Creating Solutions: Women Preventing FAS

Understanding Women's Substance Misuse

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This research is supported by many other researcher's findings. The knowledge we have generated in this document is based on our experiences. No knowledge is for the exclusive use of any one group of people. Feel free to photocopy and share any information in this document that might help to make life better for other women and families.

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Acknowledgments

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As women, we cannot predict the impact our stories will have on society.
But as mothers, we feel we have a responsibility to share our information with the community, especially the academic and policy community, to ensure our findings are used and do not become worthless,
as we have so often felt in our own lives.
Women Researchers

As you read this document you will find, from time to time, that the terms 'us', 'we' 'they' and 'our' are used in a seemingly inconsistent manner. However, as a community researcher and not of the academic community, my position in the research was always one of interface between two divergent worlds. I had the sometimes frustrating but always mindful task of straddling the worlds of privileged academia, community and the world of marginalized women. As a result it was difficult to write myself in or out of this document. My position, as Randy Stoecker calls 'the animator and consultant" was always one of balancing power. Aside from being "part translator, part facilitator, part esteem builder" (Stoecker, 1997), I was part mentor, part arbitrator, part teacher and part comrade. Most of the women perceived the power I held as power-with them. Although I had more power by virtue of my position and my education, they trusted that this was a power they could take back from me at any time and a power that was willingly shared. In essence, I held their power 'in trust' for them until they were able to exercise their belief in their own ability to use it. I continue to believe in their ability to responsibly use their power.

Chris Leischner

What is the source of our first suffering?
It lies in the fact that we hesitated to speak.
It was born in the moment
When we accumulated silent things within us.
Gaston Bachelard

" I told him about preventing FAS
and he said "how do you prevent that?"
And I said…..we change society
and change society's ideas about women and alcohol too.
We have to learn to speak up"

Creating Solutions Participant

Executive Summary

The search for a better understanding of how women recovery from substance misuse and thus prevent FAS, was the purpose of creating this participatory action research group. Initially, fourteen women and later their daughters explored the process of their own recovery and empowerment. They used Story-Dialogue methods to assist them in uncovering the source of their marginalization and to produce social action to claim their own voice and move towards helping other women through the process of "discovery". What they found was that prevention of FAS requires that we begin in early childhood to prevent the trauma's that drain young women of their ability to define themselves and avoid later mental health problems. With adequate mental health intervention and sustained family and community support, they discovered that recovery included the need for human service workers to redefine both recovery and their attitudes towards women self-medicating. They make recommendation for more women center treatment services and called on all policy makers and service providers to work beyond the confines of their limited mandates and begin more "upstream" prevention work in the area of women's substance misuse.

Background

Women who struggle with substance misuse encounter numerous barriers and few supports in their efforts to abstain from self-medicating (Beckman, 1994; Poole and Issac, 2000; Tait, 2000). There have been few studies that examine the issue of women's recovery (Kearny, 1998) and most do not examine this significant societal issue from a woman's perspective, which considers different preferences and needs for services (Addictions Research Foundation, 1996). Women have different health needs than men (Ministry of Women's Equality, 2000) and as such require recovery services that differ from that of men (Lightfoot et al, 1996). Women require smaller quantities of alcohol to progress through to addiction and they progress more rapidly towards addiction and other health related problems (Grella, 1996). Women who abuse substances report a higher incidence of anxiety, depression and other psychiatric disorders than do men (Benishek et al. 1992). Depressed women are twice as likely as non-depressed women to become binge drinkers (Rothman Schonfeld, 2000). Traumas such as rape and sexual victimization are a recurrent part of the history of many women who substance misuse (Fraupel and Hanke, 1993; Lightfoot et al, 1996). The findings also suggest that for some women, substance misuse is a strategy to deal with feelings of powerlessness (Lammers, Schippers and van der Staak, 1995). Currently, the majority of intervention services are based on male oriented models of treatment (Davis Kasl, 1992) and prevention of addictions is limited to models that assume 'will power' is the key determinant in prevention of addictions yet little is said of the issue of the social construction of women and the issue of self-esteem, a problem that is at the heart of so many of the problems faced by women in a sexist and patriarchal society (Ragan, 2000). Women's substance misuse problems exist in a context of various social and economic problems; violence, poverty, sexism, lack of supports, unemployment, and stigma. (Amaro, 1994, Finkelstein, 1994.)

Treating substance misuse in women who are pregnant comes too late to help the unborn child. Some researchers call for identification and treatment of women prior to pregnancy (Astley et al, 2000) and though most agree with identifying high-risk women for intervention, it is generally believed that prevention of addiction is the best recourse for preventing FAS. Ideally what is needed is to ensure that women receive the support and services they require to avoid self-medication (substance misuse) as a coping mechanism for dealing with mental health and post-trauma issues. In her recent work with pregnant mothers with substance misuse problems, Dr.Astley found this high-risk population of women were diverse in racial, educational and economic backgrounds and that they were often victims of abuse and challenged by mental health disorders. Of the women who achieved abstinence in her study population, 96% reported receiving mental health treatment and having more satisfactory social support networks as compared to those who failed to over come their alcohol dependence who have limited mental health intervention and few social supports (2000).

A study recently completed in Manitoba by Caroline Tait found 92% of the women in her study reported chronic feelings of depression, stress, suicidal thoughts and isolation from positive support networks. The most often discussed issues in her study were feelings of low self-esteem, frustration, despair, helplessness and hopelessness (Tait, 2000).

The purpose of this study, Creating Solutions: Women Preventing FAS, is to explore the experience of women in recovery from substance misuses, the work of women involved in recovery and to document our growing awareness of the key aspects and timing in which substance misuse prevention must take place.

This research compliments the work being done by the Prince George Fetal Alcohol Network towards preventing the birth of FAS children (Prince George FAS Network, 1998). Specific attention was given to examining and presenting key findings, which will further direct the work of FAS and substance misuses prevention.

It is our hope that this research will add to the growing body of information that calls for significant policy changes in how and when services are offered to women, how service providers view the issue of women's substance misuse and how women themselves can gain empowerment for life changes that allow them to live without substance misuse.

We also hope that this research adds to the growing body of research on women's health issues. First Nations Women's encounters with the health system (Browne, Fiske & Thomas, 2000) echoes the experience of the women in this study. The issue of appropriate quality of health care is addressed in our research as well as that of other Northern women (Leipert and Reutter, 1998) Health Care is an issue that resounded throughout our research and led to social action. Research on disabled women's experience of being healthy (Masuda, 1999) is consistent with our experience; by feeling loved, being a part of a family or community, being independent, making a contribution, having safety and predictability in our lives, we live a healthier life. Attaining and sustaining a healthier life requires more than conventional medical services. It includes elements of economic security, physical and mental safety, literacy, meaningfulness and belonging.

More than any other research reviewed, "Hearing Women's Voices: Mental Health Care for Women" spoke most clearly and closely to our reality. As well as mirroring the importance of responsive services that consider the social context of women's social environment, this research also addressed the high incidence of sexual violence that women with serious mental health issues experience. Key to our research was the reference that "substance use issues often accompany mental stress" (Morrow and Chappell, 1999).

Women recovery is not simply an issue of will power, choice or self-control. It is a process of empowerment, which begins at the community level. The need for education, employment, for family and community supports and for greater control over their own lives is fundamental to any work with addictions and to the quality of life that women's experience. In a stimulating article by Brian Kearns (1998) on the place of addictions in Population Health practice, he summarizes the nub of this complex issue.

> " Achieving a greater sense of self-control and collectivity is also characteristic of the movement from dependence to independence, which is involved in the management of addictions. Whether in prevention or treatment, this means maintaining or restoring people's capacity to take charge of their lives and connecting them to the support they need to maintain health and sober lifestyles".

Women struggling with substance misuses issues are marginalized more so than the average women as they are seen to be less deserving. They are an oppressed group in our society that have internalized a view of themselves as worthless, less intelligent and as undeserving of the privileges which others take for granted. Their chronic maladaptive approach to dealing with life's traumas is a challenge for our entire community and a responsibility of everyone concerned with health care.

Objectives

The idea for this research arose from a discussion between the Northern Family Health Society, Prince George FAS Network and the University of Northern British Columbia. More information was needed about how women "recovered" from substance misuses in order to address Fetal Alcohol Syndrome. Participatory Action Research (PAR) was chosen as the research method as it facilitated the empowerment of marginalized women (Maguire, 1987; Park et al, 1993).

When we began this research, two academic researchers, a community researcher and a group of twelve women in recovery hoped to find a simplified map for other women to understand how to get through recovery faster, easier, better. We wanted to be able to explain, in simple language, the needs of women with substance misuse issues and describe ways that could help practitioners and policy makers create a better system of care for women; a system that would help instead of hinder.

The purpose of the project was to find out more about: what drinking means to women, the process women go through to quit drinking, what women lose or gain by drinking, who benefits from drinking or quitting and finally what was happening in their lives when women quit drinking.

We thought that the answers to questions for better prevention of women's substance misuses would be found in working with the women who are already mothers and who had struggled with substance misuses and found recovery.

Instead our search lead us to an area we never thought to encounter, the world of the adolescent girl and the period of our lives when our sense of self is being defined and our sense of power established. This is a period of a woman's life that has largely been ignored in policy development (Finkelstein, 1993; Blackwell, Thurston & Graham, 1996), minimized in substance misuse prevention work and generally undervalued in a society that sends women a message that their existence depends on their ability to care for and about others but does not demand self-recognition.

Research Methods

"There is nothing so wise as a circle"
Rainer Maria Rilke

1. Design
In order to fully understand the many dimensions of women's work in recovery we needed to examine recovery from women's own perspective. In May of 1999, a meeting was organized to ask services providers to help us contact women in recovery who might be interested in being involved in our research. The call went out by word of mouth, and fourteen women attended the first information session.

We were looking for women who were pregnant or mothers of children, whether in their custody or not; who had recovered from substance misuses or had successfully abstained or reduced harm from alcohol consumption and who were prepared to meet with other women of similar backgrounds and become research members of a health promotions project. The women were reimbursed for their time, childcare, transportation and training.

Participatory action research (PAR) has been used in many marginalized communities to create empowerment and social action (Ryan and Robinson, 1990; St Denis, 1992; Brant Castellano, 1993; Hughes; 1997; Seymour-Rolls and Hughes, 1999). The principles of PAR were consistent with women centered research challenges such as " conducting research with meaningful input and participation at every stage of the research process by women from the community at large, should they wish to be involved" (Lefebvre, 1998).

Participatory action research can be considered a radical approach to research compared to the image the word 'research' usually conjures in our minds. There is such a huge component of human interaction that sets this type of research apart from what we traditionally see as research (St. Denis 1992). Not only is the process different, the employment of the outcomes suggests a major difference. Participants in a research project like this one hope to gain control of how their stories will be told by remaining intimately involved with the process from data collection through to analysis and compilation. This intimate involvement allows the participants to own the recommendations that will be directed at the people who hold positions of power over their lives. Not only do the participants own the recommendations, but they also enter the 'hopper' of issues to be addressed by policy makers with the voices of those affected still intact.

Women centered research principles provide for three main goals: (1) to document the experiences and activities of women, (2) to understand these experiences from the women's point of view and (3) to recognize women's behavior within the context of their social situations (Reinharz, 1992).

A Research Matrix was developed based on work from the Women's Research Center, Vancouver, B.C. (Barnsley and Ellis, 1992). This tool, developed for doing participatory action research for community groups, provided us with a clear and accessible means of organizing our research.

Twelve women met weekly at a community-based agency, Northern Family Health Society. Six of the twelve women were First Nations from various communities throughout Central and Northern British Columbia. All had an income levels well below the poverty line and three were involved in educational pursuits. Each of the women had achieved sobriety and were actively in

recovery, using a variety of intervention options. The age range was between 21 and 47 years of age. Most had lost custody of their children due to their addictions and 5 were fighting for custody or access of their children.

When we began, we informed the women of the loosely defined nature of doing PAR work and our desire to facilitate a process that could be jointly defined as we evolved. What we were specific about was the research goal that the women would be meaningfully active in the direction of this research. "…the group that is created will share control of the direction of this work and it could go just about anywhere." (taken from the initial group handout to the participants, 1999). The research was to be collaborative and power would be shared with them.

Of particular interest are the earlier discussions about the term "recovery". The women found this term to be conceptually confusing. Not only did it suggest a medicalized view of the issue but it seemed to mean different things to different women. The group defined recovery as a state of knowing and growing and a process of 'discovery'. This seemingly inconsequential redefining resulted in a redirected and reorientation to the research. We had no idea at this time that the redefining of 'recovery' is vital to the women's work of recovery.

2. Information Collection

> *Exploration, description, revelation are at the heart of story,*
> *as they are at the heart of authentic or vital lives.*
> *Denna Metzger(1992)*

A central concept in our work has been to bring women with substance misuse problems into the research as first person narrators, so that their voices will directly inform policy makers and theories of substance misuse work.

Though initially the research methodology was conceived as being institutional ethnography, power conflict within the research lead to the PAR women deciding that they wanted to be fully involved in the analysis. The women researchers described an imperative need to be a part of the whole process, including the analysis. There is no consensus in the literature on whether the PAR researchers should be a part of the analysis, which is problematic in doing PAR. Some research suggests that the analysis be done by the experts and then brought back for verification (Dash, 1997). However, most literature supports our contention that doing the analysis is key to the development of critical reflection and knowledge development (Whyte, 1991, p.273; Stoecker, 1997; St. Denis, 1992) and changes needed in women's health research supports the acceptance of alternative epistemologies in doing PAR (Lefebvre, 1998).

A key issue of contention was the defining of the collaborative role of researchers; academic, community and PAR women and how much each should be involved in the various pieces of PAR research, especially the methodology (Stoecker, 1997).

Development of knowledge and critical reflection happens through the process of dialogue, a methodological feature that distinguishes participatory research from other social research (Park, 1993, pp.12). The PAR group decided to describe their experience using a Health Promotions technique called Story Dialogue (Feather and Labonte, 1996) that was presented to them as an option. This method allowed them to engage in an essential critical reflection process leading to analysis and more complete understanding of their own experience.

In order to come together and participate meaningfully in all aspects of investigation and subsequent social action, we must dialogue. The more traditional form of formalized interviews or conventional questionnaires do not always allow the participant to speak in a "full voice", critical information is either missed or lost. Exploring substance misuse of women who are powerless must be understood as Peter Park (1993) wrote "in the hearts and the guts as well as in the heads and the people with problems must talk to each other as whole persons with feelings and commitment as well as facts".

Story Dialogue, as a method, takes case stories from practice and subjects them to a collective analysis to discern generalizations about a particular practice, in our case, the practice of recovery. This method, predominately used for examining health practices, was chosen for our research as it provided a number of important components not found in traditional interview formats. First, it is based on a reflexive analysis of stories that can include practitioners, researchers and women in recovery. Second, it has an ability to "give back" to those involved, in a group dialogue, which provides insights for all participants. As well, the use of stories as a means of dialoguing the work of discovery was easy for the PAR group to understand and work with; story telling for women is a familiar format. Further intensive dialoguing with service providers allowed for a degree of triangulation, a process of using multiple lines of sight to obtain a better, more substantive picture of reality (Berg, 1998).

"I think everyone of us has grown from this, sitting down and doing this. It allows us to sit back and look at our stories differently. Because it doesn't just give meaning to our lives it gives meaning to the past of our lives."

The descriptive nature of narratives allowed the women researchers to describe individual life stories and particularly the life episodes of their substance misuse work. This was a time when this life's episode took precedence over other times and where they began to see the purpose that this life's episode played in how their recovery work had developed. (Sandelowski, 1991).

3. Analysis

Stories heal us because we become whole through them. In the process of writing, of discovering our story, we restore those parts of ourselves that have been scattered, hidden, suppressed, denied, distorted, forbidden and we come to understand that stories heal. As in the word remember*, we re-member, we bring together the parts, we integrate that which has been alienated or separated our, revalues what has been disdained. .I other words, self-discovery is more than gathering information about oneself. The gathering , the coming to know, has consequences. It alters us. We re-store, re-member, re-vitalize, re-juvenate, rescue, re-cover, re-claim, re-new."*

Deena Metzger

Information collected from the Story Dialogue process, twelve months of taped meetings, field notes and the women's journals were considered narratives. The collection and review of these initiated an analysis that was a process overlapping with the continued collection of information.

This method facilitates shared meaning and in depth exploration of our experience, maintaining the integrity of PAR. Further, it ensures shared power 'with' as opposed to power 'over'(Labonte, 1996).

Second Level synthesis of the narratives is an analysis of the insights that guided the social action phase of the participatory action work. It is this synthesis of lessons that lead to the development of actions. There are three steps involved in this synthesis; building categories from our insight cards, writing theory notes based on those categories and sharing theory notes with the participants to writing up composite theory statements.

Building categories requires the research team to group together similar ideas from a range of insights. This finding of common themes has no firm rules, therefore there is some creativity in how categories are built. Qualitative researchers sometimes describe it as " a free act of *seeing* meaning" (Labonte and Feather, 1996). Though this process can be done individually, the group had chosen to work together in order to develop further insight and benefit from the process. As the development of Insight Cards requires that we operate on largely unconscious assumptions about how things fit together and why, the action of moving the cards into categories helps us to explicate these theories, making them more conscious, more public and more open to discussion. In further discussion of the categories we will not only critically reflect on the insight but we also become better able to explain why we do what we do and therefore how we arrive at a better solution for the action of prevention of FAS.

The final step in building categories is to give each category a name. Because these categories are about women's ways of achieving recovery, the name should say something about the skills, resources and knowledge required in achieving recovery. We wanted to explore issues of our lives and recovery such as power struggles, skill acquisition, attitudes of support workers, etc.. The names should represent the common theme that pulls all the cards into a category.

Once the categories have been constructed, the research team as a whole or in task groups wrote up a descriptive statement that linked all the different parts together into a "theory note". (Writing theory notes in the story group can be difficult according to Labonte and Feather and they suggest two people work together on this area). This theory note combines the ideas into a single statement. It is an attempt to explain and therefore understand the generalization of this category. We believe that these theory notes will form the basis of statements about the lived experience of women in recovery. Theory notes are an attempt to reduce a complex reality to a few general and possibly abstract points. Though it is acknowledged that we lose something of the richness of women's lives in this kind of a reduction process, at the same time we gain helpful knowledge that we can pass on to other women in similar situations.

Once the individual theory notes had been written, the group determined how these notes could be linked together into one composite theory note about the experience being examined. Completed theory notes were then read to the whole group and posted on the wall where the group decided how to organize the theory notes into a composite statement. These statements led to more questions about the process of recovery for women. The composite theory notes were collected, collated and distributed to all PAR researchers.

It is these composite theory notes that were be used to inform the social action piece of the research. This method for making sense of the data assisted us in describing and explaining recovery in a "larger, more holistic understanding. The focus was on seeing patterns/arrangements…behind the totality of what's being studied" (Carney, 1983:58)

The women were "trained" in feeling comfortable with the "data" and in the role of asking questions for information that would help them discover the dimensions of the substance misuse issue in a way that could direct their social action (Park, 1993)

We used the analogy of sorting socks to describe and direct our analysis efforts. We discussed the many different ways that we use to categorize our socks; whites, darks, labeled and sizes. As with research analysis there are many individualized methods for developing categories (Viney and Bousfield, 1991). Each category was further categorized to size, brand, ribbed or patterned. This process is no different from the description used by Spiegelberg (1982) to describe the rendering of "essences". " It consists in lining up particular phenomenon in a continuous series based on the order of their similarities. The next stage is the observation that in some of these series… certain groups of phenomenon cluster around cores that stand out as nodal points or vertices in the sequence of phenomenon. Such are, for instance, the pure colors. The surrounding shades of color "belong together" in distinct groups according to their affinity to the pure colors." (p.698).

We know when certain socks belong together by the texture, form and color presented in the sock. " …all reds cluster together in this way, we can hardly overlook the fact that underlying it is some common pattern or essence in which they all share in varying degrees, and which they all in a sense embody." (Spiegelberg, 1982, pp.698).

Once the research group has analyzed each story in this manner, we then stepped back from the analysis of the stories and invite identified community members to engage in a story dialogue with the PAR group. These individuals were from the helping professions that had had direct contact with the PAR group participants during their recovery. This choice was to ensure a level of trust that has already been established prior to engaging in the story dialogue. They were individuals who are willing to challenge the women's stories and pull out a breadth of knowledge that might not otherwise be acquired. These were people with 'sympathetic diversity' who have a shared interest in the problem and are a part of the system we wished to influence in policy change. It was in this triangulation of the women's stories and those of the service providers that we found divergent yet useful information. In acquiring this depth and breadth of information, the PAR group then re-worked the analysis. This was the group's means by which they would provide "checkable" evidence (Barnsley and Ellis, 1992) and strengthen the credibility of their work.

When we arrived at the stage of our story dialogue process where we were required to look at the ideas behind the words and further develop working categories for grouping and sorting themes, it was important to demystify the process of analysis. At times the women needed to be pushed to critically analyse and this was an uncomfortable experience for some. There was a need to ensure that the women researchers maintained their confidence, energy and commitment through out this often times grueling and confusing part of research. While it was one of their most difficult challenges it was also their most enlightening.

" The heavy side is that we are thinking really hard."
"What makes them [analysis] deep is sitting and talking about them. Talking them through otherwise they are just words on a piece of paper"
Researcher

The essential reason why the women needed to have an active and meaningful part of this analysis is that through dialogue they could "see" it, get " ahs" and critically reflect and learn.

Doing Participatory Action Research

One of the defining features of PAR is its dedication to the intent of social action as an outcome. Its aim is to empower people both in a psychological capacity and in the needed area of being empowered to politically effect social change (Park, 1993). In this case people are in charge of both the production and the utilization of knowledge. In our research, the women researchers had to wrestle the power from the institutions. They were determined to be an active part in all stages of the research, including the analysis, and changed the original research direction from institutional ethnography to a more understandable process of Story Dialogue with narrative analysis. The researching community must be involved in the entire research process (St. Denis, 1992). The act of transferring power from the "establishment" to themselves defines our group as one which is a social action organization, organized to attain power (Mondros. J and Wilson, S, 1994).

1.The Privileging of Knowledge and the Power Politics of PAR

"…popular knowledge does not come in the form of isolated facts
known to specific individuals.
It comes in packets of cultural data
generated by social groups."
Orlando Fals-Borda

The root meaning of the word *power* is from the Latin, podere: to be able. Ability is a power that comes from within ourselves. It is the power we feel when we stand in the wind and closing our eyes know that we are connected to the earth, when we know that our passion and desire is creative and good.

PAR is all about power, who has it, who will share it, how it is used and what empowerment will result. Failure to understand and acknowledge the power issues inherent in PAR is a failure to understand the intricate dynamics created in this type of research.

PAR is used to create knowledge and knowledge is power. Michael Foucault speaks to this conceptual relationship when he used the term *power-knowledge* to reflect his belief that the two are inherently and intricately linked with each embedded in the other (Palys, 1997). During the course of this research we gained a greater awareness of how knowledge is produced and what knowledge is valued. What we came to believe is that if someone has power it influences whether something is considered relevant to know as well as how that knowledge will be constructed. We found that the subtle pressure from universities to perform and publish and from the funding agency to produce "professional" findings, resulted in pressure on the research group to produce knowledge that was meaningful for the academic partners but was not necessarily meaningful for the PAR women.

We also came to believe that authentic knowledge is the knowledge created by the group for which it can do the most good. At one time in our history, as member of smaller communities, activities and services were performed by ourselves or by our neighbours or families. In time these became the territory of paid experts who were licensed or other wise recognized as being the keepers of that expertise, skill or knowledge. They were officially approved and they had the power to restrict knowledge. At one time our "knowing" was enough and we owned the

knowledge, but no longer. Access to knowledge is greatly restricted by the institutions, they determine who will have access, who will own the knowledge and with whom they will share. When the Institutions of knowledge such as Universities decide not to share in the production and dissemination of their licensed knowledge, we all suffer.

2. Beginning

Women working with women, to empower women have the best of intentions however the process of creating an equitable environment is "fraught with peril", particularly considering the concept of power. Sharing power assumes that the individuals being invited to share are able to overcome their own sense of worthlessness from living in the margins too long. As much as we attempted, through power sharing, to redistribute monies, use collaborative decision-making and build esteem, there is always a hierarchy of power. We were conscious of trying to equalize the power and as a result we were caught in the belief that too many of us get trapped in of "how do we get rid of the power?" Fundamentally this attitude created the conflict with the academic partners. We failed to take the all important step of changing our approach to one of "How can we support and help each other to better understand and critically reflect on the power issues present in this process? How do we begin to consider our own tasks of making responsible use of that power?" Instead, we allowed the politics of power to divide us and create a perception that some were hording power or misusing it and others needed to rebalance that perceived power. Academics are used to administering their research through their institutions and not with 'allowing' accountability and responsibility at the community level. They perceive the decentralization of funding as a loss of power. Our attempts to eliminate or redistribute the power had failed. The responsible use of power, by all partners, should have been to critically and respectfully reflect on the conflict and reasonably address this inherent PAR challenge.

As researchers and producers of knowledge we are aware of the intense responsibility to produce knowledge that is useable and serves the interest of those who are marginalized not necessarily of those with privilege. It is important to ask the question 'who does this knowledge serve' because the power attached to the knowledge often determines who has the authority to determine truth. Power can also be used to further entrench the power of the institutions.

3. Issues to consider

There were considerations we failed to predict however we used these as learning opportunities to further the goals of the research. These included the issues of literacy and the use of journals as data collection, the reality of substance misusing women also being Fetal Alcohol Syndrome affected and therefore requiring of differential treatment in the research design and process. We did not predict that women would be unable to maintain stable supports over a two-year period and that the poverty of their lives could be as disabling as it was. There was an oversight that dual diagnosis would be prevalent for the greater majority of women. We neglected to adequately consider that using almost any information collection method would trigger post-trauma reactions that complicate the existing dual diagnosis. More focus could have been placed on ensuring that we had talked through our individual definitions of terms like 'collaborative' and 'recovery' and who should be in this newly constructed research community.

Turning Beliefs into Actions

Our oversight in defining the term "collaborative" before we began the research project was perhaps our fatal flaw. It certainly led to a conflict of power. The academics believed that PAR should be done using a specific research methodology, institutional ethnography, while the community researchers believed that it should be done using a more approachable and understandable method such as Story Dialogue. However, we were prepared to work together in an analysis using institutional ethnography. The idea of having the research taken back to the university, analysed and brought back for validation was neither meaningful nor collaborative. The academics stated that collaborative work would only be done within certain arenas and within certain boundaries. "Only one in a thousand PAR groups can do their own analysis" was a comment made that captured the academics beliefs about doing participatory research. The institutional pressure to provide publishable material resulted in the academics determining that there was only one way to do the methodology and it did not include the women. The assumptions around collaborative analysis and the use of institutional ethnography were not openly understood or stated at the outset and with time the rift between the "expert" world and the powerless women deepened.

There are implications when beginning to explore how the PAR group could work "collaboratively". What does working collaboratively really mean? The participants did not naturally work collaboratively because like many of us they operate in a power-over paradigm. We are generally socialized and institutionalized to work in a hierarchy. It is especially difficult for women to work in a 'power-with' way and become empowered. Most of our training and experience as women has been to be passive. On both private and public levels, in our families, our laws and institutions, women receive the message that they are second -class citizens.

How then do we convince women that they can be assertive, at least in this research and that they can ask questions, make comments, own pieces of the power and ultimately change their worlds? A large part of the learning curve was to begin to understand power, within the context of the addiction, and to move women away from a belief in their moral deficit and towards the belief that they could gain power-with and power- with-in.

But was this move to empowerment ethically sound? How do we on one hand, open women up to the possibilities of their power only to have them return after each group session to a world that does not value them, a society that does not want them to assert their rights or opinions, a daily experience that batters their self esteem and a place where they are only able to survive in the moment if they remain passive. The empowerment practices at work here focused primarily on individual enlightenment and emancipation but were not directly relevant to collective action and social transformation. We were thinking this would come later however " the power to name must also be accompanied by the power to act." (Breton, 1994, p.36). While these women experienced to greater and lesser degrees, empowering cognitive and behavioral change, were they really "empowered" if those personal changes had no relevance to the social injustices which formed the context of their lives?

Participation

Doing PAR requires time, esp. if the 'community' involved is not already an established community. The "community of women" working on this project were actually brought together by service providers, they were not an existing community. However, these women are a part of

the "recovery culture" of N.A. & AA which posed problems around confidentiality, trust and information coming from one group into the other.

The women defined themselves as in "recovery" however we found out this meant varying degrees of abstinence, harm reduction, growth and development. Because this research group was new there were many initial group process pieces to consider; trust building, establishing of norms, developing rules and getting to know each other's strengths and challenging areas. There was also the reality that some women were more able than others to juggle their lives in recovery and the work of the research, which gave some women privilege over others.

Further into the research we discussed the need for pre-screening dual diagnosis; Depression, Borderline Personality Disorders, Post Traumatic Disorder being the most prevalent however this would have meant that all women would have been screened out of the research as all participants struggled on various levels with mental health issues.

There were women in the group affected themselves with Fetal Alcohol Spectrum Disorder (FASD). Although these women did not have a formal diagnosis of FASD they were self-identified and it fit with their personal histories. This disability required an adaptive environment that recognized a need for structure, consistency, brevity, variety, and persistence. It was difficult for both the research context and the arrangement of PAR to accommodate this. It was perhaps most difficult for the other members to deal with as they had no insight into the special needs of the FASD affected group members.

The academic and community partners had identified the research needs for the project but these were not necessarily the needs of the women who came to do this research. During the early stages of setting up the research, the women identified their needs as self-care, skill building and the ability to make a difference in the lives of other women. The research plan and budget did not account for self care activities but we could provide learning opportunities and exposure to community resources, libraries, access to computers and information about the services in the community that would support their "recovery" process. To meet their self-care needs we attempted to integrate self-care opportunities and model self-care behaviors.

We came to understand better as time went on that meeting these needs made the difference in keeping them involved in the research process. It provided them with opportunities for travel, self-care, a supportive collective and skills training that led to individual recognition and a sense of purpose.

It was not until the last two months of the research that the women researchers finally found their power. It took almost all of the two years for them to believe in their ability to seize power and act in their own best interests. One more year of funding would have seen quite a different group emerge. The greatest sorrow of the group is that once they have found their voice and experienced the strength of their informed convictions; they must now dismantle the group and find a way to say goodbye.

"*I don't want to see this group end. Just when we have a vision for a social action piece that could really make a difference we have to say goodbye. Just when we start to realize how to prevent substance misuse and FAS… we can't stop now…we are just beginning."*

Participant

Clarifying concepts

There was also a necessity to develop working principles in the group and collective understanding of various "accepted" terms. Concepts such as 'harm reduction', 'recovery' and "power" needed to be explored and discussed. There was limited understanding of harm reduction, relapse or women centered principles. We had been immersed in an environment of abstinence and male dominated beliefs.

We understood that what causes women to relapse most often was the need to self-medicate yet some group members were unwilling to allow any latitude for other women relapsing. We acknowledged that we held different views and tried to encourage generosity in hearing each other's realities. Early on in the process, we identified that some women were in the beginning stages of their abstinence work. While this should have been a sign that we needed to reach a group consensus on what defined recovery, we did not discuss it until later in the group process when it became a problem with women's participation.

Adjusting definitions of terms and concepts, previously taken for granted, requires time. It was an opportunity to look at our world differently. However, some of the participants values would not allow movement beyond an abstinence model of understanding. As a result these women chose to leave the group.

Poverty, Support Systems and Over Burdened Lives

To ensure the best interest of women researchers, we tried to ensure that they would have a support network in place while participating in this research. This was particularly true during more in-depth querying using the story dialogue method, which like many of the methods for inquiry can trigger a posttraumatic stress reaction. Despite efforts to sustain supports, the changing nature of these women's lives and their chaotic environments, with often unsupportive partners meant that some women were unable to maintain their involvement in the group.

Poverty is an overpowering reality of working with marginalized women. Women's work of living entails organizing their lives around this poverty; check issue day, food banks during group breaks, manipulating baby food or money from the sponsoring organizations staff and asking for support letter to get their phones reactivated. Seeing their disadvantage made personal mad it difficult not to get involved in giving these women money. Having so much more monetary resources and watching them struggle to feed their families and at the same time espousing equality left a bitter taste of hypocrisy and helplessness. The dilemma this created engaged us in critical reflection on how we chose to live our lives. Our privilege and how we cannot hide behind our words of equality and empowerment without seeing the disparities we live with each day. Who can afford to do this research because the stipends allotted through the research budget for the women was not enough nor was it reflective of the concept of shared power.

On more than one occasion, both the academics and marginalized women said that the conflicts were not about the money yet they were. Control of the budget by the community organization, who are obligated under contract to do so, was threatening to the academics and participants alike. We were always conscious of who had and who did not have money, we felt however that we were with out recourse to address this in a meaningful way.

Paying the Women as Researchers

The day to day struggle of poverty, dysfunctional relationships and being "recovered" means women develop distress due to lack of resources and supports. This results in their inability to focus on the group agenda or the research in general. This is an expectation of the paid researchers. It would be more realistic to do a research project as a paid work placement to develop job skills. Instead of stretching over 2 years @ 2 hrs a week, the research could be done at 5 days per week for 40 weeks over a shorter time. If the women were paid a decent wage even for a short term it would mean there would be more likely hood of them not having to worry about eating, rent, etc. and being able to focus on the research. Of course this may pose problems with Employment Benefits and Income Assistance.

Despite the presence of childcare, transportation, food and honorariums, without semi-stable home and social environments, and without supports to assist them, many women were unable to continue this research work. Supporting these women in empowerment requires extras resources from the community and institutions, which are not forthcoming in doing this kind of "marginalized " research. Unless we are better prepared to address the various aspects of women's lives that are impacting this research we must accept whatever energy and commitment they are able to make to this lengthy process. Partners still using, student loan worries, no money to feed family, giving support to family members in crisis and day to day poverty is their reality. Two years is too long a time to expect that recovering women will be able to maintain a stable and resource rich environment.

The line between dependency, support and trust

Establishing an empowering relationship with marginalized women is a tricky maneuver. There is a fine line between what is required to ensure a supportive, normalizing and non-blaming group environment and what some academics call "counselling". The format of the group allowed women the opportunity to nurture social supports in the relationships that were developed. We attempted to overcome self-blame by normalizing and accepting their experience and to increase self-esteem by providing an opportunity for women to hear and experience positive messages about themselves and their 'recovery". This focus facilitated empowerment but had to always be balanced with the work of research.

Rediscovering the ability to trust was a very significant starting point for the women of this group. Learning to trust each other would present as a critical element in the success of the project. According to Verna St. Denis (1992), in her work on community based participatory research, it is "very much about developing trustworthy relationships between all participants in the process (St. Denis 1992:66)."

The women of Creating Solutions all shared life experiences that had left them feeling void of any ability to trust others, whether it is individuals or institutions. Abuse, substance misuse, poverty and many other socio-economic factors caused the women to experience a disintegration of any ability to reach out and trust others.

"*…being under that system microscope, I just had it and I lost all my trust in all professionals.*"
Participant

Systems supposedly in place to help them had failed them. People who were supposed to care about them had judged them and ultimately they believed they had failed themselves.

Having the opportunity to participate in a research project like this was like being given a new lease on life. Many of the women expressed that being a part of the group significantly contributed to the rediscovery of their sense of self through re-learning how to trust again.

"*Like I said, I never trusted anybody before and now I can see the ways of trust…I learned that depending on other people made me feel stronger, I really needed that. I needed people listening to me and not judging me."*

Participant

Literacy issues

Journals in Action Research are often used to improve reflection on what is happening and in so doing create the praxis, interrelationship of action and reflection, which is vital to creating authentic knowledge. Literacy is a powerful tool in empowerment practice (Freire, 1981). However, the written word is not the only form of reflection for the purpose of dialoguing. Many of the women in our research were not able to use writing as a form of reflection. The literacy level in this group was noticeably varied. Attempts to keep journals were thwarted by the participant's inability to write and to write critically. In order to facilitate the production of critical thinking, a 10 minute time period at the end of the group focused on two key questions. "What did you see happen here in group today?" and " What do you think or feel about it?" This process provided us with a collective way of interpreting and reflecting on our research process.

Further attempts to engage the literacy community in a partnership to fund a literacy component to our work was denied by the Adult Literacy Learners Events in British Columbia (2000), as they felt our issue of addiction was not related to literacy. It was this lack of supportive resources that affected our ability to truly "empower". The successful process of gaining knowledge for action requires a process of becoming more literate, a process that is time consuming and not often supported outside of the context of a learning environment such as a college or training program.

Computer access is a significant issue when looking at gaining literacy skills. The problem of computer access and computer literacy among the disadvantaged needs to be acknowledged and addressed as a relevant point confronting our technology based society today. There is currently no program available in our community that provides low-income people with access to the computer is such a way that they are able to gain success with it. The skills that could be learned by such a program would be valuable assets in both daily living and in seeking economic independence. The acquisition of skills for those without power is empowering.

Aside from the obvious individual benefits of computer literacy and access, there is the advantage of being interconnected by way of the Internet. community activism, organization of social movements, many forms of knowledge and relationship building are engaged in on line. If strength of participatory action work is in the ability to empower people to social change, then the Internet is an invaluable tool if only we are able to create access and skill development for the marginalized individuals who most need it.

Power-within vs. power-over

Although there are many different definitions of power, the one that best fit for us is the description of power as the ability to create or resist change. In doing PAR with disempowered

women perhaps the most evident issue becomes their inability to accept the power being offered. Many have yet to redefine power as something that is internal, a self-knowledge and self-discipline, energy and realization of the personal capabilities and therefore possibilities. Ability is to know that when we make choices, write, learn, work and recreate, that we are experiencing power-within.

Starhawk, a peace activist, ecofeminist and leader in feminist spirituality provides an insightful description of power (1997). Power-over is ultimately the power of destruction. It is a power that takes, annihilates and exploits. This form of power does not create a more harmonious or thriving world. This form of power is based on persuasion and control. It is the power used by the institutions of dominance, hegemony and our patriarchal society.

Power-with-in is the ability to look inside and feel worthiness and know or feel that each of us is enough unto ourselves. Getting to this place, for women, is a difficult task. In doing PAR this has to happen first through an experience of power-with, a state explained by Starhawk as the collective side of "power-from-within". When a group of women march in a "*Take Back the Night"* march, walking side by side, they feel the power of a collective voice. As women there is a vitality and confidence we create when we work together. This state is the powerful energy we create to oppose the practices of "power-over". Labonte and Kuyek (1995) describe the transformation process as "…seeing 'power-over' for what it is, and working from our own 'power-from-within', are the means we possess to develop 'power-with'". Although we understand that this can be the case for health care workers and other professionals who come from a place of self-identity and confidence, this is not how it happened for the women in our PAR group. These women were not only afraid to exercise the power they were given but also were certain that it was not "real" power and that it would be pulled out from under them when the first power struggle ensued.

In our society we become conditioned to see power as an issue of dominance where one person has power-over another. We have become skeptical of other forms of power and have accepted the messages and structures around us. We accept the state of power as unchanging. We have become complacent in our view of power and we have grown almost accepting of its destructive forces.

Power Struggles and Empowerment

It has been said that community based participatory action research is a messy process in comparison to 'conventional research.' We know it doesn't follow a standard process and that the path is carved out by those involved. In this case, women are the carvers of the path. As women's experiences are so unique and dynamic, it would be unrealistic to expect homogeneity in any group of women working on a research project (St. Denis). The process undertaken by our 'Creating Solutions' research was no exception to this idea. The participants were rich in diversity of experience, education and knowledge. As a result, it is easy to predict that conflicts such as power struggles arose during the process. However, conflicts were not only a natural part of the journey, they lent to the experience of empowerment for all the women involved.

First, as a group, we acknowledged the power-over concept and dialogued the impact of this in our personal lives. Gaining a fuller understanding of the context of our disempowerment freed us up to experience feelings of injustice. We discussed the danger of power-over in our lives, but were not able to move into power-from-within as this had in the past been a frightening place to

be. Instead, the group developed a strong sense of "power with", a sense of collective mobilization that gave them the opportunity to acknowledge their strengths, based on their group experiences. The group began to truly see potential in themselves – that there just might be some power-from-within to take a look at.

We agree strongly with Ron Labonte (1992) when he states, "The only empowerment of any importance is the power seized by individuals or groups." The women "seized" power in determining that the academics' choice of research method would not work for them. The group's decision was to pursue the method of story-dialogue and that they would do the analysis. As difficult as it was to come to this decision, the women believed that their faith in themselves would be undermined if they allowed their stories to be owned and analysed by someone outside of their reality. The women researchers wanted full and meaningful involvement in defining their knowledge and experience.

"We've stepped out of our safety zones big time being part of this group. Sometimes it came back and kicked us in the ass, but mostly it's been good. And usually when it has kicked us in the ass it's been because of a power struggle. And we haven't fallen for that power struggle, we haven't said, okay…If you are not going to help us then stand back and let us do it ourselves. Don't put up barriers."

Participant

Considerations for Community-Based Research

1. Academics, Institutions, and Community Sharing Power

"…academically produced knowledge
is a tissue of irrelevant, partial truths
behind which the blemishes of an oppressive world remain hidden."
Thomas Heaney

Power had been a major issue for the academic and community partners. Aside from the contention about what pieces of the work we would share and who we would share it with, we could not agree on how to determine what the women could do and what were unrealistic expectations. We were also not able too see how we would share the power and most importantly how any of us could determine these questions without the women being involved as equal partners in the discussion. In order to share the power the women had to have an equal say in all decisions that were made.

The most debilitating and destructive conflict was with the academics who wanted to owned the research because this identified who had precedence to determine the route we would follow in the research. Empowerment, however, does not follow a preset route nor does it develop best in an environment of rigid and defined expectations. Because there was no willingness to openly dialogue this power struggle, a rigid environment with defined expectations was produced.

"And that is another reason why it wouldn't work by taking it [analysis] away…we can't talk about it, cause when we talk it begins to make sense."
Participant

At the core of this contention was the question of how the analysis would be done and by whom. The argument presented by the researchers to the research group was that various aspects of the work needed to be controlled so that it could meet a certain level of quality considered to appease the funders and the academic world. Neither "side" set out to knowingly usurp the other's agenda however, the lack of communication and dialogue of assumptions led to a situation that can only be described as harmful. The academics viewed the analysis one way (institutional ethnography), while the community researcher, sponsoring agency and the women participants viewed PAR as a process that required their full involvement. Communication between academic and community partners was not optimal, as key decision-makers were not always available for discussions. . One researcher was not present for the first year of the group formation and the decision-making surrounding the process of data collection and analysis.

Doing participatory action research requires that academics step out of their "turf" and connect with marginalized women in a way that is based on the reality of their lives. It is definitely not an easy shift to make, but one that we discovered is crucial in their securing a working relationship with the women that would have ultimately contributed to the project's success.

"If we have real respect for the communities we work with,
we will understand that they will tell us when we screw up,
and they won't let us lead them astray."
Randy Stoecker

2. The Authenticity of Empowerment

Authentic empowerment is the ability to not only transform the personal but to transform the political and economic structures that oppress women. A critical power analysis would have made us responsible for the use of the power we each held, which would have allowed us to work together to make political and economic changes in both the academic and community realms.

In effectively using power, both the marginalized and the privileged will need to work towards shifting paradigms of power. As a collaborative research group we failed to create a united front that could have impacted knowledge at the institutional level. We have yet to see whether the information this research group shares with the medical and social service providers will effect any policy change.

A shift in paradigm or any change in belief and consciousness can make us uncomfortable. Yet, our current societal context appears to be one of pervasive paradigm shifts. True social change and empowerment requires a significant shift in the underlying principles of how we treat each other as human beings. If we are truly motivated to change things for women in addictions and for the many social ills we currently struggle with, we must begin to change the principles of power-over and avoid engaging in battles with those in power. We must find ways to work together. When we become separate we lose our sense of community and commitment to the greater good. When we become separate we can be manipulated as things. No longer are we personal beings instead we become 'academics' or 'funders' or 'NGO's". In this transformation begins the decline into a loss of a sense of our self-worth. The women researchers uncovered this finding in their search for answers to eliminate FAS. They had lost their sense of worth, they had been objectified and in this lose they could not find out who they were. This same process can be replicated in doing community based research unless we as researchers continue to know and believe in who were are and what we do. We must continue to form relationships where we don't acquiesce to someone else's definition of who we are or should be. We need to define ourselves, name ourselves and claim ourselves in the context of empowering research. We must not doubt our own experiences and our self-definitions.

The power struggle that existed had some benefit in that it allowed us to consider our own role as producers of contemporary knowledge. We wanted our knowledge used and to do this we needed to ensure that the power inherent in that knowledge was ours to disseminate. The power that we seized, mobilizing us towards social action and changed our personal lives. Our research is successful because it meets not only the criteria of participatory action research for social change but more significantly because personal changes in empowerment did occur for the women researchers. One of the intents of empowerment research is that it strengthen all the practitioners involved(Ristock and Pennell, 1996). In the reflection process of doing PAR, all participants learned about themselves and their own stance concerning the effective use and misuse of power.
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"*The power struggle with the University made me realize…now we don't let anybody push us around (laughs) it feels good to have power. You are, were, powerless for so much things when you are a young girl, like, you don't have no power when you are younger, your parents have your power, then you are growing up and you are getting into all the drugs and all that. The drugs and alcohol have the power over you and now, it's a different kind of power; I guess power within, like you know you have the power to change things. It makes you feel good about it."*

Participant

What we learned from the Research

…understanding, not the power to manipulate, but the empowerment
- the kind of power that results from an understanding of the world around us,
that simultaneously reflects and affirms our connection to that world.
Evelyn Fox Keller

Early childhood trauma can damage a person's ability to relate to others. Because of the trauma growing up, young women feel different from others, they feel somehow detached and not a part of the crowd. They sense themselves as inadequate, unwanted and forever affected by the past. As they become women, they learn to chose isolation because they fear that being with people will trigger the rage, depression or despair they feel. They surround themselves with others or are engaged in exclusive and enmeshed relationships. (Matsakis, 1998) To avoid the possibility of this emotional pain many trauma survivors will choose to either be alone or to restrict their relationships to a few friends or to immediate family. When these "solutions" are not effective they learn to numb themselves with substances.

"I want to talk to somebody and they are sitting right there and then I get so mad. I am like just get out of my face. I get so mad at myself, I want so bad to talk to them but it just doesn't come out that way. I end up taking a drink and hibernating from everybody and I end up just denying".
Participant

Because of trust issues and dealing with guilt over drinking while pregnant women don't come forward for help.
"Where do women go who are really scared but want to be able to talk about what happened and be able to get some information". Participant

Women develop a sense of self that is skewed and damaging.
" It's one of the large barriers to recovery, that I'm a piece of garbage and I can't help it, there is no sense in me considering change." Participant

Mental health intervention is not readily accessible.

Many victims of early childhood trauma are especially susceptible to basing their self-esteem on the approval of others, on being loved by someone else and on their accomplishments (Jehu,1987) which for many women is their ability to create children.

<u>Our Key Findings</u>

There are a multitude of factors that make up the reality of a woman's life when she is substance abusing. The label of addictions is only a part of the reality of women's lives. There is a larger picture regarding our health that is completely linked to other factors that in fact determine whether or not we can be healthy and substance free. These factors are violence, early childhood trauma, literacy, second rate jobs and unemployment, food security, childcare and care-giving responsibilities, housing and transportation. Because these factors have profound effects on women's health and well-being any strategies that are developed to assist women who are substance abusing must incorporate these health determinants.

We found that:

- We began to lose ourselves as young girls (12-15 yrs.) and finding ourselves involved finding our own voice, one that could be valued by others and ourselves, a voice that can be heard.

- Young girls need empowerment and mentoring to develop a strong sense of self and to be able to avoid substance misuse. Young boys need to be socialized to be compassionate.

- Generally speaking, the world expects too much of women yet women have low expectations of what the system can do to help them.

- By defining and renaming recovery to *Discovery*, we redefine and rename ourselves, we discover who we are, which helps others 'see' us differently.

- One size of treatment does not fit all. Recovery is random and non-linear. It happens in "pockets of awareness" with a gradual unfolding of self.

- The "system" works against women, it betrays trust, denies information, judges, blames, labels, re-victimizes and refuses to respect the reality of women's substance misuse.

- There are three powers; over, with and with-in but women struggling with loss of self know only one kind of power - power over them!

- Many people still practice the shunning of women with addictions both before and after they seek help. Ironically, however women need even more support and a sense of belonging during this transition.

- Substance misuse keeps us numb and disconnected from ourselves and others - self-medicated.

- Women blame themselves for failing to meet unrealistic expectations, for perceived incompetencies and for their lack of value. They seek help, usually through family doctors, not for addictions but for mental health issues. The health care system's response to this is to prescribe medication that in turn keeps them numb and disconnected - medicated.

- Our addictions are not a medical problem, so "treatment" needs to be redefined as a continuum of women's needs for discovery across the lifespan. We need support and power that enables us to know and grow.

- As women we are socialized to think, act and feel in terms of our external relationships however as women in *Discovery* we realize our greatest relationship is with ourselves and this is found in community

with other women where we can dialogue an understanding of who we are.

- External support was found through usually one or two women who worked "out side of the box" and "hung-in". Women who believed in us so we could begin to believe in ourselves.

- Understanding spirituality in many forms, as a connection to self and to others is an essential piece of our discovery.

"Recovery" or "Discovery"

" The process of discovery is a meandering one. We set out in one direction and then turn back to another. We move ahead from the need to know ourselves to the need to know others. As important as it is to know oneself bare, so it is equally important to discover the parts of ourselves that have not yet come to our awareness. Sometimes we strip ourselves down to the essentials and sometimes we add to ourselves that which is missing".

Denna Metzger

Recovery isn't a linear process or even a cycle. It is a multi-dimensional experience of unfolding realization and growth. It is the time when women remake themselves out of the scattered, often broken, and always distorted pieces of their individual lives. Recovery is a time when they begin to understand the context of their suffering and could no longer stand idly by while they destroyed themselves in the attempts to be something they were not.
The women in this research described the process of recovery as a life long process of coming to know themselves. It is a gradual unfolding of self (Power-within) and the haphazard alignment of certain forces (power - with) that brings women to a place of being able to and not needing to self-medicate. Women 'recover' when they can take control of all areas of their lives. When they can define themselves instead of being labeled by service providers. Women recover when they can re label the process they are engaged in as one of 'normal' personal growth, growth which has been delayed by forces outside of their control instead of a sickness within the more negative medical orientation

"I am not an Indian alcoholic woman, I am human again." Participant

Women recover when they are given the opportunity and respect to be fully engaged in their personal life process, from a women's centered place of care, in a process that acknowledges their need to grow into the discovery over a period of time. Women describe the systemic and relentless disempowerment of themselves as women from a young age. Abuses; sexual, physical and emotional placed them at a precarious place when they started into the strains of adolescent development, a time of great stress. This victimization resulted for many in mental health issues that were left unacknowledged, by the system and by them. Self-medicating with drugs and alcohol became coping measures to deal with life's many and increasing stresses. Substance misuse became a way to numb the pain of women's lives.

"…we hold ourselves back from our children because of the numbness because of the pain, because of keeping secrets, because we can only be there physically." Participant

Recovery becomes the journey to find self that has been delayed.
In exploring the essence of recovery work and the core of what women say is needed to achieve discovery, we found one word to describe the solution – POWER!

Power, or "the ability" for children to protect themselves from abuses, power , or 'the ability' to define who we are as young girls and power with other women to have a voice in getting equal but different health care.

" We have no power. We are invalidated by society". Participant

Women live in a world that benefits by keeping them oppressed and drugged and numb to reality of their powerless positions.

" He wanted to put me on Valium and I didn't want that, he wanted to put me on Adavan and I didn't want that. That's the doctor I was going to when I was addicted to pills for a year. After the baby he was trying to give me all these drugs." Participant

These women are not asking to be better than anyone else, they are simply asking to have the work they do as mothers, wives, professionals and members of the society valued for it's inherent worth, a worth different that that of men's.

> *"How much of this [research] has been attempting to do that…change the word recovery, change the stigma, change all the negative stuff that keeps coming at us because we have so much damn negative…that is where we are, and until people start changing those and we start changing them in our own minds then we can't re-form a whole new identity…we can't continue with our knowing and growing because the negative puts us into a place where we can't move from."*
>
> *Participant*

Social Action to Create Change

" You educate a boy and you educate a man but you educate a girl and you educate a whole family"

Beverly Leipert

"finding your identity is not just finding yourself,
it is finding a voice to say what that identity is and what we want"
Researcher

What is social action and what does it have to do with research? Social action is ' the deliberate strategic action undertaken to bring about change (Grundy 1982 as quoted in St. Denis 1992:54). In terms of this research project, the social action piece was necessary to utilize what the women discovered about their own reality of living without power. Using the knowledge they gained during the research process, they turned disempowerment into action in opposition to a situation in need of change. According to Patricia Maguire (1987) 'by linking the creation of knowledge about social reality with concrete action, participatory research removes the traditional separation between knowing and doing (Maguire, 1987:3). The women of Creating Solutions did just that. They moved from reflecting on the key findings of their research and knowing there was an issue to be addressed into tackling the issue head on, and in the long run, effecting change in the area of health care for women in the north. What made this part of their research journey even more relevant to their findings is their decision to include their daughters in the process. Organizing a social demonstration along with their daughters seemed like a perfect chance to put into practice what their research said, girls need strong women mentors to help them find their voice and it is only through finding this voice that young women can avoid disconnection and psychological disassociation.

Because the core of these women's substance misuse appeared to be the destruction of our sense of worth and value as young girls, the women wanted their daughters to be able to experience power. The problem of women's addiction does not begin in early or late adulthood, it begins in childhood and adolescence.

Women lose touch with their identify and their voices beginning in adolescence when

> " girls in general are at risk for losing touch with what they know through experience, in part because the changes of puberty and adolescence may render girl's childhood experiences seemingly irrelevant, in part because women's and girl's experiences tend to be idealized or devalued or simply not represented within patriarchal society and culture, and in part because girls discover in adolescence that their relational strengths and resilience (their ability to make and maintain connection with others and to name relational violations) paradoxically begin to jeopardize their relationships and undermine their sense of themselves"
>
> (Taylor, Gilligan, Sullivan, 1995)

Adolescence is a time when psychological development and our patriarchal culture put enormous pressure on young adolescent girls. It is a time when "young women's psychological development combines their search for identity with their search for connection" (Holmes and Silverman, 1992). During adolescence they lose what Mary Pipher calls " their subjective fix on the universe". She describes them as "set adrift and helpless, their self-esteem hostage to the whims of others (Pipher, 1994, p.150). Young women are less likely to be confident, feel they have good qualities or feel good about themselves (Holmes and Silverman, 1992), they show a

drop in general well being (King, 1999) and report more psychological distress, drops in scholastic achievement, lower career aspirations, a higher suicide rate and more self image problems(Roth, 1991). Adolescent girls experience a marked increase in depression, eating disorders, poor body image and decrease in self-worth (Taylor et al, 1991)

At the same time our society requires young women to shut down and not say what they are feeling and thinking because if they speak they could be in danger of losing relationships with others (Gilligan, 1991). When they do this they lose touch with their own inner self. Something debilitating happens to adolescent girls as they enter this dangerous time. They lose their "resiliency and optimism and become less curious and inclined to take risks…they become more differential, self critical and depressed (Pipher, 1994). Researchers have noted the phenomenon that "by sixth grade it is clear that both girls and boys have learned to equate maleness with opportunity and femininity with constraint (Orenstein, 1994). Some believe it is that girls come to understand that men have the power and that their only power comes from finding a man and attaching yourself to his identity (Mrs. John Smith). Perhaps as Mary Pipher states young girls don't suffer from the Freudian penis envy but instead from power envy (1994, p. 20).

Without support and intervention, the loss of self-experienced in adolescence continues into adulthood. In our society alcohol is the drug of choice, it is cheap, readily accessible and powerful. With presence of alcohol and drugs in adolescent's lives, it can fully delay a process of self-discovery, which will need to be addressed in treatment or therapy. Alcohol and drugs create numbness that allows the young girl the opportunity to deny this identity loss, to not have to question their sense of self, or to confront the betrayals of themselves in order to give pleasure to others. So in the numbness of alcohol and drugs, they learn that their worthiness is determined outside of themselves by others and our patriarchal society. In the haze of alcohol and drugs and the context of poverty and violence in which addictions exists, these girls continue to try to please everyone but themselves. They do what they should and as they are told and feel angry and betrayed because they are not rewarded for their efforts. They feel trapped, desperately unhappy, used and unloved and they drink and drug to hide their pain.

As a society we fail to make allowances for young girls growth and autonomy. Any testing of limits is discouraged so in October 2000, the women and daughters of Creating Solutions decided on their next step. The National Health Summit, slated to take place in Prince George in January 2001, appeared to be the perfect opportunity to further explore their efforts of empowerment.

As the Creating Solutions group members watched the developments of the summit agenda unfold on the National Health Summit website, they soon realized that neither First Nation's or Women's issues were being addressed. The group decided that their voices and the voices of women in the north must be heard regarding health issues. As a result of their research, they recognized that women experience health and health care differently than men, a fact that has recently been supported by the Institute of Medicine as reported in the Province Newspaper (April, 2001) Social issues and mental health are two of the greatest determinants of health for women, yet neither issue was to be addressed at the 'National Health Summit.' This fact was not unacceptable given their new found understanding. The women discussed what suitable action to take.

> *" Because when we talk to other women they understand it in the same language as we do because they have experienced it. There are things that have happened in my recovery that a man can not even relate to." Participant*

They resolved to have their voices heard and determined that a social demonstration, speaking to the marginalization of women's health issues, could be an empowering and effective way to have women's voices heard. Women from Creating Solutions contacted the Summit organizers, met with them as a respectful means of communicating their intent and assumed their could be a reasonable collaborative initiative created. The summit organizers did not want to work together with the group and expressed concerns that the demonstration may reflect badly upon their work. Not to be deterred, the group saw this as an opportunity to create change and asked to present their research findings at the Summit, in an attempt to give a voice to women's and First Nation's issues.

Unfortunately, and quite predictably, the group was not invited to attend the Summit nor were allowances made to grant access to the summit (the cost was $214 per person). As a result the findings were not presented to the community of Prince George nor the various visiting dignitaries at the Health Summit. Though the research results had been previously presented in Victoria and would be presented in Vancouver and Saskatoon, our own community did not appear to value the knowledge generated by its citizens.

The creation of the 'Women's Health Gathering' became a means to ensure equal access to knowledge, and thus power for women in the North. The event was to take place as a free alternative to the National Health Summit where women could gather and share their experiences and solutions for health care change. The final product was to provide women with a chance to take part in putting together recommendations for women's health reform and present these to the National Health Summit.

"It was an eye opener because we did really know we had so many obstacles to overcome when it comes to concerns for better healthcare." Participant

For many of the women and all of the daughters in the group, this was their first experience planning and taking part in an event as controversial and significant as this. Feelings amongst the group ranged from fear to elation. As the time for the gathering neared, all of the women had gained a sense of personal empowerment from the roles they played in the process of organizing. That day was pivotal in creating a new understanding of just what it means to "have a voice" and take part in social action. The significance and value of "action" in research became obvious.

"For me it was scary at first, I had awful images in my head that we were going to be arrested somewhere, I thought man alive, five hundred delegates from across Canada, security was tight, and we are going to be out there, I was waiting for security guards to come out there and say 'hello' but that was just ignorance." Participant

During the planning process, the event drew media and government attention. The Minister for Health in British Columbia, Corky Evans, both contacted the group and subsequently made a brief but supportive appearance at the gathering. The media and government attention received by the group solidified their realization that they could have an impact on the outcome of circumstances. They realized they had both the ability and the right to create their own powerful opportunities to be heard.

"You are asking if we made an impact, well I think we did. If the Health Minister knows about this little group called Creating Solutions, well then I think we did. He's going to mention it to at least one person, and that one to another person and so on and so on."

Banners were created, speeches were constructed and hard work resulted in the Women's Health Gathering taking place on January 19, 2001 at a venue across the street from the Health Summit during the Summit's proceedings. Over sixty women attended the alternative Summit and the experience proved to be an enormously rewarding success. Numerous women found the courage to stand up at the microphone and tell their personal and often heart-wrenching stories of neglect and abuse within the medical profession and health systems.

"What was good about it was the way it [Health Gathering] *fell into place, the diversity of the people that were there, it wasn't just one group of a certain type of people it was like all walks of life from the rich to the poor to the very marginalized to women who I assumed were not marginalized, but it was good that way because we had a lot of input from everybody". Participant*

"I never realized I had a voice but now I did. It feels good to voice my concerns and not feel bad about myself. I think that when we were just gathering together and doing our brainstorming about better health care recommendations then a lot of women realized what other women are going through right now." Participant

At the end of the day, sixty-seven recommendations concerning better health care for women in the north were complied. They were directed to policy makers, health service providers and to women themselves. The following day the recommendations were taken to the National Health Summit and were included in the work of a Summit task force, set up to take a closer look at health care issues pertaining to the northern regions of British Columbia.

Overall, the social action process was very validating, revealing and productive for the participants and as a means of influencing social change. The women of Creating Solutions took on a challenge that at times they felt was beyond their capabilities. However they learned to act as if they had the authority and power and in acting this way they developed the very authority and power that they never thought they would hold.

"I didn't think we could do it right up until the day of the demonstration. I didn't realize how much I had gotten out of the group until then, I realized that we were empowered and we could do things that we wanted to or didn't think we could." Participant

This process helped the women to realize and acknowledge their own inner strength and abilities. It provided an opportunity for them to share the experience of claiming a voice, with other women. In a community like Prince George, the opportunities for women to claim their voices are relatively few and far between, especially for marginalized women. It is vital to the health of our whole community that events like the Women's Health Gathering continue to occur.

"I am so happy to see the changes in the girls after this, like one of the girls here who was so quiet is now saying she wishes she had put together a speech and gotten up and spoke. Those are the changes that we hoped for the girls being part of this group. I know I will never forget it and I'm sure the girls won't either. It's really empowering to know that you have that ability. I know what it felt like when we first started this group, wondering if we were going to make a difference. Putting in all that time and effort into coming here every week, and are we going to make a difference…and yeah, yeah we have. Some people definitely know Creating Solutions." Participant

Conclusion

When we began this research we were looking for simple solutions women could use to help women in the work of recovery. There was an inherent assumption in this that the woman was in fact in control of the various factors that lead to her addiction and that simply finding the roadmap and following it was all that was needed for her to prevent substance misuse.

We found this to be far more complicated than just about choice. The core "cure" for substance misuse appeared to be in the use and abuse of power and the lack and control of resources to women from the time they were children. The women researchers found that the starting of addictions was related to their early childhood traumas and the lack of intervention around the subsequent mental health issues. Also that women's inability to stop was not related to will power or to choice. It was related to the health determinants that affect all women's ability to live healthy life styles. This is not to abdicate responsibility for substance abusing. As women of strength and courage they accept that they made choices that were not beneficial to themselves and their families or communities. They are not laying all the blame at the feet of the "system". However, they are better able to articulate for themselves the structures that contributed to and facilitated their marginalization and subsequent addictions. They now know that they could have recovered far quicker, far less painfully and with far more positive outcome had they had in place some very basic elements in their lives. They may not have needed to self-medicate if they had been able to actualize themselves in a family, community or society that valued them and their role as mothers, sister, wives and grandmothers.

" There are ten conditions that we have to abide by
and if we don't do any of those ten conditions
they are going to come in and take our kids". Participant

Fundamentally it is this lack of value as women, the predication of abuses and disregard for their mental health that has most hastened their demise. And once there, in the substance misuse, it was the lack of acknowledgment and value of them as human beings that kept them in a state of numbness and denial. They desperately needed someone to believe in them so that we could begin to believe in themselves. They craved not just the alcohol but the acknowledgment of themselves as valid, worthy and able women. Their health and "recovery" is intricately connected to their ability to have a safe and secure environment, control of their own bodies and choice and access to respectful services that will assist them in remaining healthy.

"We desperately needed someone to believe in us so we could begin to believe in ourselves. We craved not just the alcohol but the acknowledgment of ourselves as valid, worthy and able women." Participant

The Creating Solutions researchers feel they are now better able to articulate the pieces of their recovery that would be of interest to practitioners and policy makers. They are also better able to articulate for themselves the structures that contributed to and facilitated their marginalization and subsequent substance misuse.

Recommendations and Policy Implications

If we can't get policy makers to acknowledge that high quality appropriate health care is an issue for women, especially in isolated Northern settings (Leipert and Reutter, 1998) then how can we begin to get policy makers to acknowledge that women's substance misuse is a health issue that requires a contextual solution to address the problem?

There is growing evidence of blame against marginalized women with substance misuse issues as well as a service system that is not responsive enough to addressing these needs (Minister's Advisory council on Women's Health, 1996). To begin to counteract these ineffective responses to women's substance misuse, service providers and policy makers must give consideration to:

1. Shifting Beliefs

Until we can shift our thinking about why substance misuse occurs, we will never be able to effectively address the root causes nor subsequently find solutions. The reasons for substance misuse do not lay in an individual's will power or morals; the reasons are contextual and span the many social issues. Service providers and policy makers must begin to address these larger issues. One of the most effective means of addressing these is to examine their own bias towards substance misusing women and begin to shift their thinking and beliefs towards principles of "upstream" work that considers the structural dimensions of working with oppressed and marginalized populations.

2. Medicalization of Women's Health

Medicalization refers to the inclination to take a "normal" life event such as childbirth and construct it into a medical problem requiring drugs or surgery while virtually ignoring the social and psychological aspects of the life event. While we agree that substance misuse is not a normal life event, we believe that substance misuse is a response to life events that are in fact more deeply rooted in social and psychological pieces of this complex issue.

Women are being medicated by our medical services, as a means of dealing with their powerlessness and loss of identity. Instead of putting more emphasis on the social context of this problem, our service providers individualize solutions.

3. "Treatment" Services

Rename this experience. By removing the work of recovery from the medical world and placing it into a normalized experience of growth and development, women can begin to see themselves with less judgment and service providers can begin to acknowledge the multiple factors that contribute to substance misuse. When we can begin to see women as deserving of support and services then they will be brought into the planning of the "treatment" experience, not as a passive client but as an active participant in a process of growth and discovery.

Women's role as mothers must be considered when designing any services for women. Though the creation of childcare services for children under 6 years of age currently provided in some innovative programs, it does not come close enough to the reality that women have children of differing ages that require the predictable involvement of mothers in their lives.

The design of recovery programs must also consider the factors in women's lives that will prevent their commitment to a 30-day program. Services should be designed in shorter modules

to be "worked" through according to the demands and reality of women's lives. If women can pick up where they have left their work then this is truly respecting that recovery is a random process of discovery.

Programs should be physically accessible and cognitively understandable particularly by FAS affected women whose learning needs are seldom addressed in standard treatment settings.

Treatment services are only a small part of the process of discovery (Lightfoot, Lee, Adrianne and Thompson, 1996). We believe treatment programs need to be multi-disciplinary, comprehensive and co-ordinated (Finklestein, 1993; Hagan et al, 1994) with a full range of services (Wallace, 1992).

4. The Relationship between Mental Health issues and Substance Misuse.

"Most resources for substance use are not designed to help women who have a mental illness diagnosis" (Morrow and Chappell, 1999), yet we know that most women with substance misuse problems need mental health interventions. Reducing the barriers to mental health services is only one strategy. Consideration should be given to ensuring that both issues are simultaneously addressed earlier in women's lives.

Women are not able to admit that they require mental health services because if they do their children will be taken (Morrow and Chappell, 1999). This barrier must be removed and service providers must create supportive environments that recognize the right and need of a child and the mother to maintain a close relationship.

5. Programs for Young Girls

The potential for transformation lies in service providers and policy makers' ability to acknowledge and shift their perspective towards young girls in our society. As well, the transformation lies in our community's ability to support and encourage the woman-girl relationships, as these are essential. When young girls sense of themselves is at odds with the male imaging of girls as "valuable or "good", women's voices can be psychologically life saving (Gilligan, Rogers and Tolman, 1991). They provide a counterbalance to the messages girls receive from our society, messages that cause young girls to disassociate from themselves and forfeit their vigor and potential. Little has been recommended regarding prevention programs for women and young girls that would facilitate a more positive outcome surrounding addictions. The establishment of mentorship programs for young girls, and even young boys, at school grades four to seven as key developmental times for developing social competencies and empowerment abilities is a key aspect of preventing substance misuse.

There needs to be a shift in mental health workers thinking and programs, to define mental health from an "upstream" perspective. Work with self-esteem in young women is imperative. An example of this would be the use of more gender specific group work that looked at positive reclaiming of self and identity.

6. Naming and Blaming

We believe that the crucial piece in making recovery work for women is in addressing policy makers and program provider's resistance to acknowledging information and to adjusting their attitude towards the women they serve. If policy makers and program providers acknowledge

what this and other research is telling them then they will be further along to re-examining their practice and policies. In re-examining these, they will then be required to do some things differently and more effectively. This "resistance to knowing information" is not uncommon (Nilson, 1996).

Nor is it uncommon for service providers to take a moralistic view of women's addictions and to disrespect their humanity.

> "The dilemma of community change arises whenever the restoration of individual dignity is taken as a psychological problem inherent in those who are demoralized, rather than as a moral problem inherent in the society which demoralized them. We derive our sense of worth from the whole context of relationships, which define a social being. To restore dignity we must above all treat people with respect." (Marris and Rein, 1967, p.189)

Women are asking policy makers and service providers to stop blaming them for their need to self-mediate. Instead they are asking them for support in addressing the many reasons why self-medication becomes a necessity.

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