Exploring the Influence of Social Relationships on Identity, Drug Use and Recovery among Older Drug Using Females

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Abstract

The aim of this study is to explore the influence of social relationships on identity, drug use and recovery among older drug using females. This is an important area of research given the increasing proportions of older drug users entering treatment services and recovery communities. This is a qualitative study with eight older women (average age 44.5 years) self-identified as in recovery. This study is framed within a feminist perspective and utilises a narrative approach and object elicitation methods in the collection of data. Analysis of the data shows that self-acceptance was crucial to the women's successful recovery and helped them to develop healthy relationships as well as distance themselves from their previous identities as drug users.

The study findings confirm previous studies in the recovery literature that suggest recovery communities are important in developing the social learning tools that help former drug users integrate back into conventional social spheres. The findings also provide a unique contribution to UK research in this field by pointing to further areas of interests that are currently unexplored in the literature, including how older women's changing roles and responsibilities contribute to changing relationships within the family, particularly in terms of their relationships with their mothers, adult children and intimate partners. The findings from this small, strategic case study suggests further work with a broader range of women's voices from diverse backgrounds and recovery experiences is needed to inform the development of policy and practice among the growing cohort of ageing female drug users.

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1 Introduction

This study's aim is to explore the influence of social relationships on identity, drug use and recovery among older drug using females[1]. While drug use research has largely concentrated on younger users there remains a significant gap in global research that explores the social and health care needs of older drug users and in particular older female drug users and their attempts at abstinence and recovery[2]. It is imperative our knowledge of the needs of older drug users is increased. Across the UK, treatment services are seeing rising numbers of older clients (Information Services Division, 2016; Public Health England, 2016) and Scotland's recent drug death figures show the tragic consequence of long-term drug use. The highest proportion of deaths this year was among older clients with an increasing proportion of female deaths (National Records of Scotland, 2017). The aim of this research therefore is to add to the relatively small body of studies that have explored older drug users in the UK. This qualitative study differs in that it explicitly sets out to describe and reveal the meanings older female drug users place on the events and experiences that have shaped their identity throughout their drug-using careers and recovery. Overcoming 'epistemologies of ignorance' is required to ensure older women in drug recovery receive the support they need and want (Ettore, 2015). Placing my study within a feminist framework with a particular focus on identity and how this is shaped by social networks will provide important insights into women's recovery from substance use.

The following chapter reviews and highlight the gaps in current literature around older female drug users. Chapter 3 provides a thick description of the methods used and research process. Chapter 4 describes and discusses the findings and chapter 5 offers some concluding remarks, highlighting potential areas for further research.

[1] For the purposes of this study older female drug users are defined as aged 35 years or older. This is considered appropriate as studies show that drug use exacerbates or accelerates conditions associated with ageing among long-term and chronic drug users (Beynon, 2010; EMCDDA, 2010).

[2] There are a number of competing definitions of recovery. For the purposes of this study recovery is defined as abstinent from or low risk use of drugs for at least six months prior to interview.

2 Literature Review

2.1 Introduction

In line with the study objectives to explore the influence of social relationships on identity, drug use and recovery among older drug using females, this chapter will provide a critical review of the key texts as they relate to older female drug users. The following sections will explore the main themes of 1) identities through drug use and recovery and 2) relationships through drug use and recovery. The chapter will conclude with a critical overview of the current gaps and limitations in this research area.

2.2 Identities through drug use and recovery

Identity work is grounded in the symbolic interactionist school of theory. In its classical sense, symbolic interactionism focuses on micro-level processes of social interaction and is concerned with face-to-face interactions and the ways in which these repeated, meaningful interactions shape society (Carter and Fuller, 2015). Identity as a concept is widely used in social theory and sociological analysis to understand and examine the interactions and meanings that individuals and groups use to make sense of the world. Problematic drug users though are labelled deviant and women are particularly vulnerable to this process. From a feminist social interactionist perspective, women's deviance is viewed as a social construct which goes beyond formal processes and includes informal processes of routine social interaction (Schur, 1983; p.3). Defining individuals or groups as deviant imposes social controls on those labelled while stigmatisation is used as a mechanism for maintaining control and preconceived gender norms (Schur, p.30). Early work by Goffman (1963) examined how stigma is made and reproduced. He suggested there were three types of stigma: The 'character' in which an individual is perceived as having traits that do not fit into the 'moral norms' of society; the 'physical' in which physical deformities of the body allow for stigmatisation; and the 'group', whereby stigma arises from being of a particular race, nation, religion and so on. Older drug-using women who are already in a socially subordinated position may internalise the stigmatising behaviours of society, carrying as they do the external traits (for

example bodily scars, membership of a 'deviant' group) that identifies their character as other or different from the norm. Borrowing again from Goffman (1959), recovery from drug use requires individuals to learn new ways to 'perform' in the non-drug using settings. Central to Goffman's theory is the notion that people are engaged in everyday face-to-face social interactions and as they interact they are constantly engaged in a process of 'impression management'. Crucial to this process is the need to present oneself in a way that does not embarrass oneself or others (Goffman, 1959: pp.17-25). For older female drug users, learning how to interact with non-users in the conventional world requires work and must be accompanied by a process of social learning.

Two seminal studies on recovery from drug use adopt a symbolic interactionist approach (Biernacki, 1986; McIntosh and McKeganey, 2002). Borrowing from Goffman (1963), both Biernacki and McIntosh and McKeganey argue that the motivating force behind recovery is the restoration of the 'spoiled identity' (Biernacki, p.25; McIntosh and McKeganey, p.44). Reaching 'rock bottom' or experiencing existential crises triggers the user's resolve to quit drugs. These extreme situations provide a reorientation of the individual's frame of reference and perspective. A period of abstinence or maintenance provides space to forge new social relationships and interests that help support and reinforce new identities and perspectives (Biernacki, p.99). The processes of forming an 'ordinary' identity and adoption of conventional roles (for example, mother, volunteer, worker) is achieved through social commitments to new relationships that confirm and reinforce their new identities and form a 'symbolic wedge' between their past and present identities (ibid, p.176). However, a crucial element in the process of identity formation is maintaining a biographic narrative. (Giddens, 1991: p54 in McIntosh and McKeganey, 2000; p.1503). Recovering drug users may construct a non-addict identity through three processes: 1) reinterpreting drug use as a negative experience; 2) reconstructing a sense of self in which the user rejects their past and redesigns their future, and 3) providing convincing explanations for their recovery (McIntosh and McKeganey, 2000; pp.1505-1507). These narratives are influenced by the recovery lexicon of drug researchers, practitioners (ibid, p.1508) and

those in the recovery communities[3] (Best et al, 2016; Reith and Dobbie, 2012). Re-situating themselves in a non-using context, particularly within the recovery communities, involves the adoption of new discourses that in part involves a negative reconstruction of their past using identity (Anderson and Levy, 1993). Identity materials such as new social roles and vocabularies are crucial factors in constructing the non-user identity (Biernacki, p.144). In this sense the recovery communities that are prevalent within drug treatment provision provide the language of shared experience that encourage acceptance of the committed recovering user within a community of committed non-users.

It has been argued that the desire to recover a 'spoiled identity' is integral to overcoming drug use (McIntosh and McKeganey, 2002; Biernacki, 1986). 'Reverting' to an old (unspoiled) identity, 'extending' an (unspoiled) identity or engaging in an 'emergent' (unspoiled) identity can 'transform' user identities and turn them into 'ordinary' people (Biernacki, p.179). Successful recovery is more likely to occur if the decision to stop using is based on an attempt to 'recapture a positive sense of self' rather than trying to achieve a practical objective such as maintaining children (McIntosh and McKeganey, p.92). The strength of these studies shows the importance of identity restructuring in recovery within the social contexts and the interactions therein. However both focus on the restoration of a 'spoiled identity' and underplay the structures that constrain drug users' recovery, specifically those of women.

A recent paper by Best et al (2016) has looked at identity transition through membership of Alcoholics Anonymous (AA) using the Social Identity Model of Recovery (SIMOR). Identifying the mechanisms of change, the authors propose that identity change in recovery is socially negotiated through a process of social learning and control and is transmitted through social recovery networks such as the Fellowships[4]. In the model, the person's primary identity of drug user 'shifts' to one of membership of a group that encourages and values recovery (Best et al, 2016; p.113). Important to this shift in identity is a sense of

[3] Recovery communities are comprised of members who have experienced addiction, treatment, and/or recovery. Recovery communities for the purposes of this study are made up of a range of groups including Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous and peer-led recovery cafés.

[4] The Fellowships are Alcoholics Anonymous, Cocaine Anonymous and Narcotics Anonymous

belonging, support, efficacy and meaning (ibid, p.115). This is a potentially useful model in which to explore changes in identity from that of drug user to non-drug user and could be applied to further research that encompasses women's wider social networks beyond membership of recovery groups. Certainly more work is required to examine how women re-connect and gain a sense of belonging to conventional life beyond the drug-using milieu and drug recovery.

Within the hierarchy of drugs, heroin is viewed as the most polluting (Ettore, 1992: p.77). Women are polluted in body and identity: 'spoiling the private sphere of "domestic bliss" and the public sphere of social hygiene' (ibid, p.79). Poorer physical and mental health combined with social and structural barriers exacerbate the marginalisation of older drug-using women to the edges of both the drug-using environment and society more generally. Far from being helpless victims, older drug-using women can show greater resilience through their drug-using career and recovery (Sutherland et al, 2009; p.907) and, can and do exert control in their lives (Miller, Carbonez-Lopez and Gunderman, 2015; Taylor, 1993; Rosenbaum, 1981). Increasing maturity coupled with lessons learned from life experiences may empower older women in recovery to overcome the challenges they face in attempting to construct their identities in a normative manner that fits with society's expectations of women in general and older women in particular. To date however, our knowledge of how older female drug users construct a non-using identity is scant and represents a major gap in the older drug users' (ODU) literature.

2.3 Relationships through drug use and recovery

As ageing occurs, people are prone to experience the loss of key relationships and social networks. For older drug users (ODU) the likelihood is that this may occur at a younger age than the general population. Incidences such as family breakdown, loss of job roles, mortality and morbidity among friends and significant others makes ODU increasingly vulnerable and potentially isolated (Beynon et al, 2009). Among individuals with substance use problems, women are more likely than men to have a partner with a substance use problem; childcare responsibilities; severe problems at the beginning of

treatment; trauma related to physical and sexual abuse; and concurrent psychiatric disorders (EMCDDA, 2006). Recent studies have shown that a shrinking network of drug-using associates and significant others is beneficial to reducing and abstaining from problematic drug use and that longer periods in recovery can help build non-drug using networks which in turn reduce the social and environmental triggers that may cause relapse. (Satre et al, 2003; Best et al, 2012). While ongoing relationships with drug-using partners can lead to relapse for some women, others may find these relationships develop into strong and supportive prosocial ties in which both partners can encourage and support each other in recovery-orientated treatment and settings (Leverentz, 2006, p.473). Despite conventional wisdom that suggests drug users should attempt to widen their networks of non-users, recovering drug users who enter into relationships with other recovering users may find shared experience and understanding a valuable support.

Relationships within an older female user's social network can pose ethical dilemmas for professionals. Older women who have responsibilities and obligations to long-term partners, children or grandchildren may place their own needs secondary to those of others. This can affect their motivation to enter or remain in treatment. Shame and stigma is also problematic as women may be reluctant to discuss their risk behaviours for fear of further stigmatisation by treatment providers (Koenig and Crisp, 2008; p.1049). Women may also be reluctant to jeopardise relationships by seeking help or significant others may discourage help-seeking (Koenig and Crisp, p.1051-1052). The capacity to seek help for women in abusive relationships may be limited or they may use substances as a way to cope with the abuse (ibid, p.1052). In addition, social isolation may provide additional barriers for professionals to identify problematic drug use in older women (Wadd and Galvani, 2014; Crome et al, 2011). On the other hand, it is worth noting that drug use can serve a functional purpose and offer opportunities for independence and status (Lander, 2015; Miller et al, 2015; Taylor, 1993). Lander's qualitative study explored specifically ageing and drug use among four older female amphetamine users (ages 48 to 71 years) and describes the women's resistance to feminine normative behaviour and their enjoyment of drugs and life as drug users (Lander, 2015). For some women, using drugs may provide a positive sense of self and identity. However,

wider society and the agencies that deal with female drug users provide a discourse that views these women as somehow 'other' and ignores the social, economic and cultural explanations for problematic drug use. Ethical dilemmas, stigmatisation, previous experiences of authority figures and for some, the benefits of drug use, are potential issues that could compromise professional support that older drug-using women themselves might consider appropriate.

The drive to place 'recovery' front and centre of drug policy in the UK in recent years has seen the rise of recovery communities all over Britain. Among these are the Twelve-step programmes[5], including Alcohol Anonymous (AA) and Narcotics Anonymous (NA). For some women, Twelve-step programmes can offer on-going social support that reinforces their commitment to recovery (Russell and Gockel, 2005; Hser et al, 2003). In contrast though, they can be viewed as another form of social control (Sered and Norton Hawk, 2011). Unprompted sexual advances, the counter-productivity of talking about drugs, risk of sponsor's relapse and depression and anxiety triggered by hearing and identifying with other people's problems and stories, or lack of attention paid to their own stories are all aspects that women have identified as problematic within Twelve-step programmes (Sered and Norton Hawk, 2011). Although the benefits of AA and NA for women are mixed and may not be appropriate for all women with drug-using histories, mutual aid and self-help groups have a place in women's drug use recovery bringing as they do the potential for wider drug-free social networks that can help maintain recovery. However, the Twelve-step ideology of individual responsibility may in fact obscure the underlying conditions that lead some women to use drugs in the first place.

The biological and social aspects of ageing can increase the sense of diminished self-worth among older people and particularly among ODU, for whom long-term drug use may have exacerbated the normal ageing process (Anderson and Levy, 2003). Fear of victimisation by younger drug users might encourage older users to remove themselves from active participation in the

[5] The twelve-step programme is a term applied to a number of spiritually-based recovery groups such as AA, NA and CA. they comprise a set of principles and practices for remaining abstinent and in recovery. For more details see http://www.alcoholics-anonymous.org.uk/About-AA/The-12-Steps-of-AA

drug scene to self-imposed isolation along its peripheries as a protective strategy against harm, thus ODU become 'the marginal among the marginal of society' (ibid, p.762). At the same time, long-term drug users may prefer to 'age in place' and remain in a 'familiar socio-economic environment where they know the rules and what to expect' (Levy and Anderson, 2005: p.256). Among long-term users, ties to conventional social roles and networks decline as their drug use progresses. Disengagement from relationships all add to increasing isolation and marginalisation within drug using circles (Beynon, 2009; Levy and Anderson, 2005). The female drug user's options for regaining entry into the non-drug and drug using worlds narrows as she ages (Boeri, 2013; Rosenbaum, 1981). Illegal work becomes more difficult and risky while entry into employment and 'conventional' roles are limited by the double burden of being an older woman and an ex-user (Rosenbaum, p.133). Similar to other ageing adults in society, competing in a culture that places value on youth is challenging but even more so for older female drug users.

Relationships with children are cited as important motivators to desist from drug use (Biernacki, 1986; McIntosh and McKeganey, 2002) however these relationships are rarely mentioned in the older drug users' literature. A rare example is Hamilton and Grella's (2009) study of older heroin users. They found that women were more expressive about the impact of their drug use on their families and in particular expressed regret and guilt over neglecting their children (Hamilton and Grella, 2009; p.5). It is not clear why there is a lack of research into older drug users and relationships with their children but it is clearly a gap that needs to be addressed. The maternal role and identity of drug-using women is not simply negated by increasing age. They continue to be mothers, albeit to adult children. While the social concerns that arise from drug-using parents compel policy makers and treatment providers toward protection of children less than 18 years of age, those mother/child relationships that may have been fractured while drug use was active now perhaps require reappraisal and repair. Recognising this and evidencing how older female drug users and their children respond to and manage this challenge would make an important contribution to the development of family support for older recovering drug users.

2.4 Summary

The work of Biernacki (1986) and McIntosh and McKeganey (2002) remain important studies within the drug recovery canon. Nevertheless, their work focuses on repairing a spoiled identity which assumes that this is an aspiration for most drug users. This may in fact run contrary to the lived experiences of some women (and men) who might never have perceived themselves to be unspoiled prior to their drug use. Furthermore, while they remain important studies, the lack of a gender and age-based analysis of their data precludes drawing definitive conclusions about the nature of the older drug-using females' experiences. Best et al's (2016) recent work focuses on group membership as the primary vehicle for recovery and is useful for exploring identity transitions through a social identity model. However, this limits the model to looking at the influence of relationships on identity transition within recovery communities and provides less scope to look at other external relationships, such as those with families, intimate partners and friends. It places emphasis on shared discourses, which are of course important but also important are the day-to-day presentations and performances that recovering and recovered uses must negotiate in their interactions with others. How do older women do this, what are the challenges they face and how do they overcome them? This remains an unchartered but potentially interesting area for further study.

The literature on older drug users is growing but much of it remains quantitative and related to health and treatment studies. Our knowledge of older female drug users remains limited, largely because of a lack of gender and age-based analyses and qualitative work that looks in-depth at their experiences. We should endeavour to look beyond women as a homogenous group in drug studies and explore the interactions of age, race, sexuality and social and cultural structures on identity transformation through drug use and recovery. We need also to look beyond those women in recovery communities and treatment and examine the views of women who have gone through drug use and recovery without recourse to external sources. As discussed, there remains a significant gap in our knowledge of older women's changing relationships with adult children as they go through drug use and recovery. This perhaps goes hand-in-hand with their changing roles and responsibilities within

the wider family unit. Ageing parents and grandchildren are also potentially important in facilitating changes in women's perceptions of themselves in relation to others and yet we know very little about their influence on recovery. As the proportion of older drug users increases, so will the research. It is imperative that we explore the position of older female drug users not as an afterthought when data has been collected but that we design and conduct studies that start out with this premise in mind.

3 Methodology

3.1 Introduction

This chapter describes the methodology used to explore the influence of social relationships on identity, drug use and recovery among older drug using females. It defines the theoretical position adopted, participant selection and recruitment process, data collection, data analysis, and ethical and methodological considerations.

3.2 Theoretical Position

Influenced by my own epistemological understanding of how we make sense of the social worlds we inhabit, this section provides a brief overview of the theoretical position that influenced the methodology, namely feminist standpoint theory.

There are a variety of feminist theories but it is feminist standpoint theory that offers the best approach for this study (Rolin, 2009). The methodological approach that feminist standpoint theory encourages is one in which the participants themselves describe their experiences in their own words. Telling their stories from their particular 'standpoint' increases the validity of the findings and is particularly relevant in research that seeks to explore the complexity of women's lives as understood by them. As Devault (1990) states on constructing topics for research on women's lives:

> 'The promise of feminist ethnography is that we can elicit accounts and produce descriptions of…practice and thought that are part of female consciousness but left out of dominant interpretive frames, shaped around male concerns' (Devault, 1990, p.100).

Seeking to understand how relationships might influence women's identity requires participants to reflect and describe their emotions and cognitive processes. Utilising a qualitative approach helps facilitate a conversation that seeks to understand the influence of roles and relationships on their identity through drug use and recovery from the women's own perspectives (Kvale, 1996). It is through seeing the women's recovery journeys from their

epistemological standpoint that we can attempt to understand the relationships and structures that help maintain that recovery.

The aim of this study is to understand the processes that shape and characterise older women's recovery as individuals and as a group of women who share common experiences as former drug users. This study benefits from including multiple voices that enable us to identify those areas of shared experience among this group of women thus enhancing and contributing to research in this emerging area of drug policy and practice.

3.3 Participant Selection and Recruitment

Selection

Participants were included if they met the following criteria

- Females with a history of illicit drug use.
- Self-identified as in recovery from drug use (abstinent or low risk use[6]) for at least six months in the past year.
- Above the age of 35 years.

The cut-off age of 35 years may be considered young but the health effects of prolonged drug use and its effect on the ageing body, plus the potential difficulties in accessing this hard-to-reach group, informed the decision to include women at this age. Convenience sampling was used to recruit participants with help from former colleagues with contacts with older women in recovery networks.

Participants were excluded if

- they did not meet the inclusion criteria

[6] Low risk use defined as <14 units of alcohol per week; drug use at minimum level causing no psychological, legal, employment, family or health problems (Carbello, 2009: p.83)

- Identified as having mental health or other problems that might trigger distress during the interview.

- Were non-English speakers.

Recruitment

Eight women, average age 44.5 years, were recruited from a woman's recovery café (n=4) and an employment training programme (n=4). Figure 1 outlines the participants demographic and drug using characteristics.

Figure1 Participants Demographic and Drug Using Characteristics

	Pauline	**Jane**	**Karen**	**Alison**	**Rachel**	**Sarah**	**Joanna**	**Marion**
Age (years)	50	48	45	37	39	48	44	55
Partner Relationship Status	Partner	Single	Partner	Partner	Partner	Single	Single	Partner
Children	3 (Teen & adults)	3 (Teen & adults)	1 (Adult)	1 (Child)	1 (Child)	3 (Adults)	None	3 (Adults)
Employment status	Employed	Employed	Employed	Employed	Volunteer	Volunteer	Volunteer	Volunteer
Length of time using substances (years)	33	15	23	14	22	33	19	37
Length of time in recovery	8 years	3 years	7 ¾ years	9 years	10 months	12 months	2 ½ years	5 years (relapsed in January '17)
Main substance	Heroin	Heroin	Heroin	Alcohol	Heroin	Heroin	Alcohol/ Opiates	Heroin
Onset status for opiate use	Late (age 30)	Late (age 29-30)	Early onset age 23-26 and then relapsed back age 35 - 37	Early	Early	Early	Early	Early onset age 19 -22 and then relapsed back age 30-34

The sampling method and recruitment process was largely driven by time and convenience but as this is an exploratory study the method is justified. Gaining access to hard-to-reach groups can be slow but contacts with former colleagues and experience of working in this area helped me gain access to women relatively easily. Further research in this area however should aim to explore additional avenues for recruitment including older women in treatment

services, women not in contact with treatment or recovery/fellowship organisations, and women from a wider geographical area.

3.4 Data Collection Procedure

I was aware that this population might suffer from research fatigue (Clark, 2008) and that some spend years re-telling their life story through engagement with various agencies or potentially as Fellowship members. It was important therefore to find a method of data collection that would be engaging and provide space for the women to discuss the issues that were important to them while also retaining focus on the main themes of recovery, identity and relationships. This section outlines the data collection procedure including the interview guides used, the interview process and the novel approach of object data collection.

3.4.1 **Interview Guide**

The interviews were based on two instruments that have been used to explore drug use and identity (McAdams, 2013; Biernacki, 1986). Initially, I had planned to adopt a life-course method utilising McAdam's life story technique[7] (McAdams, 2013). This is an in-depth interview that uses a life story model of identity to explore how significant life transitions are narrated and how the "self and culture comes together in narrative" (Vassilieva, 2016, p.15). Utilising a narrative approach to explore the meanings and understandings women give to their experiences would, I hoped, enable them to tell their 'story' from their particular standpoint. The McAdam interview schedule was amended to reduce the interview length to between one and two hours. I also wanted to address particular questions relating to those relationships they identified as important. The first three interviews with the adapted McAdam topic guide (see appendix 2) raised interesting insights but I was not confident this approach was answering the main research question or that the interview sufficiently focused on how the women had maintained their recovery and the relationships that had helped

[7] Dan McAdam Life Story Interview https://www.sesp.northwestern.edu/foley/instruments/interview/ Downloaded 22nd February 2017

them do so. The concept of ageing as a drug user also needed to be addressed more effectively. Following careful thought I decided to revise the topic guide, maintaining a semi-structured approach that would enable the women to expand on their responses to the themes of identity, recovery and relationships.

The amended topic guide (see appendix 3) received ethical approval and aimed to provide more focus on the key concepts of relationships and recovery and how these have influenced participants' identities. A key work in the field of recovery is that of Biernacki (1986). His seminal study looked at natural recovery from heroin use and also adopted a life course methods approach. Using this as a guide I started the interview with the demographic questions followed by the object data collection (see section 3.4.3). Once this was completed I introduced the main part of the interview with the statement "I'd like to hear about your Recovery now, how you've overcome your drug use and how relationships with others have helped or not." And then asked "Can you begin by telling me what brought you to the decision to stop using?" (Biernacki, p, 221) As the conversation developed, I asked content mining questions to explore in further depth the responses provided and issues raised (Ritchie and Lewis, 2003; pp.150-2). For example, following up on an earlier point, I asked Pauline a clarificatory probe: "*So did you feel safe in your house? You said there were lots of alcoholics coming in and out'*.

3.4.2 **Interviewing**

Six of the eight interviews took place in the participants' home. Two separate interviews were conducted in a private room, donated by one of the gatekeeper organisations. Interviews lasted between 63 and 160 minutes (average 120 minutes). A number of the women worked or volunteered, and child care arrangements prohibited lengthy bus journeys to the city centre. Interviewing in the home gave the women control over the time spent on the interview and the space in which it was conducted.

The interviews were preceded by an explanation of the study and the participants were given time to read through the participant information sheet and ask questions. The consent form was explained and signed by the participants and researcher. An initial screening process was used to ascertain

whether any mental health or other problems might cause distress during the process. No-one raised concerns and no woman was excluded from the study. Further details on strategies to minimise risk are described in section 3.6. The interviews were audio recorded on a digital recorder to ensure accuracy.

Following the interviews in the home and if invited, I spent additional time talking with the women on a variety of topics. Returning home I would write notes on how I thought the interview had proceeded and any additional comments and items of interest that were raised pre- and post-interview. In addition I would immediately download the interview onto a computer, listen to the interview and take extensive hand-written notes of the interview contents. Practicing this allowed me to begin formulating the initial coding structure and transcribe with greater accuracy.

3.4.3 **Object Data Collection**

The women were asked to identify and bring along an object that was meaningful to them to test whether this would be an appropriate method for further research. Object-elicitation methods have been used in a number of health-related studies with adults (Fenton, 2017; Willig, 2016; Romano, McKay and Bodell, 2012). I wanted to explore the meanings the women might give to their objects, anticipating perhaps a richer and deeper understanding of the values they embraced as recovering drug users. I invited the women to '*bring along to the interview a material object that is meaningful to you (e.g. postcard, pebble, scarf) – an object that you consider important to you*.' The women were interested in this aspect of the interview at recruitment and interview. Some asked what object they should bring along, what did I mean by 'meaningful' and some expressed difficulty identifying an object. Others knew exactly what object they would bring. Seven women brought an object to discuss. This element of the interview was both novel and enjoyable for the participants and researcher. Appendix 4 provides photographs and a short description of the objects.

3.4.4 **Interview challenges**

The interviews were not without challenges, mostly related to time and staying on-topic. Keen to ensure the women were relaxed and felt comfortable enough to express themselves, I did not discourage the women from expanding on their responses to my questions. I wanted the women to feel free to construct their own narratives. This meant that most of the interviews ran over two hours and I would have to stop the interview to ask the women if they had time to continue. All did. Nevertheless, a good deal of time was taken up discussing their drug history and demographics. While this could be seen as a disadvantage it did give women space to discuss the relationships that were influential at that time and beyond and encouraged reflection on statements made at later stages in the interview.

3.5 Data Analysis

Thematic analysis as recommended by Braun and Clarke (2006) was used and details of the transcription and coding methods are described below.

3.5.1 **Transcription**

Having limited time, my original intention was to use a 'clean' transcription method (Elliott, 2005: p.52). Clean transcribing focuses on the content of the interview and excludes extra verbal material such as pauses, non-lexical utterances (the 'ums' and 'ers', laughter and false starts) (Elliott, p.52). However, during the transcribing process I found myself including all of the above as they indicated the flow of the conversation. Sometimes there were long pauses which indicated the participant was thinking about the question before answering. Sometimes the pauses and false starts indicated a new point that the participant wished to raise. Frequently, the women punctuated or ended their sentences with 'do you know what I mean?' Cleaning a transcript would in effect 'clean' the women's narratives therefore transcribing the interviews in the vernacular preserves the women's voices (Devault, p.107). Transcribing my own false starts to questions, interruptions or laughter also provides a way for me to reflect on my interview technique and areas where it could be improved.

3.5.2 **Coding Methods**

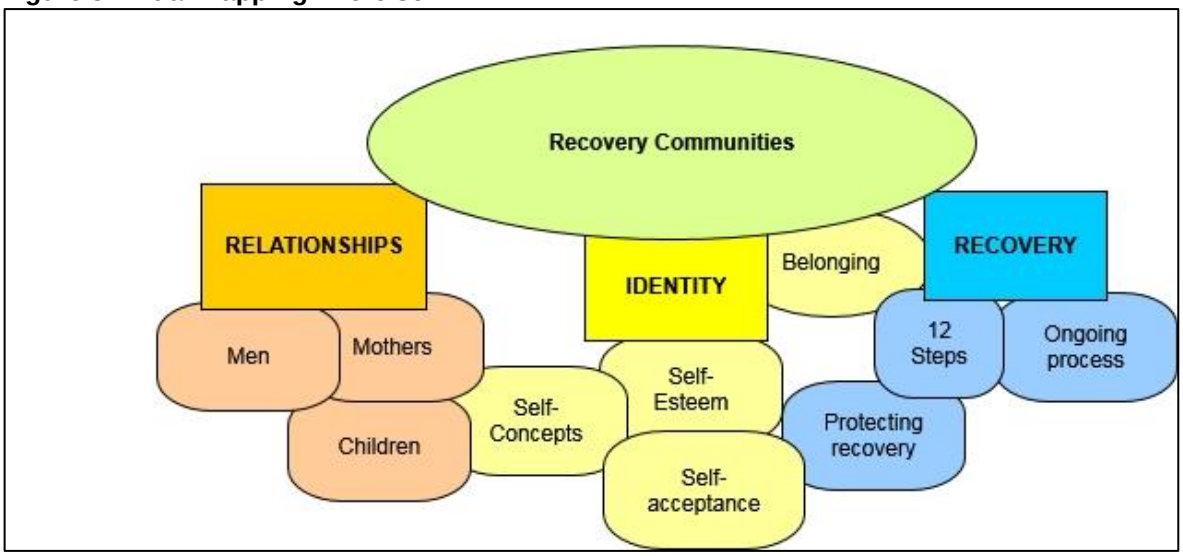
Thematic analysis (Braun and Clarke, 2006) was used to identify the main issues raised by the participants. Interview transcripts were coded thematically through six phases: familiarisation with the data, transcription, initial coding, searching for themes, reviewing themes, defining themes and report writing (ibid, pp.87-93). Analysis was both deductive and inductive. It is impossible to approach the data without any preconceived ideas of what categories might be present but it is also important to ensure any new concepts within the data are brought out in the analysis (Joffe, 2011; p.210). The transcripts and coded data were compared to highlight any potential similarities and differences between participants (Joffe, p.214). A loose framework was applied to visualise the comparisons more easily as shown in figure 2 when participants discuss protecting their recovery.

Figure 2: Coding framework Example: Protecting Recovery

Rachel	Joanna	Jane
Rachel: And I've just had to distance myself from girlfriends. And that was hard because one of them was a really, really close pal and she kinda hung about. She was using though and we were using with her and…eh, she was coming up and playing with eh wean and the dog and she's on a 105ml and I'm like [exhales] she's nae thoughts of coming off it. She's still in that active addiction and it's horrible. So I just don't see her anymore.	Joanna: Aye, nursing I wouldn't go back to that. I did think about it. I don't think I could handle it,. The shifts were just horrendous. I'd always be surrounded by drugs and that's why I lost my job. I was found stealing drugs you know and…[right] I don't want to put myself in a position where in a moment's weakness you know and…like I wouldn't go and work in an off-sales [yeah] I don't think there's any point going back and working in an environment where temptations always going to be there. I'm just kidding myself on if I think otherwise	Jane: See if sit too long in the house, the boredom kicks in and the thoughts come in 'oh, you could use, nobody would know.' [*How do you deal with it now?]* Just white-knuckle it or go and speak to somebody. Which is usually other recovering addicts, ehm, speak about it in a meeting. But aye the thoughts come in. you're not going to sue all that time and stop and never think about it., it was my best pal, it was my lover, it was my everything [yeah] <u>It was.</u> It was my first and foremost every single day. And now it's not part of my life anymore so there is sometimes when you're pissed off or bored you think a wee charge would go down a treat just now. But I know it wouldn't be one [*Hmhm. It would go on to more?]* Yep. And I kinda grasped fairly quick, if you don't pick up that first one, you cannae get mad with it. And it's only a feeling. A feeling's not gonnae kill me whereas what they're using more likely would.

Qualitative software (NVivo 11) was used to code the interviews. Themes and sub-themes were derived from repeated readings of the transcripts and observing where there was overlap between codes. A thematic map was generated to produce a visual aid to develop my understanding of the initial codes and potential themes and sub-themes within the data, as shown in figure 3.

Figure 3: Initial Mapping Exercise



Rigour can be achieved through a constant process of data review, reflexivity and a clear explanation of the analytic process (Vaismoradi, Turunen, and Bondas, 2013). As such, adopting a reflective approach to the data can uncover underlying themes and concepts that are not immediately apparent following an interview or initial transcription and review. This analytical approach sits firmly within the theoretical position adopted in that the themes emerge from the data and are not imposed from above. It is a bottom-up approach that emphasises the women's own 'standpoints'. The themes derive from the data which in turn are generated by the women's self-directed narratives.

3.6 Ethical Considerations

The study was approved by the University of Glasgow's School of Social and Political Sciences Ethics Forum. A 'Code of Safety for Social Researchers' (Social

Research Association: Downloaded 4th March 2017) was utilised to assess and minimise risks to myself and participants. No situations arose that caused concern. The women were given a participant information sheet and given time to read it and ask questions. The women were assured complete anonymity, with all identifiable information removed from transcripts and published materials. Once satisfied they understood the purpose of the study and were willing to take part, they were asked to provide informed consent.

In-depth qualitative interviewing on sensitive topics such as drug use can evoke strong memories and feelings that can sometimes be distressing. I could not predict how the questions would be received by the women or the feelings they might evoke. I felt it was necessary therefore to employ an initial screening guide to minimise the risk of causing distress. The screening process involved making clear to the women that discussion during the interview could raise sensitive issues. They were advised not to participate if they were currently experiencing stress or severe emotional distress. A general question was asked: *'Are there any reasons you can think of that might make participating in interviews about your recovery too stressful for you?'* No-one indicated any concerns but they were advised they could stop the interview and withdraw from the study at any point. There were two occasions where discussion around personal relationships caused some minor distress with the women close to tears. I immediately responded to the participants in a sympathetic and non-judgemental way and asked them if they wished to stop the interview. They declined and we finished the interviews. Two participants declined to answer some questions. I respected their choice and moved on with the interview.

A number of women spoke about other issues following the interview that were not audio-recorded. These were private insights I felt privileged to hear but respecting these confidences is an important ethical decision. While the information is 'lost' to analysis it helps me to have a more informed understanding of the challenges and opportunities some of the participants experienced in terms of reshaping their lives and identities as non-drug using women.

3.7 Methodological Rigour

The validity of any study involves the philosophical questions of 'what is truth?' This study starts from the premise that there are 'multiple ways of knowing and multiple truths' (Kvale, p.231). The theoretical position adopts the view that the women's narratives are constructed as their 'truth' as they relate it both subjectively and objectively. Nevertheless, I have to acknowledge that my own theoretical stance and interests in this area influenced the research question, methodological approach, analysis and interpretation of the data (Pyett, 2003). Emulating Pyett, I want the perspectives of the women to be understood and to represent these 'through a respectful and feminist analysis' (Pyett, p.1173).

Reliability refers to consistency throughout the research process including during interviews, transcribing and analysis. The nature of the interviews was such that the women had a large degree of freedom in terms of the direction in which they took the interview. Despite this, the women's narratives were similar in terms of the main themes raised and not unlike previous literature on female drug users and women in recovery. As noted, the interviews were transcribed twice thus lending credibility to the accuracy of the interview transcripts. Categorising, coding and analysis of the interviews are inevitably prone to the subjectivity of the researcher (Kvale, p.236) and I take full responsibility for the analysis and findings presented.

The findings of a self-selected sample of eight women cannot be statistically generalised to the whole population of older women in recovery and I acknowledge that further research in this area should incorporate older women from a range of backgrounds, ethnicities and with different recovery experiences. Although the women were offered the opportunity to validate the interviews by reading and correcting their transcripts, only three women accepted the offer and one replied with confirmation of the 'accuracy' of the transcript.

The qualitative nature of this research is such that I do not assert the positivist claims of validity, reliability and generalisability that quantitative research does. Nevertheless I hope that by providing a reflexive account of the

methods employed the reader will have the necessary tools to assess its credibility and trustworthiness.

3.8 Summary

This qualitative research project provides a strategic case study that is methodologically reflexive and aware of the challenges inherent in this form of research. The methods used sit firmly within the theoretical position undertaken. Adopting a feminist stance provides a clear approach that informs this area of study directly from the 'standpoint' of the women themselves. Furthermore, the process has enabled me to reflexively consider how I will proceed with the next stage of this research including widening recruitment to those women outwith the recovery communities and from a wider geographical area. This study will I hope provide an important contribution to the hidden voices of older female drug users during a period of increasing drug policy concern with the growing proportion of older drug users.

4 Chapter 4: Findings

This chapter explores the influence of social relationships on identity, drug use and recovery among older women with a drug using history. It provides an analysis of the women's narratives as they relate to the interactions between relationships, recovery and identities. The following sections explore the women's definitions of recovery; self-acceptance and identities; and relationships, identity and recovery. The chapter concludes with a critical discussion of the main points raised and areas for further research.

4.1 Women Defining Recovery

Understanding how these women view recovery requires us to explore their explanations of recovery as it is experienced and understood by them. The women themselves defined recovery as '*change*', '*freedom*', '*hope*', '*choice*', '*opportunities*', '*a new life*', '*being responsible*', '*fun*' and '*shit*'. They also emphasised the temporal dimensions of recovery describing it as '*transient*' and being '*in the day*'. The temporal aspect of recovery as described by some of the women fits with the language used in the Fellowships and may indicate the 'internalisation of a recovery identity' (Best, 2016; p.115). Forgiveness and self-compassion are important tenets in the Fellowships and is reflected in the women's narratives. Recovery was also described as a learning process which took a number of forms: learning from others, learning how to deal with uncomfortable feelings, learning to accept oneself in the past and the present. In this respect, recovery is a process that encompasses a range of benefits but can also be challenging. Recovery is not a process one achieves by being merely abstinent from all substances but is from the women's perspectives, an external (via social interactions) and internal (via self-reflection) learning process.

4.2 Self-Acceptance and New Identities

If a person's self-concept is produced through interaction with others then key to a healthy or positive self-concept is self-acceptance. Defined as 'a person's satisfaction or happiness with oneself, self-acceptance involves 'self-understanding and an awareness of one's strengths and weaknesses' (Shepard, 1979; p.140). Coming to terms with their past identities and forging new or

emerging identities was critical to this. Discussing their objects, the women described themselves currently and in relation to their past and future selves as illustrated in Alison's extract below.

> Alison: "I've done hundreds of ehm…shitty things that I could either spend the rest of my life feeling bad about or I could just try and have compassion and go 'right I made mistakes but that's not who I am now' and move on. So yeah the Buddha like gave me hope…as well because…your actions don't define you."

For Pauline the use of her AA Big Book represented '*change'*, '*hard work'* and a *'new perspective on life'*. It was not as Pauline said, the book itself that was meaningful but rather, what it represented: self-acceptance.

> Pauline: "It's not so much the book but what it stands for and what's in it and what's in it is very simplistic…Through the Twelve steps you'll be able to feel about yourself and disclose yourself and do this and move on. And come to know about acceptance [*uhhuh*] and accepting yourself. This is who I am."

The women's objects represented hope for a better future and symbolised inner-strength, self-acceptance and self-awareness.

Interaction with others provides reinforcement of our sense of self, positive and negative. How we present ourselves determines how we perceive others may see us. Sarah illustrates how familial and drug-related relationships can lead to a 'performance' (Goffman, 1959; Neale, Nettleton and Pickering, 2011) that needs to be adapted to different social worlds.

> Sarah: "I was the underdog, well we all were in the family cos there was always somebody there that was a stronger character, stronger eh bullying you. And then when you go into a drug-fuelled world you've got to put on this masquerade and all that. And the attitude and all that and it becomes part of you. And a lot of people in [project] were frightened to approach me cos I didn't know how to speak to people in a normal manner. Although it didn't feel like that inside I felt I was alright and being alright but obviously other people were nae seeing that (laughs)."

The women worked to control their image and identity in the social sphere. Karen for example, maintained a non-drug using identity by controlling her body image and the people she shared her biographies with:

> Karen: "I keep myself, my arms covered…I don't want them knowing my past…I don't tell [them], it's none of their business."

Evolving roles and relationships meant that maintaining a performance was an ongoing process that was challenging for some. Ageing itself can become an issue for older women who are still using substances. Marion, describes how being older impacted not only on her ability to sustain her drug use but also on her emerging identity as a grandmother.

> Marion: I just felt I was too old to be living, to be living that life, and I was a grandmother as well…I was fed up being an embarrassment to them (children). And I think I was just fed up of being me."

Engagement with the recovery communities and the training programme helped build confidence by providing opportunities to gain new skills and status outwith the drug-using world. Employment and volunteering also offered a means for the women to construct an identity that conformed to their notions of social norms and values. Being financially independent and able to pay one's bills gave the women '*value'* and '*dignity'* while working with people in crisis and/or using substances gave some of the women a sense of '*giving something back*.' Pauline for example, felt '*blessed'* that she sponsored '*hundreds of women*' through the Twelve-steps; Marion got a '*buzz'* from being co-founder of a women's recovery group; Rachel felt '*really, really good'* that people sought her advice on how to successfully withdraw from opiates. Being able to look oneself '*in the eye*' or '*admit'* to past behaviours that caused '*shame'* and '*guilt'* were factors that helped the women work to restore old, or forge new relationships. The sense of 'belonging' that the communities offered were thus crucial in 'connecting' the women to their 'social' surroundings (May, 2011: p.368; Best, 2016: p.115). Recovery communities helped the women to build new identity materials such as new roles and a shared discourse of drug use and recovery. Nonetheless, increasing '*maturity'* and '*life experience'* also offered the women opportunities to reflect on past behaviours regarding relationships with partners, parents and children. Key to the women's self-acceptance was a combination of intense self-reflection, new social networks, economic stability and increasing age, all playing a part in the process of forming new or emerging identities.

4.3 Relationships, Identity and Recovery

This section focuses specific attention on three types of relationships that were central to the women's narratives: family relationships, specifically mothers and children; intimate partner relationships, and friendships.

4.3.1 Family Relationships

4.3.1.1 Relationships with Mothers

The narrative style of the interviews prompted the women to reflect on how their relationships evolved and contributed to their identities through their drug use and recovery. Difficult childhoods were described by most of the women. Alcoholism, domestic violence and physical and emotional neglect or abuse were elements to a lesser or greater degree in the family backgrounds of most (but not all) of the women. Some of the women spoke about feeling 'inadequate' within their family environments prior to substance use leading to low self-esteem as children and on into adulthood. Four women described at length the difficult relationships they had with their mothers through their childhoods and drug-using careers. Recovery offered an important opportunity for these women to begin repairing their relationships with their mothers. For Pauline, recovery enabled her to '*forgive*' her mother and herself. This was an ongoing process that took place over a number of years and evolved through the changing nature of the relationship. Pauline's growing sense of inner-strength gained through abstinence combined with her mother's failing health helped her reconcile the fear she had felt as a child and the bitterness and anger she felt towards her mother. Forgiving her mother was for Pauline, the first step to self-acceptance.

> Pauline: "I hated my mother all my life. I resented the life of her. I had terrible contempt for her. I was always scared. I wasnae able to pull away from her because I was still scared of her for a long, long time…But see when I got clean[8], I was about 4 months clean and I went down to see her and I hadnae seen her for a long time. And as I arrived at her gate, she opened her front door and I seen something

[8] The synonym 'clean' is often used to describe sobriety and abstinence from all drugs or http://www.who.int/substance_abuse/terminology/who_lexicon/en/ (Accessed 22.08.17)

> different. My mother hadnae changed obviously but I seen something different. And what I seen was a woman that was unwell. Bad mental health [*hmm*] she looked tiny to me. She looked awful small and I felt quite powerful. And not in a bad way. I felt safe for the first time in my life…And a bit at a time I could feel my heart…I thawed out with the bitterness and anger I had with her. It melted away from me and I felt it. I felt it happening and it was one of the most beautiful experiences and I came to forgive her. And as result of that I believe I've started to forgive myself….The person that had been abusive all my life was part of me receiving the biggest gift in my life, which is forgiveness."

Karen acknowledged that while her relationship had been difficult, her mother had been supportive by looking after her daughter through Karen's drug use. Like Pauline, the failing health of her mother helped facilitate Karen's improved relationship and similarly, *'letting go'* of the past was crucial to this process.

> Karen: "She's now been diagnosed with (long-term condition)…so she lets me help her now [*yeah*] and it's not about the past anymore, well it is still about the past. There is still things I want to know…She wouldn't tell me again…So I just need to let things go."

Several of the women talked about how their attitudes toward their mothers had changed over time and through recovery. The women were more aware of their mother's own biographies and tended toward a more understanding and '*nurturing'* relationship than they had prior to and during their drug-using careers.

For many people, growing older requires changes in our interpersonal roles and responsibilities. Analysing the mother/daughter relationships suggests that transitioning from a problematic drug-using adult to an independent drug-free adult brought with it opportunities to undertake an active role within their families consistent with the social and cultural expectations placed on women as caring and nurturing (Thom, 2010: chapter 4). While some women mentioned siblings as either competitors for maternal affection or supportive of their recovery, it was the relationship with mothers that seemed to require the most emotional work. Not all reported difficulties with their mothers. Some mothers were supportive through their daughter's drug-using careers and recovery; looking after grandchildren, helping out with money when finances were tight and offering encouragement for recovery. However, for the women that did find

the maternal relationship difficult, their narratives imply that they have come to accept their mothers behaviours and that in recognising they cannot change them, the women are able to '*let go'* of the past. This process contributes to an acceptance of their own strengths and weaknesses in relation to their mothers and appears integral to helping repair those damaged relationships.

4.3.1.2 Relationships with Children

Seven of the women had children, most of them adults. Contrary to some research that has cited children as a turning point in people's recovery (Biernacki, 1986; McIntosh and McKeganey, 2002), only two women cited children as the primary reason for giving up substances. Five women at some point in their drug use, had their children looked after by grandparents or ex-partners. Similar to Hamilton and Grella's (2009) findings, facing up to the lives they and their children had led while actively using drugs brought feelings of guilt. For example, they spoke about the environments their children were exposed to and what they viewed as less than adequate parenting skills now they are drug-free.

> Jane: "And it's not 'til obviously you get clean and you think back and go my god, you wouldn't dream of that (*using drugs in presence of children)*. If you heard of somebody doing that outside you would report it."

Identifying with others, some of the women reflected back on their active drug use. For example, Karen reflected on her parenting through her current work with women. She sees in the young women she works with the effects of maternal neglect and identifies with her daughter's experiences as a child of a drug-user. The narrative suggests she views her work as redemptive, a way of making amends, of "*giving back*".

> Karen: "Sometimes I can be quiet affected by what I read from referrals and stuff. But I take time out…Because I identify with it. I identify with a lot of the stuff. Not from the parents kind of role as in my mother but from myself as a mother towards the child for what I've done to my daughter. These children, so I feel as though I'm helping them. Not as a mother or anything but giving back what I couldn't do for my daughter, if that makes sense."

For Alison and Rachel whose children were very young at time of interview, levels of guilt were less obvious than those women with adult children. The difference between their narratives and those women with adult children reveals perhaps there may be less ongoing emotional work required around their parenting relationship due to the fact that these small children are unaware of their mother's former drug use, and will probably remain so. For those with adult children who, when younger witness their mother's drug use, chaotic behaviours and/or experience separation, more work may be required to repair those relationships.

Recovery was not as the women found out a panacea for repairing the relationships with their adult children. Some of the women were still in the process of rebuilding them. Sarah's experience was not untypical:

> Sarah: "(Son) has still not forgave me eh…see I don't even want them to forgive me, that's not what I'm asking April. I've not asked them nothing but I want them to understand…And all I want my weans to know is, see the time that I was away from them and all that eh, I did care, I did miss them, I did think about them, I did love them. But [youngest daughter]…she just doesnae understand. She just thinks that I thought that would be better for them. That I was quite happy living my life and that's not the way it was…See, they'll be waiting and all because they've seen me clean for periods of time. They've never seen me on a programme or, and they still have nae really but this time I'm at a different stage of my life."

There was among the women an admission that their drug use had damaged their relationships with their children and that it was incumbent on them to give their children time to come to terms with the '*clean*' mother.

> Jane: "…all her life all she's known is an addict mum and probably didnae know me because obviously you change when you get clean and you start looking at things differently."

While Sarah has to deal with her children's scepticism that her current recovery will be successful in the long-term, Jane was more secure in her daughter's belief in her in recovery. Jane though was a late-onset user[9], and although her son was in his twenties when she went into recovery and her daughter a

[9] Older drug users have been categorised into early- and late-onset users. Early-onset users begin using drugs in adolescence or early adulthood while late onset users start later in life, in their 30s or older (Boeri et al, 2008)

teenager, their experiences were completely different from Sarah's children who were looked after by grandparents and ex-partners and who had seen Sarah attempt recovery numerous times. Jane and Pauline (another late onset user) seemed to have the most positive experience with their adult children in recovery although they too faced challenges. Anger from the children was common and its resolution could be a long process.

Learning to accept their perceived flaws as mothers, realising that they were not '*bad*' parents and showing commitment to their recovery were important steps in the process of self-acceptance and helped the women to maintain and build on those relationships with children that had not been completely damaged. Nevertheless, even where relationships with children seemed irreparable there remained a hope that these could be resolved over time by not forcing the children to accept the women's new 'recovered' identity but allowing it to become apparent over time through maintaining sobriety.

4.3.2 **Intimate Partner Relationships**

Intimate partner relationships were significant influences on the women's identities through drug use but less so in recovery. A few women experienced at least one abusive relationship with ex-partners which some described as leading to low self-esteem: feeling '*worthless*'. At time of interview, five of the women were in an intimate relationship although Pauline had taken a temporary break from her current partner who had relapsed back to substance use. Strongly identifying as an '*addict*' in recovery, this was '*sad*' but integral to maintaining Pauline's new identity. Not returning to the '*using addict*' identity was crucial: "*Under no circumstances am I prepared to go back to that April I couldnae.*" A few women had broken off relationships with ex-partners when entering recovery due to their partner's lack of support and continuing drug use. Their reluctance to support the women into and through recovery was sometimes understood by the women to relate to the financial resources they provided for their partner's drug use. Entering recovery could be viewed as the women's statement of independence from male control.

Some of the women had taken lengthy breaks from intimate partner relationships. Joanna described men as a '*distraction*' and that she was

'*concentrating on recovery*.' Alison who had been single for five years prior to her current relationship described it as the '*best thing I ever done'* and explained

> Alison: "…I waited until I was at a much better place mentally and then when I went into a relationship it was for the right reasons. It wasn't because I was frightened of being alone or I had to be with somebody. I would rather be on my own than be with somebody that I wasn't happy with."

Time in recovery without a partner provided the women with space to reassess their past relationships and their roles within them. Rachel, the only one to maintain a long-term relationship (19 years) through drug use and recovery acknowledged the support she and her partner gave each other. Nevertheless, like the other women she was also aware of the fragile nature of their recovery and the effect that a relapsing partner might have on this.

In terms of their current relationships, Pauline as we have seen places her recovery above that of her relationship. Nevertheless time in recovery and her experiences in work had helped her reassess her relationships with men, from not trusting them to now viewing them as '*just the same as us.'* Rachel's long-term relationship had evolved through their recovery so that she and her partner now spent less time together than they did when in active drug use. Having time apart helped them to '*appreciate each other even more.'* Karen's current relationship, like Pauline's was with someone she had met in recovery. Although both had been warned not to get involved with men from the Fellowships, Karen felt that living in her own flat for four years had helped her put down boundaries regarding relationships. Comparing her current and past relationships, '*there was honesty from the beginning… communication…boundaries. There was trust*.' Alison and Marion had both entered relationships with non-drug users. Marion spoke little about her new partner but was happy with her new relationship particularly as both had their own flats, he worked and was '*totally different*', in that he was not a drug user. Alison's relationship also represented a departure from her previous experiences with men:

> Alison: "I think when you think you're worthless you think why would anybody want to be with me? So you're willing to put up with, being treated you know, not very nicely at all. Ehm…and I remember when I

> started seeing [partner] I was just like; I couldn't believe how kind he was and how considerate. So I kept messaging him at first [laughter] this is amazing. But it's quite sad that… …ehm… ….that yeah, I was so shocked by somebody… …being kind or respectful."

The women's discussions of intimate partner relationships suggest that by remaining single for a period of their recovery they gained insight into their previous behaviours in and attitudes towards these relationships. They were aware this was a crucial area in which their new identity as non-drug using females could be jeopardised. Having time to reflect on past relationships and perhaps consider their own motivations, behaviours and attitudes, the women were now engaging in relationships that were emotionally and physically healthier than before.

4.3.3 **Friendships**

Contrasting past friendships while in active drug use to those formed in recovery, the women described these new friendships as mostly positive. Their new friendships were predominantly anchored within the recovery communities[10]. The communities were a significant resource for providing new relationships offering emotional and social support and a means of increasing the women's social capital. These resources contributed to an identity that was distant from the one they perceived of themselves as drug users and provided the basis for creating a new identity (McIntosh, p.111). Alison was the exception, eschewing as she did the Fellowships. She had though high social capital, coming from what she described as a '*relatively privileged*' background and having maintained contact with non-using friends prior to and during her drug-using phase. Those that had contact with former non-using friends did not usually divulge their drug-using history or at least did not talk about it. Jane for example, explains that her non-using friends would '*not understand*' how she might feel. There remains perhaps for some a continuing sense of otherness, something that sets them apart from non-users even in recovery.

None of the women had retained drug-using friends. Bonds with drug-users during an active using phase tended to be based solely around drug use.

[10] This reflects however the sampling of the participants. Wider recruitment from women who have not engaged with the recovery communities could yield further insights.

Now in recovery, they had little in common with using friends/acquaintances. Setting boundaries was crucial and this invariably meant cutting all ties. Nevertheless, it was not always easy to break these bonds and a few women showed some regret over lost friendships.

> Rachel: "I've just had to distance myself from girlfriends. And that was hard because one of them was a really, really close pal and she kinda hung about. She was using though and we were using with her and…She's still in that active addiction and it's horrible. So I just don't see her anymore. I just…I've distanced myself. It could be dangerous for me with her in active addiction."

Staying away from drug users and '*not going backwards*' was crucial to these women. Having maintained their recovery over a period of months and years, they were well-aware of the potential risks engaging in these relationships might entail.

The recovery communities offered new routines and opportunities to socialise within a group of people with shared experiences. They offered space to express feelings and emotions to people who would understand. Joanna compared this to the challenges of '*opening-up*' within the conventional sphere of '*everyday life*'.

> Joanna: "…what I find is in everyday life…People don't have a great vocabulary when it comes to talking about emotions and emotional wellbeing. But in the recovery community, it's second nature. People just talk about their emotions, how they're feeling, if they've been irrational, If they've had difficulty in communication. I find that really empowering. Ehm…and I don't have to hide."

In this sense, recovery communities offered the women opportunities to receive 'mutual validation' of their experiences (Koski-Jannes, 2002: p.196) and facilitated a cultural acceptance of emotional expression by normalising the practice through a shared vocabulary.

4.3.4 **Being Social**

Learning how to socialise in ways that were different from their experiences as drug-users was an important marker of recovery. Activities which they assumed most people took for granted, like going for dinner, could be

daunting for some: "*It's taking me out of my comfort zone*." Sarah, in recovery for 12 months, couched her new relationships in recovery as a revelation. Three decades of drug use had impeded her ability to build or maintain meaningful relationships.

> Sarah: "See like even you sitting here or going to [project] and you're learning, you're picking things up and eh even just the camaraderie that you have with people. Eh, things that I never noticed. It was just whoosh (*hand over head*). That's the way it was. You never noticed. I mean even people I dealt with for years; I couldn't turn around and say they're this sort of person or that sort of person or a lovely person because I never took any notice before. It was blinkers on wasn't it?"

Sarah's quote illustrates that in recovery she is learning how to socialise in new ways and is more perceptive toward others. Nevertheless at an earlier point in the interview Sarah talked about a recent argument with her sisters. It shows that learning new ways to socialise is difficult and an ongoing process. Old ways of reacting and behaving are no longer acceptable to Sarah and reverting back to these only reinforces her sister's expectations of Sarah the drug-user. Not Sarah in recovery.

> Sarah: I had an argument with them in the town a couple of weeks ago and it was things I had to say that was inappropriate at the time but I couldnae help myself and [sister] says 'I knew it wouldnae take you long 'til you're back to your old ways'… So they must have been talking about me at some point (laughter). And I says 'I go to recovery not a fucking brain transplant'. I was angry but I did it in an inappropriate way. I let it build up and build up. Things were going so well I thought I can't let it go so I was sprung like a coil. But today I'm aware of that, before I wasnae. I just used to run away with my mouth eh and today I can control myself."

Marion expressed the anxieties that forging new non-drug using connections can expose. Again, it shows that the social life of the drug-user is perceived as distant from that of the non-user: Disconnecting from the drug-scene means disconnecting from the social connections within it. This disconnection between the past and the present requires work and effort to make new connections in non-using contexts.

> Marion: "…my psychiatrist gave me a wee card….for a self- referral and it sat there and I used to tidy my room up and all that and it sat there and I would just move it and put it back and then I've ended up

> 'oh just fuck it I'm going to phone it.' Because the only people I knew up here were still using drugs…so I thought…pfff I can't just be clean and sit in the house forever and be feared to go out and socialise and stuff like that. Because I didn't know how to socialise."

These quotes neatly illustrate McIntosh and McKeganey's (2002) point that 'Re-entering conventional life' is difficult and is an outcome of a lengthy period outside mainstream culture and activities (McIntosh, p.93). Nonetheless, relationships within recovery communities offered many benefits to these women. Forging new relationships with like-minded people helped to develop new skills and ways of coping with a drug-free life. While Pauline and Karen embraced the Twelve-steps philosophy and Alison rejected it outright, the remaining women held reservations but considered the Fellowships useful in helping maintain their recovery. '*Trust'*, '*honesty'* and '*open-mindedness'* were key values that they respected in their relationships with others within these settings.

Relationships within the recovery communities could be challenging though. For one woman, unwarranted attention from another man posed problems with her partner as he felt threatened by this new friendship. Female sponsors in the Twelve-step programmes were a strong source of support although a few of the women had experienced difficulties, either prompting them to change sponsors or withdraw from the programme and in some cases the fellowships. Sarah and Joanna felt there was too much pressure placed on them to '*embrace'* the Twelve-steps. Joanna described feeling '*bullied'* while Sarah felt anxious that her recovery would be jeopardised by not following advice given by other members:

> Sarah: "This is what frightens me, I see it working right but see when I see people like eh still going to meetings after 25 years and still talking about what happened 25 year ago I don't want to be doing that. But I'm just too scared to make a mistake by not doing what they say. But hopefully I'll be able to grow and say 'och wait a minute' and think for myself and take out of it what I feel."

Sarah's quote explicitly shows the dilemma for those who are relatively new to the Fellowships. While she sees its philosophy and tenets for living can be successful, she fears that for her to succeed and not make a '*mistake'* in her recovery, she too will have to continue reflecting on her past as an '*addict'* over

the long-term. This is not a case, I think, of not wanting to commit long-time to the Fellowship but is more about not wanting to continue to reflect on her past. Sarah hopes she will be able to develop enough inner resources to think independently and guide her own recovery. Recovery is without doubt temporal but there seems to be incongruence between '*being in the day'* and repeating old biographies that recall what these women seem to want to forget. According to Best et al (2016), the transition to a 'maintained state of stable recovery' involves participation in recovery communities where the 'mechanisms of impact include social learning and social control thereby shaping social identity' (Best et al, 2016: p.116). It is the element of social control and the perceived imposition of a 'recovery' identity that some find unappealing.

> Joanna: "I don't want to live in AA and I don't want to turn in to like an AA Stepford Wife. Where they speak the same, behave the same. I don't want to be like that."

> Marion: "I stopped volunteering last year because it was all about recovery, recovery and my brother was like that 'Marion…you're losing yourself in your volunteering.' That if I didn't have a volunteering t-shirt on I didn't know how to talk to people…I ended up I kind of lost, lost who I was…I knew I was a volunteer but what was I after that?"

Resistance to the recovery cafes or Fellowships could be seen as a way for women to move on from a recovery identity and explore new aspects of, or gain control of their identities and present themselves in a way they considered *'honest', 'trustworthy'* and *'genuine*'.

External relationships with others were key to self-acceptance. Some of this entailed accepting that past behaviours and ideas about one's self were not of a standard that they would currently accept. For example, parenting practices were frequently used to describe how the past self was different from the present. '*Compassion'* for oneself, taking '*responsibility'* and '*letting things go*' were phrases the women used to reconcile their past and current relationships. Acknowledging past behaviours or mistakes though could be difficult. Marion described the difficulties of accepting the identity of '*addict'* but that self-acceptance of this label was partly reflected in her observations of others, what could be termed 'reflections of self' (McIntosh, p.51).

> Marion: "Probably volunteering sometimes gives you a wee shake. When you come across people and you just see wee reminders of yourself in somebody…and that's when I'll go 'I was an addict'…That's probably the shake because sometimes, it took me a wee while to realise I was an addict. I was in denial but now I'm in acceptance. I'm accepting it now. And that's hard thing, do you know what I mean? To accept…and also to accept your past and all the shite that went with it all the hurt that you've caused people…"

Self-acceptance of the former self and current selves' required for these women, extensive emotional self-reflection. Reconciling their past and current selves in terms of their relationships with others was an important step in the women's recovery.

4.4 Discussion

As noted at the beginning of this chapter, recovery meant a process of change that offered hope, freedom, choice and opportunities to gain new skills and learn new rules for living. These rules for living were grounded in the women's changing perceptions of acceptable and unacceptable social norms. These were conveyed primarily through mutual validation of emotions and behaviours within the recovery communities. By creating a space for and acceptance of emotional expression, those in recovery learnt a wider emotional vocabulary. Recovery communities may provide a safe space and group of confidants that encourage and support woman to openly share their experiences and construct new identities that are congruent with their life goals. In this sense, the women's descriptions of recovery fit the lexicon of government policy, treatment providers and the wider recovery movement (Best, 2016; Reith and Dobbie, 2012).

The women's relationships in recovery were for the most part positive and contributed to an identity that was distant from their perceptions of themselves as drug users. In contrast to Biernacki and McIntosh and McKeganey's studies, none of the women spoke in terms of 'renewing' or 'restoring' (un)spoiled identities. The women who spoke about their past identities in depth framed them within a narrative of drug use and unhappy/unhealthy relationships. These were identities they did not want to return to and in discussing their meaningful objects the women related how these represented a break with their pasts and

hopes for a better future. Nevertheless, in keeping with those studies, abstinence and deep self-reflection in treatment and the recovery communities provided the women with opportunities to process past events and relationships and develop greater self-awareness (Biernacki, 1986; McIntosh, 2002). Through a process of social learning the women developed positive self-concepts. However, for some women the recovery communities were a two-edged sword. On one side offering strong emotional and social validation and new skills while on the other restricting their sense of independence. This echoes literature elsewhere that found women resisting handing over their own sense of agency to a 'higher power' or sponsors within the Fellowships (Boeri, 2013: p.157). While the recovery communities can offer new skills, resources and networks they may also limit women's social networks (Boeri, p.156). This is not to criticise the recovery communities as they clearly provided strong bonding capital. Weaker networks outside the recovery communities though could suggest they are less effective in bridging social capital. The narratives of the women in this study rarely mentioned social networks outside the recovery communities and this is an area that would benefit from further research. How do women who are immersed in the recovery communities move on from them and how does this affect their identities and relationships? In order to move beyond the recovery identity do they leave behind their recovery companions as they left behind their drug-using friends when moving out of using and into recovery? This is worth further exploration and is currently a gap in the older drug users' literature.

As the women aged, new roles and responsibilities emerged particularly in terms of caring for older parents. That this coincided with the women's' recovery enabled them to begin repairing these relationships. More challenging was restoring or repairing relationships with children, many of whom were now adults. Shame and guilt related to parenting are recurring emotions in the narratives of female drug users (Boeri, 2013; Hamilton and Grella, 2009; Taylor, 1993) and the role of the 'mother' is one through which many women evaluate themselves. Evidence however suggests older children of substance using parents may find it difficult to reconcile the 'recovered' or 'clean' mother with their own recollections of neglect (Backett-Milburn et al, 2008). Becoming a responsible 'grandmother' may be a role through which some women attempt to

re-establish their relationships with children and redeem their identities as ‘nurturing’ and ‘caring’ females (Thom, 2010). This study offers some intriguing and tentative insights into these relationships. Further research on older female drug users requires an examination of these evolving relationships as they could offer important insights for the development of family support for this ageing cohort and their families.

Relationships with male partners were problematic throughout most of the women’s drug-using careers. Taking time out while in recovery from entering new intimate relationships offered the women time to reflect on past relationships and initiate new behaviours and develop boundaries with new partners and men in general. Other women in the recovery communities and particularly female sponsors were supportive and encouraging in helping the participants to exercise boundaries in terms of intimate partner relationships. Protecting and maintaining their recovery was more important than maintaining relationships that could jeopardise that process. These findings suggest intimate partner relationships are an area worth further exploration. In contrast to some studies (Leverentz, 2006; Koenig and Crisp, 2010) some of the women in this study decided to enter recovery despite their ex-partners’ protestations and stay single for a period of time. This helped them reflect on past behaviours and thus exert better control in their current relationships with men. Years of socialising within drug-using environments, where relationships can be transient and built on manipulation and distrust left some of the women with anxieties about forging new relationships and integrating back into ‘normal’ society. Developing self-compassion and self-acceptance was an ongoing process that recovery communities and counselling appear to have contributed to thus helping the women to reconcile past and current identities and engage in healthier relationships.

The question posed by this thesis was ‘What influence do social relationships have on identity formation, drug use and recovery among older drug using females?’ The answer is not a straightforward linear association. Certainly it would seem that early childhood experiences did have a significant influence on how these women perceived themselves and their relationships. For some women difficult childhoods were constructed as important factors in their

use of drugs and nature of their relationships during the substance-using phase of their lives. During recovery though, the direction of influence becomes more complicated and it seems, from my interpretation of the women's narratives that it is a symbiotic process in which relationships, identity and recovery are all highly interdependent. A period of abstinence and sobriety gave the women space to perform the necessary emotional work and adopt the language of self-acceptance that recovery communities and Fellowships espouse. This encouraged the women to engage in mindful reflection which led to improvements in self-esteem which in turn impacted positively on their relationships with others. Positive reinforcement from others through new relationships and activities contributed to better self-concepts that helped maintain recovery; one reinforcing the other in a constant interaction. Distancing themselves from a user identity and creating a new identity was pivotal to the process of the women's self-acceptance.

5 Conclusion

At a time when the proportion of older drug users is increasing and the health toll of long-term drug use is contributing to the premature deaths of hundreds of older adults across the UK, research that focuses on the views of older drug users is paramount. Identifying those mechanisms and processes that encourage older drug users into recovery could provide evidence that helps the development of recovery resources for this ageing cohort. This small scale but strategic study has confirmed findings from elsewhere that suggest recovery communities are integral to helping older female drug users re-engage with wider conventional social spheres. Shared experiences and a shared language provide women with tools to establish healthy relationships both to their selves and others within their social networks. Key to this process is self-acceptance.

In terms of the methods used, the richness of the data confirms that a narrative approach can generate original topics outwith the scope of the research aims and objectives. Furthermore, the generation of extra data outwith the research question demonstrates the need for further analysis of this data set and the wider topic of older females and identity work. Recognising that older female drug users are not a homogenous group; researchers, practitioners and policymakers should incorporate the voices of older female drug users from a broader range of backgrounds and with different experiences of recovery in order to provide further evidence in this relatively under-researched area.

Recovery as the women relate it is a long-term work-in-progress and is not without its challenges. The findings from this study have provided important insights that point to future directions for research, practice and policy development in the areas of familial and intimate partner relationships, and wider social networks beyond the recovery communities. This study benefits from including multiple voices of women which enable us to identify those areas of shared and different experiences among this group thus enhancing and contributing to research in this area of drug policy and practice.

> “Once I could stand up and go ‘that’s what I did’ you know…and…’I’m sorry’ and look myself in the eye I could restore relationships with people.”

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Appendix 1. Participant information Sheet and Consent Form

University of Glasgow

College of Social Sciences

Participant Information Sheet

Women in Recovery: Social Relationships and Identity

Researcher: April Shaw Email: 9907340S@student.gla.ac.uk
Supervisor: Dr Lucy Pickering Email: Lucy.Pickering@glasgow.ac.uk

You are being invited to take part in a research study conducted by an MRes student from the University of Glasgow. Before you decide it is important for you to understand why the research is being done and what it will involve for you if you decide to take part. Please take time to read the following information carefully and discuss it with others if you wish. Ask the researcher (April Shaw) if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for taking the time to read this and learn more about the study.

What is the purpose of the study?

The purpose of this study is to provide important insights in to how relationships influence identity and recovery among women who have a history of substance use. The importance of relationships on recovery, particularly among women who are over 35, is not clearly understood as yet. It is the aim of this project to add to the growing research on recovery from the particular standpoint of women who are in recovery from problematic drug or alcohol use. The findings from this study will help contribute evidence for policy and service development for women who are attempting recovery. It has the potential to make an important addition to current and future work undertaken by the Scottish Government and the UK Advisory Council on Drug Misuse into older drug users. Furthermore, the findings and learning from this study will have an important influence on the development of a PhD due to be undertaken 2017 – 2019 which will look deeper into the experiences of older substance using women.

Why have I been approached?

I am interested in talking to women aged 35 and over who consider themselves in recovery from drug and/or alcohol use. You have been approached because your experiences of substance use and recovery could make an important contribution to this study and further research.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. Taking part is voluntary and there are no consequences to your withdrawal. If you do choose to withdraw from the study, any personal information or data collected will be deleted.

What will happen to me if I take part?

If you agree to take part in this research project you will be asked to complete and sign the consent form. If you consent to take part in the study, the researcher will then invite you to take part in an interview where you will be asked to describe your life, relationships that have been/are important to you and significant episodes in your life that have been influential in your recovery. You will also be invited to bring along to the interview a material object that is meaningful to you (e.g. postcard, pebble, scarf) – an object that you consider important to you. The interview should take around 1 to 2 hours and, with your permission will be audio-recorded and transcribed. You will have the option for a photograph to be taken of your hands holding a personal object that has special meaning to you. Photographing the object is optional and is not dependent on your participation in the study. There are no direct benefits to you for taking part but you will be making an important contribution to further research and practice in this emerging area of concern.

Will my taking part in this study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence. All information which is collected about you during the course of the research will be kept strictly confidential. You will be identified by an ID number only and no personal contact details will be retained by the researcher. The transcripts will be de-identified with any names or areas removed. Pseudonyms will be used where appropriate. The interviews will be audio recorded onto a digital recorder. The recording will then be downloaded onto a password protected computer and completely deleted from the digital recorder. Transcriptions of the audio recordings will be anonymised and stored on a password protected computer.

Limitations to confidentiality

The safety of yourself and others is very important to the University. If you express current or future intention to harm yourself or someone else, there would be no grounds for maintaining confidentiality. The researcher will inform you that we need to breach confidentiality at the point of disclosure. At this point the researcher will contact the supervisor Dr. Lucy Pickering for advice. Please note that assurances on confidentiality will be strictly adhered to unless evidence of wrongdoing or potential harm is uncovered. In such cases the University may be obliged to contact relevant statutory bodies/agencies.

What will happen to the results of the research study?

The anonymised results of the study will be compiled into a Maters dissertation and will provide important material for the development of a PhD and further research in this

area. The results may also be published in peer-reviewed journals. Data gathered throughout the study will be anonymised and archived at the University of Glasgow's repository for research data (Enlighten: Research Data) and the UK Data Service (University of Essex).

Who has reviewed the study?

This research study has been reviewed by the University of Glasgow's School of Social and Political Sciences Ethics Forum.

Contact for Further Information

If there is anything you would like more information on you can contact April Shaw on telephone 0736892344 or email 9907340s@student.gla.ac.uk. Alternatively, you can contact the study supervisor Dr. Lucy Pickering 01413305072

Who do I contact if I have any complaints or concerns?

If you have any complaints or concerns regarding the conduct of this study, you may contact the School of Social Sciences Ethics Officer Dr. Muir Houston. Email: muir.houston@glasgow.ac.uk

Useful contacts

If you are feeling distressed or need emotional support then you can call **Breathing Space** (tel: 0800 83 85 87) or **The Samaritans** (tel: 116 123) where you can talk in confidence to a specialist advisor free of charge. They will be able to offer advice and information on local resources in your area. For information about **local drug treatment services** visit the Scottish Drug Services Directory or call FRANK (tel: 0300 123 6600)

University of Glasgow

College of Social Sciences

Consent Form

Title of Project: **Women in Recovery: Social Relationships and Identity**

Researcher: April Shaw Email: 9907340S@student.gla.ac.uk
Supervisor: Dr Lucy Pickering Email: Lucy.Pickering@glasgow.ac.uk

1. I confirm that I have read and understood the Participant Information Sheet for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
3. I understand that all names and other material likely to identify individuals will be anonymised. ☐
4. I understand that all research material will be treated as confidential and kept in secure storage at all times. ☐
5. I understand that all research material will be deposited and retained in an archive once the project is complete. ☐
6. I acknowledge that individuals will be referred to by pseudonym in any publications arising from the research. ☐
7. I consent / do not consent (delete as applicable) to interviews being audio-recorded. ☐
8. I consent / do not consent (delete as applicable) to my object being photographed in my hands/on its own (delete as applicable) ☐
9. I agree / do not agree (delete as applicable) to take part in the above study. ☐

Name of Participant ……Signature …… Date……

Name of Researcher ……Signature …… Date……

Appendix 2. Interview Schedule 1

Women in Recovery: Social Relationships and Identity

Topic Guide

1. Gather and/or confirm some basic demographic information
    a. Year of Birth
    b. Employment status
    c. Marital status (past/present)
    d. Children
    e. Drug Use – what and how long?
    f. Recovery episodes – how many
    g. Recovery now – how long?

2. Looking at your life's journey, its ups and downs, from where you are today, older and wiser, what have you learnt about yourself?
    Prompts: what have been the important lessons? How have your values changed over time, as you've got older?

3. A. Can you tell me about your object that you've brought along today?
    Prompts: why is it important to you, what does it mean to you, where did you get it, how long have you had it, what does it say about you?

    If the participant does not have a material object ask the following:

    B. Imagine you are telling me a story about your life. Start wherever you like
    Prompts: What are the main chapters, who are the main characters?

4. Looking back, who have been the most important people to you in your life?
    Prompts: Who was/is helpful – how? Who is less helpful – how? What impact did/does this have on how you felt/ feel about yourself/your recovery?

5. Can you describe to me an event or experience in your life that was really positive and good?
    Prompts: what happened, where it happened, when it happened (age), who was involved, what did you do, what were you thinking and feeling, what impact did this experience have on you, **how has it shaped your life,** what does this experience say about who you were or who you are.

    I don't want to dwell on the negatives in your life and if you don't want to talk about it that's fine we can skip the next question.

6. Can you describe to me an event that was a really low point in your life or something like it?
    Prompts: what happened, where it happened, when it happened (age), who was involved, what did you do, what were you thinking and feeling, what impact did this experience have on you, **how has it shaped your life,** what does this experience say about who you were or who you are.

7. In looking back on life, it is often possible to identify certain key "turning points" - episodes through which a person undergoes substantial change. Turning points can occur

in many different areas of a person's life - in relationships with other people, in work and school, in outside interests, etc. I am especially interested in a turning point in your life. Can you identify a particular episode in your life that you now see as a turning point particularly as it relates to your recovery?

Prompts: what happened, where it happened, when it happened (age), who was involved, what did you do, what were you thinking and feeling, what impact did this experience have on you, how has it shaped your life, what does this experience say about who you were or who you are.

8. Is there anything else you feel is important at this time in your life in terms of how you feel about yourself, your relationships, drug use and recovery? What does recovery mean to you? Do you view yourself as 'in recovery' or have you 'recovered'?

9. What are your hopes/dreams for the future? How do you want your story to play out?

Appendix 3. Interview Schedule 2

Women in Recovery: Social Relationships and Identity
Topic Guide

Gather and/or confirm some basic demographic information

a. Year of Birth
b. Employment status
c. Marital status
d. Children
e. Drug Use – what and how long?
f. Recovery episodes – how many? What brought about relapses?

Can you tell me about your object that you've brought along today?

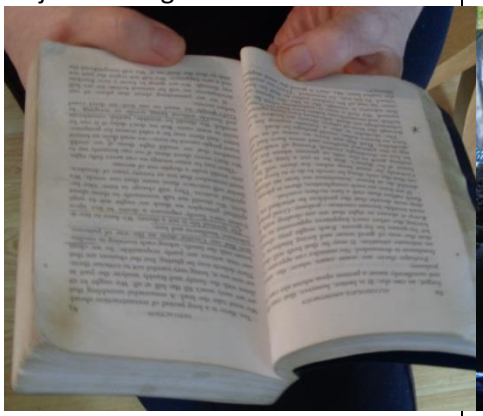
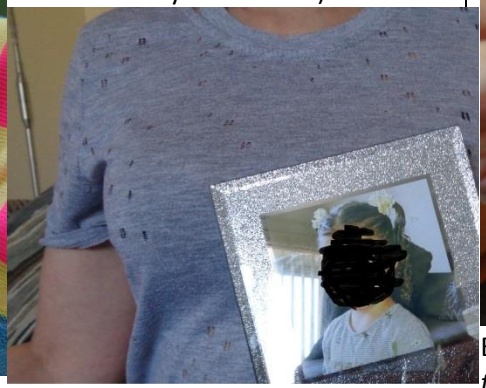
Prompts: why is it important to you, what does it mean to you, where did you get it, how long have you had it, what does it say about you?

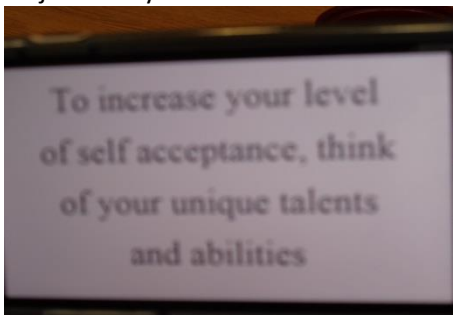
I'd like to hear about your Recovery now, how you've overcome your drug use and how relationships with others have helped or not.
Can you begin by telling me what brought you to the decision to stop using? (When was this? What was happening at the time?)

Explore the following:

- Relationships at the time (family, friends, users, non-users)
- How did you feel about yourself and your drug use?
- Did anyone or different people influence your decision to stop using? What did they do?
- Did you seek help to stop? From? How helpful?
- Who has been most helpful? In what ways have they helped you maintain your recovery?
- Has anyone been unhelpful? How have you handled that?
- How did you handle old drug - using friends? At the beginning/now?
- Tell me about your lifestyle now?
    - What do you do?
    - How did you achieve it
    - Challenges in maintaining it
- Tell me about your friends now – do they know about your past use? Non-users? What do you value about them? What do they value about you?
- How do people who knew you when you were using treat you now? Family, friends, neighbours
- How have your attitudes/values changed as you've got older?
- Can you tell me about any changes to your health as you've stopped using
    - Mental health
    - Physical health (health checks/menopause)
    - Image of self (injecting)
- What does recovery mean to you? Do you view yourself as 'in recovery' or have you 'recovered' or would you describe yourself in another way?
- Looking at your life's journey, its ups and downs, from where you are today, older and wiser, what have you learnt about yourself? What have been the important lessons? How have your values changed over time?
- What are your plans for the future?
- Is there anything else you feel is important at this time in your life in terms of how you feel about yourself, your relationships, drug use and recovery?

Appendix 4. Participants meaningful Objects

Pauline	Joanna	Rachel	Susan
Object: AA Big Book 	Object: Buddha statue 	Object: Daughters Photo (face blacked out by researcher) 	Object: Guardian Angel Pendant 
Excerpt: *It's not so much the book but what it stands for and what's in it and what's in it is very simplistic. Very simplistic. It's a great way of life for anybody who has a problem with anything. Through the 12 steps you'll be able to feel about yourself and disclose yourself and do this and move on. And come to know about acceptance [uhhuh] and accepting yourself.*	Excerpt: *There's various Buddha's around the house. Um…but I just love the way this one looks. Yeah he's just so serene. But the image of the Buddha I think it's just the serenity and love and eh… …this isn't about kind of idolatry as in the Buddha's not god. I think for me why it's important is because it represents the potential that we all have to achieve this kind of, well it's enlightenment.*	Excerpt: *She means so much to me. She … ….I mean I didnae think that I would ever get the chance to be a mum. Age was kind of getting against me and I just didnae think that it would happen. And then when I fell pregnant and it stuck it was the most nervous time of my life. I always just kind of thought…it's gonnae get took away from me again, do you know what I mean? I was up at the hospital every other week saying 'I've not felt her moving yet. She would always move but the wean means so much to me. Just so much. She's my life aye.*	Excerpt: *See when I'm reading about the angel well I've got to protect myself as well and I've got to look after myself today and I've got that capability to be able to do that. And it's always good to have a higher power, knowing that there's somebody even if it's I believe in energies, me personally…an energy eh or a thought that will help me through that day eh and that's... I mean this doesn't even sound religious to me because I don't take it as in a religion, I take it as in a faith. Even though it be blind faith. Eh, I don't think there's anything wrong with putting your hand out is there?*

Joanna	Marion	Karen	Jane
Object: Vision Board  Excerpt: *I had quite clear ideas of things that interested me and goals that I had. What inspired me. Who inspired me. Eh… …I think I was able to identify stuff that I found useful to help me work stuff out. Ehm… …and looking back on it, I don't think I give myself credit for the stuff that I done….I'm really hard on myself*	Object: Buddha statue  Excerpt: *Buddhism's a big part of my life and I try and…try and live with the principles of Buddhism. I don't like going to CA meetings or any other kind of meetings. But I'll go to the temple and I'll sit and meditate. And I like their teachings; do you know what I mean? And they've helped my head because I've got mental health problems as well*	Object: Daily Affirmation  Excerpt: …*a lot of things mean things to me now like…words and stuff, like…eh…I do a lot of reading every morning of my book. Got a wee book. And it's like positive affirmations. Eh…words. And I just google them on the internet and upload them and I reads them and I go 'this is where I could be at the now or been through'. I try and stay focused on the positive but then I can get as one of my work colleagues pointed out last week. 'You put a really good positive quote on Facebook but you didnae act like that today.' And I said 'I don't have to be like that all day. It's just something that I think about aiming for.'*	Object: None identified Excerpt: *I've got nothing that I still had from my using and I've got nothing from the time I stopped using to the now that…that I think 'oh that means anything to me' eh so…I never brought anything in.*