

SALVAGING SELF:
A GROUNDED THEORY STUDY OF PREGNANCY ON CRACK COCAINE

by

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Sixty women risked shame and loss to share their painful stories with me. With gratitude for their invaluable contribution, this work is dedicated to these strong and articulate women in hope that understanding will smooth the path to justice.

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Abstract

To explore the experiences and concerns of pregnant women who use crack cocaine, 60 pregnant and postpartum women who had used crack cocaine an average of at least once weekly during pregnancy were recruited in a West Coast urban area using flyers and snowball sampling. Confidentiality was assured and informed consent carefully obtained. In single interviews lasting two to three hours, the women were invited to describe their histories, life contexts, and experiences of pregnancy, drug use, and prenatal care. Data collection and analysis were directed by the grounded theory approach.

Forty women were pregnant, and 20 had delivered. Their average age was 28 years, education was 12 years, and parity was 2.6 children. The sample was 83% African-American, 10% White, 5% Latina, and 2% Pacific Islander; 85% were receiving public assistance.

Finding themselves pregnant while using crack threatened women's self-concepts as individuals, pregnant women, and mothers. Acutely aware of the publicized dangers of crack use, participants struggled to make the best of an already-damaged situation, using a process of Salvaging Self. Salvaging Self included two phases: Making Meaning of the situation, in which they weighed its value, hope, and risk, and Evading Harm, which included strategies of harm reduction

to reduce the risk of fetal damage or loss of custody and stigma management to avoid painful interaction with judgmental people. Women's participation in prenatal care was based on their perceptions of its role in evading harm.

To improve crack cocaine users' health care participation and pregnancy outcomes, a policy shift is needed from prohibition to harm reduction. Harm reduction policy includes decriminalizing drug use in pregnancy, destigmatizing health care interactions, increasing availability of family-centered drug treatment, and directing research toward promoting health of pregnant drug users and reducing drug-related risk.

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CHAPTER ONE

Crack Cocaine in Pregnancy:

A Medical and Social Problem

Drugs are perceived as a serious social threat in the United States. In the past decade, the government has launched a vast and expensive effort to eliminate illicit drugs from American society. During a single term of office, the Bush administration budgeted \$45.2 billion for a "War on Drugs." Seventy percent of these funds were directed at law enforcement to eliminate the supply of cocaine and other drugs in the United States (Trebach & Zeese, 1990).

As part of this surge of concern about cocaine use in American society, medical researchers have given a great deal of attention to the prevalence and effects of cocaine use in pregnancy. Resulting reports of the harms and social costs of prenatal cocaine use have fueled aggressive interventions, including prosecution of women in at least 20 states for drug use during pregnancy (Fratello, 1991; Paltrow, 1992) and a dramatic increase in the numbers of infants and children removed from their mothers' custody for drug-use-related reasons (McCullough, 1991). Political and legal efforts have been unsuccessful at reducing the supply of drugs (Rosenbaum, 1989) or restricting pregnant and parenting women's drug use behavior.

On closer examination, cocaine use in pregnancy can be reframed as a complex psychosocial phenomenon that is perhaps less an independent medical risk than it is a reflection of

more resistant social problems. To understand and influence the dynamics of drug use in pregnancy, researchers must explore the social world and perspectives of women who use drugs. Such an exploration is the substance of the present investigation.

Purpose of the Study

The aim of this study was to go directly to women who were in the social world of crack cocaine, to gather information about:

- the experience of pregnancy for crack cocaine users,
- how pregnant crack users perceive their drug use and social influences on it,
- their perceptions of their own health, health care agencies, and prenatal care, and
- their views on solutions to problems they experience.

With insight into the personal and social dynamics of women's experiences of pregnancy on crack cocaine, further studies and interventions can be planned which fit into the social milieu of this complex health problem.

To situate the problem of pregnancy on crack cocaine in its social and medical context, in this chapter I present an overview of the emergence of prenatal cocaine use as a problem, outline the scope of the problem, and conclude with a reframing of cocaine use during pregnancy as a complex, contextually-rooted phenomenon best studied via a naturalistic nursing research approach.

Changing Perceptions of the Problem: An Overview

In the mid-1980s, the news media in the United States began to report the emergence of a new drug form: crack cocaine. This highly potent substance was reported to lead users quickly down a path to criminal involvement and financial and social ruin (Kerr, 1988). By the mid-1980s, crack use by childbearing women had been linked to a growing number of obstetrical problems. Medical journals published case studies (e.g., Acker et al., 1983) and then clinical series (e.g., Chasnoff & Griffith, 1989) in which cocaine use was implicated in perinatal problems such as placental abruption, preterm delivery, and low-birth-weight infants. News stories appeared of abandonment of these sick infants by their drug-seeking mothers, as increasing numbers of drug-exposed newborns became expensive wards of the state (Goldman, 1988). Concerns also were raised about the effect of mothers' cocaine use on family stability. Cocaine addiction was described in news media as destroying mothers' parental instincts and causing child neglect (Hinds, 1990). The physiologic, economic, and criminal threats of crack cocaine were seen as risking the dissolution of the inner-city family, and a noted pediatrician warned that 20% of America's children would become a "throw-away generation" ineducable and destined for criminality, due to the effects of prenatal exposure to crack (Brazelton, in Chapple, 1990).

While reports of the perinatal harms of cocaine proliferated in the medical literature, a few researchers began to question the size and risks of the crack cocaine

problem. In 1989, as public and medical concern about crack cocaine neared its peak, a Canadian research team reported that of submissions to a pediatric symposium, studies reporting no cocaine-related increase in perinatal harm had a lower likelihood of acceptance for presentation than did reports of harmful effects of cocaine (Koren et al., 1989). By 1991, "mainstream" medical reports of the effects of prenatal cocaine exposure began to take a different tone. Researchers more consistently acknowledged the difficulty of teasing out the effects of cocaine from the effects of other known perinatal risks such as poverty and cigarette use (e.g., Coles et al., 1992), and the developmental normalization of "crack babies" over the first few years of life was noted (e.g., Chasnoff et al., 1992). In early 1992, a major medical journal published an editorial entitled, "The Problem of Prenatal Cocaine Exposure: A Rush to Judgment" (Mayes et al.). The authors noted the methodological shortcomings of many reports on perinatal cocaine effects. They warned that blaming a drug for deeper and more persistent social problems was short-sighted, and that labeling cocaine-exposed children as damaged could hamper their educational and social progress, creating a self-fulfilling prophecy.

Recent meta-analyses and critical reviews supported this challenge to the predominant view of the severe dangers of prenatal cocaine use (Lutiger et al., 1991; Zuckerman & Frank, 1992). These experts now suggest that although

seriously ill infants are indeed born to women who use crack cocaine, few neonatal effects can be associated with cocaine itself when other confounders have been controlled, and many effects appear to resolve in the first two years of life or reflect increasing influence of environmental conditions. Thus, a tempering of the initial "crack scare" (Reinarman & Levine, 1989) has begun within the medical community.

In spite of this softening of medical views, social service and criminal justice agencies continue aggressively to police pregnant and parenting crack cocaine users. The child welfare system is flooded with children who have been removed from their mothers' custody on the basis of maternal drug use. As McCullough (1991) notes:

In 1989 there were...675,000 cases involving caretakers who abuse drugs and/or alcohol...In some communities there has been as much as a 3000% increase in the number of drug-related dependency petitions granted from 1984 to 1989...The overwhelming majority of the cases fall into the "general neglect" category. These are usually single-parent families who are marginally coping, frequently living in poverty, and unable to provide for the consistent care or supervision of their children. Workers report that parental drug involvement is pushing these fragile families over the edge...It has been estimated that as many as 80% of the identified drug-exposed infants of untreated mothers will be placed in foster care during their first year of life (pp. 62-63).

When court fees and foster care costs are added to the costs of hospital care for a preterm cocaine-exposed infant, care and custody of each crack-affected baby in San Francisco costs approximately \$40,000 (Asimov, 1990).

Media campaigns launched by organizations such as the March of Dimes and Partnership for a Drug-Free America

continue to portray prenatal drug use as inevitably harmful (Zimmer, 1992). In efforts to protect the "rights" of the unborn, a number of legal cases have been tried in which states have attempted to incarcerate and/or restrict the reproductive options of women charged with drug use during pregnancy (Paltrow, 1992). These social and political conditions may alienate pregnant crack cocaine users from agencies that offer assistance with medical and social needs (Chavkin & Kandall, 1990). In sum, prenatal cocaine use remains a significant sociopolitical problem even as medical concern about its dangers begins to soften.

Cocaine Use in Pregnancy: The Scope of the Problem

Cocaine hydrochloride is a white crystalline powder prepared from the leaves of the coca plant. Cocaine blocks pre-synaptic re-uptake of norepinephrine and dopamine, producing activation of the sympathetic nervous system. This causes vasoconstriction, rise in blood pressure and heart rate, and hyperthermia, accompanied by exhilaration and a sense of power and well-being (Acee & Smith, 1987). A popular form of cocaine crystals known as "crack"¹ has been widely available since the mid-1980s at a cost similar to that of alcoholic beverages (Keith et al., 1989).

In statistical projections from a 1990 nation-wide household survey, 0.4% of American women, or 147,000, were

¹The terms cocaine and crack will be used interchangeably in this paper because their effects on the fetus have been found to be the same (Cherukuri et al., 1988).

estimated to have used crack cocaine in the past month². Virtually all were between the ages of 26 and 34. While the numbers of white and Latina women reporting crack use were too small for accurate statistical projections, among African-American women, 0.8% or 95,000 were estimated to have used crack in the past month. Although socioeconomic status was not analyzed by gender, in the entire survey sample (both men and women), crack use in the past year was higher among the unemployed than among full-time or part-time workers (NIDA, 1991).

Cocaine use among pregnant women has been reported as an epidemic (e.g., Giacoia, 1990), but on closer examination the problem appears to cluster in urban areas and impoverished populations. Population estimates may be distorted considerably by testing and reporting practices. In a sampling of newborns' hospital discharge diagnoses across the nation, the rate of drug-related diagnoses increased sharply during the 1980s, from seven per 10,000 births in 1979 to 32 per 10,000 in 1987 (Dicker & Leighton, 1991). This 1987 figure is close to the 0.4% found in 1990 NIDA survey estimates. In contrast, when urine testing and self-report were used to identify drug-exposed newborns, prevalence of

²This number appears alarmingly large, but it is minute in comparison to use of alcohol and cigarettes, two other agents known to be harmful in pregnancy. Over 44% (or 46 million) women (47% of white women, 33% of Latina women, and 33% of African-American women) were projected to have used alcohol, and 24%, or over 25 million American women (25% of white, 15% of Latina, and 25% of African-American women) were estimated to have smoked cigarettes in the month preceding the survey (NIDA, 1991).

cocaine use by pregnant women ranged from 11% to 17% in urban clinics (Feldman et al., 1992; Frank et al., 1988; Halstuk, 1990) but less than 2% in higher-income or non-urban areas (Buchi et al., 1993; Lake et al., 1992; Sloan et al., 1992).

Cocaine users have been found more likely than nonusers to be single, receiving public care, non-white, have a history of abortions and sexually transmitted diseases, and to use other drugs and cigarettes (Amaro, Zuckerman, & Cabral, 1989; Buchi et al., 1993; Graham et al., 1992; Lake et al., 1992; Minkoff et al., 1990). Researchers have related a maternal history of childhood and marital violence to drug use in pregnancy (e.g., Paone et al., 1992; Regan, Ehrlich, & Finnegan, 1987; Woodhouse, 1992). Thus, prenatal crack cocaine use appears to cluster in populations already at risk for poor perinatal outcomes. This judgment may be hampered by biased testing and reporting practices, however; white women in private care are less subject to reporting of drug use than their nonwhite or impoverished counterparts (Chasnoff, Landress, & Barrett, 1990).

Of a range of obstetrical and neonatal complications initially associated with prenatal cocaine use in simple correlations, low birth weight and small head circumference have been most commonly reported (e.g., Keith et al., 1989; Little et al., 1989; MacGregor et al., 1987; Oro & Dixon, 1987; Pettiti & Coleman, 1990). Because low birth weight is the most frequent cause of perinatal mortality in the United States (National Center for Health Statistics, 1980), these

reports have generated medical concern. In a later meta-analysis of 45 studies, however, no independent effect of cocaine on birth weight or head circumference was supported (Lutiger et al., 1991). Cocaine's effects may be mediated by maternal pre-pregnancy nutrition (Zuckerman et al., 1989) and alcohol and cigarette use (Chasnoff, 1991; Streissguth et al., 1991).

The fraction of cocaine-exposed infants who suffer adverse effects is unclear. Because infants whose mothers were not tested while in labor and who appear healthy at birth may not be screened for cocaine metabolites, many more infants may be cocaine-exposed than current figures suggest, and the percentage of cocaine-exposed neonates with complications may thus be smaller than studies of identified "crack babies" imply. The duration of the effect of prenatal cocaine exposure is also undetermined. Although news reports described difficulties of integrating cocaine-affected children into elementary school classrooms (e.g., Daley, 1991), social conditions of children's environments have been found more influential than prenatal cocaine exposure on child outcomes (Anisfeld et al., 1991; Coles, Platzman, & Smith, 1991; Phillipson & Howard, 1991).

Mothers-to-be who use cocaine, many already at risk for perinatal problems as noted above, need consistent health care during pregnancy. Actual care delivery may be falling far short of this goal. In samples of identified cocaine users, the percentage who did not receive prenatal care has

ranged from 40% to 60% (Cherukuri et al., 1988; Chouteau, Namerow, & Leppert, 1988; Gillogley et al., 1990; Melnikow et al., 1991). The association between lack of prenatal care and drug use has become so widely accepted that late or inadequate prenatal care has become an indication for drug screening of women admitted to labor and delivery suites in major urban centers including the San Francisco Bay area (Keith et al., 1989; Land & Kushner, 1990; McCalla et al., 1991; Oro & Dixon, 1987; personal communications, St Luke's Hospital, San Francisco General Hospital, UC Medical Center, Marin General Hospital).

Gaps in Current Knowledge: Reframing the Problem

Our understanding of the size, risks, and solutions of the phenomenon of cocaine use in pregnancy has been hampered by methodological limitations, biased testing and reporting, medical rushes to judgment, and the fear and stigma engendered by a large-scale anti-drug movement in political, legal, and sociocultural arenas of the present-day United States. Attribution of this women's health problem to the effects of crack (without consideration of the health effects of longstanding and resistant social problems including poverty, racism, violence, backlash against women, and political conservatism) may not only increase health risks for the disempowered but increase drug trade and use. The "crack scare" has deflected public attention from these larger problems that may seem more expensive or resistant to change (Reinarman & Levine, 1989; Rosenbaum, 1989).

Meanwhile, as a symptom of this larger social process, a substantial number of women who use crack cocaine during pregnancy are not receiving prenatal care that perhaps could reduce risks related not only to drugs but to correlates of drug use such as poverty, poor nutrition, chronic health problems, or use of legal substances such as tobacco and alcohol. As a result, many crack users are delivering low-birth-weight babies who require costly special services. Medical research on the effects of cocaine in pregnancy offers little insight into, for example, how the experience of pregnancy is interpreted by and affects cocaine users, or why women continue to use drugs in the face of fear, stigma, and social opposition. Nor will an agency-based epidemiologic approach provide clinicians with direction for care of those pregnant cocaine users who avoid health care.

When drug use in pregnancy is reframed as a social problem, social research methods become essential to its understanding and resolution. Areas for study then include the contexts in which drugs are used, the socioeconomic and cultural influences on drug use and abstinence, the role of pregnancy in the lives of women who use drugs, the resources perceived as safe and available to them when they seek help, and the obstacles they experience in help-seeking. The viewpoints of the actors in the social worlds of drug users become important. In a social research model, pregnant women become not vectors of an "epidemic" disease but reflexive persons whose possibilities for action arise out of their

experience and the conditions of their lives.

A Naturalistic Study of Pregnancy on Crack

In order to discover the meaning and context of a highly stigmatized and illegal social phenomenon as experienced by those living within it, researchers are obliged to detach themselves from agency-based data collection and pursue naturalistic, ethnographic approaches. In the following chapters, I describe such a field-based qualitative study of women who were pregnant or recently had given birth and who used crack cocaine during their current or most recent pregnancy. The purpose of this investigation was to gather information from crack cocaine users about their experiences of pregnancy, influences on their drug use, views of their health, and their approaches to the problems they encounter. This information will provide health care providers and social service workers with directions for design of drug treatment and prenatal care to meet the needs of this underserved group. In addition, these findings will reveal for policy-makers the effects of current laws, funding priorities, and child welfare policies on women and their families. Third, the results of this study will offer new directions for basic research into the realities of pregnancy under adverse conditions, and into the nature of addiction as a contextually-dependent, bio-psychosocial phenomenon.

Nurses are especially well-suited to conduct this research, for several reasons. First, nurses traditionally appreciate both the environmental and the biological bases

for illness and study social and psychological responses to such physiologic events as drug use or pregnancy. Second, unlike most physicians, many nurse researchers are trained in social research methods. Third, many nurses possess interpersonal skills from the clinical arena that can ease interactions with stigmatized and perhaps fearful research participants. Nurses' advocacy and observational skills along with systematic social science methods can produce information that may be more useful than that obtained by epidemiologic or biostatistical means.

In the next chapter, I outline the theoretical foundations for a naturalistic nursing investigation of pregnancy on crack cocaine. This is followed in the third chapter with a review of earlier field-based studies of drug users and of experiences of pregnancy and prenatal care. The method and analytic process of the present study are presented in Chapter Four, followed by three chapters of findings: the problems of pregnancy on crack, the process used by pregnant crack users to deal with these problems, and crack users' perspectives on the pivotal arena of prenatal care. The final chapter is a discussion of the significance and limitations of the study, concluding with its implications for health care providers, policy-makers, researchers, and the pregnant crack users who made the study important and enabled it to happen.

CHAPTER TWO

Theoretical Foundations:

A Feminist Interactionist Approach to Pregnancy and Cocaine

This study was conceived in a world-view shaped by feminism and symbolic interactionism; it was informed during its design and conduct by the findings of previous research into related phenomena. In this chapter, I will discuss the principles and assumptions of feminism and symbolic interactionism as the roots of the study's formulation and design.

Unlike studies within the positivist tradition, this project was not launched with the plan of testing a pre-existing theoretical understanding of how a phenomenon works. Instead, the study had the goal of discovery of theory (Glaser & Strauss, 1967). Therefore, the theoretical framework presented here mainly pertains to beliefs about how the project should be designed and conducted rather than to beliefs about the anticipated nature of the findings. These frameworks do, however, lead the investigator to look into particular aspects of a situation for answers to questions about a human action such as drug use. For example, many feminists look at imbalances of power between men and women as a source of explanation, and symbolic interactionists look at persons' definitions of situations to find reasons for behavior. Thus, although the nature of this particular phenomenon was not clear at the outset, I acknowledge that feminism and symbolic interactionism could be seen as

predicting the outcomes, in that they provided direction for how to frame the problem of drug use in pregnancy, what questions to ask, and where to look for answers. To be explicit about the influences of these belief systems, I will summarize relevant points in each and indicate how they informed the present study.

Feminism

The principles of feminist research undergird the study's purpose and design. Although feminists' thinking is vocally diverse, and feminists vary in their opinions and theoretical approaches to the public and private problems of sexism, some meta-scientific themes reappear in feminist scientific work regardless of the specific data collection or analysis method. Two topics will be addressed here: the ideological goals of feminist research, and the elements of research that commonly arise from these goals.

There are many feminisms (Miller, 1992; Reinharz, 1992), and any discussion of feminist concerns must include acknowledgment of tensions among diverse thinkers and interest groups within the wider field of feminist writers. This presentation is consciously limited and partial. In articulating what informed this study, I am telling a personal story of those points in feminist thought that influenced me rather than reporting a widely accepted abstraction.

The core ideology common to most feminists is as follows: that the experiences of women are valuable and

valid; that ideological, interpersonal, and sociopolitical conditions exist that oppress women; and that social change is needed to alleviate these oppressive conditions. These assumptions underlie most feminist research approaches, and most feminist research acknowledges social change for the good of women as within its goals, either as an outcome of the research act itself or as a result of eventual dissemination of the findings. This conscious partiality to women's interests (Mies, 1983) contrasts with the traditional claims to objectivity in positivist science, and in fact has been described by Star (in Reinharz, 1992) as:

a method of strategic heresy-- a method for understanding, from a marginal or boundary-dwelling perspective, one's own participation in socially constructed realities, both politically and personally...Feminism, viewed methodologically, is an emergent scientific method-- one which begins with the death of the subjectivity/objectivity dichotomy and which involves questioning the very bases of socialization and perception (p.241, original italics).

Thus, feminists' awareness of the social construction-- for the most part by men-- of culturally-accepted definitions of truth and value, and feminists' awareness that both men and women are caught up in activities based on those definitions that perpetuate sexist power imbalances are important roots of most feminist research approaches.

Feminist research projects, although varying in method, generally share a set of criteria for the assumptions, questions, data-gathering and analysis, and dissemination of findings (Campbell & Bunting, 1991). This approach can be condensed into a framework of six basic characteristics of a

typical feminist study. Although risking oversimplification for the sake of brevity, this list represents a distillation of the major principles found in discussions of feminist research in current nursing literature¹.

Women as the focus of the research. A feminist consciousness "sensitizes the researcher to the vital needs of women" (Duffy & Hedin, 1988). A conscious partiality toward women and an acknowledged bias in favor of women's personal and political empowerment are characteristic of feminist research (Mies, 1983, p.122). Until 1970, research on women's health problems, for example, was mainly limited to conditions that affected their ability to reproduce, and other concerns central to women's lives were left unexplored (Duffy, 1985).

Women as subjects rather than objects. Feminist researchers acknowledge, in questions and methods, that researcher and researched are humans whose perceptions and contextually-grounded experiences have value (Webb, 1984). Researchers acknowledge that both investigator and participant hold biases that are reflected in the process and outcome of research. Subjective data is considered valid (Campbell & Bunting, 1991): "The only way of knowing a socially-constructed world is by knowing it from within" (Webb, p.250). Narrative can convey the order and meaning in

¹I am not alone in attempting to boil down diverse feminist scientific writing into a list of principles or characteristics that most feminists would accept. See also Reinharz (1992, p. 240), and Cook and Fonow (1990, p. 72). Their lists are quite similar to mine, which was gathered in the nursing literature.

experience, and telling their personal stories can empower respondents in qualitative research (Mischler, 1986). In order to collect these data, feminist researchers often employ participant-observation and conversational interviewing and retain informants' original words when possible in presenting study findings (DeVault, 1990).

Relatedness of investigator and respondent. The detached, objectivist stance of the researcher in traditional positivist methods is often rejected by feminists in favor of equality and reciprocity between researcher and participant (Connors, 1988). The participant, rather than the researcher, is seen as the expert on the experience in question (Campbell & Bunting, 1991). The relational and contextual nature of knowledge and communication (Mischler, 1986) is respected. Feminist research often involves a reflexive transmission of information in a two-way conversation, an accustomed mode for women that enables mutual trust and understanding (Oakley, 1986), although care is taken not to exploit participants who may accept as friendship what the researcher intends as data collection (Finch, 1984).

Inclusion of diversity. Although common expressions and understandings exist among women, differences among women are also accepted by feminists as reflections of individuality and varied sociocultural backgrounds. Conflicts of perspective and goals within feminism itself have sensitized feminists to the range of variation present in women's

experience. For example, the experiences of racism and poverty are not known equally by all women (Joseph & Lewis, 1981). A feminist researcher seeks to encompass a range of variation in study sampling and to reflect the diverse study population within the integrating matrix of research findings (Hall & Stevens, 1991).

Focus on problems important to the women under study.

Feminist researchers seek to be collaborative with the target population, with the intent to serve these women rather than the political majority or the research establishment (Webb, 1984). The feminist goal of changing oppressive social structures is promoted by targeting for research the mystifications, or biased social structures and systems of thought, that women experience as most damaging (Harding, 1986; Mies, 1983).

Dissemination of findings to the target population.

Feminist researchers have sought ways to bring their findings to women who can use them for empowerment (Webb, 1984). For example, feminists have published their research in popular magazines and books as well as in scholarly publications. Researchers may give copies of their findings to participants and community groups and may communicate their research to women in speaking engagements and clinical practice (Duffy & Hedin, 1988).

Birth of this feminist project. A streak of "feminist heresy" led me to conceive this project and influenced many

parts of its design. In the late 1980s, when crack cocaine was hailed in the mass media as threatening morality and social stability in the United States, male crack smokers were criticized for the interesting combination of violence and idleness, but women cocaine users were most subject to public scorn. As Faludi (1991) has noted, many news articles portrayed concern that women's greed for crack cocaine was distracting or disabling them from their child-producing and child-rearing responsibilities and leading them to promiscuity and child abuse. This threat of social collapse resulted in an outcry-- and judicial actions in many states-- for restriction of personal and reproductive freedoms of women who used drugs.

As I read these news stories, I recognized that, once again, women were being blamed for a large-scale social problem without indication that their perspectives had been tapped or alternate explanations explored. Nowhere in mass media coverage appeared the voices of the mostly poor and nonwhite women who were being described in animalistic terms and set up for incarceration and forced contraception because of their drug use. I decided to seek an understanding of the phenomenon of cocaine use in pregnancy from the women themselves, and I set out to design a project that would respect pregnant drug users' perspectives, with the ultimate goal of improvement of their lives according to their own needs. I came to view drug use by pregnant women as a

socially-constructed problem-- one best studied in a naturalistic and mutualistic approach.

Many pitfalls could occur in this effort, from a feminist viewpoint. First, I could make the mistake of assuming that I understood pregnant addicts' experiences solely on the basis of sharing gender and motherhood with my informants, ignoring deep cultural and social differences likely to come between us. I could misjudge what the women were saying about their needs and their situations, and I could do harm to the participants by controlling our interaction to the extent that women suffered emotional distress or stigmatization. I could use the project to further my own career in the guise of helping the women I studied. I could generalize findings to all pregnant women who use drugs, losing sight of the unique contexts in the lives of the study participants. My approach to these methodological threats will be addressed in Chapter Four, in a discussion of the study process.

Symbolic Interactionism

The second theoretical base, symbolic interactionism (Blumer, 1969), complements the feminist perspective. In fact, a number of feminist projects have been launched within the framework of symbolic interactionism (e.g., those collected by Deegan & Hill, 1987). Here I present briefly the origins of this social psychological theory and describe in more depth several concepts that are directly relevant to this study of pregnancy and crack cocaine.

Roots of interactionism. The Chicago sociological tradition was influenced by the social philosophy of Pragmatism, as expressed in the writing of John Dewey (e.g., 1922) and further developed by George Herbert Mead (1934). In Dewey's Pragmatism, humans adjust to changing social realities by a continual process of adaptation, for which they are uniquely capable due to the existence of the mind. The mind is described not as an entity but as a process of symbolizing social objects and deliberating action plans to achieve social adjustment. Mead expanded Dewey's theory to describe the continual creation and adaptation in mind, self, and society that occurs by virtue of role-taking, or imagining the experience of another and acting accordingly (Turner, 1982, p. 310).

The sociologist Herbert Blumer applied Mead's expanded theory of Pragmatism in the social science approach of symbolic interactionism. Blumer advised the sociologist to "take the role of the acting unit whose behavior he is studying" in order to grasp the perspective of persons in social interactions (Blumer, 1969, p.86). Study of persons in society using the symbolic interactionist approach focused on experiences of self in social context and investigated interactions from the viewpoints of the actors. From this theoretical foundation arose the Chicago tradition of participant observation and naturalistic field methods in social research.

Assumptions of interactionism. Central premises of symbolic interactionism include:

- Social reality is socially produced, and the meanings of objects lie in the actions humans take toward them.
- Humans as thinking beings are capable of self-reflexive behavior that is intentional and responsive to past experiences, the actions of others, and a constantly changing understanding of the self and the situation.
- In their interactions with others, humans manipulate symbols, words, and meanings, and relate to themselves as well as to others (Denzin, 1989, p.5).

To interactionists, the individual is not a stable, structured entity with a fixed personality, but rather is an amalgam of socially-constructed perspectives always changing in response to interactions. People formulate their actions based on current meanings considered from within. Societies likewise are not unchanging bodies to which the individual molds herself but rather represent a flow of social processes, changing over time but stabilized by culture, an accumulation of shared meanings to which individuals respond in patterned ways. Several concepts in symbolic interactionism hold special interest in this project. They are: Interactions, self and identity, definitions of the situation, reference groups, and social worlds. These will be described in a little more depth.

Interactions. The core of social life, interaction may

be coarsely defined as

the result of the people involved (keeping in mind that that might be a very large number) continually adjusting what they do in the light of what others do, so that each individual's line of action "fits" into what the others do...by taking account of the meaning of what others do in response to their earlier actions. Human beings can only act in this way if they can incorporate the responses of others into their own act and thus anticipate what will probably happen, in the process creating a "self" in the Meadian sense (McCall & Becker, 1990, p. 3-4, authors' adaptation from Becker, 1988).

Thus, interaction is based on meanings, and it cannot be understood without access to some of those meanings and the history attached to them. As Blumer (1969) noted,

In my judgment, the most important feature of human association is that the participants *take each other into account*...Such awareness of another person in this sense, taking him and his acts into consideration, becomes the occasion for orienting oneself and for the direction of one's own conduct (pp.108-109, original italics).

If people take others into account in directing their own actions, drug use can be considered as more than an automatic, impulsive act, but as a product of a buildup of socially-acquired meanings and experiences.

Self and identity. To interactionists, the self is an internalized, changing understanding of what kind of person one is, an understanding built up over time by interactions in a variety of social surroundings (Charon, 1992). "We come to know who we are through others' responses to us" (Stryker, 1959, p. 116). Self-concept is formed by self-judgment (our reactions and evaluations of ourselves) and identity, the classification or label we attach to our selves in a given

social context. One may have many identities, each relevant to a different role, but all present within one's self-concept. In other words, self-concept is a combination of who we are and what we think about it. These interacting and changing aspects of the self are in themselves objects of social action. For example, a pregnant drug user may describe herself as a "dope fiend," and react to that identity in a certain way, and she may also view her identity as a "mother," and have a different appraisal of that identity. Her actions and those of others around her may be based on one meaning or the other, or both, in a given situation.

Definitions of the situation. From a symbolic interactionist viewpoint, people act on the basis of their definitions of each situation, a complex context-specific perspective formulated in interaction with the self and with others. Each action is part of a larger series of actions over time, and we view our acts not only in the present but as coming after prior acts and before other potential ones. The definition of a situation is made up of the information available to an actor by which s/he can anticipate events and respond accordingly. Charon (1992) names some of the components of defining a situation, paraphrased below:

1. Establishing goals in the situation
2. Applying a perspective, from a reference group or significant other
3. Noticing relevant objects (people, events, ideas,

etc.) in the situation

4. Taking the role of the other (seeing oneself from the other's perspective)

5. Defining the self in the situation, including assessing one's actions and others' actions toward oneself, considering past and future, judging oneself, seeing one's identity in the situation, and interpreting the situation through emotions (p.131).

The definition of a situation contains the explanations for actions. Therefore, to understand a given set of human actions, such as cocaine use by a pregnant woman, one must attempt to grasp the actors' definitions of the situation-- a tricky and essentially impossible task, like the fairy-tale challenge of trying to hold onto a slippery monster as it constantly changes form. One cannot ever totally appraise another's definition of a situation, but this concept provides a starting point from which to explore interactive phenomena such as drug use.

Reference groups and social worlds. Reference groups are social groups from which the individual gains perspectives, or sets of understandings of the world, as those meanings are continually created and modified around collective action (Charon, 1992; Clarke, 1990; Shibutani, 1955). Social worlds are reference groups held together by cooperative interaction. Individuals in social worlds share commitments to certain goals and activities, and they communicate about their pursuits in a discourse that reveals the group's

evolving consensual perspectives. Individuals are often simultaneous members of a number of reference groups and/or social worlds and maintain fluency in the discourse native to each. As we consider the influences on a pregnant woman who uses drugs, it is important to look for the different and probably conflicting reference groups to which she belongs. Does her definition of the situation in a setting such as prenatal care clinic, for example, arise from her perspective as a drug user or a mother-to-be, and how does she manage conflicts between these perspectives?

Critics of symbolic interactionism have said that this worldview is "non-economic, ahistorical, culturally limited, and ideologically biased, has a limited view of social power, and paints an odd picture of social reality" (Meltzer, Petras, & Reynolds, 1975, p.99): in other words, unappreciative of social structures and politics. These are important criticisms of a framework if it is to be applied to a social problem such as the one in question, one that is influenced to a great extent by social institutions such as health care, drug policy, and the criminal justice system.

How are social institutions explained in interactionism? In "Society as Symbolic Interaction," Blumer (1969) notes contribution of the ideas of the self and interpretation to the standard mechanized, robotic view of social institutions. Because societies are made up of acting individuals who choose either to go along with the status quo or to act

against it, explanations can be found for both stability and change. A view of social structures as fluid need not deny the powerful conservative influences within social groups; this power would be revealed in members' self-concepts and definitions of the situation. To most interactionists, if persons elect to rebel or to act in accordance with the status quo, it is not out of animalistic impulse or structurally-determined group obedience but out of an appraisal of past, present, and future scenes and interactions that indicates the best course of action at a given point. Social institutions are constituted by (and also constitute) human action rather than forming an inorganic structure around human life. When seen from this angle, symbolic interaction has the potential to show up and challenge structural inequities and obsolescences as revealed in persons' actions toward them and to identify the social interactions that maintain them.

Feminist Interactionism as a Platform for Research

In sum, both feminism, in directing our attention to socially-created and perpetuated power imbalances between men and women and promoting attention to the voices of women previously disvalued by science and society, and symbolic interactionism, in positing the socially-constructed nature of meanings and the responsive, self-reflexive root of human behaviors, can direct a search for understanding of a complex social phenomenon like addiction in pregnancy. Such a framework allows for collection of data about individuals'

perspectives and the experiences that led to these views. In this design I can gather and present information about the needs and opinions of a group of women who previously have had very little influence in the scientific world and reflect some of the variety and diversity in these women's lives. I can represent the interactive nature of both the phenomenon under study and the research process itself, and the necessarily partial quality (both in the sense of bias and the sense of incompleteness) of the analysis and the findings as they are presented. Most important, I can seek the actors' view of the problems inherent in crack use while pregnant and their impressions of what helps and hinders their pursuits.

The present study taps into a realm of information previously undescribed: shifting selves and definitions of the situation in the lives of women who use crack in pregnancy. To place this study in the context of previous interactionist research into drug use and pregnancy, relevant literature will be reviewed in the next chapter. Then, the approach and experience of this feminist interactionist project will be described in Chapter Four.

CHAPTER THREE

Drug Use, Awareness of Pregnancy, and Prenatal Care:
Review of Qualitative Literature

Although pregnant crack users' perceptions and experiences have not been studied from either quantitative or naturalistic perspectives, nurses and social scientists have studied the experiences of non-pregnant drug users and of pregnant non-drug-users. These two bodies of literature were examined as a foundation for a study of pregnant drug users' experiences. While the epidemiologic and biomedical research on crack cocaine use in pregnancy was reviewed in Chapter One, prior qualitative research provides more useful direction for the present project aimed at understanding subjective experience. Moreover, although attitudes and knowledge of "normal" pregnant women have been studied using psychometric analyses, no studies were found in which standardized instruments were used to measure pregnant drug users' knowledge, attitudes, or behaviors.¹ This deficit may be a product of investigators' doubts that drug users could be trusted as reliable research informants, or the relative scarcity of active drug users within the clinical populations usually accessed for research, or a hesitation to embark on the long process of validation of instruments for study of this relatively small, unique, and little-valued population.

In the present instance, shifting stories, variation,

¹A few studies have been conducted of attitudes toward parenting of drug users in treatment programs. These are reviewed in Kearney, Murphy, & Rosenbaum (in press).

and subjectivity are the focus of study rather than a threatening source of unreliability. In this review, I will bring together important qualitative studies of drug users², relevant studies of women's experiences of pregnancy and prenatal care-seeking, and the few studies that shed light on the experience of being pregnant on drugs. The chapter concludes with the initial questions of the present study.

Naturalistic Research on Drug Users: Addiction in Context

Drug users in context. Studies of the experiences of addicts and the social and psychological aspects of drug use reflect a coherent literature about the onset and varieties of addictive experience, the world of the drug user, and the relationship of addictive behaviors to the context of drug use. Two studies launched a growing understanding of the perspectives and interactions of drug users. The first was conducted by Lindesmith (1947), who interviewed male heroin addicts on the streets of Chicago and identified, contrary to prior belief, that there was a cognitive component to heroin addiction as well as a physiological dependence. Lindesmith's respondents told him that they did not begin purposeful regular drug use until they came to recognize certain physical symptoms as drug withdrawal and discovered that regular use of heroin relieved those symptoms. Not all users fell into a pattern of seeking drugs to relieve withdrawal. Some were occasional recreational heroin users and maintained

²"Drugs" refers here to illicit, illegal drugs, and not to prescribed or over-the-counter medications or to legal substances such as alcohol and tobacco.

other more socially-acceptable pursuits. In the next decade, Becker (1951) observed and interviewed marijuana users in the Chicago jazz music scene, and he described the social interactions and cognitive processes of becoming a marijuana user. While popular opinion in America in the 1940s and 1950s promoted marijuana as a powerful stimulant that would lead any user to social and physical destruction, Becker found that these users often did not feel any "high" on their first use. It was only through a process of learning the correct way to smoke it and to pay attention to and enjoy the subtle effects that marijuana users eventually began to seek repeated highs and claim membership in the group of individuals who understood and dared to risk the drug effect.

In the 1960s, the adaptive uses of drugs for some persons and groups were further explored by Feldman (1968), who studied youth gangs in New York City and observed that gang members used heroin to enhance their social status in the group, rather than to retreat from problems or block out reality. Drug use was risky and demonstrated courage and strength within that social world. Preble and Casey (1969), after extensive observations and interviews with 50 heroin users, reported that heroin use represented a quest for some sort of meaningful life and was treated like a job, with a sense of reward if after a day of pursuing illicit activities to obtain money and risking arrest to purchase the drug, the user was able to enjoy his "fix" at the end of the day. This

structured and orderly daily routine was again found by Hanson and colleagues (1985) in a study of 124 urban African-American heroin users. Many of these men rose early to start their licit or illicit pursuit of money, maintained flexibility in their drug habit in order to function in a variety of situations, and avoided drug treatment, which would have cemented their self-images as a hard-core addict, an identity they sought to avoid.

Waldorf (1973), after life-history interviews with 422 men and 147 women in heroin abuse treatment centers in New York state, also described variations of social identity among heroin users. He found that drug users had different degrees of identification with the "dope fiend" identity. The full-fledged dope fiend's life was occupied with drugs and drug-seeking to the exclusion of other pursuits. Not all drug users saw themselves as dope fiends, however; those who maintained relationships with non-addict social worlds by virtue of jobs, family roles, and friendships, did not usually identify as dope fiends. Some users who did identify as dope fiends spoke of a kind of last-resort utility of having a recognizable group to belong to, albeit an ostracized one, when efforts to hold onto conventional roles failed.

What leads some individuals to pursue drug-related forms of social reward and others to adhere to conventional goals? In 1972, Sutter reported on a long-term study of poor urban youths in a California city. He had hoped to identify certain

types of backgrounds or personality factors that could be used to predict those who would become heroin addicts and those who would continue in drug use over time. No simple profile emerged, however; a complex interaction of personal history, evolving life goals, and events in the user's surroundings appeared to affect which youths would participate in the drug subculture for a few years and then pursue more conventional lives, and which would remain in the drug life.

Not all drug users continue to use drugs throughout their lives, and not all drug users see themselves as physically dependent addicts. Zinberg (1984) interviewed users of heroin, marijuana, and psychedelics in order to compare controlled and compulsive use. He followed 153 male and female drug users and found that patterns of drug use tended to be stable within individuals over time. Controlled users were more likely to use drugs for recreation than to relieve depression, while the reverse was true for compulsive users. No differences were found between controlled and compulsive users in socioeconomic status, educational level, or fear of negative consequences of drug use. On the basis of this study, Zinberg developed a theoretical model of addiction in context that he labeled "drug, set, and setting." Although he was a practicing psychoanalyst, he challenged prior theories of addiction that blamed personality or pharmacology for compulsive drug use, noting:

Not only the drug and the personal needs of the user but

also the subtleties of history and social circumstances must be taken into account (p. 191).

Most studies conducted since Zinberg's work have continued to support and build on this interactive model.

Women who use drugs. Until the late 1970s, little had been written about female drug users. Waldorf (1973) found that the women he interviewed in treatment facilities were more likely than the men to come from disrupted, economically stressed, unstable homes in childhood. Women were less likely than men to engage in criminal acts before becoming drug users, and women pursued different forms of illicit earnings, such as prostitution, to obtain drugs. The women Waldorf interviewed were more remorseful and troubled about their illicit careers than were most men, appearing to carry a heavier moral burden. (He also noted that they were more difficult for him to interview.) Ironically, most had been introduced to heroin use by men, but the women, as one told him, "fall harder when they fall" (p. 174).

In what remains the only comprehensive study of the lives of women heroin users, Rosenbaum (1979, 1981) interviewed 100 women who were not in treatment, seeking to counteract the sketchy knowledge base that characterized female addicts as more deviant, unstable, out of control, and harder to treat than their male counterparts. Rosenbaum found that the circumstances of the social world of heroin users affected women very differently than men. Engagement in the drug lifestyle initially expanded but ultimately served to

shrink women's options both as an addict and as a woman in relation to conventional life.

With regard to childbearing, Rosenbaum (1979) found that heroin users believed it was unacceptable to continue heroin use while pregnant, but stopping drug use was difficult due to social pressures, physical habituation, and lack of hope for alternatives. Among the few respondents who did acknowledge use through pregnancy, continued use of heroin was rationalized by statements that 1) by the time pregnancy was discovered, any fetal damage had already been done, 2) many babies born to heroin users show no ill effects, and 3) withdrawal is more harmful than is continued drug use in late pregnancy (p. 94). The vast majority of women attempted to stop or cut back their drug use. They encountered many obstacles to improving their health during pregnancy, however, including rude and cruel treatment when seeking prenatal care. This led to avoidance of care and increased disdain and disapproval of hospital personnel at delivery, both because of the women's past drug use and the irresponsibility signified by lack of prenatal care. The heroin users "consistently expressed concern, care, and often, guilt about their role as mothers and the well-being of their children" (p. 93). Their experiences of scorn and rejection by hospital personnel during childbirth and the difficulties of caring for a sick baby produced self-doubt and feelings of failure at mothering for many respondents.

A decade later, the same research team conducted a

grounded theory study of 100 female crack cocaine users (Murphy & Rosenbaum, 1992). Again, the women's drug use started as an avenue into social reward-- either a connection with a desirable man, money and gifts, excitement of the social life in the crack scene, or simply a pleasant physical sensation. Eventually, however, if no other compelling options (such as a job or children's well-being) led the women away from drug use, the misogynistic, violent social world of crack cocaine threatened to strip them of their last assets: their moral standing and their self-respect. In the words of a participant quoted in the report's title, "It takes your womanhood."

Although pregnancy and mothering were not a central focus of the above study, over 70% of the participants were mothers and shared recollections of past pregnancies and present mothering in the course of the interviews (Kearney, Murphy, & Rosenbaum, in press). The cocaine users' experiences resembled those of heroin users in their guilt and concern about the effects of their drug use on their children, both before and after birth. The mothering experiences of heroin users and those of cocaine users differed in some ways. While heroin users could continue their mothering tasks in a fairly conventional manner once they had obtained relief from withdrawal symptoms by "fixing" each day, cocaine users would be fully occupied by their drug use during periods of crack smoking and would be less able to attend to their children. Crack cocaine use was generally

sporadic, which meant that a woman could go for days, weeks, or months without using the drug, during which intervals she would resume her other activities. In some cases, however, the guilt and pain of having taken both money and attention away from her children was so distressing that a mother would seek solace again in drugs. As one woman said,

I thought I deserved to be able to just sit down and relax and take everything off my mind. And freebasing, or smoking hubbas or crack, or whatever it is they call it-- it permitted me to do that...I mean, not that the problems are gone, but it gives you the chance, sometime, to just sit down and just wipe it from you, you know, just set it aside for a minute...but there are times it help you create a bigger problem, too (p.15).

The cocaine users were beset by other situational obstacles to parenting their children, including poverty, neighborhood drug sales and violence, unsafe housing, relationship difficulties and lack of support from the children's fathers. Some reported being pressured socially by friends or family into using cocaine to cope with their difficult lives, and others sought out the drug against others' advice in hope of gaining excitement, belonging or relief from unhappiness.

Pervasive themes of violence and abuse, male dominance, and the centrality of motherhood and children were also discovered by Woodhouse (1992) in a recent life history study of 26 women drug users, many of whom used crack, who were studied in a residential treatment facility. In this project, multiple data collection approaches were used, including individual interviews, focus groups, written statements by

the women, and drawing exercises in which the women diagrammed significant events in their lives. As did Rosenbaum (1981), Woodhouse found that most women were introduced to drugs by men.

To summarize the import of research on drug users, although concerns of women drug users have been addressed only recently in field-based research, common findings have emerged, and directions for future research are apparent. Reports of investigations with both heroin and cocaine users reveal emotional and interpersonal dimensions to drug use, as many women appear to become involved in drugs through significant others and then find themselves in conflicts between pressures to use drugs with some persons and to abstain for the sake of others, particularly their children. The lack of perceived life options, further diminished by drugs, and the compelling, absorbing drug life perpetuate women's involvement in substance abuse.

What happens when ties to drugs and ties to children coincide in pregnancy? How do women deal with these two competing involvements within their own bodies? No naturalistic studies to date have targeted specifically pregnant drug users. Little has been written about the physical experience of being pregnant and using, including issues surrounding the discovery of a pregnancy while on drugs, the effects of being pregnant on the drug "high" or the desire for it, the tensions between social expectations for abstinence and altruism during pregnancy and the pulls of

compulsive drug use, or the types of resources accepted, shunned, or not found by pregnant drug users who seek to make changes in their lives. These areas are explored in the present study.

Care-Seeking in Pregnancy

In this section, selected studies of the experience of aspects of pregnancy among non-drug-users will be reviewed. In several intensive studies with small samples, nurse investigators have examined variations of women's experiences of the discovery of pregnancy, their considerations when seeking prenatal care, and their concerns about care-related decision-making when interacting with care providers. This explicitly interactionist work provides a foundation both in content and method for a study of similar concerns among pregnant drug users.

Obstacles to care: Quantitative studies. Reasons for lack of prenatal care among pregnant drug users have not been studied. A proposed explanation is mothers' fear of the consequences of discovery of drug use, which might include stigmatization, maltreatment, reporting to Child Protective Services or criminal justice agencies, and possible loss of custody of older children or the newborn (Chavkin & Kandall, 1990; York et al., 1991). Elaborate efforts have been launched to bring drug users into health care agencies (e.g., Ali et al., 1992; Argeriou & Daley, 1992), although little is known about cocaine users' health needs and obstacles to care. In the few reports of specialized prenatal

care programs for pregnant drug users it is not known whether any positive outcomes attributed to these programs (e.g., MacGregor, Keith, Bachicha, & Chasnoff, 1989; Mann et al., 1992) should be attributed to the effect of the programs or to differences between cocaine users who are recruited for or choose to use these services and those who do not.

In research with non-drug-user groups, reasons for lack of prenatal care have included financial barriers (Gold, Kenney, & Singh, 1987), blocks to access due to distance, lack of child care, language barriers, or unfamiliarity with care delivery systems (Miller et al., 1989), perceived unimportance of prenatal care when a pregnancy seems normal (Fisher et al., 1991), denial, depression, ambivalence or unhappiness about the pregnancy (Fisher et al.; Petitti et al., 1991), and lack of awareness of the pregnancy in the early months (Burks, 1992; Sable et al., 1990).

In a review by McClanahan (1992), three types of factors were cited as related to inadequate prenatal care. Sociodemographic factors included minority race and non-English language, poverty, young age, single marital status, and rural residence. System-related factors included lack of health insurance coverage or delayed coverage, transportation obstacles, overcrowding and inadequacy in public health agencies, and negative staff attitudes. Attitudinal factors were described as lack of planning of the pregnancy, inability to accept the pregnancy, lack of recognition of

signs of pregnancy, lack of knowledge, "indifferent attitude toward prenatal care" (p.282), and "misguided attitudes about pregnancy" among certain women (p.282).

This quantitative literature raises a number of questions: Whose criteria pertain when determining the adequacy of prenatal care, the acceptability of attitudes toward pregnancy or prenatal care, or the most important knowledge about pregnancy for pregnant women? In what situations do women find themselves continuing an unplanned and/or unwanted pregnancy? How should a woman who is unsure about continuing a pregnancy care for herself while deliberating this decision? Why do some women brave systemic obstacles like negative staff attitudes, long waits, travel difficulties, and insurance bureaucracies and others do not? While these issues are highly relevant to all pregnant women, they become especially important when considering drug users, whose attitudes and actions are already believed to be outside social norms.

Awareness of pregnancy: Women's experiences. Lack of awareness of a pregnancy has been cited by several researchers as a major cause of late prenatal care (e.g., Petitti et al., 1990; Sable et al., 1990). The anthropologist Jordan (1977) noted that medical criteria for diagnosis of pregnancy (such as auscultated fetal heart sounds, physical changes in the uterus and cervix, and most importantly biochemical assays), none of which are detectable without special equipment by the woman herself, were required by

every agency she contacted before abortion or pregnancy-related care would be performed. The woman was considered not pregnant until biochemical confirmation, which often did not occur until weeks or months into the pregnancy. Interviewing women who came to a feminist clinic for abortion or menstrual extraction without such proof of pregnancy, Jordan found that among 33 women who believed they were pregnant but had not obtained a positive pregnancy test, all knew the date of sexual intercourse when they believed they conceived, 28 were convinced they were pregnant, and five were unsure. Twenty-seven of the 28 were found to be pregnant, and the other woman had been receiving pregnancy hormone injections for weight loss and thus had a biochemical cause to feel pregnant. Breast changes, missed menses, nausea, and tiredness were the most frequent indicators. Many women had felt they were pregnant before they missed a period. Thus, women's self-knowledge previously considered unreliable was found highly predictive of pregnancy status, raising questions about influences of context when women are unaware of pregnancy.

In a grounded theory study, a nurse-led research team explored in greater depth women's experiences of self-diagnosis of pregnancy. In interviews with 30 ethnically and socioeconomically diverse pregnant and postpartum women, Patterson, Freese, and Goldenberg (1986) discovered a process of "reducing uncertainty." The process began with the woman's

awareness of a "salient indicator" of pregnancy, often a physical change such as a missed menstrual period. Past experience with irregular cycles or other physical factors affected how soon a woman would connect such a factor with pregnancy. The women then formed a "working interpretation" of the signs as a pregnancy and searched for "confirming indicators" to support the hypothesis. The "weight of evidence" used by women in the self-diagnosis process varied according to context and experience. A vacillation between belief and disbelief was common in the phase of weighing the evidence. When the woman arrived at a self-diagnosis, she often sought professional confirmation, holding her conclusions in doubt until validated by a clinical test. Several women did not obtain tests for confirmation; these women were uncertain of pregnancy until four or five months, and by that time their salient indicators carried enough weight that they saw no need for professional validation.

The process outlined by Patterson, which in many ways expands and supports Jordan's (1977) findings, suggests several areas for further exploration among drug users. First, the physical indicators of pregnancy used in non-drug-users' early self-diagnosis may be less certain among drug users because of drug- or malnutrition-induced amenorrhea. Second, morning sickness may be thought to be a drug reaction or withdrawal symptom, a confusion previously reported among heroin users (Rosenbaum, 1979). Third, the awareness of salient indicators also may be impaired by the effect of

drugs on physical sensations and responsiveness. Fourth, to a drug user, the prospect of seeking professional confirmation of pregnancy may be beset by the concerns noted by Chavkin and Kandall (1990) regarding fear of incrimination or judgmental treatment. Perhaps the self-diagnostic process is lengthened or different among drug users who may be ambivalent about pregnancy, have alternative explanations for amenorrhea, are less attentive to physical symptoms, and have concerns about obtaining professional confirmation, all of which could contribute to delay in prenatal care.

Care-seeking experiences. Patterson and colleagues (1990) described the process of initiating prenatal care in the same sample. This process was termed "seeking safe passage," a concept derived from the work of Reva Rubin (1984). In Patterson's sample, the process began after confirmation of pregnancy with "letting it sink in," a phase that ranged from a few days to several months. During this time, some women considered terminating their pregnancies. Once a decision, either active or passive, was made to continue the pregnancy, the woman began to seek ways of maintaining her health and the health of her baby. Enrolling in prenatal care was not always part of this process. Some women used self-care and contingency planning, waiting for signs of a problem before seeking professional care. Others went through a search for a source of prenatal care, an undertaking that varied in length and complexity depending on access, previous experience and existing caregiver

relationships, finances, and degree of perceived risk. Some women in Patterson's sample made a deliberate decision to wait until later in the pregnancy to start care. Many of these were multiparas who felt confident in self-monitoring and wanted to postpone the unpleasantness of prenatal care, including long waits and uncomfortable exams. Women who lacked insurance and hoped for a way to avoid going to a public clinic postponed starting prenatal visits while they explored ways of obtaining private care. Pressure from others or symptoms of possible problems sometimes shortened the waiting period. Tension developed when a woman felt the need for information or reassurance and was unable to obtain prompt or satisfactory care.

Prenatal care interactions. A third nursing grounded theory study of pregnancy was Corbin's (1987) study of 20 chronically ill women's experience of the pregnancy and childbirth process. In this longitudinal study of women with conditions including diabetes and cardiac disease, Corbin identified a process of "protective governing" (p.317). In this process, women actively participated in their self-care and professional care. Acting on the basis of the relative stability of their condition and using their previously-established ways of managing their disease, they negotiated and adjusted prenatal health care and their self-care practices to protect the fetus from harm and deal with changes in their illness. The women made judgments about how

much to rely on their own versus their caregivers' desired management, depending on whether their pregnancy was progressing "on course" or "off course" in terms of expected well-being, and the perceived degree of risk represented by the deviation.

Cocaine users, pregnancy, and prenatal care. Self-knowledge in seeking and participating in prenatal care may have as much relevance for pregnant cocaine users as for the groups previously studied. Perhaps a desire to protect the unborn child competes with factors such as fear, ambivalence, and lack of awareness as drug users consider prenatal care. Educational, cultural, and socioeconomic influences have been associated with patients' degree of active participation in general health care (Cockerham et al., 1986). Drug users' lack of care participation may reflect lack of educational and sociocultural resources rather than a direct influence of drug-use-related behavior. Alternatively, perhaps drug users avoid assertive participation in care to avoid drawing attention to their drug use and thus do not receive care that meets their needs. Patterson's explanations for delayed prenatal care may also apply to drug users, in combination with the factors that may contribute to a delayed self-diagnosis of pregnancy. Perhaps the desire to avoid unpleasant waiting to be seen and uncomfortable exams, coupled with the fear of incrimination and stigmatization, is enough to keep some drug users away from prenatal care even

after self-diagnosis or confirmation occurs.

Directions for Study of Pregnant Drug Users' Experiences

For some women, pregnancy is detected well before medical confirmation could be obtained (Jordan, 1977), while for others the process of self-diagnosis of pregnancy may be delayed and prolonged (Patterson, 1986). For drug users, as Rosenbaum noted (1979), self-diagnosis may be further confused by drug-related physical changes and ambivalence about the pregnancy. This delay and ambivalence may combine to postpone the onset of prenatal care, a step that requires overcoming obstacles such as access, finances, stigma, and dislike of care procedures. Some women's worry at discovering pregnancy may not only delay prenatal care but propel them into continued use.

The qualitative research completed to date is evidence that in-depth field studies can be conducted with drug users in order to describe the experience of drug use in context, and that psychosocial processes of self-diagnosis, care-seeking, and care interactions in normal and high-risk pregnancy can be discovered using the grounded theory approach. Within a feminist interactionist perspective, the current study extends these traditions to focus on women's perceptions of pregnancy on cocaine, with the goal of identifying study participants' own perceptions of their problems and needs. In contrast to most research to date on cocaine use in pregnancy, I use my interpretations of

mothers' experiences (rather than perinatal medical records or neonatal health measures) as a data source, in order to seek a theoretical understanding from within the lives of women who use cocaine of some of the preconditions to the birth of a cocaine-exposed infant. By exploring mothers' descriptions of self-discovery of pregnancy, drug use patterns over the course of pregnancy, experiences with health care that affect attendance at prenatal care or drug treatment, eating habits, economic circumstances, relationships, family, social and emotional influences, and environmental factors such as housing and food preparation resources that the woman describes as important to her pregnancy experience, the interactions of experiences and context in the social worlds of pregnant cocaine users can be described. The potential effects of new interventions can be explored theoretically using a holistic model grounded in qualitative data. Studying "crack mothers," rather than "crack babies," will permit understanding of otherwise invisible aspects of this complex phenomenon.

Research Questions

Recognizing that I would seek to identify and answer the questions most salient to the women under study, I began this search for questions with these inquiries of my own:

1. How is the physical and psychosocial process of pregnancy experienced by crack users?
2. How do interpersonal and other contextual factors affect cocaine use in pregnancy, in the views of the users

themselves?

3. What are cocaine users' perspectives on prenatal care-seeking?

In the following chapter, I describe the methods used to address these questions, starting with the decision to collaborate with other researchers, and describing how women were contacted and recruited into the study, the nature of the interview experience for participants and interviewer, the evolution of the research focus, and the search for a grounded theory that encompasses the scope and variety of the women's pregnancy experiences.

CHAPTER FOUR

Interviewing Pregnant Crack Users:

Study Design and Process

This study of pregnant crack cocaine users' experiences was a grounded theory analysis of a series of field-based semi-structured interviews. Data collection and analysis were informed by the principles of feminism and symbolic interactionism. In this chapter, I describe the basic design of the project, the steps by which the interview data were collected, the concurrent analytic path, and the interpersonal and intrapersonal processes that constituted the data and the analysis.

Design: Grounded Theory in a Feminist Framework

Grounded theory. This project was an application of grounded theory methodology, launched and conducted in a feminist framework. The grounded theory approach to collection and analysis of naturalistic data was originated by Glaser and Strauss (1967) and has since been modified and differently interpreted by its originators and newer researchers (e.g., Glaser, 1992; Strauss & Corbin, 1990). Nurses have participated in refining and applying grounded theory since its inception (e.g., Hutchinson, in Munhall & Oiler, 1986; Quint, 1967; Strauss & Corbin, 1990; Wilson, 1977). In all these works, textual data such as field notes and interviews are used to generate a richly detailed theoretical description of a basic social or psychological process that explains a puzzling or problematic aspect of

social behavior (Chenitz & Swanson, 1986). The present study follows most closely the approach outlined in the original description (Glaser & Strauss, 1967) as refined by Glaser (1978, 1992).

Briefly put, grounded theory analysis usually proceeds from identifying concepts and categories of concepts in the data, to identifying those representing the major concern of the actors and the means by which they deal with this concern, and then to identifying an organizing structure by which both the concern and the related responsive process are situated within their relevant context (Glaser, 1992, p.4). The resulting theory is contextualized and multifaceted, in that it incorporates many relevant influences on the phenomenon and describes the relationships among them as well as how the relationships change over time (Glaser, 1978). The steps of grounded theory analysis enable the investigator to identify a core category, which is a concept that represents the central phenomenon occurring in the data, often a social action or interaction. Analysis may proceed further, to the identification of a basic social process, a human response that explains most of the variation seen within the phenomenon of interest (Glaser, 1978). When applied to the study of a health problem, grounded theory may be seen to hold an advantage over other qualitative approaches because potential interventions can be identified. Whereas phenomenology and content analysis, for example, produce

themes or holistic descriptions of a phenomenon, a grounded theory with its exploration of dynamic relationships among components of a phenomenon can be used to identify conditions or causes of a problem that are amenable to intervention. Because a range of variation of human interaction within a phenomenon is explained, an analyst can describe hypothetical situations that would enable or produce desired actions or outcomes.

The hallmark of grounded theory is the constant comparison technique. Early in the data collection process, the researcher starts to identify concepts within the data. She compares and challenges each theoretical idea with old and new data and theory, continually seeking to relate new incidents to old in theoretical categories and relationships, with the goal of devising an explanation for all the incidents that remains easily validated with original data. These "double-back steps" (Glaser, 1978, p.16) insure that the final product, no matter how abstract, will be linked to the raw data in its original form. A grounded theory thus should be easily traceable to its data sources.

Feminist influences on design. Principles of feminist research directed the selection of the phenomenon of interest (one salient to women), the sample (a diverse group of women who are living with the phenomenon), the conduct of the data collection (an interactive, equitable approach that incorporates reflexivity and sensitivity to the relationship between the researcher and the researched, and seeks input of

respondents in emergent theory) and the plans for dissemination of findings (in forms useful to the women themselves as well as to academic audiences). Feminist thinking permeated each step of the project, as the research team focused on doing justice to the study participants, respecting the data as privileged communication, seeking to represent the full range of variation of women's experiences within the study sample, and constantly attending to inequities of power and control in the recruiting and interviewing processes.

Context of the Study: The Pregnancy and Drugs Project

I conducted this study using a subset of the sample for a larger project entitled "An Ethnographic Study of Pregnancy and Drugs," known to its staff as the Pregnancy and Drugs (PAD) Project, funded by a National Institute of Drug Abuse grant to Marsha Rosenbaum, Ph.D., and Sheigla Murphy, Ph.D. In addition to the principal investigators, staff of the PAD study included a project director and two interviewers, of which I was one. The overseeing agency was a private non-profit social research institute in San Francisco that specializes in field research with hard-to-reach populations such as drug users.

The Pregnancy and Drugs project's specific aims were to describe the experience of pregnancy in a non-clinical sample (that is, women who are not receiving methadone or residential drug treatment) of heroin, cocaine, and

methamphetamine users. The investigators also sought to explore: changes in patterns of drug use across pregnancy and the postpartum period, concerns about AIDS and its effect on the unborn child and consequent changes in drug use or sexual practices, factors affecting access to and use of drug treatment, effect of significant others on decision-making in pregnancy, the role of violence in the lives of pregnant drug users, involvement in criminal activities and its effect on obtaining services, and other broad questions.

My decision to work on and use data from the Pregnancy and Drugs project, rather than recruiting and interviewing a separate sample, was based on several factors. First, staff of the PAD project had a long and rich experience in urban field research and could share methodological expertise in managing field work in unfamiliar urban settings. This process includes maintaining personal safety, conducting respectful and productive data collection with persons from ethnicities and backgrounds often very different from ours as investigators (including women dealing with violence, homelessness, criminality, and other personally threatening situations), and recruiting respondents outside of service agencies using snowball sampling and key informants.

Second, enlisting in a large study provided access to a larger and more naturalistic sample than would be available to me as a single nurse investigator recruiting participants within health care agencies. Data were collected in non-clinical field settings, from women still living the

phenomenon of interest rather than looking back on it. Many had never been in drug treatment, and a number had not been in contact with the health care system during the course of their current or recent pregnancies. Thus, this was a group of women rarely seen or heard from in the conventional world of health care research. Furthermore, because many interviews took place in the communities where the participants were living, I was able to see and experience a bit of the context of their daily lives. Walking through a neighborhood to locate a participant, dealing with parking or public transportation, facing concerns about personal safety, and interacting with people in the field setting all contributed understanding, albeit from my researcher/clinician perspective, of the conditions in which the woman lived that affected her actions in pregnancy.

Third, the principal investigators were among the most knowledgeable in the country about women drug users' experiences of pregnancy and mothering. Rosenbaum's and Murphy's command of the substantive area and important previous field research with female addicts were invaluable in both the data collection and analysis processes. Their sociological perspective enriched my nursing viewpoint and pushed me to attend to the influence of larger social forces in the lives of women who use drugs.

Sample

The Pregnancy and Drugs Project sample. The total number of participants in the PAD project was 120 pregnant

and postpartum women, 40 in the first five months of pregnancy (Stage 1), 40 in the last four months of pregnancy (Stage 2), and 40 in the first six months postpartum (Stage 3). Each group was further stratified into 20 injection drug users and 20 non-injectors, in order to study HIV risk behaviors of injection drug users in pregnancy. The design was cross-sectional, in that most respondents were only interviewed once. One woman was interviewed twice by mistake, when two different interviewers screened and interviewed her in early and late stages of pregnancy.

This sample size was very large for a qualitative design involving depth interviews. In most grounded theory studies, repeated interviews and close follow-up of 20 or 30 participants is adequate to achieve a dense understanding of a phenomenon (e.g., Corbin, 1987; Patterson et al., 1986). In a hard-to-reach, residentially unstable, highly stigmatized population such as pregnant drug users, however, it was unlikely that we would be able to ask women for personal identifiers or obtain reliable tracking information. Therefore, in order to understand the pregnancy process across time, a cross-sectional approach was selected, recruiting women at various points along the trajectory of pregnancy and postpartum. The principal investigators planned a number of quantitative analyses in addition to the qualitative interviews and required a sample with adequate cell sizes for comparative analyses. The result of recruiting

a large group was a vast and rich resource of interview data, reflecting many subtle and dramatic variations in women's backgrounds, experiences, current situations, and outlooks.

The sample for this analysis. Sixty cocaine users constituted the sample for the findings described in the following chapters. In a departure from "pure" grounded theory, the sample was expanded beyond the point of saturation or redundancy of data, which occurred after analyzing 45 to 50 interviews. Several factors were involved in extending the sample beyond what would have been required to achieve an adequate grounded theory: 1) Because the desired (and funded) sample was approximately twice the size of that of a purely qualitative study, two interviewers were collecting data simultaneously, resulting in rapid accumulation of more data than could be analyzed between interviews. There was significant lag time between data collection and receipt of transcripts for analysis, so redundant data were collected in the intervals between analytic sessions. 2) In contrast to most grounded theory studies, the larger project was cross-sectional rather than longitudinal, so interviews of many women at different time points were required to understand a process that could have been studied in fewer women followed over a period of time. 3) I chose to take advantage of available data after the point of analytic saturation in order to explore as fully as possible the range of variation in contexts and experiences and to compensate for lack of "control" over all interview

content. That is, because other study questions in addition to my own directed the interview content, each interview contained comparatively less data on "my" questions than would have been the case if I were conducting the study solely for my own ends. A larger number of transcripts were reviewed to maximize my understanding of the phenomenon in a variety of contexts.

Of the total of 60, 22 were interviews I conducted, and these were the initial focus of my close analyses. All 60 interviews were analyzed, however, and the findings reported here pertain to and are reflective of the group of 60 women.

Issues of sample diversity. The possibility of setting quotas for socioeconomic and ethnic groups within the sample was discussed within the research team, which had the goal of recruiting a sample that had the same ethnic mix as women delivering drug-affected babies in the study region, but, due to the lack of relevant research as well as the pervasive bias surrounding the phenomenon, reliable statistics on drug use within the local perinatal population could not be found¹. In spite of creative and persistent efforts to diversify the

¹The only means of really knowing the ethnic or racial makeup of pregnant drug users would be to have an accurate and universal means of screening every woman for drug use, a violation of civil liberties and not particularly useful as a health measure. Accuracy of existing statistics is threatened by judgmental and biased clinical practices, in which screening is performed and reporting is followed up on the basis of color, socioeconomic status, or behavior (e.g., Chasnoff, Landress, & Barrett, 1990; Chavkin & Kandall, 1990). For all these reasons, we have very little idea of what the ethnic or socioeconomic make-up is of pregnant drug users. Even presuming that drug use exists across all classes, it appears that cultural differences affect drug choice, disclosure, and discovery.

sample (described later in more detail), the crack cocaine users we² were able to recruit were mainly African-American, which seemed to reflect the drug use patterns of the population in the geographical area of the study. As the number of respondents increased, we decided at least to reserve at least several openings for women of races different than the majority within each stratification and in this manner were able to include the perspectives of at least a handful of women from other racial and ethnic groups who used this drug. In the end, the 60 crack users were 83% African-American, 10% white, 5% Latina, and 2% Pacific Islander. The larger sample of 120 drug users was more diverse (60% African-American, 29% white, 6% Latina, and 5% other), matching almost exactly the national statistics for drug-affected newborns in 1990 (Dicker & Leighton, 1992).

In recruiting participants and talking with professionals in the drug treatment field, we noted an ethnic/cultural clustering related to different drugs; that is, crack users in the San Francisco area were likely to be African-American, whereas many heroin or methamphetamine users were white or Latina. Thus, 50 African-Americans in a sample of 60 crack users may in fact reflect the ethnic mix within users of this drug in our sampling area. The demographics of the sample are described in more detail in the next chapter.

²Procedural and methodological comments refer to the staff and sample of the entire study where "we" is used, and to my own interviewing and analytic experiences where "I" is used.

Procedure

Recruitment. In the PAD project we recruited by self-referral using brightly-colored flyers posted in agencies and neighborhoods around the San Francisco Bay area, and by chain referral using word of mouth among participants to recruit their acquaintances into the project. Women who completed an interview were paid \$40. A person named by a participant as having referred her was paid \$20 for the referral. Screening of potential participants was done over the telephone, after the interviewer informed the caller of the extent of confidentiality applied to the data and that the questions to follow would relate to pregnancy and drug use. (The callers were invited to complete the screening at a more suitable time if they were uncomfortable answering drug-related questions at the initial call.) If the caller agreed, a short screening questionnaire was administered that included questions about the stage in pregnancy or postpartum, the type and amount of drug use during pregnancy, and current drug treatment.

The criteria for inclusion in the larger study (and the dissertation sample) were as follows:

1. Currently pregnant, confirmed by a positive urine pregnancy test at the time of interview, or within six months postpartum, as verified by birth certificates, custody documents, or phone validation from a social service caseworker.

2. Stated drug use an average of at least once per week during the current or most recent pregnancy.

3. Not in residential drug treatment or receiving methadone maintenance. If a respondent recently has been in residential treatment, she must have left treatment at least two weeks before the screening and have used drugs twice or more since leaving treatment. (The rationale for this criterion was that women who have undergone residential treatment and not resumed drug use may have an altered perspective from active drug users and are removed from the arena of illicit drug use that this study aimed to describe.)

If the caller met these criteria, the interviewer described the nature of the interview, the estimated length of time it would take (from two to three hours), and the measures that would be taken to protect her privacy. The interviewer then made arrangements to conduct the interview either at a field location such as the respondent's home (our preferred location) or at a field office in San Francisco.

Recruitment as data. The recruitment process was data collection in itself, as we learned much about our target group by what did and did not work for recruitment. It was acknowledged from the outset that pregnant drug users would probably be reluctant to participate in a study that required them to disclose their illegal and, to some, immoral practices. Nevertheless, once word got out at various self-help and drug treatment agencies around the city, calls began to come in, and interviews were conducted at the rate of

about five per week during the initial "rush." Crack cocaine users made up the majority of the early participants, and it was painfully clear that many were doing it for the money. Some women described plans to use the interview money to pay for shelter or baby clothes, and others were headed to the grocery store. On the other hand, the money was an obstacle rather than a benefit of the study to staff of some agencies contacted in the recruitment process; some objected that giving drug users money was enabling them to continue their bad habit. In keeping with our feminist beliefs, we felt strongly that the women were entitled to be compensated for their time and to use their money as they saw fit. I also came to believe during the recruitment process that among the women in the growing sample, some crack cocaine users seemed to have little sense of personal worth to lose by participating. It was as if they had already "hit bottom." Being in our study was, if nothing else, a safe and legal way to earn a little cash. One woman remarked during her interview,

I was in need of a few things today and I didn't want to resort to other things, so I came here. (024)

Pregnant crack users were so pervasively criticized in the media (and, as we later found, in their own drug-using communities) that one more incident of discovery or disclosure may not have been as threatening as we might have assumed for women on the streets. Within this group, a number had already considered or taken steps to gain treatment and

get off drugs, and participation in our study represented moving beyond the past life and perhaps helping someone else move beyond it as well. As the above-quoted participant noted,

I want to try-- That's why I came here, in hopes that you guys could maybe refer me to a drug program for pregnant women. (024)

Prostitution (her current means of livelihood, as suggested in the first quote) was less easy to talk about:

How am I able to support [myself]? That's kind of personal, so I don't want to mention that. (024)³

For these reasons, both women on the streets living from hand to mouth and women who were in the process of making changes and leaving drugs behind were unexpectedly willing to participate.

The women hardest to reach were from the middle classes. Many expeditions and phone calls were made to private OB/GYN practices and family planning agencies in middle-class areas, and "guerrilla" flyer-posting was done in shopping malls and the women's restrooms of upscale bars where young professional drug users might socialize. The few middle-class women who were recruited into the study were queried about how we could contact others from their networks.

After talking with agency workers in middle-class areas, interviewing a number of women, and reflecting on my clinical contacts with middle-class women, we concluded that middle-

³This comment also reflects gate-keeping regarding personal disclosures, a practice we encouraged to enable the participant to retain as much as possible control over the emotional aspects of the interview process. This is discussed later in this chapter.

class women had the most to lose in terms of their reputations, self-images, and family planning intentions by using drugs in pregnancy, and even more so by disclosing drug use. Pregnancy was an infrequent, carefully planned, and highly valued event, and there was little personal knowledge of actual drug-exposed newborns except in media exposes, so the threat of drugs was perceived as very great. We found through interview probes that drug-using middle-class women may have been much more likely than poor women to seek abortions when a pregnancy was discovered. Efforts to recruit at abortion clinics were only marginally successful. Thus, beyond these few insights, this study can contribute little to knowledge about middle-class pregnant drug users.

Verification of eligibility and consent process. For each interview, the interviewer met the participant at a pre-arranged interview location. (About 10% of the scheduled interviewees did not appear, not surprising considering the nature of the study.) The content and process of the interview were described, questions were answered, and informed consent was obtained. The women were told that they could sign the consent form with a name other than their legal name if they wished⁴.

For pregnant respondents, a rapid urine test for pregnancy (Abbott Test-Pak Plus) was administered to verify

⁴The Committee for Human Research at the University of California determined that the dissertation analysis would not require a separate consent form because no additional procedures or risks to respondents were entailed by dissertation project. Documents of CHR approval are presented in Appendix I.

the pregnancy. This step was added by the senior investigators based on experiences with drug users who manipulated interviewers in order to collect the money for participating. For postpartum or post-abortion respondents, documents related to having given birth or had an abortion, presence of the infant, or telephone contact with a social service agency served to validate postpartum status.

Instruments. The PAD project employed two data collection instruments, a quantitative questionnaire and a guided interview that was audiotaped and transcribed. Interviews averaged from two to four hours in length, including both questionnaire and taped portions. An interview guide for the qualitative portion was developed by the research team to outline possible topic areas (See Appendix II), and in fact the topic areas were addressed consistently in virtually all interviews, although the order and emphasis varied from one to the next.

The interview process. We conducted the taped interview first and then filled out the quantitative instrument. In keeping with the feminist goals of providing a forum for unheard voices and seeking to understand women's experiences from the perspectives of the women themselves, we outlined the overall goals of the project and then invited each participant to tell her story in the format and sequence she desired, usually starting with a brief summary of childhood experiences. Attending to feminist goals of mutuality and relationality (Hall & Stevens, 1990), we tried to anticipate

the discomforts of pregnant women by offering time to stretch or use the bathroom and providing snacks to the study participants-- to the dismay of the transcriptionists, who found the crackling wrappers disruptive to recording quality.

Reissman (1991) has noted that cultural differences may produce different story-telling modes, some of which may not be linear or chronological. We found that most women wanted to tell their story in chronological order. Sometimes women were reluctant to move on from a time period or topic area until they had represented it adequately, even if it seemed to have little relevance to the main focus of the conversation. Over time, I found myself more patient and appreciative of seemingly apocryphal stories; usually they revealed something useful about how the woman viewed her present situation.

In the interviews, I explored with special interest the process of self-diagnosis of pregnancy and women's consideration of continuing or aborting the pregnancy, as well as their experiences with health care and particularly prenatal care. The other interviewer knew of my interests and pursued these topics as well. My questions about the various topic areas evolved with my increasing grasp of the phenomenon. As theoretical linkages emerged in preliminary analyses, I sought to find new examples and contrasting cases to test the links and to discover other influences on it. Generally, however, as we added questions we still sought to

cover the original topics. Our questioning also became more adept and pointed as time went on.

The interviews were audiotaped using a small cassette recorder with attached battery-powered microphone. We told participants that they could turn the tape off at any point, but this option was rarely taken. We as interviewers sometimes turned it off, such as when it seemed that the woman needed to interrupt the interview to deal with a household situation, or if another person entered the room. One middle-class participant refused to be audiotaped but agreed to note-taking. To facilitate recall, the interviewer was re-interviewed on tape later the same day by another project staff member in order to recapture the essence of the woman's responses.

After the taped portion of the interview, which generally lasted between one and two hours, we read aloud the questions from the quantitative instrument and recorded the participant's answers on the tool. Although the questionnaire was lengthy, many questions quite personal, and women could refuse to answer any items, few exercised this option.

Some interpersonal aspects of the interviews. Rapport, valued by feminists as enhancing equality and thereby validity of the research (e.g., Hall & Stevens, 1990), was of the highest importance in these sensitive interviews. Because many topics were emotionally charged and stressful for women to recall, we put much effort into creating and maintaining a level of comfort and communication with each respondent that

would enable her to steer away from topics that made her uncomfortable and frame her experience in her own terms.

Mindful of feminist concerns about abuses of women during research conduct, I gave a lot of thought to issues of power and territory during the interviews. On one hand, I often sensed that participants began the interview in a subservient role, eager to please and wanted to say the "right" things. When this was apparent I would seek to open the field of possible responses, indicate that participants had described many ways of perceiving and dealing with the phenomenon and that I was deeply interested in the woman's personal stories and views. On the other hand, the power imbalance went both ways. I often felt at a different kind of disadvantage in a very real sense: I was a fairly naive outsider who sought something the respondent controlled-- information about her life, experiences, and insights. A complex dance of role-taking, self-presentation, and minute adjustments of thinking and behavior occurred on both sides as the participants and I navigated the interview process. While attempting to guide the content of the interaction along topics of interest to the study, I was also thinking about how the woman seemed to perceive me and the situation, what she might be waiting to see or hear in order to feel comfortable or safe, how I might alter my language, actions, or the interview to fit more easily with her demeanor, and so forth.

Occasionally, I perceived that a woman was tired, hungry, disinterested, distracted, or wanted a cigarette and was trying to make the process as brief as possible. Although I would try to complete the data collection instrument and cover most interview topics, I felt it would be unkind and unethical to ask the woman to stay longer than her comfort or patience allowed. In these two or three cases, the data were less than optimally complete. For example, one recently-delivered woman was planning to pick up her infant son from the hospital that day. Although she declined an offer to reschedule, she was unable to concentrate on many questions and a very short interview resulted. Pregnant women were often physically uncomfortable after an hour or so; as a nurse, my clinical antennae were useful in picking this up, and I would work in a break or try to finish quickly.

In many of the interviews, the newborn or older children were present during the interview and were incorporated into its interactions. Sometimes the mother and I would take turns holding a baby or distracting an older child. At times, the interview was interrupted so the mother could address her children's needs. The quality of the audiotapes was less than optimal when children were present, but we accepted this compromise readily in our desire to work within the real-life situations of the respondents. There were many exchanges of advice regarding health and child-rearing. These kinds of interactions increased our rapport and at the same time revealed variations in mothering practices and experiences.

In some cases, mothers seemed impatient and disciplined their children with harsh words, but in the majority, mother-child interactions appeared to us patient, affectionate, and age-appropriate. When a participant's parenting style differed from my own, the contrast served as data, and as one more reminder that the goals and definitions of pregnancy and mothering varied from person to person and across cultural and socioeconomic lines.

Other issues of power imbalance included race and class differences and professional status differences. Most of the time, I handled these by acknowledging them. Often, the real- - as opposed to assumed-- areas of similarity and difference between us became more clear during the interview process and enabled more effective communication. Questions were asked in both directions; participants often asked me considerately whether I understood them or was familiar with a practice, verbal expression, or geographic area that they assumed might be beyond my experience as a white professional woman. This woman was describing her introduction to prostitution and consciously avoided street slang:

105: And then really good friends of mine lived right off the-- where prostitutes walk.

Int. 'Ho' stro',⁵ or whatever.

105: Yeah, exactly! I was going to say 'Ho' stro'.' (105)

Another instance of translation:

That's when I realized, 'I'm gone.' And this is a word

⁵Whore stroll, or area commonly used for street solicitation by streetwalkers.

that we use on the streets when a person is really strung out⁶ on dope. They say. 'They're gone.' And that's when I really realized that I was off the deep end...(065)

Sometimes I pointed out my relative disadvantages in a humorous way, something like, "Could you explain that to me? I only know about this research business." Differences were understood in a subtle and mutually respectful way once rapport had been established and I was seen to be sincerely interested and not about to give advice.

Points of commonality between myself and the study participants included my familiarity with pregnancy and mothering by virtue of having two children myself, which proved to be a great source of mutuality with participants, and my increasing comfort with the drug scene, its language, social patterns, and reported sensations. When a participant determined that I knew something about the world she frequented, there was visible relaxation and a change in the tone of the conversation from tentative and sometimes testing statements to inclusive and more generous ones. This woman was impressed with my awareness of the localities of solicitation in her neighborhood:

Int.: Bayview, uh huh. Where's the main action down in Bayview? Is it Third St.?

068: Yeah! How do you know?

Int.: 'Cause I do this for a living. [Both laugh.] But I don't know everything.

068: Third. And I still be on Third right to this day.

⁶Desperate for drugs, and/or weakened and ill from the effects of drugs.

There were many instances of sharing of information about personal experiences and opinions, down to things as personal as sexual practices:

Int.: Have you ever used condoms?

056: Yeah, but I don't like it. It's too rubbery.

Int.: Yeah, it feels different.

056: Do you use condoms?

Int.: Sometimes. Yeah, I mean, the smell is...

056: Yeah, it is. Eugh! It's not, I don't know...

Int.: It changes the whole thing.

056: It do. You're right, yeah.

Women used common experiences to get their meanings across, as in this woman's discussion of what it is like to use drugs while pregnant, and why, now that she's begun to consider a treatment program, she thinks crack use is bad for the baby:

096: Yeah, very much so. Because, just think-- I don't know if you're a recovering addict or alcoholic--

Int.: No.

096: You're not? So you wouldn't know. Just think, have you ever drank?

Int.: Yeah.

096: Have you ever got drunk?

Int.: Yeah.

096: Can you imagine a little baby inside of you with the same feeling you're feeling? Whatever you feel when you do drugs or alcohol, the baby feels it two times even more. So you imagine, you know how you feel when you're drunk, right? You're all, you know, uncoordinated. and the poor little baby inside of you, it already rotates, right? But when you smoke that dope, the baby rotates, and it's like spinning around inside of you. You start contracting.

Most women seemed to perceive that I respected them and appreciated whatever they were willing to share. Thus, often there was a mutual appreciation and give-and-take between us, and by the end of many interviews I felt close to the woman, cared about her situation, and felt I had been part of a warm and sincere interpersonal exchange.

At the end of each interview, the woman signed or marked a receipt and received \$40 in cash. We requested that she keep us in mind and refer friends and acquaintances who might be eligible for the study. When interviews took place in city neighborhoods, women often saw us to our cars and otherwise made sure we were safe in what they knew was an unfamiliar environment. I never felt unsafe during the interview process with a woman in her residence, but there were times when I was on edge in an unfamiliar neighborhood. Thanks to coaching by the street-wise principal investigators, considerate guidance by our respondents, and our common sense, no physically dangerous incidents occurred during data collection or recruitment in field settings.

Post-interview procedures. We wrote field notes after most expeditions to recruit or interview outside the project offices. Also, in accordance with a procedure used in the past by the principal investigators, we wrote a one-page summary statement of each interview as soon as possible after each interview is completed. This practice gave us a way to record a brief summary of the interview content as well as descriptions of the interview setting and the participant and

capture our own feelings, hunches, and insights about the interview content and process.

Summary statements proved to be a valuable point of access into the other interviewer's perspectives as well as a quick-reference summary of the transcribed data. The simple analytic insights that occurred in our efforts to sum up what went on in the interview were often useful as starting points for new avenues of inquiry, even before the full interview was transcribed and analyzed. This short-cut to theoretical sampling was especially important in this large and fast-moving qualitative study. When a participant was recruited, we needed to schedule and complete her interview as soon as possible, given the instability of many women's lives, their fearfulness about disclosure, and the unexpected events of pregnancy. We didn't have the luxury of full analysis of each interview before moving on to the next. Hallway discussions, field notes and memos, and summary statements were means of working on and sharing analytic insights without waiting for transcribed interview data.

Another post-interview phenomenon was the need to debrief, or unload, after our forays into the tumultuous and often sad lives of the study participants. The environments of the field interviews were depressing, but much more disturbing were the stories women told us of oppression, violence, lack of opportunity, disrupted families, and bleak hopes for the future. As Lamb and Huttlinger (1989) have

noted, the reciprocal effects of the research on researcher and participants must be considered as part of the human process of research conduct. Not only do the respondents risk a sense of loss or disappointment at the conclusion of a supportive and friendly interview, but the researcher too may feel sad, angry, or helpless when faced with prolonged contact with persons experiencing suffering or involved in injurious activities.

We maintained contact with some respondents who were encountered on the street or who referred others or filled out a voluntary tracking form with address and phone numbers that could be used to re-contact them. These follow-up contacts enabled validation of analytic progress as well as personal contact for our own satisfaction. Some participants telephoned the project office to tell us how they were doing or to request information. Some requested copies of the study results and provided addresses. Memos and extended conversations with other staff helped us to debrief and problem-solve after difficult interviews. In retrospect, the prospect of doing a qualitative study of pregnant drug users as a sole investigator, which was my original plan, would have been immeasurably more difficult than the cooperative, mutually supportive team effort that enabled us to conduct a difficult project with good will and few apparent emotional sequelae.

Human Research Considerations

Confidentiality was of paramount importance in this

project. Some measures of protection were taken within the conduct of the study, and continued vigilance will be required during presentation of findings. As Ramos (1989) noted, confidentiality is more difficult to maintain when textual data are presented than when responses are in numerical form. When disclosures describe socially unacceptable behavior, confidentiality becomes even more important⁷.

Fully informed consent is also difficult in a qualitative study. The interviewer cannot predict the types of experiences the respondent can expect or the effect of sharing possibly intimate and disturbing life history data. Manipulation of informants may occur if the informant feels pressured to provide sensitive data in exchange for personal support (Ramos, 1989). In our introductory discussions on the telephone and in person with participants, we described the focus of the research, the voluntary nature of any sharing of information, and the importance of respondents' comfort and right to direct the course of the interview in efforts to reduce the risk of disclosure of material that a respondent might later regret. As respondents referred later participants in the course of snowball sampling, they told each other about the content and comfort level of the interview experience, further reducing anxiety and increasing

⁷For a thoughtful and useful presentation of means of minimizing potential harms to drug users who participate in research, see McDermott and Pyett, "Minimising Harm in Research," in (1992) The International Journal on Drug Policy, 3, 135-140.

respondents' confidence to maintain control over the disclosure of information. As a result, we were "cool" (acceptable, knowledgeable about their concerns) in the eyes of the respondents.

No complaints about the study have been lodged with the principal investigator or the IRB to date. This is a poor reflection of actual participant satisfaction with the study conduct, however, as stigmatized and legally vulnerable persons may be unlikely to risk discovery by voicing a complaint. One self-help agency counselor did call the project office to report that two women who had been abstinent from crack before they were interviewed had then used drugs, possibly due to the stressful introspection involved in the interview process. The counselor was justifiably concerned; she suggested that we refer women back to their support sources for help after the interview, which we had done, but we became even more vigilant after that point. In fact, in our perceptions, these two women were probably on the brink of using drugs anyway, but this event generated serious discussion about our roles with participants.

Perhaps the most consistent comment from women about the effects of their participation was an expression of appreciation for our nonjudgmental, supportive listening, and for the opportunity for a forum to review their life situation and gain insight. When asked if she had any final words she wanted to say on tape, one respondent remarked:

No. Only thing I want to say is I feel really good about this... It helped me... 'cause I don't speak out loud to anybody about it because I don't like to. You know, some people give you that-- instead of them just listening to what you're saying, they give you that 'negative,' and I can take their criticism [but] there's a time for everything. Sometimes you need people to listen and ask questions to find out how you feel and not try to sit there and...tell you about how you should feel and... 'Well, you know, it's all your fault.' 'I know all this, but listen to me. Sometimes I just need you to listen.' (078)

A middle-class woman remarked that she wished women had more access to nonjudgmental listening:

I would have loved to have just one time opened that newspaper and seen, 'Women: If you are cocaine-addicted and want to talk, just to talk, completely confidential, dial so-and-so for the details.' (015)

This participant had been considering abortion:

I think I'm making my decision this week. I was actually gonna come in and talk to you when I was done talking to her [abortion counselor] yesterday. I wasn't quite sure how this study was gonna work, but I kinda-- in a way, I wanted to come in just to kind of talk and listen to myself talk and think a little more. 'Cause my boyfriend works so much and sometimes we fight, and it's kind of nice to have an objective, different third person to hear what's going on. So to me, when I hear myself talk I think that I'm probably gonna go ahead with the abortion, just because I am. (028)

The risks of legal prosecution or psychological sequelae warranted careful thought. A Certificate of Confidentiality obtained from N.I.D.A. by the senior investigators protected the participants from having research data used against them (See Appendix III). Sources for psychological referral and support, drug treatment, and obstetrical care were identified and listed for respondents on a handout. A counselor was engaged to handle emergency

referrals, and an obstetrician was enlisted to handle any urgent obstetrical conditions that might emerge in the course of the interview. My clinical background as an OB/GYN nurse practitioner was a potential asset in evaluating the seriousness of apparent obstetrical problems, but none emerged. We felt committed to respecting the participants' autonomy with regard to self-care, but we made every effort to connect women with services if they indicated interest. In fact, only a few requested information; most seemed familiar with the resources in the city area.

Ethical concerns related to confidentiality and protection of human subjects were also addressed via review and approval of the larger study by the Institutional Review Board of the research agency, and approval of the dissertation research as a secondary analysis by the UCSF Committee on Human Research (Appendix I). The faculty committee directing the dissertation was available for problem-solving, and the principal investigators offered close supervision and continual assistance and expertise with regard to protecting participants from harm.

Analysis

Data analysis began in the car, as I made my way back to the research office after my first interview. I drove along buzzing with ideas and eager to write them down. Perhaps analysis had begun even earlier, during the interview, as concepts and relationships arose in my mind as the woman spoke and I questioned her about them. For example, this

woman had discussed how time sped along when she was seeking and using crack, and on questioning she confirmed that this had contributed to her lack of awareness of her pregnancy for a number of months, although in a previous pregnancy when she had not been using drugs she had realized it right away. I began considering relationships among the concepts of time, awareness of pregnancy, and effects of crack. I asked myself and the next participant, "So, if using changes the experience of pregnancy, does pregnancy change the experience of using?" As it turned out, it did, and both related to the process of realizing a pregnancy, as I recorded in an early memo. Thus, I began to identify concepts and their relationships as soon as data collection was underway.

Open coding. When I obtained the transcript of my first interview, I began the procedure of open coding, a process of "fracturing" the data into concepts that can be labeled and sorted while the analyst remains "open" or unrestricted by predetermined theory (Strauss & Corbin, 1990). The data were labeled line by line as I asked, "What is this an example of?" Discrete concepts, which may be events, feelings, actions, or qualities of an experience, an individual, or a social group, were grouped under category labels (Strauss & Corbin, pgs. 67-68). In grounded theory, each category of concepts can be described in terms of its dimensions or characteristics, each instance can be compared to other instances and the differences in the properties of each explained by contextual factors, the categories can be

related to other categories, and a theoretical interaction will begin to emerge for further exploration (Glaser, 1978).

Suggestions of theoretical relationships found in the first transcript were documented in memos, with reference to the original text. Early memos addressed the interactions of the experiences of pregnancy and of the drug high, the effect of drugs on time perception, the impact of these relationships on realizing a pregnancy, and the impact of other people's opinions on the interactions of pregnancy and drug use. These relationships were explored in subsequent interviews in a process of ongoing concurrent validation.

Each time a transcript became available, all the previous codes and new codes as necessary were used to label the data. After the two interviewers individually went through six transcripts and generated a very long list of fairly specific codes, the long list was collapsed into approximately 20 simple and general categories, similar to what Glaser (1978) terms substantive codes, for the purpose of data management. We agreed on, tested, and revised this code list. Each transcript was then recoded with the final list (see Appendix IV), using the technique of identifying the starting and ending line numbers of data segments related to each code, overlapping a number of codes when necessary. The coding was then entered into a personal computer using Ethnograph, a textual data management program.

This level of coding was essentially a data reduction

process, from which higher levels of analysis could proceed. By searching electronically through each interview, data segments for a specific code or codes could be extracted without looking through entire interviews. Each transcript was coded first by the person who had conducted the interview and then carefully checked by a second person. Where repeated disagreements occurred, coding guides were modified for clarification. A high level of inter-rater agreement was soon reached, but this practice of using two persons to code and check each interview was continued for all transcripts, thus maintaining consistency and exposing each interviewer to a wide range of interview content and process.

Increasing analytic complexity. While open coding continued, a higher level of analysis was also in progress. Theoretical coding as described by Glaser (1978, 1992) began very early in the data collection phase. For my analysis of data from crack users, I conducted theoretical coding on my home computer using Microsoft "Word" for MacIntosh, using a method of text sorting outlined by Morse (1991). In this level of analysis, data already conceptualized through open coding were re-categorized in separate files for each theoretical code.

Strauss and Corbin developed a process-oriented paradigm of concepts and their relationships (1990, p.99), including causes, consequences, strategies, context, and intervening conditions. Glaser, in contrast, although he offered many ideas for types of theoretical relationships that might be

seen (1978, pgs. 74-81), found the use of a single model too likely to "force" the data into a "preconceived full conceptual description" (1992, p.11). I followed Glaser's approach of allowing a dynamic structure to emerge from the data rather than applying a formula "from above." Texts were studied, coded, and re-examined. Discussions were held among the project staff, memos were exchanged, ideas were challenged, and each analytic claim was tested by each interviewer in her subsequent interviews and analysis.

Trying to sketch the "big picture." Several early models emerged from the complex and rich data. The first represented the conflicted relationship between the roles of drug user and pregnant woman and their associated social worlds, a conflict that increased with the increasing visibility of a pregnancy. This was first depicted as shown in Figure 1.

I then explored how this conflict related to other concepts: specifically, the trajectory of pregnancy, beginning with the process of realizing and weighing the meaning, value, and risk of a given pregnancy, and followed by the actions women took over the course of pregnancy. The actions or strategies were quite varied and generally seemed to be efforts to deal with the conflict between worlds described above. I was interested in the effect on these perceptions and actions of feeling fetal movement, because women described this as a significant and often disturbing event. I also studied all the influences and important background within the context of a woman's life during the

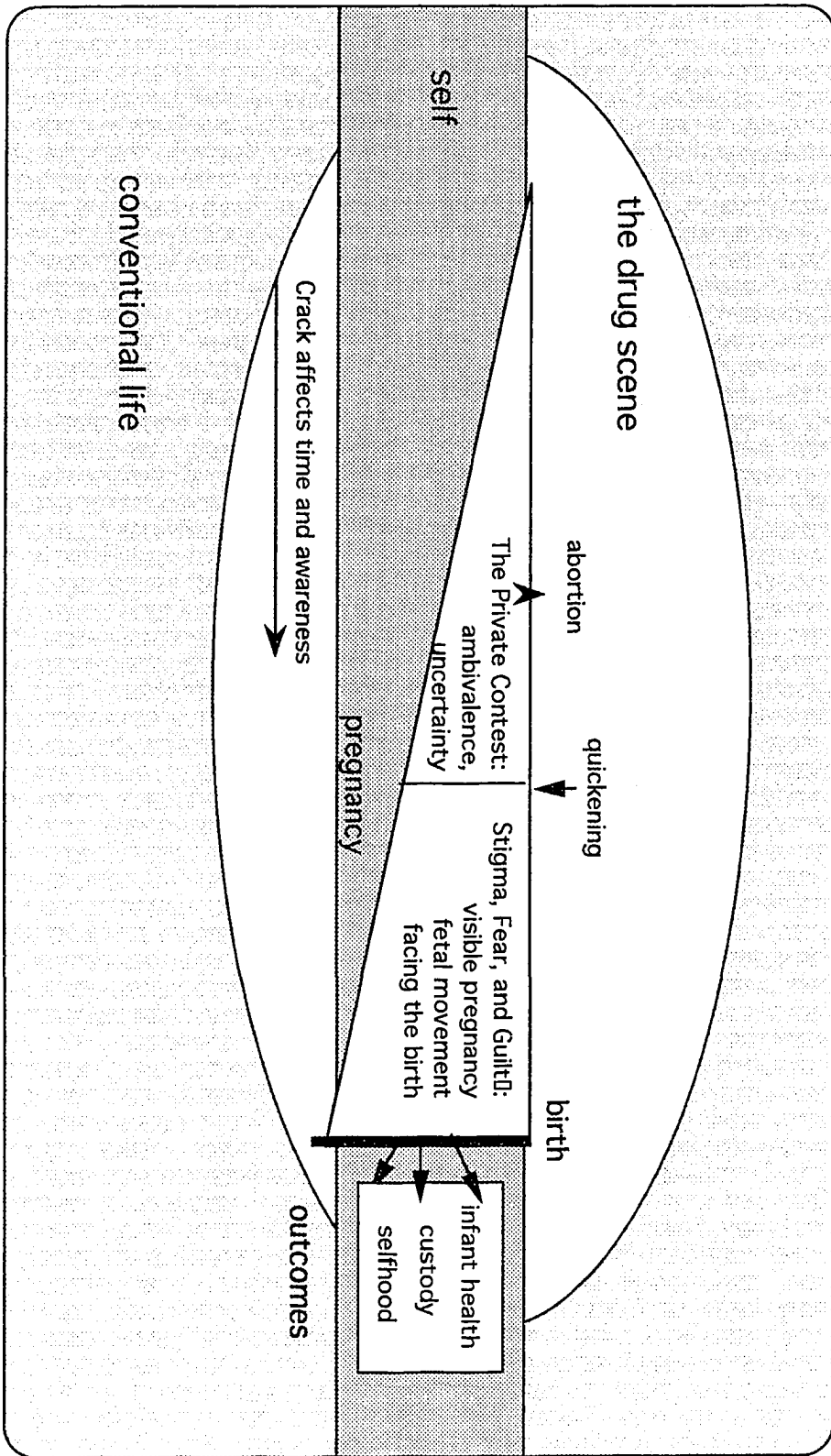


Figure 1. Trajectory of pregnancy through the drug scene and conventional life (early representation).

pregnancy, looking for explanations for why some women pursued one set of actions and other women practiced others. A series of diagrams resulted, and these were modified and sometimes discarded over time. The diagram in Figure 2 was an early attempt at a conditional matrix (Strauss & Corbin, 1990; Strauss, 1991, Chapter 26).

It was tempting at this level of analysis to leave the data behind and expound at length in memos and with colleagues about these fascinating interactions. This overconfidence was cut short, however, each time I conducted an interview and asked the participant to react to my latest theoretical idea. After proceeding with the interview in the usual fashion, probing for the lower level of concepts and their relationships, I would seek support for my latest construction. If such validation was not forthcoming, I was sent humbly back to the interview data with the latest participant's words echoing in my head, seeking to incorporate the latest reactions into the current theoretical model.

Influence of other literature on the analysis. During the later stages of data collection and analysis, I began to consider theories about pregnancy and mothering from other research. In comparison to my emerging understanding of pregnancy and drugs. For example, Corbin's (1987) study of chronically ill women's process of protective governing in pregnancy, Patterson's (1990) study of pregnant women's seeking safe passage in relation to prenatal care, and

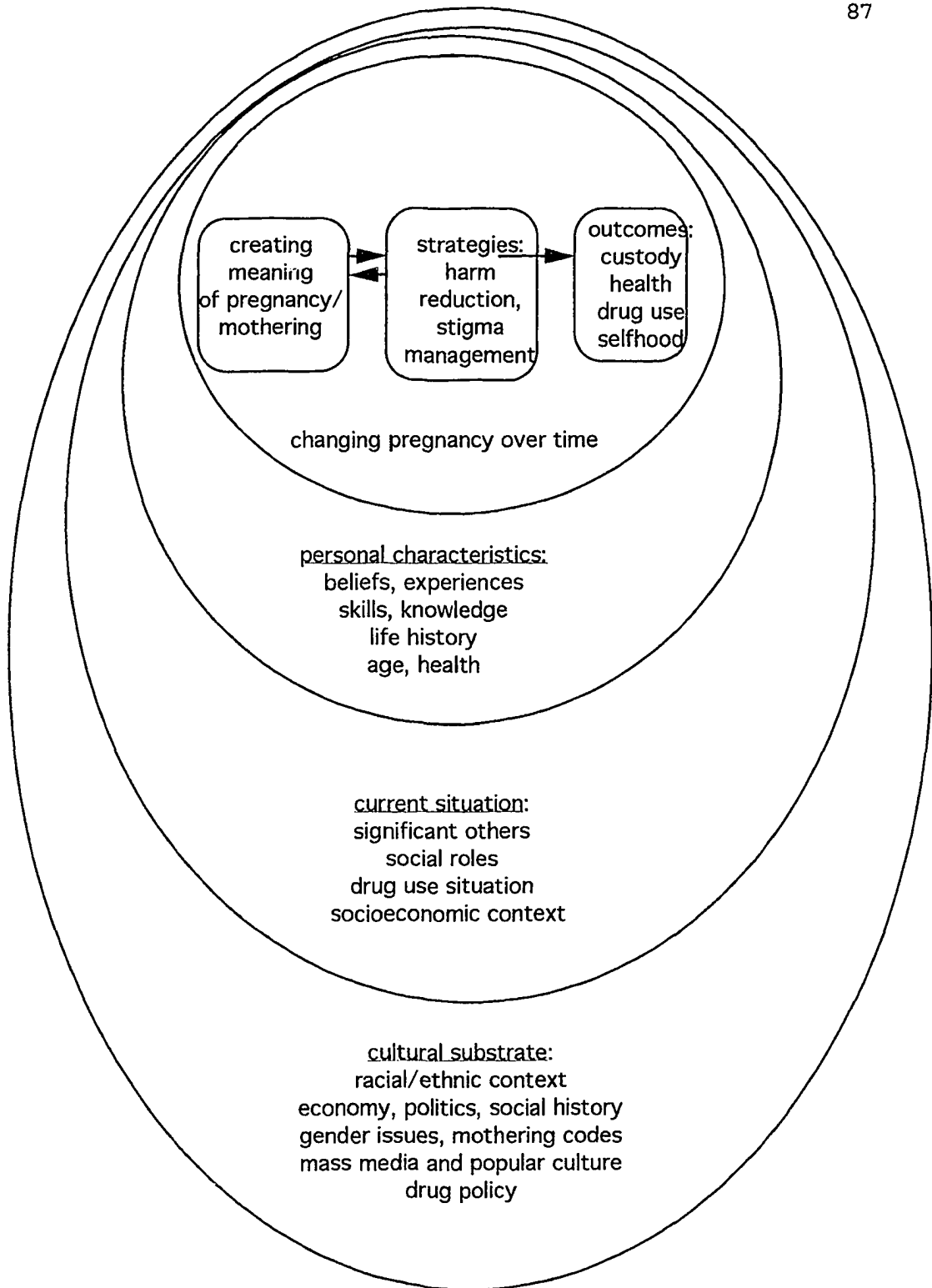


Figure 2. Conditional matrix of drug use in pregnancy (early representation).

Scheper-Hughes' (1992) engrossing study of maternal practices of mortal neglect in a desperately poor area of Brazil were compared to the stories of pregnant crack users. I asked the question, "How is this outside theory similar to and different from what we hear from pregnant drug users?" When an outside theory did not fit (and none did exactly), the comparison process helped to reveal the unique aspects of the experience of pregnancy on drugs. For example, in studying Corbin's work, it was apparent that pregnant drug users shared the chronically ill women's sense of risk to their pregnancies and their own health, but our sample was further burdened by the stigma and guilt of their illicit practices, which prevented them from interacting with health care providers in a "governing" way. Our sample shared some of the hopelessness Scheper-Hughes observed among poor Brazilian mothers that led both groups at times to give up on a particular pregnancy or infant as beyond saving, but few drug users had the comfort and direction of the version of Catholicism that in a way protected the Brazilian women from the guilt described by our American sample. Thus, this process of situating our work in the literature, usually reserved for post-study discussion in quantitative analyses, was part of the analytic phase of this study.

Discovering the central process. Glaser (1992) comforts the grounded theorist that the core category of action in a phenomenon will emerge from the data if the steps of grounded theory analysis are followed. This moment happened in the

present study one afternoon while I was comparing our data to the other research listed above. All the threads of my analytic thinking suddenly came together as I was reading one of Glaser's books, and I wrote the memo excerpted below:

I think the BSP, which according to Glaser has to include at least two stages and has to account for a wide range of variation in behavior regarding the Basic Problem, is salvaging hope. What do you think? Salvaging: because the best you can hope for is a damaged product, but you're willing to fight for that, and pay the consequences. Hope: because even if you are giving up or aborting your baby, it's because you have a vision of something better in your future. Even if you are not going to prenatal care, you are protecting your hope of at least getting custody of your baby. Even if you are still smoking [crack] or fixing [heroin], you are doing things to protect your anticipated motherhood, such as finding housing, compensating with food or vitamins, or drinking pickle juice [home remedy to remove drugs from one's system]. Women who stay high all the time in order to block out the possibility of a drug-affected pregnancy are salvaging hope of all this being a bad dream.

The process of salvaging, later expanded beyond hope to selfhood, "worked" to label the full range of pregnant drug users' responses to the basic problem: managing conflicting ideologies and their rule-breaking roles in two incompatible yet overlapping worlds, the drug scene and conventional mothering. It does not presume what it is that mothers choose to salvage (because it includes a personal weighing and meaning-creating phase) or how they will seek to salvage it (strategies varied within two basic categories), but it reflects agency and reflexivity in a socioculturally disempowered group. It represents a human response to a very different situation than those faced by Corbin's and

Patterson's samples: a pregnancy and life context assessed as already damaged and less than perfect even when the women had stopped using drugs.

Saturation. When no new concepts are discovered that relate to the central problem, process, or conditions affecting them, a grounded theory is said to have reached saturation (Strauss & Corbin, 1990). In Women on Heroin, Rosenbaum (1981) noted that she reached saturation after 50 interviews and continued data collection mainly to achieve the sample size in the proposal as funded. In this analysis of pregnancy on crack, saturation was reached at about the same number. Saturation was tested by returning to what seemed the most divergent stories within the data set, looking for negative cases in which the theory did not fit and for examples of contextual and intrapersonal influences that the model did not address. If resources and study design had permitted travel to a different geographic area where crack use was common in other ethnicities or socioeconomic classes, the conditions surrounding the theory or the specific strategies within it might have been expanded somewhat, but the basic process appeared stable.

Documentation. Records of data collection and analysis consisted of field notes, summary statements, transcripts, and memos. Memos are informal notes on the conceptualizations that emerge from each coding session that become the building blocks of theoretical statements (Glaser, 1978, p.83). Memos provide an accessible "trail" of the history of the

developing theory and its grounding in the data. They can be sorted theoretically (Glaser, 1978), and modified or extended in order to continually add to and improve the understanding of the phenomenon. New data are referenced or included as analysis proceeds, to incorporate citations that best capture the concepts and relationships in the emergent theory. By this means, the findings of the study take shape from the beginning of the analysis, and the process of data collection, coding, analysis, and redirection of data collection proceed in a cyclical fashion until no new information is being gathered and all data fit within the theoretical framework.

In this study, early memos chronicled apparent relationships between concepts, such as the link between time perception and realizing a pregnancy. By the later stages of the analysis, the memos were fairly long and complex and focused on ideas that had been revised and reworked many times. These long memos included compilations of a number of smaller ideas and represented eventual papers and dissertation sections. Notes on fragments of ideas sparked by the first sessions of interviewing and coding became discussions of the range of expression of the ideas in the expanding data set. When a relationship between ideas was discovered, content from two sets of memos was merged, and eventually the links among all the basic ideas could be explained. At this point in memos the findings were outlined

as a whole.

Maintaining rigor in analysis. Many of the procedures by which rigor was achieved have been mentioned above. During data collection, criteria for rigor in feminist research (Hall & Stevens, 1990)-- reflexivity, rapport, honesty and mutuality, and relationality-- were attended to throughout the recruitment and interview processes. As described earlier, by acknowledging our own and the participants' individuality and differences, seeking equity and points of common understanding, inviting and facilitating participants' comfort in relating their experiences in their own terms, and seeking participants' input as we approached each aspect of recruiting, data collection, and analysis, the quality of the eventual research product was improved.

The process of grounded theory produced rigor in the analysis of interview data. As described earlier, each time a conceptual "leap" was taken beyond the descriptive level, it was challenged with old and new data and substantiated with quotations from participants. Constant comparison facilitated continued grounding of the emergent theory in the data, and memos served as documentation of the progress of analysis and the specific data sources from which theoretical ideas were taken.

Further analytic rigor was enabled by the practices of the research team. The development of the initial code list was a scrupulous and intensive team effort to the point of consensus across the interdisciplinary (sociology and

nursing) group. Double-coding of each transcript by two interviewers, one who had been present at the interview and one who had not, ensured that codes were used uniformly and important concepts were not missed or misinterpreted. Each team member's analytic memos were shared and discussed among the group, enabling sociological and nursing input into each interpretation. The result, which will be presented in the next three chapters, was a theory reflecting large-scale sociocultural influences, close-up family and psychological processes, and particular health-focused self-care practices, relevant to previous research with women drug users and to changes in the drug scene over time.

CHAPTER FIVE

Findings I:

The Troubled Trajectory of Pregnancy on Crack

Sixty women recounted multidimensional experiences of pregnancy on cocaine, sharing their past and present life situations, their views about the future, and emotional responses. In the next three chapters, the common threads are presented with attention to different forms and perceptions within the women's accounts.¹ In this chapter, I begin with some descriptive information about the sample and then present the setting of the phenomenon: the troubled trajectory of pregnancy on crack. Within this trajectory lies the basic problem faced by pregnant crack users: threat to self and hope. In Chapter Six, which follows, I describe and illustrate the process used by pregnant crack users to deal with the threats in this trajectory. In Chapter Seven, I offer a close look at prenatal care, where the meanings of their situations and the actions they choose have potent significance for women who use crack cocaine.

Description of the SampleDemographics

Background. The 60 pregnant and postpartum women whose interviews were included in this analysis were a mainly

¹ Three chapters were used instead of the traditional single chapter of findings because, unlike statistical analyses that can be presented concisely in tables, the narratives that demonstrate the variations within this study require a longer format. The problems of being pregnant on crack, the process used in response to the problems, and the concerns and solutions specific to prenatal care emerged as natural divisions in the findings.

California-raised, high-school-educated, ethnically mixed but predominantly African-American group. Many had been raised in strict religious traditions. They had left home at an average age of 17. Eighty-three percent of the women had been raised by at least one biological parent, and the remainder were raised by other relatives or foster parents. Forty-seven percent of the women's parents had been married; 15% had been single, and the rest had been common-law spouses, widowed, or divorced.

Ninety percent of the study participants had borne children (including the index child if delivered), and 78% had had one or more therapeutic abortions. About half had lost custody of children at some time and/or relinquished children informally. The following table presents more details of these characteristics.

Table 1. Demographics

	<u>Mean</u>	<u>Median</u>	<u>Range</u>
<u>Age</u>	28.1 years	28.5 years	20-39 years
<u>Education</u>	12.0 years	12.0 years	9-16 years
<u>Parity</u>	2.6 children	3.0 children	0-7 children
<u>Ethnicity</u>	83% African-American		
	10% White		
	5% Latina		

2% Pacific Islander

<u>Religion</u>	<u>Current</u>	<u>In Childhood</u>
Catholic	22%	23%
Fundamentalist Protestant	45%	60%
Liberal Protestant	12%	13%
other	5%	7%
none	15%	0%

Socioeconomic status. Eighty-five percent were receiving public assistance; 57% had relied on this as their main income for a year or less, with a range of one month to 15 years. One woman was employed, one other was receiving unemployment, and two lived by illegal incomes. Average income of the 60 women was \$646 per month, supporting an average of two persons. Living situations included apartments (28%), daily- or weekly-rate hotels (18%), housing projects (22%) and homelessness (15%).

Substance use. Most of the women had started using drugs early in high school and become regular users by age 18. Drug use went beyond crack cocaine to a variety of other substances. About one-fourth had used some heroin in the past, 12% had used a significant amount (over 100 times), and one was still using heroin. More than three-fourths had used some powder cocaine (either snorted or injected, as opposed to crack cocaine, which was smoked), 45% had used a significant amount, and one was still using powder. One-third

had used some methamphetamine, two had used a significant amount, and one was still using it. Marijuana was the most prevalent drug used other than crack cocaine. Ninety percent had used marijuana, 75% a significant amount (mean days of use was 1200), and 22% were current marijuana users.

Crack cocaine use, in days of use over the woman's lifetime, averaged 950 days (median 780, range 24-2920). Fifty-seven percent had used crack in the 30 days preceding the interview, and 43% had smoked some crack in the past seven days. Crack cocaine use in the current or most recent pregnancy is displayed in the table below:

Table 2. Average Frequency and Cost of Crack Cocaine Use

Pregnancy Stage at study	Days used		Stage 1		Stage 2		Stage 3	
	Before knew	After knew	Days used	Cost/day	Days used	Cost/day	Days used	Cost/day
1 (n=17) mean	44	10	54	\$159	----	----	----	----
2 (n=23) mean	36	66	78	\$72	17	\$33	----	----
3 (n=20) mean	54	72	83	\$103	43	\$74	17	\$52
Total (60) mean	44	45	67	\$107	29	\$52	17	\$52
range	0-140	0-210	0-210	0-999	0-120	0-300	0-120	0-300

Legal substance use by the crack smokers was also of interest. Alcohol use was considerable. Forty percent reported that they currently drank alcohol, and 72% said they drank in pregnancy, in quantities as shown below:

Table 3. Alcohol Intake (Equivalent of Ounces "Hard Liquor")

	<u>Mean</u>	<u>Median</u>	<u>Range</u>
Current drinks per week	6.7	1.2	0-80
Drinks per week:			
before knew was pregnant	27.8	12.0	0-100+
after knew	17.5	2.0	0-100+
Drinks per day:			
before knew was pregnant	6.8	2.1	0-44
after knew	3.9	0.2	0-44

Tobacco use was also common. Eighty percent reported smoking currently, and 87% said they had smoked in pregnancy, in amounts shown below:

Table 4. Cigarettes Smoked per Day

	<u>Mean</u>	<u>Median</u>	<u>Range</u>
Current smoking	12	10	1-60
Before knew was pregnant	18.5	12	1-80
After knew was pregnant	12.0	7.5	1-60

Pregnancy Discovery and Outcomes: Descriptive Statistics

Fifty-seven of the 60 women were either pregnant or had delivered live infants. Two had had therapeutic abortions, and one had miscarried. At the time of interview, 28% were less than 20 weeks pregnant (Stage 1) or had miscarried or aborted, 38% were between 20 and 40 weeks pregnant (Stage 2),

and 33% were between five days and eight months postpartum (Stage 3). Of those still pregnant or whose pregnancies had ended in the first trimester, the average gestational age was 21.5 weeks, with a range of 6 to 36 weeks.

The most common reasons for first suspecting this pregnancy were physical symptoms (48%) and missed menstrual period (40%). Eighty-seven percent confirmed their pregnancies with a health care provider, and the remainder either used home pregnancy tests or the test used in this study for confirmation. Average gestational age for first suspicion of pregnancy was 7.7 weeks (median 8, range 1-20), and the average weeks of pregnancy at confirmation was 11.4 (median 9, range 1-28). Seventy-eight percent had obtained prenatal care, at a mean of 6.1 visits across the sample (including those at all stages of pregnancy); 76% of those with prenatal care went regularly. Emergency departments were also used for pregnancy-related concerns by 27% of the sample.

Of the 20 women who had given birth, their 22 infants (including two sets of twins) were an average of four months old at the time of interview. Eight (all 4 twins, 4 others) were born prematurely, at a mean of 6.3 weeks before their due dates. Average weight of the 22 infants was 5.32 pounds (median 5.8, range 1-8; one set of twins was born 11 weeks early and weighed about one pound each, skewing the mean birth weights downward). The infants spent a median of 5 days in the hospital after birth, and 32% of the mothers said

their infants had showed signs of withdrawal. Seventy-three percent had their infants living with them, one was with the mother's parents, and five infants (23%) were in custody of Child Protective Services.

The Troubled Trajectory of Pregnancy on Crack

The Bad News of Pregnancy on Drugs

The experience of being pregnant on crack, as revealed in analysis of the 60 interview transcripts, was a difficult ordeal for all the study participants. Although some were happy to be pregnant, none were completely so, and many were deeply troubled by the discovery of a pregnancy. I will begin by summarizing the backgrounds of the study participants and proceed to the experiences associated with finding out about a pregnancy.

Life history before pregnancy. For almost all the 60 women in this sample, growing up involved being excluded in one way or another from mainstream American life. Many were raised by single mothers, and most grew up in working-class or impoverished households. As the earlier description reveals, the majority were women of color. At least one-fourth told of abusive, drinking, or drug-using households. Strict religious beliefs and harsh parenting practices were common. Only a handful of the participants described peaceful, uneventful childhoods, but on the other hand few felt destined from a young age to pursue a life in drugs. One woman said, "My mother would turn over in her grave." (101)

Several women had learning impairments and had faced obstacles at school. For some participants, a pregnancy was the impetus to leave high school. Other women left for other reasons, such as delinquency or boredom, but half the participants completed high school. A number had worked steadily at technical or office jobs for much of their lives. Of the large number of women receiving public assistance at the time of interview, a number had been working until their current or recent pregnancies, and thus in a non-pregnant time the sample might have a more working-class character than it otherwise appeared. There were also women who had been raised on public assistance, had never held a job, and had received aid themselves since becoming mothers at a young age, and women who had held responsible management positions until drugs, childbearing, or personal tragedies had intervened. Thus, variation in social and economic background was reflected in participants' personal histories.

Meeting up with drugs. Several women encountered drugs in their homes as young girls, but the most common scenario was introduction to drugs by high school peers, older siblings, or boyfriends. A number of women sought out drugs as a way of numbing the pain of sexual abuse, other violence, or deaths of significant others, but no women in this sample were coerced into using drugs. They more often had been curious and attracted by the excitement of the drug scene.

For most, marijuana had been their first illicit drug. Some had used a variety of other substances in addition to

crack, and others had only used crack and marijuana. Not all the participants were or had been heavy drug users. Some had only used on weekends or paydays. The majority, however, had slipped into using several times a week by the time they became pregnant:

But it's like, don't look at it like I'm really doing it because I want to do it...You get hooked...when I get my check it's like I'm just drawn to it...where I used to take care of my business and do all kind of stuff before I even [bought drugs], it's like it's all on the back burner...Now [drugs are] Number One. And...I don't like that...I want the baby too bad to try to hurt it. (018)

Many had made efforts to stop using crack in the past, and a number had been successful for periods of time. Drug use was not a constant full-time pastime for most women. More than half had the responsibility of children and thus had conventional lives outside of drugs, albeit lives that were at times difficult to maintain.

Discovering pregnancy. Crack use in pregnancy was universally rejected in the reference groups described by the study participants. Even women heavily engaged in the drug scene found the idea of being a pregnant drug user unthinkable or at best a predicament to be avoided at all costs. The publicized dangers of crack use in pregnancy were well known and generally accepted. Even women who had given birth to healthy babies after smoking crack believed that they had been lucky and might not escape the next time. The effects of mass media programs, public service messages, and news stories about damaged babies born to crack users were frightening. (In almost every field interview, even in tiny

hotel rooms, a television set was on when I arrived.) Women attributed any abnormalities in their friends' children to the effects of crack. Some remembered criticizing other women who smoked crack while pregnant. To find oneself in this situation was acutely embarrassing and frightening. Therefore, a crack user's discovery of a pregnancy was fraught with doubt and pain.

When the possibility of pregnancy was first realized, a crack user was already launched into its trajectory. Symptoms of pregnancy did not begin until weeks or months after conception, so by the time a woman began to consider the possibility of being pregnant she also had to consider what had already happened. Therefore, the process of realizing a pregnancy was also a process of realizing a drug-affected pregnancy, i.e., an already-compromised situation. With this discovery, a woman suffered a sudden blow to her self-appraisal. If she acknowledged being pregnant, she would be forced to reframe her position as among the most ostracized class of persons in an already-marginalized social group. This was a deep blow to many, the last straw in a drug-initiated sad and demoralizing downward slide. Reflecting these concerns, a number of women endured prolonged periods of debate and uncertainty about the presence of pregnancy.

Physical signs were the most common reason for suspecting pregnancy:

How did I found out? I didn't have no period, that's how I found out...I noticed it right away, yeah, especially

'cause I hadn't had no problems before.(058)

But when I missed it two times I went, 'Wait a minute.'...And that really tripped me out because it's like the third week of my pregnancy I felt like I was pregnant, but I was like, 'Well, I can't get pregnant. I'm not pregnant.' But then four or five weeks come, though, and I'm...throwing up and hate this guy for nothing. 'Just get away from me.' Crying because I can't get no pickle...I'm like, 'God. I know I'm not pregnant'...but then I thought, 'Maybe I am.'(014)

Some women noticed changes in their reactions to drugs:

Well, I know when I'm pregnant, because...like my body, when I'm doing drugs I have no problem. When I get to throwing up and get dizzy spells and stuff, I go, 'I'm pregnant.' In two months' time, when I go to take a hit or something, I'm throwing it right back up...I recognize the symptoms.(094)

For others, another person's comments were the first indication of a possible pregnancy:

A couple of people had looked at me and they didn't know me from Adam and they was talking about, 'Oh, you're so pretty pregnant.' 'I'm not pregnant. you're crazy.'... [Then] I threw up one morning and I thought, 'Where did this come from?'(081)

When I went to see my mother, she told me, she said, 'Are you pregnant?...You better go to the doctor...' 'cause I think you're pregnant. You're starting to gain weight,' and she said, 'You have that look.'(096)

He told me right away. But I just like said, 'No, God would not do this to me. We don't have any way to live'...'Cause I started filling in, my chest, my dress...and getting hungry...and bitchy if he didn't let me go to [soup kitchen] to eat. 'All you think about is eating! Eating! You must be pregnant, you bitch!'(041)

Many women said that the effects of crack, the crack high, and the drug life delayed their awareness of pregnancy:

I took pregnancy tests but they kept coming up negative. But I think what it was, I had so much dope in my system my tests were coming up wrong...and then when I found out I was pregnant with him, I was already four months...[before that] I was, 'Well, I can keep using 'cause I'm not hurting him. there's nothing there.'...So

I mean, 'I ain't hurting nobody but myself'... So I went on ahead. (085)

Doing so much drugs, I didn't notice I was pregnant...I was always running back and forth to L.A. and stuff, you know, selling some drugs...When you're doing stuff like that you don't take time to go and check out anything. Who cares? You know? (002)

Yeah, I probably would have known. But the point is like I didn't care. (067)

Others were busy with conventional crises and pursuits and delayed confirming the pregnancy:

Yeah, I thought, 'I think I am.'...but it was all rushing and trying to get the place together. My son was in the hospital. My mom was in the hospital. My daughter went in the hospital. So, it was like, all that stuff was happening around me so...I didn't even have time to think about it. (050)

So much had been going on. Christmas had just passed and it was the New Year and then I was trying to figure out what to do about the apartment and da da da da, and I just wasn't paying attention. (087)

Time and awareness: Effects of crack. Discovering a pregnancy and following its progress were altered by the effects of crack cocaine use and the distractions of drug-seeking activity:

When I was smoking crack and I was pregnant, I was numb most of the time. So I didn't really feel the baby. (089)

You don't really pay attention...When you get real deep into it, you don't pay attention to body functions. Long as you can move your arms and your legs and you smell good, you're all right. (012)

I wasn't even aware that the baby was kicking, you know?...I was just so high all the time. (092)

Time went faster when they used crack, many women remarked. Whether this was a change in their perception of time when high or a result of the hectic and intense

activities related to obtaining and smoking it, the end result was that the weeks and months of pregnancy went by quickly. Women found themselves missing appointments, discovering they were too far along for abortion, missing opportunities to obtain housing or make other arrangements for the new baby, and progressing to their due dates before they had a chance to reduce their drug use. One woman said, "Doing this drug, it contains so many hours, you don't know." (002). Others agreed:

Yeah, it do [go faster], because before you know it a month or two have passed and you're like, 'I'm still doing the same shit. Damn!' (014)

It goes really fast...It's like, Whew!...And you really aren't doing anything...It's not like it's a constant smoking...It's just the time...You know you have to have something done, a responsibility done, and you don't get there. But you're looking at your watch and it just, Whew! And you don't-- It doesn't concern you. (058)

The significance of pregnancy was blunted and its trajectory accelerated by the effects of crack.

The private contest²: Whom to tell, what to do. Women's responses to the possibility of pregnancy were troubled and ambivalent. Even before they were certain they were pregnant, many began to consider what had already happened, what their current circumstances were, whether to continue the pregnancy, and what the consequences would be. Several found these deliberations so difficult that they tried to ignore the signs of pregnancy:

I thought... 'Maybe I'll have a miscarriage.' I just

² Thanks to Sheigla Murphy for articulating this concept.

didn't think...I was like, 'Maybe I'm just nervous. My nerves are bad and my period ain't come yet.' I'm trying to find every excuse not to think that I was pregnant, and I refused to go to a doctor. So I was like, 'I'm not pregnant.' (047)

I pretty much knew, but I guess I didn't want to believe it...And don't want to be. You try to make it, like make believe you're not pregnant. (098)

In some cases, whether conscious or not, it was advantageous not to recognize a pregnancy. If one was unaware of being pregnant, she could not be accused of knowingly risking harm to her child when smoking crack.

Once the pregnancy was fairly certain, many women considered the possibility of abortion. Quite a few had aborted past pregnancies, under different circumstances:

I didn't want no kids then 'cause I was working. (097)
I didn't feel that I wanted to give up our life, 'cause we always went camping...it turned out for the better for us. (002)

I thought about it...I had an abortion. I had a miscarriage. I said, 'Can I carry a baby and do I want a baby?' And I said, 'But I'm not gonna go out and just kill some kid.' The first one I killed [aborted], I mean, I wasn't gonna have a some-man-that-raped-me baby. And I was only 16. (047)

Well, the first one was when [my daughter] was six months old. And it was too soon and we were, at [my job] we were on strike...And then the second one... we had first started smoking [crack], so I just, 'No, I don't want no kid,' because I had that in my system...The third time was I didn't want to have one because I didn't want to have nothing to do with [the father]. (050)

For some women, abortion was unacceptable, either in general or for this pregnancy:

I don't believe in abortions. I don't want to get into that abortion rights and all that other shit, but I don't believe in it...But I can understand like some women, like rape victims that they come up pregnant and

they abort. I understand that, but that's a whole 'nother thing.(058)

I was more scared of having an abortion than I was of having them [children], because I say, 'Well, the Lord he'll take me, he could take me just as quick as in getting an abortion as he can me having [the baby]. I'm killing something, you know, I'm taking a life,' I say.(001)

Two women were pregnant with twins. When they discovered this special circumstance, both had changed their minds in the middle of abortion procedures:

They say,...'You're pregnant with twins.' I seen them [on the ultrasound scan]. I'm like, 'Call off the abortion.' It's a sick person that don't want one but want two, now ain't it?(081)

I was at XXX Hospital on the table ready to have an abortion. And the doctor came in; he said, 'We're having some kind of complications or something. We want to give you an ultrasound.' And that's when they seen the two heads and two whatever it was...I got up off the table. I said, 'I haven't went too far, have I?'(094)

Many women felt the father of the baby had a right to influence an abortion decision, and some attempted to keep the new pregnancy secret. Sometimes this was unsuccessful. One woman discovered her sister-in-law in the row behind her at the pregnancy testing clinic and thus lost the chance to keep her pregnancy secret from the father. Another father-to-be was present at the testing and was able to interpret the results of the pregnancy test as the health technician performed it, spoiling the woman's plan for a secret abortion. Women who told the father-to-be then had to deal with his opinions and his advice. Because they believed the father had a claim on the pregnancy outcome, many took his position into account, but several went against the fathers'

wishes. This woman continued her pregnancy:

He didn't want me to have a baby. He was like, 'Well, you just getting...your life back together.' (097)

This woman had an abortion:

He had to come and pick me up from this [abortion] clinic, and I told him that I had a miscarriage...If I told him that I was pregnant, he would never want me to have an abortion. (015)

Several others continued the pregnancy to please the father.

One or two were uncertain who had fathered their child.

While abortion beliefs, readiness for a baby, and the father's input affect pregnancy-related decisions for many non-drug-using women, crack users also had to consider potential impact of the pregnancy on their drug use and of the drug use on the outcome of the pregnancy. If a woman felt she was likely to continue using, she considered abortion more seriously:

That's what makes me think I don't need this baby...because I'm using. I like drugs. I know they're no good for me. I know what they do to my life. But right now, this is where I want to be...I've got a doctor's appointment [to discuss abortion] tomorrow. Because...this is being stupid. Why bring these drug babies into the world like that? (019)

In contrast, if a woman thought a pregnancy would motivate her to stop using and this was her goal, she might continue it:

I know if I get pregnant, I could stop the drug. This was the only way I could stop. (006)

I found out I was pregnant. And to me it was like a message from God saying, 'Okay, now I'm giving you one more chance. If you blow this, your ass is out.' (096)

This woman's comment reflects a number of common

considerations:

Well, right away I thought, 'Gee, what should I do, have an abortion?' That's the first thing that hit my mind. And he had just been put in jail...and I told him I was pregnant and he lit up. 'Oh, that's great.' I said, 'Whoa, what about all the crack we've been doing?' He said...'I really, really want this baby. Please consider keeping the baby.'...So I thought about it good and hard and I couldn't do it again. I couldn't have another abortion. I thought, '...If this baby is strong enough to live through what I just put it through, this baby is meant to be here.'...But I was still really scared.(104)

A few women felt they had no choice but to continue an unwanted pregnancy. One woman said she had been "too lazy" to go get an abortion until it was too late. Another was rejected by an abortion clinic because of her drug use. A third didn't discover her pregnancy until four months, when she could not bring herself to end it. These women expressed sadness and frustration at their predicaments.

Discovering a pregnancy plunged women into pained assessment of their life situation and their drug use, as they faced taking on the identity of a pregnant drug user. The only ways to avoid this were to abort the pregnancy or stop using drugs, both extremely difficult. This stress led some women to use more crack during this time. For many, deliberation about whether the pregnancy was real, whom to tell, and what to do continued for months until it was too late for an abortion. Even after a decision had been made, many continued to mull over their life situations, looking back in guilt to earlier in the pregnancy and ahead in fear to delivery and the future, wondering whether they could follow through with their plans and whether they had done the

right thing.

Using in early pregnancy. A crack user who let it be known that she was pregnant faced harsh criticism and pressure in the crack world. Before her growing belly was unmistakable, a woman could continue her usual drug activities without harassment as long as those around her did not know, but if she wanted to share the news of her pregnancy and enlist the support and congratulations of her partner, family, and acquaintances, these disclosures meant dealing with their criticism as well. The women in this sample who continued to smoke were constantly belittled and shamed for smoking while pregnant:

[My man and I] started out fighting and arguing. 'I don't want no crack head bitch,' and all this other stuff... [Women crack users told me] 'at least your baby is innocent, you know. Don't do that to your baby.'...Yeah, everybody gonna tell you what you shouldn't do...but still they giving me more dope.(014)

Once pregnant, women crack users lost autonomy. Few drug sellers would "serve" them. This pregnant crack smoker had to wait for her male partner to buy the drugs:

When he felt he wanted to smoke, too. Like if he don't feel like he want to smoke, he don't go. 'Cause he say he don't want me to smoke, either.(101)

If a drug seller knew a woman was pregnant, he (most were male) would refuse to sell to her, not wanting to be implicated in ostensibly harming her fetus. The women themselves agreed they might be doing wrong:

Even drug dealers won't sell to you. Matter of fact they like almost want to beat you up for doing it.(050)

I would try to hide my stomach because I knew that I was

doing wrong. Like when I would go to buy dope, because some of the guys do respect you enough, they respect your unborn child. You know, they're like, 'We ain't selling you nothing.' (097)

In early pregnancy there was no fetal movement or large belly to remind them of the pregnancy, and many women had difficulty changing their usual drug use activities. It was hard at times to adopt the social construction of the tiny fetus as a separate person. Women criticized themselves and expressed frustration as they struggled to avoid the compulsive, all-consuming ritual of smoking crack:

I don't know how to put it because it's in me, it's a part of me, but then like it's separate. What I do to me is affecting it...I'm thinking I'd rather not do it [smoke crack]. I'd do this to me before I'd do it to it. I can't explain it right, but it's not part--it's part of me but it's not. (023)

Getting high with the baby in your stomach...to me it's just not right...It goes out [of your mind] eventually, but...You know, since I went to the doctor and found out that I was really pregnant, it's really sticking with me...as far as, 'You're pregnant, you're pregnant... Happiness, sadness. You're pregnant. you're really going through it...it's a trip because I don't really catch myself until it's too late [to stop smoking crack]. It's like, 'Damn, what are you doing?' (014)

The hardest thing about this whole time in my life right now is when I be starting to remember that there's somebody else inside of me. And sometimes you can start [smoking crack] where you can't remember...That's the hardest thing. I get mad. (024)

This woman commented on the effect of television messages:

It's like I forget that I'm even pregnant...especially at this stage 'cause you can't even see anything...But in the back of my mind, it tells me every time I take that hit, it says, 'You know, you're-' You know what did this to me? That commercial, when the baby smokes. (019)

Thus, the first half of pregnancy was for many a time of guilt, frustration, indecision, loss of autonomy,

confrontation with the intensity of their crack habit, and struggle to remember and "respect" the baby-to-be. These experiences were threats to their former non-pregnant sense of self, as women were suddenly faced with their own and others' deeply-held prescriptions for pregnancy behavior, most of which they had already violated by the time they found themselves pregnant while smoking crack.

The Changing Reality of the Baby

Quickening. Feeling the baby move was a turning point for many women. The reality of pregnancy became tangible, and the separateness of the growing fetus became more and more apparent. As one said,

It becomes real constantly instead of just every time you go to the doctor. Plus it makes you realize, if you've had a child already... 'Whoa, I'm really going through with this, aren't I?' Because by the time you feel the baby move, it's too late to change your mind about anything. (104)

Women who had been considering abortion now found it much harder to face, and women who had postponed confirming the pregnancy or had not experienced early signs now had more evidence. Sometimes the evidence appeared for the first time while smoking crack:

It wasn't until one day I was sitting down and I felt this kick and I said, 'Uh uh. That is too familiar.'...I had [the pipe] up to my mouth and it was like, I just let go. It just fell. And everybody looked and I just walked out the room. (050)

Smoking crack became a different experience when the fetus moved because it meant a woman could not ignore that she was pregnant. There was a range of responses to the

sensation of movement while smoking. For this woman, the first movement ended her drug use:

I felt the baby kick, I put the crack pipe down...and left it and haven't been back to it since, 'cause I felt the baby kick. Like this baby is living inside of me and there is no way on God's earth I'm gonna feed it dope. (047)

Others continued to smoke but felt badly:

It moves every time when I use now. Right now, like I said, I used the other day and it just made me sick. The baby was kicking me in the stomach. (058)

For some women heavily involved in drugs, although they expressed commitment to a pregnancy, crack cocaine dulled both awareness of movement and a woman's caring about it, until afterward:

You block out everything and just-- all you're thinking about is dope. The baby moving, you don't care. House burn down, it does not matter. Dope is just all you're thinking about, dope. (085)

When you do get some, you be kind of leery about hitting it [smoking]. But that urge is so strong you gonna hit it anyway. Then you forget about the baby moving and stuff. And then after the fact, like when you go home at night...I be making it move...[to reassure myself] the baby's still there. (023)

This woman had birthed premature twins and was regretting her actions:

They would move. They would get to doing flips. I thought, 'Oh God!'...but after a second you go right back to doing what you're doing...The drug, it overpowered any feeling that I had...'You can kick 'til the cows come home. I'm doing what I want to do.' (094)

In another more benign interpretation of fetal movement, one woman said she used it as a sign to take a break and eat:

Baby might get up under my ribs and let me know he hungry. That means put the pipe down and get some food. (101)

The numbing effect of crack and the intensity of the desire for it were stiff competition for even the strongest pregnancy commitment among women deeply involved in drugs.

"Out to here:" Visibility of pregnancy. The more obviously pregnant a woman became, the more pressure she experienced from both the drug world and the conventional world to abstain from drugs, and the more moral condemnation she encountered. For the handful of women who subsisted or obtained drugs by prostitution, visible pregnancy was a major obstacle:

As long as you can't see it, it's cool. but if your belly is real big...and you're standing out there...then it's shameful.(024)

She smokes crack like this...I mean, she doesn't even [care], like she's WAY out here...And then she smokes crack constantly, constantly, and she doesn't even give a-- you know...I mean, I know, at least I feel guilty. I know I shouldn't be doing what I'm doing.(003)

Hypocrisy was common in the drug scene. A drug seller who knew a woman would buy from another dealer if he refused on moral grounds would often agree to sell her crack, saying that if she was going to do it anyway she might as well buy from him. One woman wisely observed that a person's moral convictions were not as strong as the desire for drugs:

You could go out and get your money and buy you all that shit if you want to, go smoke it, 'cause long as you smoking it with somebody they could care less if you're pregnant. But long as they have it to give to you, then they'll say, 'Oh, you're pregnant.'(068)

As pregnancy progressed, buying drugs became harder. Smoking crack with other people became harder. The stigma that came with knowingly pursuing an illicit activity that

could harm the unborn was painful to bear:

I'd make a little money, give out a few hits or whatever, and then I'd go outside...In the house they could always see. That's where I said to myself, 'God, my guilty conscience. I don't want them to see me smoking a piece of crack and I may be pregnant.' (047)

Yet, because they had been steeped in the same cultural messages warning against drug use in pregnancy, most women agreed they were doing wrong. At times women would tolerate or even appreciate others' efforts to limit their smoking:

It depended on who it was coming from and whether or not I felt that they really had my best interest at heart or not...I felt like I shouldn't be using and just not wanting to...have a stigma attached to me. And also...a little bit is one thing and a lot is another thing. (087)

At other times, the desire for a hit and for autonomy and self-determination was stronger:

I tell him he can't make me stop smoking...[that] just make me smoke more because...he have told me what to do. (101)

The insoluble tension between autonomy and responsibility, perhaps real to many pregnant women, was salient in crack users' pregnancy experiences. Although fetal movement made the baby-to-be seem a more separate being, pregnant crack smokers still perceived-- although it was difficult to explain-- that while carrying the fetus they remained autonomous individuals. The right to control one's own body and actions conflicted with the pregnant woman's socially-assigned responsibility to the fetus that was loudly voiced, albeit unevenly upheld, in the crack world.

As pregnancy continued, the impossibility of their position was more and more difficult to ignore. Pregnant

crack smokers were stigmatized by both their drug-using peers and the conventional world. Many could not avoid seeing, smelling, and being offered this powerful drug in their homes and neighborhoods. They were expected to remove themselves from the people and pursuits that had formerly structured their lives and direct themselves to the uncertain rewards of anticipated motherhood, a role that was very difficult to maintain in the crack world and not easy in the conventional world, either.

Most women had a few acquaintances who had grudgingly accepted their crack smoking, and with whom they were more or less at home. When they ventured outside the circle of drug users, however, they faced huge penalties for their actions. Prenatal care was the chief scene of these encounters in pregnancy and will be discussed in a separate section. Childbirth was the next, and inevitable, collision with the implications of their drug use.

Facing the Music: The Birth Encounter

The childbirth process was the one point in the pregnancy experience where all women felt they would have to engage with the conventional world. Fear of discovery of their drug use and loss of custody of the newborn was the major preoccupation of the women through the second half of their pregnancies.

Being revealed as a "crack mother" meant shame and guilt within their families, acquaintances, and service providers. This label was a blow to women's self-images as responsible

mothers and intelligent and moral women. The more unusual that label in a woman's social world, the more stigmatizing it became. In other words, a middle-class woman who had never known a crack-affected baby was more fearful of stigma among family and friends than were women whose sisters and neighbors had smoked crack in pregnancy.

More frightening than stigma, however, was the probable loss of custody of the newborn that would ensue. Again, the more real that threat in a woman's experience, the greater her fear of this loss. If she had lost other babies, the fear was most intense. Two said they would like to deliver at home or far from the city in hopes of escaping the drug testing and Child Protective Services (CPS) scrutiny they knew was their lot in an urban hospital. If a pregnant crack user had seen other women lose custody, she considered it a serious threat. Women who did not associate with other drug users socially or who had the support of middle-class resources expressed much less apprehension about losing their babies; their main concerns were potential fetal damage and stigmatization in their social groups.

Anticipating delivery. As time went along, women thought about preparing for the birth by seeking stable living situations and establishing prenatal care. Some women achieved these goals and others did not. The effect on time perception of using and pursuing crack, as described earlier, made the weeks and months speed by for women who were still using. There were long bureaucratic processes to obtain

public assistance and low-income housing, and when a woman was involved in smoking crack, these processes were difficult to follow through:

The time flew by. It flies by fast and...it's really weird because sometimes I'd have appointments and go, 'Oh, that stupid thing.'(058)

I would always say, 'I'm gonna stop and get myself together.'...But then at the end everything just hit the fan.(097)

I can't even explain my own actions as far as deep down, I haven't been ready for the baby, right?...And then I think about what I have to-- I have to slow down...I recognize it.(078)

The plan to abstain from drugs in order to be clean at delivery sometimes worked and at other times backfired. For several women, the due date was miscalculated or labor began prematurely, and they had not had time to stop using crack. For two others, the baby was late, and the frustration of waiting and abstaining for all those months combined with the discomforts of pregnancy became too much:

I was clean all the way up until the night she was supposed to be born. And she wasn't born, so I ended up messing up and I smoked a bunch that night. And then the next night she was born, so she tested positive for it.(031)

I tapered it all off. And then he was late. And I got all frustrated and I ended up using.(087)

In the hospital. As labor started, women reviewed how recently they had used drugs and faced again their fears of damage to the baby and loss of custody. These fears were layered on other concerns about delivery, such as fear of pain and the unknown, as well as excitement about seeing the

baby. For many crack users, however, health care providers were seen not as support sources but as potential adversaries with the power to grant or deny her the right to take her baby home. Thus, most women in this sample entered labor alone, usually without a male partner, and without anticipating the comforting presence of benevolent experts.

Even women who had been drug-free for many months feared delivering a damaged baby, because they knew that drug use early in pregnancy could affect fetal development:

I was, 'How many feet she have? How many hands?' So those worries were there. (097)

Women who had used crack recently were even more apprehensive:

I was scared that they were gonna say, 'Nope, you're not taking your baby home.' (098)

I took a hit...I got a horrible pain...Instantly I started to cry. Just the thought of maybe I'm going into labor...I got another pain and then I knew...I went and laid down in my bed trying to make it go away. 'Don't do this to me, God.' (041)

An even more frightening situation loomed when a woman was involved in criminal justice proceedings. Giving birth to a drug-affected baby was not a crime in their state, but some women believed otherwise. However, women already involved in the criminal justice system but released from jail into a parole-type diversion program could be returned to jail for delivering a cocaine-positive baby. This woman was not in a diversion program but believed these procedures could happen to anyone:

I used crack during that pregnancy, but I stopped. ...'Cause if it come up in your tests...your baby will get took....That's how they do it now...I seen this one lady...and I seen these people come in the door with green suits on and shirts from [penitentiary]...And then she say, 'What did I do?' 'Your baby tox screen came up positive for cocaine. We have a new law now. The baby get token and you go to jail.'...She started crying and they was reading her her rights and shit, and they rolled the whole bed out of there.(064)

Women's experience of losing custody stood out as the most painful in their lives:

It was horrible to lay there, and like I went through 18 hours labor, hard pain. And they say, 'Okay, it's a boy.' And I name him and they say, 'He can't stay in the room with you.' God!...That hurt.(019)

This woman whose baby had tested negative and had escaped loss of custody still felt insecure about being in the hospital:

I did have those worries because I remember even though they said I could go home...when 5:00 came...you know how they take baby pictures? I didn't want to do none of that shit...I said, 'We'll just take some pictures when we get home.' But I didn't want to stay no longer than I had to... and that's all I was afraid of.(097)

For most crack users, the hospital ordeal was a gauntlet to be run. Who they were and what they had done were subject to scrutiny and condemnation, while they worried about their infants and dealt with the physical and emotional aftermath of birth.

After the Baby

Women who took their babies home reported both happiness and letdown. There was joy at delivering a healthy baby and having custody. There were also lasting guilt and fear that some sign of harm due to drugs would still appear. Mothers

whose infants had withdrawal symptoms felt remorse when they saw the baby's shaking and stiffness they had been told was due to drugs. Any health problems, even colds, were feared to be evidence of drug-related damage. And the boredom and restriction of being in the house with a newborn grew on many women, especially those who had been employed:

I don't know if it's due to the depression you go through afterwards or what...I'm still unhappy and I'm going through some stuff. But I think what it is now is just plain old stress. I'm home every day and I need to be out. I'm pretty much used to being out and doing something constructive. (088)

Some women had custody of their infants but were under CPS surveillance. They were also in drug treatment programs as a condition of being allowed to take the babies home. They endured violations of privacy in CPS evaluations of their housekeeping and child care. They struggled to restructure a life that had formerly revolved around drugs and drug users into one that centered on child care and daily responsibilities. Treatment programs required daily attendance, self-examination, drug testing, and focus on setting new directions-- often into territory a heavy drug user had never explored, such as skills training and job interviews. For some, this was invigorating and exciting, and for others, it was a grueling ordeal to be endured for the sake of regaining or maintaining custody. There was constant fear of "relapse" into drug use and loss of custody in spite of all their efforts.

Women who had lost custody at delivery faced the same

expectations of reform were applied by the courts before reunification with the child, but without the constant incentive of having the baby at home. Loss, shame, guilt, and discouragement made it difficult to attend programs and follow the exacting stipulations for child visiting and court processes. They faced inconsistencies, red tape, and baffling "Catch-22" requirements, such as renting acceptable housing-- impossible to afford on public assistance except in drug-saturated projects and hotels-- without receiving child-related welfare aid until custody was regained.

Under these strains, it was hard to steer away from drugs. The people to whom the woman turned for support now held unacceptable temptations. Some fell back into using, while others did abstain while they struggled to find satisfaction with new acquaintances and their mothering roles in their new conventional lives. The women who were most successful in resisting drugs after giving birth were those who had held steady jobs, had non-drug-using friends, were having their first child or had raised previous children, had successfully stayed away from drugs in the past, and had come from reasonably stable family backgrounds. In other words, women who had little experience of failure and the personal, social, and economic resources for a modicum of success in conventional mothering were best prepared to accept the restrictive stipulations of the courts and manage the responsibilities that came with the mothering role.

The Basic Problem: Threats to Self in Pregnancy on Crack

The trajectory of pregnancy for these women who used crack cocaine entailed many experiences and concerns common to other pregnant women in the United States, but the nature of the pregnancy experience was altered to some degree by the psychoactive effects of crack and to a profound degree by the social unacceptability of their actions. Women who had used crack in pregnancy faced the basic problem of dramatic losses in three areas of their sense of self: self as individual, self as pregnant woman, and self as mother.

As individuals, they risked loss of autonomy and social acceptability. Although a woman might have already lost or willingly given up acceptability in the conventional world by becoming a crack user, she also lost acceptability in the drug world when she became pregnant. A woman's conception of the kind of person she was, such as a kind or thoughtful or nonviolent woman, was threatened when she believed she had risked the health of her unborn child. Drug users violated standards for ethical or likable or humane behavior simply by becoming pregnant.

Autonomy, already under siege for pregnant women in American culture, was further restricted when drug use was involved. A woman's chance to be the kind of pregnant woman she may have hoped to be-- perhaps devoted to the fetus, careful of its welfare, compliant with social rituals surrounding pregnancy, and excited about its birth, or simply

socially and economically stable by the time a pregnancy was conceived-- was threatened by the discovery of a pregnancy on crack. As crack smokers faced their socially-assigned duty to serve as a protective envelope-- to abstain from an ever-increasing variety of activities (according to current beliefs) in order to protect and produce an unblemished child-- they realized they had failed even before realizing the pregnancy. Most of these crack users agreed with social expectations of altruism and self-denial for pregnant women, as demonstrated by their earlier condemnation of other pregnant crack smokers. Thus, they risked failure to reach their own pregnancy goals.

In women's self-images as mothers, losing custody or birthing a damaged child was central and intolerable. Mothering was of high importance to many women in the sample, both for those who had older children and those carrying a pregnancy to term for the first time. To break the rules for mothering and fail to protect one's child from harm, or to lose the opportunity to nurture it, meant a permanent, stigmatizing scar on a mother's self-concept.

Guilt and fear were prominent in women's accounts of themselves as mothers, overshadowing positive emotions of motherhood such as love, excitement, and happy anticipation. Looking back, they expressed guilt, a marker of their awareness that they had violated mothering expectations (both social requirements and their own personal standards) and placed their babies at risk. Looking ahead, they spoke of

fear of loss of custody and worry that harm might be revealed at delivery or as the child grew up. Fear of continuing to use drugs was also common, as women described their vulnerability to the allure of crack. Threats to self as mother were the most salient in the many considerations of the trajectory of pregnancy on crack, because they involved the baby-to-be and a future relationship that could not be redone or repaired once harm had occurred.

Each part of the self-concept affected the others. For example, the self-as-individual was affected by decisions to take on a pregnant or mothering role, because a socially-acceptable individual would not embark on pregnancy unless prepared to meet its expectations. Thus, when a drug user discovered and continued a pregnancy, it meant taking on incompatible selves, each rooted in different social worlds and not supported in combination by any large-scale social structure or process.

As the path of pregnancy was quickly traveled by the women crack users, the risks to these important parts of themselves increased until all came to a climax at the point of childbirth. The outcomes of that climax in terms of self, pregnancy, and motherhood would be determined by the women's actions in pregnancy and their context. Pregnant crack users' actions cohered in a basic process of dealing with pregnancy on crack, the subject of the next chapter.

CHAPTER SIX

Findings II:

The Process of Salvaging Self

Although the treacherous course of pregnancy on crack brought discouragement, guilt, and fear to many women, none simply sat passively and waited for the end. Each described, sometimes directly and at other times in round-about stories, their intended means of confronting and dealing with the situation: a process of salvaging self. In this chapter, I outline this basic social-psychological process of pregnancy on crack.

Salvaging is defined as "the act of saving imperiled property from loss" (American Heritage Dictionary, 1982), and the word applies in this phenomenon because the women viewed many parts of their self-concepts as at grave risk. In salvaging, women pursued a broad range of actions in order to function in their worlds in accordance with how they viewed themselves. Sometimes this involved making big changes in order to reconnect with a self they had lost during periods of heavy drug use. At other times it involved sticking to current practices to confirm the validity of the current self in spite of criticism. Like the shipwreck image that "salvaging" brings to mind, pregnancy on crack was a frightening event that mandated action in a time-limited situation, sacrificing comfort and the status quo in order to reclaim what was left of something of greater importance.

Salvaging actions were aimed at reclaiming three parts

of self-image: individual, pregnant woman, and mother. Women's statements of salvaging self in these three areas reveal their goals within the pregnancy situation. The core strategies used in salvaging, described later in this chapter, were directed at these personal goals.

Salvaging Self as Individual

A woman's dissatisfaction with her view of herself as a person was often brought to light in the context of pregnancy. Although her intentions to improve herself as a person were woven into her actions in the pregnancy and mothering arenas, sometimes a woman's plans were directly related to bettering herself. Often these plans had to do with changing or controlling her drug use, or maintaining herself in spite of drugs:

You don't have a life when you're using. You're just surviving and you're not living. And I'm tired of surviving. I want to live...I want to start that over again...Tired of having no money, tired of being embarrassing. Tired of my life, tired of the way I look. Ready to have something better in life...I want to be somebody, I want to be a part of this human race all over again.(012)

I'm tired of doing what people want me to do...I want to live. So much of my life has just been wasted on drugs and on low self-esteem. I'm sorry I had to pay the cost...to learn that, hey, I am a person, I am somebody. And now, it's like, yeah, I count.(063)

For the women above, pregnancy was the impetus to stop using crack and leave the whole drug lifestyle, rather than just stop during pregnancy for the baby's sake. In some cases, on the other hand, pregnancy or mothering was a threat to a woman's sense of self:

I'm not having no more babies. Two years from now, this baby'll be two. I can see myself doing something really productive instead of just, you know...It's always either I've gotten pregnant or went back on a mission [for drugs.] I wanna do something. I don't want to be stuck on the [crack] pipe for the rest of my life and I don't want to be like this [pregnant] every year for the rest of my life, you know? (045)

When pregnancy or mothering threatened a woman's individual selfhood, abortion was an act of salvaging self. This woman had an abortion in high school:

I made all the arrangements for the abortion 'cause there was no way that I was not gonna graduate from high school...That's just not part of my life.(087)

This woman was older and had other children. She had an abortion the week before the interview:

It was the hardest decision I've ever made in my whole life...I thought,...'You can do it. you can take care of him. You can.' And I would say, 'No I can't. I can't. I have to abort it. I want to go back to school. There's so many things I want to do in my life.'(015)

This woman described a past birth when she relinquished a month-old child to her aunt, in order to regain her selfhood, which she felt would have been trapped by mothering:

I wasn't ready for this child...I gave him to my aunt...I breastfed him for like three, four weeks and I said, 'Okay, y'all come and get him now. Give him some formula. He should be held.' I was not ready to have another little baby around me...I was just getting back to where I could kinda be free.(081)

Thus, the context of pregnancy provided the chance to rethink one's direction in life and take steps to protect things of value. The actual choices varied greatly, but the motive, salvaging self, was the same across these decisions.

Salvaging Self as Pregnant Woman

The participants in this study had definite ideas of how

they wanted to be as pregnant women, and harming their fetuses by drug use was not part of that picture. Although all had used drugs early in pregnancy, many felt they could regain at least part of what they viewed as important in their self-images as pregnant, which would involve using drugs less, more carefully, or not at all. The opportunity to "do" pregnancy correctly could perhaps make up for failures in the past:

I wanted a baby...I did drugs with my daughter and I did them completely, the whole time. And I felt like I was extremely lucky to have a healthy child...and I said to myself, 'If I ever do this again, I'm not gonna use drugs because I might not be lucky the next time.'(102)

I just said, 'I can't do it any more because I refuse to have another one of my child be born addicted. 'Cause maybe this time God is not gonna grant me the satisfaction to say, 'Oh, yeah, my baby's healthy.'(012)

Even if the pregnancy had started out badly, this woman believed there was still time to save it:

It's never too late to stop. I mean, like I'm seven months and I'm still trying to stop. But a woman who uses excessively every day crack cocaine...they're two or three months pregnant and, 'Well, fuck it! The baby's already fucked up. I might as well continue to smoke.' Uh huh! That's not true...You CAN turn it around. It's never too late to have a healthy baby.(045)

Salvaging self as pregnant woman sometimes involved denying one's self as an individual, sacrificing autonomy and self-gratification for the pregnancy's sake:

I'm realizing I have a very, very bad weakness for this stuff [crack]...I have to be really rationally hard on myself now, because...I have a life living inside me who has no choice, no say in what I am doing...I know there's gonna be effects already...I'll deal with that when the time comes. But right now I'm dealing with how healthy an infant, how healthy of a child he can be...I've got about three more months to go...The three

months of advantages is gonna kind of outweigh the disadvantages. (051)

Now I want to not use any more, because I think that if any damage has been done, I feel in my heart-- now, this may not be true, but this is just my thinking-- that if any damage has been done, it may be able to be corrected before I have it. (023)

The study did include several women who had not found a way to salvage their pregnant self during pregnancy. Their focus instead was on maintaining an autonomous individual self or, more commonly, avoiding confrontation with the issue until they could think of a way to take action. One woman was asked, "How do you feel about being pregnant again?" she answered,

I don't know. Sometimes I just-- I don't know. I try not to think about it. (011)

Another who had delivered preterm twins looked back at her drug use and concluded that she had ignored her better judgment because she had wanted to be stopped by the system and salvaged by outside forces. Her comments reflect the conflict between an autonomous self-as-individual and a more altruistic self-as-pregnant-woman:

Only reason I can see I didn't take the pills [home remedy to remove crack from the baby's system] was because I wanted something like this to slow me down, 'cause as long as I was a big-headed person, 'Ain't nothing gonna happen to me. I can smoke as long as I want to smoke and do what I want to do.'...Having my twins to come out like this really changed me. (094)

When a woman felt unable to conduct a pregnancy as she thought it should be done and felt unable to reduce her drug use, routes to managing the internal conflict included having an abortion or using drugs to not think about it, to salvage

the hope that a way to reconcile the situation would emerge in the future. Salvaging self as pregnant woman involved reaffirming the actions a woman felt were in concert with her beliefs and values for pregnancy.

Salvaging Self as Mother

The most powerful and universal type of salvaging for the women in this study was protecting the self who was a decent, good mother. The two greatest threats in pregnancy on crack were related to the mother role: threat of giving birth to a damaged baby, and threat of losing custody. Thus, much of the women's concern was directed at self-as-mother, as they sought ways to preserve or regain a mother self-image they could accept.

Some women, interviewed after they had lost custody or given birth to a preterm infant, were trying to rectify an already-damaged mother self-image. Others, still pregnant or having delivered a healthy baby, were looking ahead with guilt and fear to the kind of mother they wanted to be with this child. Some women who had other children and felt they had not mothered them well were seeking to reclaim or improve or protect their selves as mothers. Each new child brought change to one's mother status, and for the women who participated in this study each child represented another risk and another chance.

This woman was looking forward to her first baby. She had not used drugs for several months and was not worried about losing custody, but her early drug use was still a

concern:

I'm ready to be a mom. I just want the baby to come out healthy in a hurry, 'cause I still...feel like the baby, I did a little damage or something...I tell God, '...Give me a hell of a labor, but give me a healthy baby.' (047)

This woman was expecting her second child, and she was concerned about loss of custody. She hoped to avoid the CPS investigation she had endured with the first baby, a process that had cost her the respect of her family:

I said in my mind that it's gonna be a clean and sober baby, that I will have him and be able to bring him home without the, pardon my French, the fucking CPS involved in it...They're really, they're in your business...They call you. They want to come to the house all the time. They want to come check on him...And it's just wasted energy when you could be doing something else positive. (058)

Another woman hoped that taking on a self-image as mother would change her drug use:

It was like, 'I want a baby now. Maybe that'll change my life.'...That I would stop using drugs...because it's a responsibility, and I have this thing about getting high around babies. You know, I just never did that 'cause I respect little kids and I don't think it's fair that a little kid should have to be growing up in that type of environment. (092)

Sometimes a woman had to relinquish her self-image as a mother in order to be able to regain it in the future. This woman's family refused to take custody of her second child when it was removed from the mother, because they knew that without the barriers to seeing the baby found in the foster care system, the woman would have little incentive to stop using drugs:

It was really sad for me...My family wasn't going to take her because they feel that...if they take her I'll

never get help, which was true...But then I'm happy because it's like my life is so much better in just that short period of time...So, if I get my daughters back [I'll] just pretty much try to have a family.(097)

Loss of custody could be a strong impetus to reduce drug use, as for this woman who had lost other children and now was pregnant again:

If they hadn't of took my kids, I probably still be using, but just not as I been doing...But I probably would still be doing it. So, that's why I say it is a learning. He did it for a reason, you know, the Lord did it for a reason. To make me really look at the things I'm doing before it really gets bad.(001)

Retaining or regaining custody was foremost on many women's minds:

If I ever lost my children...to me that would be the worst thing that could ever happen to me. And I never wanted to appear to be a bad mother, ever, I mean even to myself, regardless of what anybody else thought...I take very good care of my children...I could not even fathom having my kids taken away from me, and that is what convinced me that I could not have a child that was born addicted to cocaine.(102)

This woman was HIV-positive, homeless, and pregnant. She had decided to continue the pregnancy when advised that there was a good chance the baby would not be infected with HIV, and the pregnancy had become a stimulus for reclaiming her remaining years. Mothering was her most important goal for her remaining years:

When I get around my son I try to be like a mother supposed to, but I really haven't got a chance to really be a mother to my son because we don't have a place, and I just be praying to God that I get my own place where I can be with my son and be a mother to him where he can have some good memories of me. Because he [will] outlive me.(017)

Salvaging self as mother was interwoven with efforts to

salvage self as pregnant and self as individual. Sometimes one goal of salvaging aided another, as when stopping crack use while pregnant also advanced one's goals as an individual and a mother. At other times they were in conflict, such as when being pregnant or stopping drug use conflicted with goals for autonomy and other forms of self-fulfillment. Each woman described some form of agency in her situation, if only making the best of what life had dealt, and many women's stories included huge efforts and major life changes as a result of the current pregnancy experience and its outcomes.

The Salvaging Process: Making Meaning and Evading Harm

Salvaging was approached in a two-phase process. These two steps were interactive and cyclic, in that they could repeat over and over during a pregnancy and afterward, and each part of the process affected the other. Salvaging self involved an assessment phase, making meaning, in which the woman gauged her situation and its meanings to her, and an action phase, evading harm, in which the woman used strategies of harm reduction and stigma management to move toward her salvaging goals.

A variety of situational factors affected the type of actions available to a pregnant crack user and the relative success of her attempts. These are represented in Figure 3. Many of the contextual factors were described in Chapter Five in relation to the trajectory of pregnancy on crack. Her life context was constitutive of a woman's options in the salvaging process and had great influence on her success. For

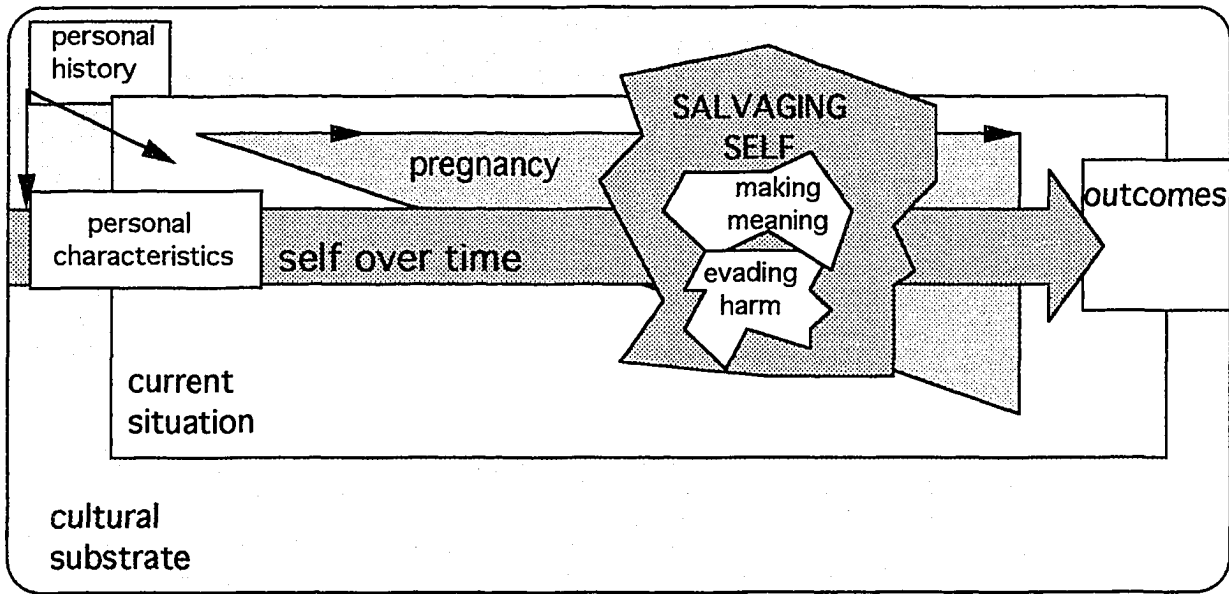


Figure 3. Salvaging Self: Process and Influences

Elements of Diagram:

<u>Cultural Substrate</u>			
social history of US	politics	economy	
gender and racial issues	mass media and popular culture		
<u>Current Situation</u>			
significant others	children	social roles	living arrangements
financial situation	drug scene	current drug use patterns	
<u>Personal History</u>		<u>Pregnancy Over Time</u>	
family background		trajectory from discovery	
growing up		to delivery, including:	
socioeconomic roots		acknowledging pregnancy	
racial experiences		changing reality of the baby	
schooling, training		facing the birth	
intro. to drugs			
values, beliefs of origins		<u>Salvaging Self</u>	
		Making Meaning:	
		value, hope, and risk	
<u>Personal Characteristics</u>		Evading Harm:	
beliefs, attitudes		harm reduction	
knowledge, skills		stigma management	
personality			
age, health			
<u>Outcomes</u>			
self as individual	self as pregnant woman	self as mother	

example, if she lived in poverty with three other children, no job skills, and a possessive and abusive partner, the resources and strategies available to her for salvaging self were different than if she had a job, savings, a supportive mate, and evidence of other successes in her experience. Yet even women with no apparent history of independent breakthroughs in their life stories found pregnancy a time to aim for greater things. Social and cultural messages about pregnancy, mothering, and personal autonomy reached even women who had seen little achievement in their lives. Pregnancy was a time to reclaim what conventional social wisdom promised: another chance.

Making Meaning

Each woman used a different constellation of strategies to salvage self in pregnancy. The particular efforts that made sense and were within reach of an individual were determined by her definition of the situation, as described by symbolic interactionists (please see Chapter Two). Three elements of that definition had special import. These were: the value of the pregnancy and the changes being considered in that unique situation and time, the hope or likelihood of making the changes or succeeding at the salvaging, and the type and degree of risk posed by taking action or letting things continue as they were. These three factors were weighed as women took action to deal with their pregnancies.

Value. The worth of the pregnancy and the baby-to-be was a factor in women's salvaging actions. While each pregnancy

was important, the present pregnancy had relative value in comparison to other pregnancy opportunities. If a woman felt she had little chance of ever becoming pregnant again, the present pregnancy was regarded as more valuable than if she believed she could have a baby at any time in her future. As a pregnancy progressed, it increased in relative value, as the fetus became more "real" and motherhood moved closer. When the two women who carried twins were told about the multiple gestations, they both felt that a twin pregnancy had more value than a singleton. When a woman felt that her current pregnancy was her final opportunity to be the kind of mother she wanted to be, it had more value than if she felt confident that she was in good standing and had plenty of time to realize her mothering goals. The pregnancy had value simply as entailing the creation of another being:

[Smoking crack] make me sad, too, afterwards, real depressed...I'll be thinking about I'm giving the baby dope...And it's like, 'Why?' I know it's a life.(019)

In a valued pregnancy, drug-related effects attributed to the fetus brought remorse:

The babies were withdrawing. They were kicking off this stuff. I said, 'I'm never gonna do this to them again.' So I cleaned up.(081)

I don't know how nobody gonna smoke when they pregnant, I mean, babies go wild...I'm serious! It go wild...like trying to come out...Like it was trying to escape this shit...Like when they say a baby can feel that shit, I don't understand how nobody can do that shit to their baby.(013)

Women who viewed the fetus as helpless and dependent on them felt pressed to act in the fetus's behalf:

Like last month I blew all my money [on drugs]. [Then] I had my old man go get a hamburger. I had to eat it...I cannot see knowing you have a weakness and sitting up there smoking and knowing you have a life in you, too, at the same time and not feeding your child...I don't care if I throw up...because as long as I got some food in him...I feel a little bit better about what I'm doing...because this is my child's life. (051)

Women who had abortions and the woman who gave her baby to her aunt valued the potential for a child but did not believe that the specific pregnancy was irreplaceable or critically important in the face of other considerations. Women who looked to the specific pregnancy as a chance to change their lives placed high value on the pregnancy.

As the baby became more tangible, often the value increased:

Before then it was like, 'No, I'm not really pregnant.'...I guess it was like I'm in denial or for fear that I might lose it I don't want to be too attached or something. And like now, if I lost this baby, I don't know what I would do...I want it too bad. (023)

Finally, as an example on the extreme of the range of valuing, the woman with HIV infection placed very high value on her pregnancy as her last chance for motherhood. The value of a pregnancy, and specifically a healthy baby that she could take home, influenced the strategies a women used to salvage her selfhood in the situation.

Hope. Pregnant crack users' hope of successfully achieving change influenced their actions in pregnancy. The woman with HIV mentioned above had considered abortion until a health care provider told her she could maintain her health

during pregnancy and had a good chance of having a healthy baby. Women judged their hope of carrying the fetus to term, of avoiding drugs, of maintaining custody, and of being the kind of mother they wanted to be:

I pray I'll make it. If I make it the next two months, then-- which she said usually if you miscarry you do it within the five to fourth month...If I make it through them, everything's gonna be all right. And I kind of think when the baby really start moving that that'll make me like really not even consider trying to go get high at all. (018)

Oh, I'm gonna keep this one. I'm fit to be clean until I have it...Last hit and I threw pipes and all out, so, I know I ain't going to buy none...I plan to bring this one home with me. (066)

I want to just have a baby to be healthy...That's what worrying me right now. Once, after that, I can deal with anything. I've learned how to deal with it. (070)

It's important to know that the whole saying about 'Once an addict. always an addict,' that only holds true if that's the life you want to lead. If it's not, there is hope. (088)

Some women saw little hope of change. Others decided to rise above the negative warnings they received. This woman described a time when she was unable to change:

It's a lot of women that have used while they were pregnant and they just couldn't do nothing else about it...Like me, I was stuck on using. (081)

They're like, 'Fuck it, I might as well smoke the next six months if I already screwed him up...And that's how they think. Because I thought like that before...When you read it about any drug, they always tell you the first three months and that's when the baby's developing its brain...They take away hope that your baby can come out any other kind of way but fucked up, if you didn't take care of yourself the first three months. (086)

For a few, drug treatment programs promised hope:

I've just been recommended to them, but no one really

told me how they operate and stuff. But I hope they have a good support group where if I wanted to use I could run up there. Instead of going to get the drug, I'd run up there first.(023)

I'm going in [residential treatment], simple as that... I'm going 'cause I'm pregnant...I'm only seven weeks, so I'll be there probably through my whole pregnancy. By the time I get out of there, I should be stable enough to know better...I need to be away. I need to be somewhere peaceful so that I have more time to get to know myself and as far as the growing of my child.(014)

Women's hope for change was a product of their past experiences, their information sources, their judgments about obstacles in their environments, and the resources they saw as available to assist them in their efforts. Hope could change over the course of a pregnancy and from one pregnancy to the next, depending on the life situation in which a pregnant crack user found herself.

Risk. The third element of women's definitions of their situations was the risk entailed in continuing to use drugs while pregnant. Two major risks to self-as-mother were of concern: Fetal damage and loss of custody. Women had differing appraisals of the actual harm crack could cause to the fetus:

It's really scary. I feel, I don't know how every woman feels but as far as I'm concerned I feel like, you know, one day I be just smoking crack or something and my baby's heart stopping, or, you know, it's like, it scares me.(014)

I guessed that something was gonna be wrong. I mean, you're taking a chance. But I guess I just got one of them old lucky breaks...Anything could have been wrong with him. Anything.(085)

I had heard about the fact that it's more harmful to do drugs in the beginning...because that's where development takes place. So I was really concerned that

he might have something wrong with him, some deformity.(102)

There are users and there are abusers, and not that I've gotten away with using drugs during pregnancies, [but] it's, I think it's a matter of how you take care of yourself. You know, the amount of drugs probably has more to do with it.(041)

My sister used to show me this video all the time about drug babies, crack babies...Have you ever got drunk? Can you imagine a little baby inside of you with the same feeling you're feeling?...When you smoke that dope, the baby rotates, and it's like spinning around inside of you. you start contracting.(096)

It seem like if I-- this is what it seem like to me-- it seem like...some babies come out, there's something wrong with them if you use a little drugs all the time, to me. But...if you get pregnant, you take and you use your little drugs every now and then but not through the whole thing, it's okay to me. It's okay to use drugs, but in that last month you better stop or you ain't gonna bring your baby home.(064)

Them babies be wanting them hits.(066)

Even for women who were not overly concerned about fetal damage, loss of custody could be a serious risk:

I said, 'Oh yeah, I smoke pot. But there's nothing wrong with that.' And she, the lady, the nurse or whatever strongly enforced into me that if I had this child with marijuana in my system they were going to take that baby....'Oh, it only takes three days to get crack out of your system, where it takes a month to get the marijuana out.' So, I just...smoked the rock.(041)

There was like one friend, she did it through her pregnancy and nothing happened. And her kid wasn't taken. But she didn't do it eighth or ninth month.(050)

Some women perceived a difference in policy among institutions:

There was one girl I knew in Oakland who had six crack babies, and it's like but Oakland is not San Francisco. They don't care. You can just bring the babies home.(085)

The risk of losing custody was most real for women who had lost custody of other babies. This type of risk was the most frightening to all mothers, even more than the risk of fetal harm due to crack. If the baby was born with a problem, women felt they would be discredited as mothers but could or would deal with the consequences, but not to be able to mother the child at all was a threat to their motherhood that was unbearable to many.

Evading Harm

Once she had established a definition of her situation, the strategies used by pregnant crack users to manage threats to self as individual, pregnant woman, and mother were directed at evading harm. Harm to self as individual could include loss of autonomy or change in life course. Harm to self as pregnant woman included shame, remorse, prenatal health consequences, or rejection by social groups. Harm to self as mother could include loss of custody, which harmed the mother-child relationship and the child itself, or fetal damage, which would be a blow to a woman's image of good mothering as well as injurious to the child. Strategies for evading harm fell into two categories: harm reduction and stigma management.

Harm reduction. Harm reduction was directed at minimizing risk to the fetus and to the future mother-child relationship. Strategies were based on an individual's beliefs about the mechanisms and seriousness of fetal damage, the duration of drug metabolites in her body, the procedures

for drug screening in local health care agencies, and the likelihood of loss of custody in her situation.

1. Using less crack. The most common strategy, one that addressed both fetal damage and loss of custody, was to change or reduce drug use. Each woman spoke of this plan in one way or another, and about half had stopped or dramatically reduced their drug use at the time of interview. For some, this started even before confirmation of pregnancy:

I didn't smoke as much...I would want to take a hit, but I wouldn't take as much because I'm thinking, 'I don't know here.' (047)

I was staying away from coke. Because I had the doubt in my mind that I might be and I didn't want to take any chances...I was like slowing down; I wouldn't get high as often and I was just like slacking back...I 'd say, 'I don't know if I might be pregnant.' (050)

Confirmation of pregnancy was an impetus to begin reducing drug use:

Getting high with your baby in your stomach...To me it's just not right. It doesn't feel right...And that's putting worry on me, so I know I should, I better stop soon... You know, since I went to the doctor and found out that I was really pregnant, it's really been sticking with me. I mean, since it's been confirmed and I got my vitamins and all that. (014)

Some women were managing to abstain from crack, while others were still struggling to do so:

At one point I was like doing it every day. And then I just stopped like every other day, and now...Yesterday I messed up. (050)

I kept on saying, 'I have to stop. I have to stop.' And I remember once I would go like for these periods... around 11 or 12 days [without crack]. Then I'd get some more money and [buy drugs]...I think 15 days that one time was the most. (097)

Women applied a variety of tactics to smoke less crack. They stayed away from smokers and the locations where crack was sold, focused on the pregnancy and applied will-power while others smoked, kept busy, and entered drug treatment programs:

[When] I continue to do it, I'm like, 'Damn,' and I feel real depressed. That's why I been getting out of the house now more often...I leave, I go shopping, I do something to occupy my time. Eventually I feel I'll get it out of my system.(014)

People would come by and some would...sit there for a while and I'd go into another room and...I said, 'Just go ahead [and smoke crack], you know, I'm fine.' I'd go into another room and...I'd be like, 'Oh, no, I can't go back in the room.'(050)

I keep myself busy...or another thing I do is I give the money to him [partner].(058)

When I came home [from the hospital], I went and signed up. I liked it...It's just counseling....[when I want to use] I just go to a meeting or something, or I'll call my mother.(085)

I know I cannot mess with anything, well, from when I go next week to the [drug treatment program], I'm gonna do my best not to mess with anything until I deliver this baby.(023)

Drug treatment was useful to some women and not helpful to others. The most common view of treatment was that it only helped if a woman had made an internal commitment to stop using crack. If treatment were pressed on a woman who was not ready to stop using, it was bound to fail. If a woman was committed to abstinence, treatment could provide support. Women also viewed attending drug treatment as an indication to custody agents that the woman was trying to better herself:

The meetings just got redundant...But I just figured out, if you want to quit crack, if you want to quit anything, it's just in your mind. You just have to want to quit...Not have somebody...come and tell you, 'Hey, it's not good for you. Don't do it.' That's shit...[But] As long as I'm in a program, as long as I keep on trying, as long as I'm in something, they don't care if you're still using as long as you're in a program, which I don't understand that.(058)

2. Maximizing pregnancy well-being. Another important strategy to reduce the harm of crack to the fetus was to make up for the tolls of drug use by eating well, taking vitamins, and using folk remedies to remove drugs from the body:

I was like into like trying to drink a lot of milk and healthy foods and eat fruits...I would try to eat a balanced meal. I used crack but crack wasn't my whole world.(097)

Right now, the best thing that I think that I can do is get all the food and nutrition that I could get, because the baby receives everything that I eat and if I only eat crack, man, it's gonna only eat crack.(024)

Yeah, I take my vitamins, and I eat a lot of vegetables, I mean a LOT of vegetables, and I drink lots of milk and I take a calcium pill, and iron pill, and a prenatal pill. Plus I take antibiotics because the doctor prescribed it...because it cleans your system.(070)

I take vitamins. And then. like I say, I eat and I sleep. That helps a lot, too. Even, like say even if I indulge [in crack], I like to eat like the healthy foods...I kind of like to eat things that will make the baby strong-- juices. What the drugs take out I try to kind of like put back in.(078)

3. Reducing stress. Avoiding conflict and worry was mentioned by several women:

Instead of steady kicking yourself in the ass about [using crack]...The more I be down on myself, it definitely ain't-- it's definitely not good for the baby.(078)

I can fight pretty good...That's another thing I have to stop. I be arguing with a lot of people nowadays and I forget I'm pregnant. And I will fight anybody at any

given time, and that's bad.(014)

4. Abstaining to avoid detection. Preventing loss of custody, or reducing harm to the mother-child bond, entailed other related strategies. As in preventing fetal damage, abstaining from crack, especially at the end of pregnancy, was the most common plan, although it was difficult to predict the delivery date:

I did stop, but...she didn't come on time...I thought I had two more weeks.(041)

First it was just, 'Don't do it as often,' or 'don't do it after a certain point. 'Then it became, 'Okay. well, I can do it up to my ninth month...Okay, well, it takes eight days to get out of my system, so it may take 12 days to get out of her system. So I'll just make sure I don't do drugs for 12 days before she's born.'(102)

5. Using home remedies to clear the system. Using folk recipes to remove drugs from the body reduced the risk of losing custody due to a positive toxicology screen:

I been drinking a lot of pickle juice and eating a lot of pickles. 'Cause that cleans your system out...Yeah, I been drinking vinegar too...I'm gonna make sure there ain't nothing in my system with this one.(066)

[I was] drinking lots of juices, cranberry juice, 'cause I was so strung out [using heavily] I didn't want shit to show up on the system.(099)

I was taking these pills, okay, that somebody had introduced me to...You can take Golden Seals...and you can take niacins...I know I could take these pills right here and it's gonna clear my system. So I don't have to worry about this. They're not gonna do nothing about my kids 'cause they're not gonna catch it in my kids' system.(094)

6. Taking visible steps to prepare. Completing pregnancy-related responsibilities such as finding or improving housing were other strategies that improved a

woman's chances of maintaining custody of the newborn. This "taking care of business" became a priority as pregnancy progressed, so that if a social service worker evaluated the mother's preparation to care for her infant, the setting for child-rearing would be judged adequate.

7. Obtaining or avoiding prenatal care. The role of use or avoidance of prenatal care as a harm reduction strategy is central and will be discussed in the next chapter. In brief, women's participation in prenatal care was based on their judgment about care providers' role in harm reduction. When care providers were viewed as threatening, women stayed away and were left to their own devices to monitor their pregnancies and figure out how to reduce harm. When health care was seen as an asset in reducing risk of fetal damage or loss of custody, women were more likely to obtain prenatal care.

Stigma management. Stigma management, the second kind of evading harm, was directed at reducing social rejection, shaming, derision, and manipulation. Stigma was encountered in the conventional world of prenatal care and non-drug-using family and friends, and also in the crack world, where male partners, drug sellers, women friends, and others freely criticized women who were pregnant and continued to smoke crack. Critics rarely acknowledged the addictive nature of the drug or its ubiquity in poor neighborhoods but placed all blame for fetal risk on the mother-to-be.

1. Smoking less. To escape the pain of being stigmatized, pregnant crack users used a number of strategies. Using less crack was desirable on all accounts, and this was the effort most often made. Because obtaining drugs was difficult and shameful, women who otherwise would not have reduced their drug use ended up using less crack. One woman intentionally used the stigmatization of the drug world to help her use less crack:

I done told everybody I was pregnant just so some people could come up to me and say, 'Well, I'm not supposed to give you no crack.' That helps me.(068)

2. Evading or deceiving critics. When they were continuing to use crack, women applied evasion tactics, such as hiding drug use, avoiding critics in the drug world, avoiding the health care settings where they had encountered lectures and scolding, staying away from groups of people who were openly derisive, and buying drugs from dealers who were not openly scornful. Women who did not have a dealer who would sell to them sometimes told drug sellers they were buying for someone else or prevailed on someone to buy the drugs for them, often for a payment of part of the purchase.

I'd lie. No, I'd say it wasn't for me, it was for another person out of town or something.(019)

I would go to her house and buy it, tell her it was for my cousin, and come home.(085)

People wouldn't sell it to me. So, I have to give my money to other people to go buy it for me [and they come back with less]. Yeah, you know they be pinching.(102)

As noted in the description of the trajectory of

pregnancy on crack, hiding the pregnancy in the drug world was a way of evading stigma:

I really only carried it in my stomach. And plus using crack you lose weight. And I've always been big, big-boned...and a lot of people didn't even know...Plus I wear a lot of big stuff. (085)

3. Keeping up appearances. Maintaining a neat, well-dressed appearance was another strategy for "passing" or avoiding detection as a drug user in conventional settings:

I also keep up a certain appearance...I never wanted to have an appearance that looked like a drug addict...So any time I've ever done it, no one has ever known about it. And I've [only] done it in my own home. (102)

4. Acting like a mother. In another form of stigma management, women sought to improve their mothering image both to themselves and others by cultivating maternal feelings and focusing on the coming baby:

I think I can make a difference for me myself and for my child and for a lot of people. I been a role model for so long in my life, why stop now when I got my own kid to be a role model for?...I have enough to be explaining...[I don't want to have to explain to my baby], 'You don't get no tennis shoes 'cause I smoked up your [welfare] check.' (047)

My mother feels like because I was on that crack stuff, she feels like I guess I'm not responsible enough to take care of a baby. But I think I am. I think when the baby comes, I mean even though I'm not showing too much responsibility right now by smoking that stuff, you know, I'm not gonna lie about anything that I did 'cause I know when I was wrong. (003)

5. Taking an assertive stand. To deal with stigmatization in interpersonal encounters, some women drew attention to other more acceptable aspects of themselves, such as their truthfulness, good intentions, or simply their humanity. One woman spoke out in her own defense in a health

care setting:

I said, 'You know what? Yeah, I was a drug addict. I'm still a recovering addict. But I'm a human being before I'm anything else.' And that really like took her [by surprise], and she says 'You know what? I apologize.'
(086)

Evading the harm of stigmatization was as time-consuming and important in salvaging self as reducing risk of custody loss or fetal damage. No woman could evade stigma completely, however, because each had internalized the social norms that made crack use in pregnancy a taboo. All acknowledged that even if they had reduced the risk to the fetus, they knew they were doing wrong.

Stigma management and harm reduction were sometimes in opposition, such as when a woman avoided prenatal care to evade disrespectful treatment and thus increased her risk of loss of custody. Many conflicts were especially acute in prenatal care settings, as will be described in the next chapter.

For women who had the support and conviction to stop using crack, evading harm was comparatively simple. For women who continued to use crack, complex combinations of strategies were required. These were often accompanied by guilt about past actions and fear of future losses, feelings that sometimes fueled renewed efforts to reduce the use of crack. The more a woman smoked, the less time she was aware of these feelings, however, and the less time she could apply to evading harm.

Summary

In a process of salvaging self, pregnant crack users weighed the meaning of their situations and took actions to evade harm to themselves, their fetuses who were part of themselves, and their futures as mothers, which entailed the well-being and custody of their babies. Their definitions of the value, hope, and risk entailed in smoking crack while pregnant directed the strategies they used to address the situation. Although women described many obstacles to reaching their goals for themselves, each had developed some form of agency in her situation rather than acting as a pawn of circumstance. The salvaging process was deliberate, often altruistic, and enacted out of caring and concern for the baby-to-be and the opportunity to give the future child the kind of mothering it deserved.

In the final chapter of findings, I will present women's descriptions of their efforts in an arena where the salvaging process was most important and most difficult: prenatal care. This discussion will illustrate the many incompatible expectations facing pregnant crack users, and the care and creativity with which they navigated this uncharted social territory.

CHAPTER SEVEN

Findings III:

Damned If You Do, Damned If You Don't:

Salvaging Self in Prenatal Care

Of all the instances of salvaging in pregnant crack users' accounts, the most complex and significant were interactions that occurred in the context of prenatal care. In this arena, women perceived and dealt with a level of risk that in some cases outweighed the advantages available to them in the health care system. The salvaging process, with its three goals of salvaging self as individual, pregnant woman, and mother, was applied in prenatal care settings in the two-part process of making meaning and evading harm. In this chapter I provide examples of variations in each phase as they occurred in prenatal care.

Making Meaning

Pregnant crack users judged the value, hope, and risk of degrees of participation in prenatal care at a given point in time. These judgments were heavily influenced by personal history, including past experiences with health care, and past pregnancy experiences that contributed to current attitudes about doctors, nurses, and hospitals. Information from significant others, particularly other women who had had children, also was important in women's assessments. The availability of care that met their felt needs was considered, as were the relative advantages of obtaining care versus avoiding the health care system. Timing in pregnancy,

wantedness of pregnancy, views of the pregnancy as proceeding normally or abnormally, and degrees of confidence in self-monitoring of pregnancy health also influenced the meaning-making process.

Value. The value of the pregnancy, of the potential assistance of health professionals, and of the act of participation in prenatal care were weighed for themselves and in light of a woman's drug use. Drug use increased the importance of health care for some women because they looked to care providers to detect and treat drug-related fetal effects:

They just checked everything thoroughly. They knew that I was on drugs, and when they did the sonogram, they did an extra-- my sister said, we always compared what happened when she went and I went-- I said, 'They looked at the brain, the thighs.' And she goes, 'Well, they didn't do all that to my baby.'...They was just basically extra-cautious.(047)

I saw the sonogram where I could see the head and the liver is formed, the lungs are there. And that secured me much more and it made me feel like, 'Oh,' [sighs] especially after knowing this girl that was pregnant. She was on crack. She lost her baby. It had no lungs.(070)

This woman was critical of herself as she reflected on the way she valued prenatal care as "license" to use cocaine:

I made sure I got to prenatal care because that was my way of being able to continue to get high...Yeah, that everything was going along okay and that I wasn't doing anything to harm the baby...'Cause I had every test imaginable done...When I got the results back from the amniocentesis, that made me feel even better, and that was just another reason for me to go ahead and get high some more, because the baby was fine.(102)

A number of women believed that health care providers should be able to detect or predict any abnormalities or

problems. This was a mixed blessing, because although they believed that drug-related damage might be corrected or prevented, women who had not disclosed their crack use were concerned that their drug use itself might also be revealed in tests and examinations. From a clinician's perspective, some women seemed misinformed about the purpose of routine testing procedures, believing that simple measurements such as fetal heart auscultation or urine testing for protein and glucose could detect drug use:

They take a test every prenatal appointment...And you take your urine test and they test for drugs.(058)

It was like no secret. I wasn't trying to hide it, 'cause soon as they took my urine they was gonna know anyway...Every time you go for your pregnancy they take it, yeah, and they test it for drugs.(085)

For women who were having some success at abstinence, this was valuable, because they felt it detected problems and helped them stay motivated, but for others who were unable to stop smoking crack it represented a reason to avoid care.

Testing and technology were a valuable part of prenatal care for some women, and sometimes the main reason to attend:

I wanted another child, a boy, hopefully, And I'm just waiting to see. I can't wait for my first doctor's appointment or my second doctor's appointment where they can tell me the sex.(050)

For others, however, technology simply created more inconvenience. This woman had just delivered her fourth child:

I'd go in one door and come out the other door [laughs] and I'd say I went to the doctor...I just didn't like them sitting up there all the time ask these same questions, and they don't check you, they just listen to

the baby's heart and all that. I can listen to his heart 'cause he's inside me. I feel him...That was always good in case something was wrong. They wanted me to take a sonogram, but I didn't never go...I thought I had better things to do.(101)

While the hands-on care was of varying value to this group of women, almost every study participant placed high value on prenatal vitamins as a means of optimizing health and mitigating the effects of drugs. Several women who were reluctant to go to health agencies went to pharmacies or supermarkets and purchased prenatal vitamins. A few mentioned taking more than the prescribed one pill per day:

Whenever it moved, I fed it...A lot of fruit, doubled my vitamins, drank a lot of water and juice.(098)

One of the most potent predictors of the value of prenatal care was the woman's parity. Those who had been through previous pregnancies reported more confidence in their own self-assessment of pregnancy health, and less appreciation of prenatal care's contribution to pregnancy outcomes:

I've gained forty pounds. I'm healthy. I've been pregnant before. I know how to have a baby. Years ago women did not have to go every month or whatnot to the doctor.(041)

I know my body...Had I felt that there was something wrong, I would have rushed there. But after this being my third child...I was pretty attuned.(087)

I never went for prenatal with either one of my children...Oh, yes, yes I did! I went for the first one...And what they did, I went there, they gave me vitamins, they test to see if the baby's heart-- if the baby was alive...And I'm like, 'I feel the baby moving inside of me. I know the baby's alive,' okay? For vitamins, I'd buy my own vitamins.(094)

I don't think they help you out at all...It's like they

push you on the stomach. They do a urine test every time you go in. 'All right, you're doing fine. See you next month.' So I don't think I get no help from them at all.(052)

This woman felt some appointments were more valuable than others:

When I went to the doctor and I knew they were just gonna say, 'Okay, you can go home,' like you get on the scale and measure your stomach, I'll just probably reschedule that. But like the ones where you had to go for the testing for sugar and that APT? They test-- when? Like 16 weeks. If there was any tests of that sort I made sure I kept it.(097)

The value of care, and in particular the vitamins and iron pills available there, in comparison to the effort required to go and the competing value of offers of drugs, was a consideration for women who were still using crack. The value of encouragement to stay off drugs was of comparatively little value if a woman was not prepared to implement the advice:

I believe I did [go to care] once or twice. It was kind of hard to do when you're getting high...Just that you're addicted. You're addicts. [If] somebody kept feeding you money, you're not gonna want to walk out the door.(098)

This woman had attended care sporadically:

I felt that those vitamins and those irons were really important 'cause I know that they give the baby the nutrition that she needs. [but] I was just too lazy [to go]. I just put crack first, totally...They have this on-site worker on crack. And they were really trying to work hard putting all they efforts into helping me...And I just didn't want it...I just wasn't ready...When I left and went home, if I had some dope or if I had any way to get some dope or anybody was gonna give me some, that was coming first at that time.(097)

On the other hand, women who had made the decision to abstain from crack sought and sometimes found support and praise for

their efforts in prenatal care settings:

Well, I volunteered and told them...They told me, 'Congratulations.'...I was saying in my mind, I just couldn't see myself carrying a baby for nine months and to have them take it away from me, 'cause there's so much you have to go through to get the baby back.(096)

And, for a few women, a health care provider had given them human kindness and caring, which was extremely valuable and rare in participants' experience. This was felt to help in reducing drug use. This woman carried the HIV virus and had been treated badly in previous health care:

I know [my nurse practitioner] is worried about me...If it wasn't for [her] I'd be dead right now...People just don't understand. Just a little bit of kindness can do a fucking lot. It really can.(063)

This woman had endured extreme abuse in childhood:

When I went to [medical center], they treated me really nice, kind of like I'm somebody, not like, 'Oh, she's on MediCal,' or 'She's homeless'...I never thought a doctor could treat me nice like these people did...I never thought there was so many nice people in the world.(062)

On a more pragmatic note, women also appreciated the value of prenatal care as a way of demonstrating good pregnancy behavior. A good prenatal care record reduced scrutiny and enhanced their chances of retaining custody:

Now, if I waited till I was five months pregnant to start prenatal, they'll test [my urine for drugs] then. It's like, 'Why didn't she come in? She should have been in.'(023)

I seen a doctor about four or five times and it didn't look too good, my record...They think by me not taking care of my health when I was carrying him, they're scared that I might not take care of his health if he was in my custody.(102)

Several women pregnant for the first time had little concrete idea of what the value of prenatal care actually was, but

they went anyway because they had been told it was important by a peer with experience or by mass media:

This other lady, she's on drugs and she was talking to me last night about it. She was pregnant with her daughter, and she said it was very important to go through prenatal care...I don't know much how true it is, but I was gonna go anyway.(014)

It's on TV. It's all over the community, It's all on radio advertisement, people just talking...it's not like it's not available and it's not like people don't tell you...especially in those communities. It's everywhere in [poor section of city], prenatal care is.(097)

In summary, the value of prenatal care varied according to a woman's judgment of its ability to provide important or reassuring information or support, the priority of vitamins and technological procedures, and the relative value of attendance in maintaining custody of the newborn. The value of prenatal care and of the pregnancy and baby-to-be was weighed with the hope of a successful outcome of the pregnancy and the risks of attendance and disclosure of drug use.

Hope. The likelihood of a good pregnancy outcome and abstinence were judged by women in considering prenatal care. If they felt the fetus was probably already damaged by their drug use, some felt there was little hope of useful help from caregivers. Likewise, if a woman felt there was little hope of escaping drug testing and loss of custody because she had continued to use drugs, she might avoid care. On the other hand, if a woman was doing well in abstaining from crack, or if she had faith that health care could help her have a good outcome, she was more likely to obtain care.

Hope was a subtle aspect of meaning, one that could change from day to day through a pregnancy and from one pregnancy to the next. This woman went through a period of hopelessness when she thought her fetus had died:

The last time I went to the doctor, they were like looking at me funny. So I kind of knew something was wrong and I didn't go back. I missed three appointments, 'cause I was scared. I thought they were gonna tell me my baby was dead or something...I would miss [appointments] because I was scared to hear the news. (085)

Then the same woman was assaulted in the elevator of her housing project and went to an emergency room, where a sonogram told her the baby was indeed alive. She regained hope for the pregnancy and returned to prenatal care.

Hope for help from the health care system was linked to women's feelings of its value, as noted earlier. The ability of care providers to detect problems and offer help predicted a woman's likelihood of hoping for such help. Women who felt able to monitor their own pregnancies and prevent problems had little hope of benefit from prenatal care, other than as a measure of protection against custody loss.

The most influential role of hope in relation to prenatal care was a woman's hope of changing her drug use and thus becoming acceptable to caregivers or able to benefit from care. If a woman believed she could stop using crack or escape detection, she was more likely to get care:

I was, 'I'm gonna stop, I'm gonna stop or they'll take my baby...'Cause I had already figured out...that if they didn't find it in my urine that they couldn't take my baby...'cause they didn't have it in writing. So, I was like, 'I'm gonna stop'...but this time [because I

had been smoking while in labor] I knew that I didn't have a chance to keep this baby. (097)

By the time my next doctor's appointment is, I will be clean for at least a week. And I'm gonna tell them, 'Why don't you guys test me?'...So they'll test me and it's gonna be negative. And then they're gonna look at me and it's like, 'Yeah, good.' (023)

Hope of help from medical professionals was heavily influenced by previous experience, as noted in the discussion of value of care for women with previous pregnancies. This woman, early in pregnancy, described a previous neonatal death after heavy drug and alcohol use early in that pregnancy. She now viewed the medical profession with less confidence but retained responsibility for the consequences:

I went to my appointments and stuff...but they didn't never suspect me...[but] I knew this baby was doomed from the start. I don't care what those doctors say when they say, 'Oh, you're pregnant and you can stop using drugs and your body will be okay.' That's a lie...I'm not saying [it was] because the doctors didn't notice it or nothing. It was me. (006)

Thus, the hope for help from health care sources was a part of a woman's hope for the pregnancy as a whole and her beliefs about her own ability to take what she felt were appropriate actions. Women with life histories that had given them confidence in themselves and in health care were likely to utilize care to help them reach their pregnancy goals.

Risk. The risk of attendance versus non-participation, and of disclosure of drug use versus non-disclosure, was the most influential consideration of risk related to prenatal care. This judgment process amounted to being "damned if you do, and damned if you don't." Going to care entailed risks,

and not going also entailed risks.

Risks of not going to care included missing the chance to remedy problems or obtain services that might reduce the harm of drugs. Women with late onset or lack of prenatal care also risked drug testing in prenatal care or at delivery and consequent possible loss of custody, due to suspicion of drug use. Loss of custody and fetal harm were the two main risks of not getting prenatal care:

I was keeping as healthy as I could...But the point that got me was, 'Okay, but what happens if I have her prematurely? What happens if I haven't even been seen? What happens if I get to be eight and a half months pregnant and I can't get a doctor to see me?... Basically, I wanted to keep D. and her whole birth a secret...And it was like, 'Well, okay, they took my kids. They're gonna take my baby. I know they're gonna take my baby.' (031)

Risk of going to care was closely linked to the amount of drugs a woman had been using. This woman used drugs in her first pregnancy and did not during her second. Her evaluation of the risk changed when she reduced her drug use:

I stayed away. Once a month I'd go just to make sure it was alive. It kicked, but just I was SCARED...They'd take me to jail right then! Oh! But on the second one, I just did it on my own, I 'said no.'...So I wouldn't worry [about going to prenatal care]...I went all the time. (019)

This woman felt strongly that incriminating policies scaring women away from care would result in fetal harm:

Women are gonna think, 'Fuck it,'...having their babies in alleyways...So what do you want? You wanna help these women or you want a bunch of dead babies, finding them in the garbage can, throwing them down ho'-town garbage chutes and that, because they're scared of what the government or the police or CPS is gonna do to them, you know? 'Cause that's what's gonna end up happening. (045)

On the other hand, risks of obtaining prenatal care included discovering drug-related damage, being identified as a drug user and evaluated by custody authorities, and being stigmatized as a crack user. Women weighed all these considerations as they faced decisions about prenatal care attendance and disclosure of their drug use.

Fear of discovery of drug-related damage was a factor for several women. Some women avoided visits when blood tests were taken, feeling their drug use or a problem related to it would be detected, and others were fearful of problems but like the participant cited earlier were much relieved and reassured when tests proved the pregnancy was progressing well. Discovery of damage would label a woman to herself and others as a bad mother, bringing guilt and stigma:

I'm worried. I really am. But then I pray to God, 'I'm trying. Just bear with me. Just please help my baby to be all right.'...because if my child come out and there's something wrong with it, I'll feel real shitty. I mean, I will feel extra bad. Therefore, I have to do something about it now.(014)

Fear of stigma was widely held. Women described avoiding care because they had no money for decent clothing or knew their grooming was poor. Many women spoke of the pain of being treated poorly by health care personnel:

It's taboo to do drugs while you're pregnant, but I feel that I'm still a person. I should still be treated with respect and so should my baby, no matter if it comes out with one eye, one nose or whatever...I just feel that if the society treated people with drug habits more like people and stopped just treating them like they're dirt, they ain't shit, people would come and ask for help more.(045)

I know my mistakes, you know? I don't like people to

tell me things 'cause I already know. Like, 'You know you're not supposed to be doing that.' 'I KNOW that!... Will you please stop?' I can't stand it when somebody just keeps lecturing me about what I'm doing wrong. I already know in my heart what I'm doing wrong.(003)

Crack use brought more stigma to pregnant drug users than any other form of substance use. Disclosure was a frightening experience:

She [social worker] had asked me did I drink or use drugs and stuff. And I admitted to her I did cigarettes...And as far as drinking, she didn't say nothing about it. I told her I had about three beers a week...But when it came to the crack, it's like, she's like, 'Ohhh.' [Her attitude changed] for a minute...'cause it's like she looked down on me. And it's like, 'Yeah, they're gonna take this baby from me.' It's like I don't know if she did it to make me scared. I was already scared, but I'm trying to be honest with her 'cause I want it so bad...That got to me 'cause of her attitude.(018)

For women who did receive prenatal care, whether or not to disclose their crack use to health care providers was another double-bind situation. Disclosure meant being identified as a drug user, tested for drugs, and most likely evaluated at delivery by custody authorities. Some women felt that honesty in admitting crack use would be looked on favorably as part of an effort to turn over a new leaf, and could also be a way to enlist support and obtain the best possible care. Non-disclosure meant a risk of being discovered anyway in a drug test and put through worse scrutiny as a dishonest person, or denying the medical staff what might be important information for care of mother or baby. Women chose to disclose or not to disclose based on

their perception of the risks of each¹. Sometimes disclosures backfired and women wondered if they had done the right thing:

I just tell them, I go, 'I smoked some cocaine...Nothing much, just a couple of hits.' But I was just sort of scared...that something might be happening to my baby...I don't know, my baby wouldn't be in this trouble right now if I didn't tell them, 'cause at the time they weren't testing.(002)

This woman had used drugs through two previous pregnancies and disclosed her use in one but not the other. She was pregnant with her third child and weighing the risks:

It's like a set-up. You trust them to come in there. You tell them that, 'I'm using drugs,'...So you're thinking, 'Okay, everything's gonna be okay. They're gonna help me.' Because I'm gonna tell you the truth. I'm scared to go to the hospital to have this baby. I'm thinking I'd rather have it at home. I'm really scared because I don't want to go to jail and I don't want them taking it from me, either...I didn't tell them about it when I had N..I'm not sticking my foot in my mouth, no. But see, I knew there was gonna be, something was gonna come out with W. So it was like there was no hiding it.(045)

Based on their experience, women had no confidence in the confidentiality of medical records. One woman was told her disclosures were confidential, but when her boyfriend posed as a social worker and called the clinic to ask if she had used drugs, a staff person released the information immediately. Women knew their records would be labeled and the hospital staff would be notified at delivery, so disclosing drug use meant a chain of events and new risks.

There was concern, however, that non-disclosure might lead to less than optimal health care, for women who placed

¹Thanks to Katherine Irwin and Sheigla Murphy, who first articulated this concept in relation to disclosure.

faith in care providers as able to remedy drug-related harm:

I told my doctor,...'Please have all your important instruments near you, because I used with my baby.' (043)
When I go to my prenatal care appointment, I'll tell the doctor, 'I fucked up, I smoked. Is my baby okay? I don't want nothing to happen to him. Please don't let nothing happen to my baby.' (051)

I told him, 'I'm doing drugs,'...because I wanted to make sure that he knew everything that was going on with me. In case anything would go wrong, he would know. (070)

A number opted not to disclose. Some believed they could "pass" as non-drug-users and sought to avoid scrutiny:

If you don't indicate that you on drugs or show signs of being on drugs, they don't test you...I mean, they would know. It could be your baby's heartbeat or something like that. They could look at you, sometimes. But they didn't never suspect me. (006)

This woman's response reveals her effort to protect what little privacy she could call her own:

No, I don't [plan to tell]...'cause it's like this. I'm a private person, and I just feel if I tell them they'll be all up in my business and I can't deal with that. I just, like right here this is my own little world... This is just for me, here...To see someone in my business like that, I couldn't do it...I can't put myself through it...[Tell] the doctors? No, no! That's a big mistake. (052)

In sum, the risks of going to prenatal care and being exposed as a drug user were considerable, and women weighed these risks against the risks of not going at all. Value, hope, and risk related to prenatal care were balanced in a cognitive and emotional process of making meaning.

Evading Harm: Strategies for Navigating Prenatal Care

Women's strategies for evading harm in the arena of prenatal care were based on their judgment of the potential contribution of the health care system to this pregnancy

goal. The degree of anticipated help in harm reduction and stigma management determined whether and how a woman utilized the health care system.

Context also influenced care participation. Delays in insurance coverage, crises at home such as evictions or family illnesses, and the powerful influence of crack itself, (as noted in the discussion of value above) were obstacles to prompt or complete care. Ambivalence about continuing the pregnancy (as noted in the trajectory of pregnancy on crack) also served to delay prenatal care for women who considered abortion until mid-pregnancy. In spite of these barriers, 78% of the study participants had attended prenatal care, and several of those who had not were too early in pregnancy to begin prenatal visits. Therefore, a large majority of the sample did obtain prenatal care as they pursued their goal of evading harm.

Harm reduction. In the process of reducing fetal damage and risk of loss of custody, prenatal care played a large and sometimes multi-faceted role. The value, hope, and risk entailed in prenatal care predicted how a woman would manage the care experience. Many of the strategies women used to reduce harm have been presented in Chapter Six, and in women's comments about making meaning in the preceding section. The strategies will be reiterated here with several more examples.

Most women went to a health agency to confirm their pregnancies, and generally they did so quite early, as the

median gestation of 9 weeks at confirmation suggest (see Chapter Five). Thus, chemical assays were of use in harm reduction when they provided with useful information. Knowing how far along one was in pregnancy aided women in gauging the effects and potential damage of their drug use. Several women who had previous pregnancies used their own knowledge of body changes to determine their stage in pregnancy and decide when they could make use of prenatal care:

You need to go at least for the half just to make sure. Just kind of put insurance on it...Once the baby started moving, I guess, is what kind of really triggered me to get out there over to the hospital...I knew I was pregnant but I didn't know for sure how far. So when the baby started moving, that like told me. I knew I was in the fifth month.(087)

I knew I had to go...I can calculate the months...Yeah, so, 'It's like time. I got to go now.'(097)

Prevention of fetal damage was a responsibility most women took on themselves, using the strategies described in Chapter Six that included eating well, resting, avoiding stress, and reducing drug use. Vitamins were part of this plan for most women, and for these most did seek at least one visit of formal care. A few knew they could purchase vitamins outside the system. For some women, the health care system was used as an ally in preventing fetal harm. These women were likely to be having their first babies, not have endured what seemed like betrayals by the system, and to be successfully reducing their drug use, or to have a health care provider whom they had known and trusted for years:

I've been going there [public clinic] since I got here...They're really nice people.(058)

For many women, especially those with other children, which meant 90% of this sample, prenatal care was less than omniscient and trustworthy. Many had had negative experiences at care in the past or simply had not seen its value in medical terms. In addition, most women with other children felt competent to identify prenatal complications and take care of themselves properly. Some, however, found prenatal care valuable as a way of salvaging the role of pregnant woman, directing their focus on the pregnancy and the future and turning their attention away from crack, thus evading harm. Women deliberately sought structure and support of abstinence in prenatal care:

Once I got into the program I started going to my prenatal visits on time and stuff and I really got into the pregnancy. (092)

And then now it's like I have to get it together because I don't want anything to be wrong with the baby and stuff...And it's not just slow down, I have to stop. And that's why I'm gonna go to that program...I figure by me telling them that [I use crack], that would make me stop using. So it was like something to give me more strength. (023)

All women acknowledged that prenatal care and abstinence at the end of pregnancy could avert the grievous harm of custody loss. Many women who felt they knew well how to care for themselves and prevent fetal damage nevertheless complied with prenatal care for the sake of averting an investigation by custody authorities. This was not a duplicitous or hypocritical strategy. These women were sincere and single-minded in using every resource they could find to salvage the hope of reducing fetal harm and retaining custody:

I don't think if the person isn't ready it's not going to help. If they still want to get loaded and use they're gonna do that. 'Cause now I have a different outlook. I know what all the services available to me are...There's a lot of help out there. You gonna help yourself.(097)

I had asked [my social worker] to be there [at the delivery] too, 'cause I figured that would look real good if she's there to witness the birth and get me through this...and we got really close within those six days. And as a matter of fact, she's my sponsor [in drug program] now...And so we have this tight relationship now and she's a real big part of my sobriety.(092)

Cooperating with custody agents and demonstrating good faith and sincerity was important:

When I had him, they had already made up their mind to report me. But what it was, I got in the [drug treatment] program four days after I went home. The next day after I went home, I called up [program] and got in, and I got two clean urine tests and it was okay. I made a effort, so they didn't report me...The same social worker that I have, I like her because she could have reported me, but because I tried, she didn't.(085)

Only if you act funny you get treated funny. That's usually if you act silly and won't let them help you, then that's when they get mad. I cooperated...It was like I was so scared. But I talked to the man [social worker] real nice and he talked to me and it was like he seen...something like, 'If it hadn't of been for me,' or whatever he sees in me-- as he said, 'Being strong'-- then he would have took him, I guess.(098)

Women who continued to use crack considered the risks related to disclosure presented earlier as they found their way through the system. If they had stopped using, the prospect of retaining custody was much less frightening, and attendance at care was relatively free of risk. Because many women went back and forth in their drug use patterns, however, they made efforts to be drug-free at appointments:

I'm in the prenatal care, yeah. Like but yesterday I

missed it. If I have other plans [i.e., prenatal appointment], I just can't, you know, party first.(058)

I would be like, 'Well, I know I have an appointment,' and be clean for it...I don't know which one of the appointments they're gonna test me, you know? So that's good.(059)

For those unable to resist crack, not appearing for care often seemed less risky than incurring a positive drug screen. Each woman acted in the way that she felt was most likely to protect herself as a mother and the custody of her baby-to-be.

Care was often sporadic. Women faced considerations of drug testing, the suitability of their appearance, and their current concerns about the well-being of the pregnancy, while dealing with the chaos, engrossment, and competing concerns of life in the crack world. A few women who had been heavily involved in drugs said that during their entire pregnancies they ignored the advantages of care, but for the large majority of women, missed appointments were inadvertent, intentional as a protective strategy, or a result of fear of harm or stigma.

Stigma management. Stigmatization was an important barrier to prenatal care for the women in this sample. In managing this stigma, women considered carefully the way powerful members of the conventional non-crack world would look at them and respond to them. As noted in the discussion of the risks of stigma, being treated as less than human was sometimes more painful than not knowing if your pregnancy was proceeding normally.

In prenatal care settings, women were forced to venture outside their families and drug-using social groups, most of whom presumably had insight into the complexities of the women's lives. They entered an arena where their only identity was as women who were breaking the rules of pregnancy, perhaps subverting the best efforts of medical science, and placing their babies-to-be at risk. It was a fearsome prospect for many women in this sample, especially those who already were stigmatized for their race and class in many settings of their lives:

Do you know that in California they automatically test you if you're a woman of color?...It's true. If you're white, they won't test you unless you have a history... If you're Mexican or black, they automatically [snaps fingers]...When I went to go give birth to her...they looked down on me. They make you feel like you might as well just have your baby at home just to avoid the humiliation of the way they treat you, because they treat you like you're garbage. (045)

Stigmatization in prenatal care was managed, first of all, by attempting to reduce drug use to remove the stigma. Some women who were succeeding in abstaining from crack avoided stigma by enlisting the support of care providers and seeking to move from a pregnant crack user identity into a recovered-drug-user identity. They sought to replace the autonomy, excitement, and drug-related gratification of the crack world with the pride of salvaging self-as-mother, doing something "positive" for themselves and their future children:

I'm trying to go somewhere where I feel comfortable and I feel that the atmosphere around me is not negative, it's positive in a way that they want to help me if they

see me wanting to help myself to do for this baby...Not to make me feel bad about being a pregnant woman and on crack but to make me feel good about being a pregnant woman and using crack, to see something better for myself and my child.(024)

Women who were ready to move beyond the drug world felt prenatal care providers could assist in this process, as in the strategies described above for cooperation with the system to gain custody.

For about half of this sample, who were still engaged in the social world of crack, such a turn-around was still out of reach or held less interest. As described in Chapter Five, stigmatization was a daily concern, but it was felt most deeply in prenatal care. Health care was the place where drug users faced the consequences of their actions with fear and guilt. When personnel further humiliated them, pregnant crack users were extremely reluctant to return:

I don't want her [social worker] to be involved with me being in no kind of programs...And that's my attitude with her, because I think she looked at it real negative, which is negative in itself. And for somebody on drugs to be pregnant, and the way I talk about how I want this baby, for me to sit there and tell her, 'Yeah, I do cocaine,' it's like, how do you think I felt?...I don't need her.(018)

In summary, strategies for managing stigma in prenatal care included avoiding care, selective avoidance of health agencies where stigmatization had occurred, selective disclosure, passing as a non-drug-user, maintaining pride and autonomy, and seeking to re-join the conventional world.

Summary: Salvaging Self in Prenatal Care

Navigating prenatal care was a central focus in pregnant

crack users' strategies for salvaging self. Prenatal care could be a source of important support or a frightening process, depending on each woman's past experience, social network, drug use status, and recent interactions. Each individual acted according to her unique definition of her situation, judging its meaning in terms of value, hope, and risk. This meaning and the strategies that emerged from it were heavily influenced by provider attitudes perceived in health care interactions. The degree to which prenatal care could advance a woman's efforts at evading harm predicted her level of participation in the health care system.

CHAPTER EIGHT

Discussion: Harm Reduction and the Public Good

The findings of this study add to the body of literature on pregnancy experience and drug use in social contexts. They provide insights into the effects of current policy and practice and suggest new directions for health care practice, policy, and research. In this concluding chapter, I discuss the adequacy, significance, and limitations of this research effort, its theoretical contributions, and its meaning for health policy, practice, and research in the arena of pregnancy and drugs.

Adequacy of The Theory of Salvaging Self

Adequacy as grounded theory. A grounded theory analyst is obliged to demonstrate a coherent and complete process of theory development. Elements of the analytic process that are presented as evidence of adequacy include the basis within the original "sensitizing questions" for selection of the initial sample and later theoretical sampling decisions, description of how major categories emerged from the data, support in original data for hypothesized relationships between categories, and changes in theory that led to identification of the core category or central process within the phenomenon (Strauss & Corbin, 1990, pp.252-257). These methodological concerns were addressed in the description of the study process in Chapter Four.

The content of the grounded theory must also be

evaluated, both in terms of its internal adequacy-- as Strauss and Corbin (1990) define it, its completeness, complexity, logic, and inclusion of context and change over time-- as well as its external adequacy, or utility to practitioners and scientists in explanation and problem-solving in a variety of situations. Glaser & Strauss (1965, p. 260), early in their work, developed four concise and practical criteria for effective grounded theory that address both internal and external adequacy. These are: Fitness, accurate representation of what is going on in the phenomenon, in such a way that anyone in contact with it would be able to recognize her experience in the theory. Understanding, the richness and sensitivity of the final theory reflecting a deep and participatory grasp of the subtleties of interaction within the phenomenon. Generality, applicability to a wide range of changing situations related to the phenomenon, including suggestions of ways to adapt the theory to new variations of the phenomenon. Control, the indication within the theory of ways in which persons might be able to affect the process or outcomes of the phenomenon.

If we examine the theory of salvaging self in light of these four requirements, it survives fairly well. I tested the fitness of salvaging-- its accuracy in portraying the phenomenon so that those involved could readily recognize its utility-- in three "critic" groups: the study participants, other project staff who were familiar with the study

population, and persons in contact with the population in health care or social service interactions.

In my view, the fitness of the emerging theory to the women who were interviewed for the study was the most critical test. In the last several interviews, after each woman had finished her story I gave a theoretical reiteration of her experience. The usual response, once I found language to communicate my idea of salvaging self, was something like, "Yeah. Exactly. I'm trying to do this, and it's so hard." Women seemed relieved to hear a professional, albeit one in sweater and jeans, recognize their struggles for "something positive."

To some of my fellow project workers, the concept of salvaging had immediate fit, while for others it required testing and deliberation. In the development of the theory, the team made an essential contribution in suggesting the change from salvaging hope to salvaging self, to reflect the women's efforts to maintain their identities in the present as well as the future. Salvaging was in the end accepted not only for the present analysis but also as a model for understanding the wider experience of the women in the larger study, those using drugs other than crack.

The ideas of salvaging were presented in several research conferences in their final form and to a group of practicing nurses in an early stage of the analysis. I expected these nurses (from an intensive care nursery where

approximately a third of the tiny patients were drug-exposed) to be my harshest critics. Traditionally advocates for the ill infants and angry at they perceived as selfish, uncaring mothers (see Adams, Eyler, & Behnke, 1990), this audience asked tough questions and were moved and impressed when I read quotations from pregnant drug users that demonstrated the mothers' caring, suffering under stigma, and efforts to make positive change in their lives. The nurses began to reframe the difficult behavior of some mothers in the nursery, described as selfish, removed or angry, as reflecting the meaning of the situation-- fetal harm, threatened loss of custody, and stigmatization-- rather than as resentment of staff and lack of concern for their newborns. A nurse told me later that my presentation was discussed for weeks afterward as nurses shared their new insights into this most difficult patient care situation.

Understanding, the ability of a grounded theory to reflect the subtleties of complex interpersonal phenomena, is achieved in salvaging self by including three different dimensions of meaning-- value, hope, and risk-- in which the variations of women's individual goals, experience, and circumstances are taken into account-- and three different categories of self at stake in the process-- individual, pregnant woman, and mother-- which hold differing priorities for each pregnant crack user. Each individual brings a different set of definitions and goals to a pregnancy on

crack. Variation in her actions and outcomes can be explained to some degree by these individualities, which in turn reflect the uniqueness of her history and context.

Generality, the ability of a theory to adapt to changing situations within a phenomenon, is also made possible by the range of variation of the two triads of concepts within meaning and selfhood. If the theory were tested in another group, such as in a different ethnicity or nationality, these triads might be expanded or modified. For example, I would question the applicability of the concepts of selfhood in cultures where individuality and autonomy is less important than in the cultural substrate of the United States.

Control, the utility of a grounded theory to suggest interventions in a phenomenon, might be tested in salvaging self by addressing the meanings of the harm pregnant crack users seek to evade and the obstacles they face in doing so. For example, with changes in public and professional attitudes toward addiction, managing stigma by shunning prenatal care would no longer be necessary. Likewise, if removal from custody were replaced with mother-infant treatment as a consequence of discovery of crack use at delivery, fear of loss of custody would be removed as another obstacle to prenatal care.

Adequacy as feminist research. Criteria for rigor in feminist nursing research have been developed by Hall and Stevens (1990). The criteria related to content are:

credibility, coherence, complexity, consensus (among data sources), relevance, and naming (giving credibility to women's experiences through labeling in their own words). Many of these appear to overlap with those for grounded theory rigor and can be evaluated in the terms provided by Glaser and Strauss (1965), above. Hall and Stevens' process criteria are: reflexivity, rapport, honesty and mutuality, and relationality (collaboration in the research process). These were addressed in Chapter Four. Some limitations are discussed in a later section of this chapter.

The one feminist criterion that is not addressed in the grounded theorists' criteria for adequacy is that of naming, and this was not achieved in this theory. I did not discover a concise and comprehensive expression of their experience within the narrative of these study participants. This failure can perhaps be explained by the fact that many of the women in this study had never before had the opportunity to express their concerns about their situation and were struggling to describe their experience for the first time through stories and examples. My use of theoretical terms such as "salvaging" and "stigma" stand as provisional, admittedly outsider expressions of what Glaser (1978) called "what is going on here."

Achievement of Study Aims

This study was conducted to gather information about four topics: the experience of pregnancy for crack users, the

influence on their drug use during pregnancy, their views on health care, and their opinions on avenues for change. In each area, the study yielded new insight into a complex phenomenon.

The experience of pregnancy. Crack users described their experience of pregnancy with mixed emotions, and across the sample there was a wide range of responses to their situation. Some women tried to ignore it, others made sweeping changes in their lives, leaving drugs and seeking conventional satisfactions, and many remained in the middle ground, trying to avoid drug use for the sake of their self-concepts but not relinquishing completely their ties to the world of crack. The idea of salvaging self integrated these efforts as ways of preserving something of importance in high-tension situation: women who continued heavy crack smoking sought to preserve their autonomous individual selves, while women who gave up crack were focusing on their pregnant woman and mother selves, and women who kept a foot in both the crack world and the conventional world were seeking a way to protect elements of all three.

Salvaging self reveals the pivotal importance pregnant crack users placed on pregnancy and their maternal identities. Even those who had long ago abandoned the trappings of conventional life considered reclaiming the components that went with motherhood-- love, responsibility, a future, a source of stability and purpose. A deep,

fundamental caring about their infants as extensions of themselves was a common thread in these stories. When high on crack they lost that caring. For many, these periods of emotional vacuum unsettled their worlds as pregnant women and brought guilt and fear, but for a few, they offered relief from emotional burdens that seemed too great to bear. Overall, these women saw their infants as individuals with rights even before birth. Women who continued to use crack nonetheless shared the ethic of their peers and their burden of fear and guilt.

The accounts of the women in this sample challenge the myth of pregnant crack users as amoral drug fiends who are heedless of the effects of their actions on the unborn. Although the majority matched the demographic stereotypes of "down and out" impoverished individuals deeply enmeshed in the world of drugs, the values for pregnancy and mothering among women in this sample were solidly mainstream. Their problem was how to bridge the fearsome distance between where they were when they discovered a pregnancy and where they believed they should be to mother a child. Across the troubled trajectory of pregnancy on crack, women attempted to bring their lives and their selves closer to what they felt their babies deserved.

Influences on drug use in pregnancy. Crack use in pregnancy was a product of meaning and context. Women judged the meanings of the pregnancy, their drug use, their

impending motherhood, and the obstacles in themselves and their surroundings in terms of value, hope, and risk. In retrospect, some women's judgments seemed realistic and their goals attainable, while others appeared impossible, albeit heartwarmingly optimistic. The popular mainstream ethic of "Just Say No To Drugs" seemed laughable in some women's circumstances, yet on the basis of their judgments of the value of their pregnancies and motherhood, their optimistic hope for a new direction in life, and their wholesale adoption of media-fueled beliefs about the grave risks cocaine posed to fetuses, some women with no visible path away from drugs still intended to find a way to say no.

The context of most of these women's lives was poverty (either recent or life-long), non-white race, little more than a high-school education, scarcity of role models for either career advancement or stable family life, and links to men who themselves were subject to oppression, criminal involvement, and lack of realistic paths to lasting prosperity. A handful of women had career experience and/or were involved with a man with a steady job. These women had an easier time reducing their drug use than did women whose surroundings and loved ones were involved with drugs, and who lacked a sense of hope for a prosperous future.

All the women took responsibility for their drug use in pregnancy, refusing to shift the blame to society or their circumstances. In a single sentence, a woman might rail

against her lack of treatment options, social support, or opportunities, and then firmly state that she expected herself to be able to leave drugs alone and turn her life around for the sake of her baby. Many were critical of their lack of social and cultural power and opportunity, but when pregnancy came into the picture, maternal resolve and altruism were expected to overcome such obstacles. As a result of this ethic of responsibility, the unscripted nature of their taboo situation, and the dearth of pathways to a better life, many women were isolated from sources of help and encouragement. Those who had a stake in conventional life (Waldorf, Reinerman, & Murphy, 1991), consisting of familial, social, and/or personal knowledge of the means and worth of a lifestyle not centered on drugs, had better odds of leaving the drug world completely.

Views on health care and their own health. While the women in this study obtained prenatal care at a rate somewhat better than other samples (e.g., Melnikow, 1991), very few engaged in health care with security or enthusiasm. Their participation was affected by the obstacles to care discovered in non-drug-user groups, such as financial and family stressors (Green, 1990), depression and denial (Pettiti, et al., 1990), ambivalence about keeping the pregnancy (York et al., 1991), lack of awareness of pregnancy (Burks, 1992) and lack of perceived value of care when pregnancy seemed normal (Patterson, Freese, & Goldenberg,

1990). Their drug-related obstacles, however, were much greater. As Chavkin and Kandall (1990) predicted, fear of custody loss, incrimination, and stigmatization related to drug use were major barriers for pregnant crack users.

Although involvement with health care agencies was inconsistent across the sample, all the women in this study were concerned about and took steps to preserve their own health. As they pursued their goals of evading harm to themselves and their fetuses, women employed a variety of strategies for staying healthy, most of which seem very sound. Almost all reduced their crack use, took vitamins, and attempted to improve their eating and sleeping patterns.

On the other hand, the heavy alcohol and cigarette use reported by this group threatened to undo any benefits of nutrition and rest. Although they did reduce their use of these substances in pregnancy, women were nowhere near as fearful of their effects as of the effects of crack. In point of fact, the research to date on the effects of cigarettes and alcohol on fetuses (e.g., Chasnoff, 1991; Streissguth et al., 1991) is more thorough and convincing than the research to date on crack's effects, yet media coverage and public policy and opinion place crack and other illicit drugs on a much more dangerous plane. Crack users were thus limited in their judgments and strategies by the information they received from the cultural substrate of American life.

The handful of women who mentioned home remedies to

remove crack from their systems, including golden seal and niacin, vinegar, and pickle juice, provided a window into an underground knowledge base of health maintenance shared by pregnant crack users. The value of these remedies is unknown, and women's confidence in them may reduce their motivation to follow other more certain approaches to harm reduction. The existence of this underground pharmaceutical knowledge is testimony to pregnant crack users' lack of other sources of information about reducing harm to their infants.

Opinions on solutions to problems. The participants in this study had a range of ideas to address the problems of pregnancy and drugs, reflecting their levels of hope for their own situation. Some opinions were in the form of advice to other women: Don't try crack, or stop using it before you get pregnant. If you are using it and you discover you're pregnant, you can stop and you can have a healthy baby. Other opinions related to changes in the systems that affected women on crack. Some mentioned changing custody laws, creating more treatment centers where pregnant women could go and where women could bring their babies, and increasing housing options for women who wanted to get away from drugs.

The most powerful and universal advice, however, related to reducing stigmatization of pregnant crack users. Both within their own social groups and in health care agencies and the larger society around them, women felt poorly understood and unfairly ostracized for their crack use. For

some, this stigmatization led to more drug use, as they struggled to retain some autonomy. For many, it led to guilt, hopelessness, and avoidance of potential sources of help. Women asked to be treated like human beings who cared about their children and were trying to do better.

In sum, in achieving the aims of this study, information was gathered that not only explains pregnant crack users' actions but shows their integration in the moral life of the surrounding culture. The revelation of the inner life of pregnant women on crack, although limited in many ways as discussed below, allows us to identify common American values and goals in a group previously thought to be un-American and anti-social, and to see crack users' evasion tactics as efforts to achieve those goals in roundabout ways, with sometimes contrary results. Pregnant crack users join with many American women who face conflicts between autonomy and responsibility as they move toward motherhood.

Limitations

As in all research, this study was limited by its instruments: in this case, human interviewers who carried their own opinions and biases. We were women outside the race, class, and social worlds of many drug users who participated in the study. Therefore, the questions we asked, the responses women were able to give, and our analysis of those responses all were colored by our differences in cultural meanings and power. The study was limited by the

size and demographic homogeneity of the sample, and by the cross-sectional design that relied on participants' recall to describe experiences over time. Data collection was limited by the realities of women's lives: discomforts of pregnancy, needs of other children, and other competing concerns such as social service appointments. Analysis also may have been limited by the analytic biases of my feminist perspective, which may have placed more blame on context and less on women's "faults" than another framework might have done.

The extremely sensitive material of these interviews and the attendant need for scrupulous confidentiality limited the way findings could be presented. Case studies and detailed illustrations would have made for fascinating reading but in almost all cases would have made possible the identification of participants. I decided to err on the side of caution and not include or create such stories. Fabricating patched-together stories using pseudonyms seemed to risk misrepresenting what were complex and unique circumstances. Instead, I have chosen to present the common threads of emotion and cognition discovered in a systematic analytic process, and women's expressions of variations on these, at the cost of omitting what are undoubtedly important elements in the contexts of these women's lives.

Theoretical Significance

Findings of this study cannot be generalized beyond the group they came from. Yet, they provide food for thought in

comparison to other kinds of pregnancy and mothering experiences and other studies of drug users. Several comparisons will be made in the hope of broadening our views on these complex phenomena.

Salvaging's relation to previous studies of drug users.

The stories of pregnant crack users uphold Zinberg's (1984) explanatory model for drug use as an interaction of drug, set, and setting. Zinberg observed that the pharmacological nature of a drug, the personality or perspective of the user, or the social setting in which drug use took place did not individually predict when drug use would occur or lead to compulsive use. Instead, the interaction of all three components occurred in each drug use situation. In the case of crack cocaine, the physically and psychologically engrossing stimulant effects of the drug, the personal history, hopes, and habits of the drug user, and the pathways and resources for continued use or abstinence within the social and economic environment interacted to explain the relative likelihood of a pregnant woman's continued crack use.

Whereas pregnant crack users' strategies of evasion and deception and their continued drug use may appear illogical and self-destructive rather than self-preserving, another investigator of a "salvaging operation" in the drug world also viewed deviant activities as means for self-actualization among those with no other access to

recognition, dignity, and meaning. Bourgois (1989) described crack cocaine sellers' struggle for survival and personhood amid a "conjugated oppression" of racial and economic marginality. The crack economy was seen as a movement of resistance among those who had no hope of achieving American goals by other means, and the ugly internal dynamics of the crack trade (control of competitors through violence and mistrust) were mimicry of the frontier-oriented, every man-for-himself model of American individualism that pervades American media and history. For young men in an urban ghetto, a career in the crack economy, although dangerous and often short-lived, was preferable to the degradation of public assistance and minimum-wage jobs. Likewise, pregnant women's crack use and their efforts to maintain some autonomy and self-respect when rejected by both their own and mainstream American communities were means to personal dignity and affirmation.

The only previous study of pregnant drug users in context, Rosenbaum's (1979) study of 100 women heroin users, was also validated in the present research. Heroin users, like crack users, cared deeply about their children and believed that continued drug use was unacceptable in pregnancy but often did not discover pregnancy for several months due to drug-related masking of pregnancy symptoms. They sought to reduce harm to their infants by reducing heroin use and seeking prenatal care, but like crack users

had little information on harm reduction and faced stigmatization in health care settings.

Crack users differed from heroin users in their drug, set, and setting. The pharmacological nature of crack, the availability of treatment, and the worsening socioeconomic environment a dozen years after Rosenbaum's heroin study made crack users' predicament even more difficult than that of the women on heroin. In fact, pregnancy on crack cocaine may be a more common phenomenon than on heroin, because while heroin suppressed both sex drive and fertility, crack use does not impair fertility and is often accompanied by sexual activity. Heroin use required periodic dosing but enabled relatively normal living patterns and participation in daily life, while crack use is engrossing and interferes with eating, sleeping, and functioning in the conventional world. In addition, heroin users had the option of switching from an illicit drug to methadone during pregnancy, while crack users have no safe and legal substitutes for their drug. Heroin users a decade ago had relatively better social service support and opportunities for employment than do crack users in a period of economic recession and cuts in funding to social welfare agencies. Both heroin users and crack users expressed concern for their infants and attempted to reduce harm to their unborn children. In sum, Rosenbaum's findings of the experience of pregnancy for heroin users are seen also in pregnant crack users, but the nature of crack and the lack of

adequate treatment present greater obstacles to prenatal health, economic resources are now fewer, and the consequences are therefore more ominous.

Salvaging's fit with theories of pregnancy experience.

Substantive theories of pregnancy and prenatal care-seeking experiences discovered by Patterson and colleagues were supported by the present study. Patterson's (1986) theory of "reducing uncertainty" in discovering and confirming pregnancy was validated in pregnant crack users' stories, with the addition of drug-related factors as confounding women's "salient indicators" of pregnancy, emotional distress as complicating the "working interpretation" of pregnancy, and fear of stigma and custody loss as obstacles to finally seeking professional confirmation.

Patterson's (1990) theory of "seeking safe passage," a concept originated by Rubin (1984) and rediscovered in the process of prenatal care-seeking, was also upheld by the present study. Pregnant crack users' efforts to salvage self were a search for safe passage of an already-compromised pregnancy through a uniquely dangerous situation, like navigating through a mine-field of threats and barriers. Crack users' efforts can be seen as all the more heroic because in their view the best they could hope for was a damaged product.

Corbin's (1987) theory of "protective governing" among chronically ill women in pregnancy also has support in

salvaging self. Like Corbin's sample, crack users were highly protective of themselves and their fetuses, interpreting their own well-being and managing their own care rather than submitting to ill-informed medical plans unless a problem was perceived. Unlike the chronically ill women, however, crack users had few resources of information or money for self-care or health agencies, and they had little hope of a collegial relationship with health care providers. This contrast reflects the distance in American health care between the disease model of addiction, espoused by major professional groups and public health policies, and actual care delivery. If crack use were in fact handled as a chronic illness rather than a moral failing and indicator of child neglect, pregnant crack users would be better able to participate in the mutual care management enjoyed by Corbin's sample.

A thought-provoking comparison could be made among salvaging self and two analyses of mothering, Ruddick's (1989) Maternal Thinking and Scheper-Hughes's (1992) Death Without Weeping. Ruddick conducted an informal survey of American mothers' concerns and proposed that mothers employ a unique kind of thinking that is fueled by their love for their children and their desire to enable their offspring to flower into their destiny as individuals. Learned in their caregiving practices, this thinking is directed at protecting, nurturing, and training children. While I found remarkable parallels to these goals in mothering on crack

(Kearney, under review), the resources with which drug users aim to protect their children differ from those on which Ruddick's assumptions are based.

While their goals for mothering and their love for their children resemble Ruddick's model, crack users' mothering environments are more like those of the impoverished Brazilian mothers in Scheper-Hughes' anthropological study. The grinding, politically-perpetuated, multi-generational poverty in the Brazilian slum meant constant hunger and illness. Mothers bore many pregnancies, endured miscarriages and stillbirths at a high rate, and lost many children to starvation in the first year of life. In these circumstances, supported by their cultural and religious understandings of the temporary nature of human existence, Brazilian mothers were found to practice "mortal neglect," allowing weak, malformed, or passive infants to die rather than seeking heroic rescues. Mothers often did not consider their babies to be fully alive or develop the attachments we have come to expect of mothers until the infants had shown their will to live and survived their first year. As a Norteno visitor, although she shared their Catholic faith, Scheper-Hughes was appalled by this practice and attempted to salvage several children before she came to understand the pain and futility of these efforts. Women who use crack cocaine in pregnancy carry Ruddick's American expectations for attached, passionately involved mothering but live in environments not

unlike Scheper-Hughes' South American slum. Their refuge in crack cocaine, like the Brazilian women's refuge in religious doctrine, is one of the few routes out of this impossible double bind. When there is no hope of being the kind of mother acceptable to self and society, detachment becomes a reasonable path.

Health Policy and Practice: From Contagion to Harm Reduction

Drugs as contagious: The current model. Current policy for control of drug use is based on a model that is labeled as health-focused but in fact has moral content. Drug use in pregnancy has been treated as a social epidemic, in which pregnant women are exposed to and then become the vectors of a contagious agent, crack cocaine, which infects the fetus as its host. Medical research reveals this orientation in its narrow focus on crack's epidemiology and its biomedical effects on infants.

The "infectious" nature of drug use is communicated on a large scale through mass media, including scare-oriented news coverage (Reinarman & Levine, 1989) and "public service" messages by organizations such as Partnership for a Drug-Free America. The rhetoric used by the latter group was analyzed by Zimmer (1992) as designed to create an intolerance to any drug use, extending beyond personal abstinence to a crusade to remove all illicit drugs from society. Zimmer identified the following six themes in the promotional material of Partnership for a Drug-Free America, each of which is easily

recognizable in federal and state policies and reflects the social epidemic model:

1. Drug use is immoral, unnatural, and leads to immorality and criminality.
2. All drugs are addictive.
3. All drug users are potential addicts, regardless of circumstances of the drug use.
4. All drug use is harmful. Even casual, recreational use detracts from the user's ability to contribute to society.
5. Drug use destroys free will; therefore, involuntary treatment and other losses of civil liberties are justified in controlling drug use.
6. Drug use, if uncontrolled, will destroy society.

Levine (1992) observed that such themes were the basis for the Prohibition movement and legislation earlier in this century as well as for current penalties for drug-related crimes. Levine and others have noted, however, that drug use has always been present at a fairly stable level in Western societies; the public and political response to crack cocaine in the past decade is only the most recent of periodic "drug scares," in which socially powerful groups call for control of substances thought to threaten their own stability (Beisel, 1990; Levine, 1992). Historically and in the present crack scare, policy founded on this moral epidemic model has been unsuccessful in reducing drug-related crime, drug

trafficking, or drug use itself (Trebach & Zeese, 1990).

In this epidemic model, pregnant drug users are cast as scapegoats for a threatened collapse of American society (Faludi, 1991; Pollitt, 1990). As vectors of this moral plague, women have been effectively accused of abandoning their roles as workhorses of childbearing and childrearing when they fall prey to their own hedonistic desires. Policies have focused on detection and custody removal in cases of maternal drug use, rather than on early intervention, family support, and harm reduction. The stigma engendered by this message and its policies has alienated women from their own social groups and their sources of help, cemented their powerlessness in American society, and burdened them with guilt, hopelessness, and fear.

The moral epidemic model has both engendered and been fueled by the federal War on Drugs abroad and in the United states, as well as by the suppression of medical reports of null findings of the prenatal effects of cocaine and the lack of any reports on the maternal experience of cocaine use. Using the rhetoric common to anti-drug crusades as listed above, human rights of pregnant women have been restricted in courts (Seigal, 1992), and the lives and health of mothers and infants have been risked unnecessarily through alienation from health care and lack of funding for woman-centered treatment (Weber, 1992). Huge sums of public money that might have been spent on early intervention and treatment have been

directed to the "drug war" effort and the expansion of the criminal justice system to handle the resulting offenders (Trebach & Zeese, 1990).

Harm reduction: An alternative model for policy. The harm reduction model assumes that drug use cannot be eradicated from society and posits that policies should focus on reducing the harms that can result from drugs. Drawing from the work of Trebach (1987), Rosenbaum (1989), and others, I have reframed the social epidemic rhetoric cited above to demonstrate the assumptions of harm reduction:

1. Drug use is widespread, includes legal substances such as alcohol and nicotine, and for the vast majority does not lead to changes in lifestyle or moral turpitude.
2. All drugs are not the same in terms of potential harm and addictive power, and illicit drugs are not necessarily more dangerous than legal substances.
3. Some drug users become heavily involved, but many others try drugs only a few times or remain casual users. The setting of drug use and the personal history and circumstance of the user influence the individual's likelihood of continued or heavy use.
4. The vast majority of drug users do no harm to others and little to themselves. In cases where harm is likely to occur, policies should be directed at reducing the harm rather than at punishing the drug use.
5. Drug use does not disable moral judgment or free will,

and harmful actions resulting from drug use should be punished no more or less harshly than other actions of the same category.

6. Drug use is not contagious or threatening to the stability of society. Drugs have been present in Western societies since early history, and informal social controls are effective in limiting drug use to certain settings and purposes.

Based on a social adaptation paradigm rather than the moral epidemic model, the public health approach of harm reduction has been applied successfully in other nations with regard to drugs. In the Netherlands, for example, no criminal penalties are applied to possession of drugs for personal use, although drug sales carry a range of penalties based on the nature of the substance. Drug treatment is available on demand, and since decriminalization in 1976 use of heroin and marijuana has declined (van Vliet, 1990). In Australia, reduction of harm related to alcohol, tobacco, and other drugs has been adopted as the official rhetoric, and efforts to reduce the harms related to high alcohol consumption and tobacco use have produced a drop in drunk driving and in tobacco-related deaths. Provision of clean needles and methadone treatment for injection drug users has wide public support, and the AIDS rate has remained low (Wodak, 1992). A growing body of research literature and annual international conferences on harm reduction are evidence that principles of

harm reduction are gaining worldwide support.

In the United States, the addition of filters to cigarettes and seat belts to cars may be viewed as examples of harm reduction, as are public education about designated drivers. Condom distribution and education about safer sex are harm reduction efforts in response to the threat of AIDS that do not levy penalties against homosexuality. Needle exchanges and instruction on bleaching syringes and needles for injection drug users are less well-accepted examples of a harm reduction approach.

Harm reduction for pregnant crack users. A change in policy and practice from prohibition to harm reduction is the most promising avenue for engaging pregnant crack users in health care and improving their health and family outcomes. At present, however, when health care workers are placed in the role of enforcers of legal sanctions against women who use drugs in pregnancy, as is the case in several states, women who know they are breaking the law are unlikely to obtain care or be open with their care providers (Chavkin, 1990). When health care records are used as evidence of parenting ability, as they were in the jurisdiction where these interviews took place, women are equally fearful of attending care or disclosing drug use.

Women are deeply committed to minimizing risk to their unborn children in spite of their drug habits. Health care providers have much to contribute to this effort, including

health monitoring, nutrition counseling, up-to-date research information on drug effects, and referral to sources of lifestyle improvement such as housing, education, and employment assistance. These efforts may serve not only to improve women's health and the health of their infants but also to encourage women about their own capabilities and reveal alternatives to the drug life. Most important, a true policy and practice shift to harm reduction and away from a moral epidemic model would eliminate the stigmatization and stereotyping that pregnant crack users object to from health professionals. Such de-stigmatization requires acknowledging that some women may continue to use crack and are at the same time interested in continuing to participate in health care and minimize their risk. It requires being willing to help drug users without condemning them for their substance use.

Drug treatment on demand is a necessary component of harm reduction for pregnant crack users. At present, however, drug treatment for pregnant and parenting women is inadequate and in short supply (Reed, 1987; Weber, 1992). Increased funding for new and expanded programs of a variety of configurations that are designed for pregnant drug users and mothers with their infants would be a constructive use of money now directed at law enforcement and foster care programs.

In sum, a harm reduction approach to crack use in pregnancy is needed in order to: free women from the fears

that keep them away from sources of health care, provide realistic and more complete public information about drug use in pregnancy, enhance treatment accessibility and adequacy, and enable health workers to work with rather than against pregnant drug users in improving health outcomes.

Directions for Research

As health professionals gather more information on women's experiences of crack use through clinical practice and research, they will be better able to advise women on harm reduction. Recently, researchers have suggested that the harms of crack may be less pervasive than previously claimed, and that other lifestyle factors may contribute to crack's negative effects in pregnancy (Zuckerman et al., 1989). Further study is needed in this area. The appetite-suppressant effects of crack, for example, may be as much or more to blame for infants' low birth weight as the drug itself. The practice of drinking alcohol while smoking crack to moderate its stimulant effects (French, 1993) also has health implications. If health professionals can provide research-based information and support to pregnant crack users without demoralizing or disempowering them, drug users may come to see health care as a benefit to themselves and their future as mothers, rather than a risk.

To better understand pregnant drug users' relationship to the world around them, longitudinal studies by culturally-similar investigators would yield useful information about

within-culture views and shifting perspectives over time. More study is needed of women who have abortions for drug-related reasons, and of middle-class women who are pregnant and use drugs.

The relative effectiveness of different forms of drug treatment is an important area for study. As funding increases for pregnancy-specific drug treatment, little is known about which models work for which individuals, or which are most cost-effective or feasible. Naturalistic methods of data collection can add to the usual abstinence measures in evaluating drug treatment programs.

Nurses can continue to contribute to research on health care interactions of pregnant drug users. With new insights from the other side of the drug user-caregiver dyad, nurses will be able to improve health care delivery based on the voices of women previously unheard in the health care arena. A study using observation or recording of encounters between drug users and health care workers would yield fascinating data. Experimental efforts to raise the consciousness of health care providers, incorporate harm reduction in care, and de-stigmatize the treatment of pregnant addicts would be another logical and exciting outgrowth of the present study. In sum, research is needed on different experiences and longitudinal views of pregnancy on drugs, on the effectiveness of lifestyle-related harm reduction strategies, on treatment effectiveness, and on improving health care

interactions for pregnant women who use drugs.

In the final analysis, as the women in this study claimed, the efforts of health professionals to help a woman escape from an unwanted drug lifestyle are of little use unless the woman herself wants to stop using drugs. Pregnancy is for many an impetus to begin this effort, but when this motivator disappears, women are left in dead-end life situations with many stressors, and drugs are an attractive alternative. Large-scale social and economic changes will be required to reduce obstacles to success and confidence for women in the lifelong grip of poverty and drugs.

Conclusions

In this study, we have seen the cognitive and emotional interior of crack use in pregnancy. We have seen that pregnant crack users are American women whose values, goals, frustrations, and perseverance arise from the same soil that produced "Betty Crocker" and a female attorney general. Yet, their access to either of these versions of the American Dream has been hampered by social processes of oppression and exclusion, and their hopes have been diverted and dissipated over time. The harms of drug use in pregnancy are symptoms of social problems and exclusionary practices extending far beyond the inner city. As individuals, professionals, and citizens, if we shift our attitudes and policies from exclusion and stigmatization to inclusion and harm reduction, we will regain a group of articulate, strong, and caring

women who have been detoured by dead-end lives into the world of crack cocaine and kept there by the scorn of the public.

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COMMITTEE ON HUMAN RESEARCH
OFFICE OF RESEARCH AFFAIRS, Box 0962
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

CHR APPROVAL LETTER

TO: Dyanne D. Affonso, Ph.D., R.N. Margaret H. Kearney, MS, RN
Box 0606 N-623

RE: Pregnancy and Cocaine: A Grounded Theory Study

The Committee on Human Research, the UCSF Institutional Review Board holding Department of Health and Human Services Multiple Assurance #M-1169, has reviewed and approved this application to involve humans as research subjects.

APPROVAL NUMBER: H1778-07587-01. This number is a UCSF CHR number and should be used on all consent forms, correspondence and patient charts.

APPROVAL DATE: December 19, 1991. **Expedited Review**

EXPIRATION DATE: January 1, 1993. If the project is to continue, it must be renewed *by the expiration date*. See reverse side for details.

ADVERSE REACTIONS/COMPLICATIONS: All problems having to do with subject safety must be reported to the CHR within ten working days.

MODIFICATIONS: All protocol changes involving subjects must have prior CHR approval.

QUESTIONS: Please contact the office of the Committee on Human Research at (415) [REDACTED] or campus mail stop, Box 0962.

Sincerely,

[REDACTED]
Reese T. Jones, M.D.
Chairman
Committee on Human Research

HEPC Project # 91007587

CHR APPROVAL LETTER

TO: Dyanne D. Affonso, Ph.D., R.N.
Box 0606

Margaret H. Kearney, MS, RN
N-623

RE: Pregnancy and Cocaine: A Grounded Theory Study

The Committee on Human Research, the UCSF Institutional Review Board holding Department of Health and Human Services Multiple Assurance #M-1169, has reviewed and approved this application to involve humans as research subjects.

APPROVAL NUMBER: H1778-07587-02. This number is a UCSF CHR number and should be used on all consent forms, correspondence and patient charts.

APPROVAL DATE: December 2, 1992.

Expedited Review

EXPIRATION DATE: January 1, 1994. If the project is to continue, it must be renewed *by the expiration date*. See reverse side for details.

ADVERSE REACTIONS/COMPLICATIONS: All problems having to do with subject safety must be reported to the CHR within ten working days.

MODIFICATIONS: All protocol changes involving subjects must have prior CHR approval.

QUESTIONS: Please contact the office of the Committee on Human Research at (415) [REDACTED] or campus mail stop, Box 0962.

[REDACTED]
Reese P. Jones, M.D.
Chairman
Committee on Human Research

HEPC Project # 91007587

COMMITTEE ON HUMAN RESEARCH
INITIAL SUBCOMMITTEE REVIEW APPLICATION
COVER PAGE

225

PRINCIPAL INVESTIGATOR (UCSF Faculty) Dyanne D. Affonso, Ph.D., R.N. **University** Professor **Family Health**
(Name & Degree) Dept. Care Nursing
Mailing Address Box 0606 **Phone** [REDACTED] **Is P.I. Sponsor/**
(Campus) Box 0606 **Number** [REDACTED] **Advisor Only? YES**
CO-P.I. **University**
(Name & Degree) Margaret H. Kearney, PhD cand. **Title** Doctoral Student **Dept. Family Health Car**
Mailing Address N623, Doctoral Study Room **Phone** [REDACTED] **SUBMISSION Nursing**
(Campus) N623, Doctoral Study Room **Number** [REDACTED] **DATE Nov. 30, 1992**
PROJECT TITLE
(Up to 150 Spaces) Pregnancy and Cocaine: A Grounded Theory Study

EXPEDITED REVIEW CATEGORY NUMBER 8 (from PART V-B of the UCSF Guidelines for
Research Involving Human Subjects, October 1987)

NAMES/DEGREES OF ALL OTHER INVESTIGATORS:

SITE (Check and discuss in protocol):

- Parnassus VAMC SFGH MtZION
 Other UCSF site Foreign
Other Institute for Scientific Analysis

HISTORY OF THIS PROJECT:

Previous CHR approval # H1778-07587-01
 New
 Modification (Highlight changes in protocol.)
 Renewal (Expiration Date 1/1/93)

SUBJECTS (Discuss in protocol.)

Estimate total number of subjects at all sites checked above.
(If multicenter, discuss overall number of subjects in protocol.)
Number (This Year) 0 (Total for Study) 60
Source(s) (interview data from another study)
Reimbursement _____

PROCEDURES (List all procedures to be done for purposes of the study, including surveys, chart reviews, etc.):

analysis of data collected for another study

Special Subject Populations: (Check and discuss in protocol. See Appendix G of CHR Guidelines.)

- HIV-Infected Individuals
 Minors
 Fetuses, Pregnant Women
 Those Unable to Speak or Read English
 Those Unable to Consent for Themselves
 Prisoners

FUNDING:

Will this study be funded?
 Yes No Pending
 Federal Gov. Other Gov. (i.e., State, City, WHO)
 Pharmaceutical/Device Co. Other Private
 Campus & University-wide Programs
 Departmental

Agency/Sponsor Name (Grant/Contract #, if known):

USPHS NRSA Predoctoral Fellowship
F31 NR06627

PRINCIPAL INVESTIGATOR'S SIGNATURE & DATE

(See reverse side for instructions and format.)

COV-SUB.OK (8/92)

Pregnancy and Cocaine: a Grounded Theory Study

Introduction. A dissertation research plan is described that will consist of analysis of data from a larger study. The UCSF doctoral student (Co-PI on this application) will participate in data collection and analysis for the larger project, but this participation will not alter the aims or conduct of the study as already approved by the IRB of the sponsoring agency and funded by NIDA. Therefore, approval of the UCSF Committee on Human Research is requested only to comply with School of Nursing academic requirements.

Study aims, background, and design. The dissertation focus falls within the aims of the larger study, entitled "An Ethnographic Study of Pregnancy and Drugs" (NIDA RO1 DA06832), being conducted by Marsha Rosenbaum and Sheigla Murphy of the Institute for Scientific Analysis, a private non-profit research organization in San Francisco. Because much of the research to date on drug use in pregnancy has focused on its effects on infants, the larger study was designed to describe the experience and context of the pregnant drug user herself. Pregnant and postpartum drug users (n=120) will be interviewed using qualitative and quantitative data collection techniques.

The dissertation study is an analysis of the interview data from cocaine users (n=60), a subset of the larger sample. This smaller analysis will focus on the pregnant and postpartum cocaine user's perspectives on mothering, drug use, and health care systems. Cocaine use in pregnancy has been associated with low birth weight and neonatal abnormalities, but pregnant cocaine users are less likely than are non-users to receive prenatal care that might identify and treat such complications. Information about pregnant cocaine users' perspectives on health care and perceived barriers to care will enable improvement of health programs and policies. Data collected as part of the procedures of the larger study will be analyzed to obtain this information.

Subject population. The sample for the larger study will consist of 120 pregnant and postpartum drug users recruited by flyers and chain referral from the San Francisco Bay area. The sample for the dissertation study will consist of 60 cocaine users from within the larger sample. No additional sampling procedures will occur in order to recruit this subset of participants for the dissertation study.

Procedures. No procedures from the larger study will be added or altered for the purposes of the dissertation research. In the larger study, after telephone screening and verification of pregnancy or postpartum status, respondents will be interviewed in a private location for a total of two to three hours. A one- to two-hour audiotaped qualitative interview will be conducted, and a one-hour interview will be completed using a structured questionnaire. Data will be analyzed using grounded theory methods and standard statistical techniques.

Risks. The dissertation study will not introduce any new risks to participants in the larger study. Risks of loss of confidentiality have been addressed in the larger study by deletion of all names and identifiers from study materials and storage of

all study materials in a locked file in the project office. A Certificate of Confidentiality has been obtained from NIDA for the project. The same protections will apply to the dissertation data. The risk of emotional distress has been addressed by careful informed consent, provision of psychological or obstetrical referrals when needed, and by supportive and sensitive conduct of the research.

Benefits. There are no direct benefits to respondents as a result of either the larger study or the dissertation analysis. General benefits to the target population include improved treatment programs and public policies in health, social service, and criminal justice.

Consent process. There is no separate consent process for the data analysis entailed in this dissertation study. In the larger study, participants will be fully informed of the aims and procedures of the study at initial contact and before the interview, the consent form will be read aloud and all questions answered before signature (or pseudonym) is obtained, and informants will be invited to contact the investigators at the project office if questions arise after the interview.

Qualifications of investigators. The faculty advisor and dissertation chair for the doctoral student Co-PI is Dyanne D. Affonso, Ph.D., R.N., Professor of Family Health Care Nursing. Dr. Affonso has conducted several large funded studies of pregnant and postpartum populations. Author of numerous scholarly articles and a text on maternity nursing, she is faculty director of a state-funded project administered by the Department of Family Health Care Nursing to oversee case-management nursing care of cocaine-using pregnant women and their infants.

The Co-Principal Investigator, Margaret H. Kearney, M.Ed., M.S., R.N., is a third-year student in the Ph.D. program of the School of Nursing. She has analyzed qualitative data as a research assistant with UCSF Nursing faculty and has conducted a pilot study involving observations and taped interviews with cocaine-using mothers in a drug treatment setting. Ms. Kearney participated in data analysis in a previous study with Rosenbaum and Murphy at the Institute for Scientific Analysis and is a research assistant on the current NIDA-funded study of pregnancy and drug use. The investigators of the larger study have expressed their support for Ms. Kearney's participation and are willing to collaborate in an advisory capacity with the dissertation committee.

PAD QUALITATIVE GUIDE -- SHORT FORM
Revised 1/15/93

CHILDHOOD

- Family scene
- Family setting
- Violence
- Drug use
- Year when left home

EARLY DRUG USE

- Age when first used drugs
- Setting where first used drugs
- Reasons for using drugs
- Consequences of early drug use

SCHOOL, WORK AND DRUGS

- Early goals
- Changes over time
- Effects of drug use

LEGAL HISTORY

- Arrests
- Jail/prison time
- Significant others' arrests and jail/prison time

HEALTH HISTORY

- Serious illnesses
- Chronic problems
- Injuries
- Medications

REPRODUCTIVE HISTORY

- First sexual experience: setting, voluntary vs. involuntary
- Birth control: types, reasons, experiences, failures
- STDs, other women's health problems
- Infertility or "ultra" fertility problems

PAST PREGNANCIES

- Age at first pregnancy, situation
- Outcome of each pregnancy: abortion, miscarriage, birth, child still living vs. deceased; reasons for outcomes
- Feelings and decisions each time, situation
- Drug use: effect on decisions, health
- * Strategies to control drug use

- Family: baby's father, others' involvement incl. violence,
- * Perceptions of the effects of violence on pregnancy
(probe for relationship between violence and drug use;
effects of drug use on help seeking for domestic violence)
- * Perceptions of the effects of drug use on pregnancy
- * Sources of information about effects of drug use during pregnancy
- * Their goals and biggest threats or fears (e.g. arrest, custody loss, fetal damage)
- * Strategies employed to control threats or fears

CURRENT/MOST RECENT PREGNANCY

- Situation, reactions, decisions, factors involved in decisions
- Changes in lifestyle since pregnancy, incl. family scene, violence, illegal activities
- * Perceptions of the effects of violence on pregnancy
(probe for relationship between violence and drug use;
effects of drug use on help seeking for domestic violence)
- * Perceptions of the effects of drug use on pregnancy
- Changes in drug use, needle sharing, treatment plans, factors affecting these, feelings about it
- * Strategies to control drug use
- Experience with treatment, prenatal care, social service agencies
- Changes in sexual practices, partners
- * Their goals and biggest threats or fears (e.g. arrest, custody loss, fetal damage)
- * Strategies employed to control threats or fears

CURRENT/EXPECTED SITUATION WITH NEW BABY

- Feelings about being a mom
- Custody situation, family, baby's father's roles, agencies involved
- Managing responsibilities, incl. drug use
- Drug use after delivery: when, how, what drugs
- * Strategies to control drug use

FUTURE EXPECTATIONS AND PLANS

- Children, custody, relationships
- Work, living situation
- Drug use
- Treatment, other services

OTHER IMPORTANT AREAS NOT COVERED

AN ETHNOGRAPHIC STUDY OF PREGNANCY AND DRUGS
(#1 R01 DA06832-01A1)

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CONSENT FORM

The purpose of this three year research project is to study drug use during pregnancy. Information obtained during this project may eventually benefit the society and pregnant drug users by providing a better understanding of the experiences of women who use drugs while pregnant.

Your participation in this study will be for the time it takes to complete one interview (3-4 hours). In addition you will be asked to submit to a urine test to verify your pregnancy. A smaller sample of respondents may be asked to participate in an optional follow-up interview, but it is not necessary that you complete a second interview.

Although everything discussed during your interview is completely confidential, there may be some risks associated with your participation in this research project. To protect you from the small risk of your loss of confidentiality: 1) a number will be substituted for all names on the project records, transcripts and in any staff discussion of data; 2) after transcription, tapes will be erased; 3) yours and any other names will be separated from any interview schedule or transcription; 4) the data will be available only to project staff; 5) a Confidentiality Certificate has been obtained from the Department of Health and Human Services, stating that we are authorized to protect the privacy of the individuals who are the subjects of this study by withholding their names and other identifying characteristics from all persons not connected with this research.

This interview is completely voluntary. Scientific Analysis Corporation cannot compensate you for any stress you might experience, so if you feel uncomfortable during the interview, you may refuse to answer any questions or you may terminate the interview. If you do so, you will not be penalized in any way.

If you would like further information about the research and your rights as a

THE INFORMED CONSENT FORM HAS BEEN PRESENTED AND EXPLAINED TO MY SATISFACTION. I UNDERSTAND THE RISKS AND BENEFITS INVOLVED, AND I CONSENT TO BE TESTED AND INTERVIEWED.

Respondent: _____ DATE _____
 SIGNED

WITNESSED BY: _____ DATE _____
 SIGNED



Alcohol, Drug Abuse and
Mental Health Administration
Rockville MD 20857

JUL 22 1991

Marsha Rosenbaum, Ph.D.
Institute for Scientific Analysis

Dear Dr. Rosenbaum:

Enclosed is the original Confidentiality Certificate No. DA-91-76 issued to the Institute for Scientific Analysis, and other participants who are conducting research known as "Ethnographic Study of Pregnancy and Drugs." This Certificate affords the Principal Investigator the privilege to protect the privacy of research subjects by withholding the names and other identifying characteristics of those subjects from all persons not directly connected with the conduct of this research. This Certificate is effective upon the date of the commencement of the research project and will expire at the end of July 1994.

If any questions or problems arise during the period this Certificate is in effect, please do not hesitate to write or call (301) [REDACTED]. If any changes as delineated in implementing regulations occur, the Principal Investigator must inform this office. Until the new regulations are implemented for section 301(d) of the Public Health Service Act, 42 CFR Part 2a (42 U.S.C. 2a.6) should be used.

[REDACTED]

Special Assistant to the Director
Office of Extramural Program Review
National Institute on Drug Abuse

Enclosure



CONFIDENTIALITY CERTIFICATE
No. DA-91-76

Office of the Director

issued to

EMPLOYEES OF THE INSTITUTE FOR SCIENTIFIC ANALYSIS
AND OTHER PARTICIPANTS

conducting research known as

"ETHNOGRAPHIC STUDY OF PREGNANCY AND DRUGS"

In accordance with the provisions of section 301(d) of the Public Health Service Act (42 U.S.C. § 241(d)) this Certificate is issued in response to the request of the Principal Investigator, Marsha Rosenbaum, Ph.D., Institute for Scientific Analysis, [REDACTED], to protect the privacy of research subjects by withholding their identities from all persons not connected with the research. Dr. Rosenbaum is primarily responsible for the conduct of this research.

Under authority vested in the Secretary of Health and Human Services by that section, all persons who -

1. are employed by the Institute for Scientific Analysis and its contractors and cooperating agencies; and
2. have, in the course of that employment, access to the information which would identify individuals who are the subjects of a research project entitled "Ethnographic Study of Pregnancy and Drugs,"

are hereby authorized to protect the privacy of the individuals who are the subjects of that research by withholding their names and other identifying characteristics from all persons not connected with the conduct of that research.

The research project will conduct a three-year ethnographic-type study of drug use during pregnancy in the San Francisco Bay area. The research will employ indepth interviewing, fieldwork and close-ended questions as the primary data gathering tools. The operative theoretical perspective guiding the proposed research is a combination of reference group and differential identification, role theoretic, and stigmatization theories. The project staff will interview a total of 120 pregnant or postpartum adult women who are using heroin, methamphetamine or cocaine singly or in combination and who are not in treatment. To gain a fuller understanding of the entire experience of drug-involved pregnancy, 40 women (20 of them will be injection drug users) will be interviewed from each of the three stages: the first five months of pregnancy; five months to full-term; and delivery to six months postpartum.

The qualitative interview guide will be a semi-structured instrument aimed at exploring the introduction and initiation to each drug used; social environments of use; pressures to use or not to use; the relationship of pregnancy to patterns of use; and barriers to treatment; methods of ingesting drugs; violence; involvement in criminal activities; and high-risk AIDS behavior (including needle-sharing and sexual practices).

As provided in section 301(d) of the Public Health Service Act (42 U.S.C. 241(d)):

"Persons so authorized to protect the privacy of such individuals may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings to identify such individuals."

This authorization is applicable to all information obtained pursuant to the research project entitled, "Ethnographic Study of Pregnancy and Drugs, NIDA grantee 1 R01 DA 06832-01," which would identify the individuals who are the respondents in the research conducted under that research project.

This Certificate does not represent an endorsement of the research project by the Department of Health and Human Services.

The Certificate is effective upon date of the commencement of the research project and will expire at the end of July 1994. The protection afforded by this Confidentiality Certificate is permanent with respect to subjects who participate in the research during any time the Certificate is in effect.

Date: 7/19/91



Charles R. Schuster, Ph.D.
- Director
National Institute on Drug Abuse

PAD CODE LIST -7/29/92

SHEIGLA, BECKY, MAGGIE, KATY, AND HENRIETTA

1. STAGE1: Experiences, discovery, pressures and decisions within the first five months of pregnancy (applies to current and past pregnancies). Includes issues concerning abortion and miscarriages. Trying to get pregnant (Can be double coded with Stage 2 if period of pregnancy cannot be determined)
2. STAGE2: Experiences, pressures and decisions within the last 4 months of pregnancy (applies to current and past pregnancies). Issues concerning baby moving, showing and stillbirths. Birthing experiences.
3. MOTHERNG: Postpartum experiences and reactions to newborn responsibilities. Experiences, attitudes, opinions and standards of mothering role with the newborn and/or other children. Response and reactions to the baby's health and/or special needs. Evaluation of other people's mothering abilities (including their own mom's) and motivations to become a mother.
4. SEXAIDS: Discussion of AIDS and risky behaviors (i.e. needle sharing and bleaching). Feelings and experiences with condoms, birth control, STDs.
5. CONTRLUSE: Any attempts to reduce/change drug use (during pregnancy or outside of pregnancy). Motivations, routes of administration, approaches, and tools used to control use. Includes attitudes, expectations and experiences of any form of drug treatment or barriers to treatment.
6. AGENCIES: Experiences and any dealings with any social service agency **other than** child protection and custody services. (hospitals, clinics, homeless shelters, WIC, AFDC, GA, SSI, schools etc.)
7. VIOLENCE: Accounts and reactions to rape, molestation, assault upon the respondents as an adult or a child, intimates of the respondent (friends, family or lovers). Times when they have acted out in violence (Child Abuse). Reactions to the violence in their social scenes.
8. GROWUP: Accounts of their lives growing up. Family settings, friends, education experiences and so forth.
9. CUSTODY: Feelings and accounts of custody battles over children (their own or other's battles) formal or informal. Includes dealings with child protection services.
10. MOMHLTH: Health issues during pregnancy and general health history. Methods of taking care of themselves. Accounts of injuries, conditions, suicide attempts, hospitalizations, complications, and methods of coping and maintaining health. Includes woman's mental health issues that they define as needing treatment.
11. CHILDLHPTH The child's health during or after birth. Special needs,

complications, injuries hospitalizations of any of their children. Includes accounts of health of other children and rumors of friends' kids.

12. MEN: Accounts of their relationships with the men in their lives, i.e. the baby's father and his role, their own fathers, their family, lovers and friends. Their relationship to the male networks, reference groups and notable male agency staff in their adult lives.
13. WOMEN: The role and influence of female networks, reference groups and notable female agency staff in their lives. Either their own mothers, friends, extended family or female lover's role in their adult lives (and pregnancy).
14. FUTURE: Discussion of hopes, plans and worries for the future. Any statement which reflects respondent's future orientation (could be how respondent felt about the future at a past time).
15. PREGUSE: Drug use during pregnancy. Changes over time. Methods of reducing, reasons for increases. Beliefs, opinions, pressures to use/not use, consequences, feelings and reactions. Drug purchases while pregnant.
16. DRUGUSE: Drug scene, using outside of pregnancy, initiation into drugs (double code with hustling when referring to selling drugs).
17. HUSTLING: Ways of getting money illegally. The hustling career, prostitution, drug sales pre, post or during pregnancy (double code with drug use when selling drugs).
18. MONYJOBS: Legal work history and goals. Acquiring and managing legal finances (including AFDC, GA and SSI). Budgeting strategies.
19. CRIMJUST: Respondent's or respondent's significant other's run-ins with the law and jail time. Any criminal justice system's impingement on their lives.
20. RELIGION: The role of spiritual beliefs/institutions in respondents' lives. Experiences, beliefs, religious laws or spirituality in relation to drugs and life (i.e. childbearing, mothering, abortion, self identity).
21. METHMEMO: Sections of text which refer to the methodology of interviewing or the relationship between the interviewer and respondent (i.e. periods where the respondent mentions how tired, hungry, stressed she becomes because of the interviewing process). Not routine tape breaks.
22. LIFESIT: Feelings, reactions, descriptions and responses to housing food, clothing and basic necessities, situation and condition. Includes accounts of tragedies, losses, and cruel twists of fate (i.e., deaths, losses from fires, earthquakes, floods, etc.).

23. RACECLASS: Any mentions which reflect respondent's views of status, prestige, sense of social standing. Statements that reveal sense of class standing. Mention or implication of racial attitudes or discrimination.