saying, I felt good about me. And I felt good about being a mother.

4.1.d. Ambivalent

(On being a mother) At first I didn't like it. But now I have to deal with it.

4.2 Children: participant's narrative references or describes children in a neutral fashion; valued: discusses positive feelings for children including love, care, and pride; de-valued: participant references ambivalent feelings for children including resentment and detachment.

4.2.a. Value-neutral

She's gonna be five months on the 9th. She's just a big healthy baby. What more can I say?

4.2.b. Valued

And I'm like right now, everything in my life of value, they, my kids are the only thing in my life of value.

I only have one demand...that she go to school. You get an education. I demand that out of my children. And then, and they respect that. My 17 year old daughter she's in a magnet school. SouthWest High. My 15 year old daughter is in a magnet school. My 11 year old son is in a magnet school. And all of them want to be something. All of them have their goals set in life.

4.2.c. De-valued

I really didn't want no kids.

5. Self/identity discourse – past: participant’s narrative references and possibly evaluates a former self, may describe connection to or difference from present self; present: participant’s narrative references and possibly evaluates attributes of present self, may contrast with past characteristics, values and priorities; future: participant discusses personal commitments that guide her imagined future; not self: participant rejects particular attributes as belonging to the self, distances self from de-valued others.

5.1.a. Past self

I was like, her cousin or somebody. I wasn’t her mother. I was like her cousin because she has seen me here and there, and then I just go away. Like fade away. But now I today, I could buy my baby and my kid some clothes.

5.1.b. Present self

If I don’t structure a form, a format for my life, then I’m not gonna ever get the purpose of who, a sense of who I am and what I’m here for. And I know there’s a purpose for my life.

5.1.c. Future self

I want to be, I see myself working. Holding down a job. And I plan to live somewhere along this, somewhere along by this water with my kids. Um, as long as I, I’m able to, able to provide for us, I’m, I’m happy. As long as my, long as we be together. Long as I can teach them things and they can teach me things.

5.1.d. Not self

My biological mother is an addict herself. She never was there for me. And I’m not... She choose drugs over me. And I’m not gonna choose drugs over my kids. I can’t.

6. Mental Health: participant’s narrative references psychological and/or emotional problems as pertaining to the self, may be connected by the participant to her drug use.

6.1 Anger

Only thing I need to work on is my anger problem. I have a really bad anger problem.

6.2 Self-Esteem

After I got raped it made my self-esteem go very low.

6.3 Depression

I’m so sick of anti-depressants. I’ve, I can write a book about anti-depressants. I, I’ve just been on like every anti-depressant. It’s supposed to help people with, with depression and stop cravings they say.

7. Judgment/Evaluation of Self : Self: participant explicitly evaluates or judges her former or present self, either positively or negatively, possibly through comparison with others. Other: participant explicitly discusses her interpretations of others' judgments of the self.

7.1 Self

I am not a good mother. I really, I really, I have never been a good mother. I mean I provided, a good housekeeper, kids are always clean, they're always fed, but actually a good mother, I wouldn't even categorize myself in that place cause I haven't raised any of my children the way I should have.

7.2 Other

I didn't make a report. None of the times I got raped. I never called the cops. I had gotten raped 3 times, never called. I was afraid that the cops there knew what I was doing and they weren't going to believe me. My own friends and the people in the neighborhood didn't even believe me.

8. Family of Origin Characterization: participant describes early family life in positive, negative or mixed terms, possibly connected by participant to later drug use.

8.1 Positive

My mom is very smart. My mom has a master's. My mom knows eight languages. My mom is very well-educated. She was raised on the army base in Germany. So my mom is, you know. So I just come from a good you know, place.

8.2 Negative

When I was a young girl, my father was an alcoholic, and he used to drink a lot. And, he ain't never used to see about me. And, my father and mother used to fight all the time, my father used to always get drunk, come hit on my mother, hit on me.

9. Authority: acceptance: participant's narrative implicitly or explicitly references or reacts to treatment program authority as benign , may openly acknowledge self as legitimate subject of authority; resistance: participant's narrative implicitly or explicitly references or reacts to treatment program authority as punitive, may openly dispute legitimacy of authority over self.

9.1 Acceptance

When you get here you need to go to orientation phase. That's the rules and then you take a test about the rules. That's the basic. Then there's step one done. NA and AA has twelve steps. It's like the commandments.

I've learned that, um, that I'm not good about, um, authority. I don't like authority. But I'm accepting it, because I know in order for me to live and change I have to accept, um, other people's ideas and not my own.

I truly want to get everything this time, I'm being very attentive in my classes, I want to know everything I can about what they say this disease is.

9.2 Resistance

And I can't... I got to structure for this and oh, man. I'm forty years old. Man, you gonna tell me I can't go this place, go to that place. Hard.

10. Goals/Future Perspective – participant acknowledges or rejects future life plans or commitments. Future intentions may be general or specific in nature, and may relate to future self.

To me, I got too many, too many goals that I wanna achieve. I got my high school diploma. I got my computer certificate. Um, I'm gonna go get my license for cosmetology. I want to get my real estate license. But I know I can't do it all at once. Right now my goal is to find a job, stay positive for my kids, me and my kids, get us a little car because it's kind of hard catchin' the bus with these two.

That person has like 13 years clean and 6 years clean. And I'll be imaginin' in my mind, you know, one day I'll be up in that chair saying I got 13 years clean too.

An addict should never have goals, but live on a day-to-day basis. Cause once they have goals they have expectations. Once you have expectations, then you feel, if you follow those expectations and you don't follow through those expectations, it's very hard for an addict.

11. Fear: participant explicitly acknowledges personal fear, concern or anxiety related to the possibility of treatment 'failure' or inability to maintain recovery

My family has threatened me if I ever do. Uh, they'll take my daughter away. So my biggest fear is that I'll fail them or I'll fail myself.

12. Changes: participant discusses broad or specific areas of self-change, may be related to re-structuring of values, priorities, or commitments, and/or new ways of relating to others.

My attitude changed a lot because I was the type of person that nobody couldn't tell me nothing. I was, me, I surrounded around my own world. Only me in my world. If you came in my world, you was a victim. That's, that's how I used to feel.

13. Learning: participant explicitly discusses learning, possibly in relation to the treatment program, or characterizes herself as a learner in the treatment community

I'm learning how to wake up everyday clean. And can stay clean all day, you know. If I do the right thing and I make the right choices.

That's one thing I'm learning here. They're making me stop and think, you should be independent.

14. Thinking/Reacting: participant discusses a specific type of self-change related to decision-making, action mediated by planning and deliberation

I'm able to make a little better decisions. I think more than I used to. I, it's not like I just... like when I was out there usin', I didn't think about anything. Just did what I wanted to do. But now I think about everything. I think about a decision before I make it. I assess it. I go through what's gonna happen if I go do it this way.

15. Turning Points: participant explicitly connects significant life events, positive or negative, to changes in self or life trajectory (such as entry into treatment)

But I think my real wake up call was the 8th street rapist, because he killed one woman and raped 5 others.

You don't always need treatment, sometimes you just need a wake-up call, you know, a message from God. It doesn't always have to be a bad message. For me it was, you know, seeing new life, you know, part of my life.

16. Inside/Outside: participant distinguishes in her narrative between life within and beyond the boundaries of the treatment community, may discuss connection or lack of connection between these realms

In treatment which is a lot different than out there. You have more bills, you have more stress, you have frustration. You don't got groups everyday. You got everyday life to live.

17. Something/Nothing: participant expresses damage to or loss of self/identity in her narrative, possibly contrasted with a newly discovered or desired self

It made me feel like that I was nothin'. That I, I didn't matter to nobody. But now just for today, I know that I am somebody.

I think it's important for me to work on myself because I, if I don't work on myself and become somebody, like my family, then I'm gonna be nobody.

18. Narrative Position: Focused on self-in-relation to the treatment program, participant expresses membership in treatment community, possibly feelings of inclusion/exclusion or isolation/connection, through her use of different position statements.

18.1 I-statements

I get the most out of an IC {individual counseling}, a one-on-one therapy. Or a group therapy. The rest of 'em, I really could care less about the co-dependency, job development, relapse prevention. Then they have this group, which is bonding from five to six. I think it's the most ridiculous thing in the world. They want you to bond with other people kids. I don't really, I mean, I do 'cause I have to.

18.2 They-statements:

They tell you, "Ah, just do what you got to do and don't worry about it." You know? Well, shit, I'm scared.

18.3 We-statements:

We don't want a new person coming in and then going out, going out by themselves so they send another peer out with them.

18.4 You-statements

When you get here you need to go to orientation phase. That's the rules and then you take a test about the rules.

19. Comments on Interviewer: participant explicitly acknowledges me as active participant in interview situation, makes explicit statements or assessments of me that contextualize her comments on a particular topic, possibly self and identity.

Like with you, we would call you normal. What we mean by normal people, people who would never use drugs. People who like, never been abused. You don't look like you went through an abusive marriage or abusive relationship with your mom, dad, or whatever. Okay addicts, I'm a gonna be a addict for the rest of my life.

Patterned Codes

Intersection of self codes with addiction, motherhood and Twelve Step discourse in text passages. Necessarily implicates personal identity.

1. Self/Mother

My daughter's gonna grow up and she's not gonna love me because she's gonna be embarrassed when she has a junky as a mother.

I think that I'm a great mother today. Regardless of what I did in the past.

I can't consider myself a mother.

2. Self/Addict

I'm definitely an addict. If I, I, I'm so much an addict to that if I...some things I love, say for instance that candy bar I was eatin'. I eat a candy bar, I gotta have another one. I'm, I'm just that much of an addict.

3. Self/Twelve Steps

It's like the first step is about honesty. If I'm not honest with you, or with, first with myself because to your own self you have to be true first. If I stood up here and deceived myself then guess what I'm gonna do? I'm gonna go smoke dope and die.

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