Older Women Managing Relationships and Navigating Health in Drugs Recovery: A Qualitative Study

By

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Abstract

The proportion of older people using illicit drugs in the UK has increased significantly over the last decade. Despite this, there are relatively few UK studies that explore the lived experiences of older people who use illicit drugs and fewer still that seek to understand the experiences of older women. The aim of this thesis therefore is to contribute a number of important insights into this neglected area of older women's experiences of drug use and recovery. It does this by exploring the lived experiences of 19 women from Scotland and North East England ranging in age from 36 to 60, who made the move from illicit drug use to recovery, focusing specifically on their social relationships, health and bodies, and the therapeutic landscape available to them as mid-life and older women.

Grounded in symbolic interactionism and methodologically feminist, this study is qualitative in design and approach. Seeking to explore the women's experiences from their particular standpoints, the semi-structured interviews included the use of meaningful objects. Including objects in the interviews provided a collaborative opportunity to explore the memories, images and meanings women gave to their possessions. Data analysis was inductive and followed Braun and Clarke's six phases of thematic analysis, including an open and selective coding strategy. The data analysis raised important insights into the relatively unexplored area of family dynamics among older women in recovery. This demonstrated how recovery was for many a work in progress in which interactions with others, participation in social activities, belonging to social networks and engaging in everyday routines encouraged them to set boundaries and assume more control over their relationships. Thus they developed a sense of self far removed from their former identities as women who used drugs. Recovery as it was felt by the women was a complex bodily process in which the absence of drugs brought forward new pains and bodily sensations which they had to learn to manage and understand as ageing, recovering, drug-free bodies. The findings further highlighted how menstruation and the menopause were events that could interrupt and disrupt the women's bodies and where symptoms needed to be re-interpreted as natural bodily processes.

This thesis contributes to the wider literature on people who use drugs and crucially adds women's voices to the neglected but important area of older people's experiences of recovery from illicit drug use. The women's stories weave a rich tapestry of experiences that go beyond the usual tropes of pregnancy, motherhood and intimate relationships. They reveal how relationships with significant others are just one thread in their recovery. Disentangling the threads in the women's narratives, a picture emerges of women's everyday interactions and relationships with objects, significant others, treatment others, and their own ageing and recovering bodies.

Key words: older women, drug use, recovery, ageing, relationships, health, treatment.

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Acknowledgements

In these acknowledgements, I would like to start by saying that I am not '*giving voice*' to the women who participated in this study. They have lent me their voices and given me permission to take their stories to a wider audience. The purpose of this thesis is to make sure their views and experiences are added to the canon of work on women's experiences of drug use, treatment and recovery and my hope is that I have represented their views sensitively and respectfully. That the women afforded me the opportunity to listen to their stories and to represent them is my privilege. So my first and heartfelt thanks go to the women who participated in this study and to the women that took part in the pilot study for this thesis plus the many women I've met along the way who inspired me to undertake this study.

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Author's declaration

I declare that, except where explicit reference is made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

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Signature:

Glossary of Acronyms and Terms

ACRONYOMS

AA	Alcoholics Anonymous
ACMD	Advisory Council on the Misuse of Drugs
BBV	Blood Borne Virus
CA	Cocaine Anonymous
COPD	Chronic Obstructive Pulmonary Disease
CPN	Community Psychiatric Nurse
DRD	Drug Related Deaths
EOU	Early Onset Users
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
LOU	Late Onset Users
MAT	Medication-Assisted Treatment
MMT	Methadone Maintenance Treatment
NA	Narcotics Anonymous
OEM	Object Elicitation Method[s]
OHT	Occupational Health Therapy
ORT	Opiate Replacement Therapy
OPWUD	Older People Who Use Drugs
OWIDR	Older Women in Drugs Recovery
OWWUD	Older Women Who Use Drugs
PWUD	People who use Drugs
SDF	Scottish Drugs Forum
WWUD	Women Who Use Drugs

TERMS

Aye	Yes
Boak	To retch or vomit
Cannae	Can not
Dinnae	Did not
Doesnae	Does not
God	Capitalised when referred to in terms of formal religion such as a Christian deity
god	Lower case when used as an exclamation or not used as a reference to a formal religious deity
Gonnae	Going to
Heebies [The]	A feeling of minor fright, anxiety, nervousness, apprehension
Ken	Know
Shite	Shit (faeces)
Wasnae	Was not
Wee	Small or little

Chapter 1: Introduction

The thesis presented here has been a long time in the making. Not only in the four years spent physically gathering the material and data, processing and analysing it, and drawing it together into a coherent structure but also in the many years spent researching different aspects of substance use among populations of people who use drugs. Its inception was born out of frustration at the way women who use illicit drugs are secondary in the large body of drug-use research despite the fact that they are (and have been) more heavily sanctioned against than their male counterparts, morally (Ettorre, 2015) and legally (McIvor & Burman, 2011). Although many women take illicit drugs solely for pleasure and without any problems occurring, for those whose use becomes unmanageable for them to maintain, this is often a result of factors other than drug use on its own. As will be shown in later chapters, issues such as trauma, violence and poverty can exacerbate women's use of drugs. However, drug use is also a pleasurable experience and is tied up with a sense of belonging to other like-minded people. This thesis however, is not about women who take drugs; rather it is concerned with how women with a history of drug use age into their recovery. The purpose is to explore how these women who are approaching mid-life or older, have through their interactions with others, worked through their recovery. Throughout this thesis, I show how relationships in the private and therapeutic spheres helped the women who participated in this study, gain a sense of control over their lives that for many became unmanageable toward the latter stages of their drug use.

Historical Context

The older people who use drugs (OPWUD), who are written about in academic journals and the media are the cohort of people born between the late 1940s and late 1980s (Boeri, 2018; Moxon & Waters, 2016). The majority of women who took part in this study were born in this period and began using drugs recreationally in the 1980s and 1990s. From the 1970s and particularly through the 1980s, social, economic and political changes were altering the face of the communities that some of this study's participants grew up and entered adulthood in - the urban industrial areas and semi-rural mining communities of Scotland and North East

England. As this period progressed, many of the older industries that had provided employment in these areas declined rapidly leading to rising unemployment and fewer jobs. Nevertheless, a larger proportion of young people and the rapid expansion of the UK drug market increased the availability and affordability of a range of drugs including cannabis, heroin, cocaine and MDMA (EMCDDA, 2010). The increase in younger people experimenting with and taking drugs led to what some called the 'normalisation' of drug use wherein the recreational and non-stigmatised use of drugs became culturally and socially accepted by the wider non-drug using population (Pennay & Measham, 2016).

It is in this period then, that many people who use drugs (PWUD) termed *older* began their use of drugs. Smokeable heroin was introduced to the UK in the late 1970s and its use, along with other drugs, expanded throughout the 1980s and into the 1990s. Responding to this, drug policy in the UK embarked on a programme of harm reduction measures, moving away from punitive responses to ones that emphasised harm reduction, treatment and rehabilitation (Neale, 2002). The combination of treatment and harm reduction measures such as opiate replacement therapy and needle exchange programmes, plus people adapting their drug use as their life-circumstances and attitudes change (Boeri, 2018; Moxon & Waters, 2016) is such that there are increasing numbers of older people who have used or are using illicit drugs in the UK today.

Defining Terms

There are three key terms that are used throughout this thesis that should be defined before proceeding. The first, o*lder women*, in the context of this thesis refers to women who are aged 35 and older. The reasons for this are explained in chapter 2. Second, d*rug use* refers primarily to illicit drug use and concerns the use of opiates and stimulants, such as heroin and cocaine. However, it also encompasses all legal and illegal substances that have mind-altering effects (including alcohol and prescribed medicines). The terms *problem* or *chaotic* drug use concern drug use that causes its consumers significant social, financial, legal, physical and mental health problems. In this sense it is the effects of drugs rather

than types, frequency or methods of drug consumption that is considered problematic.[1] Third, the term *Recovery* is a nebulous concept (Laudet, 2007) but this thesis adopts a loose definition that encompasses the Scottish Government's characterisation as:

> '[A] process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society' (Scottish Government, 2008).

However, recovery is not just about 'taking or not taking drugs' (Neale, Nettleton & Pickering, 2012: p.15). *Recovery* is also defined as women achieving and sustaining improvements in relationships, health, employment and other areas of their personal (and public) lives (Neale et al, 2012). This thesis therefore uses a broad definition of recovery that encompasses a move from problem drug use to sustained improvements in life.

Thesis Outline

The structure of this thesis is as follows: Chapter two provides a review of current research on older people who use drugs (OPWUD) and outlines why this is an area that requires more research and importantly, where this thesis sits within the canon. Chapter three presents the conceptual framework underpinning this research: focussing on its symbolic interactionist foundations and the conceptual lenses through which the women's narratives are explored. Chapter four sets out the research questions and provides a comprehensive description of the methods used to undertake this study. Chapter five introduces the 19 women who participated in this study to the reader and describes the meanings ascribed to and conveyed through their objects. Chapter six describes the women's social relationships through the concepts of connecting and belonging, highlighting some

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[1] The terms *problem* or *chaotic* drug use as it is applied throughout this thesis is not used pejoratively and bears no judgement. They are terms used by the women themselves at points during their interviews and are terms commonly used in the literature.

of the challenges they faced when building new relationships or renegotiating old ones. Chapter seven builds on the work reviewed in chapter two by adding the voices of women describing their bodies and health as they aged into their recoveries. Chapter eight moves on from the women's views on their recovering bodies and explores from their standpoints, the therapeutic landscapes available to them in the past and present. This chapter demonstrates that within health treatment, these women's histories as women who have used illicit drugs are never far from their present recovered selves. The concluding chapter draws together the women's voices and presents the key findings, implications for research and future directions, limitations and strengths of the study and some final thoughts.

Chapter 2: Reviewing the Literature

Chapter Overview

Chapter two provides a critical review of the literature on older people who use drugs (OPWUD). The chapter begins by defining what is meant by the term OPWUD and follows with an overview of literature on the physical and mental health implications for OPWUD, and the provision of medical treatment. Section 2.2.3 explores the role of social factors on women's substance use and recovery with a specific focus on the influence of relationships, stigmatisation and socio-economic structures. The chapter concludes with an overview of the current gaps and limitations in research and how this thesis will contribute to a better understanding of older women who use drugs.

2.1 Defining Older People who use Drugs

For the purposes of this study, 'older' in the context of problem drug use is defined as aged 35 years and older, in line with published Scottish and European research (Mathieson, Hamilton, Wallace & Liddell, 2019; Vogt, 2009). This cut-off may seem young but as discussed in the following section, long-term drug use is likely to accelerate the ageing process and its accompanying conditions. Some authors suggest long-term drug use among people who start at a younger age may have a biological age some 15 years older than their chronological age (Bachi, Sierra, Volkow, Goldstein & Alia-Klein, 2017; Vogt, 2009).

While some people who use drugs 'mature out' of use by their late twenties or early thirties (Winick, 1962), the proportion of OPWUD in treatment in Scotland has increased from 29% in 2006/07 to 51% in 2016/17(ISD, 2019). Suggested reasons for this increase include ageing demographics, increased availability of illicit drugs and improvements in access to treatment and harm reduction measures (EMCDDA, 2010). Recent studies of OPWUD in the USA (Boeri, 2018) and the UK (Moxon & Waters, 2016) shows that over the life-course people adapt their drug use according to other life events and continue using beyond their thirties. For some OPWUD, 'lengthy drug careers [are] a triumph of adaptability' (Moxon & Waters, 2016: p.83) although not all drug careers occur over a long time. Some people

begin using illicit drugs in their late twenties and older. This has led to the categorisation of OPWUD into *early* and *late onset* users with early onset users starting drug use in adolescence or early adulthood and late onset users starting in their late twenties or older (Boeri, Sterk & Elifson, 2008; Johnson & Sterk, 2003). There is some evidence that early-onset users are better protected against drug-related harms due to their having more knowledge and experience whereas late-onset users may be prone to health-related harms due to naiveté and riskier drug-using behaviours however there is still relatively little data to confirm this (Boeri, Sterk & Elifson, 2008; Johnson & Sterk, 2003).

2.2 Health and Treatment

Ageing or maturing into drug use can bring with it a range of health problems. This section outlines some of the literature exploring the intersection of drug use, ageing and gender on health and treatment outcomes.

2.2.1 Physical and mental health

The most extreme consequence of drug use in Scotland is captured in its annual drug deaths figures. In 2019, data for Scotland showed people over 35 years old accounted for 73% all drug-related deaths (DRD) (National Records of Scotland, 2020). Premature deaths in Scotland have been gradually increasing since the beginning of this century. Moreover, the proportion of women's drug deaths in Scotland increased from 19% in 2004–2008 to 29% in 2014–2018 (Tweed, Miller, Schofield, Barnsdale & Matheson, 2020). Comparing the annual averages for these two periods, the percentage increase in the number of DRDs was significantly greater for women (212%) than for men (75%) (Tweed, Miller, Schofield, Barnsdale & Matheson, 2020). Possible explanations for this increase among women include ageing, changing patterns of drug use, intersection of poverty and other factors, as well as changing treatment and other health and social care provision (Tweed et al, 2020). The intersecting factors that increase the chances of mortality are multiple and there can be no doubt that increasing age and morbidity, especially from long-term drug use are factors in these individual deaths.

As people get older, their body's ability to process drugs changes: for example, body water content and lean body mass reduce with increasing age which can lead to increases in drug serum levels (the concentration of a drug in blood serum) (Dowling, Weiss & Condon, 2008). Elimination of drugs through the renal system is further reduced with age so that this combination of age-related changes in physiology can increase adverse drug reactions in older people while long-term drug use may exacerbate a decline in kidney function that can lead to earlier onset of diabetes among older adults (Dowling, Weiss & Condon, 2008). Respiratory disorders and cancers of the oesophagus and lungs are also increased with long-term use of drugs, particularly the inhalation of cocaine and crack-cocaine (Akwe, 2017). A UK study of patients (17.4% female) entering a methadone maintenance programme for opioid dependence found statistically higher rates of blood-borne viruses (BBVs), and physical and mental health morbidity in those aged 50 years and over compared to those aged under 50 (Badrakalimuthu, Tarbuck & Wagle, 2012). Similarly, a Scottish study demonstrated older people (over age 35 years) who use drugs were more likely than younger people who use drugs or people in the general population, to be admitted to hospital with a range of health issues such as respiratory problems, hepatitis C, liver disease and depression, (Scottish Drugs Forum [SDF]a, 2017).

In terms of gender differences, two USA-based studies demonstrated that older drug using women exhibit poorer overall health status and more chronic physical and mental health problems than men (Grella & Lovinger, 2012; Rosen, Smith & Reynolds, 2008). A 25 year follow-up of 343 methadone patients (44.3% female) found significantly more women than men considered their health to be poor (27.3% v 8.4%, $p<0.001$) and women reported higher rates of heart disease, circulation problems, asthma, bladder problems, colitis/bowel problems and arthritis (Grella & Lovinger, 2012) In contrast, men reported higher levels of hearing problems and slightly elevated levels of diabetes (Grella & Lovinger, 2012). Scottish hospital admissions data provide further evidence of gender differences in physical and mental health outcomes. Older women who use drugs (OWWUD) were admitted to hospital with higher rates of chronic obstructive pulmonary disease (COPD), asthma and depression while men were admitted with

higher rates of liver disease (SDFa, 2017). There are no definitive answers as to why these differences might exist but it is known that there are higher injecting prevalence rates among men who use drugs compared to women (Zahnow, Winstock, Maier, Levy & Ferris, 2018). Therefore, it could be that women who use drugs are more likely to smoke their drugs compared to men which might account for the higher rates of respiratory disorders (Strang, Grif, Powis & Gossop, 1999). On the other hand, men who use drugs may have higher levels of alcohol use and hepatitis virus, which may account for the higher admissions for liver disease. Moreover, OPWUD who have engaged in injecting are at higher risk of having BBVs such as the hepatitis C virus (HCV) and human immunodeficiency virus (HIV) than the general population (Degenhardt et al, 2017). A mixed method study conducted in Barcelona with 118 women who use drugs (WWUD) (mean age 39 years) reported that HIV-seropositive females were older and that their virus acquisition was associated with injecting drug use, having a HIV-seropositive sex partner, depressive and antisocial personality disorders (Gilchrist, Blázquez, & Torrens, 2012). Moreover, women who were in abusive relationships were less able to negotiate safer sex practices (Gilchrist, Blázquez, & Torrens, 2012). While these findings point to the increased psychosocial and behavioural risk factors for BBV acquisition among OWWUD they also point to co-occurrence of health problems interlinked through the physiology of ageing and social factors such as poverty, domestic violence and drug use.

In terms of mental health, the psychological effects of long-term drug use can increase depression, self-harm and memory disturbance in OPWUD (Sidhu, Crome & Crome, 2012). In addition, drug use may be precipitated or exacerbated by a range of risk factors including mental health illness, bereavement, social isolation, lack of social support and financial difficulties (Lintzeris et al, 2016; Mauro, Canham, Martins & Spira, 2015; Babypaul, Czernicki & Kunnumpurath, 2014; Gray, 2009). Although not exclusive to older people, they can be factors in the continuation or onset of drug use among this cohort. An examination of 140 methadone maintenance patients aged 50 years and older (35.7% female) showed women were more likely than men to have a major depressive episode, agoraphobia and panic disorder while men were more likely to have hypertension

and diabetes (Rosen, Smith & Reynolds, 2008). Grella and Lovinger's (2012) follow-up study also reported significantly higher levels of psychological distress, depression, and suicidal ideation and suicide attempts among women compared to men (Grella & Lovinger, 2012: p.309). Both studies reported poorer overall mental and physical health functioning among the methadone clients compared to the general population of adults of similar age. In addition, adverse childhood experiences are associated with lifetime mental health illness and substance use among older people (Choi, DiNitto, Marti & Choi, 2017; Larkin, Aykanian, Dean & Lee, 2017; Chauhan & Widom, 2012) suggesting drugs and alcohol use are a coping mechanism to mitigate emotional pain and trauma. However, a qualitative study of 38 older (50+ years) people who used heroin (50% female) did not find any major differences in health between the men and women with both discussing depression and concerns around hepatitis (Hamilton & Grella, 2009). Yet, women who use drugs are potentially more prone to mental health conditions than their male counterparts given that many are likely to have experienced emotional, physical and sexual violence and exploitation (Gilchrist, Gruer & Atkinson, 2007; McKeganey, Neale & Robertson, 2005). While existing research suggests gendered differences in physical and mental health problems among OPWUD, the evidence to confirm this is currently limited. As Rosen et al (2011) have highlighted, the lack of focus on gender differences in the literature is a limitation in understanding the complex physical and mental health needs of older men and women who use drugs.

One area in which older women's health is distinct from men is in the natural life-transitioning event of the menopause. Limited evidence suggests OWWUD may be at risk of earlier onset of menopause than women in the general population (Schoenbaum et al, 2005) and that methadone treatment can be complicated by issues related to the menopause (Tuchman 2007). Symptoms such as hot flushes may be confused by both the client and treatment provider as symptoms of opiate or methadone withdrawal (Tuchman, 2010; Johnson, 2008). Furthermore, women with self-medicating drug using histories experiencing increased levels of physical discomfort, insomnia, irritability, anxiety, and depression during their menopausal transition may be at higher risk of relapse (Tuchman 2007). A range of biological and psychosocial factors associated with

ageing can increase older women's vulnerability to BBV and sexually transmitted infections (STI). For example, dyspareunia leading to abrasions and tears increases the risk of infection (Tuchman, 2013). Older post-menopausal women are less likely to discuss condom use with sexual partners particularly if they have been in a long-term relationship, and may be less assertive than younger women to enquire about sex partners' past drug and sexual history (Tuchman, 2013). Transitioning through the menopause and not using condoms makes older women more vulnerable to HIV and STI (Andany, Kennedy, Aden & Loutfy, 2016). A large-scale US study of 571 menopausal women showed HIV infection and immunosuppression were associated with earlier onset of the menopause, increasing the risk of osteoarthritis and heart disease (Schoenbaum et al, 2005). According to Chrisler (2011), menopausal women are stigmatised through negative attitudes toward older women where their ageing body and signs of ageing such as wrinkles and grey hair result in women's loss of status sooner than for men. Consequently, leaks, lumps and lines are the stigmatising marks that culturally distance older women's bodies from the youthful bodies we are exposed to through the media and thus our social expectations of healthy, in-control women (Chrisler, 2011). Similar to other ageing adults in society, competing in a culture that places value on youth is challenging but even more so for older people who use drugs (Boeri, 2018, 2013; Anderson & Levy, 2003; Rosenbaum, 1981). The social marginalisation of women who use drugs combined with the intersection of being an older woman past her reproductive years possibly inhibits wider medical and sociological interest in this particular group of women. Nevertheless, awareness-raising around the menopause in the media (Hinsliff, 2020; Ferguson, 2020; Moran, 2020) combined with increasing academic and policy interest in OPWUD may open up opportunities for further research in this area. In the meantime, chapter seven of this thesis takes an exploratory look at the experiences of ageing into the perimenopause and menopause among some of the women who contributed to this study.

Having explored some of the literature on the potential *implications* of drug use for older people's health, the following section looks at studies of older people's *experiences* of medical treatment for problem drug use and health in recovery.

2.2.2 Medical Treatment Provision and Health in Recovery

Formal or medical treatment for problematic drug use, as well as the physical and mental ill health that often accompanies such use, is integral to some people's recovery, although social and structural barriers exist that make it difficult for some to access treatment. Qualitative studies among this cohort provide some evidence that people may be reluctant to admit a problem with their drug use because of the perceived stigma they might experience (Ayres, Eveson, Ingram & Telfer, 2012; Wu & Blazer, 2011; Conner & Rosen, 2008; Radcliffe & Stevens, 2008). Findings from this thesis add further evidence to support this and are discussed in chapter eight. In addition to being or feeling subject to stigmatising processes, OPWUD might mistrust others (Smith & Rosen, 2009), choose to isolate themselves (Ayres, Eveson, Ingram & Telfer, 2012) and/or have low expectations of health services (Beynon, 2009). A UK qualitative study of twenty OPWUD (10% women) highlighted the negative feelings many had of accessing health services, particularly where there were younger active people who used drugs (Ayres, Eveson, Ingram & Telfer, 2012). Smith and Rosen's (2009) qualitative study with 24 (58% women) methadone patients aged over 50 years, found that addressing self-isolation was key to getting OPWUD to engage with treatment and support. Mistrust of others because of violence and past trauma experiences, difficulties in personal relationships and ageing all contributed to the shrinking of people's social networks. Having and sustaining healthy social relationships is a key component of successful drug treatment outcomes and recovery, as discussed further in chapters five and six of this thesis.

Phenomenological studies of methadone treatment have sought to understand older clients' lived experiences of drug use and medication assisted treatment (Hightower, 2016; Malvini Redden, Tracey & Shafer, 2013). Understanding clients lived experiences of drug use and medication assisted treatment from their perspectives highlights a number of important themes including the impact of methadone on participants' relationships with others, attitudes of being an older person who uses methadone, mental health stresses, issues around attending methadone clinics for daily pick-ups and the need for other treatment besides methadone (Hightower, 2016; Malvini Redden, Tracey &

Shafer, 2013). In Malvini Redden et al's (2013) study, participants judged their drug use as a moral failing and expressed disappointment at their need for help to quit using and maintain recovery. In Hightower's study (2016), participants talked about lack of employment and financial difficulties. Both studies propose a holistic approach for recovery that goes beyond medical support and encompasses social supports that can help OPWUD become more self-sufficient. Although both Malvini Redden et al (2013) and Hightower's study (2016) looked at both men and women, the findings were not differentiated by sex. However, studies of women who used heroin (Rosenbaum, 1981) and methamphetamines (Boeri, 2013) support these findings.

Rosenbaum (1981) argued methadone treatment in particular 'narrowed' women's opportunities. They remained addicted to a substance, tied to their treatment conditions, and the routine of these conditions maintained their links to other people who use drugs and contributed to additional health problems associated with methadone (Rosenbaum, 1981). Boeri (2013) argued women's choices regarding treatment is highly constrained by their social circumstances and available options, as well as by professional opinion. Despite these findings originating from research in the USA, they have resonance for women in Scotland and other countries in the UK. The usual port of call for women who experience problematic drug use in the UK is to engage with the NHS and local authority drug treatment providers unless they have recourse to funds that enables choice over treatment. However, not all people who use drugs resort to formal treatment structures, some people give up 'naturally' (Granfield & Cloud, 2001; Biernacki, 1986) while others use recovery communities and 12-step Fellowships (Dossett, 2013). Nevertheless, for many UK women who find their drug use problematic and require help to resolve their difficulties, state-sponsored medical treatment is often one of the first steps to recovery.

Insights from feminist research on the 'therapeutic landscapes' available to women requiring treatment for their drug use suggest interventions promote the prevailing social norms of femininity and motherhood (Love, Wilton & DeVerteuil, 2012). For example, the focus on re-establishing 'ordinary' daily routines and limiting 'risky' behaviours appears to be linked to assumptions about the kinds of

lives women should be leading and does not challenge the structural conditions of material deprivation and social oppression that many clients face prior to and following treatment (Love, Wilton & DeVerteuil, 2012: p.393). Aspirations of recovery that are located in the social roles of mother, wife, partner and carer are roles that professionals and the wider community deem appropriate, rather than those to which women may aspire (Thom, 2010). However, women's experiences and aspirations are affected by a range of interacting factors and material inequalities that are potentially beyond their personal control (Neale, Nettleton & Pickering, 2014). In contrast, Cloud and Granfield (2008) suggest the sociocultural taboos and stigma associated with women who use drugs can serve as important incentives for them to quit using which may translate into more recovery capital for women compared to men in terms of motivation. A focus on 'narratives' of recovery and the construction of a new non-addict identity has some ground in the recovery literature (McIntosh & McKeganey, 2002; Vigilant, 2008; Watson & Parke, 2011; Radcliffe, 2011; Vandermause, Severtson & Roll, 2012) but what *is* missing from the key recovery texts is an understanding of the ex-users experiences of their health and bodies.

In *Beating the Dragon* (McIntosh & McKeganey, 2002), the participants' health is discussed in relation to the impact of drug use and methadone treatment yet there is no discussion of health in recovery. Similarly, Biernacki's (1986) seminal work on recovery without treatment discusses withdrawal and cravings but does not explore people's health beyond their drug use. In contrast, other academics have explored bodies and health in recovery (Neale, Nettleton & Pickering, 2012). In one UK study, bodily adjustments relating to weight, libido, bowel movements and menstruation were explored (Neale, Nettleton & Pickering, 2012). The authors found that compared to people who used drugs, people in recovery endured more bodily discomfort and pain over a longer period (Nettleton, Neale & Pickering, 2011). The use of opiates and opioids masked for many their bodily pains but in recovery, the emergence of aches and pains were perceived as the result of general wear and tear from prior substance use, stress, tension and ageing (Neale et al, 2012: p. 126). Disentangling these pains in recovery from their past drug use was difficult for participants to ascertain. In order to more fully

understand the impact of health on recovery ‘a fuller appreciation of the lived experiences of recovery must incorporate and give greater attention to the body’ (Nettleton, Neale & Pickering, 2011). This thesis provides that attention in chapter seven by seeking to understand what it means to move from a drug using body to a recovered body as these women aged into their recoveries.

Moving on from health and formal treatment structures, the following section reviews current research that explores the social factors affecting older people who use drugs.

2.2.3 Social factors

This section concentrates on the role and influence of social factors on women’s substance use and recovery, specifically focusing on relationships, stigmatisation and socio-economic structures.

2.2.3.1 Relationships, stigmatisation and socio-economic structures

As ageing occurs, people are prone to experience the loss of key relationships and social networks while the biological and social aspects of ageing can increase the sense of diminished self-worth among older people, particularly among OPWUD, for whom long-term drug use may have exacerbated the normal ageing process (Anderson & Levy, 2003). Disengagement from relationships through the death of drug-using friends, friends who use drugs and enter recovery and stop using, or age-segregation within the drug using environment, all contribute to increasing isolation and marginalisation within drug-using circles resulting in OPWUD becoming the ‘marginal among the marginal of society’ (Anderson & Levy, 2003: P.762). However, a shrinking network of drug-using associates and significant others can be beneficial to reducing and abstaining from problematic drug use (McIntosh & McKeganey, 2002; Biernacki, 1986). A Glasgow study of people recovering from heroin use found that those who were completely abstinent from all substances reported significantly higher quality of life scores and had higher numbers of non-users in their social networks compared to those who were

maintained on opiate replacement therapy[2] (Best et al, 2012). Ageing may also be a protective factor in terms of recovery as older women may have more supportive social networks encouraging recovery from drug use (Weisner, Matzger & Kaskutas, 2003). Having longer periods in recovery can help build non-drug using networks which reduces the social and environmental triggers that can cause relapse.

The influence of parental substance use on children (Straussner & Fewell, 2018; Kroll, 2004;) and young adults (Greenwood, 2018; Bancroft, Wilson, Cunningham-Burley, Backett-Milburn & Masters, 2004) is documented and UK substance use strategies have aimed at ameliorating the effects of problematic drug use on families, and particularly the children of parents who use illicit drugs (Advisory Council on the Misuse of Drugs, 2011). Far less attention though has been given to understanding the complex relationships between older parents who use drugs and their adult children. Exceptions to this are USA-based research such as Hamilton & Grella's (2009) study of older people who used heroin in which they found 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. Similarly, Jessup et al (2014) describe how parenting and grandparenting is a primary motivation to stop drug use but also how for some, reconciling relationships with adult children can be fragile and challenging. Interpersonal relationships can be both a source of support and potential triggers for relapse. Some of the women who took part in an MRes dissertation pilot study for this PhD thesis described the difficulties they faced in repairing their relationships with adult children (Shaw, 2017). Even in recovery, rebuilding trust was a long process however life events, such as becoming a grandmother, could be important in helping some women maintain abstinence and reconcile with adult children (Shaw, 2017). The grandparent role, which usually occurs later in life, is a role through which some women attempt to re-establish their relationships with children and restore their identities as 'nurturing' and 'caring' women (Thom, 2010). Chapter

[2] In Scotland, the primary opiate replacement therapy (at time of writing) is substitution of methadone or buprenorphine for heroin use.

six throws some light on this aspect of the participants' relationships with their adult children as well as the influence of family dynamics on their recovery attempts.

Caregiving for family members can reinforce abstinence or reduce drug and alcohol intake (Jessup et al, 2014) while multiple responsibilities and obligations to ageing parents, long-term partners, children or grandchildren can lead some older women to subordinate their needs to those of others (Koenig & Crisp, 2008). Some women feel entering treatment will negatively affect relationships with significant others or they might lack alternative sources of care for family members both of which can affect their motivation to enter or remain in treatment (Koenig & Crisp, 2008). In addition, social isolation provides additional barriers for others to identify problematic drug use in older women. Shame and stigma are also problematic as older women may be more reluctant to discuss their risk behaviours for fear of further stigmatisation by treatment providers (Koenig & Crisp, p.1049). Drug addiction, older age, depression and poverty are all factors that on their own or combined can lead to experiences of discrimination or negative attitudes *from* treatment providers that result in more negative attitudes *towards* treatment and barriers to seeking help (Conner & Rosen, 2008). Furthermore, it is important to consider power dynamics in the relationships between older women who use drugs and professionals from whom they might seek help. Previous experience of authority figures, deference to expert opinion and a sense of hierarchy between patient and provider as well as perceived or actual stigmatisation are potential issues that can compromise professional support that is appropriate to OWWUD. Chapter three explores stigmatisation conceptually while chapter eight engages with the women's narratives to explore their range of experiences with treatment providers.

The socio-economic structures that older women engage with highlights the disadvantages that those who are further marginalised also face. There is certainly evidence to suggest ageism occurs in the workplace with age-related stereotyping such as beliefs that older workers are less competent, have lower physical and mental endurance or are more resistant to change than younger workers (Gordon, 2020). The double burden of being an older woman and an ex-

user can narrow their options for [re-]entry into the workforce (Rosenbaum, 1981). Employment in the conventional sense is constrained if women have spent years out of the workplace or worked in the 'black'[3] economy. Nevertheless, other socio-economic factors should also be taken into account including the interaction of ageing, adverse childhood experiences, education levels, neighbourhood effects, histories of incarceration and homelessness (Choi, DiNitto, Marti & Choi, 2017; Larkin, Aykanian, Dean & Lee, 2017; Crane & Joly, 2014; Chauhan & Widon, 2012). The challenges older women face in continuing or abstaining from drug use is influenced by a wide range of structural and systemic factors. As Carl Hart states:

> *'A great deal of pathological drug use is driven by unmet social needs, by being alienated and having difficulty connecting with others. The majority of people who avoid drug problems, in contrast, tend to have strong social networks.'* (Hart, 2013 p.15)

Connecting with others, in other words making and maintaining healthy social relationships, is a key factor in many people's successful recovery. Within this thesis, the importance of connecting with others is discussed in chapters five and six wherein the women describe processes of connecting and belonging through their meaningful objects and narratives. Still, from a Bourdieusian perspective, evidence suggests older women who have higher levels of social capital such as strong social relationships, higher levels of education, secure housing and economic security are able to regain their mainstream roles and control their drug use better than those with less social capital (Boeri, 2013). In addition, ageing itself may bring its own advantages.

In Lander's (2015) longitudinal study of older women who used amphetamines, she demonstrated how the women used their age and ageing as a form of social capital in order to gain advantages in certain social contexts, for example to receive lighter prison sentences or access treatment. As older women, they were aware of other people's expectations of them as 'chronic drug abusers'

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[3] Business activity and income that is part of a country's economic activity but which is unrecorded and untaxed by its government.

or ‘problem others’ and their knowledge and experience of this expected identity was used to obtain certain advantages (Lander, 2015: p.278). Age and ageing was used to subvert and resist normative expectations of how older women should behave. The women in Lander’s study framed their narratives within discourses shaped by their conceptions of age-appropriate behaviour. For instance, one participant spoke about trading sex, stating ‘it’s not acceptable as a grandmother’ (Lander, p.275). Lander’s work is novel in that she acknowledges the embodied aspect of identity production as it emerges through the women’s social position, age and functionality. Long drug-using careers in a socially-excluded position means older drug using bodies are relatively worn out, illnesses become apparent and friends are lost. One woman positions herself as an outsider and emphasises her otherness but at the same time there is a narrative of caring for friends and home that lies within a framework of normative femininity. The women in Lander’s study adhered to socially accepted standards or norms of behaviour such as motherhood and caring for others.

Drug use among older people can serve a functional purpose and offer opportunities for independence and status that can mediate difficult lives and circumstances. For some, using drugs provides a positive sense of self and identity. Nevertheless, in wider society a discourse that views women who use drugs as somehow ‘other’ and at the very least downplays the social, economic and cultural explanations for problematic drug use continues to prevail. For older women who use drugs or are in recovery, being ‘hidden’ or at the least ‘marginalised’ in drug policy and research is another obstacle to their visibility as women with valuable life experiences who can potentially use their skills and experience to help others.

2.3 Conclusion

Scotland’s drug deaths highlight the consequences of opiate/opioid drug use with increasing numbers of people over the age of 35 losing their lives, leaving behind family and friends. It is a serious concern that women account for the fastest growing proportion of drug-deaths. While there is a growing body of academic research exploring the effects of drug use and the treatment needs of older people who use drugs, there still remains comparatively less work exploring

the day-to-day lived experiences of older women who use drugs or in recovery from problematic substance use. Perhaps older women's marginality in society explains their relatively limited presence in the addiction literature.

Epidemiological studies that examine the physical and mental health effects of long-term illicit drug use are important but a gendered analysis is required given, amongst other things, the social and physiological differences between men and women. Where, for example, can practitioners learn about the potential effects of the perimenopause and menopause on older women who use drugs or in early recovery? Moreover, more needs to be uncovered in terms of the structural and systemic barriers that are faced by many older women who use drugs or who are in recovery. Nevertheless, growing concern around the health and social consequences of older women's drug use is producing some inspiring sociological studies (Boeri, 2018; 2013; Lander, 2015). Although the scope of this review is limited, it is clear that further research is required to explore a range of issues (including health, behaviours, attitudes and experiences) of older women with drug using histories. While there are a growing number of studies that explore the intersection of drug use and ageing, the gaps in analysis lie in the intersections between drug use, ageing, gender and the body. 'Knowing that we do not know' is not an excuse for ignorance but 'caring not to know' (Tuana, 2006: p. 4) is a deliberate practice of discrimination toward older women who use drugs or are in recovery. We should care about these women because their experiences matter: their lives have meaning for them, their families and wider society. If we can understand what helps and hinders women in recovery who have experienced the harmful effects of drug use, we may begin to understand how best to provide support that has relevance to them.

This study adds to the current research on older people who use drugs by providing a unique UK perspective that explores the lived experiences of ageing, health, and engagement with treatment and wider health services among women in mid-life with a prior history of drug use. It adds further qualitative evidence to the rich but relatively scarce body of work on older women in recovery and attempts to fill some of the knowledge gaps mentioned. The next chapter sets out

the conceptual roadmap used to understand the lives of mid-life and older women in recovery from problematic drug use.

Chapter 3: Older women using drugs or in recovery: A conceptual framework

Chapter Overview

Following the predominantly health-focussed studies in chapter two, chapter three sets out the conceptual framework that is used to build an understanding of how women develop and shape their sense of self through their interactions with significant others and wider health and social structures. Section 3.1 begins by outlining the symbolic interactionist foundations of this study, and moves on to explain a synthesis of *doing, being and becoming* and the conceptual processes of *belonging* and *stigma*. Each of these offers a conceptual lens through which the women's interactions with the material and social worlds around them, including the therapeutic landscapes they work through in recovery, are explored. Section 3.2 discusses embodiment as the approach used to explore how the women experience their bodies through recovery, with a particular focus on Drew Leder's (1990) concept of 'dys-appearing' bodies. The chapter concludes with a discussion on the efficacy of this theoretical framework and the contribution this approach will make to current research in this field.

3.1 Symbolic Interactionism

Symbolic interactionism offers a heuristic tool to explore how older women who are in recovery from drug use make sense of the world around them by exploring the meanings they give to their interactions within their private and public social spheres. It has been used elsewhere in drugs research as a framework for understanding how individuals subjectively make sense of their world through repeated micro-level face-to-face interactions and how these define and shape their identities and sense of self (Boeri, 2018, 2013; McIntosh & McKeganey, 2002; Taylor, 1993; Biernacki, 1986; Rosenbaum, 1981). Symbolic interactionism is an appropriate lens through which to study the recoveries of older women with a history of using drugs, as it understands drug use and recovery as behaviours that arise out of individuals' interactions with the social contexts in which drug use and

recovery take place. It can inform our understanding of how older women develop meanings in relation to their drug use and recovery.

Herbert Blumer (1969) developed the concept 'symbolic interactionism' and regarded the concept as based on three underlying principles. Firstly, people act toward things (for example - objects, institutions or guiding values) based on the meanings the things have for them as individuals. Secondly, meanings are derived from the social interactions people have with each other. Thirdly, meanings are managed and revised through an interpretive process used by individuals in dealing with the things they encounter (Blumer, 1969, p.2). Accordingly, symbolic interactionism views meanings as 'social products' that are formed through the activities of people as they interact (Blumer, p.5). Interpretation of these meanings is a 'formative process' in which 'meanings are used and revised as instruments for the guidance and formation of action' (ibid, p.5). In other words, our perception of who we are in relation to others and the social systems in which we live (our 'self') is worked out through our interactions with others. Individuals are constantly engaged in 'mindful action'; negotiating and making meanings of situations, objects and symbols (Carter & Fuller, 2016, p.2). Meanings are intersubjective, perceived, and open to interpretation and therefore social, dynamic, fluid and open to change.

Before moving on, it is worth defining in more depth the concept of self as this is central to the women who took part in this study and their sense of themselves and their place within the wider social world. George Herbert Mead, a major contributor to the foundation of symbolic interactionism, divided the components of the self into 'I' and 'Me' (Mead, 2015). 'I' is the self as subject and is the response of the individual to the attitudes of others (Mead, 2015: p.175). 'Me' is the self as object and is the organised set of attitudes of others that is expected or 'assumed' by the individual (ibid, p.175). Self-awareness or reflexivity is the human capacity to be both subject and object to one's self; to be able to think as a subject ('I') about one's self as an object ('Me') (Howard & Hollander, 1997: p.94). The individual experiences themself from the perspective of others, from the 'generalised standpoint' of the social group to which they belong and within a social environment in which the individual and others share the same

contexts of experiences and behaviours (Mead, p.138). It is from the standpoint of the 'generalised other' that people perceive themselves and make sense of the world around them (Mead, p.154). The 'self-conscious' individual adopts the attitudes and behaviours of the group and conducts theirself according to those rules set out by the generalised other (ibid, p.155). Just as meanings are open to change and interpretation, individuals have multiple selves that react to different situations, experiences and relationships to others. Their interactions with the social and physical worlds they inhabit and move through and the dynamic meaning-making that accompanies those interactions, shows why symbolic interactionism with its underlying principles of intersubjectivity and interpretation provides an appropriate conceptual lens through which to understand the first question in this thesis: what influence do social relationships have on women's sense of self as they age into drugs recovery?

A second proponent of symbolic interactionism was Erving Goffman who used the sociological perspective of Dramaturgy to explain how individuals present themselves in their everyday interactions with others (Goffman, 1959). Goffman defined interaction as any occasion when a given set of individuals are in each other's continuous presence and dramaturgy is likened to the theatrical performance wherein individuals interact face-to-face as performers and audience. Like actors in the theatre, people inhabit numerous roles throughout their lives. As such, a social role (the characteristic or expected social function of a person in a particular situation or environment) involves multiple parts and routines that are presented to different audiences depending on the situation or context. Goffman's dramaturgy is a useful approach to inform an understanding of women with a history of drug use as the success or failure of a performance can have far-reaching consequences for WWUD, particularly in relation to the range of medical, social, legal and economic structures they must navigate.

Women who fail to 'perform' gender appropriately can be seen to possess what Goffman referred to as identities that are 'spoiled' (Goffman, 1963: p.91). As 'drug users', women (knowingly or unwittingly) carry an identity that to the generalised other possess 'characters' that do not fit into the 'moral norms' of society. They belong to a 'group' whose public image is discredited and largely

unfavourable and might carry 'physical' marks on the body that identify them as 'other' (Goffman, 1963: p. 14). In the addiction recovery literature, 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 back into 'ordinary' people (Biernacki, p.179). Moving from the drug using world to the 'straight' world requires social learning of new rules, scripts, and behaviours that must be remembered or re-learnt or learned anew (Best et al, 2016; McIntosh and McKeganey, 2002; Biernacki, 1986). Women in recovery must present a new character that is congruent with their idea of a recovered drug user to an audience who will also have preconceptions and expectations tied to recovery. On top of this, their new character must be congruent with their own and the audience's idea of the socially responsible woman. The tensions between other people's expectations and the women's ideas of what should or could be expected of them and what they were willing to give (or not) are explored later in chapter six.

Having outlined the appropriateness of symbolic interactionism to conceptually ground the study, the next section explains the synthesis of *doing, being and becoming* and the conceptual processes of *belonging* and *stigma* that are used to examine the women's social interactions with the world around them.

3.1.1 Doing, Being, Becoming

Borrowing from occupational science and therapy (Wilcock, 1999; Hitch, Pépin & Stagnitti, 2014), the combination of *doing, being, becoming* is relevant for understanding women's health and wellness in recovery from substance use that became unmanageable for them. For example, recovery 'includes all the things people do, the relationship with what they do with who they are as individuals and through this process [of recovery] they become different' (Wilcock, 1999: p.2). In *doing* recovery, individuals are 'constantly engaged in purposeful doing' (Wilcock, 1999: p3). As will be seen in some of the women's narratives, and highlighted elsewhere (Best, Savic, Beckwith, Honor, Karpusheff, & Lubman, 2013; Neale,

Nettleton & Pickering, 2011), activities that are meaningful and have purpose are important for people aspiring to or in recovery. For example, AA, NA and other Fellowships actively encourage attending one meeting per day for ninety days at the beginning of the transition from addiction to recovery.

Beyond the process of doing is *being*. *Being* refers to an inner state of being, the *self* - the essence of which distinguishes us and what we do from others and what they do. Nevertheless, that suggests something that is static or one-dimensional whereas individuals are and can *be* the sum of many parts. Therefore *being* can be multifaceted, involving (and evolving through) different roles (Hitch, Pépin & Stagnitti, 2014). According to Maslow (1943), from whom the broad definition is taken, *being* involves self-actualisation. Self-actualisation is being able to realise one's full potential, to become what 'one is capable of becoming' (Maslow, 1943: p.383). However, *becoming* is not a singular event, individuals have multiple *becomings*: becoming recovered, becoming employed, becoming a grandparent. *Becoming* also suggests movement, holding the promise of a future, one that has potential for 'growth and transformation and self-actualisation' (Wilcock, 1999: p.5). It relates to changes and developments over time, an ongoing process across a person's lifetime (Hitch, Pépin & Stagnitti, 2014: p.238). Nonetheless, we should not lose sight of the fact that there are variations and disparities in the experiences of doing, being and becoming in recovery between those with more and less recovery capital, as demonstrated in the works of Boeri (2013) and Cloud and Granfield (2008). In *doing* recovery, individuals are *being* and *becoming*, recovered. Developing further Wilcock's synthesis of doing, being, becoming, Hitch et al (2014) argue that becoming also depends on others providing feedback, stimulation, reassurance and affirmation of progress. Therefore this thesis explores older women's recovery experiences and the influence of social interactions on their actions (*doing*); how the women saw themselves (*being*); how their experiences of being a woman ageing in recovery affected their development (*becoming*); and how their connections to others and the social world were affected by the social expectations of the generalised other (*belonging*). The importance of social interactions and relationships in shaping recovery are the essence of what encourages a sense of belonging to something that transcends the

individual and helps them do recovery, be and become recovered. It is to the concept of *belonging* that we turn to next.

3.1.2 Belonging

Belonging is a conceptual tool that can help in the study of relationships between individuals and their wider social worlds. As will be shown throughout this thesis, and particularly in chapter six, a sense of belonging for the women in this study is an important adjunct to their ability to connect to (and disconnect from) others. Belonging in this sense is defined as a 'sense of ease with oneself and one's surroundings' (May, 2011: p.368). Although May looks at belonging in relation to social change, her approach is useful in this thesis because it offers some perspective on how individuals interact with the wider social world through a sense of belonging (or not) to that world. Our sense of self is constructed in our interactions with others and in the abstract notion of collectively-held social norms, values and customs, but belonging also requires the right to participate in the world. Belonging then is socially and situationally stratified. Not all people belong in all settings and some belong in some settings more than others. Furthermore, some people may *feel* they belong in some spaces but not others, and those spaces where they *feel* they belong may be on the margins of society. Nevertheless, being socially marginalised does not necessarily equate with *not* belonging. Individuals may identify with and seek out the company of other similarly marginalised individuals. A recent study that explored identity transitions through recovery communities suggested that identity change in recovery is socially negotiated through a process of social learning and control that is transmitted through social recovery networks (Best et al, 2016). 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 belonging, support, efficacy and meaning (Best et al, p.115). Furthermore, belonging is a dynamic practice that is temporal in nature. Our sense of belonging can change over time, as well as place. As our sense of self changes so does our sense of belonging and as our sense of belonging changes so does our

sense of self. Belonging is then a multidimensional experience in which people experience multiple senses of belonging across time and place.

As a conceptual tool for conducting qualitative research, symbolic interactionism helps us drill down and explore the perceptions older women in drugs recovery have of their place in the world and their sense of belonging in that world. Nonetheless, recovery and belonging can be challenged by stigmatising processes, consequently the next section discusses stigma as a concept for exploring women's recovery from illicit drug use.

3.1.3 Drug use and Stigma

Goffman (1963) defined stigma as an 'attribute that is highly discrediting' (Goffman, 1963: p.13). An attribute may be of a bodily, character or tribal type that is socially discrediting and leads to social disapproval. When an individual displays evidence of or possesses an attribute that makes them different from others' expectations, particularly if they are of a 'less desirable' kind, this attribute is called a 'stigma' (Goffman, 1963: p.12) and they may be viewed (and labelled) as 'outsiders' or deviants (Becker, 1963). A stigma constitutes a discrepancy between a virtual social identity and an actual social identity. That is, a discrepancy between the attribute and categories expected of an individual and the attributes and categories they actually possess. Stigmatisation is the social process by which the stigma affects those who are associated with it, including the stigma-bearer and those around them. Nevertheless, attributes considered discrediting in one setting or at a particular point in time may not be considered as such in another. For example, the use of marijuana in the USA has rapidly shifted from a socially stigmatised behaviour to one whose recent legality is estimated to raise $1 billion annually in tax revenue in California alone (Reuters, 2018). The USA's marijuana users are now acceptable consumers, not the deviant 'others' of the past (Becker, 1963). Therefore stigma can be seen as a political process used by those in power to define who is *in* or *out*, normal or deviant (Sanders, 2014). This process *creates* prejudice and discrimination against those *produced* as deviant or outside the norm. Consequently, practices of othering and exclusion can reduce individuals' life chances and opportunities while their stigma attribute or

character (in this case drug use) is associated with other differences such as gender or class. Consequently, stigma is not an innate fixed property. It is outside the self and perceived. It is an interactive process based on perceptions of difference between two or more people. Socially constructed and fluid, stigmatisation of individuals and groups acts as a function of social and political control to reinforce appropriate behaviour that is considered normal and moral by those in positions of power and wider society. The stigma that is attached to women who use drugs is a social construct that exacerbates the social and economic barriers that create the health and social problems associated with problem drug use. This is one reason why we should care to know and understand the lived experiences of older women with histories of drug use, in order to highlight and illuminate the lives of those who are overlooked in the addiction field, in terms of research, policy and practice.

Social and structural constraints are built and placed upon PWUD by more powerful individuals and authorities through formal and informal sanctions. Those with 'stigma potential' or a discreditable identity will try to hide their stigma from others for fear relationships and life chances might be negatively affected by disclosure of the stigmatising attribute (Anderson & Ripullo, 1996). It is worth noting the difference between discredited and discreditable identities. Discredited identities are those whose stigmatised attribute is known prior to or upon presenting themselves to others; the discreditable identity belongs to a person whose stigmatised attribute is not known or visible to others. As a result, the discreditable must manage information about them that might lead to their discrediting (Goffman, 1963: pp.57-58). Harris (2009) describes how PWUD with the hepatitis C virus (HCV) are potentially discreditable rather than discredited. The signs and symptoms of HCV are 'invisible' particularly in the chronic phases of the disease consequently people with the virus can employ a variety of strategies to conceal its stigma potential thereby remaining potentially discreditable but not actually discredited (Harris, 2009: p.36). A variety of management strategies (such as confrontation, concealment and distancing) may be used to resolve stigma-related problems that are influenced by the social settings in which they occur (Gunn, Sacks & Jemal, 2018; Earnshaw, Smith & Copenhaver, 2013). Different

social settings contain different features and normative identity scripts. Normative identities are informed by social contexts that locate individuals within situations informed by commonly shared backgrounds. Therefore, socially defined deviants may experience problems because of pasts that are different from the normative standard (Anderson & Ripullo, 1996: p.28). For example, managing a drug user identity among family may be different from strategies used in the workplace (Earnshaw, Smith & Copenhaver, 2013) and may be compounded by the intersection of other structural attributes such as class, gender and race (Gunn, Sacks & Jemal, 2018).

In this thesis, I borrow from Graham Scambler (2004) who offers a useful analytical approach to explore experiences of stigma among older women in drugs recovery (OWIDR) by distinguishing between *felt* stigma and *enacted* stigma. Felt stigma refers to the shame and expectation of discrimination that prevents people from talking about their experiences and stops them seeking help. Enacted stigma refers to the experience of unfair treatment by others. A literature review of the stigmatisation of people who use drugs proposed that *felt* stigma is as damaging as *enacted* stigma since it leads to withdrawal and restriction of social support (Lloyd, 2013). One study that examined internalised ('felt') stigma among people who injected drugs found it was associated with depression, low self-esteem, and greater severity of substance dependence (Cama, Brener, Wilson & Von Hippel, 2016). Drug treatment systems and interventions can compound the sense of felt shame through enacted stigma and have a negative influence on physical and mental health stemming from exposure to discrimination and the tension and stress that arise from interactions with non-users. This may reduce reporting of health issues and discourage health-care seeking related to drug use (Ahern, Stuber & Galea, 2007). For example, the punitive delivery of treatment and experiences of pharmacy dispensing is said to reinforce the 'junkie' stereotype and a sense of disenfranchisement from drug treatment policies and service delivery (Lancaster, Santana, Madden & Ritter, 2015; Lloyd, 2013). However, it is worth noting that poorer physical and mental health may affect how people perceive discrimination and stigmatisation in contrast to how discrimination and stigmatisation affect health.

The notion that people's experiences with treatment may shape their identity and the way they relate to treatment policies and services suggests that structural conditions of treatment have important implications for people who use drugs (Ahern, Stuber & Galea, pp.229-30) but so too do the interactions of gender, age and class. Therefore, an analysis of older women with histories of using illicit drugs needs to consider how stigma is enacted and felt in those settings most salient to their drug use and recovery. To this end, the concept of felt and enacted stigma is used to explore the women's views on the therapeutic landscape available to them and any potential facilitators and barriers to their recovery.

3.1.4 Women, drug use and stigma

Recent studies have shown some women find it difficult to overcome the negative stereotyping of *problematic* drug-using women as promiscuous, dishonest, unclean, 'bad' mothers (Gunn et al, 2018; Sanders, 2014; Earnshaw et al, 2013; Sanders, 2012). Women with criminal records also have to contend with the double identity of 'addict' and 'criminal' (Gunn et al, 2018; Sanders, 2012), and as noted in chapter 2, mental health issues are also prevalent among women who use drugs (Grella & Lovinger, 2012; Rosen, Smith & Reynolds, 2008). For example, one study of 266 drug-using women in Glasgow identified high rates of neurotic disorders (85%) likely to need treatment (71%) (Gilchrist, Gruer & Atkinson, 2007). Add then the label of 'mentally ill' and we begin to see how multiple, co-existing negative identities are carried by drug-using women leading to multiple intersecting processes of stigmatisation.

The consequences of stigmatising processes on accessing treatment and recovery were touched on in section 2.2.2. Further evidence shows older methadone maintenance treatment (MMT) clients experience multiple and concurrent forms of stigmatisation, the most common combination being drug addiction, poverty and ageing (Conner & Rosen, 2008). The intersection of multiple stigmas is particularly problematic for individuals as they experience more negative attitudes toward treatment and identify these stigmatising experiences as barriers to seeking treatment (Conner & Rosen, p.258). The stigma of ageing is another concern as older people who use drugs are more likely to experience

multiple stigmas that are exacerbated further by deterioration in their physical and mental health. Although mid-life is viewed as a transition period in the life course in which disruptions and changes in family life and workforce participation occur (Long & Porter in Baruch, 1984), the normative role expectations of midlife and older women run parallel to the stereotypes of women who use drugs for pleasure, as a coping strategy or for other reasons. Furthermore, options for regaining entry into the non-drug world narrow as women age (Boeri, 2013; Rosenbaum, 1981). Entry into employment and 'conventional' roles are limited by the double burden of being an older woman and an ex-drug user (Rosenbaum, 1981; p.133).The concurrent stigmas of ageing, being a woman and an 'addict' may be particularly difficult to navigate and overcome.

Socially constructed stigma as it relates to older women who use drugs carries with it the intersection of drug use, ageing and gender stereotypes. Women in this situation carry more than a double burden, they must navigate and manage multiple stigmas that are both felt and enacted. Important then to women's self-conceptions but a relatively neglected area of research in the addiction literature is the centrality of the body: the vehicle through which life is experienced and meanings conveyed to others. With this in mind, the following section outlines the key concept used to illuminate our understanding of women's embodied experiences of drug use and recovery as they age: the dys-appearing and ageing body.

3.2 Embodiment and Drug Use

Our interactions with others and the world around us are embodied encounters in which we experience our bodies through our engagement with the social world. Life is experienced through our bodies and our bodies convey meanings to others. For example, by the colour of our skin or through the way we dress. These meanings provide the basis for making social distinctions of difference based on race, sex, gender, age and class (Ettorre, Annandale, Hildebrand, Porroche-Escudero, & Rothman, 2017, p.44). These distinctions in which the body is central affect the social patterning of health and illness, access to health care,

attitudes of health providers and epidemiologies of public health practice (Ettorre, Annandale, Hildebrand, Porroche-Escudero, & Rothman, 2017, p.45). Echoing Foucault's (1977) concept of the 'docile body', the body is also the site for regulation and surveillance (Ettorre et al, 2017, p.45). The production of normative standards related to the body is shaped by the moral values of Western society. That is, the codes of behaviour which are deemed right or wrong either through law or through the accepted standards of the majority or from a Foucauldian perspective, those in power (Foucault, 1977). These moral values reproduce social inequalities while simultaneously reinforcing normativity – thus making social bodies that produce either normalised or stigmatised identities (Ettorre et al, 2017; p.46). Bodies can also provide a way of examining the relationship between agency and structure where agency is viewed as the capacity to act with free will, independence and intentionality within the constraints of social structures such as gender, race and socio-economic position that influence our life chances and opportunities (Ettorre et al, 2017, p.47). The human body then is an embodied social agent in which our bodies and social relationships interact and affect each other in an ongoing process (Nettleton & Watson, 1998). In order to explore the participants' embodied experiences of ageing in recovery, the concept of the dys-appearing body is outlined in the following section.

3.2.2 The Dys-appearing Body

The *Dys-appearing body* (Leder, 1990) is a concept that is helpful in understanding the experiences of older women with histories of living less conventional lives than what is normatively expected of women. The concept has particular resonance in terms of the women's experiences of their own bodies, their physical and mental health and their interactions with health and drug treatment. It is through the *dys-appearing body* that I explore women's narratives around health and treatment. Drew Leder looks at the human body as a 'lived' body, a lived structure that is the 'locus of experience' (Leder, 1990: p.5). The lived body is an embodied self that 'lives and breathes, perceives and acts, speaks and reasons' but it is also an 'object available to the external gaze' (Leder, 1990: p.6). It is, following Mead's concept of the self, both subject (I) and object (me). Therefore, the self is embodied and meanings are made through people's

interactions with the material, physical and social world that surrounds them. Dys-appearance[4] occurs when the body undergoes some disturbance, when it 'seizes' the person's awareness (Leder, p.70). Pain is noticed when it stands out from all the other bodily sensations we experience. Pain hurts and is the 'concretisation of the unpleasant' (Leder, p.73). Pain reorients our attention inward and 'reorganises our lived space and time, our relations with others and with ourselves' and becomes 'a manner of being-in-the-world' (Leder, p.73). In other words, pain disrupts our connection with the external world, inducing self-reflection and isolation. It constricts our being-in-the-world back to an awareness of our own body and the particular body area where the pain is felt.

Both health and illness exhibit alienations from the body – in health the body disappears and attention is directed towards the world; in illness the body dys-appears and attention is directed inward to the self. Nevertheless awareness of our bodies is also social and requires intersubjectivity. Our awareness and self-understanding arise out of our corporeal experiences with others. That is, how we perceive others see us, and how we view them (Leder, p.93). Our perspective of the world is broadened through our interactions with others and Leder calls this 'mutual incorporation' (ibid, p.94). We share for instance laughter, tears and sadness – we feel empathy. Alternatively, we may become self-conscious of our bodies when we perceive the objectification and negation of another's gaze. In a study of women's recovery from drug use and sexuality, one woman described herself thus:

> *"I'm ashamed of my body. It is ugly and gross. I have a giant belly and I've gone up several sizes and I don't dare to show myself naked. I'm probably grossing myself out a lot, I think."* (Skårner, Månsson, and Svensson, 2017: p.334)

The other's perspective is internalised and we become conscious of the self as an alien thing. This disruption of communication produces social dys-appearance

[4] 'Dys' originates from the Greek prefix, meaning bad or ill, Additionally, Leder utilises the Latin root 'dis' meaning away, apart, asunder.

(Leder, p.96). Social dys-appearance can be affected by, among other factors, physical and cultural differences, aesthetics and socio-cultural-economic power differentials. Susceptibility of the body to the intention and attention of an 'other' is a primary mechanism of social dys-appearance and is particularly relevant for vulnerable and marginalised individuals.

The concept of the dys-appearing body is one that is valuable for exploring women with a history of drug use, particularly those approaching mid-life as this is a period in life when the body is potentially undergoing significant transformations such as the peri/post-menopausal period. Drug use, recovery and biological changes (including for some younger women, the return of their menses) may bring about heightened attention to the body although some caution is required as these are normal and necessary processes that are not in themselves dysfunctional or alienating. Furthermore, bodily dys-appearance is also related to affective emotions such as anger, anxiety and depression. Emotions too can be an alien presence giving rise to and resulting in bodily dys-appearance (Leder, p.84). Ageing, recovery and abstinence may be moments when women who use drugs re-evaluate their bodies and may be a time when 'the assumption of a novel body renders problematic what was previously tacit' (Leder, 1990: p.90). The women's discussions of their health and bodies are explored further in chapter seven with a particular focus on ageing and embodied emotions.

Ageing is associated with 'expectations and assumptions' of appropriate behaviour related to the social world and the body (Sandberg, 2008: p.119). Therefore, performing age and gender according to social norms is crucial for being perceived as socially acceptable and responsible. Research on OPWUD points towards some interesting insights into ageing among older women who use drugs but they lack the social context which would draw out the potential complexities that older women who are using drugs (or who are in recovery) experience in relation to their ageing bodies and coping strategies (Badrakalimuthu, Tarbuck & Wagle, 2012; Grella & Lovinger, 2012; Rosen, Smith & Reynolds, 2008; Lofwall, Brooner, Bigelow, Kindbom & Strain, 2005). The social and embodied effects of ageing on the lives of older women in drugs recovery in the UK is a relatively unexplored area

therefore, in *caring to know*, this thesis adds further findings and makes some effort to contribute to this little known area.

Conclusion

Symbolic interactionism provides the conceptual foundation to explore the interactions of older women with a history of drug use at the micro level of face-to-face interactions while remaining mindful of the macro factors such as gender and class that shape and influence their lives and identities. An important component of these interactions is the perception women have of their place in the world and their sense of belonging, which is explored further in chapters 5 and 6. In addition, relatively little is known about how older women experience their bodies as they move out of drug use and into recovery. This is an important but limited area of research within the drug research and recovery literature and chapter 7 provides some insight into this aspect of older women's recovery. There is a significant gap in the drug use and recovery literature that explores older women's experiences of stigmatising processes, the settings in which they occur and the strategies deployed to mitigate or resist them. Therefore, it is a rich area of research in which to develop our understanding of how recovery is experienced, in terms of the women's encounters with felt and enacted stigma through their interactions with their wider social and therapeutic communities. Chapter 8 provides further work on this as it relates to women's experiences of health treatment. We know there is some evidence that older women who use drugs are reluctant to ask for help due to perceived or enacted discrimination therefore we should consider the role of somatic and affective dys-appearance through drug use and recovery. The concepts of *doing, being, becoming* and *belonging, stigma* and *dys-appearing bodies* are useful tools that will inform a phenomenological understanding of women's embodied experiences of drug use and recovery through the temporal phase of mid-life. Furthermore, the foundational approach of symbolic interactionism will help us gain some understanding of the influence of social relationships on women's sense of self as they age into drugs recovery; their views on the therapeutic landscape available to them as well as any potential facilitators and barriers to their recovery; and finally, their embodied experiences

of recovery. Having provided an overview of the literature on older people who use drugs and the concepts that ground this thesis, the following chapter provides an in-depth description of the methods adopted to gather and analyse the women's narratives.

Chapter 4: Methods

Chapter Overview

Chapter four provides an overview of the research questions followed by a rationale and description of the methods used and the fieldwork undertaken for this study. Beginning with the research questions in section one, section two outlines the methodological position adopted for the study, followed by a description of ethical approval and considerations in section three. Section four provides a description of the fieldwork and data collection process and section five outlines the transcription process, data analysis and coding. Section five provides some reflections on the interview and fieldwork process and section six concludes the chapter with some thoughts on the efficacy of the study's research methods.

4.1 Research Aims and Questions

From the outset, the aims of this PhD were to explore how mid-life and older women have through their social interactions transitioned from problematic drug use to self-identified recovery and consider how ageing bodies and processes impacted on women's recoveries from drug use. The research questions for this thesis were developed from piloting the methods and original questions in my dissertation for the MRes in Sociology and Research Methods titled, '*Exploring the Influence of Social Relationships on Identity, Drug Use and Recovery among Older Drug Using Females'* and which I briefly describe below and reference where appropriate.

In 2016, I was funded to undertake a one-year research training master's (MRes) linked to the PhD programme as part of the ESRC funding scheme. The aims of the MRes dissertation were two-fold: the first was to explore the influence of social relationships on identity, drug use and recovery among older drug using females (Shaw, 2017). The second was to pilot the object elicitation method (OEM) utilised for this PhD and discussed further in section 4.4.2.2. The MRes dissertation study was conducted between April and September 2017 and the main research question asked '*how do older women who use illicit drugs negotiate their identity*

through their drug using careers and recovery.' The main findings from the MRes dissertation study confirmed recovery communities were integral to helping the women re-engage with wider conventional social spheres. Shared experiences and a shared language provided the women with tools to establish healthy relationships to both their selves and others within their social networks. Key to this process was self-acceptance. The questions for this PhD thesis evolved from the MRes dissertation and are as follows:

- What influence do social relationships have on women's sense of self as they age into drugs recovery?

- How do older women with a history of problem drug use experience their bodies in recovery?

- What are the women's views on the therapeutic landscape available to them and potential facilitators and barriers to their recovery?

Section 4.4.2.1 provides further details on how the topic guides for the MRes dissertation and this PhD thesis were developed.

4.2 Methodological Position

The methodology of this thesis is underpinned by an interpretivist paradigm. From this perspective, reality is regarded as being socially constructed and subjective. This is in contrast to the positivist approach that sees the world as external and objective. Positivist approaches hold that the researcher is independent of what is observed and tend toward deductive methods of inquiry, focusing on observable and concrete facts. Interpretivist studies do not separate the researcher from the research process and tend toward developing ideas through an inductive approach that focuses on people's subjective meanings. From this interpretivist stance, the theoretical position of feminist standpoint theory is chosen to shape the methodological approach of this study.

Feminist standpoint theory is an interpretivist approach that provides a methodology for understanding 'relations of power as a distinctive kind of obstacle to the production of scientific knowledge' (Rolin, 2009: p.219). Within the context

of social research, standpoint theory enables researchers to reflect critically how power structures shape or constrain research questions, methodologies, assumptions and interpretations of data (Intemann, 2010: p.785). For example, Scotland's drug treatment data estimates there are currently around 2,500 women who use drugs (WWUD) over the age of 45 in treatment (private correspondence: ISD, 2015) although a recent report suggests there may be as many as 10,214 women experiencing 'problem drug use' aged between 35 and 64 (ISD, 2019). These 'estimates' are interesting in themselves because if women are barely visible in the official data then their needs are subsumed within a system of treatment modalities that do not take account their experiences. Rolin (2009) writes of 'hermeneutical injustice' wherein one's social experience is obscured from collective understanding (Rolin, 2009: p221). The omission of women's prevalence figures in official statistics puts women at a disadvantage when it comes to making sense of their social experiences. Feminist standpoint theory offers a way for different experiences to undermine 'hierarchical power structures and counteract the negative effects of oppression on knowledge production' (Intemann, 2010: p.791).

There are two main strands to standpoint theory. The first is that people's standpoints are based on knowledge that is situated (Campbell 2015; Wylie, 2012; Comack, 1999; Hartstock, 2019): our material life structures, our understanding and our knowledge, are situated within particular times and spaces, cultures and peoples (Hartstock, 2019). However, they are 'partial situated knowledges': therefore individuals' standpoints are not reified but multiple, contradictory, fluid and changeable (Hartstock, 2019: p.244). The second holds that people who are marginalised or otherwise unheard are epistemically advantaged in understanding their position (Wylie, 2003; Intemann, 2010). In other words, they are critically conscious and aware of their social position (Intemann, 2010; p. 787). Both positions have been criticised for being too 'essentialist' or individualistic (Hekman, 1997). Wylie counters these criticisms by stating that women's position and understanding do not necessarily mean they have 'epistemic privilege of how or why their oppression originated or is maintained' but they do have an alternative knowledge and understanding that can be compared and contrasted to

the dominant world-view (Wylie, 2003; p.37). For example, the addiction literature for decades concentrated on the biological and psychological issues relevant to women while ignoring the social and cultural aspects of women's drug use. Not until the work of Rosenbaum (1981) were sociological frameworks applied to the study of drug-using women, highlighting as they did, women's unique perspectives on treatment regimes, drug-using cultures, behaviours and recovery journeys (Boeri, 2013; Taylor, 1993; Rosenbaum, 1981). Acknowledging that not all women share common experiences and that their knowledge like all knowledge is partial, this study provides a partial account of older women who are recovering from illicit drug use and a partial account of the participants' lives as it relates to their relationships and health as understood by them at a particular point in time.

The methodological approach that feminist standpoint theory encourages is one in which the participants themselves describe their experiences in their own words. The drawing together of their stories from their particular 'standpoint' will enable the pulling out of the interconnections between relationships, health and recovery and demonstrate how these interact to influence women's sense of self in mid-life and older age. Seeking to understand the meanings these interactions have on women's identities requires participants to reflect and describe their emotions and cognitive processes. As such, utilising a qualitative approach helps facilitate a conversation that seeks to understand the influence of roles and relationships on the women's sense of self through drug use and recovery from their own perspectives. 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.

4.3 Ethical Approval and Considerations

The study was approved by the University of Glasgow's College of Social Sciences Research Ethics Committee (ApplicationNo:400170200) 22nd June 2018. Data from the study is compliant with the UK General Data Protection Regulation

Act (GDPR) and the UK Data Protection Act 2018, and also follows the University of Glasgow's Good Practice Guides to Records Management[5]. For safeguarding, a 'Code of Safety for Social Researchers'[6] was utilised to assess and minimise risks to myself and participants. Women who expressed an interest in the study were given the participant information sheet shown in Appendix 1 and given at least two days to read through it and ask questions. The women were assured complete anonymity, with all identifiable information removed from transcripts and published materials. For example, all names and identifying information were removed from each transcript and all names used in this study are pseudonyms. Once satisfied the women understood the purpose of the study and were willing to take part, they were asked to provide informed consent, as shown in Appendix 2. No situations occurred that caused concern although there were occasions when I avoided asking some women about certain aspects of their lives, particularly where children had been taken into care. For example, Kerry (interview 14) was clearly reluctant to talk about two children that had been adopted and when I asked her about her relationships with social work, she spoke about one child being taken into care which was distressing for her then, and at time of interview. I could have probed further and gleaned some interesting data but I felt this would be exploiting her willingness to talk to me and I was anxious not to leave her in an emotionally vulnerable state.

In-depth qualitative interviewing on sensitive topics such as drug use can evoke strong memories and feelings that are sometimes 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

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[5] Accessed at: https://www.gla.ac.uk/myglasgow/dpfoioffice/rims/goodpractice/ (Date: March 2017)

[6] Social Research Association: Accessed at: https://the-sra.org.uk/common/Uploaded%20files/SRA-safety-code-of-practice.pdf (Date : 4th March 2017)

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 when discussion around personal relationships caused some minor distress with the women close to tears. I immediately endeavoured to respond to the participants in a sympathetic and non-judgmental 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 interviews. 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.

4.4 Fieldwork

This section describes the fieldwork period looking firstly at the selection and recruitment process, followed by data collection including an account of the interviews together with some of the learning gained from the experience. Next, an explanation of the data analysis including details on the transcription process is provided, followed by a consideration of the ethical approach and appropriateness of the methods utilised in this study.

4.4.1 Participant Selection and Recruitment

This section outlines the selection and recruitment process used to obtain the sample of 19 women over age 35 with a history of drug use. The cut-off age of 35 years could be considered young but the decision to include women at this age was informed by previous research on older people who use drugs (Scottish Drugs Forum, 2017; Vogt, 2009). Firstly, as discussed in chapter two, the health effects of prolonged drug use and its effect on the ageing body suggests that women who were early onset users and engaged in long-term drug use will have a biological

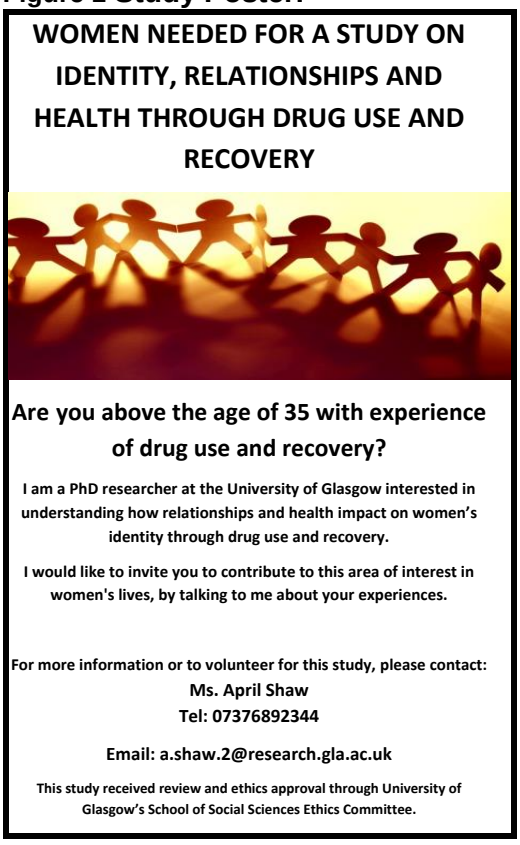
age that is potentially 15 years older than their chronological age (Bachi et al, 2017; Vogt, 2009). Long-term drug use in this study is defined as 11 years or more (Han, Gfroerer & Colliver, 2009). Secondly, as Moxon and Waters (2018) showed in their study of older people who used drugs recreationally, there are a range of potential difficulties in accessing this hard-to-reach group such that an opportunistic approach was required to ensure an appropriate number of women were included.

4.4.1.1 Selection

Convenience sampling was utilised in this study, as OPWUD and particularly OWWUD, are a hard-to-reach group (Moxon and Waters, 2018). Purposive sampling that engages with different sexualities, races and socio-economic backgrounds was deemed inappropriate due to the potential difficulties in recruiting and because this is not a comparative study, in which the goal is to explore participant experiences and understandings based on structural differences. Rather, the goal of this study is to explore the women's transitions through drug use and recovery based on their relationship and health experiences and the subjective meanings they give to these aspects of their lives. Participation was voluntary and the study was advertised through email distribution by contacts and colleagues; on flyers and posters in locations where people in recovery meet, such as recovery cafes[7]; and posted on online recovery sites. Figure 1 shows the poster that was used. Women were given enough information to know what the study was about, who was conducting it and for what purpose, and to choose whether they fit the study criteria. In this sense, they performed the process of self-selection.

[7] Recovery cafes are spaces where people recovering from addiction and family members can access peer support, share experiences and in some areas, provide information and support around benefits, employment, and up/re-skilling and so on.

Figure 1 Study Poster.



Women who chose to participate were included if they met the following criteria: 1) women with a history of illicit drug use; 2) self-identified as in recovery from drug use (abstinent or low risk use[8]) and 3) were 35 years old or older. Participants were excluded if: 1) they said they did not meet the inclusion criteria; 2) identified as having mental ill health or other issues that might trigger distress during the interview or 3) were non-English speakers. In the event, one woman was excluded as she was in recovery from alcohol use and another because her recovery was from over-the-counter and prescription drug use. Neither had engaged in illicit drug use.

[8] 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)

4.4.1.2 Recruitment

Applying for ethical approval, I anticipated recruiting 15 to 25 women to the study between July 2018 and July 2019. In the event, 19 women participated in the study and they are introduced to the reader in chapter 5. The sample size was chosen to reflect the anticipated challenges of recruiting older women with a history of drug use (Moxon and Waters, 2018). Although recruitment was largely opportunistic in the sense that the participants were not purposively sampled, there was an attempt to ensure the views of women from different geographical areas were included to minimise the clustering of participants from predominantly urban areas in the West of Scotland. For example, I contacted voluntary and other non-statutory organisations working with women who have used drugs in Fife on the East coast of Scotland, Banff in the far north area of Moray, Aberdeenshire, the Highlands, Oban, and in the South of Scotland, Dumfries and Galloway. All of these areas are rural or semi-rural. Recruiting from these areas met with varying degrees of success and as a consequence, women were recruited from the North, West and East of Scotland and the North East of England from a range of rural, semi-rural and urban areas. Recruitment for studies that explore the views of PWUD in the UK frequently focuses on treatment and support services in urban areas, consequently, the voices of women from rural areas are heard less often (Vivancos et al, 2006; Tolland, Kouimtsidis & Reynolds, 2003). Therefore, women from semi-rural and rural areas were included in this study to explore their experiences of recovery in geographically different environments. Efforts to recruit women from the southern counties of Scotland were unsuccessful despite contacting 14 service providers, initially cascaded through one gatekeeper and then followed up by myself. Three services in Dumfries and Galloway responded but had no clients who fitted the participant criteria.

The women who did participate were recruited via former colleagues I had worked with and contacts made at subsequent meetings throughout the fieldwork period. For example, I met the first participant Jennifer at a research group meeting in early 2018. We talked about our respective work and she offered to participate in the study without any prompt from myself. Following ethical approval a few months later, I contacted Jennifer to see if she would still be

interested in participating. I likewise met a worker who suggested one of her clients might be interested in the study and another woman from a recovery café, both of whom I had met during the MRes dissertation pilot study for this work in 2017 (Shaw, 2017). Both were contacted in 2018, agreed to participate and were interviewed. Third-sector support services and recovery networks were contacted to advertise the study and identify potential participants with varying results. For instance, two contacts had large networks of associates through their social media accounts. Moreover, both are very active and well regarded within the recovery communities. Through these communities I was able to recruit and interview eight women. Women contacted me directly via email or phone and if they indicated an interest in the study were given a participant information sheet, verbal information and the opportunity to ask any questions. The women were given time to consider their involvement and if they agreed to take part, an interview was arranged at a time and place convenient to them. Ten women chose their home as the location for the interview; five were interviewed on their work premises; and, four chose to come to my university office. Each interview was carried out in a private space.

4.4.2 Data Collection Procedure

This section outlines the procedures for collecting participant data for the study. It describes the development of, and rationale for the topic guide, the use of object elicitation methods, the interview process including reflections on the interviews and some of the challenges encountered during the fieldwork period.

4.4.2.1 Topic Guide

As noted, the topic guide for this thesis was piloted and developed through work carried out during the MRes dissertation study (Shaw, 2017). Influenced by the work of Miriam Boeri (2013) and her life history approach, the initial questions in the MRes dissertation study were guided by the work of Dan McAdam's life-history topic guide (McAdam, 2013) . An amendment to the MRes study's ethical approval was later sought to help focus more on relationships. The changes

allowed for a more natural conversation although in the final analysis both guides produced important data on the women's relationships, health and treatment experiences. The revised MRes topic guide can be viewed in Appendix 3. The advantage of being able to pilot the topic guide for this PhD study was that it helped me hone the questions, identify challenges in the interview process, and follow up areas of further interest. For example, the pilot study interviews raised interesting findings around resolving relationships with elderly mothers, siblings and adult children (Shaw, 2017). In contrast to other studies on drug-using women, intimate partner relationships were not the central focus of their narratives (Engstrom, El-Bassell & Gilbert, 2008; Rosen, 2004; Comfort et al, 2003). I wanted to see if this held true among a second cohort, hence the development of the first research question, what influence do social relationships have on women's sense of self as they age into drugs recovery? Developing the topic guide shown in Appendix 4 for this PhD study, I developed a looser structure to the questions around personal relationships. I brought in more opportunities for the women to discuss the professional/statutory and other therapeutic relationships that they experienced through their periods of drug use and recovery, thereby giving room for discussion relating to the women's views on the therapeutic landscape available to them and potential facilitators and barriers to their recovery.

The advantage of piloting questions during the MRes dissertation study was that I was able to develop a more effective set of questions around bodies and health for the PhD. During the MRes dissertation study I had introduced the topic of health with varying degrees of success, asking women directly 'Can you tell me about any changes to your health as you've stopped using?' and prompting them to discuss their mental and physical health as well as what they thought about their own body image. Health and body image was sometimes raised spontaneously with the women sharing their thoughts during the course of the interviews. However, when I asked them directly about body image or the perimenopause/menopause, the women seemed surprised, embarrassed, or reluctant to answer. I had misjudged the ease with which I thought women would engage in this topic. Asking some participants directly about their bodies can be sensitive and personal (Cunningham-Burley & Backett-Milburn, 1998; p.145). People may find it difficult

to talk about their bodies because they do not have the language to express themselves. In Tulle's research on runners, focusing the questions on training, injuries and body maintenance in the first instance helped to facilitate a discussion of the body.[9] Reviewing the responses to the pilot questions, the findings provided some data on the women's mental and physical health symptoms and diagnoses but far less on how they experienced their ageing bodies in recovery and very little on their interactions with the therapeutic landscapes available to them. To resolve the challenge of helping women feel comfortable to talk about their bodies in recovery, adapting questions from previous studies with older women gave me the confidence to prompt the women to discuss appearance and the corporeal aspects of ageing (Liechty, 2012; Hofmeier, Runfola, Sala et al, 2017). The opening health question moved from the piloted question '*Can you tell me about any changes to your health as you've stopped using?'* to the more open *'How is your health today? How does it compare to when you were in your twenties?'* Asking about health less directly did promote discussion around the ageing body without my perceiving any sense of participant discomfort or reticence. Nevertheless, as interviews progressed the question became less prescriptive and I simply asked '*tell me about your health?'* In line with the methodological approach adopted for the PhD, it was important the women were able to construct their narratives around health from their particular standpoint and that they were not led down paths of enquiry that *extracted* rather than *constructed* data through the interview process. To this end, the more open health-related questions of this PhD study helped me and the women to develop a conversation about bodies, ageing and health that was more nuanced and detailed than those I had with the women in the MRes dissertation study and went some way to answering the PhD research question, *how do older women with a history of problem drug use experience their bodies in recovery?*

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[9] Tulle, E, *Life history research – how history shapes lives.* Scottish Graduate Summer School. 19th June 2018: University of Edinburgh

4.4.2.2 Object Data Collection

Piloted in the MREs dissertation study and repeated in this thesis, was the use of object-elicitation methods. Object-elicitation methods (OEM) have been used in a number of health-related studies with adults and entail asking participants to choose and discuss a personal object that is meaningful to them (Fenton, 2017; Willig, 2016; Romano, McKay and Bodell, 2012). Using object-elicitation is a collaborative process and can help build rapport between the participant and researcher. For example, the participant and researcher can engage in co-construction of a photographic image of the object (Romano, McKay and Bodell, 2012). In line then with the methodological approach, participants were asked to identify, bring along and discuss an object that was meaningful to them. The women then decided how they would like the object to be photographed. All the women decided to hold the objects in their hands while I took the photograph. While I wanted the women to have control over this process, there were two occasions where I had to ask the women to cover an identifying feature of their objects. My aim was to explore the meanings the women might give to their objects, anticipating perhaps a richer and deeper understanding of the values they embrace as women in mid-life with a history of drug use.

The women were invited to '*bring along to the interview an object that has special meaning to you – an object that represents how you feel about yourself or is important in other ways.'* The invitation was framed in this way to allow the women to choose the object based on what was significant to them rather than focusing specifically on an area which may have had less importance or constrained their responses to a particular sphere of interest, such as recovery. The object and meanings given to it were then discussed during the interview. The technique has the advantage of avoiding interviewer bias and minimising socially preferred responses (Emmison and Smith, 2000) by allowing participants the freedom to reveal insights about themselves that might otherwise not be captured in a structured or semi-structured interview. Similar to Shinebourne and Smith (2011) who used a combination of drawings and interviews with women in recovery from drug use, I was aware that participants with a history of treatment and recovery communities or self-help groups may describe their experiences in the language of

those groups. In AA for example, 'old timers may tell polished, hour long stories – months and years in the making – of their lives as alcoholics' (Lave and Wenger, 1991: p.80). The OEM data from the pilot study provided a rich and deep understanding of the women's self-perceptions through drug use and recovery and proved to be an aspect of the interview that the women enjoyed engaging in. The success of this approach determined its use in this thesis. Most of the women chose one object. Lorna chose two, four women chose not to identify an object and Ruth sent a photograph of her object with a piece of writing describing its meaning several weeks after the interview had been conducted. The use of OEM provided a collaborative opportunity to explore the memories, images and meanings women gave to their objects, and how the women's objects reinforced their sense of self. Further detail on OEM, descriptions and analysis of the objects is provided in chapter five.

4.4.2.3 Interviewing

'If you want to know how people understand their world and their life, why not talk to them?' says Kvale (1996: p.1). I chose an in-depth qualitative interview method in order to understand how women make sense of their relationships and health in recovery. Interviews are 'construction sites of knowledge', an 'interchange of views between two persons conversing about a theme of mutual interest' (Kvale, 1996; p.14). In-depth interviews allow for a combination of structure and flexibility (Skinner, 2012; Ritchie & Lewis, 2003) that structured quantitative surveys alone cannot replicate. In contrast to a structured interview, one that is qualitatively in-depth allows the interviewee and researcher to explore areas of interest that may come up during the course of the discussion, thus allowing a change of direction that might illuminate an area of interest *not* anticipated by the researcher or participant. Furthermore, they allow the researcher to explore topics of interest pertinent to the study, use probing techniques to reach a better understanding of responses, and respond to topics that might arise from the discussion. Other key features include collecting data from the interaction between researcher and participant, and the thoughts, emotions and knowledge that participants may not have explored before (Ritchie

and Lewis, 2003: pp. 141-142). For example, Kate (interview 11) when recalling her mother said:

> *K: I was going to see my mum for the first time in years and she got out the car_and_she, we just sort of looked at each other and it was 'you've got to mean it this time.' 'I do.' And we just sort of fell into each other's arms really. [A: Hmhm] I've never talked about that you know.*
>
> *A: Well I feel honoured, thank you. [K: oh]. Are you okay talking about it [K: yeah, yeah]_ _*

This excerpt shows how recalling past events might raise hitherto unexplored thoughts and feelings. Furthermore it demonstrates how the researcher should remain aware of the potential emotions that might arise from these recollections and allow space for the participant to develop their thoughts or withdraw from that particular line, if they so wish.

Feminist methods have traditionally taken a qualitative approach to data collection, rejecting the positivist approaches that emphasise objectivity and detachment, arguing instead for a more egalitarian, open and active process between researcher and participant (Skinner, 2012; Kvale, 1996; Lincoln and Denzin, 2003; DeVault, 1990; Oakley 1981). Anne Oakley (1981) effectively argued that it is impossible for the researcher to separate themselves from the interview process and the participant with whom they are engaging. Participants are sometimes as curious about us as we are of them. Sometimes they seek confirmation of their views or information they think we might have. To not respond openly is to set up a barrier between researcher and participant. As Oakley succinctly states 'the masculinity of the "proper" interview is to observe that a sociology of feelings and emotion does not exist.' (Oakley, 1981: p.251). Quite often, I have found that the conversations following interviews, when the recorder is switched off, have revealed further insights. For example, following one of the interviews, the participant revealed additional information on something she spoke about during the interview. I sensed the participant felt embarrassed and attempting to reduce any unease, I spoke about my experiences on the same topic. In this regard, reciprocity during or following the interview

might be regarded as self-indulgent 'sharing' but self-disclosure is a way of building a more sensitive and empathic relationship with participants (Grant, 2014; Harris, 2009; Harding, 1987; Oakley, 1981). Moreover, sharing information can reduce the power imbalance in interview situations (Grant, 2014). Of course, this is not advocated in all circumstances and judgement calls are required. Eighteen years' research and interview experience though informs any decisions about self-disclosure.

The question of how to handle participant information after the recording has stopped is challenging. My practice is to omit this data from any formal analysis, viewing it as a private conversation which the participant has not given consent to use. However, making notes of what we see, feel and hear are *crucial* for developing the analysis through all its stages (Silverman, 2000). Recording these details and referring back to them through the analysis and writing-up period can sometimes help resolve any discrepancies or inconsistencies in the participants' narratives which can then be resolved through re-analysis, explanation or omission if appropriate. Despite attempting to reduce the power differential that is inherent in the interview process through self-disclosure and omission of unrecorded data, and striving to obtain a more egalitarian approach, I acknowledge the interview process is not one of equal partners (Kvale, 1996). I do in fact have a greater degree of control in terms of the direction of the interviews than the participant does. Nevertheless, utilising a narrative approach to explore the meanings and understandings the women gave to their experiences enabled them to tell their 'story' from their particular standpoint. Consequently, the analytical method is inductive, allowing the themes that were important to the women to be identified and brought to the fore.

4.5 Managing the Data

Analysis begins from the moment the data are collected with participants, including taking fieldnotes from first contact through to post-interview and on-going note-taking during the transcribing phase. In this section, a reflexive consideration of the transcribing process is described followed by a critical discussion of the analytical and coding method adopted.

4.5.1 Transcription

There is general consensus in the literature that transcription involves interpretation and representation (Davidson, 2009) yet it is also generally agreed that too little attention has been given to the transcription process itself (Davidson, 2009; Bucholtz, 2007; Duff & Roberts, 1997; Green, Franquiz & Dixon, 1997; DeVault, 1990). Transcribing has been described as a political and situated act embedded in disciplinary conventions and concepts (Bucholtz, 2000; Duff & Roberts, 1997; Green et al, 1997). Transcription as an analytical tool is text that 're-presents an event and is data constructed by a researcher for a particular purpose' (Green et al, p.172-3). The researcher as transcriber is engaged in an embodied act. The researcher is not absent. They are implicated in the interview and in the very act of translating that interview into text.

Communicating what is said in an interview requires interpretation of the data collected. In this respect, interpreting what is said requires decisions about content. What is transcribed? What aspects of the data are selected and organised? As researcher and transcriber I am in a position of power – I can alter the tone of conversation by omitting words. I can make myself appear more articulate than I am by leaving out the 'ums', 'ers', nervous laughter and of course, the garbled questions. We choose the segments of talk to transcribe and that we deem significant to the research. This however must be interpreted from 'some point of view whose view is then chosen' (Green et al, 1997: p.173): the researcher's outsider perspective and goals, or the participant's insider perspective and goals? The researcher must also engage in an interpretive process when signalling silences, for these might be meaningful pauses rather than absence of talk. Should the researcher choose to re-present laughter or the ums and ers that pepper people's conversations and how should these be interpreted? DeVault suggests standard transcribing practice that smooths out respondents' talk is one way that women's words are distorted (1990: p.107). It is often a way of discounting and ignoring those parts of women's experience that are not easily expressed. For example, when participant speech is peppered with *'you know'*, this might reflect less a participant's ability to articulate themselves than perhaps the working through of thoughts and feelings or a request for understanding (DeVault, 1990:

p.103). Transcribing requires interpretation and the researcher must engage in an interpretive process that is reflexive, honest and respectful.

Transcription is also representational and partial (Bucholtz, 1997; 2000). How is an interview transcribed and what decisions do we make about its form? For example, do we use block paragraphs of speech, indicating with pseudonyms each speaker? Or do we use columns of speakers? How for example, do we ensure the nuanced details that might show the (co)construction of the narratives, for example when talk overlaps or obstruction occurs as one speaker interrupts another (Bucholtz, 2007: p.788). Nor is everything recorded: for example, non-verbal interactions. Field notes though, can supplement what is not digitally recorded and decisions will be made to expand or make clear aspects of verbal interaction that require it. Transcription is also about linguistic representation (Bucholtz, 2007). However, while this is a non-linguistic study that is more concerned with discourse content rather than discourse structure, I did consider whether to use standard or non-standard English. My decision was for interviews to be transcribed in vernacular /non-standard English. My participants are mainly Scottish and to turn their speech into Standard English is, in my view, culturally insensitive and inauthentic. Furthermore, it can be revealing to capture pronunciation or culturally specific words that indicate emphasis in particular parts of speech. I have used an on-line Scots and urban dictionary to provide consistency in translation and spelling. Having lived in Scotland three decades I am aware there might be a need to translate what is heard for readers unfamiliar with Scots. For example, Ellen (age 50, recovery 6 months) said

> *'I wouldn't inject. It gives me the **Boak** just thinking about it. Ooh. Ooh even the smell of it gives me the **heebies**.'*

In this instance, '*boak*' means 'to retch or vomit'[10] and '*the heebies*' derives from the term 'the heebie-jeebies' meaning 'a feeling of minor fright, anxiety,

[10] Accessed from Scots Tongue: http://www.cs.stir.ac.uk/~kjt/general/scots.html (Downloaded: 23//01/2020)

nervousness, apprehension.'[11] It is incumbent on me to translate those words that are unfamiliar to readers outside Scotland but as the transcriber it is easier to transcribe as I hear it on the recording. Having said this, I am also aware that an audience may make assumptions or judgements about speakers based on how their voices are represented (Bucholtz, 2007; 2000; Duff & Roberts, 1997). There is potential to inadvertently represent speakers as ignorant, ill-educated or inarticulate. People may find the use of non-standard English as stereotyping. But, much I think depends on how this is done and in what context. So, when there is a moment when someone is swearing or inarticulate, I indicate if they are angry or taking time to gather their thoughts. This is signalled in the text if an explanation is required. However this again needs to be balanced with the needs of the audience and the research question itself therefore, it is only done if it adds to (not detracts from) the analysis.

A further issue is that being English I automatically tend to write my own speech in Standard English despite having a strong West-country accent where, for example, the 'r' is emphasised and lengthened. When transcribing though, I don't reflect this. Without this accent, it could denote to a reader unintended social status differences. Transcribing my own false starts to questions, interruptions or laughter provides some balance to this and also an opportunity for me to reflect on my interview technique and areas to improve. Research though needs to balance readability, accuracy and representation (Duff & Roberts, 1997). The interviews are transcribed in non-standard English for reasons already discussed however in the final write-up and for publications, I will use standardised English, if and only if, this does not detract from the final analysis. Nonetheless, Table 1 outlines the transcribing conventions that I have used, indicating to the reader particular aspects of speech, bearing in mind the caveat that this is a transcription based on my hearing of the recording and someone else may pick up on different intonations, length of pauses etcetera.

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[11] Accessed from Urban Dictionary: https://www.urbandictionary.com/define.php?term=heebie%20jeebies (23/01/2020)

Table 1 Study transcript conventions

Symbol	Meaning
[*laughter, noise outside, coughs*]	Contextual details added by researcher
(_)	Short pause
(_ _)	Long pause
[?]	Unidentifiable speech
Underlined	Words that are emphasised
CAPITALISED	Speech that is loud
Wave underline	Speech that is quiet
'so I told her about… Can you tell me…	Overlaps – a vertical line shows words said spoken simultaneously
Word followed by / (e.g. diaz/ = diazepam)	/ indicates incomplete spoken word

While the 19 interviews were transcribed in the vernacular they were not entirely transcribed verbatim. That is, not all content from the women's narratives were transcribed. I omitted conversation that I considered irrelevant to the final analysis. For example, Terri talked at length about her children and while these relationships are important in terms of Terri's recovery an in-depth discussion of her children's occupations or the fact they live independently of Terri was not relevant to this study. Consequently, this segment of the interview was not transcribed. However I note this within the transcript, as shown in the following extract:

> *"[son 1] is 37, [son 2] coming up 30 and [daughter] she's 25. (T chats about children's occupations 24.16.03 – 25.45.13). So they've, I've pretty much tried to keep them in line ken. They've had their ups and downs and that could've led to pretty serious consequences like but they've managed to keep their heads above water and get on with their lives as well ken. They're all workers. They're all workers (chats about children all living independently 25.53.06 – 27.04.08)."* (Terri, age 59, recovery 10 years)

It could be argued that cutting dialogue from an interview might skew the tone of the interview or subsequent analysis. Also, something may be left out that could later be deemed important. However, as long as the transcript provides an accurate description of material cut from the interview, I think it is permissible to leave out content that is unrelated to the overall research question. This is particularly the case where interviews are lengthy and contain divergence from the research question. For example, the interview with Fiona was 150 minutes and

throughout the interview we took breaks for cigarettes and coffee. Whilst the recorder remained switched on Fiona spoke about her husband's family, their finances and their previous home. Furthermore, the family were in and out of the kitchen where we sat doing the interview and I had a hot flush toward the end of the interview. All this was on the tape but none of it was relevant to the overall research questions. As such, this incidental information is left out of the final transcript. Nevertheless, long interviews are not an excuse to take shortcuts on the transcription process. Evelyn's interview was four hours long and only identifiers (names and places) were edited out, everything else was transcribed.

I checked a sample of five transcripts against the recorded data for quality control to ensure they were trustworthy and in context when heard again. In addition, seventeen participants were given the opportunity to read through their transcripts. I had no direct way to contact Terri and Kerry without going through a third person, so maintaining their confidentiality was extremely important and consequently, their transcripts were not passed on for checking. Of the seventeen who were given the opportunity to read and check their transcripts, twelve took up the offer and five responded. Janine wanted her transcript but '*not for comment - it might be nice for [*son*] to have stored away in a file.'* The other four were positive although none verified their accuracy. Rather, the transcripts seem to have helped them put their recovery into some context and gave them a sense of achievement:

> *'Good morning April. Yeah we went to Newcastle too. It was a good day. I felt lighter after talking with you. I have been reading the transcript wow. I really opened up about a lot of stuff to you. I got emotional while reading some of it too. It came at the right time also as I've been struggling & believing that I'm not changing. Reading that made me see I have changed a lot & even changed from when we done the interview. You made it really easy to talk & I appreciate you for that. I bet that took ages to type up as well! We went through a lot! Hope you have a great day.'* (Claire, age 39, recovery 18 months)

> *'Wow that took a long time to read I actually feel really emotional reading it back thanks so much for forwarding it to me*.' (Kate, age 60, recovery 5½ years)

> *'Morning April, What a perfect view to read my life story, in the words of Fat Boy Slim 'I've come a long, long way baby'. Reading your transcript made me realise just how grateful I am. Life has certainly dealt me a few heavy blows and yet I'm still here. Loving life and being the best human bean that I can be.'* (Fiona, age 44, recovery 17 years)

> *'Thanks for sending it on. Jeez, I sniff, cough and say ehhh a lot. It was a bit weird reading that but strangely ok.' (*Maya, age 42, recovery 14 years)

Ensuring the women had the opportunity to check their transcripts was important to the methodological stance adopted and integral to the spirit of a feminist approach. That the women chose to be so generous with their time and words deserves reciprocation and in this sense my aim was to ensure their standpoint was accurately recorded and reflected.

4.5.2 Data Analysis and Coding

The analytical approach of this study is inductive although it is impossible to approach the data without any preconceived ideas of what themes or concepts might emerge from the raw data (Joffe, 2011; p.210). Nevertheless, an inductive analysis develops concepts and themes from the data and is an iterative process whereby the data are collected and analysed simultaneously (Bryman, 2016). Whilst grounded theory was considered, I chose thematic analysis as the technique for analysing data for the following reasons.

Thematic analysis is a flexible and useful heuristic device for managing and producing a detailed account of data and is widely used within qualitative drug-based research (De Maeyer, Vanderplasschen, Camfield, et al, 2011; Shannon, Kerr, Allinott, et al, 2008; Rhodes, Watts, Davies et al, 2007). The advantage of thematic analysis is its relatively simple yet robust analytical strategy. Braun and Clarke (2006) set out clearly defined instructions on how to carry out a thematic analysis of the data. Interview transcripts are coded thematically through six phases: familiarisation with the data, transcription, initial coding, searching for themes, reviewing themes, defining themes, and report writing. In contrast grounded theory requires similar processes but entails two time-consuming activities: line-by-line coding in which each line of a transcript is coded and

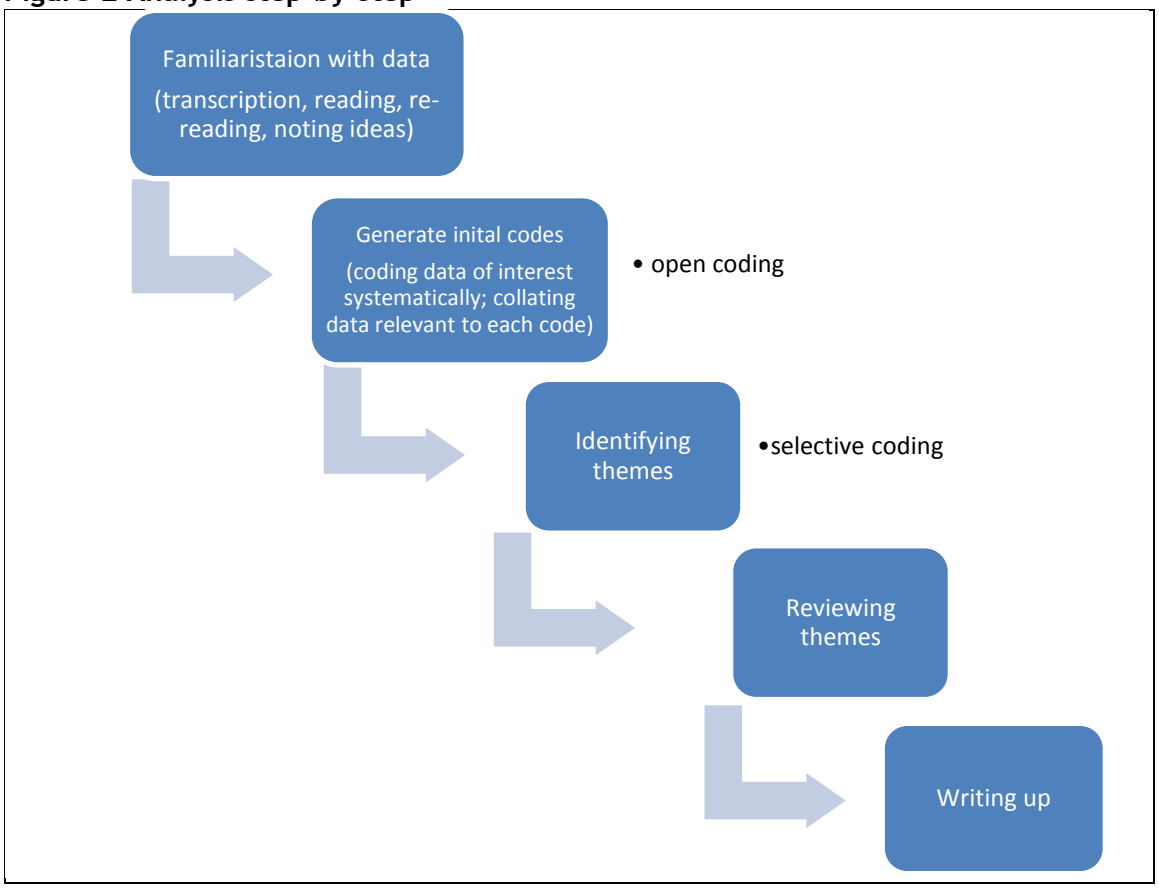
theoretical sampling, whereby participants are sought until theoretical saturation is reached and key issues in the research are explicitly defined (Charmaz, 1996). Borrowing however from grounded theory, the stages of open and selective coding provide a systematic approach to the development of themes while developing codes based on verbs instead of nouns focuses attention on the social processes in the data (Bryant, 2014) as shown in table 2.

Table 2 Coding stages

Data	Open Coding	Selective coding
I usually surround myself with the people that I've met since I got clean. Ehm…because they'll tell me straight if my thinking's off the wall. And they know the feelings of the fear and low self-esteem.	Surrounding self with others Relationships in recovery People being honest Safety Empathy from others	1. Belonging 2. Understanding 3. Feeling safe

Both methods comprise familiarisation with the data (transcribing by the researcher is highly recommended to achieve this), coding, developing themes, keeping memos (Charmaz, 1996) and notes (Braun and Clarke, 2006). The analytical process is set out in Figure 2. I used the qualitative software package NVivo 11 to code and categorise data from the 19 interviews. The use of computer software designed to handle large amounts of textual, visual and audio data is preferable to the large volume of data that is generated by multiple copies of 50 page transcripts.

Figure 2 Analysis step-by-step



Following each interview, notes were taken including how I thought it had progressed and any challenges or additional information I thought appropriate to remember for future information. Transcribed interviews were read through at least twice for familiarisation. At this stage, ideas about themes began to emerge and coding began to take shape. A theme is a unit of meaning that is observed in the data by the reader of the text and a code is a textual description of the semantic boundaries of a theme or component of a theme (Guest, MacQueen & Namey, 2014). It was following the transcription of the sixth interview (Fiona) that I started systematically generating the initial codes into a codebook. As an example, the top level theme of stigma was subdivided into three open codes and then selective codes as shown in table 3.

Table 3 Coding Example: Theme of Stigma

Open Code	Brief definition	Full Definition:	When to use:	When not to use:	Example:	Selective Coding
Felt Stigma (Scambler, 2004: p.35)	Stigma that is felt by the participant	Felt stigma refers to the shame and expectation of discrimination that prevents people from talking about their experiences and stops them seeking help.	Apply code when a participant talks about feeling they might be stigmatised or discriminated against by others. Also when they talk of feeling shame. And when this feeling stops them from seeking help.	Do not apply this code if participant is talking about stigma that is actually enacted by another or others toward the participant	*"The guilt and the shame of god, the guilt and the shame I felt from that was absolutely horrendous and I just think a part of that although I got caught up in this cycle of like constantly feeling guilty and shame, maybe that held me back a bit as well."* (Maya)	Feeling Stigmatised
Enacted Stigma (Scambler, 2004: p.35)	Behaviour that discriminates against a participant	Enacted stigma refers to the experience of unfair treatment by others	Apply code when a participant talks about actual instances of discrimination by another person	Do not apply this code if participant is talking about stigma that is felt rather than actually experienced as an actual discriminatory event	*"This practice nurse is still there now so if you need your bloods taken for anything, I'll go in and she'll say 'oh you've got no veins have you? Tried with you before, there you go there's the needle.' And I take my own blood at the doctors. She won't go near us."* (Gillian)	Being Stigmatised
Stigma Avoidance	Avoiding felt and enacted stigma	Participant actions avoidance of any stigmatising information about themselves and their drug-using past	Apply to actions taken to avoid stigmatising behaviours from others toward participant		*"I didn't want my kids to think badly of me. You know, so I would lie to them to make myself feel better or so they didn't find out or so they didn't look at me that way or judge me or. I never wanted them to look at me the way that doctor did."* (Grace)	Avoiding Stigma

From the initial coding of the top level themes, more codes were added as more transcripts were added to the file. Between August 2019 and October 2020, the NVivo file evolved through six versions as codes were refined, merged or added to, and transcripts were re-coded in light of these refinements. For example, the node 'relationships' held 20 child nodes at the end of coding in the first version and at version 6 (the final version) there were 28 child nodes. In version 4, the '*Health'* node was revised with further refinement and ditto in version 5 for the node '*Control'*. One of the challenges of thematic analysis is that I sometimes found it difficult to 'see the wood for the trees'. Looking back at my research diary, I make note to:

> '*Go back to the women's narratives and look at their stories in the whole. In terms of analysis, I need to look at the women's narrative in the round. I've been pulling out chunks of coded transcript – looking at it within in its near context within the text. I need though to look at these narrow texts in relation to the whole.'* (Research Diary, 25.05.2020)

Returning to the transcripts and reading each as a whole meant there was a wider frame of reference when exploring coded segments of text. For example, discussions on childhood events early in an interview shone a light on some of the discussions around relationships later in the interview. Reminding myself of the women's stories in the round was important in shaping the findings presented in the following chapters.

4.6 Reflexivity

Reflexivity in research requires the researcher to be 'cognitive of [their] role and position as it affects [their] understanding in the research process' (Grant, 2014: p.2). Our background and life histories play a role in the research process. In the interviews, I expected my age and gender to be an advantage as I was at that point in the research process, a 52 year old woman. I have worked in substance use research for almost 20 years and as I have aged so have a seemingly larger proportion of the people I have been interviewing for different projects over the years. I have sympathy and empathy for PWUD that experience social problems which comes from my professional and personal encounters. My age and gender

was an advantage in terms of having some understanding of the bodily changes that mid-life women experience and helped overcome some of the challenges associated with discussing the body, as mentioned earlier. Reflexivity then is built into this project, from my own personal understandings of drug use, through questioning my motivations for undertaking this thesis, diaries kept throughout the PhD process, fieldnotes that detail pre- and post-interview descriptions, thoughts and feelings. As Shaw (2010) declares:

> *'By engaging in reflexivity, that is, proactively exploring our self at the start of our research enquiry, we can enter into a dialogue with participants and use each participant's presentation of self to help revise our fore-understanding and come to make sense of the phenomenon anew.'* (Shaw, 2010: p.6)

4.6.1 Interview challenges

Conducting interviews with people who have experienced complications associated with their use of drugs has inherent challenges. To begin with, the topics explored are often sensitive in nature and examine what has been termed the 'intimate sphere' (Birch & Miller, 2000). For example, I have conducted interviews on topics such as drug overdoses (Rome, Shaw & Boyle, 2008), and injecting practices and sex behaviours (Gilchrist et al, 2016; Gilchrist et al, 2017). Interviews with women who use drugs often contain accounts of physical and sexual violence. The challenge then, is to provide an opportunity for participants to talk through these experiences while at the same time remaining aware of the impact this may have on the participant once the interview is over. As Birch and Miller (2000) have discussed, the qualitative interview can also become a site of therapeutic practice – without the intention of the researcher. Both sites of practice entail

> *'…acts of self-disclosure, the revealing of intimate personal meanings in the presence of a listener'* (Birch and Miller, 2000: p.190).

Participants may not intend to treat the interview as a therapy session but afforded an occasion to talk and be listened to, outside of their usual social circles, participants sometimes find the interview an opportunity to reflect upon

and talk about what is felt on a deeper level. Reading back through my fieldnotes I came across these comments from Maya (via email) and Claire (via text):

> *"Hi April. Just want to say it was nice to spend time with you yesterday although it was a bit surreal, almost like spending time in therapy."* *(*Maya, age 42, recovery 14 years)

> "*Good morning April…It was a good day. I felt lighter after talking with you."* (Claire, age 39, recovery 18 months)

Recognising that deep reflection by participants may occur both during and following an interview, the researcher must be prepared to engage sympathetically and non-judgementally. They must also be aware of the need to access other forms of support or professional help if they think the participant requires it. Importantly though, the researcher must be reflexive in these encounters and not exploit or manipulate participants into revealing events, thoughts, feelings they might later regret by positing themselves as a quasi-therapist (Kvale, 2006: p.482).

There is also the issue of responding to one's own feelings. For example, the penultimate interview in this study (conducted with Terri, age 59, recovery 10 years) instigated a feeling of anger in me that I think I controlled but still expressed in my response to her telling of events. By the time of Terri's interview, I had heard stories of sexual, physical, psychological violence and in this 18th interview, I felt really angry on Terri's behalf and all the women that I had spoken to over the years. Terri was talking about her daughter being lesbian and not having children, she was '*bothered*' by this, '*felt*' she (Terri), had contributed to '*this*'. I wanted her to know that none of the guilt she felt was her responsibility:

> *Terri: Oh god, ken…just partly what does bother me is _ I feel I've contributed to the fact that she's maybe not wanting a relationship wi a man because eh of everything I've been through wi men, ken that's the only thing. And I keep saying to myself I wouldnae like to think I'm stopping her having this.*

> *April: Can I just stop you there? I shouldn't be saying this because I am just here as a researcher right [Hmhm] but none of that is your fault [no]. None of that is anything to do with you or it being your fault [Hmhm]. That's the men [aye]. Know what I mean?*

Looking back at the transcript, it reads like I am overstepping my role as the researcher but at the time, I wanted Terri to know that she should not feel guilty; her daughter's decisions were her own and influenced by the men in her life not her mother. In the memo following the interview, I note in relation to my comments to Terri:

> *"I think I was overwhelmed by the number of women who had been on the recovering end of bullshit from men and I wanted her (Terri) to know she wasn't in the wrong. At all."*

Achieving a balance is difficult when conducting interviews with people whose histories may contain traumatic events or regretful behaviours. In the following extract, Kate expresses regret at how she has lived her life and I respond in what was meant to be a comforting way but ended up sounding trite:

> *Kate: …looking back its most of my life. Where's my life gone? I want my life [chuckles]*
>
> *April: yeah. Is that how you feel like, like you've missed out on a large part*
>
> *Kate: oh yeah definitely. Definitely.*
>
> *April: how does that make you feel?*
>
> *Kate: sad. I wish I could go through my kids growing up again, you know. I wish I could_ _ _ yeah it's just sad_ _*
>
> *April: but then you had to go through that to get to where you're at now (0.49.30)*
>
> *Kate: I know but I actually said to someone the other day 'I am so sick of hearing that I have to go through all that. I had to go through everything or I wouldn't be the person I am today so I'm happy with it.' What a load of bolloks*
>
> *April: right okay, I take that back.*
>
> *Kate: I had a son who died. I had a daughter who died. I had a child that was adopted. I missed half my kids growing up. I got with men who were really, into really bad relationships. No I wouldn't go through it all again given half a chance. I wouldn't would I? I don't you know, I am an addict and I'm, grateful that I'm in recovery but I'd have been even more grateful if I hadn't been an addict at all. If I'd left school and gone to university and married and had my children and. Some people say it's boring but I think it sounds like bliss. Oh sorry, I'm going on.*

> *April: no, no, no it's fine, carry on if you want to. I'm sorry if I offended you there by saying that (0.51.45)*
>
> *Kate: No I'm not offended at all, no. I just got on my soapbox a bit.* (Kate, age 60, recovery 5½ years)

Attempting to comfort a participant who reveals regret or remorse is not in itself wrong but clearly, as shown in my interaction with Kate, it can sometimes be misplaced. I am not aware I have used the phrase '*but then you had to go through that to get to where you're at now*' prior to Kate and if I have I certainly had not had the same reaction. Nevertheless, I was embarrassed at myself for saying it, apologised to Kate and did not repeat it again (and for future reference would not). Following Kate's interview and re-analysing Jennifer's transcript, I came across the following passage in which Jennifer said:

> *"It's terrible isn't it? But I do see that my past has made me who I am today and I like who I am today. So that makes it feel alright. Makes it feel like it was all, not worthwhile, but that something positive has come out of it."* (Jennifer, age 44, recovery 10½ years)

Jennifer was the first woman I interviewed, Kate was the eleventh. Looking back, I wonder whether I remembered this phrase at a sub-conscious level and repeated it. I cannot be sure but this example demonstrates that even with the experience of conducting hundreds of interviews, it is still possible to learn important lessons from our encounters and interactions with participants during each interview process. Reviewing my research diary, I noted the dilemmas around probing participants for further information that I encountered through the fieldwork period. I wrote:

> *'Should I have probed the women's backgrounds during their drug using days more robustly? I let them tell me as much or as little as they wanted. Remember Gillian, raped by a [authority figure]…Evelyn was on Valium from the age of 13 – why? I didn't explore this but then I didn't want to open up something that might be traumatic for her. She later in the interview talks about difficulties in discussing certain things with her partner. Doesn't want to open a can of worms with him. Also Kerry who had Asperger's, bullied from young age, has had a lot of mental health problems, daughters in care etc – I didn't want to press any of the women about their past. They could open up to me if they wanted. Some did, some didn't. Was that wrong? I don't think so. I was interviewing women in their homes. Most had had mental health problems. Most were on their own. I couldn't*

> *leave them with traumatic memories resurfaced? I think I was right not to even though it means I can't be entirely sure what kinds of trauma they experienced. Isn't it enough to know that there was trauma – do we always have to be specific? For an example of why it's not always appropriate to probe see page 46 of Evelyn's transcript (recording time around 3.36.00 – 3.38.00) and why she couldn't identify and talk about a meaningful object.'* (Research Diary 30.04.2019)

Besides the 'therapeutic' challenges that occurred, there were two interviews that were difficult for entirely different reasons. Kerry informed me during the interview that she had been diagnosed with Asperger's. I have no experience or knowledge of Asperger's or autism but I felt before Kerry told me this that there was something different from the usual interview. For example, there was very little eye contact and no deviations from the questions. Answers were straightforward and direct. No metaphors to illustrate a point, rambling or skirting around a question. The only time Kerry spoke more openly (for example without a direct question or prompts) was when she talked about her object, a childhood soft toy. Ellen on the other hand was bi-polar and focussed on one topic only, her relationships with GPs. Despite asking questions about other relationships, she kept returning to this one area. Probing for further responses with both Kerry and Ellen was not productive and in line with the feminist methodological stance of this study, both maintained control over the topics they wished to discuss. Indeed, throughout all the interviews I was conscious that together we were constructing a narrative but from my perspective, my role was to facilitate not lead on that co-construction.

4.7 Conclusion

This study aims to be methodologically reflexive and as a researcher in this area for almost two decades I am aware of the challenges that are characteristic of research with hard-to-reach groups. Adopting a feminist stance provides a clear approach that informs this area of study directly from the 'standpoint' of the women themselves while the qualitative methods chosen sit firmly within the theoretical position undertaken. Convenience sampling and self-selection within

the parameters of criteria for eligibility enabled a sample of nineteen women from a range of backgrounds and areas across the north of England and Scotland. Semi-structured interviews alongside the use of objects facilitated the women to narrate their recovery stories on their own terms. The transcribing process was carried out with care and reflects the women's interviews as closely as is possible with some editing out of sections of narratives that I felt were extraneous to the overarching themes being discussed. Familiarisation with the interviews allowed an inductive coding approach with a thematic analysis of the women's narratives. Ethical approval and considerations were paramount to this study, given the sensitive nature of the enquiry and it is hoped this chapter provides a reflexive and considered account of the methods used to shape this study.

Next in chapter five, the women are presented to the reader through a discussion of their meaningful objects. After this, the following chapters will lead the reader through the women's narratives highlighting the key issues raised by the women in relation to their relationships and health in recovery from substance use.

Chapter 5: Introducing the Women and their Meaningful Objects

"I just carry them about with me and I see it as Mary's there with me helping me through my recovery." (Sara, age 44)

Chapter Overview

In this chapter the women are introduced to the reader through their meaningful objects. The chapter begins with an introduction to the women followed by a short discussion on the object elicitation method and analysis. The third substantive section engages with the women's object narratives. It is in this section that the women's voices are first presented to the reader. We hear from their standpoint, the meanings conveyed through their objects (or absence of) and the ways in which their objects act as ways of doing, being and becoming. It is this section that foregrounds the values and attributes the women hold important and helps sustain their recovery. Chapter five concludes with a summary of the findings and reflects on the efficacy of this method.

5.1 Introducing the Women

Nineteen women with a history of using illicit drugs and recovery participated in the study. The women were aged between 36 and 60 years with a mean average age of 47 years. The women resided in a mix of urban (N=10), rural (N=6) and coastal locations (N=3) across the North East of England and Scotland. Fifteen women were early onset users, starting drug use in their teens and early twenties. The earliest reported drug use was Kate at age seven, stealing pills from her mother. Four women were late onset users, starting in their late twenties and early thirties, the age at which others were maturing out of their drug use. The participants used a range of drugs including heroin, cocaine, crack-cocaine and skunk weed[12] between 7 and 47 years, with mean average length of time 21 years.

[12] Oxford English Dictionary (2020) Originally: a potent strong-smelling strain of the cannabis plant; (now chiefly) any of a number of especially potent strains of cannabis; Skunk contains a high

Kate, as the oldest woman at 60 and the earliest to start using drugs had the longest duration of drug use while Fiona aged 44, had the shortest duration at seven years. Apart from Kate who started using drugs in the 1970s, most of the women began experimenting with drugs during the 1980s and 1990s, starting mainly with cannabis and MDMA, and moving on to heroin and cocaine. Some of the women spoke about their involvement in the dance scene of the 1990s where they started using MDMA/ecstasy, later moving on to opiates and/or cocaine but most did not mention engaging with any subcultural movements.

The mean average age at which the women gave up drug use because it had become too challenging to maintain was 34 years old, ranging between 26 years and 54 years of age. Six of the 19 women had, in Winick's (1962) terms, 'matured out' of their drug use by the age of 30; five stopped using in their thirties; six stopped in their forties, and two in their fifties. The women described themselves as in recovery (N=12), recovered or in recovery and using drugs recreationally (N=3), beyond recovery (N=3) and stable on prescribed methadone (N=1). The mean average time in recovery from substance use was 9 years and ranged from 6 months to 18 years. Recreational drug use included intermittent use of cocaine, cannabis and alcohol (Maya), amphetamines (Jane) and heroin (Ellen).

Jane was the only woman not to have children. Among the remaining women, four had children who were looked after by grandparents or taken into care. Just over half (N=10) reported being in a romantic relationship at time of interview (in fact, Jennifer got married a few weeks after her interview), the remainder were single. Though not asked, some of the women described their backgrounds as working class (N=3) and middle-class (N=2). At interview, nine women were in paid employment, seven volunteered their time and skills (five of those in recovery groups), one woman attended college, one woman was not in employment but considering Open University; and one had recently given birth and

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concentration of THC (tetrahydrocannabinol), the principal narcotic component of cannabis.: Accessed from https://www-oed-com Downloaded: 27/10/2020

was considering future employment in elderly care. Table 1 shows the demographic profile of the participants.

Table 4 Participant profile.

Pseudonym	Age	Age started using Opiates/opioids	Length time Drug Use	Main Drugs	Self-reported Recovery Status	Time in recovery (years)	Locations
Jennifer	44	15	18	Heroin	Beyond	10½	Urban
Lorna	53	early teens	22	Heroin	In recovery	18	Rural Town
Kate	60	7	47	Heroin, Alcohol, Pills	In recovery	5½	Urban
Claire	39	teens	22	Heroin, Crack	In recovery	1½	Village
Evelyn	38	13	23	Heroin, Crack, Pills	In recovery	3	Urban
Kerry	43	17	21	Cannabis, Amphetamines, Heroin	stable on methadone	5	Rural Town
Ellen	50	30	19	Heroin	In recovery & recreational use	6 months	Village
Jane	39	14	25	Heroin, Alcohol, Amphetamines	In recovery & recreational use	15 yr alcohol free	Coastal Town
Terri	59	29	20	Heroin	In recovery	10	Coastal Town
Shona	60	28	20	Heroin	In recovery	12	Coastal Town
Nina	55	late 20s	14	Heroin, Crack	In recovery	12½	Rural Town
Janine	47	11	15	Alcohol, Poly-Drug use	In recovery	21	Urban
Maya	42	17	11	Heroin	Recovered & recreational use	14	Urban
Sophie	55	25	25	Alcohol, Pills	In recovery	5	Urban
Gillian	40	14	16	Heroin, Crack	Beyond	10	Urban
Fiona	44	20	7	Heroin, Crack	Beyond	17	Urban
Grace	49	15	29	Cocaine, Skunk weed	In recovery	5	Rural Town
Ruth	36	11	15	Heroin	In recovery	10	Urban
Sara	44	14	28	Cocaine	In recovery	1½	Urban

5.2 Their Meaningful Objects

This section begins with a brief introduction to the meaning of objects, followed by a description of the method and analytical stages involved in this aspect of the interview. As noted in chapter four, this method was chosen because it is one that gives women who have a history of engagement with drug treatment and health services an opportunity to present and discuss an aspect of importance in their life in a relatively spontaneous fashion and of their own choosing. As an approach, it is grounded in the feminist research principles of the co-production of knowledge between participant and researcher. It is through the discussion of their meaningful objects that knowledge is co-produced and fundamentally, led by the participants.

5.2.1 Introduction

Objects that hold a special meaning for people are more than functional – they evoke emotions and provide owners with a sense of comfort, pleasure, attachment or well-being (Kroger & Adair, 2008). They entail a temporal aspect, functioning as symbolic links to past events, the self in previous life phases and future selves (Romano MacKay and Bodell, 2012; Kroger & Adair, 2008; Digby, 2006; Belk, 1988). Adopting a social constructionist approach, objects express the instrumental and symbolic expressions of their owner's personal and social identity, reflecting their values and belief systems (Dittmar, 1989: p.160). During periods of loss, especially for those in later life, objects and possessions may 'signify and anchor an individual's sense of personal identity' (Kroger & Adair, 2008: p.6). Belk describes how objects are a major contributor to our 'extended self'(1988: p.140). In this analysis, the extended self includes self plus possessions (Belk, 1988: p.140). Conversely, if we construct a sense of self through our possessions, the loss of them can signify a 'lost sense of self' (Belk, p.143). People who use drugs often talk about possessions they have pawned, lost or had stolen. Loss of possessions and meaningful objects can result in 'identity deprivation' (Belk p.148) and a lost sense of security (Digby, 2006). The use of object-elicitation methods (OEM) in this study provides a collaborative opportunity in

which the women and I explore the memories and meanings they give to their objects. The aim of this chapter is to examine the following questions:

- What are the objects and what meanings do the women give to them?
- What, if anything, is the common thread running through the objects?
- What role, if any, do objects play in the women's recoveries?

Before answering however, a short description of the method, the objects and data analysis is provided in the next section.

5.2.2. Method

Of the 19 participants, 13 brought an object that was photographed by me; two spoke about an object but did not provide a photograph; four women had no object to discuss. The objects brought along by participants are listed in Table 1 and ranged from jewellery to childhood toy bears, and sporting objects such as trainers and darts. Eight objects were acquired as gifts or heirlooms from friends and relatives. Kate's wooden box and Fiona's engagement ring were handmade, the remainder were manufactured.

Table 5 Participant, Age and Object

Participant	**Age**	**Object (*named by participant)***
Jennifer	44	Grandmother's Ring
Janine	47	Photograph Frame
Maya	42	Trainers
Sophie	55	Lego Wonder Woman
Gillian	40	No Object
Fiona	44	Engagement Ring
Grace	49	Photograph of pet dog (not seen or provided)
Ruth	36	Wee Koala*
Sara	44	Sister's Rings
Lorna	53	*Velveteen Rabbit* book and Pluto**
Kate	60	Wooden Box
Claire	39	Promise Box***
Evelyn	38	No Object
Kerry	40	Doggy*
Ellen	50	No Object
Jane	39	Dart
Terri	59	Photograph of Self (seen but not provided)
Shona	60	No Object
Nina	55	Butterfly Necklace

*Soft toy;
**Soft toy based on Walt Disney's character Pluto the dog;
***Box filled with cards printed with Bible verses.

As discussed in section 4.3.2.2, the women were asked to bring to the interview an object that was meaningful to them. They were invited to bring along any object (or photograph if unable to bring or show it) *'that has special meaning to you – an object that represents how you feel about yourself or is important in other ways.'* I left it open intentionally to their interpretation although some direction was needed for those who were unsure what I meant. For example, some of the women wanted to know if it should represent their recovery or relationships because this was how the information for the project was framed. Nevertheless, I encouraged the women to think about an object that was simply meaningful to them and not necessarily about the broader interview topics. Four women did not

include an object in their interview and this is discussed further in section 5.3.7. For those that did, before we started the interview I asked the woman at what point she would like to talk about her object. Some, like Lorna, started the interview with the object, Jennifer and others at mid-point between topics. Only Sophie's interview ended with an object and that was because we ran out of time to complete the interview. When the women were ready to discuss their object I asked '*Can you tell me about your object that you've brought along today?*' and if needed I would prompt with questions like '*Why is it important to you? What does it mean to you? Where did you get it? How long have you had it?*' And, '*What does it say about you?*'

5.2.3 Analysis

To start the analysis, I segmented the text that contained all discussion around the objects, or their absence. Sometimes this was as much as 19% of the transcript and as little as 1%. At times, the objects were discussed within the structure of questions relating to said object, at other times discussion of the object led us down other avenues. The objects were coded with the nodes shown in Box 1, initially using an inductive approach. As the analysis progressed along with further reading around the meaning of objects, I was interested in the way objects were used by the women, as holders of memories and as objects with purpose. A paper by Csikszentmihalyi & Rochberg-Halton (1981) offered a way to make sense of these thoughts. For example, I borrowed their coding categories relating to object types and object memories. Rather than just listing *what* the object was, with Csikszentmihalyi & Rochberg-Halton's framing I could look at them as an object of *'contemplation'* and/or an object of *'action'*. That is, an object whose use includes physical handling, interaction or movement or an object whose use is mainly through reflection or contemplation. Likewise, coding people's memories of their objects required some finessing.

Table 6 Object codes & description.

Code	Description
Object	All discussion relating to participants' meaningful object
Emotions, Feelings and Attributes	Emotive descriptions applied when talking about object including 'feelings' and ascribed attributes (relating to either the object or giver of object)
Object_ importance	Why is the object important to the participant
Object_ meaning	What is the meaning that is conveyed by the object (as described by participant)
Object_connections	Symbolic Connections between object and place, person, time
Object_Identity	As the object relates to the participants identity/ies
Object_none	No object brought to interview and discussed
Object_Photo	Photograph of the participants' object(s)
Object_reflection of self	The object represents or reflects aspects of the participant's personality or sense of self
Object_Repair	relating to repairing identity, relationships etc.
Object_Temporality	The objects represent time either as memory, recollection or future (and change over time): e.g. Terri's photo of self: ""I keep that because looking back, thinking back to when I was like that I actually thought there was nothing wrong with me."
Object_memories	Participant describes memories that are held within the object
Object_memories_Heirloom	Objects handed down in the family (Csikszentmihalyi, M., & Halton, E. (1981).
Object_memories_Memento	Memories in general, not associated with a particular occasion. Includes descriptions of sentimental associations (Csikszentmihalyi & Halton)
Object_memories_Recollection	Memories of specific occasions (Csikszentmihalyi & Halton)
Object_Tools for Living	The object as a tool used in/for everyday life (different from an 'action object' as it can be both a tool for interaction and contemplation). E.g. Claire's Promise Box "I use this every morning when I get up and after I've prayed and stuff"
Object_Type	Short title describing object (e.g. toy, book, ring)
Object_Type_Action Objects	Objects whose use includes physical handling, interaction or movement
Object_Type_Contemplation Objects	Objects whose use is mainly through reflection or contemplation

Coding the objects brought out the many meanings the women ascribed to them as well as the meanings I, as the coder, saw in them. I have hopefully maintained a respectful and objective analysis of the women's object narratives, focusing on the meanings the women gave to them.

Box 2 shows an extract of Jennifer's object narrative and the codes ascribed to that segment of text. In this quote on the meanings she gave to her object, Jennifer discussed the *Connection* [C] to her grandmother (deceased), mother and aunt; her *Identity* [I] as she perceived how others (her mother and aunt) viewed her; *Temporality* [T] in terms of the past (as someone who would pawn the ring) and the present (now she would not pawn it); *Emotions and Attributes* [EA] in terms of having gained trust; and Repair [R] in that she was perceived as being 'on a different path', one of recovery and abstinence.

Figure 3 Jennifer's Grandmother's Ring: Meaning.

Jennifer's Grandmother's ring

Quote: "It meant like, I was glad I got it cos [*gran*] was my pal and I invested a lot of time you know doing things with her and that that maybe other grandchildren didn't [C]. But see to be given something of value that my mum and my aunt trusted me with and knowing I'm not going to go and pawn it or you know whatever [I; EA; T; C; R]. And my mum really wanted me to have it so that meant a lot that they [C]. It was like that they trust that my life is on a different path now [I; R]. So that was quite significant."

Broad Meaning: Shown she is trusted by her mother and aunts

Narrow Meaning: Identity;
Temporality ; Repair
Emotions and attributes; Connection

Reflecting on the process of this method, objects are a useful tool for co-constructing a dialogue that is led by the participant and provides a space in which participants can discuss aspects of their lives that are salient to them. The women's object narratives were an opportunity for me to hear about the

experiences and people who add to the women's sense of identity that is rooted in their past, present and future.

5.3 Reflecting on Objects: Being, Doing, Becoming, Belonging

This section describes the major themes that emerged from the women's discussion of their meaningful objects. It begins with a description of their objects' meanings in relation to the women's connections with others, continues with reflections of self, repair and recovery, objects as tools for living, and concludes with a summary of the main findings. These are the women's voices talking about meaningful 'things' from their own standpoints. Hereon, we begin to discern the attributes and principles the women value in their lives, as they are and as they hope to be. Furthermore, this section presents the foundations for the key themes that will be introduced to the reader throughout the remainder of the thesis including the importance of connections, temporality and self-reflection. This section starts to show how recovery from problem drug use is a process of doing, being and becoming through everyday micro-interactions with the social world of people and things. For some women, the objects represented their doing recovery, being genuine and honest and becoming true to one's self. For some, the objects acted as symbolic bridges differentiating periods of time such as between drug use and recovery, or pre-drug use and recovery.

While people may use objects to convey an image of themselves, the objects chosen for this study reflected aspects of the women's identities as they saw themselves but not their 'total' identity: 'only a complete ensemble of consumption objects may be able to represent the diverse and possibly incongruous aspects of the total self' (Belk, 1988: p.140). But even then that is unlikely because people tend to present that which they wish others to see (Goffman, 1959). Asked to bring along an object, the women chose objects that presented a particular story and aspect of their life that they wanted me to hear about at that moment, as well as those that were easily accessible. The remainder of this chapter explores the meaningful objects the women chose (or not) to present in their interviews.

5.3.1 Connecting with others

Most of the objects, particularly jewellery, were directly related to living and deceased relatives. For example, Jennifer and Sara's rings provided a connecting thread to their deceased grandmother and sister respectively. For Fiona and Nina their jewellery (an engagement ring and butterfly necklace) connected to their living relatives (Fiona's husband and sister and Nina's mother); Kate's wooden box, Janine's photograph frame and Sophie's Wonder Woman were gifts from their children and grandchild. And then there were those that some carried throughout their lives, such as Lorna's Pluto and Kerry's Doggy, soft toys gifted to them in their childhood. And, objects gifted as tools for living, such as Claire's Promise Box – a box of cards with promises found in the bible that she read each day and sometimes gifted to others. These simple, inexpensive objects carried within them emotions and attributes ascribed by the women that tell stories of love, loyalty, trust, strength, comfort and consolation. As Turkle (2007) stated

> *'As people exchange objects, they assert and confirm their roles in a social system... A gift carries an economic and relational web: the object is animated by the network within it.'* (Turkle, 2007: p.311)

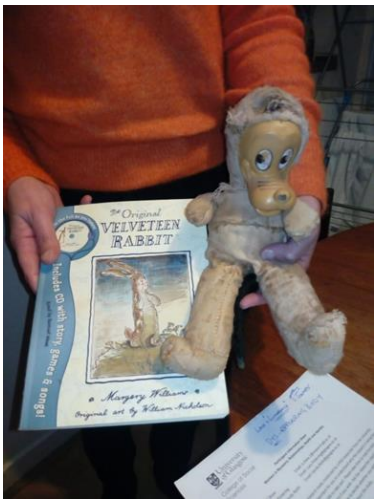
These objects were given energy through the interconnection of relationships. In the stories told of them, they not only carried the narrator and the listener to memories of people and places, they situated the narrator within a particular frame of reference. One in which they were a child or adult connected to people, places and moments in time. As narrators telling their object's story, the women situated themselves and the object within a network of relationships that had themselves and the giver at the centre of their story.

Objects of mourning and memory were common among the possessions chosen. Sara and Jennifer's rings, Grace's [unseen] photo of her dog and Lorna's Pluto all carried within them the women's memories of significant others; sister, grandmother, dog and father. In this respect, the possessions of the deceased (Sara and Jennifer's rings) contained the extended self of the deceased (Belk p.144). Sara, aged 44 and in early recovery (18 months) said of the rings she

inherited from her sister: *"I just carry them about with me and I see it as Mary's there with me kinda helping me through my recovery."* Jennifer, also aged 44 and in long-term recovery (10 ½ years) said of the ring she kept "*it does make me feel closer to [gran]*". These objects, as with others, possessed something of the giver and by extension provided a connection between the living and deceased.

Some of the women used the language of 'salvation' when talking about their objects (Dossett, 2015). Members of the Fellowships are said to undergo a 'spiritual awakening' during their recovery that results in changes in their perceptions from having a negative world view to feeling connected, loved and guided by a Higher Power (Vandivier, 2020). A Higher Power is God (or god) as understood by the individual – there is no proscribed religious God in the Fellowships (Green, Fullilove & Fullilove, 1998; Dossett, 2013). Nevertheless, similar to the participants in the pilot study for this thesis, spirituality was a concept that was a key factor in some of the women's narratives and manifested through their choice of objects (Shaw, 2017). Lorna's narrative around her book *Velveteen Rabbit* was replete with references to religion and spirituality. Age 53 and 18 years in recovery, Lorna at one point described her early recovery in Narcotics Anonymous (NA) and how the book's story along with other 'fairy tales' helped her make sense of the 'spiritual' awareness she was experiencing as well as achieving a level of authenticity she felt she had lacked prior to her starting recovery:

> *"But anyway so I bought this book. I'd taken a lot of solace and comfort out of reading to my daughter when I got clean and I started that you know when you're reading fairy tales and you start to see, and it all became very spiritual you know and I thought oh my god because I was just in NA and they were telling me about ehm spiritual principles and honest and I started to think of god metaphorically...so I had all this like all these things going on with fairy tales. I was like oh my god it's all been before my eyes, the answers have all been here all the time. So it was all this and then I got this book _ and really for me, such a spiritual book. It's just really about someone becoming real. Becoming their authentic self. Which is what I*



realise I try to do. Which is what I've always been trying to do. The identity that I seek through all these things that I like attach myself to"
(Lorna, age 53, recovery 18 years)

Lorna's spiritual awareness was connected primarily to her recovery and her attendance at NA. It was through embracing the NA's 'spiritual principles'[13] that she 'tries' to become 'real' and 'authentic.' That she is 'always trying' suggests that Lorna's identity construction was an ongoing project requiring emotional and cognitive effort from her and one that was built through attachment to 'things' metaphorical and objective.

Claire's Promise Box was a connection to the 'Christian woman' Betty, who gifted it to her and to her links, past and present, to the village church she attended as a child and adult. Aged 39 and in early recovery, Claire at the time of her interview had recently moved from the village she had lived in most of her life to an urban area, a few miles away. Fetching the box and cards from her bedroom, Claire said:

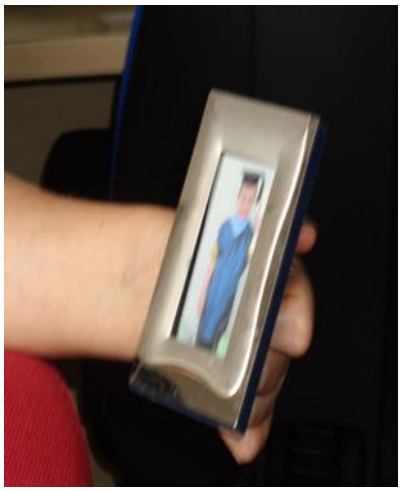
"Probably the biggest meaning of it though is that Betty gave us it...she's just a fantastic woman. She's a real strong Christian woman...when I look at her I just think like you can see God in her you know she's just lovely...just the fact that she gave me that and just how much it's helped us nearly every day since moving away from hers. Yeah. It's a lovely thing to have."
(Claire, age 39, recovery 18 months)

Whilst eschewing formal religion and its 'manmade rules' Claire described Betty as someone '*you can see God in.*' In this sense, the promise box retained, as Claire

[13] NA 12 principles: hope, acceptance, surrender, honesty, open-mindedness, willingness, faith, tolerance, patience, humility, unconditional love and, sharing and caring. Accessed at: https://nawol.org/2012_12princ.htm. Downloaded 3.02.21

saw it, aspects of Betty the gift giver but also something powerful and transcendent.

Janine's object was a photograph frame holding a photo of her son in his nursery graduation outfit. Aged 47 and in recovery for 21 years, Janine was the participant with the longest period in recovery. An elder statesman (sic) in AA, Janine described her son as "*on loan from a higher power or from God*."



"It sits above my bed and it's a dodgy old frame. I like beautiful things. [Hmhm] I believe the William Morris thing 'don't have anything in your home that's neither beautiful or useful.' But that's neither useful nor beautiful but it's because it's got that wee daft photograph in it and he made it for me at nursery." (Janine, age 47, recovery 21 years)

Waking up every morning, this object was the first thing she saw. The photograph of her boy in a plain 'old' frame reminded her she was a mother. As a mother, she felt valued and validated. This is an object that was made for her. On that frame were the fingerprints of the little hands that made it. This was the physical manifestation of the mother-child bond, as well as the spiritual connection (through her son) to a 'higher power', the fellowship, its members and other aspects of her life: each and all providing a backdrop of connection and belonging. Lorna, Claire and Janine were all Fellowship members and, similar to findings elsewhere (Dossett, 2013; 2015), each drew on resources and discourses within the Fellowships to help them construct their personal idea[l] of a Higher Power and the powerful transformative experiences of their recoveries.

Sometimes, deep connections are forged with animals (Brooks, Rushton, Lovell, McNaughton & Rogers, 2019; Sanders, 1990; Belk, 1988). The important connection forged between animals and humans in a dyadic pet-owner relationship was clear in Grace's narrative of her meaningful object, a photograph (unseen) of

her deceased pet dog. Grace, aged 49 and 5 years in recovery, apologised for forgetting the photograph however it was the photograph that represented the subject of the object, her dog. The dog became part of Grace's family and could be viewed as part of her 'extended self' (Belk, p.155). The dog was an extremely important connection to her and one in which she engaged in the 'construction of humanness' (Sanders, 1990) describing him as: *"my wee best friend, my husband, my brother, my partner do you know what I mean [yeah] at one point he was everything to me that wee dog."* The dog was male so perhaps not surprising that Grace attributed human male identities to him. However, it is also worth noting that Grace was placed in different foster homes from age 9 to 16 following the death of her mother. Her father '*couldn't cope'* raising four children and stopped visiting Grace shortly after she was taken into care "*because apparently it wasn't good because I was upset every time he left..."* She did not see him again until she was 17 after she had run away from a foster home. Still, the dog came into Grace's life when she was 35 years old and had died aged 10 years. His loss was still strongly felt three years later. Reminiscing and describing her feelings for her dog, Grace said

> *"It's weird. It was like we already knew each other from before. It was like our souls you know what I mean. That was how it felt...I felt like he was a really special gift given to me at that time in my life [April: when you needed him?] yeah when I needed someone….like he was like I don't know it was just like a dad, like everything."* (Grace, age 49, recovery 5 years)

Memories of loved ones past and present provide the thread connecting the women to their objects. Some objects, also seemed to provide a metaphysical connection or at least engendered a sense of something other-worldly as in Grace's dog "I felt like he was a really special gift" or Claire's Promise Box that reminded her of the 'God'-like gift giver. The connections, whether concrete or transcendent, were strong and helped sustain the women's recovery, each connection reminding the women they were loved and valued by others and that they were worthy of being loved and valued. The next section explores the temporal nature of the objects and how they linked the women's respective pasts, presents and futures.

5.3.2 Temporality

Meaningful objects are often interpreted in the context of past experiences (Csikszentmihalyi & Rochberg-Halton, 1981: p. 21). Possessions link us to our past and are a 'convenient means of storing…memories and feelings' (Belk, 1988: p.148). Discussing their objects, the women moved through time, recollecting past events and embodied emotions but also signalling the changes made over time and the journeys travelled. Terri, age 59 and 10 years in recovery showed me a photograph of herself, gaunt and pale, toward the end of her drug-using period. Terri's object acted as a reminder of her past: *"When I look at that photo and I see ken um it's like a great big ball of anger was in me and how I was and how I am the now"* This was not an object that evoked happy memories. It was an object that reminded Terri of poor health, abuse and time lost. The emotion it evoked was '*anger'*, or rather a remembering of the anger she felt in the past while at the same time it confirmed the recovery Terri was successfully pursuing in the present. Terri's photo acted as a symbolic bridge between Terri's past trauma and her present recovery.

Time in the present was conveyed through the objects. Lorna's objects for example provided confirmation that it was 'okay' for her to be herself.

> *"Not only is Pluto very much like the Skin Horse (in the book The Velveteen Rabbit) but this very much reminds me of what I'm doing, know what I mean…It's okay for me to be the fuck up that I am. It's okay for me to be broken in the ways that I am. It's okay that I have these crazy fucking melt downs, you know."* (Lorna, age 53, recovery 18 years)

Comparing herself to Pluto and Skin Horse in the book, it was authenticity and being 'real' that was important to Lorna's sense of self. According to Lorna, she may have been imperfect but she was at least genuine. As Skin Horse said to Velveteen Rabbit: *'When you are real you don't mind being hurt... because once you are real you can't be ugly, except to people who don't understand'* (Williams, 2004).

There was a bittersweet quality to some of the objects. Kerry, age 43 and five years in recovery, was the only participant in the study receiving a methadone

prescription. Her object was a soft toy called Doggy, given to her when she was a small child. Doggy brought forth memories of a difficult childhood in which she was bullied with little sympathy from her mother and sister but also prompted memories of being comforted by this constant companion and confidante. Recently diagnosed with Asperger's, Kerry said of Doggy:

"I suppose keeping him that length of time shows that I can care about something, that I have got some compassion eh because sometimes when I done those tests for the autism it came I was quite low scored on the empathy scale eh and I thought, when I thought about it aye I didn't really care about a lot of people eh. Like if Jim [partner] fell down and broke his leg I would care but if the neighbour done it I'd be like [K shrugs] and 'what's that got to do with me?' And I think and Jim says sometimes 'you cannae say that.' And I'm thinking 'but I dinnae ken. Who should I care about?'... So I think aye I can care about some things eh [yeah]." (Kerry, age 43, recovery 5 years)

In her remembering, Kerry's object demonstrated that love could exist in the world outside her immediate family and school environment as a child while also showing she was capable of love as an adult. Being diagnosed with Asperger's Syndrome helped Kerry understand her apparent lack of empathy while on the other hand, the possession of Doggy over a period of 39 years provided confirmation that she was a woman capable of caring.

As well as looking to the past, an object could signal a present and future self. For example, Sophie, aged 55 and five years in recovery, said of her object, a Lego figure gifted by her grandson: "*I will continue to be that Wonder Woman…*'. Janine's photograph of her son's nursery graduation encapsulated a potential future for herself and her son:

"I'm hoping that one day he will be standing for real and if he is with his wee cap and gown on I'll be standing beside him with this [laughter] for a wee joke." (Janine, age 47, recovery 21 years)

These objects were aspirational in that Wonder Woman represented a strong feminine icon that was symbolic of Sophie as she was in the present and aimed to be in the future. Valuing education '*very highly, I always thought I was stupid',* Janine's photograph presented a future academic son, graduating from university with Janine at his side, the mother-son bond still strong; Janine supporting him in the future as she remembered his birth motivating her to complete her university degree.

The objects presented and discussed, held within them the women's personal histories and future aspirations. Discussing the meanings of their objects, the women remembered and created a narrative, a story that opened up their past, present and future for reflection. In their objects, the women demonstrated over time, their journey from addiction to recovery. From women who had lost and abandoned aspects of themselves, to women who had discovered or recovered features of themselves such as authenticity and the ability to love themselves as they were, are and intend to be. The following section takes this a little further and examines the women's reflections on their selves and their identity through their meaningful objects.

5.3.3. Reflections of self and identity/ies

The objects were sometimes framed in terms of reflecting aspects of the participants' self and identity. Or rather, their identities in terms of how they *see themselves* and how they wish to *portray themselves* to the outside world. Jane, aged 39 was one of the few women who continued using illicit drugs recreationally. In recovery from problematic alcohol use, Jane's main drug of choice was amphetamines. Her object was a dart that she called 'Red'. It was replete with meaning and reflections on her selfhood. Not only did the dart reflect '*a new me*', its plasticity reflected her mental health (Jane was diagnosed with schizo-affective disorder); the tip of the dart reflected her new-found confidence and the red in the flight was a reflection of her hair which was dyed red:

April: what do the darts say about you then?

Jane: well…I suppose I've become a lot more self-confident. And I suppose it, the sharpness of them is an indication of how my tongue has become

April: of how your tongue

Jane: Yes. Because I just put up with shit for years and years off people. And now I don't put up with any. Because if someone upsets me I just tell them. If someone is making me uncomfortable in my house I just tell them 'out.' I don't put up with that…see why it's got red on it? Normally my hair's red and that's why it's called Red." (Jane, age 39, alcohol recovery 15 years)

Jane's description of her dart and its specific characteristics reflected aspects of her personality and appearance that she had clearly thought through for the interview. Its meaning was wrapped up in its appearance from tip to flight and metaphorically, the dart represented a stronger Jane, a woman who no longer allowed people to take advantage of her.

Maya's trainers and Fiona's engagement ring were also strongly reflective of the self. For example, Maya, a recreational user of illicit drugs (mainly cannabis), aged 42 and 14 years in recovery from heroin use, described her trainers and by extension herself, as '*kicked in but still functioning.*' But, they were also a reminder of the work she had done on her personal development and the relationship with herself:

"[I] got involved in taking part in like complimentary therapies where it be like reiki, Indian head massage and started to look at the relationship I had with myself. How spoke to myself." (Maya, age 42, recovery 14 years)

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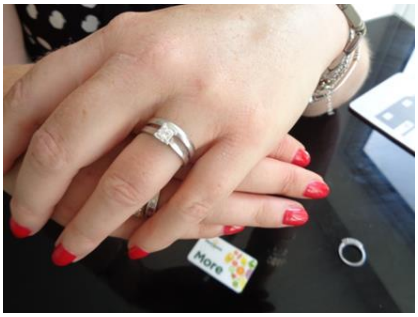
While it was not these trainers specifically, but any trainers worn since Maya started her recovery, they nevertheless symbolised the challenges Maya faced (‘*kicked in’*) and the fact that she had overcome them (‘*still functioning’*). They acted as a reminder of how far she had travelled in her recovery and the work that that had entailed, particularly in how she regarded herself.

Fiona, aged 44, was 10 years abstinent from illicit drug use and described herself as beyond recovery: ‘*that part of my life is over.*’ Her object, a bespoke engagement ring, reflected Fiona’s individuality. When asked what the ring said about her, Fiona replied:

> *“I’d say unique because I don’t come across many people that have led the life I’ve had. So when I look at my ring it reminds me how unique I am because it was made special for me.”* (Fiona, age 44, recovery 10 years)



Fiona considered herself ‘*unique’ h*aving had a life that was characterised by violence and poverty in childhood as well as being party to extremely dangerous situations and a victim of multiple acts of violence during her period of using drugs. The ring, handmade by her sister, reproduced her sense of difference and importantly, her self-worth: it was ‘*made special for me.’* Having survived and overcome physical and emotional trauma, Fiona’s object narrative spoke of a woman who was strong and capable, ‘*even now, I’m not a victim*’; and a woman respected and treated as an equal by her third husband:

> *“I think one of the things, whether that had been made out of platinum, whether that would have been made out of metal. It wouldn’t have mattered. Because it’s what it meant. [Hmhm] it’s that kind of promise. I mean on my wedding ring, on the inside we have ‘together’. Engraved on the inside of our wedding rings. Because Derek and I no matter what we do, we do it together. It’s a very solid relationship.”* (Fiona, age 44, recovery 10 years)

Fiona's previous marriages were short-lived and like many of her relationships were characterised by domestic violence. Derek at 70 plus years was much older than her previous partners (*'we used to make jokes about the student and pensioner's discounts')* and treated Fiona as an *'equal'*. Unlike previous partners, Derek supported and encouraged Fiona, and the ring and its engraved sentiment of partnership and equality embodied this relationship as well as Fiona's own sense of strength and uniqueness.

Motherhood was a strong indicator of internal identity and self-worth and was reflected in some of the objects. Janine's photograph of her son represented her belief that motherhood had '*shaped'* her and demonstrated the importance to her of being a '*good mother*.' Similarly, Lorna's *Velveteen Rabbit* book signified the importance of '*trying'* to be a mum through her drug use. The salience of this identity was important not just for the participants' sense of self-worth but also in terms of their perceived identity by others. Kate's wooden box, handmade by her daughter, provided an identity that reached back through time, one in which she was '*loved enough*' by her daughter despite the hardships they encountered as a family. At 60 years old, Kate was one of the eldest women in the study and had been in recovery for five and half years. The box, given to her by her daughter had been lost and returned to Kate following a period of homelessness:

"It meant the world to me. I only ever had two things that my kids had made at school other than paintings and this was one of them. That I can remember anyway. Yeah like I was saying, I was in a woman's refuge in [English city] I think and when I was there my house was turned over and as I said from light bulbs to carpets everything went...Anyway, what I hadn't realised was that my daughter had taken a handful of things out of my house and taken them to her house. One of them was this and it's meant a lot to me from day one. It means more to me every day actually and…I don't know whether I want to be buried with it or give it back to my daughter one of the two…I keep going back to the word love don't I?

> *[Hmhm] no matter how hard her life was, she bothered. She loved me enough to make me this box."* (Kate, age 60, recovery 5½ years)

Kate had kept this handmade box for about 30 years and it evoked memories of her past, both positive and negative. Importantly though, it provided evidence of love from her significant others. Similar to Fiona's ring and Janine's photograph frame, the hands that made the object were integral to the object itself, as the objects retained the identity of their creators.

As noted previously, Lorna's identity as a mother was salient to her, particularly in terms of how she thought she was perceived by others. As the extract below demonstrates, the inner emotional turmoil felt by Lorna and the '*façade'* played out for the outside world was mediated by the impression management she undertook as a caring, loving and responsible mother enacted through reading to her daughters:

> *"Even when I was using I would read to her. I would nod off with Cherry Tree Farm in my hand. But I would still try to do it still try to be a mum. So try to fulfil that other identity. Keep it together. I thought if I can keep the outside if I can keep that together ehm then everything else will be okay."* (Lorna, age 53, recovery 18 years)

Nevertheless both Lorna and Kate found it hard to accept their identities as 'good' mothers. Kate said: "*Probably something my kids have told me a lot but I still find hard to accept is that I actually wasn't a bad mum all the time*." Lorna said of her performance as a mother: "*…the façade was quite big for me because you know I just feel so chaotic inside quite a lot of the time*." Lorna's use of past and present tenses indicated the mental instability she felt as a woman who used drugs when her daughters were younger and this was still present as a woman in recovery. However, both women revealed through their object narratives the complexities of re-building or constructing identities when what one considers to be true of one's self does not match what is perceived by others. It requires balancing the authentic self with the performative self.

5.3.4 Tools for Living – doing, being, becoming

Belk notes, 'having possessions can contribute to our capabilities for doing and being' (Belk, 1988: p.145). I would go further and suggest that some of the women's objects represented 'tools for living' that extended beyond 'having, doing and being' and contributed to the women's capabilities of doing, being and *becoming*. As discussed in chapter three, becoming, in this sense refers to 'notions of potential and growth, of transformation and self-actualization' (Wilcock, 1999: p.5). Tools for living were objects the women used most days for interaction and/or contemplation, and directly or indirectly helped the participants maintain their recovery and help others. This was clearly seen in Claire's Promise Box: *"I use this every morning when I get up and after I've prayed and stuff… there's always something I can take from those cards."* The cards could also be used to help others, as Claire would sometimes give them to other women in recovery. Maya's '*kicked-in'* trainers were another tool for living and recovery. They were of course one of many pairs she had had since her recovery but they were symbolic of the emotional and physical work that Maya had put in to her recovery. Talking about her trainers and her decision to give up drug use, she said:

> *"I thought okay I'll go for it cos I'm not right and I need to start doing something about it. And since then exercise in all different shapes and forms has been for me has been, the thing that I've been most consistent with. So we're going back ehm_almost 14 years, 13 years and the importance of exercise for me is not just for my physical but for my mental and emotional well-being it's like pfff I won't, I won't go any long periods of time without exercise...so there's different things that are very therapeutic but the theme of it all was about keep active, keep moving, keep mentally well. Not always easy to do [laughs [yeah]] you have difficulties at time, people with mental health ehm but that's why I brought them, they've been hugely important to me. If I didn't have a pair of trainers then there's something far wrong."* (Maya, age 42, recovery 14 years)

As a tool for living, Maya's trainers represented bodily discipline and control. Embodied in these '*kicked in but functioning'* trainers was Maya's past as a woman who used drugs and her present and future as a woman in control of her drug use and body. The trainers were a disciplinary tool that signalled her physical and

mental health. If they were used and being used, she was in good health; if not, '*there's something far wrong*.'

Janine's photograph of her son could be viewed as an indirect tool for living. Sitting directly above her bed, it was a reminder every morning and night that she gave '*the tools of my recovery*' not only to her son but also to other members of her Fellowship home group. Material possessions as tools for living are important for developing feelings of efficacy and competence over the social and physical environments and may be particularly important to women who have experienced physical and sexual abuse (Fitzpatrick, Elphingston-Jolly, Friend & Payne, 2018). In this respect some of the women's objects were tools for doing, being and becoming.

5.3.5 Emotions and Attributes

Emotional sentiment, experience (feelings) and attributes were discussed in the object narratives. These emotions sometimes referred to the object itself and indicated the instrumental nature of the objects:

> *"It's about pleasure. It's about keeping my mood up or lifting my mood. It's about trying to, helping me if I'm not feeling motivated for the day."* (Maya's trainers)

> *"I'm quite happy with that because for me this is like a kinda symbol of strength right but it's also a symbol that you can be vulnerable [Hmhm] and still be strong… I've had it for two years now and she still works. She's still illuminating the way for me, she's still lighting my path [lighting your way?] yes. She's still lighting my path." (*Sophie's Wonder Woman)

> *"I just love it [yeah]. It holds so many memories. And it's unique."* (Fiona's Engagement Ring)

Nevertheless, the objects did not always elicit positive sentiment as noted with Terri's photograph of herself and Kerri's Doggy. Ruth was the youngest participant at 36 years old and had been in recovery for 10 years. Her object, a soft toy she

called Wee Koala, held both positive and negative emotions: *"it's kinda like a bittersweet sort of thing"*. Koala's story was revealing of Ruth's recovery journey. Unlike Lorna's Pluto or Kerry's Doggy which were gifted in childhood, Koala had come into Ruth's life as an adult and it belonged to her sons rather than her. In fact, this was the only object that belonged to another person and not the participant. Given to her eldest son by his nursery teacher while Ruth was arrested and in a police cell, Koala represented the distance travelled from Ruth's personal nadir to full recovery:

"That wee bear's going nowhere because I think it shows. I think it does symbolise the change. It does symbolise the change. Because I know where that bear came from. I know how that bear was put into his hands. It was put in his hands because he was going to foster care or whatever that night ehm…but then it's like a bear that my two boys have loved. I know. So it's ended up being something that's cherished know what I mean? And there's maybe that's just like the journey through our lives. Bit of a rocky start and then and now it's something that's loved." (Ruth, age 36, recovery 10 years)

Ruth's Koala was both symbolic and instrumental: symbolic of her recovery and instrumental as a reminder of her journey. In this respect, Koala could also be viewed as a tool for living.

Feelings of absence and closeness were associated with Jennifer and Sara's objects, both rings inherited from their grandmother and sister respectively. In this sense, spatial and emotional proximity and distance to the original owner was conveyed through the objects. For example, Jennifer who was preparing to get married a few weeks after the interview said of her grandmother's ring:

"It does make me feel closer to gran… my mum was saying to me 'are you gonnae wear any jewellery at the wedding?' I said 'I think I'm going to wear gran's wee necklace. Have a bit of her with me….I miss gran a lot." (Jennifer, age 44, recovery 10½ years)

Wearing the ring reminds Jennifer of her grandmother's absence while at the same time recalling the emotional bond they had. Equally important and as shown in Figure 3 earlier in the chapter, the self-worth that Jennifer has worked to achieve through her recovery is reflected in the entrusting of the ring to her by her mother and aunt, confident that Jennifer would not pawn it.

Similarly, the wearing of Sara's sister's rings offered closeness to her sister and feelings of comfort:

"I always fiddle with them, I don't know. I think it's like a wee kind of comfort thing I think maybe. So I just carry them about with me and I see it as Mary's there with me kinda helping me through my recovery." (Sara, age 44, recovery 18 months)

Behind most of the objects was a subject. The subjects (a person or pet) associated with the object were often ascribed emotional attributes: they were or had been '*kind*', '*constant*', '*empathetic*', '*loving*', '*compassionate*', '*understanding*', '*open*' or they had '*gentleness*', '*strength*', '*stability*', '*loyalty*' '*trust*' and '*love*.' These attributes can be understood as personal values that the women sought in others and as ways to be and become themselves.

5.3.6 Repair

The objects represented the action of repairing or restoring one's health or relationships to a healthy condition. For example, Jane's dart was a metaphor for repair, specifically in relation to her mental health. She said of the dart:

> *"The reason I use plastic ones is because they break and that represents the way sometimes you break. Your head breaks, but you can replace it you can fix it."* (Jane, age 39, recovery 15 years)

Nina's butterfly represented the repair of her relationship with her mother as well as being a metaphor for recovery. Aged 55 and in recovery for 12½ years, Nina said:

"I think originally the butterflies were there and as I say I knew that the butterfly was a kinda recovery symbol for women. So I thought well you know that's a nice little thing there. So I don't think I've actually had the bloody thing off…so it does mean a lot to me as I say I've come full circle with my mum which is nice. Because I resented her for years." (Nina, age 55, recovery 12½ years)

Likewise, Jennifer's engagement ring represented the repairing of relationships with her mother and aunts:

"But see to be given something of value that my mum and my aunt trusted me with and knowing I'm not going to go and pawn it or you know whatever." (Jennifer, age 44, recovery 10½ years)

For Terri, the photograph of herself as a woman in active drug use reminded her of the ongoing and not insignificant repair to herself:

"When I look at that photo and I see...how I was and how I am the now, back then and the only way to get it all out was to do it to myself. Now all that is out. I've been lucky enough to survive it. And still be here to tell the tale of it all and now I'm going on to a new chapter. Much better one. A happier one." (Terri, age 59, recovery 10 years)

Indeed, the metaphorical nature of the objects presented helped the women tell a story, one that was non-threatening and developed in their own words and on their own terms. They highlighted what was important to them at a particular moment in time. Moreover some of the objects could be described as a reminder of the past that helped the women ground their recovery in the present (and look to the future); they represented a change from one state of being to another (Silver, 1996). Terri's photograph illustrated this well as did Claire's Promise Box which acted as a daily reminder of when she was '*homeless and desperate*' to where she

was at time of interview, a woman in recovery and in her own accommodation. Ruth's Wee Koala represented clearly the metaphorical and transitional nature of some of these objects, for he symbolised *"…the journey through our lives. Bit of a rocky start and now it's something that's loved*."

5.3.7 No Objects

Having described the women's objects and analysed their narratives, this section explores the narratives of the four women who did not identify an object to discuss. All participants were asked to bring along an object for the interview if they wanted but only Gillian indicated at the recruitment stage that she did not have an object to talk about. Ellen, Evelyn and Shona only mentioned having no object when it was raised at the start of their interview. There were several reasons for not bringing or discussing a meaningful object but in Evelyn's case this was to avoid resurrecting negative emotions concerning her three children who had been taken into care and two that remained on the island (from where she had moved). Nevertheless, while stating she had no object that she wished to display or discuss, Evelyn did talk about the absent objects that were meaningful to her. Despite the fact her objects were painful to consider in the present, Evelyn aged 38 and in early recovery, could see a future in which she would be able to look again at her meaningful possessions.

> *"I've got a photo album in there and they never, I never get it out because then I have to accept getting vulnerable. If Graham (partner) asks, I really struggle with that because sometimes I'm scared it will and I get vulnerable when I speak about stuff…I think because I haven't accepted all that. Because I haven't forgiven myself for all that, that damage I did over there…I think there'll be a time when I look at that stuff that holds meaning to me. I can be in that place where I talk and I can revisit that and get, get to that acceptance level. However I know I'm not there at the minute."* (Evelyn, age 38, recovery 3 years)

Evelyn's absent (but present) objects, at time of interview, were not positive reminders of past events or people although they were certainly meaningful because she described them as such. Instead, her possessions were reminders of

the children she had lost. Similar to Ruth's Wee Koala, Evelyn's possessions (and the photograph album in particular) held memories and meanings that reminded her of a past she had left behind but could not forget. Unlike Ruth however, Evelyn had not yet reached a stage where she could accept the past, forgive herself and move on. Nonetheless, the meaningful possessions she had, remained in a cupboard ready to be opened and looked at again. The temporality they represented was perhaps suspended by their being kept out of sight. That she had not thrown them away indicated (I think) that she was working toward accepting her past as it was and her future as it might become.

Gillian, aged 40 and abstinent for 10 years, would not describe herself as beyond recovery but she did not consider herself in recovery either: "*It feels like it was a different fucking lifetime... I don't feel like it's part of who I am now.*" For Gillian, objects were not as important to her, having lost so much through her addiction. Other women in this study had also lost possessions through their drug using days as we saw with Kate whose house was burgled and she was made homeless. For some people who use drugs, the loss of possessions through theft, homelessness or pawning possessions for money is an occupational hazard and one that has been discussed elsewhere (McIntosh & McKeganey, 2002; Taylor, 1993). However, what is striking about Gillian's narrative was that she equated objects less with material loss than with her expectations of other people.

> *"I don't think I've got one thing that I could say 'this really represents to me'. Like they honestly don't have that much importance [that's okay]_ I think through addiction, you're like, I don't know you lose so much don't you? And then I think, god, Jesus Christ this is pretty deep, pretty quick but I think _ if you don't _ put as much importance on something, an object, it doesnae matter if you lose it, it's not going to hurt you. It's like if you have no expectations of people, your never gonna be let down [yep] and that's kinda how I live my life [right] if that makes sense."* (Gillian, age 40, recovery 10 years)

For Gillian, objects were like expectations – if no value or meaning was put on them then if they were lost, the 'pain' of the loss could not be felt. Similar to Evelyn, Gillian's interaction with possessions and objects spoke of self-protection. Both women maintained some cognitive or emotional distance from possessions. By

not attaching importance to them (objects and people), they could not harm or disappoint.

Ellen and Shona were not as forthcoming on why they didn't have an object but both were emotionally 'angry' during the interviews. Shona, one of the older women in this study, said:

> "*I'm actually wanting to dance on somebody's grave now. [A: are you? Right okay] And spit on it which is bad. It sounds bad.*" (Shona, age 60, recovery 12 years)

Ellen's anger was rooted in her frustration with living in a relatively isolated community and in a house she did not like. Aged 50, in early recovery and using opiates occasionally, Ellen said when asked if she had an object she would like to talk about:

> *"I think my life's so shite I don't even have a fucking object do you know…I actually can't think of anything at the moment I mean I tried to do some art work but I find it hard to even. Just even doing anything in the house. Because I hate, I hate being in the house you know… aye its pfff just can't be bothered you know."* (Ellen, age 50, recovery 6 months)

The interview took place in Ellen's home, a small cosy flat full of knick-knacks and pieces of art. Even though she claimed to hate her flat, it was hard to imagine she had no object of meaning. However, it is worth noting that Ellen was grieving for a pet dog that had died a few weeks prior to the interview. She contacted me several weeks on from the interview with a photograph of her new pup therefore it is quite possible that had I visited her at a later date when she had her new dog, the interview may have been very different and included a meaningful object. The same applies to Shona, in that her demeanour may have been different had she not been experiencing family problems at time of interview.

Returning though to objects and lack of attachment, Belk via Goffman's *Asylum* (1961) suggested the unintentional loss of possessions could be viewed as a loss or 'lessening of self' (Belk, 1988; p.142) and if some of those objects belonged to or represented others then this could be a loss of the extended self of others

(Belk, p.143). This has some merit in terms of Evelyn's personal history. Evelyn was in and out of psychiatric care wherein patients are required to relinquish personal possessions. Moreover, she had 'lost' three children to adoption services. It is not surprising then that possessions for Evelyn were so painful to recall, but remembering also that she had not lost these items; they were still meaningful. However, the anticipated pain of recalling, handling and discussing them was too great. In this respect, she did have a diminished sense of self and a visceral loss of the extended self of others, in this case her babies. The 'psychic power' of Evelyn's objects then were great but their 'psychic energy' was too negative at this stage in her recovery (Csikszentmihalyi & Rochberg-Halton, p.9). If the loss of possessions is symbolic of the 'death of self' *(*Ferraro et al, 2011: p.169) perhaps for some people who use drugs, the loss or absence of certain possessions is the 'death of self' that is no longer desirable. For some, this may be a material rejection of a spoiled identity; an identity worth losing in order to 'become' another, new, better self. In Gillian's case this was a mother identity, an identity that she protected very carefully. If 'one knows who one is by the objects one owns' (Csikszentmihalyi & Rochberg-Halton, 1981: p.xi) then perhaps for some people, the absence of objects indicates a selfhood that is unencumbered by unnecessary or negative associations and for them, this is their selves in a purer, truer state of being.

5.4. Conclusion

Discussing the women's objects (or absence) in these interviews has provided a fertile seam of data that illuminates the women's sense of themselves in relation to others and over time. Talking about their objects, some of the women differentiated the lives they had led, and the women they were during their drug use, to their present lives. The objects represented strong interpersonal relationships that reinforced the women's self-worth. Furthermore, the objects represented achievements in recovery (butterfly necklace, Pluto and *The Velveteen Rabbit*) and valuing relationships (jewellery, wooden box, dart, photographs) while embodying values such as trust, constancy, friendship, loyalty and self-discipline. Most of the objects were gifts and carried memories of others,

sometimes negative but mostly positive. The objects also signified success in social integration. This is especially meaningful for women who at times in their lives have implicitly and explicitly felt an outsider in their social environments. The gifting of objects strengthened the women's relationships to others. Furthermore, the objects embodied aspects of the giver as demonstrated in Claire's promise box and Sara's rings and the handmade objects made for Kate, Fiona and Janine. The 'meanings' behind the objects were generated not only by the participants, but also in part, from the meanings they had to others. The objects chosen by the women functioned as an embodiment of connection between people, but equally, the objects went beyond connecting the participant to an 'other', they also signified re-connection and re-integration to family and society. The objects reflected back to the women attributes and emotions that nourished and supported their sense of self-worth.

Returning to the original questions asked at the beginning of this chapter, I would argue that this method was effective in the co-production of the interview. It enabled the women to lead the interview, giving them control over the subjects that mattered most to them and offered time to explore their meanings. It was a novel approach that most of the women engaged with and reported enjoying. However, what is particularly clear is that these objects conveyed multiple meanings, linked as they were to identities and connections; acting as conveyors of time that hold memories of the past, as tools for living in the present and offering visions for the future. They were also objects that reflected the emotions and attributes that the women valued and aspired to. The common thread running through the objects was the 'connection' they represented, acting as symbolic bridges to people (alive and deceased), places and periods of time. Even among the women who did not choose a meaningful object, there were still stories that illuminated their absences. The role the objects played in the women's recovery narratives were reflective. Like a mirror, they reflected the transition from women whose identities were damaged by unmanageable drug use and often challenging relationships, to women who were actively repairing identities through healthy relationships and bodily care. Some women associated their objects with spiritual awareness and personal growth that nourished their connections to others that in turn, positively influenced their self-esteem and sense of authenticity. Moreover,

the objects often encapsulated and symbolised the profound changes made by the women. Finally, the multiple meanings ascribed to the objects by the women provided insights into the work that was required to achieve their personal recoveries. The objects showed how in *doing* recovery through connecting, reflecting and repairing, the women engaged in a process of *being* the women they aspired to *become*.

The following chapter builds on the object narratives and the connections they represent by shining a light on the women's relationships and exploring their influence on the women's sense of self as they aged into their recoveries.

Chapter 6: Connecting and Belonging

"You kinda find your tribe" (Nina, age 55)

Chapter Overview

In chapter six, the women's evolving relationships within their social networks are explored through the lenses of connectedness and belonging. Their narratives raise important insights into the challenges women in recovery face when building and re-building new and existing relationships. The chapter begins with an introduction to the concepts of connecting and belonging and moves on to briefly look at the women's remembering of belonging in childhood and adolescence. The following sections explore the women's recovery processes as they disconnect from relationships that are no longer helpful and make new ones that engender belonging and improvements in self-worth. Family and recovery communities are central characteristics in the women's narratives and the remainder of this chapter considers the influence these social relationships have on women's sense of self as they age into their recoveries.

6.1 Conceptualising Connecting and Belonging

As social creatures, people's sense of belonging is usually associated with connections to something, someone or somewhere. Human connectedness occurs when people actively engage with others, activities, objects or environments that results in a sense of well-being and belonging (Latimer, 2013; Hagerty, Lynch-Sauer, Patusky & Bouwsema,1993). However, feeling connected and belonging are not necessarily contiguous. A sense of belonging requires some form of connection therefore connectedness can be a precursor to and reinforce belonging (Crisp, 2010). Yet, one can be connected but not feel a sense of belonging or have a sense of belonging but not feel connected (Crisp, 2010). Belonging involves emotional attachment, it is a 'feeling of being home and safe' (Antonsich, 2010: p.647). People perform connectedness and belonging throughout their lives - moving in and out of different places, spaces and relationships, connecting and disconnecting as they go. Belonging therefore has a temporal and spatial element that changes over time 'partly in response to changes in our self' but also to changes in people

and the world around us (May, 2016: p.372). Moreover, belonging is a multi-dimensional and self-reflexive condition in which individuals engage in a 'constellation of multiple belonging' (Pfaff-Czarnecka, 2013: p.10). People engage in different levels of belonging that are interrelated in the sense of social locations, identifications and emotional attachments, as well as ethical and political value systems (Yuval-Davis, 2006). Belonging is multi-dimensional in that it comprises race, religion, gender, class, sexuality and so on, as well as attachment to places, spaces, groups and cultures, and is a social system in which people judge their own and others' belongings (Antonsich, 2010; Yuval-Davis, 2006).

6.1.1 Remembering & Reimagining Belonging

During childhood and adolescence, young people learn through play and other forms of socialisation the social groups to which they belong and wish to connect to. Gillian (aged 40, recovery 10 years), said of her early heroin use*: "I thought 'this is what I want to do every day for the rest of my life. Now I know that I belong somewhere.'"* Gillian's sense of belonging to a drug culture gave her a sense of purpose in life*: "It was the first time that I thought 'this is what life's about.' I felt me calling in life."* Similar to many of the women in this study, Gillian's early memories of a sense of self were as the '*outsider'*. Other terms the women used to describe themselves as girls and adolescents were '*a fuck-up,' not part of things', 'scapegoat', 'never felt valued at all, always felt like the oddball,'* and *'a kinda weird kid'*. These feelings and identities as oddballs and misfits were felt as adult women too. Their memories of themselves as children and sense of their place in the world along with their connections to their social world resurfaced during the interviews, or as Lorna described them, were '*reimagined'* in adulthood. In the following extracts Lorna cast her mind back to describe her feelings of disconnection from others around her. She remembered feeling a sense of connectedness and belonging as a young child but as she matured into adolescence she found she did not belong within the same network of friends, at least not in a way she felt comfortable:

> *"I can remember when I was in primary 7 and it was like the school dance and all of a sudden these boys that I'm running about the street with*

> *collecting frog spawn and all the rest of the stuff that you do. Started coming to my door in a different way. Not two at a time. Just one _ And you know they started to look at me a different way and that really crushed me. And they started fighting about who was going to take me to the dance. Because as a young girl I was quite a pretty young girl. I wasn't really aware of that at 12. I wasn't really aware of that but ehm so of course they treated me different. It all changed and I lost lots of friends. So immediately I lost trust in boys [yeah] from that experience ehm _ and obviously I'm hugely sensitive as well do you know what I mean ehm which I think is part of my addiction ehm. It's like our friendship wasn't important any more do you know what I mean?"* (Lorna, age 53, recovery 18 years)

The loss of friends, trust and belonging is in Lorna's remembering, emotionally painful. The memories of this experience are woven into a narrative that Lorna uses to explain in part, her '*addiction*'. Later in the interview, she talks about people's attitudes towards her when she was using heroin:

> *"See out there, how I was treated by the general public out in the world and by the police and by the changing attitudes as I became thinner and more obvious. It was more obvious I was a junkie. As that became more obvious and my physical appearance, I just, I was baffled by people's attitudes. Because I'm, very personable. Middle-class. Well-spoken. Articulate. Able to converse on many subjects.... It was a bit like reliving that 'I am what you see'. Reliving that 12 year old moment again and again and again. People's attitudes...it's the attitude when you become a non-person. Where you become your disease. Where you become just a junkie. You become that label, you know and that really rubs with me you know because it is again that rejection. Rejected by society because I'm not conforming to the certain standards that you require me to conform to because I'm suffering and we don't want suffering people in society. We want happy, shiny people in society so I don't fit, so I don't fit. So I am no longer human and I am no longer worthy of your love and respect and your care. So I had all this is what I carry with me, all these rejections. Ehm reimagined, know what I mean…"* (Lorna, age 53, recovery 18 years)

Lorna's narrative demonstrates connecting and belonging as active processes that are relational, negotiated and performative; something people do through their social interactions (May, 2011; Antonsich, 2010). It also demonstrates a sense of disconnectedness and alienation to wider social structures. Unable to match the normative expectations of the behaviour and appearance of a middle-class woman, this time the rejection is from the wider social world, not a cabal of 12 year old

boys. As an adult woman, Lorna *relives* and *reimagines* the rejection she felt as a 12 year old girl. For some of the women, the sense of alienation felt as an adult was a continuation of the sense of alienation felt as a child and adolescent. Where drug use and the sociability that came with it provided a sense of belonging for a period of time, eventually feelings of disconnect and not belonging led the women to reassess their lives as they were and as they could be. The next section considers this further and explores how the women re-shaped their relationships as they moved from drug use and into recovery.

6.1.2 Disconnecting in to Recovery

The sense of alienation from significant others and the wider social world that some PWUD experience has been discussed elsewhere (Anderson & Levy, 2003; McIntosh & McKeganey, 2002; Biernacki, 1986) and the women in this study experienced similar feelings of estrangement and separation from others. Claire decided to finally quit using drugs after two decades of use when she realised there was '*nothing and nobody left'* to help her. Describing her decision to quit, she said:

> *"I couldn't carry on the way I was going so there was nobody on my case like mum and dad had been for years. Workers ehm _ friends and stuff you know 'you need to do something. Do this. Try this.' And you know I had nothing left and nobody left."* (Claire, age 39, recovery 18 months)

The alienation from family, friends and treatment providers that Claire felt, acted as a strong motivating force for her to finally quit drugs and enter recovery. Claire's sense of self was diminished by the absence of people looking out for her or caring for her. For some of the women, it was the disconnection and isolation brought about by their use of drugs that encouraged their move into abstinence and recovery. Leaving behind the drug-using milieu however could be difficult. Ruth, for example, spoke about the sense of loneliness she felt in the early days of her recovery and how she returned to her drug-using networks to reduce the social isolation she experienced:

> *"I would like go to meetings. I would just I would see people there and then I'd come home and I'd be in by myself and then you can only do that for so long like the fear of creating new relationships with people. And*

> *then coming home and feeling isolated. There was that in-between bit so I ended up uh _ the fear of starting new relationships was too much so I just turned back to people I knew because the loneliness was kinda getting to me."* (Ruth, age 36; recovery, 10 years)

The *'in-between bit'* in which Ruth feared creating new relationships was one where drug use in the past was a balm to low self-esteem and confidence while the future was yet to be shaped by new connections. In that present *'in-between,'* Ruth was learning to deal with her fear without using drugs. Going to AA meetings was '*scary*'; communicating with people was difficult *'I couldn't look anybody in the eye, if somebody spoke to me I got all flustered...I really struggled...'* Alleviating the loneliness she felt at this stage in her early recovery, Ruth returned to the people she knew and felt comfortable with *'the same people that I'd used with.'* Working on her confidence and self-esteem was crucial to Ruth's recovery, not only from drug use but also from the associated lifestyle and intimate relationships that accompanied it:

> *"I still kinda felt _ like I wasnae worth anything, I wasnae _ I don't know, I didn't deserve a good life sort of thing ehm I was still attracted to people who didnae treat me right. Ehm but in the last three years that's really changed because I realised I was still making they mistakes and I realised I was headed back down that path of picking up drugs again and I had to really look at why that was and it was because I was still living in the chaos... I was _ ehm still attracted to, I was still talking to people like my main group of friends were still people who were actively using...even though like I was going to 12 step fellowship meetings and stuff I found it really hard to build relationships with people and that was just really like I had really low self-worth and really low self-esteem and I didnae think I was good enough for people to like sort of thing (yeah okay) so I was still doing that you know hanging about with that kind of people and ehm and I was, wasnae living honestly as I should've."* (Ruth, age 36; recovery, 10 years)

Feeling undeserving, Ruth's ability to make connections and build new relationships was difficult and took time to develop. It was seven years into her recovery that Ruth felt able to move on from the '*chaos*' and '*addict lifestyle*' she had maintained while abstinent. Ruth's example clearly shows the precarious nature of recovery for some women. Moving from the familiar environment of drug use with all of its networks, connections and routines to the unknown territory of

recovery and fellowships is daunting, especially for women who carry past histories of domestic abuse and violence. Returning to environments that are familiar even if they carry the threat of danger might be preferable to being isolated and feeling alone.

Some women though maintained connections from their past, considering them important to their support networks. Grace (age 49, recovery 5 years) for example, maintained contact with long-standing friends who continued to use drugs. These friends were not in Grace's local area so were infrequently visited but maintaining the connections was a process of active engagement that Grace felt important to sustain. Nonetheless, Grace's connections to her recent past were disrupted and displaced by her social distancing from the local drug scene:

> *"You think you've got friends don't you and I've still got like friends that I've had for 30 years. Just maybe two or three but I can always I don't have to speak to them for 6 months and I can pick up the phone and it's like we spoke yesterday [yep] which is really important. But the friends you think you've had over the years. People coming to your house for coffee and going and taking kids to school and whatever. They just all kind of _ when I stopped taking drugs and stopped _ people coming to my house. When I wasn't available for their needs. They all disappeared _ I really thought they were my friends. And I would think to myself I know how they treat other people but thought they wouldn't treat me, why would they treat me like that because I, I've never done them any harm but they did but that's just life for drug addicts you know."* (Grace, age 49, recovery 5 years)

Grace was still it seems, coming to terms with the disruption and disconnection from her social networks. At five years in recovery, Grace felt a sense of loss and disbelief that the friends she had known for years – shared her home and drugs, confidences and childcare with - had treated her similar to others whom she had seen rejected from the local drug scene. Having lived in the same house for over two decades, she felt a sense of shared history with the '*disappeared*' friends. She now subscribed to the understanding that this was '*just life for drug addicts*' – it was normative behaviour and should be expected. There was no consideration that it was perhaps her recovery from drug use that stopped people coming to her house. Nevertheless, in order to connect to and rebuild supportive social networks,

Grace and other women in this study had to undergo processes of disconnecting, not just to those in drug-using networks but also to those seen as no longer helpful in sustaining healthy relationships.

6.1.3 Disconnecting and Reconnecting

Some of the women spoke about breaking social bonds that they felt were not healthy or helpful to them and their recovery. Disconnecting from relationships the women considered problematic, unhealthy and unhelpful was not without its challenges but at the same time, letting go of long-standing relationships in order to maintain recovery was vital for some of the women. The relationships the women had with their families, and particularly their mothers, was often complicated and maintaining a sense of control in these relationships was difficult for some. Breaking, losing or minimising contact were ways in which the women were able to manage these difficult relationships.

Remembering family life as children, some of the women's narratives spoke of domestic violence, a sense of not belonging and for a few, time spent as a looked-after child in foster care or children's homes. Leaving home was a source of escape from the fraught family life they experienced and as adult women, managing these relationships in a healthy way was important. In the MRes dissertation pilot study (Shaw, 2017), maternal relationships were a source of difficulty for some of the participants and the same difficulties were discussed by the women in this study. Evelyn for example, had moved from an island to the mainland and found new connections and by extension belongings. Her sense of belonging was connected to her new partner, his family, their baby and her new flat in a new city. Leaving behind the island, her family and the legacy of her drug use (three children adopted, another two living with their father, unmanageable drug use, and multiple detentions under the Mental Health Act (1983)) was not without some fear: *"Shitting my pants because I've always lived on that shitty island but do you want to know something. It's worked man…"* Life had become difficult on the island and her relationship with her mother had broken down to the extent that Evelyn did not contact her mother for over a decade. This strategy worked in Evelyn's favour *'…that worked for me. Because I felt like I was always getting caught up in madness.'* In recovery, Evelyn reconnected with her mother

but whilst still '*scared*' of her mum, Evelyn set boundaries that she used to help her maintain some control in their relationship and in her life:

> *"What I need to do is boundaries to keep what I've got know what I mean then I'm going to fight for that because my mum's and I don't mean this in a nasty way. My mum's back there. My mum's older right. [Baby] Tom is _ all I have is us. All that Tom's got is me and Graham, his dad right. Because I spend the majority of my time myself with Tom. He looks to me for all this right. If I start lowering my boundaries and be like start going to pubs and clubs with my mum when she's over than that's me inviting the devil in."* (Evelyn, aged 38, recovery 3 years)

In her new environment, support from her current partner Graham and his father, in addition to outside support from social services contributed to Evelyn's ability to care for her baby. Nevertheless, Evelyn's re-building of a 'new' life meant disconnecting from parts of her past life. Of the island she had left, she said *"I had to leave there to get my recovery."* Of people she had known, they *"serve their purpose _ you'll outgrow them or they'll outgrow you or you just do different things on your journey."*

Similar to Evelyn, Kerry had a difficult childhood and felt compelled to leave home when she was 16. Having spent years trying to '*repair*' the relationship with her sister and mother she eventually decided to stop. In doing so, her mental health improved:

> *"I don't see my mum or my sister. I haven't seen them in 11 years this year. We never got on growing up me and my sister. My mum didnae care less about what happened to me, that's what it seemed like so _ I tried like once I had my kids to try and repair the relationship but nah. There's nae point trying to fix something that's not going to fix is there? [No]. It's just making me more stressed and more upset and I think I'm better off without that eh and once I cut them out my life it was, it was a bit of a relief eh. I know that sounds awful but I've got my close friends and my family eh. I've got my auntie and I'm happy enough with that honestly I'm happy enough with that."* (Kerry, age 43, recovery 5 years)

Having a supportive partner and network of long-held and trusted friends, Kerry felt able to break the familial bonds with her sister and mother. Like Evelyn,

discussing her mother raised uncomfortable feelings particularly around the guilt Kerry felt for feeling the way she did. Kerry said *"I know that sounds awful"* while Evelyn stated "*I don't mean this in a nasty way*". What the narratives in this and the pilot study (Shaw, 2017) demonstrate, is that relinquishing the obligations women think they have to their mothers is one of the more difficult relationship transitions women who use drugs or in recovery experience. For example, Janine said of her mother: *"I let her go. I let her go. Ehm _ _ yeah. Big, big taboo thing for a daughter to do but I had to do it."* Breaking the mother-daughter bond may be regarded as taboo in some families but this thesis and the MRes pilot study provide important evidence of the challenges some women in recovery feel in the daughter role. The women internalised what they perceived as the socially normative expectations of how a daughter should be and act. However, moving into their recovery, these expectations differed from their own perceptions of themselves and their own needs and wants as women in their own right, rather than the daughters they thought they should be. The tension between the expectations of others and their own wants and desires led to feelings of guilt for some. The expectations, attitudes, beliefs and values within families and society more generally are important elements of the social context in which recovery is performed (Berger, Asaba, Fallahpour, & Farias, 2020). And of course, women are daughters to fathers too, and for some women in this study relationships with their fathers were also challenging. Many had grown up with violent fathers who abused their mothers and sometimes, them and their siblings too. In the following extract, Fiona talked about breaking the relationship bond with her father '*bit by bit'* and like Janine, she considered it outside the norm for a daughter to do this to a parent:

> *"I've always know my dad's been a violent bully. But how as a woman do you stand up to that? How as a daughter, do you challenge that? And I won't ever say it was okay, I kind of distance myself from him because I don't like him. And I refuse to be around people I don't like. One of my biggest sayings is 'if you don't bring joy to my table, there's no seat for you.' And I distanced myself little bit by bit."* (Fiona, age 44, recovery 17 years)

Even as women in mid-life with all their life experience, there was a questioning of appropriate and socially acceptable behaviours in relation to challenging parents

and disconnecting from the parent-child relationship. These findings are important, for while there is a lot of research exploring women's relationships with children and intimate partners, there is far less that engages with women's relationships with their parents and their mothers in particular. Most of the women's narratives included discussion around their mothers, and more often than not how their mothers challenged and undermined the women's sense of self-worth and self-esteem. Comparing the literature to the findings from this and the pilot study suggests this is an overlooked area.

6.1.4 Reconnecting and Rebuilding

Building a credible abstinent identity relies on the symbiotic nature of relationships. Abstinent identities are reflected to some degree in how others perceive and believe in the veracity of the performance (Antonsich, 2010; Goffman, 1959). For example, Claire's engagement with her church community requires the performance of an abstinent identity from which she builds her sense of self-worth through performing interviews and testimonials in front of an audience:

> *"I think people need to know that people can get well. People need to see that. Especially other people in addiction and stuff…I do it like I just said to push myself and get through that fear and I think you know all my recovery is about stepping out that comfort zone, pushing myself and doing stuff to build my confidence and self-esteem and self-worth and stuff you know. It helps with that stuff."* (Claire, age 39, recovery 18 months)

Reconnecting to people, whether family or the wider world requires work and for some of the women they spoke about this in terms of '*building'*: Building connections, building self-esteem, building on the work they had already done on themselves. In Claire's extract she discussed 'building' the relationship with her family. She showed how in recovery, trust was built up over time, how she was present not just physically but also focused emotionally when she was with them. Claire recognised the differences between her past and current relationship with her children and found it emotionally difficult to contemplate:

> *"…other important relationships are with my family now. Building on that. It's taking time to put things right and for them to trust me ehm _ but I'm just, it's different now because I'm with them now, I'm with my kids, I'm present with them and um _ a lot more honest with them. I can listen to them a lot more than I did _ I feel emotional when I think about it because it is so different from what it used to be."* (Claire, age 39, recovery 18 months)

Multiple periods of abstinence followed by evermore chaotic behaviour engendered a lack of trust and confidence in Claire's recovery and this was something she had to work at proving to her children, and other family members. The person recovering from substance use needs to prove to others that their abstinent identity is genuine and this often takes time.

Building relationships with family can be difficult, particularly when there is tension between people's remembering of them in the past and their expectations of them in the present as shown in Sophie and Maya's extracts below:

> *"Aye and even like building relationships with your family. If it doesnae work, it doesnae work. You cannae keep you know pedalling the bike when the tyres are flat...for a lot of times me being the ehm the facilitator of making things right, of doing things, being the carer. That suited everybody in my family and then now that I'm not doing it, somebody else has to do it and eventually they've had to become alright with that...it's like we need to rebalance this because that's the only way that families can coexist. It needs to be balanced."* (Sophie, age 55, recovery 5 years)

> *"I'll be saying to my older brother soon enough 'I am not, I am no one's carer and I don't want to be. I don't want to assume that role. I don't want to take on that role any longer for my mum. My mums going to be leaving the care unit, find her somewhere to stay down where you live' because I spent all of my days being a carer, caring for people and I don't want it. I don't want it anymore. I've had it imposed on me and I'm in a position now where I can say 'no, I deserve to have my life and focus on me."* (Maya, age 42, recovery 14 years)

In the past, Sophie's role was to be the '*carer*', the go-to person in the family. Despite some pushback from family members, Sophie's refusal to continue in the carer role resulted in a recalibration of her familial relationships. Maya was still in the process of renegotiating her role as carer within the family but like Sophie, she

was determined to develop a new dynamic in which she would have more control over the demands made on her. An important finding in this respect is that recovery is not just about the actions of the person who is abstaining, it is also about the actions of family members, relinquishing their patterns of behaviour toward and expectations of the women's roles within the family.

Building the foundations for healthy relationships with the self and others is important for maintaining a sense of being valued and we see in Ruth's narrative how she builds feelings of self-worth incrementally:

> "*And just like it was kinda baby steps. Tiny baby steps. There was loads of wee things and I'm just trying to think of what they were because it was just like loads of wee things like that kinda thing that just kinda built me up a wee bit.*" (Ruth, age 36, recovery 10 years)

Ruth uses the lessons she learned from her evolving relationships in recovery as a foundation for relationships with family and others. In turn, this leads to a better sense of self – one in which she can hold her '*head up*' and look people *'in the eye.'* In other words, one in which she feels equal to others and not less than:

> *… that's kinda rippled out into, that's the foundation of how like I started, changed my view of relationships and how people should be treated and how you should be treated yourself and I've kinda took that and built on it and expanded it into my immediate, like my family. My siblings and my mum. And worked on my relationships with them from that.*" (Ruth, age 36, recovery 10 years)

Ruth acknowledges the hard work and time that is required to rebuild relationships and reconnect with family members: *"I had to work really hard. Be really patient…it's just like chipping away."* Rebuilding relationships in recovery requires managing the expectations of other people, whether family or wider society.

6.1.5 Reconnecting, Rebuilding and Belonging

Throughout this study reference is made to the recovery communities that played a seminal role in nurturing and developing a sense of connectedness and belonging for many of the women. As discussed elsewhere, recovery communities offer a 'collectivity' through shared meanings and experiences (Pfaff-Czarnecka,

2013: p.18) and offer resources and moral guidance to help members follow an alternative life-path (Pfaff-Czarnecka, 2013; Russell & Gockel, 2005; Hser et al, 2003). Although most had engaged with recovery communities and Fellowships at some point in their recovery, those in early recovery were more likely to be attending such groups (3 of 4 women) at time of interview than those in long-term, stable recovery (6 of 15 women). Echoing findings elsewhere in the recovery literature (Bathish et al, 2017), the women in early recovery were more likely to report connections to other women in recovery whereas the women in long-term, stable recovery were more likely to report a wider field of connections beyond other recovering individuals. Nevertheless, having the opportunity to connect to other women in an actively positive way refutes the women's lack of self-belief brought about by gendered expectations, personal differences and structural and economic inequalities. Moreover, recovery communities offer opportunities for personal growth and development. They also offer space to lead, to take control and become the symbolic teacher, mother, nurturer. In other words, helping and supporting connections to others and creating a sense of belonging. Indeed, one of the cornerstones of the 12-step fellowships is the notion that 'to keep it you have to give it away' (Alcoholics Anonymous, 2001). In other words, in order to maintain and sustain their own sobriety, fellowship members work with and support others who are trying to recover.

Connectedness and belonging though are not just matters of personal freedom. People may wish to belong to certain groups but their socio-economic status may limit their choices as might personal attributes such as gender, age and illness. Past behaviours can also impinge on the present, for example a criminal record may be a significant barrier to some occupations, groups or communities (Gunn et al, 2018; Sanders, 2012). Moreover, belonging to certain groups can convey negative associations for others, particularly when those groups are marginalised, stigmatised and adversely labelled (such as people who use drugs) (Sanders, 2014; Harris, 2009; Anderson & Ripullo, 1996). The performative aspect of connecting and belonging to groups outwith an individual's field and habitus entails hard work. Entering new spaces and locations, building and maintaining new relationships requires individuals to learn new habits, new ways of communicating and new ways of being. This 'boundary crossing' (Pfaff-Czarnecka,

2013: p.22) if successful, enables individuals to acquire new knowledge and experiences that can help empower them to cross other social boundaries. As Janine's experience demonstrates, recovery communities are one element in which women who have used drugs can cross boundaries of connection and belonging:

> *"…where I'm from a working-class town, you don't get to meet you know _ people from other well you know what it's like in the UK, its different classes, different educations, different countries. Because of the 12-step programme, AA, NA, I've met people from all over the world. Gained different perspectives, different view-points. It's took me out of that West coast of Scotland, Irish catholic mentality and opened my mind…"* (Janine, age 47, recovery 21 years)

For Janine and some of the other women, recovery communities offered opportunities for wider social participation. Within and out with the Fellowships the women met and socialised with people from different social classes and backgrounds, learned new ways of being and further engendered a sense of connection and belonging by building on and reinforcing their social capital.

In marginalised groups, individuals who achieve successful boundary crossing can be seen as role models for others (Pfaff-Czarnecka, 2013) and offer opportunities for meaningful social bonding. Nina described how the recovery community offered a '*tight bond'* with other women - a bond that allowed Nina to *'speak the same language'* and express herself in ways she could not with her family:

> *"So I started going and I got to know the other girls so we formed quite a tight bond and it was just good to just talk about it because my family I couldn't talk about it because that was then, this is now do you know and I didn't have any friends here…You kinda speak the same language…it's quite refreshing to have a group of women who are all there to watch each other's backs…I can understand how she's feeling and why she's feeling that and well you know there's a connection there."* (Nina, age 55, recovery 12½ years)

Unable to talk with her family about her past and having moved back to Scotland after two decades away, the bonds Nina developed with the other women were built on shared understandings and a sense of protection which were important in

helping develop trust within the group. Nevertheless, being able to talk about their past in a safe and non-judgemental environment is just one element of developing connections and a sense of belonging. Connecting and bonding with others is also about '*being heard*', knowing and feeling that your views are listened to and regarded by others. It is the reciprocity of human connection that is essential for engendering a sense of connectedness and belonging:

> *"Just being heard has built that esteem and that value. That is one of the most powerful things that I've experienced. Being heard."* (Janine, age 47, recovery 21 years)

Making connections leads to a process of bonding and ultimately to a sense of belonging to a '*tribe*'. In addition, connecting, bonding and belonging with others in recovery communities helped some women develop skills and increase their feelings of self-worth. When describing a recovery cafe she was involved in developing, Claire noted that there were benefits in differences of opinion, no matter how difficult that might be to negotiate at first:

> *"And I'm so glad I've stuck with that and I've had some battles with people in there as well but it's really helped me self-esteem, self-worth thing, build that ehm_and just doing something for other people. Just really helps."* (Claire, age 39, recovery 18 months)

As women recovering from problem drug use, belonging was not just related to the recovery community, belonging was also about connecting through addiction:

> *"We've all been through similar things, similar experiences and the drugs, the addiction side. Ehm_and that's okay when I'm with them. There's no judgement. It's okay to talk about that stuff when I'm around them."* (Claire, age 39, recovery 18 months)

Claire found connections and a sense of belonging through the recovery community but also through the shared experiences of 'addiction'. It was this common experience that connected the women to others.

6.2 Conclusion

Connectedness and belonging are multidimensional, performative and socially constructed. Individuals must weigh the advantages and disadvantages of

belonging as creating opportunities or restrictions on ways of being. This is illustrated in the women's narratives regarding their move out of drug use, their connections to families, and their engagement with recovery communities. The influence of social relationships on the women's sense of self was an important aspect of their recovery. In changing their lives, moving from drug use to recovery, the women lost, gained and rebuilt relationships along the way. As the women aged into their recovery, their sense of self was constructed in their interactions with others and in the abstract notion of collectively-held social norms, values and customs. Belonging also required being able to participate in the world. In other words, participation and belonging required acceptance by others. For women who had experienced periods of social isolation, self-imposed or otherwise, re-connecting with the wider social world was challenging. The challenges were not only in the structural conditions of the social world but also in the embodied habits of the women and those around them. In particular, some of the women felt challenged in their relationships with parents, especially their mothers. Managing other people's expectations of them while convincing others of their abstinent identity, required diplomacy and boundary-setting that the women needed to learn. They were no longer the women remembered prior to or during their drug use. The women's sense of self-worth was forged through connections, new and old, built and rebuilt on their own terms.

For the women in this study, recovery was an ongoing process in which they rebalanced doing, being and becoming by setting boundaries with others, assuming more control over relationships and developing a recovered identity that others could view as authentic, honest and genuine. The interaction between doing, being in, and belonging in recovery, promoted a sense of moving forward and normalcy. Engaging in ordinary routines, participating in social activities and belonging to social networks unrelated to active drug use encouraged the women's developing identities and sense of self as women in their own right, rather than women defined by substance use. Further research into the role of families on older women's drug recovery would fill a major gap in our understanding of recovery. As women age into mid-life and older, their roles and responsibilities can change within the family, they may be expected to take on a larger caring role for

older parents (or grandchildren). Further work around mid-life and older women's relationships with their mothers in particular, would aid our understanding of family dynamics and how they might help or hinder recovery from substance use. Gathering evidence on this issue could help family support and treatment services assess the need for developing support programmes and materials for older women actively using drugs or in recovery, and their families.

Chapter 7: Bodies and Ageing in Recovery

"The first thing I noticed when I got clean was that life hurts" (Lorna, age 53)

Chapter Overview

Chapter seven builds on the review of health studies in chapter two by adding the women's views and experiences of their health and bodies as they aged into mid-life and older. The women gave voice to the health issues that affected them and indicated some of the health challenges they experienced in recovery. The chapter begins with a brief overview of the women's thoughts on their bodies in recovery with a focus on reported mental and physical health, seeking to understand what it means to move from a drug-using body to a recovered body. Following this the analysis turns to ageing in recovery with a focus on menstruation and the menopause, and follows up with a brief look at embodied trauma. The chapter concludes with a summary of the findings and potential implications for research and practice.

7.1 Bodies in Recovery

As discussed in chapter two, women who use drugs (WWUD) are more likely to have poorer mental health than their male counterparts (Grella and Lovinger, 2012, Rosen et al, 2008). Plus, adverse childhood experiences and/or experiences of violence, abuse and exploitation in adulthood are more prevalent among women who use drugs and are often considered to be a trigger for or cause of mental health conditions (Choi et al, 2017; Gilchrist, Gruer & Atkinson, 2007). The women in this study reported a range of mental health conditions including anxiety, bi-polar personality, schizophrenia and depression that many had experienced prior to recovery, and some prior to their onset of drug use. Most had experienced or witnessed physical and/or sexual violence as children and/or adults. At least seven women had been prescribed anti-depressants for decades. Nonetheless, most of the women described improvements in mental health after they stopped using drugs although this occurred gradually over time in recovery.

Discussing early recovery and mental wellbeing, Fiona (age 44, recovery 17 years) said, *"I would say the first couple of years in recovery. It's a very dangerous place, psychologically."* Referring to her and other women's vulnerability regarding intimate relationships, Fiona was not alone in highlighting this as an issue. Claire, just 18 months into her recovery, labelled her behaviour in a previous recovery period as '*crazy*' although she suggested this was a strategy to manage anxiety:

> *"I had a period of time a few years ago when I was completely clean and some of the behaviours, some of the stuff that I was doing with men, using men to make me feel good. You know I was sleeping around a lot ehm. I mean it was a short-term fix thing. I suppose it was a bit like, it was addictive behaviour you know…So you know I see that as quite crazy behaviour. And just my whole thinking. I mean I get a bit of anxiety now but it was just horrendous then, my head wouldn't stop. I think I had some kind of breakdown or something _ and obviously I relapsed..."* (Claire, age 39, recovery 18 months)

The relationships Claire described were short-term and not intended for long-term commitment. Claire viewed her behaviour at that time as '*dangerous*' and '*crazy*' although it served a purpose – using intimacy was Claire's means to improve her self-esteem and sense of self-worth. For Jennifer, aged 44 and describing herself as beyond recovery, coming to terms with her past life meant coming to terms with her body:

> "*So I see it as just being a normal body that doesnae _ and I think that those behaviours that I learned to manage life for a long time _ see my body as a sexual object, something that I used in some transaction [Yep, yep] Where those behaviours were probably the hardest ones to change. Stopping drugs was hard but even when I stopped drugs I continued those behaviours at periods you know here and there. So _ I think today I see my body as, it's just a body. It doesnae have any power or anything like that."* (Jennifer, age 44, recovery 10½ years)

Remembering her body as a transactional object Jennifer recalled she '*learned quickly how powerful*' her body could be in helping her manage life emotionally and materially but:

> *"_in getting what I wanted in one hand I took away in another hand. It took me a long time to connect with my body and feel like I was alright with it."* (Jennifer, age 44, recovery 10½ years)

Learning how to manage embodied behaviours and feelings, in ways that did not leave them feeling exploited, was important in enabling some of the women to come to terms with their bodies in the past and appreciate them in the present.

In terms of physical health, some of the reported conditions included chronic obstructive pulmonary disease (COPD) and emphysema which some participants attributed to smoking drugs including heroin, cocaine and crack-cocaine; nerve pain and deep vein thrombosis occurring from injecting drug use; and trigeminal neuralgia and fibromyalgia, rheumatoid arthritis and arthritis that occurred in recovery. Seven women had cleared the hepatitis C virus (HCV), contracted during their period of using drugs. No women had hepatitis B or C at time of interview. While most of the women described their current physical health as good there were concerns that irreparable damage had been done to their bodies as a consequence of their drug use. Women in long-term and early recovery expressed concern that risk behaviours in the past might have consequences for their health in the future:

> "*It does concern me that ehm…there's maybe some damage that I've done maybe in my past or ehm that's going to come back and bite me on the arse. That's going to come back ehm and kill me maybe … Ehm so it can come back so there's nothing, I'm constantly aware of my mortality now I think. And I think that's because I'm fucking over 50. And I just think about how careless I was with my health and my life."* (Lorna, age 53, recovery 18 years)

> *"I've got a lot of fear as well you know because my family all die young with cancer you know…and I went for genetic testing and they said I've got a 80% chance of lung cancer but didn't stop me using or smoking or anything like that. Now I'm more thinking about it now. I went when I was 40, now I think about it. I'm like that 'oh fuck' you know. But what's for you is for you, you know what I mean. That's the way I've got to think. I cannae sit and just dwell about it."* (Sara, age 44, recovery 18 months)

Both Lorna and Sara felt a sense of their own mortality as women in mid-life: Lorna because she was '*over 50*' and Sara as she approached her mid-40s. Lorna's

'*concern'* that past '*careless'* behaviours had contributed to known (HCV) and unknown health conditions was underpinned by the helplessness she felt when she said *'so it* [HCV] *can come back so there's nothing...'* Sara's fear was compounded by a family history of cancer and while worried about the consequences of her cocaine use, knowing there could be a genetic propensity to cancer, she accepted it as something she had no control over. Both women felt a sense of powerlessness regarding their future health status. Nonetheless, Sara and Lorna's narratives illustrate how some women make sense of their health in the present, which is anchored to behaviours in the past that have potential to impact on health and wellbeing in the future. Moreover, the pervasive social value of individuals taking personal responsibility for their health may be such that, no matter how long women have been in recovery, former actions, lifestyles and behaviours that were potentially physically injurious to health and wellbeing are used to explain illnesses by the women themselves and their health providers (Kearney, 1999). Perhaps because of a tendency to accept their current health as a consequence of past behaviours, some of the women compared their health to other PWUD and spoke about pain and illness as something to be endured.

A number of the women described their health as good although they suffered pain on a daily basis. Grace, for example aged 49 and in constant pain throughout our interview, considered herself '*lucky'* and was '*grateful'* for her health, aware as she was of her peers' morbidity and early mortality:

> *"Aye I've got a sore hip but on the whole I'm not too bad. I have got chronic lower back pain anyway because I got kicked by a horse a few years ago but on the whole, I've got asthma, but on the whole my health's really good. And I know I'm lucky and I'm grateful because I know a lot of people at my age whose health is not nowhere near as good and you lose a lot of people. There's always someone passing away. Like every week there's someone else. If it's not someone you know it's a friend of a friend or a friend's cousin or. And it's not always heroin. People always think its heroin overdose. It's not always heroin you know."* (Grace, age 49, recovery 5 years)

Comparing herself to her peers, Grace highlighted her perceived better health but still brought into focus the fragility of bodies – not just Grace's body or drug-using

bodies but all bodies. Terri, some 10 years older than Grace, felt she had been lucky that her heroin use had not resulted in more severe health consequences:

> *"But like I says my health now, obviously I'm feeling all the aches and pains and whatnot … so I'm aware of all the different things that's going on wi my body but the most thing that I do thingy is the nerve pain. All the damage I've done to my nerves with all the injecting in my legs and things like that. Ehm but I'm not really complaining either. Especially when I think back what I put my body through and how I've come out the other end of it as well is really I've no lost limbs... I've been eh lucky that way too cos it was pretty chaotic my life was and even wi the drink, the drink itself after the drugs."* (Terri, age 59, recovery 10 years)

It seems that having survived their drug use, some women were stoical in regard to their health in the present, '*grateful'* for having coming through their drug use relatively unscathed. Stoicism can be related to sociocultural factors that influence attitudes to health and health-care seeking such as social and physical environments, familial and generational influences or experiences of hardship and adversity (Moore, Grime, Campbell & Richardson, 2013). Many people grow up in homes where there are unwritten rules for discussing illness – be cheerful, don't complain, don't make a fuss. As Sophie, age 55 and 5 years in recovery said of her mother's approach to ill health or familial problems: *'you werenae allowed to wallow in anything. You werenae allowed to lick your wounds or be hurt. Just get on and get it done.'*

A tendency to 'blame' people who use drugs for their own behaviour and consequences thereof, plus the stigma associated with injecting drug use and bloodborne viruses is such that complaining about their health could result in some form of felt or enacted stigma from others (Scambler, 2004). Moreover, it has been argued that certain types of pain and illness (such as that associated with substance use) are experienced as 'moral events' involving internalised and externalised shaming and blaming (Werner, Isaksen & Malterud, 2004). This is explored further in chapter eight through the lens of felt and enacted stigma. Yet, there is a danger that emphasising personal responsibility for their health disregards the historic circumstances of the women's lives. Acknowledging older women who have used or use drugs may have health complications related to events, circumstances and environments other than their drug use is important as

women's understandings of their health is rooted in their own biographies and their former and current life choices, conditions and experiences (Kearney, 1999). Maya, age 42 and a recreational user of illicit drugs, recommended that people working with older women who use drugs should remember, *"We are people with complex issues and often very challenging histories, not necessarily of our own making."*

7.2 Ageing in Recovery

Some women spoke about changing their outlook on health as they got older. Jennifer, now aged 44, felt she had *'weathered the storm'* of her 18 years of drug use *'reasonably well'*. Acknowledging that smoking heroin had damaged her lungs she nevertheless felt *'relatively fit and healthy'* and took care to attend regular appointments for general health matters:

> *"I feel like my attitude towards my health, I would never, like I went for a smear test last Tuesday. I never miss anything. I feel really privileged to be in a country where we get those regular checks for free. Ehm, so I buy into all of them."* (Jennifer, age 44, recovery 10½ years)

Similar to Jennifer, Janine's values towards her health changed although she was explicit in relating this to ageing: *"As I've got older my health has become more important."* Janine further equated this change in attitude toward changes in her own feelings of self-worth, *"I think gradually there's been an awakening of self-worth that's directly related to self-care."* This awakening was prompted by her sponsor in AA who encouraged good nutrition, exercise and sleep. From Janine's perspective, changes to her diet and general self-care had led to improvements in her health and self-worth.

Returning to Leder's (2015) dys-appearing body, abstaining from drugs and entering recovery revealed aches, pains and other symptoms that were absent while the women were using drugs. Lorna said:

> *"The first thing that I noticed when I got clean was that life hurts. [A: in what way?] Physically. Ehm_obviously I'd been using opiates for years and years and years. Not feeling any pain apart from the pain of withdrawal. And once that's over I realised 'my god, my bones have aged somewhat.'*

> *You know, my joints are slightly sore. Or my lower back's sore with sitting. Things that I would never notice because I was constantly stoned and you just don't notice them…I felt like an old woman complaining to the doctor 'This is sore and that's sore.' And he was like 'Lorna, these are everyday aches and pains that you've just not felt because you've been taking a painkiller all your life.'"* (Lorna, age 53, recovery 18 years)

Similarly, Kate and Shona noticed an increase in bodily pain when they stopped using opiates. Kate, aged 60 and 5½ years in recovery said, "*I think when I was using drugs, it masks so much doesn't it*" while Shona said:

> *"I never thought I had bad health until I stopped [chuckles]. Ehm I always thought I was okay. Soon as I stopped oh my god. I think I went from a 20 year old to an 80 year old [laughter]. Just the pains you get and you're beginning to realise what other things you have, things that are wrong with you that you didn't think you had."* (Shona, age 60, recovery 12 years)

Lorna and Shona likened their painful bodies to old bodies and recovering bodies. The ageing body combined with the drug-free body culminates in a body that begins experiencing aches and pains that were previously anaesthetised by a range of substances. Applying Leder's (2015) hypothesis of the dys-appearing body, the ageing, recovering body seized the women's attention. During their drug using period, their bodies went unnoticed until withdrawal pains seized their attention. In recovery, with no opiates or other recreational drugs in their system, pain or discomfort was noticed when it interrupted their consciousness. At this point the women's bodies were no longer 'absent', instead they disturbed or 'dys-appeared' (Leder, 2015).

In addition to a reduction in or absence of illicit drug use, the decrease or absence of prescribed drugs also heightened the women's awareness of pain. Shona spoke about a decrease in her prescribed drug use leading to an increase in arthritic pain:

> *"Back then ehm I…when I was obviously getting so much pain killers, taking my painkillers and Valium, never felt pain eh. Never felt anything eh. Total numb feeling it was, I suppose. But now I'm in pain all the time."* (Shona, age 60, recovery 12 years)

Nina, age 55, worried about the long-term effects of her opiate replacement therapy (ORT). Having been on Suboxone for over 10 years she was concerned

about the toxicity of the drug and its potential long-term effects but at the same time she also worried that stopping its use altogether, she would find it difficult to manage her arthritic pain:

> *"And that's the other thing because I am older and I'm weaning myself off this pain medication, when I was young I never had any aches and pains. I was like 'oh fuck' you know so there is this as well. I think your body gets used to aches and pains but basically because I've anaesthetised myself for so many years, I'm just, can't cope with it. So that does concern me a bit."* (Nina, age 55, recovery 12½ years)

Nevertheless, some of the women were reticent to blame all their aches and pains on the absence of drugs and felt that they were experiencing the 'natural' bodily discomforts of the ageing process. Shona, who felt she went from a 20 year old to an 80 year old when she gave up drugs, nevertheless attributed much of her pain to ageing:

> *"I put a lot of things down to I'm getting old because I am."* (Shona, age 60, recovery 12 years)

Ageing, like pregnancy, menstruation and menopause is a naturally-occurring bodily event. All are normal body functions that include 'regular and extreme bodily shifts' however it is 'cultural prejudices [that] lead us to forget or devalue such changes' (Leder, 2015: p.89). Growing older and experiencing the effects of ageing on the body is of course natural but it is also *dys*-functional requiring a re-evaluation of the body as it brings the aches and pains of ageing into the realm of bodily dys-appearance (Leder, 1990). In the following section the women's experiences of ageing into the menopause is explored.

7.2.1 Ageing into the (Peri-) Menopause

The women were at different stages in their reproductive lifespan. Some were still menstruating or entering into the perimenopause while a few were post-menopausal, either naturally or post-hysterectomy. This section reveals some of the women's discussions around menstruation and the menopause and its impact on their recovery.

Menstruation

Some women who use drugs experience amenorrhoea, the absence or cessation of menses (periods) in women of reproductive age (Mburu et al, 2018). Four participants mentioned an absence of menses during their drug using period. For Jennifer, looking to the future, this meant:

> *"All that weight loss to not having periods for years. That's osteoporosis in the post."* (Jennifer, age 44, recovery 10½ years)

Perceived infertility due to drug-induced amenorrhoea may result in unplanned pregnancy (Mburu et al, 2018; Bell & Harvey-Dodds, 2008) during active drug use and following abstinence when the women's menstrual cycle begins again. Fiona found out she was 26 weeks pregnant following detoxification from methadone, heroin and diazepam and said:

> *"I didn't realise I was actually pregnant because I'd not had regular periods for about 2 years."* (Fiona, age 44, recovery 17 years)

Maya and Claire spoke about their menses returning after abstaining from drug use, both discussing the fact that their periods were heavier than they remembered prior to drug use. Claire viewed them as another step in her recovery, albeit an uncomfortable one:

> *"PMT[14] is horrendous. I dread it. And it seems to surprise us each month. I'm like what's going on, why do I feel like this and why is my head racing and it was my flatmate who said 'you're due a period Claire, I can tell. This is the way you go when you're due your period.' So yeah, I really struggle with it. It's, you know, this recovery stuff, getting used to feelings and thoughts anyway, it's hard enough without all that going on. PMT stuff."* (Claire, age 39, recovery 18 months)

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[14] Pre-menstrual tension (PMT) is the name given to a collection of physical and emotional symptoms that can occur in the two weeks before a woman's period.

These findings support other studies on women recovering from heroin use (Neale, Nettleton & Pickering, 2012) however Claire went further than the women in that study and likened her feelings to withdrawal or cravings, fearing that sometimes she would relapse:

> *"So, each month I think I'm going to relapse on something. And it's gone from drinking to using heroin to I'll take some LSD that'll be alright because I'll have a spiritual experience and it's not really a relapse. Just this crazy always think I want to use or um convinced I'm going to relapse cos 'I can't cope' [said in higher pitch] you know [laughs] cope with this. I haven't yet, thank God but ehm and hope I don't but um…last night I woke up hot. Really hot. I'd had strange dreams. Sweating just racing brain, heart going a little bit from this dream that I had. And it was like when I was detoxing, you know I'd wake up all of a sudden red-hot, soaked in sweat so I thought this reminds me of withdrawal. Yeah. I don't find it easy this time of the month I really don't. And I think that anxiety gets a lot more when I'm due my period."* (Claire, age 39, recovery 18 months)

As with the previous sections on new and emerging bodily pain, learning to deal with the returning bodily sensations and the emotions that accompany the menstrual period is challenging for some women. For some women in early recovery and still learning to manage their emotional wellbeing, menstruation involves to some degree, a process of remembering and self-discipline. Insights into the potential for relapse caused by the return of menstrual symptoms and the anxiety that can accompany them suggest this is an area of women's recovering health that requires further enquiry.

Menopause

Seven women discussed their experiences of the perimenopause, the transition time to the menopause,[15] when menstruation ceases altogether. Two women were on hormone replacement therapy (HRT).[16] Jennifer used a combination of HRT and mindfulness practice to manage her symptoms which

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[15] Menopause is defined as having occurred when a woman has not had any vaginal bleeding for a year.

[16] Hormone replacement therapy (HRT) is a treatment to relieve symptoms of the menopause.

she described as '*extreme'* and having '*a significant impact on* [her] *wellbeing.*' Symptoms included brain-fog, anxiety, fatigue and loss of libido. Prior to receiving HRT she had visited her GP to discuss her symptoms:

> *"My doctor, my GP initially diagnosed me as being depressed and I was…offended almost because I knew I was feeling a bit down but I didnae feel like I was depressed. This was a male doctor and I sought a second opinion and went to a female doctor and she got it instantly and she went 'no, you're not depressed this is what's going on for you.' And just to have someone to validate that and go 'yep, this is.' And I thought that's what it was."* (Jennifer, age 44, recovery 10½ years)

While Jennifer attributed her anxiety to something other than depression, her experience echoes those of women elsewhere with regard to health concerns diagnosed as psychogenic (McGregor, 2020; Tuchman 2010). Seeking a second opinion, she felt her concerns were better understood and substantiated by a female physician. Jennifer felt that the menopause was an issue that needed to be discussed more, particularly for women in recovery:

> *"I think that menopause as well is something that should be talked about. Maybe in general but especially for women in recovery. Ehm, who I think you're programmed to always bring things back to yourself and look at yourself and what's going on with you then going through this period of my life this is not something that is the result of my past or, it's just something that all women go through."* (Jennifer, age 44, recovery 10½ years)

Grace said of her experience before accessing HRT:

> *"I just felt like I had baby brain. Everything was getting on top of me. I was getting forgetful. I was thinking I was on something when I wasn't. Just I don't know. Couldn't concentrate. Wasn't sleeping properly. Hot flushes. Over and over. They just got worse and worse and worse. Headaches. Restless. Emotional. You know back to crying at an advert on the TV. Things like that."* (Grace, age 49, recovery 5 years)

Probing further, Grace recalled not liking the feeling that she was *'on something'* and like Claire who experienced the sensation of withdrawal and cravings around the start of her periods, found this worrying and uncomfortable. These findings are important in demonstrating that older women in recovery from drug use can experience peri-menopausal and menopausal symptoms that are similar to the

effects of narcotic drugs and drug withdrawal. Moreover, Jennifer's comment that women in recovery are encouraged (or '*programmed')* to engage in self-reflection is pertinent. It is not, as Jennifer's comment seems to suggest, a period that requires personal self-reflection on past behaviours, actions or thoughts but rather it is a natural bodily transition that requires medical and/or social support and understanding in the present.

Having considered the women's self-reported health and experiences of their bodies and ageing in recovery, the next section explores trauma as felt and embodied by the women.

7.3 Embodied Trauma, Embodied Emotions

Most of the women discussed having experienced some form of physical or psychological trauma. Trauma, in a psychological sense is defined as 'a psychic injury, especially one caused by emotional shock, the memory of which is repressed and remains unhealed.'[17] In the *Body Keeps the Score*, Van der Kolk (2015) suggests post-traumatic stress disorder (PTSD) is embodied and carried on in the body long after the trauma has stopped. Trauma leaves 'traces on our minds and emotions, on our capacity for joy and intimacy, and on our biology and immune systems' (Van der Kolk ,2015: p.1). Janine, who was sexually abused as a child, described the relief she felt after her hysterectomy believing that the trauma experienced in her past was a contributing factor to the cervical cancer she suffered as an adult:

> *"I got really ill, I got cancer in my womb and...I think [childhood] trauma affected that as well...because see when it was removed, the hysterectomy, I have never felt more at peace, more stable, more balanced, more healed."* (Janine, age 47, recovery 21 years)

The sexual abuse Janine suffered was embodied as she felt it, in her reproductive organs. She felt the surgical removal of her womb removed in some way the childhood trauma, leaving her '*more healed.'* Terri, who was

[17] Oxford English Dictionary: https://www.oed.com/view/Entry/205242?redirectedFrom=trauma#eid.

raped as a child expressed how that had affected her health and that even with counselling the physical and mental health effects of the trauma remained:

> *Terri: …and it's the amount of years that it's took [yeah] that's, it's a hard part as well. And it's all the drugs and the drink and how it affected my health as well into the bargain. Because I'm in pain every day, every day. Seven days a week, I'd say.*
>
> *April: Does that stem from the rape, the physical injuries from the rape?*
>
> *Terri: No, that's to do wi the drugs but I'm kidding myself and obviously wi the drink because I wouldnae have sex with anybody unless I had a drink in me because of that happening eh I just all seize up. My body would just totally seize up. And it's just so, so unbelievable how much that could just change your life like that. Ken, somebody could sit and speak to you for hours but when that person goes away it's just there again.* (Terri, age 59, recovery 10 years)

Terri was particularly graphic in describing the intense embodied emotions she still experienced in times of distress. A few months earlier, she had been outed as a woman who used drugs on social media. Here she described the emotions she felt at this violation of her privacy:

> *"Oh I was devastated. Eh I emailed the police. Please it will only take you 10 minutes to go down to her house and ask her to take that post down because it's affecting me mentally and all these people commenting...And I was like I was drained with it come the Monday… totally drained. I was really gutted about the whole situation like. And it went from there to they were actually going to put me under the counsellor because I told the doctor 'that is on my mind in the morning when I wake up. When I go to my bed.' I said 'I am so embarrassed that I feel humiliated at all the amount of people that's joined in and that. Honestly' I says 'I feel absolutely gutted wi this.' And I actually lost weight just in that wee space of time wi the stress of it. I'll never forget it. I'll no, that'll never just go away."* (Terri, age 59, recovery 10 years)

Carrying trauma in the body and feeling the embodied emotions had a temporal aspect that was not easily shaken. Flashbacks (involuntary recurrent memories) cause people to relive the mental and physical experience of trauma when they are reminded of it. Terri's experiences of embodied trauma stemmed from her past as a child-rape victim but the same emotional and physical reactions are felt as she was abused online in the present. Terri imagined she would never forget how she felt, her embodied humiliation carried into the future. Time contracts as

embodied emotions and trauma are felt and relived. The past, present and future seemingly combine. Maya described how images evoke memories for her that are painful to bear:

> *"Like I was saying with the photo…because how horrible the image it creates for me in my mind you know I can see myself, I can remember the feelings and how I felt at that time and it was so horrendous."* (Maya, age 42, recovery 14 years)

Sophie's trauma is relived through the sound of cracking knuckles. As she explains here, this aural memory is one that has remained with her and has shaped her attempts to maintain harmony in her own environment.

> *"I never saw myself as being strong for myself because I think I've always been very much go with the flow and you know um try not to, I don't like conflicts [Hmhm]. I don't like, it's like when my mum and dad used to argue I used to always hear the noise of noisy knuckles cracking [Hmhm] I used to hear that so see when I hear somebody doing that now I still get that kinda [inhales] and I think I try and do everything that I can so that there's no any arguments or what I do is I then try and keep spinning all these plates to keep everybody else happy."* (Sophie, age 55, recovery 5 years)

The re-telling of events in the women's lives could also be a trigger for remembering trauma and its associated feelings. In this example, Ruth (age 36) recalled a meeting with a probation officer, social worker, head of service and addiction worker where they discussed the very real possibility of taking her son into care:

> *Ruth: Like I says I wasn't losing [son]. Didn't even hesitate. I'm like 'I'm not losing my boy, no way. He's not going into the care system.' Ehm and they were like 'so you need to go home and get rid of [the boy's father].' And I was like 'I cannae. He's not going to go.' So like my probation officer actually walked with me to the police station and we went and got two police along to my house and they, they put [the boy's father] out.*
>
> *April: and how did that work then? Did he come back or*
>
> *Ruth: He followed me about the streets for like 3 months.*

April: Right. (Something happens here because I ask) Do you want to move off that subject?

Ruth: I don't know, I've never felt like, it's still quite thingummy isn't it. It's making me feel a bit shaky.

April: Yeah, let's move off that you know if you want. I don't want to make you feel uncomfortable.

Ruth: No, it's, I feel alright. I've spoke about this before but it's never made me feel quite so thingy like I feel like I'm right back there again in that chair in the [project] but eh… (Ruth, age 36, recovery 10 years)

This section highlights that despite all the work the women have put into their recovery, the trauma they have experienced throughout their lives, is still carried within their bodies. Research elsewhere has described the return of emotions in early recovery as something akin to becoming 'un-numb' (Neale, Nettleton & Pickering, 2012: p.93) but eventually, emotions settle and people learn how to manage them more effectively. The findings in this study echo those of Neale et al (2012) but also demonstrate that even in long-term recovery the body still 'keeps the score' (Van der Kolk, 2015) when remembering past events and traumas.

7.4 Conclusion

Chapter seven builds on the studies described in chapter two by illustrating through the women's narratives, the complex bodily processes felt by those in recovery from problem drug use. The women described a number of mental and physical health symptoms that echo the studies cited in chapter two. Captured within these narratives however, the women describe a level of stoicism that helps them to adapt to their dys-appearing bodies as new aches and pains emerge through their recovering and ageing bodies. The long-term effects of prolonged illicit and prescription drug use are concerns for these women, as is the cessation or reduction of some prescribed medications. The intersection of the ageing and drug-free body brings to the foreground changes in the women's values toward their health where greater self-care is taken.

The women's voices reveal how the body and health in recovery involves much more than abstinence from drugs. Moving from drug use and into early

recovery is potentially a time of increased vulnerability for some women in terms of their sexuality, return of libido and need for intimacy and support. Understanding the body and their sexuality as it was in the past and its centrality to feelings of self-worth and self-esteem required the women to learn how to deal with their emotions without exploiting their bodies. Research into this aspect of women's early recovery could help raise awareness and inform practice around this period of potential vulnerability. Moreover, the women needed to interpret new and emerging bodily pain without the anaesthetising effects of drugs. In addition, women approaching or in mid-life also dealt with changes in their reproductive cycles. Menstruation and menopause were events that could interrupt and disrupt the women's bodies and where symptoms needed to be re-interpreted as natural bodily processes. Menstruation and menopause as described by the women suggests symptoms that resemble drug withdrawal which can be particularly challenging for women in early recovery if they are unaware of the similarities. Understanding these sensations as natural could help reduce anxiety for women in early recovery and mid-life/older women in active drug use, MAT and recovery. Implications for practice suggest ensuring treatment staff and prescribers are knowledgeable around this aspect of older women's health as this could enable the offer of appropriate support. Moving from the body in active drug use to the body in recovery is not without its challenges for women in mid-life and older. New sensations and feelings, physical and mental, must be re-interpreted in light of their ageing and drug-free bodies. Understanding what it feels like for women making this transition in relation to the therapeutic landscape that is open to them is the focus of the next chapter.

Chapter 8: Treatment and Ageing in Recovery

"I don't understand why people in recovery never seem to be recovered in the eyes of medical professionals." (Fiona, age 44)

Chapter Overview

In chapter seven, the women voiced their views on the health issues that affected them as they moved from drug using bodies to recovering bodies. They revealed the complex bodily processes the women needed to interpret in light of their drug-free and ageing bodies. This chapter moves on from an exploration of the women's views on their health to address the research question: *What are the women's views on the therapeutic landscape available to them and potential facilitators and barriers to their recovery?* The aim is to show the reader how women in recovery continue to carry the felt and enacted stigma processes of their former drug careers into mid-life and long after their use of illicit drugs has ceased. Chapter eight illustrates the continuous thread that runs through the women's medical encounters from past to present beginning with the women recalling their medical treatment as WWUD and follows with their treatment experiences in recovery. The women's treatment experiences in recovery are looked at in relation to their encountering stigmatising processes followed by their positive encounters with medical practitioners. The chapter concludes with a summary and implications for future research and practice.

8.1. Remembering Health Treatment in Active Drug Use

As discussed in chapter three, stigma can be defined as an 'attribute that is highly discrediting' (Goffman, 1968: p.13) and individuals thus stigmatised are labelled as 'outsiders' or deviants (Becker, 1963). As a social construct and process, the stigmatisation of individuals and groups acts as a function of social and political control and power (Sanders, 2014). This process creates prejudice and discrimination against those considered deviant or outside the norm. Women who have a history of using drugs may find it particularly challenging to overcome the

negative stereotyping associated with drug use (Gunn et al, 2018; Sanders, 2012; Earnshaw, Smith & Copenhaver, 2013). In this first section, the women's experiences of treatment during active drug use are explored through the lens of felt and enacted stigma (Scambler, 2004).

Drug treatment systems and interventions can compound the sense of felt shame through enacted stigma (Koenig & Crisp, 2008). Discrimination and the tension and stress that arise from interactions with health and treatment personnel can have a negative influence on physical and mental health which may reduce reporting of health issues and discourage health-care seeking related to drug use (Ahern, Stuber and Galea, 2007). Fiona said of PWUD attitudes to health treatment:

> *"Addicts don't go to the doctor. Addicts don't get the proper medical care because of stigma. Because of shame. Because they see themselves as being such a drain on the resources. So by the time you realise there is a serious health issue it is too late."* (Fiona, age 44, recovery 17 years)

Fiona's insight supports research elsewhere that as a consequence of stigmatising processes (particularly those that are felt and internalised as shame), some WWUD will take steps to hide their drug use from health professionals to avoid felt or enacted stigma (Anderson and Ripullo, 1996). Most of the women recalled numerous incidents of enacted stigma from hospital and GP practice staff, dentists and other health workers - ranging from inappropriate breaches in confidentiality to sexual abuse. Seeking health treatment as a woman using illicit drugs could be a mixed experience as shown in this extract from Claire who, while still using heroin, required treatment for an infection:

> *"I had this infection in my stomach and my pelvis they wouldn't even treat us properly. They were saying it was probably, this doctor, this consultant I saw said it was probably an STD. I said I hadn't slept with anyone in a few years. 'Oh well it'll be lying dormant'. And I went for a scan and it was like an internal scan and I said 'you're scanning the wrong part. It's in the muscles here I can feel it.' And he just wouldn't listen to us and you know he said it was an STD and then he said I was constipated because I was taking too much heroin and I'm like 'it's not constipation'. I couldn't walk you know I was in a right old mess so I refused to go back to this hospital so it was that doctor from the GP surgery who sorted us out. She rushed*

> *blood tests through and had us in hospital that day. And I went to another hospital, they were fantastic. They were really respectful you know and I didn't feel judged..."* (Claire, age 39, recovery 18 months)

In Claire's remembering, her knowledge of her body and the symptoms were dismissed by the first doctor who saw her. Like Jennifer, Claire sought another opinion. The second doctor she saw listened and treated Claire with respect. Knowing their own bodies, and being familiar with its rhythms and idiosyncrasies, women want to be listened to by staff involved in their treatment.

A few women with comorbid diagnoses of substance use and mental health illness spoke about not being heard and there being a lack of joined-up working between different prescribers. In the following extracts, Ellen and Evelyn, both from small communities, expressed their sense of frustration at this perceived lack of attention from treatment staff to their voices and knowledge of their own bodies. Living in a remote village with a limited number of doctors in the area, Ellen had been barred from or discharged herself from many of the local GP practices. Physical and mental ill health was pretty much a constant for Ellen so her relationships with health professionals were the central subject through much of the interview. Only six months into her recovery, it was clear that a lack of control over her health and treatment was core to her anger and frustration. This was augmented by the perceived lack of joined up care between the different medical structures in place to help Ellen. Referring to her treatment as '*absolutely horrendous'* Ellen further described how different medical approaches left her *'stuck in the middle'* and lacking any sense of control with her embodied self, at the heart of it:

> *"Because what had happened, I was seeing a CPN (community psychiatric nurse) and I was seeing the doctor and it was as if they were arguing between themselves. They were arguing between each other. She was saying one thing. He was saying something else. And I was just stuck in the middle [yeah] like not well. Like I was like pfff and then I ended up, I did end up in hospital. Which could have been avoided if they* h*ad actually just worked between them. It's like 'please work together.'* (Ellen, age 50, recovery 6 months)

Asked if she ever felt in control of her medication or treatment, Ellen said '*No, never. No. because they just won't, they won't listen to you know they actually*

won't.' She described her treatment as '*cruelty*'; she gets '*upset over it'* and feels *'like I'm a hostage to the doctors'* because of the medication and prescribing regime.

Evelyn's experiences of treatment while living on an island off the UK mainland were comparable to Ellen. Both lived in communities far from urban centres, their experiences of mental health and drug and alcohol services and staff were similar. Evelyn was prescribed by the mental health team, drug and alcohol team and her GP. She said of this period:

> *E: Because mental health would give me my prescription for all my mental, my mental state, all my antipsychotic, all that kinda stuff plus my diazepam for my anxiety right. So that was off Dr [NAME] so then I'd have my psychiatrist giving me all that. Giving me that, all my mental health medication plus my sleeping tablets and my diazepam. Then I'd have drug and alcohol giving me my methadone and diazepam because they never check with each other*
> *A: so you're getting double dunt of Diazepam*
> *E: well you haven't heard*
> *A: right okay*
> *E: and then I'd be getting my pregabelin off drug and alcohol as well. Then off my GP I'd get my diazepam, my dihydrocodeine tablets and my sleeping tablets…I think towards the end when they all stopped, when you're in the mental health ward they all and they all say 'right well okay I'm going to be the main prescriber.' But they're that fucking chaotic, the doctors too by the way."* (Evelyn, age 38, recovery 3 years),

The lack of joined-up care that Evelyn and Ellen describe, cannot be conducive to promoting good mental health, but as women with poor mental health and lacking personal agency in terms of treatment their experiences expose the confusing medical and treatment system they are expected to navigate. Recalling an incident where she was given another compulsory treatment order, Evelyn described how her explanation for her mental health was disregarded by medical

staff while at the same time, responsibility for any 'poor' outcomes was Evelyn's alone and not those who made the decisions about her treatment and care:

> *"I'm having withdrawal and they're saying its mental health, you know. 'Section you for your own fucking. Because you're a danger to yourself'. Well actually no, I've been snorting cocaine for the last few days. Partying, drinking. I haven't had any sleep for 72 hours but you're telling me aye. Well let's listen to the person and you know if they're admitting because you know mental health will take responsibility for so much I believe and drug and alcohol will, to a certain degree. But if you totally fuck up, none of them want to know by the way. That's my experience too."* (Evelyn, age 38, recovery 3 years)

The perception of not being listened to and an absence of personal control in situations similar to Ellen and Evelyn's carries the threat of potential reluctance to engage with treatment services or health professionals. Their past experiences colour how they perceive future experiences playing out. For example, Lorna remembered past regimens of prescribing in which surveillance and punishment were administered. This remembering brought forth memories of anxiety and discouraged action in the present which could lead to health problems if symptoms of ill health were left too long without consultation:

> *"I tend not to go to doctors unless I'm actually really concerned…I think the whole appointment system and like having to stick to a time and having to remember to go and all that. And that might come from my using days as well. From missing appointments and not turning up and losing out on prescriptions because you haven't turned up. And punishments for not coming along to an appointment and your script will get stopped and this'll happen. So there was always some sort of anxiety attached to it so it might come from that. I don't really know I haven't really explored that. I just know I don't go*." (Lorna, age 53, recovery 18 years)

A perceived lack of control over their medical treatment stemming primarily from feeling they are not being listened to, is a concern for women who do or have used drugs. The disregarding of women's voices in health care is an act of symbolic violence and a stigmatising process. It is a form of 'epistemic injustice' in which the subject's capacity to 'pass on knowledge' is undermined (Rance & Treloar, 2015: p.31). Listening to women could reduce what might be perceived by some as an unequal power relationship between them and their health providers. Kearney

(1999: p.161) suggests 'paternalistic or controlling tactics in therapy/treatment may replicate past abuse and push women away from help' or make them resistant to treatment. Grace's extract below in which she described seeking help for her cocaine use demonstrates how resistance to the therapeutic relationship could be enacted by women who felt they were negatively judged by practitioners:

> *"I really liked that doctor. I had a relationship with her over 20 years…and obviously bringing my children up she's been their doctor as well _ and she looked at me with absolute disgust that day. And I ended up I just burst into tears. Because I'd been before for help with alcohol ehm [to the same doctor?] yeah [and what was she like with that?] She wasn't too bad. She referred me to someone else...I could just see it in her face. It looked like she'd just stood on something. Maybe she'd thought I'd lied to her. Which I can understand as well. But as a doctor, you know. Because she just shook her head, you know."* (Grace, age 49, recovery 5 years)

Although Grace offered some understanding of why her GP may have reacted in such a way (that she had not fully disclosed the extent of her substance use), Grace still recalled the stigma felt and enacted and in response to the GPs reaction, Grace changed her doctor. Her narrative also highlights the disparity in approaches to problematic substance use. Grace was offered counselling for her alcohol use but her drug use, she felt, was judged differently. Recalling this incident, Grace said:

> *"I think it's harder for women of a certain age to come into recovery and to be open and to be honest and to get the help that they need. I think there's still a lot of stigma there."* (Grace, age 49, recovery 5 years)

Women in mid-life and older seeking help for substance use must feel they are able to discuss their health concerns without fear of judgement. Asked what made a good doctor, Lorna responded:

> *"Empathy, compassion, lack of judgement. Just like your basic things that you do when you respect another human being and their existence and their right to be..."* (Lorna, age 53, recovery 18 years)

For Lorna, a good doctor respects and recognises WWUD and their '*right to be*' in the world. It is a fundamental human right that she feels some doctors do not follow. Lorna's and the other women's experiences regarding treatment during

active drug use support findings from elsewhere (Tuchman 2010; Conner & Rosen, 2008) but it is equally fair to repeat that WWUD and the women in this study also engaged with doctors who they felt provided good care and support. In the following section, the women's experiences of treatment in recovery are explored with a particular focus on the impact of the hepatitis C virus (HCV). The women's narratives reveal continuing stigmatising processes in recovery, prompting the question, when is a women in recovery considered recovered by treatment providers?

8.2 Experiencing Health Treatment in Recovery

In recovery, the women's experiences of treatment were mixed. This section explores those experiences, starting with the women's encounters with stigmatising processes followed by the women's experiences and views on positive care and treatment.

8.2.1 Encountering stigmatisation

Remembering past interactions with medical and treatment staff shaped the women's views of the therapeutic landscape available to them in the present. Having experienced discrimination and stigmatisation across different medical disciplines and remembering her treatment in a maternity ward some seven years previously, Gillian said:

> *"I will blatantly lie to any medical professional if I can get away with it rather than say 'oh aye I used to be a heroin addict.' 100 percent."*
> (Gillian, age 40, recovery 10 years).

Anticipating the judgement and discrimination of health workers based on her previous experience, Gillian's strategy was to conceal her past drug use. Like other women in this study, Gillian had contracted the hepatitis C virus (HCV) and cleared the virus at time of interview but the diagnosis continued to shape her own and their treatment experiences in the present.

The centrality of HCV on the women's conception of themselves and their experiences with medical professionals cannot be underestimated. Evidence

demonstrates that women with bloodborne viruses (BBV) such as HIV or HCV are subject to stigmatising processes (Paterson, Backmund, Hirsch, & Yim, 2007; Fraser & Treloar, 2006; Lawless, Kippax & Crawford, 1996). Nine women in this study reported a previous diagnosis of HCV and all recalled experiencing discriminating practices across different health providers including maternity staff, practice nurses and dental practitioners while in active use. Nevertheless, in recovery a former diagnosis and the presence of antibodies could elicit explicit and implicit stigmatising behaviours from health workers as shown in Gillian and Shona's examples below:

> *"I was absolutely fucking furious that they…oh god yeah…I'm still pissed off about it you know. I mean its seven year but I'm still pissed off about it...Well at first my mam was there and the nurse came in and said 'Gillian you can't breastfeed because you've got Hep C. Oh did your mam know about your hep C?' I said 'well it's a good job that me mam does know about hep C.'... But more important was the information which was completely fucking inaccurate. There was never ever any risk whatsoever to the kids but she was making out I was like harming my children. But not only was I harming my children she was telling all my visitors about it."* (Gillian, age 40, beyond recovery 10 years)

> *"I was in the hospital oooh I think it was this [indicates face/neuralgia] and they had it down I was hep C. And I wasnae, I was clean at the time with the [inaudible]. And I says to them 'I'm no hep C'. And I thought it was weird because I'd been put in a room myself. And I says to them 'I'm no hep C'. 'You not?' I went 'no, I went through the treatment, cleared it.' I got put back in a ward with other people and I thought 'hmm interesting.'"* (Shona, age 60, recovery 12 years)

For both women, the memory of these events stayed with them. While Shona was somewhat circumspect (and we cannot know why she was put in a room on her own), Gillian still felt the raw emotion she experienced on that maternity ward when her patient confidentiality was compromised. The contribution of health professionals to the stigmatising process of people living with HCV is clearly described in Harris's (2005) study of the 'Medical Encounter' but as the findings from this study suggest, that process can still be experienced in recovery and long after the virus has been cleared.

Discrimination and differential treatment based on moral judgement combined with a focus on treating the condition rather than the person living with the condition engenders felt and enacted stigma for those seeking (or who have sought) medical treatment (Harris, 2005). Women who contract a BBV may carry the double burden of being viewed as 'diseased' and failing as 'carers and nurturers of the next generation' (Lawless, Kippax & Crawford, 1996). In other words, these are women who do not live up to the appropriate social and gendered roles that are expected in society. They are 'abject bodies' (Ettorre et al, 2017; Kristeva, 1982) who have 'crossed some line' in the social order (Douglas, 1966; p.114). For the women who had contracted HCV, this was a highly stigmatising condition. Most recalled enacted stigma from medical staff and all had felt stigmatised because of their condition. Terri's experience of being HCV positive and then clearing the virus was complicated. In the following section, she describes the emotional toll of continually disclosing this aspect of her medical history:

> *"…every time you go to an appointment you've always got to mention your past. It always comes into the equation...and I still have to say because I've got the antibodies. And it is really, I dread hospitals and that right. I hate it."* (Terri, age 59, recovery 10 years)

Terri not only fears having to disclose her HCV status but she clearly feels that she is being judged by some (not all) medical staff. Feeling stigmatised combined with the possibility of being actively stigmatised is still anticipated even after 10 years in recovery. Terri has internalised stigma and as an ex-user feels less deserving than 'normal' patients *"you don't feel you've got the same say when you're on drugs."* She has a perception that there is a hierarchy of patients in which those with a history of addictions are below those without. For example, Terri talked about having contracted HCV possibly through a blood transfusion in the 1980s but failed to fill in a claim form because she thought it would be dismissed due to her drug using past: *"right away they'd be like 'no you contracted that because of your drug use.'* Although Terri cannot be certain she contracted HCV via the blood transfusion, she accepts that it is likely her '*fault'* and her felt stigma is a barrier to potential compensation for what in fact could be a medically induced illness.

A consequence of felt and enacted stigma on women with a history of HCV is that the 'discreditable' (HCV carrier) must manage information (HCV diagnosis) about them that might lead to their 'discrediting' (Goffman, 1968: pp.57-58). Harris (2009) describes how people who use drugs with the hepatitis C virus (HCV) are potentially discreditable rather than discredited. The narratives of some of the women in this thesis suggest that the process of managing a former discreditable identity as someone with HCV is still practiced in order to maintain creditable identities in the present. It seems for some women, clearing the virus does not mean they have overcome the potential to be discredited for their past HCV status. This is important because as the women in this study confirm, just disclosing an HCV diagnosis led to their association as a person who injected drugs. The practice of injecting meant they had 'crossed a line' and as such were morally responsible for their illness: 'The person, who injects by breaking the boundary of the skin, epitomises the monstrous or abject' (Harris, 2009: p.41). For women who injected, this embodied practice was one that resulted in stigmatising processes long after their drug use had ceased. Attending recent hospital appointments, Terri and Fiona described some of the attitudes they had experienced from hospital staff once their former injecting use was revealed:

> *"…I feel like a broken down record the amount of times because I'm saying the same thing over again and I'm going 'here we go again. It's to do with my past that my veins are like this.' Some of them are alright, some of the nurses. They can maybe go 'look you could just have they veins, it could well no be nothing to do with your past. And the past is the past.' [Hmhm]. But you've got other nurses that could be a wee bit, you could tell. You actually sense the coldness of them, ken? As in they can't be bothered with the likes of me basically [Hmhm]. That's what the bottom line is. They just can't be bothered. Their job is to help the people that's right not well. Not the people's that's eh got addictions and things like that. [April: Like even though you're 10 year clean] You're still there. You're still in that situation that you go 'here we go again'…it's highly embarrassing like."* (Terri, age 59, recovery 10 years)

> *"I mean even recently I had to go into hospital, I had to go to a day care unit to get some blood taken and a nurse actually said 'oh I see you've had a naughty past.' And I remember looking at her and I said 'the words you're looking for are I've had an addiction. It's over 17 years ago. Clearly you're still judging me based on my medical history' [Hmhm]…It's the*

stigma. It's the judgement. And I think medical professionals can be quite judgemental." (Fiona, age 44, recovery 17 years)

These extracts show how stigmatising processes are implicitly or explicitly enacted by hospital staff calling out the women's injecting past but equally how they are internalised and felt by the women. Terri felt embarrassed while Fiona felt judged. In response, Fiona confronted the nurse's comments and rephrased them back to her. In contrast to Terri who did not react, Fiona challenged on two fronts the nurse's judgment of her as a former user of illicit drugs and the nurse's professionalism.

The experiences of the women in this study who did not inject revealed ongoing felt and enacted stigmatisation. Returning to Ellen, in very early recovery and living in her remote community, her relationships with numerous doctors was extremely challenging for her as illustrated in this extract:

Ellen: I've got arthritis in my, my hands [Hmhm]. And I damaged my neck but because it's like to do with pain I have never been to see her (the doctor) once without her mentioning drug taking. And I'm like 'do you want to just forget about that. Just forget about it for 5 minutes and just listen to what I'm saying.' Because she's not listening to what I'm saying, at all. Do you know. So I'm like pfff. So I'm in two minds about changing my doctor.

April: Is there another doctor you can see then or is there another one in [town].

Ellen: Oh I've been banned from a few now. I've just lost the plot with them because I'm like 'you're not treating me right. You're not treating me like…if I hadn't had that problem, would you be treating me completely different?'

April: What, you mean if you hadn't had the drug problem?

Ellen: Aye. Oh totally. (Ellen, age 50, recovery 6 months)

Ellen's belief that her history as a woman who used drugs determined her treatment in the present exposed the stigmatisation she felt. Finding it difficult to communicate her needs to her current GP was frustrating for Ellen and she had resorted to buying prescription medicines to treat her arthritis. Explaining why she

bought Gabapentin[18] to ease the pain in her hands instead of seeking them from her doctor, she said:

> *"...because I'm too scared to go and ask for them...I do want to put in a complaint because I don't think it's right. I think it's like torture. It's like that woman's getting enjoyment out of it. You know it's like being in control, it's like I'm fucking 50 year old do you know."* (Ellen, age 50, recovery 6 months)

Her ability to change doctors was limited by the rural area in which she lived and as such, Ellen's strategy of confrontation and challenge was a highly precarious one. In addition, her illicit purchase of Gabapentin had the potential to be dangerous as it increases the risk of depression and suicide ideation as well as having serious abuse potential (Evoy, Morrison & Saklad, 2017). Specifically mentioning her age suggests to me that feeling she was not being listened to and thus lacking a sense of control over her health and pain management, Ellen perceived her maturity and corporeal experience were dismissed by the doctor treating her.

Chronic pain, such as arthritis, can lead to a sense of losing control over health and lives, but equally women with low confidence and trust in health professionals can also demonstrate resignation to health conditions through actions such as submissiveness, helplessness and negativity (Kearney, 1999). Nevertheless, there is evidence to suggest that some physicians are reluctant to prescribe some pain medications with potential addictive properties (such as opioid analgesia) to patients with a history of substance use (Baldacchino, Gilchrist, Fleming & Bannister, 2010). Interviews with a range of physicians including pain specialists suggest various reasons for this reluctance including fear of addiction, misuse or diversion of drugs as well as prejudice regarding pain-seeking behaviour with said patients often considered 'guilty until proven innocent' (Baldacchino et al, 2010: p.272). Early recovery for older women may be a particularly challenging time as they come to terms with their changing bodies and bodily sensations while at the same time their interactions with health and treatment workers involves learning

[18] Gabapentin can be prescribed to treat nerve pain.

how to communicate these sensations effectively. For those who experience chronic pain, proper pain management must be provided otherwise health practitioners (prescribers especially), run the risk of patients seeking pain relief that is non-prescribed, of unknown quality, sought from the black market and not medically managed, thereby further complicating poor health and raising the risk of potential overdose for women in recovery seeking relief for chronic pain.

Ruth, age 36 and abstinent for 10 years had recently seen her doctor. He refused to prescribe a drug that would have helped her insomnia because of her history of illicit drug use:

> *"…so quite recently it would have been this year and I went to the doctors and I was like having some trouble sleeping and I was feeling a wee bit down and stuff and I was explaining to the doctor how I was feeling and they were like 'well you know we cannae give you this because it's addictive.' Like and you're just automatically like that was the first thing that come out their mouth and I was just like 'really after all this time, that's you think I'm here, back here chasing'… maybe they've just seen it happen too much or maybe they go through it too much, like that scenario or whatever. But it's just remembering to, dealing with that person sitting in front of you not the person you dealt with 10 minutes ago or two weeks ago or do you know what I mean?*" (Ruth, age 36, recovery 10 years)

Ruth understands why the doctor would not prescribe but as she perceived it the doctor de-personalised the therapeutic relationship and negated her 'recovered' identity. The doctor associated Ruth with people actively using drugs and with her former drug-using, (self-acknowledged) pill-chasing self. The ten years of recovery from age 26, the challenges faced and overcome: from lying in the prison cell (see chapter 5) to her life as it was now, folding back through time to the past. As Fiona said:

> *"…your addiction never seems to be historic. Whereas with a criminal conviction it's classed as historic, when you've had an illness it's classed as historic. You're in kind of remission for example. Or you've healed or recovered. I don't understand why people in recovery never seem to be recovered in the eyes of medical professionals."* (Fiona, age 44, recovery 17 years)

Whether a former injector or not, this study provides further evidence of the

stigmatising processes experienced by women with a history of illicit drug use long into their recovery. The role of mental health illness in relation to the women's felt and enacted stigmatisation was not raised by the participants during the interviews and therefore no analysis has been carried out to explore the relationship between the women's perceived treatment and mental health. Nevertheless, the findings do support the work of others (Ahern, Stuber & Galea, 2007) by demonstrating the reluctance of some women, such as Ellen, Lorna and Gillian to report health issues and seek timely health care. As some women perceive it, being recovered or in recovery does not negate their past drug-using histories among some treatment providers. However, that is not the whole picture. Many of the women were keen to point out the positive attributes of treatment providers and the therapeutic landscape available to them and we explore this in the next section.

8.2.2 Encountering encouragement

Making time and building consistent relationships with health care providers were considered important attributes for helping women into recovery and encouraging them to maintain good health as they moved further away from their drug using past. Finding time to listen to the women was appreciated, as was going beyond what the women perceived as usual practice. For example, Kate's GP would call *"every couple of months just to say 'how are you?'"*, while Claire's GP offered social as well as medical support, as she would *"come to child protection meetings with us."* Making and taking time to listen to the women was important and helped the women feel valued. Terri's GP would "*just sit and let me blabber on."* However, more than simply letting Terri 'blabber on' the GP also listened and then provided Terri with a sense of agency over her treatment:

> *"And then he'd say 'right what are we doing the now? Are we going to start cutting you down?' and I'd be like 'well, we'll try it.' Because he spent all that time wi me, I was willing to try anything and I thought, and I kept saying to myself 'I'm, not letting him down either. I am not letting this man down.'"* (Terri, age 59, recovery 10 years)

Responding to the GP's investment in her (giving her time, listening and offering her some level of control over her treatment) Terri resolved not to disappoint him.

Having a good relationship with a doctor was important to the women and key to building such a relationship was consistency.

A sense of consistency and continuity is important for many patients interacting regularly with health professionals (Bastemeijer, Voogt, van Ewijk & Hazelzet, 2017). Having a regular, consistent and dependable GP was important for Kerry, who had been recently diagnosed with Asperger's, a condition that makes it challenging to build relationships: *"I'm trying to see the same one so I've got some consistency so he knows me."* Knowing someone is there to care for you, albeit in a professional way, and is familiar with you and your health care needs, is reassuring. However, as described by Jennifer, building relationships over a long period with health workers can bring about tensions, albeit unintentional:

> *"The only one of my doctors who brings up my drug using past is the phlebotomist. She's lovely right…loves a wee chat…She's known me for years. So I probably initially disclosed that information to her that thinking that someone like her should know. And then every time we meet now she always asks me stuff ehm…I don't feel like she's being judgemental in any way but…I just wish she wouldnae bother saying it. But she couldnae be any nicer and she thinks I've done fantastic in life and all that."* (Jennifer, age 44, recovery 10½ years)

This extract demonstrates the potential challenges that might occur between patients and health personnel. Although the phlebotomist knows Jennifer's drug using history, is non-judgemental and likeable, at the same time her knowledge of Jennifer's past and regular references to it and her achievements in recovery, are a source of embarrassment for Jennifer. Meanwhile, the phlebotomist has no idea she causes these uncomfortable feelings because Jennifer does not verbalise her discomfort. For some women, positive reinforcement from health staff long after drug use has ceased can be as uncomfortable as being negatively judged for their past.

As well as time and consistency, personal attributes such as empathy, compassion and respect were considered important by the women. Recognition of the women's rights as '*another human being*' was voiced by Lorna who pointed out that making '*bad choices*' does not mean people who use or have used drugs are '*bad people*.' Honesty between health staff and the women was essential for

encouraging and developing good therapeutic relationships. Returning to Ruth's remarks about being compared to other people who use drugs, most of the women spoke about manipulating doctors for prescription painkillers or anti-depressants at points in their period of illicit drug use (which rather supports the judgements of some of Baldacchino et al's (2010) sample of physicians). Nevertheless, doctors that prescribed on demand were viewed as weak and therefore less respected and more easily manipulated. Evelyn said of her past behaviour with GPs: "*You know if your doctor weakens once you know, that works for me so I keep them.*" However, describing her GP at the time of interview as '*hard core',* Evelyn said*:*

> *"She's just like wow 'I'll be your doctor, I'll help you when you're physically sick or mentally. However if you're coming to me wanting drugs, it's got to be a no.' That's what people need...I kept the same one cos I knew she was good. Because if I went there and I went 'oh I need some Valium.' She'd be like 'on your bike.'"* (Evelyn, aged 38, recovery 3 years)

Still in relatively early recovery, Evelyn's goal was to maintain her abstinence, new family and home. Having a GP she had built a relationship with in her most recent rehabilitation facility, she chose to continue seeing her, not least because the GP would maintain strict boundaries with Evelyn in terms of prescribing medication.

Doctors who were '*open'* and *'honest'* with the women about their drug-using history were considered essential for recovery. Despite some of her negative experiences with medical practitioners, Fiona found a doctor whose straightforward approach sent her along the path of holistic health care:

> *"I've had a great doctor…And he was one of the first doctors that I've come across that's been very open with me about my addiction and he said 'right. Let's be honest Fiona you're not getting tablets. There's no way I'm giving you tablets'. He said 'if you have an addictive personality. If I give you anti-depressants there's you for another 20 years.' So he got his prescription pad and he wrote exercise, healthy eating, leave your job, set a goal. And I looked at him with this prescription and I said 'are you shitting me?' He went 'No Fiona. You have a history of addiction. I'm prepared to help you holistically.' He said 'you are not going to get better with medication' he said 'your whole past will tell you that.' He said 'so I'm not just going to be someone who is going to dish out a prescription for you.' He said 'go and find some joy in your life.' And I remember looking*

> *at him and thinking 'really?' but he was right. And that's when I went the holistic route. Um about finding what made me happy. And actually what advice he gave me was absolutely true. Should he have said about addiction? I was quite glad that he did."* (Fiona, age 44, recovery 17 years)

Giving women a sense of agency over their health care is essential if the women are to feel they have control over their treatment. Fiona's GP may have refused the drugs she sought and wrote a social prescription but in doing so he enabled Fiona to reassess her 'addiction'. He helped her acknowledge the damage anti-depressants had on her health in the past and might have on her recovery in the future. Furthermore, he encouraged Fiona to treat her mental health condition through alternative means such as exercise, diet and goal-setting. Evelyn's GP similarly refused to prescribe medication she thought non-essential however Evelyn's agency lay in the fact that she knew her GP's prescribing practice, and chose to remain in her care because of this knowledge.

There is a fine line that health professionals walk in their treatment of women with a history of using drugs. Providing the participants in this study with a sense of agency in terms of their health care instilled a sense of responsibility over their own recovery. Important too, was that the women were validated in terms of their health needs. Women who were listened to and heard, whose opinions were sought and acted upon, who had managed to build a relationship with their GPs and other health professionals, were more satisfied with their health care than those who did not experience these simple yet effective structural and personal attributes. In addition, offering women alternative ways of managing their health other than through medication can provide them with a sense of agency. Treating women as 'authorised knowers' (Tuana, 2006: p.9) of their bodies acknowledges and respects their bodily experiences and feelings whilst at the same time respectfully setting boundaries.

8.3 Conclusion

In conclusion the women's views on the therapeutic landscape available to them were mixed. The narratives of the women interviewed for this thesis

demonstrate that enacted stigma within the health care system dogged them long after their drug use had ceased. The women's experiences of treatment in recovery were varied but staff consistency and having time to listen were structural attributes considered important to facilitating their recovery. In addition, honesty, empathy, compassion and respect were some of the personal attributes that engendered positive therapeutic relationships. Despite the positive staff attributes described, the women were nevertheless subject to discrimination and stigmatising attitudes in treatment, even among those in long-term stable recovery. Some carried the triple burden of being an older woman with a drug-using history and a past diagnosis of HCV. The findings suggest that in terms of medical care and treatment, women in recovery can find it difficult to leave the label of former drug user behind. For some older women, coming to terms with the aches and pains of drug-free and older bodies, felt and enacted stigmatisation is a potential barrier to seeking health care.

There are two very clear implications for research, policy and practice suggested by the findings. Foremost is the need for improved communication between health practitioners and women in recovery: strengthening women's ability to ask pertinent questions regarding their health and treatment, and encouraging practitioners to listen to women's concerns, is important for maintaining good health and pain management. Improving communication would also cultivate women's sense of agency over their treatment. Secondly, while there is clear evidence of felt and enacted stigma by health staff toward people with BBVs, the findings in this study suggest these attitudes and practices of discrimination are still prevalent for women with a history of HCV and/or injecting behaviours, long after they have cleared the virus or ceased injecting. Educating nursing and other health practitioners about hepatitis C, other BBVs and illicit drug use, could help reduce the stigma associated with them and improve therapeutic relationships.

Chapter 9: Conclusion

"You think you put the drugs or the drink down and your life's automatically gonnae get better and it doesnae. It's a lot of lot of work, a lot of hard working."
(Ruth, age 36)

Chapter Overview

In the introduction, I argued this study was needed to advance UK research on mid-life and older women's perspectives on and experiences of drug use, treatment and recovery. As I come to the end, I still maintain the voices of the participants in this study should be heard, not least because they provide unique and original insights into the processes of recovery for mid-life and older women in the UK with a history of problematic drug use. As noted in chapter two's review of current research, the major gaps in our understanding of older people who use drugs or are in recovery is the perspectives of mid-life and older women. This thesis provides additional useful insights to those studies by exploring the intersection of gender, ageing, drug use and recovery through the voices of women with lived experience.

Here in the conclusion, I want to take the reader through the key findings, drawing out the major factors that help and/or hinder women in recovery who have experienced harmful effects of drug use. The structure of this final chapter presents first, the key findings drawing on the themes that emerged through the analysis and within the context of the relevant research question. There follows a section on implications and future directions for research and practice. Finally, the conclusion rounds off with a discussion of the limitations and strengths of this study and final thoughts.

9.1 Key findings

The main aims of this study were to explore, from a sociological perspective, the impact of relationships and ageing on the recoveries of women in mid-life and older with a history of problem drug use. Grounded within a symbolic

interactionist tradition (chapter 3), the everyday interactions of the women are explored as they learn how to manage their recovering and dys-appearing bodies (Leder, 1990) and the stigmatising processes that are felt by and enacted upon them (Scambler, 2004). Looking at the women's relationships with self and others through the concepts of doing, being and becoming helped focus analysis on the influence of social interactions on the women's actions (doing); how they saw themselves in comparison to their pasts and potential futures (being); and, how their experiences of being a woman ageing in recovery affected their development (becoming). Finally, the narratives raised important aspects of the women's sense of themselves and their place in the world through their sense of belonging. Adopting a feminist approach that put the women's voices front and centre (chapter 4), this unique study contributes to the literature by presenting the voices of 19 women living in Scotland and the North East of England who had lived experiences of drug use and recovery. Their voices give valuable insights into the social interactions and bodily experiences that accompanied their journeys from women who used drugs to mid-life/older women in recovery. They add new and important findings to studies on older people who use drugs and recovery studies, by exploring the intersection of gender, ageing, drug use and recovery from a feminist standpoint. Using a novel and creative method to undertake qualitative interviews, along with a thematic analysis of the data, a picture emerges of relationships with objects, significant others, treatment others, their ageing-recovering bodies, and importantly their relationships with their self.

Adding to the literature on older people who use drugs (chapter 2), the women in this study describe from their standpoint their experiences of ageing-recovering bodies. They make an important contribution to research that explores the impacts of drug use on people's mental and physical health and importantly, how it feels to be an older woman in recovery (chapter 7). The women articulated the ongoing work they performed to convince others of their authentic recovering/recovered identities (chapters 5, 6 and 8). In performing an authentic identity, the women spoke of learning new ways of being in the world and, how over time new habits and ways of being transformed not only how they saw themselves, but also how they viewed their relationships with others. Introduced to the reader through their meaningful objects (chapter 5), their artefacts showed

how the women drew on the symbolism attached to them to narrate their stories of recovery from problem drug use and recovery from past selves. There is merit in the argument that some people are trying to recover a 'spoiled' identity (McIntosh & McKeganey, 2002; Biernacki, 1986) but it is also the case that for many of the women in this study, reverting back to their former identities prior to drug use was not an overwhelming desire. Feeling like outsiders as children and adolescents and their experiences as women with substance use issues often in violent and exploitative relationships (chapter 6), many of the participants in this study simply wanted to leave old identities and ways of thinking and behaving behind. The meaningful objects the women chose illustrate how they valued the connections that linked them to new ways of being in the world. Whether connecting to people, animals or things, discussing their objects or indeed their absence, provided the women with a unique space of their own choosing to reflect on their relationships, and the attributes and values that were important to them.

The first research question asked '*What is the influence of social relationships on women's sense of self as they age into recovery?*' Based on the women's narratives, this was a two-way process in which the women's growing confidence, improved self-esteem and self-awareness influenced their social interactions and relationships with others and vice versa. The women spoke of the importance of (dis-)connecting, (re-)building and belonging in helping them move from lives disrupted by problem drug use to lives that, for most, were fulfilling and grounded in their recovery. Remembering their move out of drug use that had become too unmanageable to maintain and in to recovery, the women recalled having undergone a period of isolation and alienation from their families and others. Borrowing from Goffman's dramaturgical approach (1959), as the supporting players left the stage the women were left alone. The findings suggest that for some of the participants, the loss of meaningful connections was a catalyst for change. This study along with its pilot (Shaw, 2017), point to the relatively unexplored and potentially important dynamics of mother-daughter relationships. As these women aged into their recoveries, the expectations of family members – their mothers, adult children and siblings – diverged from the women's own needs and desires. As discussed in chapter 6, overcoming and resisting the carer role that others expected of some of the women required

negotiation and honesty. Although age was not explicitly discussed in terms of relationships, clearly some of the women were entering or had entered the stage of mid-life when adult children had or were leaving home, grandchildren were present or on the way, and older parents required more time and potential care. As the women built and developed new (and old) relationships, they engaged in interactions over which they exerted some level of control. For some of the women, returning to old familiar, familial roles of being the go-to person or carer was no longer a position they wanted or needed to fill. Unwilling to participate in social and familial relationships that did not nurture or support their recoveries or respect their sense of self and place in the world, the women disengaged and disconnected from unsupportive relationships. Instead they made connections to new supportive ones or rebuilt existing social relationships with clear boundaries defined by the women themselves. An important finding emerging from this thesis is the role of family members' expectations of and their attitudes and behaviours towards women in recovery: sometimes helpful, sometimes not.

Recovery communities were important enablers for some of the women, helping them build connections to peers through the sharing of experiences, knowledge and language. Being listened to by others increased the women's self-esteem and helped them gain a sense of self-worth that was lacking towards the end of their problematic drug use. For the women in this study, recovery was an ongoing process in which they rebalanced doing, being and becoming by setting boundaries with others, assuming more control over relationships and developing a recovered identity that others, and they, could view as authentic, honest and genuine. The interaction between doing, being and belonging in recovery promoted a sense of moving forward and becoming the women they aspired to be. Engaging in ordinary routines, participating in social activities and belonging to social networks unrelated to active drug use encouraged the women's developing identities and sense of self as women in their own right, rather than women defined by substance use.

The women's narratives around health and ageing in recovery shed new light on embodied experiences of recovery among mid-life and older women with a history of drug use (chapter 7). They build on the health studies described in

chapter 2 by providing detail on what bodily recovery *felt* like for these women. The second research question asked '*How do older women with a history of problem drug use experience their bodies in recovery?*' The women's voices tell us that recovery as it was felt by them was a complex bodily process. Echoing research elsewhere, an assumption of health improvements brought about by abstinence from substance use belies the emerging aches and pains previously masked by drug use (Neale, Nettleton & Pickering, 2012). Most of the women had co-occurring mental and physical ill health while in active drug use and while there were some improvements over time, a number of the women continued to experience chronic pain and health problems in recovery. For others, the absence of drugs brought forward new pains and bodily sensations.

As these women provided new insights into the complex bodily processes felt in recovery, they revealed a stoical approach to ill health and pain. This stoicism combined with a tendency to frame their present health in terms of their past drug use. The aches and pains of their dys-appearing bodies were perceived as a consequence of their drug use and/or the natural consequences of ageing. Borrowing from Leder (1990, p.90), for some of the women in this study 'the assumption of a *recovered* body rendered problematic what was previously tacit.' However, this is not to say women thought of their recovering-ageing bodies as bodies in decline. Some of the women actively worked out to maintain good physical health and almost all practiced some form of meditative or therapeutic practice to maintain good mental health. As demonstrated in the impromptu display and discussion of photographs of themselves, despite their new and emerging pains, the body in recovery was preferable to the body in active drug use. The participants' discussions around their menses and [peri-] menopausal symptoms shed further light on a neglected aspect of research in the addiction literature. Adding to the work of Tuchman (2010) and Schoenbaum (2005), the women's narratives highlighted and confirmed the similarities between the effects of drug use and withdrawal and the symptoms of pre-menstrual tension and the peri-menopause/menopause.

Another important aspect of recovery for a few of the women was using sexual intimacy to improve their sense of wellbeing and self-esteem in the early

stages of their recoveries. Psychologically this was a difficult time and for some, returning to past behaviours in order to receive physical or emotional comfort was perceived as unhelpful in the longer term. Moreover, the remembering of past traumas and physical and sexual abuse were carried and physically felt by some of the women. Learning how to manage painful memories without substances required courage and acceptance that they were women who deserved to be valued and loved. For most of these women, their ageing-recovering bodies as vehicles for pain and comfort were ones that had to be re-learnt in relation to their now drug-free bodies. Valuing their health in recovery the women took steps to ensure greater self-care however, as with social relationships the women had to learn to negotiate their way through the therapeutic landscapes available to them.

Seeking to answer the third question, '*What are the women's views on the therapeutic landscape available to them and potential facilitators and barriers to their recovery?*' the women discussed their interactions with treatment providers and health staff. What clearly stood out in the women's experiences were the ongoing challenges of leaving behind the drug-user identity, even long after they had stopped using drugs. From their standpoint, overcoming the stigma associated with the drug-user identity was an ongoing process in relation to some of their encounters with health workers. The women were aware that some of their interactions with health services were predicated on the fact that they had been problem drug users in the past. Some of the women accepted the stereotyping of PWUD as pill-popping, drug seekers – readily accepting that their past behaviours justified this perception. However, as women in recovery, some for over a decade, being reminded of or having to justify or explain their past in relation to current health issues was frustrating and stigmatising. This was particularly distressing for those women with prior HCV diagnoses who encountered what they perceived to be implicit and explicit discrimination. Internalising felt and enacted stigmatisation left some of them feeling helpless in terms of their ability to seek and convey information about their health to medical staff, while at the same time perceiving doctors and other health workers were not listening to them. The importance of these findings should not be underestimated given that this was a sample of women who were learning to reinterpret and understand their recovering and ageing bodies. Whether consciously practiced or not, implicit or

explicit stigmatising processes are active barriers to seeking help (Ayres, Eveson, Ingram & Telfer, 2012; Koenig & Crisp, 2008). Furthermore and importantly, such processes are barriers to understanding the changing body which may have implications for mid-life and older women's health and wellbeing. Nevertheless, positive and supportive interactions were also encountered.

Structural and personal attributes such as making time and consistent therapeutic relationships, were considered important to aiding a healthy recovery and maintaining good mental and physical health and wellbeing. Still, as was made clear by the women in this study, encountering stigmatising processes and/or feeling stigmatised are potential barriers for older women seeking support or treatment for health issues that may or may not be related to past drug use. As older women with discreditable identities, their recoveries are facilitated by therapeutic landscapes that provide treatment that is consistent and non-judgemental and in which their views and embodied experiences are listened to, acknowledged, considered and appropriately acted upon. That women did at times experience such therapeutic interventions within existing health structures, is evidence that where this is practised it offers motivation and encouragement that is reciprocated through better communication between health workers and the women.

A common thread that runs through the women's narratives is the importance of social and therapeutic interactions in helping the women develop a sense of personal agency. Feeling they had more control over their relationships, bodies and health, the women's sense of self-esteem and self-worth increased. Having options and choosing their own course of action into and through recovery, the women's sense of agency was felt and acted upon in the context of other individuals and social structures. Women who endure significant disruptions in their lives may require or rely on numerous agencies, experts, relatives, peers and others to assist them through difficult periods and challenging life events. The women's narratives throughout the findings in this study highlight the contingent nature of recovery. These women may have gone down their final recovery road with or without medical treatment nevertheless, none of them recovered without the help of others. While developing, nurturing and practising a sense of personal

agency was salient to the women's self-efficacy, it was also contingent on the interactions of others. In doing, being and becoming the women they wanted to be, they engaged in lengthy and sometimes difficult processes of learning how to set boundaries. At the same time, they worked hard to nurture and cultivate a sense of belonging through their interactions with others.

9.2 Implications and Future Directions

The findings suggest a number of research and practice implications that might be considered for future directions. The participants in this and the pilot study have highlighted the challenges faced by older women in repairing and rebuilding healthy relationships with parents, siblings and adult children (chapter 6). Looking beyond women's intimate partner relationships and social relationships in recovery communities, future research that explores women's relationships with their mothers, fathers, siblings and adult children would shine a light on the relatively unexplored dynamics of these important and often fractured relationships. Gathering evidence on this issue could help existing family support and treatment services to assess the need for developing support programmes and materials for older women actively using drugs or in recovery, and their families. Developing therapeutic interventions that help mid-life and older women and their families manage past tensions and set boundaries in the present and future could enhance and support the transition from women who used illicit drugs to recovered mother/daughter/sister. Enabling women and their significant others to manage difficult relationships may reduce further risks to women's health, including the very real risk of overdose and death, and may help facilitate and sustain the long-term recoveries of women who use drugs and their families.

Second, given the potential for some women in early recovery to use their bodies and sexuality to manage their emotional wellbeing (see chapter 7), improving women's self-efficacy through interventions that address counter-productive behaviours could help reduce sexual health risks that leave women vulnerable to abuse and potential relapse. Understanding how women manage this period of early recovery could inform and enhance the development of therapeutic alliances. Furthermore, trauma-informed counselling should be offered at the

point where women will benefit most effectively. Actively listening to women and responding accordingly would be the first step to understanding the ongoing impact trauma has on their mental and physical health and wellbeing in recovery.

Third, while this study has looked at women's experiences of menstruation, peri-menopause and menopause, there is still a great deal of research required to understand these aspects of women's natural bodily processes through drug use and in recovery. For example, understanding the relationship between the menopause, drug use and risk behaviours, and exploring the impact of the menopause on HCV and other health-related issues, could help identify areas of women's health not currently considered in the UK addiction literature. Furthermore, ageing into midlife and older is not a barrier to sexual enjoyment nor should it be a barrier to addressing sexual health concerns. Older women must feel they can approach and openly discuss their sexual health needs with drug treatment and other health providers. Therefore, auditing treatment providers' awareness, knowledge and confidence in raising and discussing these health issues would help identify any information and training needs. Furthermore, the growing proportion of older women in the UK who use drugs raises the possibility of increasing drug deaths, as already evidenced among women in Scotland (Tweed, Miller, Schofield, Barnsdale & Matheson, 2020) and so it is imperative that older women who are using drugs are able to access health care and social support without fear of discrimination. The women in this study, although now in recovery, had with few exceptions, been victims and survivors of domestic and sexual violence, and had experienced trauma and mental health disorders. Therefore women of all ages with a history of drug use require gender-informed, gender-appropriate services that are holistic and take account of women's bodies and social landscapes over time. Women are more than the sum of their reproductive parts and require women's services that take account of the bodily and social changes that occur over their lifetime, not just those that focus on reproductive health and motherhood.

Four, the findings in this study demonstrate some of the challenges women experience as they come to terms with their changing bodies and bodily sensations. These include learning how to communicate effectively their new

bodily sensations to health and treatment providers. Some of the women in this study discussed avoiding seeking support or advice for health conditions, fearing they would not be listened to or their views not respected. Women in general, not just women with drug-using histories or older women, should be able to communicate symptoms and concerns openly without feeling judged or disregarded. Future directions in health provision for people who use drugs should seek ways to increase health practitioners' abilities to engage more effectively with older women who use drugs on a range of health issues. A first step in this direction would be to carry out a comprehensive and systematic review of health-focused interventions whose aims were to improve patient/doctor communications and knowledge. A second step would be to engage with treatment providers in the UK to explore the potential facilitators and barriers to better communication between them and their patients/ clients. A scoping exercise of a range of health workers, including GPs, could explore their attitudes and willingness to engage with people who use drugs including older women. Leaving the identity of drug user behind was important to women's sense of self but for many of the women in this study it was a label that was difficult to overcome in some of their medical encounters. The implications are such that serious consideration should be given to understanding the attitudes and practice of a range of health professionals working across the NHS.

9.3 Limitations and Strengths

Whilst this study has drawn attention to the embodied recoveries felt and experienced by older women in the UK with a history of drug use, in order to gain depth of understanding with this hard-to-reach group the sample is small. A larger sample of women from across the UK and a greater number of women in active drug use or with drug using histories who don't understand themselves to be in 'recovery' could provide a wider range of experiences to explore. Speaking with a greater number of women in their fifties and sixties may have elicited further information on the peri-menopause and menopausal period in women's lives, thus adding to the relatively scant literature originating from the USA. Moreover, including older women from other marginalised groups such as homeless women,

BAME women and women in the criminal justice system may have added insights into the structural and socio-economic barriers and inequalities that impact on drug use, treatment and recovery among this cohort of women with a history of drug use. As it was, the women who did take part in this study did not talk about structural or socio-economic barriers and this absence of explicit discussions around such conditions is a limitation of the study. As such, the findings of this study represent the voices of 19 women living in the UK with their own particular standpoints. They cannot be said to be the universal experiences of all older women with a history of drug use, although the methods used to collect the data and the findings could be transferable to health-based studies with populations of OWWUD elsewhere in the UK and beyond. Nevertheless, despite the small sample, the voices in this study provide important new data and shed new light on what it feels like to be a woman ageing into recovery in the UK. Echoing the work of qualitative research elsewhere:

> [This study] *is only a tiny window into a few individuals' experiences, but* [it] *is designed to facilitate women's explanations of how they view their* [health and recovery] *in context and what is important to them, rather than what a distant investigator has decided to measure*. (Kearney 1999: p.11)

Despite the sample size, it is my contention that this thesis provides a detailed tapestry that weaves a picture of the lives of older women in recovery. It weaves the threads of their pasts, presents and futures and adds to the literature on older people who use drugs and the recovery literature by providing insights into the lived experiences and social and therapeutic interactions of these women. It explores from the women's standpoints and within a context of ageing and health, journeys from being a woman who uses drugs to becoming and being a woman in recovery.

This is a rigorous study that has used a robust and detailed process, including an informative and valuable pilot study. With a strong theoretical framework (chapters 3 and 4), this thesis provides greater depth and understanding on an issue that is relatively unknown in UK addiction studies. Already the work has generated interest in relation to the object elicitation

method and findings, and has been presented at a number of conferences and seminars. Taking this work forward and disseminating among policy makers, service commissioners and academics in the field is a key aim and objective of the study. Ensuring the findings are given back to the women who participated in this study and the networks that facilitated their recruitment is *also* important. It will be part of the dissemination strategy undertaken to guarantee their voices are heard and the findings are published and known beyond the pages of this thesis. The women's voices provide unique perspectives on their embodied recoveries, as felt and experienced by them. Their experiences were singularly personal to them, yet taken together they illuminate the shared experiences that shaped these women's lives and provide an original and important contribution to the canon of addiction and recovery studies.

9.4 Final Thoughts

Writing these final thoughts and reflecting on the journey this thesis has taken, the overarching message I want *you* the reader to take from this study is the effort and resilience these women put into their recoveries, often over many years. As Ruth said at the start of this chapter, recovery is not just about abstinence, it also involves hard work. It involves learning how to interact without the drugs that mask their pain and hurt, learning how to be honest to themselves and others, learning how to belong – accepting others and being accepted, learning how to manage their bodies and emotions. Recovery is doing the everyday, being in the everyday and becoming the person they want to be. Recovery is achieving and meeting their own expectations and learning how to manage the expectations of others. As the women aged into their recoveries and beyond, relationships and health became more significant and it was the authenticity of their social interactions that sustained and nourished their recoveries. The women in this study are approaching or at a period of mid-life and older. As the past and its attendant chaos recede, the memories encapsulated in objects and people sustain their present and offer hope for their future. For some of the women, recovery was still very much present in their lives. It was part of their routine, their everyday practice. For others, recovery was about distance from the drug-using

past, distance from the recovery label and distance from a past self. To give the last word to Gillian:

> *"It feels like it was different lifetime. Like it happened to somebody else. I don't feel like it is part of who I am now."* (Gillian, age 40, recovery 10 years)

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Workshop Presentation

Tulle, E, Life history research – how history shapes lives. Scottish Graduate Summer School. 19th June 2018: University of Edinburgh

Appendix 1: Participant Information Sheet

University of Glasgow

College of Social Sciences

Participant Information Sheet
Women in Recovery: Relationships, Health and Identity

Researcher: April Shaw Email:
Supervisors: Dr Lucy Pickering Lucy.Pickering@glasgow.ac.uk
Professor Gerda Reith Email: Gerda.Reith@glasgow.ac.uk

You are invited to take part in a research study conducted by a PhD researcher 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) for more information on anything that is unclear. Take time to decide whether 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 and health influence identity and recovery among older women in recovery. 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 mature drug users.

Why have I been approached?

I am interested in talking to women aged 35 and over who have a history of illicit drug use. 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 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. I (April Shaw) will delete all personal information and data if you choose to withdraw from the study.

What will happen to me if I take part?

If you agree to take part in the study I will invite you to take part in an interview where you will be asked to describe the relationships that have been/are important to you and your health now and in the past. You will also be invited to bring along to the interview and discuss an object that is meaningful to you (e.g. postcard, pebble, scarf) – that you consider important to you. With your permission, I would like to photograph your hands holding the personal object. Bringing along and photographing the object is optional and you do not need to do to take part in the interview. The interview should take around 1 to 2 hours and, with your permission will be audio-recorded and transcribed. 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 that is collected about you during the course of the research will be kept strictly confidential. You will be identified by a false name only and no personal contact details will be retained by the researcher. The transcripts will be de-identified with any names or areas removed. False names 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 in a locked room.

Limitations to confidentiality

The safety of yourself and others is very important to the University and researcher. 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 her supervisors 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 PhD thesis and will provide important material for the development of further research in this area. The results may also be published in peer-reviewed journals or other media, such as blog posts. Your anonymity will always be protected in any publications. 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). If you agree and consent, your anonymised data may be requested and used by other approved researchers for further data analysis and possible publication.

Who has reviewed the study?

This research study has been reviewed by the University of Glasgow's College of Social Sciences Ethics Committee.

Contact for Further Information

If there is anything you would like more information on you can contact April Shaw on telephone xxxxxxxxx . Alternatively, you can contact the study supervisors Dr. Lucy Pickering (01413305072) or Professor Gerda Reith (01413303849).

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 College 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)

Appendix 2: Participant Consent Form

Title of Project: **Women in Recovery: Relationships, Health and Identity**

Researcher: April Shaw
Supervisors: Dr Lucy Pickering Email: Lucy.Pickering@glasgow.ac.uk
Professor Gerda Reith Email: Gerda.Reith@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 consent / do not consent (delete as applicable) to my anonymised data being deposited and retained in an archive once the project is complete. ☐
6. I understand my anonymised and archived data may be shared with other approved researchers for further analysis and research. ☐
7. I acknowledge that individuals will be referred to by a false name in any publications arising from the research. ☐
8. I consent / do not consent (delete as applicable) to interviews being audio-recorded. ☐
9. I consent / do not consent (delete as applicable) to my object being photographed in my hands/on its own (delete as applicable) ☐
10. 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 3. MRes Revised Topic Guide

Women in Recovery: Social Relationships and Identity

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: PhD Topic Guide

Women in Recovery: Relationships, Health and Identity

Demographic Info

Object-Elicitation

1. Can you tell me about your object that you have 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?

Relationships and Health

2. So let's start with relationships, and can you tell me about the people in your life now – What do you value about them? What do they value about you?

Explore the following:

Relationships:

- How do these relationships compare to when you were using?
- Did/Has anyone or different people influence/d your decision to use/ stop using? What did they do?
- Did you seek/have you sought help to stop? From? How helpful? Explore experiences if any with statutory agency staff (e.g. social workers, addiction workers etc.)
- Who has been most helpful? In what way have they helped you?
- Has anyone been unhelpful? How have you handled that?
- Are you involved in any community activities or voluntary work (outside fellowship)?

Health:

- Compared to when you were using, how is your health today?
- Have you experienced changes in your health since entering recovery? If so, what are they?
- Have your attitudes/values changed toward your health changed as you have matured?
- What are your experiences of engaging with health workers (e.g. GPs, addiction workers, hospital staff)
- Is there anything you feel it is important for people to know in terms of how older women who use or have used drugs think or feel about their bodies and health?

Final Questions

- Plans for the future?
- Anything else you feel is important at this time in your life that we have not discussed and you would like to raise?