Interpersonal trauma, substance misuse and pregnancy: A phenomenological exploration of pregnant women and midwives in Scotland

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Declaration

I, Naomi Margaret Waddell, declare that this thesis is my own work and that no material contained in it has been submitted for another academic award.

Signed: Naomi Waddell

Date: 22.05.2018

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Abstract

Background: The relationship between interpersonal trauma (IPT) and substance misuse is complex and multi-factorial, but has not been examined fully in the existing few studies involving pregnant women who misuse substances. UK based midwifery education and practice is unique, but there is limited evidence regarding midwives experiences and perceptions of supporting this client group.

Aims: The aim of this study was to chronologically map out pregnant women's past experiences of abuse and substance use, explore their experiences and perceptions of their journey to motherhood and explore midwives' experiences and perceptions of supporting this client group.

Methods: A qualitative study was conducted. Five eligible pregnant women supported by specialist midwifery services in Central Scotland were recruited. Data were collected using a life history calendar (LHC), followed by an in-depth, semi-structured interview. Six eligible midwives were recruited from one NHS board in Central Scotland. In depth, semi-structured interviews were carried out.

Findings: Individual LHCs were converted into chronological timelines. Transcribed interviews were analysed using Interpretative Phenomenological Analysis. The life history calendars revealed the pregnant participants' experiences of IPT and substance misuse as complex, interconnected and ongoing, including during pregnancy and motherhood. Three major overarching themes emerged from the *pregnant* participants' interview transcripts: "psychological trauma", "dabbling to addiction" and "addiction and the identity of pregnancy and motherhood". Three major overarching themes emerged from the *midwifery* participants' interview transcripts: "psychological trauma", "stigma" and "managing unmanageable situations".

Conclusions: This study sheds new light on the lived experiences and perceptions of a previously under-researched and largely misunderstood group of vulnerable women. It highlights some of the challenges faced by midwives in clinical practice. Important areas for future research are highlighted, along with implications for multi-disciplinary education, policy and practice.

Glossary of terminology/list of abbreviations

Addiction – NHS Choices, (2015) definition of addiction is used - “not having control over doing, taking or using something to the point where it could be harmful to you”.

Clean – Used by the pregnant participants to describe themselves as not using illicit/illegal drugs/abstinence/taking only prescribed opiate substitution medication.

IPT - Interpersonal trauma.

IPV - Interpersonal violence.

Jaggers – Used by pregnant participants when talking about intravenous drug users.

The rattle - Used by pregnant participants when talking about withdrawal from substances.

PTSD - Post-traumatic stress disorder.

Polysubstance misuse – Drugs.com, (2017) definition of polysubstance misuse is used – “the abuse of 2 or more drugs that cause impairment or distress”.

PWMS – Abbreviation for pregnant women who misuse substances/pregnant women with problematic substance use/are substance dependant. Also used at times for newly delivered mothers.

Substance misuse - Mental Health Foundation, (2017) definition of substance misuse/abuse is used, that is “the continued misuse of any mind-altering substance that severely affects person’s physical and mental health, social situation and responsibilities”.

Vallie’s – Used by pregnant participants when talking about Valium.

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Chapter 1 – Introduction

1.1 Introduction

The aim of this chapter is to provide an overview of the literature and the background to the current study. First of all, an overview of the literature regarding interpersonal trauma (IPT) is presented. This is followed by a discussion of the literature regarding substance misuse. The wide and far-reaching range implications of both of these issues are described, including the impact on health and wellbeing, perceptions of substance users and the intricacies around disclosure of abuse.

1.2 Interpersonal trauma

The definition of what constitutes trauma has evolved in recent years (Jones and Cureton, 2017). Trauma was defined in the Diagnostic and Statistical Manual of Mental Disorders (3rd Edition) (DSM-III) as an event "outside the range of human experience" (American Psychiatric Association (APA), 1980, page 236), however, the DSM-IV (APA, 1994) and DSM-IV-TR (APA, 2000) brought about a more extensive definition, including events such as a road traffic accident and the death of a loved one. Between this more inclusive definition and the DSM-5 (APA, 2013a), however, a shift occurred as researchers suggested that it should be the event and not the symptoms themselves which were used to determine if something was traumatic. Trauma was therefore re-defined as exposure to actual or threatened death, serious injury or sexual violence in one or more of four ways: a) by directly experiencing the event; b) from witnessing, in person, the event occurring to others; c) by learning that such an event happened to a close family member or friend; and d) through experiencing repeated or extreme exposure to aversive details of such events. IPT is now therefore recognised as resulting from a variety of experiences including childhood maltreatment, sexual assault, physical assault, domestic violence, war, bereavement and crime.

Experiences of trauma are commonplace and remain embedded within global culture and economics, particularly amongst women and children (WHO, 2016). It is estimated that 1 in 4 adults worldwide have experienced physical abuse as children and many report having experienced neglect and emotional abuse (WHO, 2016).

Exposure to a spectrum of violence may be also be commonplace (Finkelhorn et al. 2005). Furthermore, 1 in 5 women and 1 in 13 men report surviving childhood sexual abuse (CSA) (WHO, 2016). CSA however, rarely occurs in isolation and is commonly interrelated with other childhood adversities (Draucker et al. 2011, Felitti et al. 1998, Gilson et al. 2008, Guthrie, 2004, Hillis et al. 2000, Leeners et al. 2010, Lukasse et al. 2001, Prentice, 2002, Van Der Kolk, 2014) and a sizeable difference between known and unknown cases of childhood maltreatment within the UK is known to exist (Radford et al. 2013).

With regards to experiences of trauma in adulthood, 30% of women in England and Wales are reported to have experienced interpersonal abuse since the age of 16 (Office for National Statistics, 2014*).* Within Scotland, the number of reported incidents of violence against women has continued to increase since 1999. For example, there were 58,439 reported incidents in 2013-2014, which rose to 59,882 in 2014-2015 (The Scottish Government, 2016). Additionally, these incidents are not isolated events as 5% of those experiencing partner abuse in the previous twelve months, said it had happened too many times to count (The Scottish Government, 2010/11), yet just over half of these incidents are recorded as a crime or offence (Scottish Government, 2016). It therefore seems that despite the increase in reporting, IPT against women remains a mostly hidden crime in this country (The Scottish Government, 2012/13).

1.3 Interpersonal trauma and wellbeing

IPT is widely recognized as leaving an imprint on the mental and physical wellbeing of survivors and may impact on many aspects of a survivors' life, including their relationships, feelings, identity, thoughts and behaviours (Felitti, 2002, Van Der Kolk, 2014). Survivors' responses to IPT may be so significant, that their emotional and physical equilibrium is impacted (Van Der Kolk, 2014) adversely affecting many systems, functions and responses within the body (Felitti, 2002, Van Der Kolk, 2014).

Exposure to traumatic experiences in early life has been found to alter brain structure (Vythilingam et al. 2002) and is associated with an alteration in neurocognitive functioning. This is significant as the part of the brain affected, the hippocampus, is

part of a group of structures that play an essential part in memory, spatial awareness, experiencing emotions such as anger and fear as well as learning and motivation (Gould et el. 2012, Luener and Gould, 2010, Tamminga, 2005, Tull, 2016).

Changes in the neuroendocrine system increase the likelihood of developing post-traumatic stress disorder (PTSD) (Pervanidou et al. 2012), which is the clinical manifestation of posttraumatic stress (APA, 2000). PTSD can significantly harm the health and wellbeing of survivors of trauma (Holditch-Davis, Bartlett, Blickman, & Shandor Miles, 2003) as they live with intrusive memories of traumatic experiences, disturbing flashbacks, nightmares and dissociative episodes (Newport et al. 2003, Van Der Kolk, 2014). Subsequent problems with self-protection, self-regulation and agency may be experienced, but many survivors never receive a diagnosis of PTSD (Seng, 2002).

More recent developments recognise that multiple or repeated experiences of IPT may lead to complex trauma (Mooren and Stofsel, 2015), whereupon survivors experience a gamut of reactions and symptoms which develop beyond PTSD symptomatology (Courtois, 2004). Complex trauma is compounded by the relationship the survivor has with the perpetrator, as many of the survivors' core belief systems are challenged and may lead to a disruption in thinking, particularly when the trauma has been experienced during a survivors' formative years (Mooren and Stofsel, 2015). Feelings and beliefs around safety, trust, self-esteem, intimacy and relatedness, power and control may be disrupted. Furthermore, a myriad of feelings may be experienced including sadness, guilt, shock, confusion and shame (Van Der Kolk, 2014).

There is strong evidence of health related problems and physical complaints associated with IPT and overall results from previous research suggest that interpersonal trauma is a non-specific factor for psychopathology and physical health problems (Kessler and Greenberg). Trauma survivors experience higher rates of somatization disorder characterized by gastro-intestinal disorders, gynaecological problems and pain, unexplained medical conditions and symptoms, report poor overall health and the aetiology of conditions including heart disease, gastrointestinal disorders and kidney disorders might, for some people, lie in their trauma history (Ellsberg et al. 2008, Fuller-Thomson et al. 2012, Evans-Campbell et al. 2006, Felitti,

1998, Felitti, 2002, Golding, 1999, Gould et al. 2012, Hilden et al. 2004, Iverson et al. 2013, Karatzias et al. 2015, Lesserman, 2005, Lynch et al. 2012, Norman et al. 2012, Talbot et al. 2009, Spataro et al. 2004, Sugaya et al. 2012, Vythilingam et al. 2002). Furthermore, IPT increases ones risk factor for chronic fatigue syndrome (Heim et al. 2009), obesity and Type II diabetes mellitus (Thomas et al. 2008), fibromyalgia (Imbierowcz and Egle, 2003), lung disease, malnutrition, vision problems (Spatz Widom et al. 2012) and sexually transmitted diseases (Hillis et al. 2000).

IPT is also associated with increased mental ill-health, including depression, psychotic symptoms, psychosocial disorder, PTSD and suicidal ideation (Ferrari et al. 2016, Fuller-Thomson et al. 2012, Janssen et al. 2004, Shenk et al. 2010, Spataro et al. 2004). These may be further compounded (Draucker et al. 2011, O'Dougherty et al. 2007) as many survivors may not have found adequate help and have ongoing difficulties in understanding what happened to them as children (Glaister and Abel, 2001).

Studies to date however, tend to focus on the impact of a particular experience of abuse in childhood. Given that most survivors of abuse will have experienced other forms of abuse, a rather fragmented picture of the cumulative effects of trauma is portrayed (Alvarez-Lister et al. 2014). Nonetheless, exposure to multiple childhood adversities, in particular domestic abuse and physical violence, is associated with intellectual, academic and behavioural problems (Holt et al. 2008, Samms-Vaughan and Lambert, 2017), difficulties in managing emotions and the ability to form positive relationships with others (Latsch et al. 2017), a higher level of trauma symptoms (Alvarez-Lister et al. 2014, Evans et al. 2008, Messman-Moore et al. 2000, Radford et al. 2013), depression (Gallo et al. 2017), suicide attempts (Sachs-Ericsson et al. 2017), future experience of intimate partner violence (Yan and Karatzias, 2016) and "age-related-disease risks" in adulthood (Danese et al. 2009). Furthermore, childhood victimisation experiences increase with age, particularly for children who were maltreated by a parent or carer (Radford et al. 2013).

1.4 Experiences of childbearing following trauma

Pregnancy, childbirth and motherhood are viewed as a positive rite of passage by many women (Edwards, 2005), nonetheless, this is a time of great anxiety for most women and a hugely significant part of any woman's life (Paradice, 2002, Lev-Wiesel. 2009). Perhaps unsurprisingly, exposure to negative life events prior to and during pregnancy have been found to have significant outcomes for the mother and the baby in terms of poor overall health and morbidity and mortality (Beck, 2001, Howard et al. 2013, Martin et al. 2006, Milgrom et al. 2008, Nole et al. 2003, Robertson et al. 2004, Thananowan and Heidrich, 2008). This has also been found in relation to exposure to interpersonal violence during pregnancy (Ahmed et al. 2011, Bhatta and Haque, 2015, Boy, 2004, Janssen et al. 2003, Lukasse et al. 2009, McFarlane, 2016, Sarkar, 2009, Silverman et al. 2006, Yampolsky et al. 2010) and natural disasters, such as earthquakes, on pregnant women and their babies (Harville et al. 2015, Hibino et al. 2009, Punamäki, 2017, Simeonova, 2009, Tan et al. 2009).

Studies to date have however, tended to focus on the impact of childhood trauma, sexual in particular, with few studies exploring the deleterious impact of other types of childhood trauma (Koniak-Griffin and Lesser, 1996). Perhaps this explains to some extent why Lev-Wiesel et al (2009) suggest that in the pregnant population, CSA is a trauma that causes the greatest negative long term effects. Survivors of CSA have been found to embark on their first pregnancy at a younger age (Lukasse et al. 2009, Roller et al. 2011), report considerably more of the common complaints in pregnancy and are more likely to smoke, have a higher Body Mass Index and report more mental distress (Lukasse et al. 2009). Furthermore, survivors of CSA are more frequent service users (Leeners et al. 2010) and in view of their higher distress levels, are more likely to experience increased poor health, which in turn leads to high risk pregnancies (Yampolsky et al. 2010).

Furthermore, CSA survivors have higher levels of depression in pregnancy, particularly amongst women who report the use of force and when abused by a family member (Benedict et al. 1999) and display higher levels of dissociation and post-traumatic stress symptoms prior to and following delivery (Andersen et al. 2012, Lev-Wiesel et al. 2009) which has been found to be detrimental, adversely affecting both

birth-weight, length of gestation (Seng et al. 2011) and maternal well-being following delivery (Lev-Wiesel, 2009, Seltmann et al. 2013, Seng et al. 2013). This in turn, has implications for parenting due to impaired bonding (Seng et al. 2004, Seng et al. 2013). Additionally, survivors may avoid antenatal care for fear of the physical examinations involved, as these may trigger flashbacks of the CSA they have been subjected to (Cole et al. 2009, Roller, 2011). PTSD may compound these fears and result in a reluctance to access adequate antenatal care (Bell et al. 2013), which may be alleviated by the midwife-mother relationship (Peeler et al. 2012).

Nonetheless, disturbing memories of abuse may be provoked during childbearing and touch, dissociation and feelings of fear, panic and powerlessness during the birthing experience may be very powerful for survivors of CSA (Parrat, 1994, Rhodes, 1994, Smith, 1998a, Smith, 1998b). The findings of Parrat, (1994) were confirmed by Roller, (2011) and Seng et al. (2004) who also revealed that survivors were at different stages of recovery and remembering from abusive experiences. Additionally, some of the women in the study by Roller, (2011) revealed that they engaged in negative behaviours, including the use of substances in order to control the pain from intrusive re-experiencing.

Following childbirth, the severity of the CSA the mother endured may further compound later parenting as a result of depressive symptoms experienced (Seltmann and Wright, 2013) and many survivors report significantly more overall parenting stress and find intimate aspects of parenting more challenging (Douglas, 2000). The impact of all forms of childhood abuse affects adaptation to parenthood therefore potentially extends across generations (Lang et al. 2010). This has clear implications for midwives as they must not only promote the well-being of women in their care, but their families too (NMC, 2008).

Many aspects of childbearing may however, promote positive feelings following trauma in childhood (Montgomery, 2013). Klingelhafer, (2007) found CSA survivors associated breastfeeding and motherhood with a sense of reclaiming their bodies and their sexual identities, therefore gave them a sense of healing from their history of CSA (Wood et al. 2010). On the other hand, Wood et al. (2010), found that the dissociation experienced in order to help cope whilst breastfeeding their infants, leaves many

survivors feeling little joy or emotion about this experience. Nonetheless, Prentice et al. (2002) found that CSA survivors were more likely to breastfeed than women who had not experienced CSA.

1.5 Screening for adverse life experiences

Screening all pregnant women for a history of adverse life experiences and psychiatric illness is recommended as maternal perinatal health has significant costs for maternal, infant and family welfare (Meltzer-Brody et al. 2011). Routine Enquiry (RE) of abuse was introduced into the priority health settings of maternity, A&E, mental health, substance misuse, sexual health services and community nursing in Scotland in 2008 (NHS Scotland Programme, 2013). Routine enquiry aims to enable earlier intervention and improve health outcomes by giving survivors of different types of trauma the opportunity to discuss issues and access support if needed and should take place during the antenatal booking appointment with a midwife (NHS Scotland, 2017). The figures regarding RE and disclosure of different types of trauma, CSA in particular, within NHS Lothian are however, very low (NHS TRAK, 2012-2017). The majority of staff are found to open the RE page, but not ask the questions. Furthermore, they do not return to these questions at any other time during pregnancy or the early postnatal period. This appears to be due to a variety of reasons including lack of time, resources and privacy (NHS TRAK, 2012-2017).

A number of barriers for midwives asking pregnant women about trauma histories have been identified. These include limited time, support or resources to respond appropriately to women and feeling overwhelmed at the prospect of asking (Eustace et al. 2016, Henriksen et al. 2017, Husso et al. 2011, Jackson and Fraser, 2009, Lazenbatt et al. 2015, Mollar et al. 2009, Taylor et al. 2013, Thomas et al. 2016). Midwives own personal experiences of domestic abuse were found to affect their perceptions about asking about domestic violence by Mezey et al. (2003). Barriers to asking women about IPV have, however, been found to be similar amongst a number of health care professionals, practising across a range of specialities (Waalen et al. 2000). For example, emergency department workers revealed feelings of ambivalence towards victims of IPV as although they expressed openness and willingness to help people attending who had been victims of IPV, they felt that victims of IPV had a responsibility to disclose and manage IPV (Zijlstra et al. 2017).

Midwives have however, identified the importance of routine antenatal questioning about men's violence towards women (Stenson et al. 2004) and found an increase in disclosures regarding domestic violence when asked (Price et al. 2007), yet, like other health care workers, appear to shy away from discussing sexual issues including CSA with patients (Haboubi, 2005, Lee et al. 2012, Verhoeven, 2003). Guthrie, (2004) found that many workers feared causing more harm than good by asking about CSA. However, Prescott, (2002) warns that by not asking about abuse histories, health care professionals may be inadvertently reinforcing the social taboo surrounding CSA, suggesting that it is of no importance. Talking about childhood sexual abuse however, has been found to be helpful (Chouliara et al. 2007) and Leeners et al. (2010) found that many survivors would welcome being asked about CSA and many would disclose if asked (Kramer 2004, Mcgregor et al. 2010).

1.6 Disclosing trauma histories

A number of barriers to disclosure of trauma have been identified in the literature. These include lack of time and preparedness of practitioners to ask, anxiety and fear about the possible negative consequences of routine screening and women feeling that the problem is theirs to keep (Bachuss et al. 2003, Gielen et al. 2000, Hamberger et al. 1998, Hayden et al. 1997, Hegarty and Taft, 2001, Rodriguez et al. 2001, Simmons et al. 2011). Disclosure has however, been found to be worthwhile (Gerbert et al. 2008), women feel comfortable about being asked (Brown, 2000, Leeners et al. 2010, Wendt et al. 2011) and many would disclose if asked (Kramer, 2004, Mcgregor et al. 2010). Many women may have tried to tell before but were not believed (Erdmans et al. 2008) or experienced a negative reaction to their disclosure (Jonzon et al. 2004). Some describe "testing the water" regarding disclosure, wishing it had been discovered sooner (Guthrie, 2004). Factors found to help women disclose include feeling supported and receiving a sensitive response (Hegarty and Taft, 2001, Rollans et al. 2013).

1.7 Interpersonal trauma and substance use

There is a strong body of evidence supporting associations between IPT and substance use, although research to date has tended to focus on the impact of

childhood trauma. Nonetheless, quantitative studies show significant and consistent associations between sexual abuse (Asberg et al. 2012, Freeman et al. 2002, Mullen et al. 1999, Ompad et al. 2005, Ullman et al. 2013), multiple forms of abuse (Afifi et al. 2012, Ahmad et al. 2013, Dube et al. 2003, Garland et al. 2013, Medrano et al. 1999), family history of violence/physical abuse (Chermack et al. 2000, Fergusson et al. 1998, Gutierres et al. 2006, Lansford et al. 2010) and substance misuse.

Associations between childhood experiences of physical and sexual abuse (Brems et al. 2002, Tripodi et al. 2013), physical abuse and parental drug/alcohol use (Nyamathi et al. 2001), emotional abuse and maternal substance use (McLaughlin et al. 2012) and substance misuse have also been revealed. Furthermore, qualitative enquiry by Erdman et al. (2008), Clum et al. (2009), Hall, (1999) and Hall, (2000) describe and explore complex abuse histories and women's trajectories of life following childhood abuse. Issues around teenage pregnancy (Erdman et al. 2008), substance misuse from adolescence onwards as a means to cope (Clum et al. 2009), feelings of loss of childhood (Hall, 1999) and marginalization (Hall, 2000) are revealed. Garland et al. (2013) surmise a "feedback loop between substance misuse and psychological distress" however, the complex mechanisms underpinning this have not, as yet, been fully investigated. Furthermore, contemporary research may yield different results. For example, data collected in the '80s and '90s (Mullen et al. 1999, Ompad et al. 2005, Fergusson et al. 1998, Hall, 1999, Hall, 2000, Medrano et al. 1999, Nyamathi et al. 2001) may reflect a time when people were less open to discussing issues around child abuse and substance use, which may have resulted in under-reporting of experiences.

A smaller number of studies examine associations between IPT in adulthood and substance use. These suggest significant and consistent associations between IPT in adulthood and substance misuse amongst different populations of women (Guitierres, 2006, McCauley, 2009, Poole et al. 2008, Rees et al. 2011, Shannon et al. 2008, Simoni et al. 2004, Sullivan et al. 2012). Whilst some of the participants in a Scottish based survey by Dolev and Associates, (2008) were already using substances prior to the onset of domestic abuse, most participants felt that there was a link between their use of substances and domestic abuse. Over half of the participants reported that their substance use had increased during the time they were

experiencing abuse, some felt that it had stayed the same, but none reported that it had decreased. Women were cited as using substances in order to dull the physical and emotional pain they were experiencing as a result of domestic violence and in order to escape the reality of the situations they were living in. Lifetime experiences of IPT are also positively associated with substance misuse with a cumulative effect suggested by Ullman, (2013) and Hedtre et al. (2008).

1.8 Substance use/misuse

Substances have been used and misused in many societies worldwide and throughout the ages and as such, do not present a new phenomenon (Edwards, 2004). However, contemporary illicit drug and alcohol misuse are costly to all levels of society on a worldwide scale. In financial terms, illicit drug and alcohol misuse are costly in terms of healthcare, crime and criminal justice, employment and loss of earnings. These are estimated to cost more than $587 billion in the United States of America (Center for Disease Controls and Prevention, 2016, United States Department of Justice, National Drug Intelligence Centre, 2011), however, this figure is set to increase, as the aging population of people with substance use disorders is expected to double from an estimated 2.8 million to an estimated 7.7 million (Han et al. 2008). In Australia, illicit drug and alcohol use cost $56.1 billion dollars (Ministerial Council on Drug Strategy, 2015). The financial costs of problematic substance use in England and Wales (Home Office, 2016) are estimated to be £21 billion per year, whilst in Scotland, these are estimated to cost £7b/year (NHS, 2012, Scottish Government, 2012, Scottish Government, 2014), which The Scottish Government, (2016) equates to costing approximately £1800 per adult.

The route to taking substances is multi-factorial. Human beings are natural pleasure seekers driven, in part, by a series of chemicals which are released in response to what we like and want (Saah, 2005), furthermore, personality traits such as risk taking and impulsivity, response to stress and genetic factors are multiple variants that predispose one to trying, using and becoming addicted to substances (Kreek et al. 2005). Added to this are environmental factors such as widespread availability of substances (Hall, 2012), role modelling behaviour (Scaramella et al. 2002), peer pressure (Osgood et al. 2013) and acute and chronic stresses resulting from a variety

of sources including family dysfunction and relationship problems (Hawkins and Catalano, 1992). The neuropsychological basis of addiction theory posits that chronic drug use impairs learning, memory and dopamine system to the extent that habitual drug seeking behaviour takes place. This behaviour is further influenced by the stimuli associated with substances and may go some way to explain why people continue to use substances in the face of stigma and the impact on home and family life (Everitt et al. 2001, Kent and Berridge, 1993).

Women's drug use and treatment entry demographics have been found to differ significantly from men's (Powis, 2009, Wechsberg et al. 1998). Women tend to be younger, use smaller amounts and use for a shorter length of time than men (Wesetermeyer and Boedicker, 2000, Powess et al. 2009). They are also less likely to use intravenous drugs (Powess et al. 2009). Additionally, women's drug use has been found to be significantly influenced by having a substance using sexual partner (Wesetermeyer and Boedicker, 2000, Powess et al. 2009) with most female intravenous users in the study by Powess et al. (2009) reporting to have been injected for the first time by their male partner.

1.9 Alcohol misuse

Scotland is reported to have a particularly unhealthy relationship with substances, in particular alcohol (Scottish Government, 2012) and in 2015, 20% more alcohol was sold per adult in Scotland than in England and Wales combined (NHS Scotland, 2015). Recent Scottish government legislation has aimed to address some of the issues associated with the availability of cheap alcohol in Scotland, nonetheless, alcohol sales have increased in recent years (Scottish Government 2009, Scottish Government 2016).

Despite theories around the "French Paradox", whereby the consumption of red wine may play a protective role against coronary heart disease (Ferrieres, 2004, Renaud and de Lorgeril, 1992), there is no evidence for recommending the consumption of alcohol (Grønbæk, 2009) and current advice from the Department of Health (DOH), 2016) supports this approach. UK government alcohol guidelines were recently changed in order to reduce potential associations between alcohol and ill-health (DOH, 2016) and with regards to drinking alcohol in pregnancy, advice from the Chief Medical

Officer for Scotland is clear, that is: ‘avoid alcohol when pregnant or contemplating pregnancy, no alcohol means no risk’ (DOH, 2016, The Scottish Government, 2016).

Health and social care problems related to alcohol use within Scotland remain a major cause for concern (NHS Scotland, 2012). In order to facilitate discussion of alcohol intake with the aim of helping individuals reduce their intake to safer levels, Alcohol Brief Interventions (ABI) should take place within the priority settings of A&E, mental health and antenatal care and in the period between 2016-2017, 86,560 ABIs were delivered (The Scottish Government, 2017).

1.10 Drug misuse

Within the United Kingdom (UK), substance misuse rates are currently higher than in Europe (Home Office, 2016). Given the mostly hidden nature of drug use, accurate prevalence rates are hard to obtain, however, figures regarding the seizure of drugs within Scotland suggest the scale of the problem to be high (The Scottish Public Health Observatory (ScotPHO), 2017). It is, however, estimated that in Scotland, in the period 2013-2014, there were 61,500 15-64 year olds with problematic drug use, the majority (70%) of whom are male. The percentage of people seeking treatment for heroin in Scotland has however fallen since 2006/07, as has the number of people injecting heroin and sharing drug related equipment (NHS Scotland, 2017). Of the female drug users in Scotland, most are of childbearing age and many report their first use of illicit drugs as teenagers. Opiate use is common, however, poly-substance misuse, including the use of alcohol, is widely reported amongst this group (NHS, 2012, ScotPHO, 2017).

Increased physical and mental ill-health are associated with substance misuse (Adrian and Barry, 2003). Depression levels have been found to be significant amongst heroin users entering treatment (Teeson et al. 2005) and amongst people accessing needle exchange programs (Brienza et al. 2000). Major depression levels are also reported to be high amongst people on methadone maintenance therapy (Callaly et al. 2001, Peles et al. 2007). Harvard et al. (2006) however, found that the rates of major depression declined significantly amongst people on methadone maintenance after 12 months of treatment, but it was found to significantly impact treatment uptake and

retention and was associated with greater drug use, risk taking behaviours and poorer physical and mental wellbeing.

Nonetheless, Holt and Treloar, (2007) found that drug users in treatment used a variety of self-care strategies in relation to anxiety and depression and Drumm et al. (2005) found that drug users considered themselves to be actively involved in increasing their wellbeing in terms of sexual health, nutrition, exercise and seeking medical attention. This finding was also reported in a study by Duterte et al. (2011), who found that drug users were strongly aware of their health and wellbeing. Their behaviours were also reported to be similar to the non-drug using population, for example, they tried to achieve regular eating patterns, a good night sleep, regular exercise and took multi-vitamins. Nonetheless, injection drug use has been associated with increased health service use (Chitwood et al. 1998), in particular emergency room treatment (Cherpitel, 2003, McGeary and French, 2000, Sterk et al. 2002).

1.11 Substance misuse in pregnancy

Neonatal and obstetric outcomes are poorer amongst pregnant women with problematic substance use (PWMS) and the effects of substance use during pregnancy are well documented (Bandstra et al.2010, Day et al. 2005, Maguire et al 2016, Narkowicz et al. 2013, Oyelese and Cande, 2006, Pinto et al. 2010, Scottish Executive, 2006, Simmat-Durrand et al. 2014, Singer et al. 2016, Wright et al. 2007, Zhao et al. 2017).

The use and misuse of substances are known to be harmful to fetal and maternal wellbeing and are associated with ectopic pregnancy, miscarriage, placental insufficiency, reduced fetal growth, low birth weight and preterm delivery (Keegan et al. 2010, Kutlu, 2008). Fetal alcohol spectrum disorders (FASD) may result in lasting learning and development difficulties, fetal alcohol disorder (FAD), which results in distinctive facial features, restricted growth and learning and development difficulties (Alcohol Focus Scotland, 2017), earlier delivery, lower birth weight and withdrawal symptoms in the new-born baby (Bauer et al. 2005).

Additionally, long term morbidity and mortality are found to be significantly increased amongst women who have misused substances during pregnancy (Kahila et al 2010, Minnes et al 2012) and substance misuse is associated with a significant number of maternal deaths in the UK (Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRACE-UK), 2015). Furthermore, PWMS face additional challenges including social deprivation, fear of involvement of multiple agencies and guilt around drug use as well as feeling distressed, stigmatized, vulnerable, marginalized and judged by staff as a result of their substance use (Banwell et al. 2006, Chandler et al. 2013, Cleveland et al. 2013, Hardesty and Black 1999, Howell et al. 1999, NHS, 2012, National Institute Clinical Excellence, (NICE), 2010, Reid et al. 2008, Scottish Government, 2011, Stadnyk et al. 2007, Walsh, 2011).

Nonetheless, pregnancy has been found to be a time of positive change and a "window of opportunity" in studies by Daley et al. (1998), Jessup et al. (2005) and Radcliffe, (2011b). Motherhood, too can be a time of self-reflection as Chandler, (2013), McLelland et al. (2008), Mosedale et al. (2009) and Reid et al. (2008) reveal that mothers in these studies are very aware of the detrimental impact substance misuse had on their children's lives and were found to develop strategies to try to keep their children safe. Furthermore, Hardesty and Black (1999) found that motherhood provided a "lifeline" for Latina women. Within the UK, Chandler et al. (2013) and McLelland et al. (2008) explored these mothers struggle with substance misuse and mothering. Within the context of parenting, they revealed a number of issues including ideas around not fitting in with society's notions of "ideal parenthood", a desire to try to protect their children from their drug use and on-going stigma. Additionally, Radcliffe (2011b) found that they longed to be "normal mums".

1.12 Perceptions about the substance misuser

Substance misusers appear to challenge ideas around societal norms as attitudes towards people who misuse substances has been found to remain, over all, mostly negative (Scottish Government, 2009), particularly towards those who misuse drugs (Home Office, (2016). Edwards, (2006) describes a "spectrum" of acceptance or deviance regarding substance users, whereby societal attitudes and prejudices differ considerably, depending on what people are using and who is using them. This

“spectrum” perhaps in some ways explains why dependence on a widely accepted, yet potentially addictive substance such as tobacco, may be considered almost inevitable, but this understanding will probably not be conveyed towards other known addictive substances, such as heroin.

1.13 Health care workers attitudes to people who misuse substances

Negative, moralistic attitudes towards substance misusers have also been found to exist amongst health professionals in a variety of studies (Chang et al. 2013, Harling et al. 2012, Howard et al. 2000a, Howard et al. 2000b, Monks et al. 2013, Richmond et al. 2003, Van Boekel et al. 2013) suggesting that health care workers may be “encultured” into treating substance users with disdain. Additionally, significant minorities of health care professionals regard substance misusers as “immoral” (Howard et al. 2000a, Howard et al. 2000b) and many have been found to regard working with substance misusers as “less important” (Gilchrist, 2011). Furthermore, some health professionals have been found to view illicit drug users so negatively, that they would go to the extent of rejecting further education and training in order to avoid contact with them (McLaughlin, 2006), but it remains unclear if health care professionals perceptions of substance misusers are related to their professional or personal barriers or beliefs.

De Bertoli et al. (2014) suggest that international drug policy may affect health care professionals’ attitudes regarding working with people who use substances, however, education (Ramirez-Cacho et al. 2007, Puskar et al. 2013) and personal use of substances (Richmond et al. 2003) have been found to positively influence health professional’s attitudes towards this client group. However, this was in contrast to the findings of Ford et al. (2014) and McLaughlin et al. (2006).

1.14 Midwifery practice in Scotland

Midwives in Scotland provide a unique public health role for childbearing women and families within a number of national health and social policy frameworks (NHS, 2009, The Scottish Government, 2007, The Scottish Government, 2008a, The Scottish Government, 2008b, The Scottish Government, 2010, The Scottish Government,

2011a) and are the first point of contact for all pregnant women (NHS, 2013). The overarching principles for maternity care and practice in Scotland aim to challenge health inequalities and provide the corner stone of contemporary Scottish midwifery practice, which is delivered within diverse geographic locations and wide socio-demographic contexts (The Scottish Government, 2011b).

A number of midwife-led and consultant-led maternity services are provided within 14 NHS Boards across Scotland. Antenatal care is currently provided in both hospital and community settings and the majority of women in Scotland are supported by community based midwives within the antenatal and postnatal period (Scottish Government, 2017). There are, however, substantial differences amongst the NHS Boards regarding the availability of choice of place of birth and most women deliver their babies within the hospital setting (NHS, 2009).

Women and their families generally express high levels of satisfaction with the current maternity services in Scotland, nonetheless, a new model of care, “Best Start” (Scottish Government, 2017), is currently in the early stages of implementation. “Best Start” (Scottish Government, 2017) is expected to improve the quality, choice and safety of maternity and neonatal services in Scotland through the provision of a more holistic, person-centred model of maternity service delivery. Women will be supported closer to their own homes, normality will be facilitated and the care and support of vulnerable women will be improved. These goals will be achieved through a number of recommendations which include continuity of midwifery carer, person-centred maternity and neonatal care and a universal model of multi-professional working.

A number of factors including the changing needs of women and families, changes in birth rate and NHS work force considerations in Scotland have driven the recommendations within “Best Start” (Scottish Government, 2017). These recommendations mark a seismic shift in the provision and delivery of maternity services for women, their families and maternity care workers (Ross-Davie, 2017). In terms of midwifery practice, many midwives face significant changes in education, development and how and where they work (Ross-Davie, 2017).

1.15 Conclusion

This chapter has provided an overview of the literature regarding interpersonal trauma and substance misuse. Trauma histories are commonplace amongst women. Studies to date tend to focus on the impact of childhood trauma amongst non-pregnant women, however, abuse is known to occur at various times in the lives of many women. Women's experiences of childbearing and mothering may be impacted by the trauma they have experienced. Screening all pregnant women for a history of adverse life experiences and psychiatric illness is recommended, however, a number of barriers for midwives asking pregnant women about trauma histories, CSA in particular, have been identified. A number of barriers to disclosure of trauma have been identified in the literature, however, it appears that women feel comfortable about being asked and would disclose if asked.

There is a strong body of evidence supporting associations between IPT and substance use however, this tends to focus on associations between childhood trauma and substance use amongst non-pregnant populations. Neonatal and obstetric outcomes are poorer amongst pregnant women with problematic substance use, yet few studies to date have explored interpersonal trauma as a possible mechanism underlying their use of substances. Furthermore, PWMS face additional challenges including social deprivation, fear of involvement of multiple agencies and guilt around drug use. Pregnancy and motherhood have however, been found to be a time of positive change, yet attitudes towards people who misuse substances has been found to remain, over all, mostly negative, including amongst health professionals.

1.16 Thesis structure

This introductory chapter provided an overview of the literature, in order to position the study within the wider literature. Chapter 2 will present the findings of two narrative literature reviews. Literature review 1 – "The pregnant substance user", identifies the current evidence base regarding possible associations between IPT and substance misuse amongst pregnant women. Literature review 2 – "Midwives' perceptions of the substance misuser", identifies the current evidence base regarding midwives experiences and perceptions of supporting pregnant women who misuse substances

(PWMS). Chapter 2 ends with the aims of the study and the research questions. Chapter 3 details the methodology employed in this study, in terms of the decisions made, the data collection and the analysis of the data. The findings of this study are presented in Chapter 4. First of all, the findings from the pregnant participants are presented. This is followed by the findings from the midwife participants. The overall conclusions are then presented. Chapter 5, the discussion chapter, presents the key findings of the study, the implications for practice, future research, the strengths and limitations of the study and the conclusions that can be drawn. Finally, my reflexive journey is provided in Chapter 6.

Chapter 2 - Literature review

2.1 Introduction

Two narrative literature reviews were undertaken. The overall aim of the literature reviews is explained first. This is followed by the rationale for undertaking narrative literature reviews. The first narrative literature review undertaken - Literature review 1 – "The pregnant substance user" aimed to identify the current evidence base regarding possible associations between IPT and substance misuse amongst pregnant women. The methods employed to conduct this review are explained. The results of this review are then presented, followed by a discussion of the gaps identified.

The second literature review undertaken was Literature review 2 – "Midwives perceptions of the substance misuser", aimed to identify the current evidence base regarding midwives' experiences and perceptions of supporting pregnant women who misuse substances (PWMS). The methods employed to conduct this review are explained. The results of the review are then presented, followed by a discussion of the gaps identified. This is followed by an overall conclusion regarding the results and gaps identified in two narrative literature reviews.

A summary of the gaps identified in Literature review 1 is then presented, followed by the proposed study responses to these gaps. A summary of the gaps identified in Literature review 2 is then presented, followed by the proposed study responses to these gaps. Finally this chapter ends with the aims of the study and the research questions.

2.2 Aims of literature review

A review of previous, pertinent literature is a fundamental feature of any academic work and helps identify areas where a wealth of research exists, or areas where further research is required (Webster and Watson, 2002). Furthermore, reviewing the

literature brings together current evidence and helps the researcher justify their area of study (Aveyard, 2010). This literature review aimed to identify potential limited evidence base regarding possible associations between IPT and substance misuse as well as midwives experiences and perceptions of supporting this client group.

Systematic reviews of the literature, particularly Cochrane reviews, play an important role in helping to make sense of the evidence when clinical healthcare decisions are required (Moseley et al. 2009, Starr et al. 2009). As the name suggests, systematic reviews are carried out in a methodical and orderly manner. They answer specific questions that have been made explicit at the beginning of the review, thereby enable an unbiased assessment of primary research evidence, particularly the results of specific treatments and interventions (Forward and Hobby, 2002). However, as they are carried out at one point in time, they become outdated whenever new evidence is available (Brown and Sutton, 2010).

Narrative literature reviews are often criticised for being undertaken in a less rigorous manner than systematic reviews. First of all they do not normally set out the methodological approach used to identify, select and critically appraise results of the studies included, hence allow for replication of the review by another author (Brown and Sutton, 2010). Furthermore, there is the potential for bias due to the broad nature of the questions used as the basis for the narrative review as well as the broad array of literature included (Rother, 2007).

In contrast to a narrative review, meta-analysis involves the precise mathematical combination of the results from a large collection of original data in order to integrate the findings (Glass, 1976). Interpretation of results of meta-analysis may be troublesome however, as many readers may not be conversant with the statistical techniques employed. Not unlike the results from a systematic review, meta-analysis has the potential for inaccurate conclusions to be presented or taken from the data, due to the inclusion of poor quality studies which thereby affects reliability.

Integrative reviews also play an important role in evidence-based practice. However, concerns surrounding lack of rigour, bias and inaccuracy exist around the complexities involved in combining different methodologies. Furthermore, despite strategies to

improve the quality of data collection and extraction, integrative reviews may be poorly conducted in terms of analysis, synthesis and conclusion (Whittemore and Knafl, 2005).

For this study, a narrative review as described by Green et al. (2006) was chosen for each subject. The reviews of the two subjects aimed to increase my knowledge regarding possible associations between IPT and substance use in pregnant women as well as midwives' perceptions of supporting pregnant women with problematic substance use. Furthermore, the reviews aimed to identify gaps in the current literature. This approach therefore provided the best fit for a study using Interpretative Phenomenological Analysis (Smith et al. 2009).

In order to minimize and address concerns around rigor, transparency and replication, some of the steps associated with a systematic review were adopted for each review (Brown and Sutton, 2010, Bryman, 2012, Nightingale, 2009). I was keen to be able to include a wide range of papers and be able to scope the literature more widely, therefore a specific research question was not set for either review. However, to ensure rigor and consistency in approach, a set of criteria were developed in order to help identify which papers to include in the reviews. The systematic approach for each narrative review is explained further in the following sections.

2.3 Literature review 1 – "The pregnant substance user"

2.3.1 Search strategy

The subject Librarian was consulted regarding the search terms used, after which, an explicit and detailed search of relevant electronic databases was conducted. The following databases were searched: MEDLINE, AMED - The Allied and Complementary Medicine Database, CINAHL (Cumulative Index of Nursing and Allied Health Literature) Plus with Full Text, Psychology and Behavioural Sciences Collection and PsychINFO. The following search terms were used: substance-related disorders OR alcoholism OR substance misuse OR substance abuse OR drug abuse OR drug misuse OR alcohol abuse OR alcohol drinking and combined with pregnancy OR pregnant women. These search terms were then combined with: sex offenses OR

incest OR physical abuse OR child abuse OR adult survivors of child adverse events OR emotional abuse OR psychological trauma OR stress disorders, post-traumatic. The following inclusion criteria were employed in order to assess relevance:

- Explore possible relationship between IPT and substance misuse amongst pregnant women (self-report or patient/government records).
- Include pregnant women aged 18+.
- Published in English.
- Published 1990-2017.
- Primary and secondary research.
- Qualitative, quantitative and mixed methods studies.

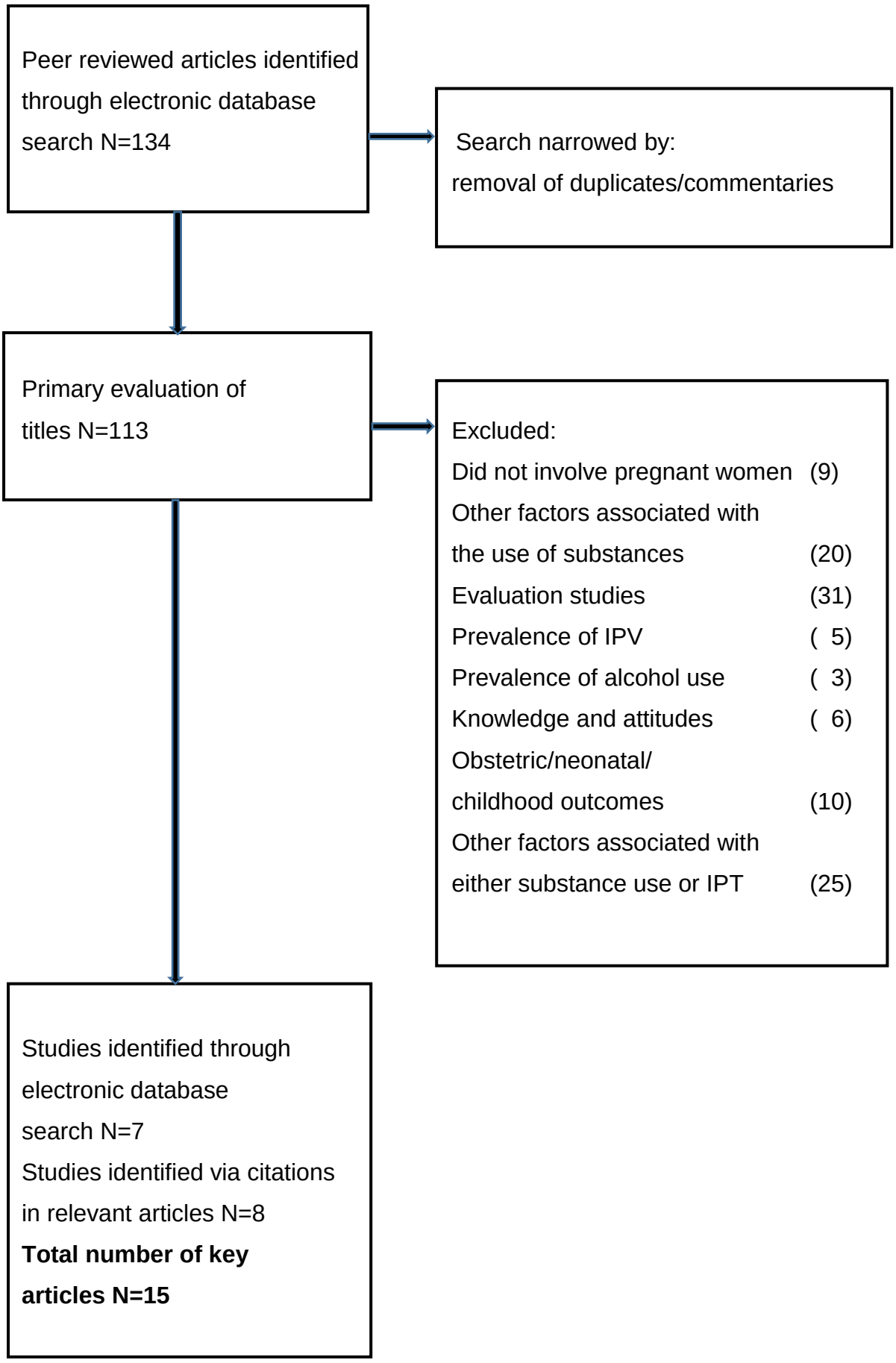
Relevant articles cited in reference lists and bibliographies of the literature were also explored. The search was undertaken in July 2017. It focussed on papers published over a twenty seven year period between January 1990 and July 2017. Studies which did not meet the above inclusion criteria were excluded.

Table 1 (a) Database search – The pregnant substance user

	Query	Limiters/Expanders	Last Run Via	Results
S4	(substance-related disorders OR alcoholism OR substance misuse OR substance abuse OR drug abuse OR drug misuse OR alcohol abuse OR alcohol drinking) AND (pregnancy or pregnant women or pregnant) AND (sex offenses OR incest OR physical abuse OR child abuse OR adult survivors of child adverse events OR emotional abuse OR psychological trauma OR stress disorders, post-traumatic)	Limiters - Published Date: 19900101-20171131; Publication Year: 1990-2017 Narrow by SubjectMajor: - pregnancy Narrow by Language: - english Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Plus with Full Text;eBook Collection (EBSCOhost);AMED - The Allied and Complementary Medicine Database;MEDLINE;Psychology and Behavioral Sciences Collection;PsycINFO	134
S3	(substance-related disorders OR alcoholism OR substance misuse OR substance abuse OR drug abuse OR drug misuse OR alcohol abuse OR alcohol drinking) AND (pregnancy or pregnant women or pregnant) AND (sex offenses OR incest OR physical abuse OR child abuse OR adult survivors of child adverse events OR emotional abuse OR psychological trauma OR stress disorders, post-traumatic)	Limiters - Published Date: 19900101-20171131; Publication Year: 1990-2017 Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Plus with Full Text;eBook Collection (EBSCOhost);AMED - The Allied and Complementary Medicine Database;MEDLINE;Psychology and Behavioral Sciences Collection;PsycINFO	1,253
S2	(substance-related disorders OR alcoholism OR substance misuse OR substance abuse OR drug abuse OR drug misuse OR alcohol abuse OR alcohol drinking) AND (pregnancy or pregnant women or pregnant)	Limiters - Published Date: 19900101-20171131; Publication Year: 1990-2017 Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Plus with Full Text;eBook Collection (EBSCOhost);AMED - The Allied and Complementary Medicine Database;MEDLINE;Psychology and Behavioral Sciences Collection;PsycINFO	18,297
S1	substance-related disorders OR alcoholism OR substance misuse OR substance abuse OR drug abuse OR drug misuse OR alcohol abuse OR alcohol drinking	Limiters - Published Date: 19900101-20171131; Publication Year: 1990-2017 Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Plus with Full Text;eBook Collection (EBSCOhost);AMED - The Allied and Complementary Medicine Database;MEDLINE;Psychology and Behavioral Sciences Collection;PsycINFO	454,555

A total of 134 papers were identified. Following initial screening, 106 papers were excluded. This is represented in table 1(b).

Table 1 (b) Identification of papers - The pregnant substance user



The reasons for exclusion are given below. Each excluded study is cited in Appendix 1:

- Nine studies did not involve pregnant women. For example, Letourneau et al. (2007) examine the timing and predictors of returning to smoking after pregnancy (table 2).
- Nineteen studies explored other factors associated with the use of substances by pregnant women. For example, Hanson et al. (2015) examine the role of social support in preventing alcohol exposed pregnancies (table 3).
- Thirty studies evaluated treatment/service provision. For example, Calabro et al. (1996) determine whether health education materials were more effective when written at a lower rather than a higher reading level (table 4).
- Five studies focussed on the rates of IPV amongst pregnant women. For example, Yang et al. (2006) estimate the prevalence of, and to investigate the risk factors for physical abuse against pregnant aborigines in Taiwan (table 5).
- Three studies examined the prevalence of alcohol consumption amongst pregnant women, but not in relation to IPT. For example, Morris et al. (2008) explore differences in drinking cessation between black and white women who become pregnant (table 6).
- Six studies explored women's knowledge and attitudes towards substances, but not in relation to IPT. For example, Witbrodt, (2008) aimed to see if women could identify differences between their actual and standard drink sizes (table 7).
- Ten studies explored obstetric/neonatal/childhood outcomes. For example, Hjerkinn et al. (2009) aimed to describe neonatal findings among children of substance-abusing women (table 8).
- Twenty four studies explored other factors associated with either substance use or IPT. For example, Erickson and Torrigan, (2008) explored associations between trauma, intravenous drug use and child abuse potential in pregnant substance users (table 9).

Following these exclusions, a total of fifteen papers were assessed as meeting the aims of the review and were selected to be included. These studies were categorised as studies which explored lifetime experiences of IPV/IPT and

substance use, IPV/IPT during pregnancy and substance use and childhood abuse and substance misuse. These are presented below in Table 10.

Table 10 Included studies - Interpersonal trauma and substance use/misuse studies.

Author	Data collection	Country	Methodology	Type of abuse
Kvigne et al. (1998)	-	US	Quantitative	Lifetime IPV/IPT
Martin et al. (1996)	-	US	Quantitative	Lifetime IPV/IPT
Martin et al. (2003)	1990s	US	Quantitative	Lifetime IPV/IPT
Salomon et al. (2002)	08/92-07/95	US	Quantitative	Lifetime IPV/IPT
Tuten et al. (2003)	01/94-01/99	US	Quantitative	Lifetime IPV/IPT
Curry, (1998)	Early 90s	US	Quantitative	IPV/IPT during pregnancy
Eaton et al. (2012)	10/09-02/10	South Africa	Quantitative	IPV/IPT during pregnancy
Connelly et al. (2013)	03/09-01/12	US	Quantitative	IPV/IPT during pregnancy
Brems et al. (2002)	Mid ‘90s	Alaska	Quantitative	Childhood abuse
El Marroun et al. (2008)	04/02-01/06	Netherlands	Quantitative	Childhood abuse
Fogel et al. (2001)	Mid ‘90s	US	Quantitative	Childhood abuse

Table 10 Interpersonal trauma and substance misuse studies (cont.).

Author	Data collection	Country	Methodology	Type of abuse
Horrigan et al. (2000)	Mid '90s	US	Quantitative	Childhood abuse
Nelson et al. (2010)	01/99-08/01	US	Quantitative	Childhood abuse
FrankenBerger et al. (2015)	2010	US	Quantitative	Childhood abuse
Haller and Miles, (2003)	-	US	Quantitative	Childhood abuse

The following categories were then used to critically appraise the trustworthiness, relevance and results of the remaining papers, in a structured, systematic way; aim, methodology, design, sample, findings and relevance (Bryman, 2012, Critical Appraisal Skills Programme (CASP), (2013), Coughlan et al. 2007, Jack et al. 2010, Long et al. 2002). A detailed review of each study is presented in Appendix 2.

An analysis and synthesis of the key findings is now considered under the following headings: lifetime interpersonal trauma and substance misuse in pregnant women; interpersonal trauma in adulthood and substance use in pregnant women; interpersonal trauma in childhood and substance misuse in pregnant women.

2.3.2 Results of literature review 1

2.3.2.1 Lifetime interpersonal trauma and substance use/misuse in pregnant women

Potential associations between pregnant women's experiences of IPT during their lifetime and their use of substances were explored in five quantitative studies by Kvigne et al. (1998), Martin et al. (1996), Martin et al. (2003), Salomon et al. (2002) and Tuten et al. (2003). All of these studies were conducted within the US and identified positive associations between lifetime experiences of trauma and problematic substance use amongst pregnant women however, a number of limitations were evident.

Women of low income were recruited in the studies by Kvigne et al. (1998), Martin et al. (1996) and Martin et al. (2003). Martin et al. (1996) and Martin et al. (2003) explored poly-substance misuse in pregnancy, whereas Kvigne et al. (1998) concentrated on alcohol use only. Strong positive associations between violence and alcohol use were found in all three studies. Reporting of alcohol use during pregnancy however, may be perceived as more socially acceptable than other substances, therefore the findings may not be an accurate reflection of participants' use of other substances.

Participants' use of substances in relation to exposure of IPT were explored in the study by Martin et al. (1996) and Martin et al. (2003) (n=85), whereas Kvigne et al. (1998) collected data regarding trauma exposure in order to examine demographic patterns of substance use amongst women (n=177) who did and did not consume alcohol during pregnancy. Martin et al. (1996) and Martin et al. (2003) found that participants who had experienced violence were much more likely to drink alcohol, to smoke and to use illicit drugs prior to and during pregnancy. They were also more likely to use more substances prior to and during pregnancy. Moreover, those who had experienced all types of violence demonstrated more substance use disorder symptoms (Martin et al. 2003). However, although all these studies recruited women of low income, none of the studies used samples that were ethnically diverse, thereby limiting transferability and generalisability of findings. This is particularly so for Kvigne et al. (1998), who recruited Northern Plains Indian women, therefore caution needs to be taken in applying the findings from this study more generally to women out-with this ethnic group and country.

Domiciled and homeless women's use of addictive substances in relation to their experiences of IPT, PTSD and partners' use of substance use were explored by Salomon et al. (2002), whereas domiciled and homeless women's initial psychosocial functioning and treatment outcomes were compared by Tuten et al. (2003). Salomon et al. (2002) found an interaction between CSA, PTSD and drug use, however, it is unclear how many of the participants were pregnant and how many were already mothers. This is of particular relevance as the time around pregnancy, birth and the postnatal period are times of major social and psychological change for women during which time, adaptations are required that may affect women's physical and mental

wellbeing (Royal College of Midwives (RCM), 2012) and therefore may impact upon their use of substances. Salomon et al. (2002) explored poly-substance use whereas Tuten et al. (2003) limited the substances used to cocaine, heroin and alcohol. Salomon et al. (2002) found that women with a history of IPV were more likely to report PTSD and the use of drugs and alcohol by their partner. The mechanisms and directionality between these findings however, were not explored. Homeless participants in the study by Tuten et al. (2003) were found to face additional challenges and have poorer outcomes than domiciled women. Homeless women reported more mental ill-health including major depression, higher rates of suicide attempts, suicide ideation and reported more experiences of abuse. Furthermore, they were shown to have poorer social networks and use and spend more on illicit drugs and alcohol (Tuten et al. 2003). However, clinical treatment bills were used to compare treatment outcome variables between the two groups of women in the study by Tuten et al. (2003). Finances may be implicated in whether or not medical treatment is available or undertaken for any length of time in the US. It is therefore not possible to determine from the evidence provided, if treatment bills provide a true reflection of women's motivation with regards to treatment for substance misuse.

Moreover, transferability and generalisability of the findings by Salomon et al. (2002) and Tuten et al. (2003) are limited out-with the areas or country studied. For example, Salomon et al. (2002) recruited homeless mothers and pregnant women randomly enrolled from one area of Massachusetts, where at the time of data collection, approximately 15% of residents were known to live below the poverty level. Almost 83% of the sample recruited by Tuten et al. (2003) were African-American, over 80% of whom were found to be unemployed. Neither study, therefore, used samples that were wholly representative of the US, as they were not socially, culturally or ethnically diverse. In addition, it is worth considering the possible difference between being poor and homeless and poor and housed and whether these two groups can be used for comparison. For example, some of the ongoing psychological problems experienced by these very specific groups of women may have been compounded by their financial or residential status.

2.3.2.2 Strengths, limitations and gaps in existing evidence

The aforementioned studies suggest positive associations between lifetime experiences of trauma and problematic substance use amongst pregnant women. However, a number of important gaps have been identified which warrant further enquiry. None of the studies included in this narrative review researched the sequencing of trauma and the use of substances. Therefore further research is required into lifetime IPT and substance use histories using a method which collects data in a clear, chronological way. This would address issues of temporality and potential issues around recall bias and self-report in retrospective studies (Freedman et al. 1988). Furthermore, this method would provide an opportunity to more fully explore the mechanisms and directionality between IPT and substance use.

There is also an absence of qualitative enquiry. This methodology would allow a deeper insight into, and understanding of, the lives of pregnant women who misuse substances and the issues and concerns that they may face. Additionally, research which gives insight into pregnant women's choice of substance may be beneficial. For example, Martin et al. (2003) demonstrated that alcohol use was more common than illicit substances prior to pregnancy. Enquiry into the factors that may have fostered this would provide new insights into what influences participant's decision making processes and add additional depth to the findings. Edwards, (2006) and Nutt, (2010) reflect the substance one uses could be due to a number of factors including acceptability, availability, culture or cost. At present however, this has not been fully explored amongst PWMS, yet may have implications for policy and practice. Furthermore, evidence regarding how women feel about using substances during pregnancy and what may or may not motivate them to seek recovery from substance use disorders is scarce. Enquiry into this would help provide a fuller picture of the impact of substance use in pregnancy or the impact of pregnancy on substance use. As a result of the analysis of the current literature, pregnant women with a history of IPT and problematic substance appear to be an under-researched population, particularly within the United Kingdom, as the studies that exist were undertaken predominantly in the United States. As such, relatively little is known or understood about this group of women in the United Kingdom. An important gap has therefore

been identified as socio-economic, cultural and drug use differences may exist between the populations studied to date and UK based populations.

2.3.2.3 Interpersonal trauma in adulthood and substance use/misuse in pregnant women

Potential associations between women's experience of IPT during pregnancy and substance use were explored in three quantitative studies (Connelly et al. 2013, Curry, 1998 and Eaton et al. 2011). Two of these studies took place within the US (Curry, 1998 and Connelly et al. 2013), whilst one study took place in South Africa (Eaton et al. 2011). All three studies identified positive associations between experiences of trauma during pregnancy and substance use.

Pregnancy status, alcohol intake and experience of IPT were assessed by Eaton et al. (2011). IPV was found to be associated with alcohol use amongst most participants. Furthermore, 61% of the pregnant women attending the Shebeen at the time of data collection were drinking alcohol. Additionally, binge drinking was reported twice as often amongst pregnant women that non-pregnant women. However, the majority of participants in this study were male (n=1210). Only 13.3% of the female participants (n=910) were pregnant. What is more, participants were recruited form unlicensed drinking establishments, known as Shebeens, which are unique to townships in South Africa. The reported figures may not therefore be an accurate reflection of IPT and substance misuse out-with South Africa.

The study by Connelly et al. (2013) examined the co-occurrence of IPT, poly-substance use problems and depressive symptoms in the perinatal period, whereas the study by Curry, (1998) examined the relationship between IPT and alcohol and tobacco use. Psychosocial issues were reported in both these studies, as were the use of substances and IPT. Both studies found associations between abuse by male partners and the use of substances, however, both involved women known to be of low income therefore generalisability and transferability of the finding from these studies is limited. Furthermore, participants in the study by Connelly et al. (2013) who were born out-with the US, reported lower rates of IPT and substance use. This represented more than half of the sample (n=1868), some of whom were not pregnant.

The reported figures may not therefore be an accurate reflection of IPT and substance misuse out-with the study settings or the US population. The authors however, suggest that cultural attitudes regarding issues such as IPT and substance use, particularly amongst Latina women, may explain the low reported rates of these amongst this group of participants.

2.3.2.4 Strengths, limitations and gaps in existing evidence

The aforementioned studies suggest strong associations between experiences of trauma during pregnancy and substance use, however, a number of important limitations have been identified. The studies took place in areas of known social deprivation and adversity, thereby limiting generalisability and transferability of findings out-with these areas. The studies involved the collection of retrospective, sensitive data, therefore there may be issues regarding recall bias and self-report regarding disclosure of abuse and the use of substances during pregnancy. In addition, the mechanisms underlying the associations between the women's experiences of trauma and their use and choice of substances were not explored fully. It could be argued that data collected in a clear, chronological way may improve not only the recall of traumatic events but address temporality in relation to experiences of abuse and the use of substances.

A gap that was identified is the absence of qualitative studies which explored women's experiences of trauma during pregnancy and substance use. The use of qualitative enquiry could add depth and meaning to findings of studies exploring IPT during pregnancy and substance use. Again, none of these studies were conducted in the UK, therefore pregnant women with a history of IPT and problematic substance appear to be an under-researched population in this country. Consequently, little is known or understood about this group of women in the United Kingdom. For this reason, research is required to develop the evidence-base in this area and to shed light on the issues around IPT and substance use in this under-researched population in the United Kingdom, thereby more fully understanding their issues and concerns.

2.3.2.5 Interpersonal trauma in childhood and substance use/misuse in pregnant women

Potential associations between abuse in childhood and substance misuse during pregnancy were explored in seven quantitative studies. Associations between childhood experiences of different forms of abuse and substance misuse were examined by Brems et al. (2002), El Marroun et al. (2008), Frankenberger et al. (2015) and Haller and Miles, (2003) whilst Fogel et al. (2001), Horrigan et al. (2000) and Nelson et al. (2010) explored associations between childhood experiences of physical/sexual abuse and substance misuse. Five out of the seven of these studies took place within the US (Fogel et al. 2001, Frankenberger et al. 2015, Haller and Miles, 2003, Horrigan et al. 2000, Nelson et al. 2010), whereas the study by Brems et al. (2002) was undertaken in Alaska and El Marroun et al. (2008) in the Netherlands.

The findings of these studies suggest associations between childhood trauma, ongoing psychological distress and the use of substances. Women in the studies by Brems et al. (2002), Fogel et al. (2001), Haller and Miles, (2003), Horrigan et al. (2000) and Nelson et al. (2010) were found to use a variety of substances including cannabis, alcohol, tobacco and cocaine. Cannabis use was the focus of the study by El Marroun et al. (2008), whilst Frankenberger et al. (2015) concentrated on alcohol and tobacco use.

Whilst the women in these studies appeared to display elevated psychological symptoms, only the women in the studies by El Marroun et al. (2008), Haller and Miles, (2003) and Nelson et al. (2010) had these clinically assessed, whereupon psychiatric comorbidity was found to be common. Furthermore, it is unclear if Horrigan et al. (2000) were exploring a causal relationship between abuse in either childhood or adulthood or the potential cumulative effect of these.

The majority of these studies took place in the nineties (Brems et al. 2002, El Marroun et al. 2008, Fogel et al. 2001, Horrigan et al. 2000, Nelson et al. 2010) during a period of significant social change. The research evidence has developed and practice evolved since these studies were undertaken. Furthermore, although perhaps representative of the areas the studies took place in, all of the studies involved women

known to be of low income. In addition, samples in the studies by Haller and Miles, (2003), Horrigan et al. (2000) and Nelson et al. (2010) do not reflect ethnic diversity. For example, the majority of the participants (n=77) in the study by Haller and Miles, (2003) were described as comprising mainly poor women of colour. Moreover, although the majority (66%) of the participants in this study were pregnant, their results were based on the finding from a sample of n=77. It is therefore necessary to exercise caution in the interpretation and use of these findings to inform practice.

Finally, participants in the study by El Marroun et al. (2008) were not representative of the region where the study took place and Fogel et al. (2001) findings were based on a sample of n=63. Fogel et al. (2001) did however, recruit from a unique population, that is, participants who were pregnant and incarcerated, so perhaps this size of sample is a reflection of focussing on a population that may be difficult to recruit. Generalisability and transferability of the findings from these studies is nonetheless, limited.

2.3.2.6 Strengths, limitations and gaps in existing evidence

The studies included in this section of the review suggest strong positive associations between experiences of childhood trauma and substance use, however, a number of methodological issues have been identified. Furthermore, no studies to date have fully explored the possible mechanisms or directionality of the relationships underlying substance misuse and no studies were identified which use qualitative enquiry, yet would provide richness and depth to the quantitative findings. As a result, research to date does not fully explore the trajectory of women's lives following exposure to childhood trauma. Furthermore, data collection techniques relied on self-reporting of retrospective data, but like studies before, the information was not collected in a clear chronological way. Data collection using a method of doing so, could help address potential issues around recall bias and self-report. None of these studies were conducted in the United Kingdom, highlighting an under-researched population and subject area.

2.4 Literature review 2 – "Midwives perceptions of the substance user/misuser"

2.4.1 Search strategy

The subject Librarian was consulted regarding the search terms used, after which, an explicit and detailed search of relevant electronic databases was conducted. The following databases were searched: CINAHL (Cumulative Index of Nursing and Allied Health Literature), ASSIA (Applied Social Sciences and Index and Abstracts), MEDLINE, PsycInfo, Psychology and Behavioural Sciences Collection. The following search terms were used: Substance-Related Disorders OR Alcoholism OR substance misuse OR substance abuse OR drug abuse OR drug misuse OR alcohol abuse OR alcohol drinking then combined with Prenatal Care AND Midwifery OR Nurse Midwives OR midwi* (truncated) OR Attitude of Health Personnel OR Health Knowledge, Attitudes, Practice. The following criteria was employed in order to assess relevance:

- Explore midwives' experiences and perceptions of supporting PWMS.
- Include midwives.
- Published in English.
- Published 1990-2017.
- Primary and secondary research.
- Qualitative, quantitative and mixed methods studies.

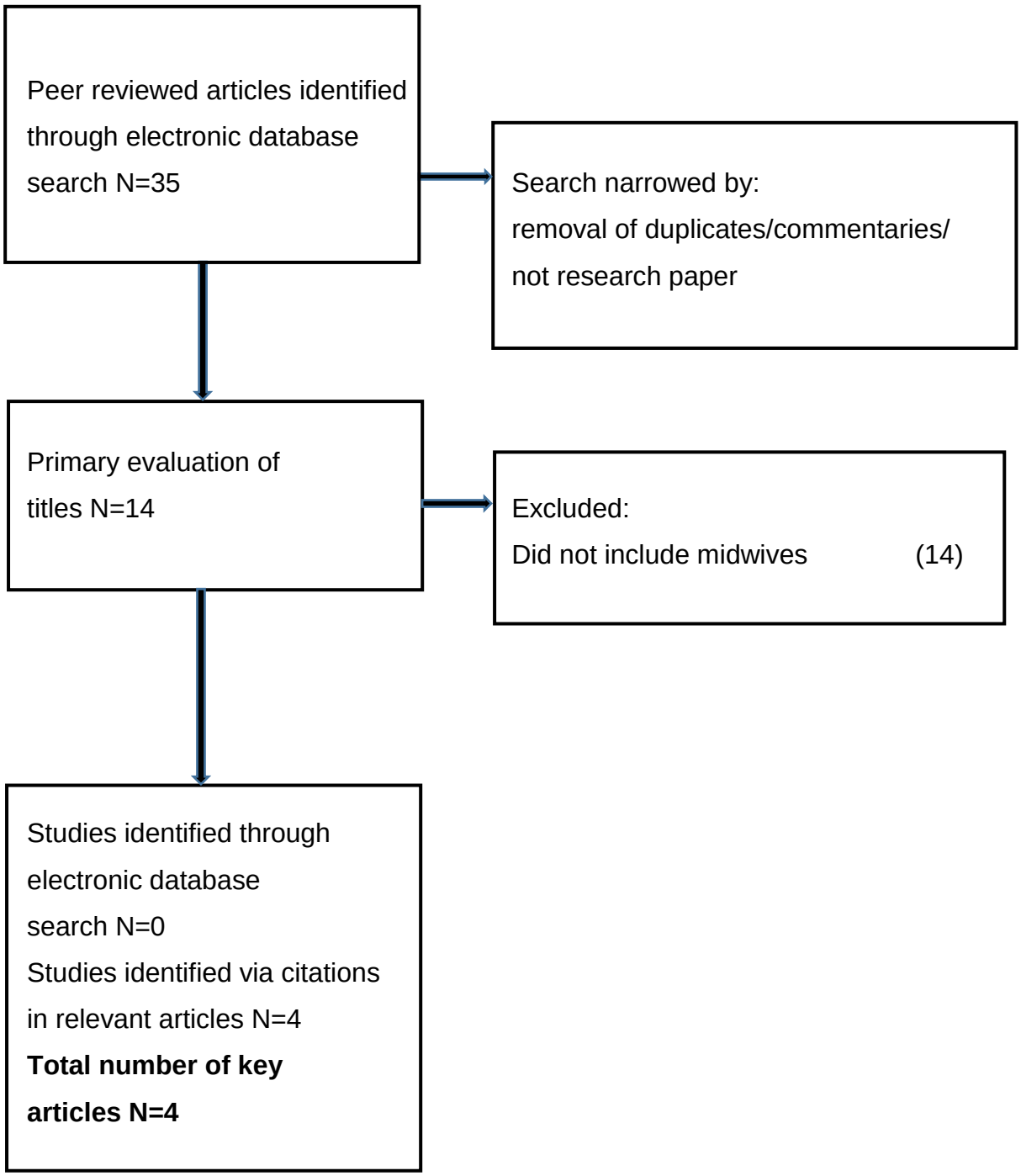
Relevant articles cited in reference lists and bibliographies of the literature were also explored. The search was undertaken in July 2017. It focused on papers published between January 1990 and July 2017. Studies which did not meet the above criteria were excluded.

Table 11(a) Database search - Midwives perceptions of the substance user/misuser

Query	Limiters/Expanders	Last Run Via	Results	
S5	(Substance-Related Disorders OR Alcoholism OR substance misuse OR substance abuse OR drug abuse OR drug misuse OR alcohol abuse OR alcohol drinking) AND prenatal care AND (Midwifery OR Nurse Midwives OR midwi* OR Attitude of Health Personnel OR Health Knowledge, Attitudes, Practice)	Limiters - Published Date: 19900101-20170131 Narrow by SubjectMajor: - midwifery Narrow by Language: - english Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Plus with Full Text;eBook Collection (EBSCOhost);AMED - The Allied and Complementary Medicine Database;MEDLINE;Psychology and Behavioral Sciences Collection;PsycINFO	16
S4	(Substance-Related Disorders OR Alcoholism OR substance misuse OR substance abuse OR drug abuse OR drug misuse OR alcohol abuse OR alcohol drinking) AND prenatal care AND (Midwifery OR Nurse Midwives OR midwi* OR Attitude of Health Personnel OR Health Knowledge, Attitudes, Practice)	Limiters - Published Date: 19900101-20170131 Narrow by Language: - english Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Plus with Full Text;eBook Collection (EBSCOhost);AMED - The Allied and Complementary Medicine Database;MEDLINE;Psychology and Behavioral Sciences Collection;PsycINFO	238
S3	(Substance-Related Disorders OR Alcoholism OR substance misuse OR substance abuse OR drug abuse OR drug misuse OR alcohol abuse OR alcohol drinking) AND prenatal care AND (Midwifery OR Nurse Midwives OR midwi* OR Attitude of Health Personnel OR Health Knowledge, Attitudes, Practice)	Limiters - Published Date: 19900101-20170131 Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Plus with Full Text;eBook Collection (EBSCOhost);AMED - The Allied and Complementary Medicine Database;MEDLINE;Psychology and Behavioral Sciences Collection;PsycINFO	242
S2	(Substance-Related Disorders OR Alcoholism OR substance misuse OR substance abuse OR drug abuse OR drug misuse OR alcohol abuse OR alcohol drinking) AND prenatal care	Limiters - Published Date: 19900101-20170131 Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Plus with Full Text;eBook Collection (EBSCOhost);AMED - The Allied and Complementary Medicine Database;MEDLINE;Psychology and Behavioral Sciences Collection;PsycINFO	2,138
S1	Substance-Related Disorders OR Alcoholism OR substance misuse OR substance abuse OR drug abuse OR drug misuse OR alcohol abuse OR alcohol drinking	Limiters - Published Date: 19900101-20170131 Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Plus with Full Text;eBook Collection (EBSCOhost);AMED - The Allied and Complementary Medicine Database;MEDLINE;Psychology and Behavioral Sciences Collection;PsycINFO	455,296

A total of sixteen studies were identified. Following initial screening, all of the studies were excluded. This is represented in Table 11 (b).

Table 11 (b) Identification of papers - midwives perceptions of the substance user/misuser



The reasons for exclusion are given below:

- They did not include midwives. For example O'Loughlin et al. (2001) aimed to determine if general practitioners followed current practice guidelines.

Each excluded study is cited in Appendix 3.

Following these exclusions**,** a total of four relevant papers were identified via citations in relevant articles as shown in Table 12.

Table 12 Maternity workers attitudes towards PWMS

Author	**Data collection**	**Country**	**Methodology**	**Midwife only sample**
Jenkins, (2013)	04/05 2011	UK (England)	Quantitative	Yes
Miles et al. (2012)	2009	Australia	Qualitative	Yes
Radcliffe, (2011)	2008-2009	UK (England)	Quantitative	No
Raeside, (2003)	-	UK (Scotland)	Quantitative	No

The following categories were used to critically appraise the trustworthiness, relevance and results of the papers identified in a structured, systematic way; aim, methodology, design, sample, findings and relevance (Bryman, 2012, CASP, 2013, Coughlan et al. 2007, Jack et al. 2010, Long et al. 2002). These are presented in Appendix 4. A detailed review of each study is presented in Appendix 4.

An analysis and synthesis of the key findings is now considered under the following heading: maternity workers attitudes.

2.4.2 Results of literature review 2

2.4.2.1 Maternity workers' attitudes

Three UK based studies (Jenkins, 2013, Radcliffe, 2011, Raeside, 2003,) and one Australian study (Miles et al. 2012) explored maternity care workers attitudes towards working with PWMS. Two of these studies employed quantitative enquiry (Jenkins, 2013 and Raeside, 2003) and two employed qualitative enquiry (Miles et al. 2012 and Radcliffe, 2011) to explore this subject matter. The studies by Jenkins, (2013) and Miles et al. (2012) concentrated specifically on midwives attitudes towards this client group.

Midwives, sonographers and postnatal ward staff in the studies by Radcliffe, (2011) and Raeside, (2003) were found to make a series of negative assumptions and judgements, and in some cases expressed anger (Raeside, 2003), about PWMS. Both studies found that negative attitudes were commonplace. In addition, midwives and other maternity care workers negative discourse was found to centre round this client groups timekeeping and appearance, as well as their drug use (Radcliffe, 2011). However, it is unclear how many of the sample (n=22) in the study by Radcliffe, (2011) were midwives and the majority of the relatively small sample (n=50) in the study by Raeside, (2003) were nurses.

Both quantitative studies (Jenkins, 2013, Raeside, 2003) used a questionnaire previously adapted for use in a study by Ludwig et al. (1996). It was originally used by Sherer et al. (1989) to examine Tanzanian nurses' personal and professional characteristics, their knowledge of AIDS and their stance towards their role in caring for people with AIDS, homosexuals and terminally ill patients. Ludwig et al. (1996) adapted their questionnaire, in order to examine US based neonatal nurses' backgrounds, attitudes and knowledge of caring for babies exposed to cocaine in-utero. The questionnaire comprised six demographic questions and 20 five-point Likert rated statements. Half of the statements were positive and half were negative. The findings of Raeside, (2003) reflected those of Ludwig et al. (1996). Participants were found to display more positive attitudes towards the babies of substance using mothers, rather than towards the mothers themselves. Furthermore, staff who had completed specialist neonatal education and those with long service, held the most

negative attitudes towards this client group. This finding may however, reflect that the neonatal life course focusses on the baby rather than the mother. Additionally, participants were found to have little formal education regarding substance misuse. However, the study by Raeside, (2003) took place within an area reported to have significant problems with substance misuse, so perhaps longer serving staff felt overloaded with this client group. In-service education appeared to have a mildly positive effect on attitudes towards this client group, but this finding is unexplained.

This does contrast however, to Jenkins, (2013) findings. Whilst the majority of participants in this study had undertaken no formal education regarding this subject, they appear to fare better with regards to their knowledge and attitudes. Then again, most reported a lack of recent experience of supporting this client group and almost half had been qualified for less than five years. Also of note, substance misuse was not reported to be a significant problem in the area of study. In addition, the sampling methods used may have attracted participants with a particular interest or opinion in the subject, rather than reflecting midwives attitudes in general.

Furthermore, these studies ask important questions that are difficult to explore fully with the use of a questionnaire. Whilst participants may indicate that they agree/disagree with a statement, it is unclear if their answers truly reflect what they think or feel (Bryman, 2012, Greenhalgh, 2010). For example, participants were asked if they strongly agreed, agreed, had no opinion, disagreed or strongly disagreed to statements about PWMS. The statements included “I feel angry in reaction to women who use drugs in pregnancy” to which 49% disagreed, “individuals are responsible for their own drug use” which 34% agreed with and “I believe working with drug using women is rewarding” to which 36% had no opinion. However, these options do not give participants the opportunity to explore why they feel the way they do. This is noteworthy, as although participants overall reported positive and non-punitive attitudes towards PWMS, less than half of respondents (49%) agreed to “feeling sympathetic towards women who use drugs in pregnancy” (Jenkins, 2013). It would have been valuable to find out if participants’ answers were driven by professional or personal experience or their personal beliefs (Barnett et al. 1995).

The qualitative studies by Miles et al. (2012) and Radcliffe, (2011) provide more insight into maternity care workers' and midwives' experiences and perceptions towards working with PWMS. Midwives in the study by Miles et al. (2012) found their role rewarding, however were found to face challenges not only from their clients' needs but the systems in which they worked. They felt they were trying to make a difference to the lives of pregnant women with problematic substance use and acknowledged the need for compassionate and accessible services. Furthermore they valued and identified the importance of continuity of care and recognised the need to build partnerships with the women they supported. This is in sharp contrast to the maternity workers and midwives in the other studies identified.

Miles et al. (2012) however, concentrated on the lived experience of midwives working specifically with pregnant women with problem substance use. These midwives would have had specialist training in working with this client group and perhaps a particular interest in working with them. It is also unclear if problem substance use is high within the area the study took place, therefore there are limitations regarding transferability and generalizability of findings out-with the study settings. Radcliffe, (2011) found that antenatal staff were found to have negative attitudes towards substance-misusing women and women prescribed methadone. Specialist midwives and drugs workers however, were found to be more empathetic and less likely to resort to stereotyping pregnant women who misuse substances, when compared to those without specialist education.

2.4.2.2 Strengths, limitations and gaps in existing evidence

The small studies included in this part of the review suggest that some maternity care workers hold judgmental and moralistic attitudes with regards to working with pregnant women with problematic substance use. Three UK based studies were identified (Jenkins, 2013, Radcliffe, 2011 and Raeside, 2003), however only Jenkins, (2013) focussed on exploring midwives' attitudes. This study however, fails to explore midwives' attitudes in any depth or provide a way for participants to explain why they feel the way they do about this client group. One other study by Miles et al. (2012) focussed on midwives attitudes, but this involved specialist practitioners. Furthermore,

it took place within Australia were midwives education varies and cultural differences may exist from midwives who practice in the UK.

Many issues may influence one's attitudes towards marginalised groups (Becker, 1963) but have not been fully explored in any of the studies identified. Education and length of clinical experience appears to both positively and negatively influence attitudes, but the reasons behind these findings have not been fully explored. Moreover, no enquiry has been made regarding participants' awareness of the possible mechanisms underlying substance misuse, including negative life events. It is therefore unclear if midwives have knowledge and understanding of previously discussed evidence of the potential negative sequelae of exposure to adverse life events and the possible impact on the pregnant women they support.

Moreover, studies to date do not address the issue that many of the participants may themselves have experienced IPT or be affected by substance misuse on a personal level. This is important, as it may impact on midwives' attitudes and perceptions towards supporting women with trauma histories and problematic substance use. Studies to date leave unanswered questions regarding midwives' attitudes and perceptions towards PWMS, highlighting an important gap in the literature. There is a need for research in this area, using a UK based sample of midwives with experience of supporting pregnant women who misuse substances.

2.5 Conclusion

A narrative literature review was undertaken which aimed to identify the current evidence base regarding possible associations between IPT and substance misuse amongst pregnant women. Fifteen studies were identified which suggest associations between negative life events and substance misuse in pregnant women/new mothers. Whilst a link between IPT and substance misuse is suggested, this review has highlighted a number of important gaps in the literature which require further investigation. To begin with, despite strong evidence regarding potential cumulative effects of lifetime IPT, studies to date in this area have focussed mostly on the impact of childhood trauma, childhood sexual abuse (CSA) in particular. Whilst

understanding the impact of CSA on the health and wellbeing of women is important, IPT may continue throughout women's lives, therefore research regarding the cumulative effects of ongoing traumatization is also vital.

Furthermore, none of the studies to date aim to fully explore possible associations between IPT and substance use amongst pregnant women, therefore it is difficult to determine to what extent IPT affects the initiation and use of substances in this particular group. Moreover, research to date has employed quantitative methodology. This may be for a number of reasons. Firstly, the collection of quantitative data may be less intrusive for participants than face to face interviews particularly when discussing sensitive topics such as IPT and substance use. However, this could have an impact on engagement and accuracy of information. Secondly, collection of quantitative data may prove less time consuming for both participant and researcher, particularly if data is collected from patient clinical records as in the studies by Martin et al. (1996) and Nelson et al. (2002) or gathered routinely during admission/assessment for treatment/services such as in the studies by Brems et al. (2002), Haller and Miles, (2003) and Tuten et al, (2003). However, although these methods of data collection provide valuable information regarding the prevalence of trauma and the use of substances, they fail to fully capture information regarding experiences or provide understanding or depth to the women's stories. As such, they may not fully encapsulate the range of traumatic experiences and events pregnant women have survived. Additionally, none of these studies used a method which would help participants re-call the chronological order, detail and significance of life events, such as a Life History Calendar (Freedman et al. 1988). This would help address a number of important issues such as potential concerns regarding possible recall bias of complex life events and self-report in retrospective studies. In additional, the use of a life history calendar would help provide a fuller picture of the trajectory of women's lives following IPT, thereby help shed light on the meaning of these experiences for these women and how these affect their substance misuse.

Problematic substance use is a worldwide problem (WHO, 2016) yet twelve out of the fifteen studies identified took place within the United States (Connelly et al. 2013, Curry, 1998, Fogel et al. 2001, FrankenBerger et al. 2015, Haller and Miles, 2003, Horrigan et al. 2000, Kvigne et al. 1998, Martin et al. 1996, Martin et al. 2003, Nelson et al. 2010, Salomon et al. 2002, Tuten et al. 2003). No studies were identified that

have been undertaken with a UK based population of pregnant women. This is important as there may be differences in the experiences or perceptions of IPT and the use of substances amongst a UK based population where ethnicity and cultural attitudes may vary. PWMS are a group of vulnerable women who may have potentially complex health and social care requirements, yet little appears to be known about them in the UK. This is an important gap in the literature as UK midwives' education and practice is unique. Midwifery practice within the UK is embedded in the primary health care system where midwives are recognised as autonomous practitioners (RCM, 2012). Midwives' educational requirements meet International Confederation of Midwifery (ICM) standards (ICM, 2011, RCM, 2012), thereby the maternity care that women in the UK receive is arguably different from the countries studied to date.

Polysubstance use was explored by Brems et al. (2002), Connelly et al. (2013), Fogel et al. (2001), Frankenberger et al. (2015), Haller and Miles, (2003), Horrigan et al. (2000), Martin et al. (1996), Martin et al. (2003), Nelson et al. (2010) and Salomon et al. (2002) whereas Eaton et al. (2012) and Kvigne et al. (1998) concentrated on the use of alcohol. Curry, (1998) and Frankenberger et al. (2015) considered alcohol and tobacco use, El Marroun et al. (2008) examined cannabis use and Tuten et al. (2003) concentrated on cocaine, heroin and alcohol use. The substances enquired about in the aforementioned studies may reflect the drug of choice/availability in the countries were the studies were undertaken or reflect the time the studies took place.

Furthermore, samples in studies to date are not generally representative, as they mostly involve women who live in areas of deprivation or face additional challenges such as homelessness. This makes it difficult to establish if some of the ongoing psychological problems experienced by these very specific groups of women are compounded by their current financial or residential status. Generalizability or transferability of findings from these studies is subsequently limited. Besides, studies to date mostly concentrate on acts of physical and/or sexual violence and do not enquire about other acts of coercion that may have long term implications for the physical and mental wellbeing of survivors (Stark, 2009) and consequently, do not reflect the growing awareness that IPT may not be related only to isolated acts of physical and/or sexual assault (Brewin et al. 2000, Cromer and Smyth, 2010, Nilsson

et al. 2010). This may, however, reflect previous knowledge and awareness of what constitutes abuse and reflect the time these studies were undertaken.

A second narrative literature review was undertaken which aimed to identify the current evidence base regarding midwives' experiences and perceptions of supporting PWMS. Four studies were identified that explored maternity care workers' attitudes and experiences of supporting PWMS. These studies suggest that substance misuse challenges some maternity care workers' ideals of the meaning of motherhood. However, several limitations have been identified. These include a lack of research which focusses specifically on UK based midwives' experiences and perceptions of supporting this client group and a lack of qualitative methodology. Therefore, there remains limited evidence regarding UK based midwives' attitudes towards supporting this client group.

Only one study focussed on exploring UK based midwives' attitudes towards PWMS (Jenkins, 2013). The midwives in this study were found to hold generally positive attitudes, but the majority of participants were found to have little recent experience of supporting PWMS. Furthermore, the study took place in an area with low reported rates of problematic substance use. Moreover, the methodology employed fails to enable full exploration or explanation of attitudes or perceptions of participants and fails to provide rich data or allow participants meaning making to emerge from the data (Bryman, 2012).

The use of a questionnaire with a choice of responses ranging from "strongly agree", "agree", "no opinion", "disagree" or "strongly disagree" does provide indications to how participants feel, but does not give them the opportunity to explore why they feel the way they do. Participant responses could be driven by professional or personal experience or their personal beliefs (Barnett et al. 1995). Furthermore, Van de Mortel and Thea, (2008) found that social desirability response is common in questionnaire based research, whereby participants present a more positive image of themselves. This has obvious implications for research results, particularly regarding participants' attitudes and feelings towards sensitive subjects.

Miles et al. (2012) used qualitative enquiry and focussed on midwives' attitudes towards supporting PWMS. It revealed that the participants in this study found their

role rewarding but challenging. They were found to value the opportunities their roles gave them to build trusting relationships with their clients, however, they were all specialist practitioners who had received specialised education and training in working with PWMS. Furthermore, this study took place within Australia were midwives' education differs and cultural differences may exist from UK based midwives. The findings therefore, may not be fully transferrable to the UK.

No qualitative studies have explored these issues with a UK based sample of midwives, therefore midwives' knowledge, perceptions and attitudes towards supporting substance using pregnant women has not been fully explored in this country. Given the reported rates of substance use amongst childbearing women within the UK (Home Office, 2016, Scottish Government, 2016) this is of particular significance to pregnant women and midwives in the UK, particularly as midwives are the primary carer for the majority of women in the UK. UK midwives' education and practice is unique, which places them in a unique position to develop relationships with women that are "intrinsically different" (page 20) from those with other health care providers (Leap, 2010). They are required to provide individualised, compassionate care in order to facilitate appropriate and effective delivery of care (National Institute for Health and Care Excellence (NICE), 2012) which is beneficial to both women and midwives (Kirkham, 2010), yet there is limited evidence regarding their experiences and perceptions of supporting PWMS.

The findings of the studies to date are useful and offer some valuable insights. However, in order to fully explore how midwives feel about supporting this client group, participants need to be able to fully explain the 'whys' behind their answers. Negative attitudes towards PWMS in the study by Radcliffe, (2011) appear to result from length of professional experience, perhaps suggesting professional burnout. This is important for midwives and the women they support, as the relationship between women and midwives shapes women's childbearing experiences (Hunter, 2001). Studies are therefore required which shed light on both PWMS and midwives' perceptions and experiences of the maternity services.

The studies by Jenkins, (2013), Radcliffe, (2011), and Raeside, (2003) fail to do this in any depth. The methodology employed by Miles et al. (2012) did achieve description and interpretation of participant's experiences and perceptions, but

focussed on specialist midwives. Whilst this is important, the majority of midwives who provide support to PWMS do not receive specialist education, therefore it is important to explore their thoughts and feelings and if these impact on their professional practice.

2.5.1 Summary of gaps identified in the literature

2.5.1.1 Literature review 1 – "The pregnant substance user"

Studies to date have used quantitative methodology, no qualitative studies were identified involving PWMS. The proposed study will address a number of aforementioned gaps identified in the literature. The significance of trauma may be unique during pregnancy, as this is a time when women may reflect and rethink important relationships in order to "make room" (page 1) for their relationship with the baby (Huth-Bocks et al. 2013). Pregnant women who misuse substances in the UK appear to be a group of vulnerable women, about whom, relatively little is known. This is with regards to their life histories, their use of substances and their experiences of pregnancy and motherhood. Potential associations regarding pregnant women's trauma histories and subsequent substance use are an under-researched area, particularly within the UK. Research is therefore required which sheds light on this group of vulnerable women. New knowledge would help create understanding of their experiences and perceptions of pregnancy and motherhood.

In summary:

- No UK based studies were found.
- No studies collected data regarding IPT in clear, chronological order.
- No studies collected data regarding substance use in clear, chronological order.

Present study responses to these gaps:

- The study will employ qualitative methodology in order to provide a unique insight in the lived experience of PWMS.
- PWMS who live in Central Scotland, UK, will be recruited in order to gain insight into UK based women's experiences and perceptions.
- Data will be collected in a clear, chronological way in order to collect PWMS accounts of negative/memorable life events and their use of substances.

- Data regarding PWMS negative/memorable life events and substance use/misuse will be converted into chronological timelines in order to map the sequencing of these events.

2.5.2 Summary of gaps identified in the literature

2.5.2.1 Literature review 2 – "Midwives perceptions of the substance misuser"

Studies to date have mainly focussed on maternity workers' attitudes towards PWMS, rather than midwives. UK based midwives knowledge and attitudes regarding supporting this client group have received little attention, yet their knowledge and attitudes have potential implications for professional practice. This requires further enquiry. These issues have important implications for all health and social care workers and findings from these under-researched groups could be incorporated into pre and post-registration education programmes. New knowledge generated could be incorporated into professional practice which may positively impact upon PWMS experiences and perceptions of the time around pregnancy and motherhood.

In summary:

- One study was identified that focussed on midwives' attitudes; quantitative methodology was used.
- No qualitative studies were identified which explored UK based midwives' experiences and perceptions of supporting this client group.
- Previous research leaves many unanswered questions, that is, the evidence does not explore or explain the feelings and attitudes of midwives regarding their experiences and perceptions towards PWMS.

Present study responses to these gaps:

- This study will employ qualitative methodology in order to provide a unique insight into the lived experience of midwives with experience of supporting PWMS.
- Practising midwives based in Central Scotland, UK will be recruited in order to gain insight into UK based midwives experiences and perceptions of supporting this client group.

2.6 Aims of the study

This study aims to chronologically map out pregnant women's past experiences of abuse and substance use, in order to illustrate common pathways through which these occur and explore possible mechanisms underlying these. It will explore pregnant women who have a history of substance use (PWMS) experiences and perceptions of their journey to motherhood and explore midwives experiences and perceptions of supporting this client group.

Qualitative methods were used in the current study, in order to address the following research questions:

1) What are the mechanisms underlying substance misuse in a sample of pregnant women in Scotland?

2) To what extent does a history of interpersonal trauma influence the initiation and use of substances in this sample?

3) What are PWMS' experiences and perceptions of their journey to motherhood?

4) What are midwives' experiences and perceptions of supporting PWMS through pregnancy and the early postnatal period?

This chapter has presented the findings of two narrative literature reviews. These aimed to identify the current evidence base regarding possible associations between IPT and substance misuse amongst pregnant women and identify the current evidence base regarding midwives' experiences and perceptions of supporting PWMS. The evidence for each review was brought together and the gaps in the literature were identified. The rationale and research questions were then formulated. The following chapter will detail the methodology employed in this study. The recruitment process and the challenges faced during this time and how they were addressed are discussed. Data collection and transcription are detailed, followed by data analysis. As far as I am aware, this will be the first study to explore these issues and concerns in depth, in a United Kingdom context.

Chapter 3 – Methodology

3.1 Introduction

The aim of the following chapter is to describe the research methods employed in the study and the rationale for employing these methods, in order to answer the research questions set out in the previous chapter. First of all, the justification for using qualitative methodology is explained. The research process is then described. This includes ethical considerations, sampling, recruitment and data collection. The challenges faced during this process and how I attempted to address these are also described. I have aimed to be transparent and open about the research process in order to enhance the quality and rigour of this piece of qualitative research (Given, 2008, Moravcsik, 2014). The reflexive work I undertook throughout the study is described in my reflexivity chapter, which aims to provide an open and honest account of my experiences during this study.

3.2 Justification for using qualitative methodology

The literature reviews undertaken in Chapter 2 demonstrated a lack of qualitative enquiry regarding possible associations between interpersonal trauma (IPT) and substance misuse in pregnant women. Quantitative methodology has been previously used in all the studies identified and included in the narrative review. The studies identified provide valuable information regarding the incidence and prevalence of IPT amongst participants, however, no studies explored this subject fully, in context, from the perspective of the participants. Qualitative enquiry has been adopted previously regarding UK based maternity care workers' experiences and perceptions of supporting pregnant women who misuse substances (PWMS), however qualitative studies to date have not focussed specifically on UK based midwives' experiences and perceptions of supporting PWMS. One UK based study was identified that focussed exclusively on midwives (Jenkins, 2013). This study employed quantitative methodology, therefore midwives' attitudes, thoughts and feelings regarding supporting pregnant women who misuse substances remain unclear and under-researched.

Given the limited understanding of the possible mechanisms underlying substance misuse amongst pregnant women and the limited amount of understanding regarding midwives' experiences and perceptions of supporting PWMS, qualitative methodology was chosen for this study.

Qualitative enquiry does not confirm a hypothesis, it helps to see the world through the participants' eyes and explore how each participant makes sense of the world around them (Rees, 2011). Qualitative methodology helps capture a more authentic awareness of each participants' interpretations of a situation or phenomenon (McLeod, 2008). It provides opportunities to probe deeper into participants' answers, where appropriate, thus move beyond their initial responses and answers in order for the complexity of a phenomenon to be realised (Atieno, 2009, Bricki and Green, 2017, Thompson et al. 1998). Qualitative methodology would therefore provide more than flat, superficial data of the association between IPT and substance misuse amongst pregnant women and midwives' attitudes towards supporting this client group - it would also acknowledge participants' wider social context and their thoughts, feelings and behaviour's. Furthermore, sensitive issues that may be disclosed in this study require a person-centred, holistic approach to data collection, which could be achieved more successfully by means of a qualitative enquiry (Hollowaay and Wheeler, 2010).

3.3 Justification for using Interpretive Phenomenological Analysis

Interpretive Phenomenological Analysis (IPA) is an established qualitative research methodology. IPA originated within the field of psychology however, is now expanding into wider areas of research in health and social sciences, highlighting what Smith et al. (2009) describe as the "small p" and the "big P" of IPA. That is, researchers from other disciplines may not be psychologists, but can still be interested in psychological questions.

IPA first emerged within the 1990s', but draws on important ideas and theories from phenomenology and hermeneutics, in particular Husserl and Heidegger. IPA is a systematic approach which allows detailed examination of each individual's lived experiences and detailed examination of what lived experiences mean to each

individual. IPA focusses on the consideration of each participant's account of their own experiences and perceptions, recognising them as meaning makers, therefore providing a fuller picture and deeper understanding of what these experiences mean to each individual. Within IPA, the researcher is required to develop a phenomenological attitude, that is, recognise that one does not know all one's preconceptions and yet remain empathetic. This is a continually reflexive process, where the researcher is required to consider and acknowledge what they are bringing to the study and what influence this may have on it. This approach allows unique insights into the lived experience of small, homogenous samples and is therefore, suitable to research involving under-researched topics and populations where there is a need to develop the understanding of their needs, issues and concerns. It is the focus on the individual meaning making of their experience, which makes IPA a phenomenological method of enquiry (Smith et al. 2009). In order to understand the core theoretical underpinnings of IPA, an exploration of phenomenology is required and will now be considered.

Edward Husserl is considered to be the founder of the phenomenological movement as a philosophy and a descriptive method of enquiry (Wojnar and Swanson, 2007). Husserl considered that consciousness is central to all human experiences and as such, was concerned with attending to the essence of lived experience. In order to realise and describe the true nature of a given phenomenon, Husserl proposed that one must "go back to the things themselves", in order to capture the essence of a phenomenon in its purest form. To do this, a series of reductions are required during which time the researcher must put to one side, or "bracket" the taken-for-granted aspects of the world, in order to avoid being distracted or influenced by one's own preconceptions, experiences and assumptions about a given experience (Tymieniecka, 2003).

Heidegger, Husserl's student, however, sought to expand upon the work of Husserl and took phenomenology beyond description. Heidegger's central concern was with "Dasein" (there-being). The pivotal difference between Husserl's descriptive phenomenology and Heidegger's hermeneutic phenomenology is that he was concerned with how the "phenomena", are thus the "totality of what lies in the light of day or can be brought to light" (Heidegger, 1953). He believed that to properly reveal

human lived experience, it must be considered in context to place, time and environment, rather than taken in isolation. Therefore, rather than try to set aside possible outside influences for the researcher and the participants, the researcher is encouraged to reflect upon and consider these, rather than explore an experience or phenomenon in isolation. This approach acknowledges that the research participant and the researcher are influenced by their own pasts and experiences which may shape the research process and analysis. This interpretative process requires the researcher to move back and forward between the whole and the part and back to the whole - the hermeneutic circle (Heidegger, 1953), in order to properly understand any given part.

IPA is informed by hermeneutic phenomenology and as such, is concerned with how research participants make sense of what is, or has, happened to them. As it recognizes the researcher's role in interpreting these experiences, IPA is engaged in a double hermeneutic. That is, the researcher is "trying to make sense of the participant trying to make sense of what is happening to them" (Smith et al. 2009). With relevance to this study, Miles, (2013) suggest that midwifery practice and hermeneutic phenomenology share similar concepts and philosophies; they both pay attention to and respect the uniqueness of each individual and their lived experiences; they both consider each individuals experiences and perceptions in context; and they are both concerned with shedding light on individuals experiences and what these mean to them.

Miles, (2013) posit, that it is the exploration of "what it is like to be" that makes hermeneutic phenomenology "a perfect fit" for research undertaken regarding midwifery. Hermeneutic phenomenology provides midwifery researchers with a methodology that allows deep, unique insights into, and reflection of, the complexity of the lived experience of the women midwives support. Furthermore, it allows valuable insights and reflection of midwifery practice, recognising that midwives and women share some aspects of each other's lived world. New understandings can therefore be gained by employing this methodology, which may influence policy, guidelines and practice.

3.4 Consideration of other qualitative approaches

Before selecting IPA as the methodology of choice, other widely used qualitative approaches were considered, including Grounded Theory and Thematic Analysis. Grounded theory method is an iterative and rigorous process that is concerned with explaining social processes and allowing theoretical ideas to emerge from different types of data (Glaser and Strauus, 1967). Grounded theory method has diversified over time (Maz, 2013) and although this methodology places an emphasis on research which takes place within, and can be applied to, real-world situations and is suitable for under-researched areas (Maz, 2013, Harris, 2014), it was rejected for this study. The emphasis of this study was to gain a unique insight into the lived experience of the participants. IPA was therefore more in keeping with the research aims. IPA may also result in a theory, however, this was not the aim of this study.

Thematic Analysis is a method employed to identify, analyze, interpret and report themes (Braun and Clark, 2006). However, unlike IPA, thematic analysis does not have clear, theoretical underpinnings or utilise a clear framework (Bryman, 2012, Smith et al. 2009). Braun and Clark, (2006) however, argue that theoretical freedom allows this method of analysis to be flexible, useful and able to provide rich data. Furthermore, unlike IPA, thematic analysis does not have an idiographic focus. That is, IPA focuses on the meaning of the unique experience of each individual, thereby their “particular claims” (Smith et al. 2009) are not lost when analysis moves onto more general claims. Such focus fit better with the aims of the present study.

3.5 The participants

In keeping with IPA methodology (Smith et al. 2009), purposive sampling was used to recruit two small homogenous samples, that is, one sample of pregnant women with a history of problematic substance use and one sample of practising midwives with experience of supporting PWMS. The samples where homogenous in that both groups of participants would have shared experiences rather than share sample characteristics. Part of the inclusion criteria for the pregnant participants was that they were being supported by specialist substance misuse midwives. This would

ensure that they had had the opportunity to disclose histories of IPT. It also ensured that participants would be able to receive regular support following participation in the study if required. Part of the inclusion criteria for the midwives was that they had experience of supporting this client group in order that their experiences and perceptions could be explored in depth.

A sample size of twenty PWMS and twenty midwives was originally considered in the early stages of this study. However, over time, a number of important aspects of the study were taken into consideration. Steeves, (2013) advises that attention must be given to the depth of data required, whilst Britten, (2006) draws attention to consideration of how long the interviews may last, and how feasible it is for a single researcher to deal with the data generated. Data collection was expected to take no longer than twelve months, therefore consideration to available time was required. Moreover, in keeping with an IPA study, a smaller sample was more feasible (Smith et al. 2009). The aim was therefore to recruit six PWMS and six midwives. However, due to issues regarding recruitment of PWMS, data collection was completed following recruitment of five PWMS and six midwives.

3.5.1 Profile of the pregnant participants

Five eligible women being supported by The PrePare Team in Edinburgh and the Vulnerable Infant Project (VIP) in Fife were recruited (Figure 1). The mean age of the pregnant women was 29.6 years age. All participants had had more than one pregnancy. None of the participants were in employment. Three out of the five participants were in a relationship. Four of the five participants had social work involvement. All of the participants had had some or all of their children removed into care at some point due to their problematic substance use. Not all of the women had had all of their children returned to their care on a permanent basis. Two of the participants were interviewed within private areas within their children's nurseries. Three participants were interviewed in their own homes, in the presence of their specialist substance misuse midwife.

In order to protect participants identities, transcripts were saved under Pregnant Woman (no.1-5). On the transcripts however, they were given pseudonyms, therefore

Pregnant woman (no.1) became Jane, Pregnant woman (no.2) became Jenny, Pregnant woman (no.3) became Rebecca, Pregnant woman (no.4) became Tina and Pregnant woman (no.5) became Liz. Their pseudonyms are used when discussing their data. In order to further protect their identities, their gestation is stated in trimester only.

Figure 1 The pregnant participants

Name	Gestation	History of interpersonal trauma	History of substance misuse
Jane (no.1)	Third trimester	Yes	Yes
Jenny (no. 2)	Third trimester	Yes	Yes
Rebecca (no. 3)	Third trimester	Yes	Yes
Tina (no. 4)	Third trimester	Yes	Yes
Liz (no. 5)	Third trimester	Yes	Yes

3.5.2 Profile of the midwife participants

Six eligible midwives were recruited (Figure 2). Recruitment of midwives took place from within in a variety of settings within the Maternity Services in NHS Lothian, a single NHS Board in Scotland. The length of participant's clinical experience ranged from eight years to thirty years. The participants were based in a variety of areas within the maternity services. All six participants had recent experience of supporting PWMS. Two participants were interviewed in private areas within their workplace. Four participants were interviewed in their own homes.

Participants transcripts were saved as midwife (no 1- 6). On the transcripts however, they were given pseudonyms therefore midwife (no.1) became Jen, midwife (no.2) became Karen, midwife (no.3) became Katie, midwife (no.4) became Holly, midwife (no.5) became Sandra and midwife (no.6) became Samantha. Their pseudonyms are used when discussing their data. In order to help protect their identities, their area of clinical practice is not disclosed.

Figure 2 The midwife participants

Name	Area of practice	Experience of supporting PWMS
Jen (no. 1)	Community	Yes
Karen (no. 2)	Hospital based	Yes
Katie (no. 3)	Community	Yes
Holly (no. 4)	Community	Yes
Sandra (no. 5)	Hospital based	Yes
Samantha (no. 6)	Hospital based	Yes

3.6 Recruitment

3.6.1 Pregnant women

Recruitment commenced in October 2015. Eligible pregnant women were introduced to the study by their specialist substance misuse midwife. After introducing them to the study, the substance misuse midwives explained verbally, the Participant Information Sheet and Consent Form (Appendix 5) in order to ensure their understanding. Interested pregnant women did not need to agree to take part or sign the consent form at this time. They were provided with written copies of the Participant Information Sheet and Consent Form to keep if they wished, in order for them to take some time at home to consider taking part. Following this, they were asked to contact their specialist substance misuse midwife if they would like to participate in the study. They were also advised that they could contact me directly if they wanted more information about the study, prior to making any decisions. When an eligible woman expressed an interest in taking part, the specialist substance misuse midwife would then notify me via email in order to arrange a suitable date, time and location for the participant.

Two pregnant participants were recruited within the first month. It quickly became apparent however, that a number of obstacles may be encountered during this process. These are highlighted in the notes taken from my reflective diary (Appendix 6). For example, the first participant, Jane (pseudonym), was unable to meet the

researcher in the antenatal clinic of the local hospital as planned, as she lived some distance away and public transport was problematic for her. Following discussion with my supervision team around safe places to meet participants, the specialist substance misuse midwife arranged for me to meet Jane in a private room within her child's local authority nursery. Jane however, forgot that she had an appointment with her drug worker at the same time and did not turn up for the newly arranged appointment. The appointment was however, rearranged and data collection took place the following week. Recruitment and data collection with this group was completed after thirteen months, in November 2015.

3.6.2 Midwives

Recruitment commenced in October 2015. Recruitment posters were placed within prominent non-clinical staff areas in both maternity units in NHS Lothian (Appendix 7). A copy of the recruitment poster was cascaded to community based staff by the community midwifery team leaders via their NHS email addresses. Interested midwives were asked to contact me, whereupon I sent them a copy of the Participant Information Sheet and Consent form (Appendix 8). They were not required to sign any paperwork until data collection took place.

A number of minor problems were encountered during data collection i.e. staff being sent information but not providing dates and times to be interviewed as well as difficulties rearranging appointments due to last minute shift changes for participants. These are highlighted in the notes taken from my reflective diary (Appendix 9). Nonetheless, recruitment and data collection was relatively straightforward and completed within nine months, in July 2015.

3.7 Ethical considerations

This study aimed to explore a number of potentially sensitive subjects therefore raised a number of ethical issues. Researchers have a responsibility to protect participants' rights and having access to their private thoughts, feelings and actions should be treated as a privilege (Locke et al 2007), therefore, key ethical principles of informed

consent, capacity to give consent, avoidance of harm to participants and maintaining confidentiality and anonymity (Department of Health, 2005) were acknowledged and adhered to at all times. Extensive discussion around these issues took place with my supervision team throughout the duration of the study. The specialist midwives who had agreed to help me recruit participants, along with experienced midwives not directly involved in the study were also consulted regarding the potential ethical implications involved. Following these discussions, a number of strategies were developed to minimise or prevent them and will be now be considered.

Prior to data collection, approval was sought from The Faculty of Health, Life and Social Sciences Research Ethics and Governance Committee, Edinburgh Napier University. The application ethical approval was submitted in December 2014. A few minor clarifications were required i.e. I had to make it clearer that I would not meet PWMS in their own homes. Following this clarification, approval was received in January 2015. NHS Research Ethics Committee approval was sought in May 2015. Minor clarifications were requested regarding participant safety i.e. clarification about what action would be taken if PWMS disclosed issues regarding their personal safety and what action would be taken if midwives raised issues around confidentiality and safe practice. Furthermore, committee members enquired about the mechanisms that would be put in place for all participants if they required support following their participation. These aspects were clarified and full approval was granted in August 2015. NHS management approval was received following this.

Four months into data collection however, recruitment numbers were low for pregnant women. In order to try and increase interest and participation in the study, I applied for a minor amendment in order for an additional specialist substance misuse midwife, in another area of NHS Lothian, to recruit eligible women. This was granted and did appear to help as some interest was received from pregnant women in this area, however, recruitment continued to be challenging. Whilst the specialist substance misuse midwives appeared to be able to find women who were interested in participating in the study, where to see them was proving problematic as they requested to be seen in their own homes. I therefore applied for a substantial amendment in order for this to be undertaken. This was granted in May 2016. This amendment permitted the recruitment of a further three pregnant women. The last

three women were seen in the presence of their specialist substance misuse midwife. This aspect of the interview process and the possible impact this may have had on data collection is discussed in my Reflexive Chapter.

3.8 Consent procedure

Prior to data collection, time was invested with all of the participants, during which I introduced myself and explained the purpose of the study. I explained the Participant Information Sheet and Consent Form verbally and in writing. Participants were advised that their informed consent would be reflected upon during data collection, recognizing that this was an ongoing process (Turner-Henson, 2005). The participants were advised that they may find talking about their experiences and perceptions helpful, but that this was not expected to be a therapeutic encounter.

The Definitions of Maltreatment (Appendix 10) were explained to the pregnant participants verbally and in writing prior to data collection, in order to provide clarity for them and provide consistency throughout the study. I then explained the life history calendar (LCH) (Appendix 11). All participants were given the opportunity to ask any questions they may have and were advised that they could refuse to answer any questions at any time. They were advised that they could stop the interview at any time and that they did not need to provide a reason for doing so.

The pregnant participants were reminded that if they disclosed any information indicating that their baby or themselves' were at risk of immediate harm (i.e. current use of illicit substances, current experience of abuse), I would report this to their specialist substance misuse midwife as per ethical standards. The midwife participants were reminded that any disclosures of unsafe practice would be discussed with a Supervisor of Midwives as per ethical standards. The participants were then asked to sign two copies of a consent form, one copy for themselves and one which was kept as part of the research process.

3.9 Wellbeing of participants

3.9.1 Pregnant participants

As part of my research training, I had undertaken a good clinical practice course in order to increase my awareness of the safety and quality requirements required for ethical research. Furthermore, as a practising community midwife, I had clinical experience of supporting pregnant women who disclose substance misuse and women who disclose histories of abuse, which enabled me to conduct all aspects of data collection in a sensitive, non-judgemental and empathetic manner. Additionally, all of the pregnant participants had been given the opportunity to disclose their experiences of trauma and substance misuse prior to participation, with their specialist substance misuse midwife. This was particularly important regarding trauma histories, in order to minimise potential distress arising from new disclosures during data collection.

None of the participants had completed a LHC before. All of the participants became upset during data collection, particularly during completion of their LHC. At these points, they were offered a break and data collection was stopped, however, they all chose to continue and this proceeded when they indicated that they felt able to do so. At the end data collection, all participants were asked if they had any questions or comments about the process and given time to do this if required. At this time, each of the five pregnant participants spoke of how valuable it was to them to complete the LHC and that they wished they had been given the opportunity to complete a LHC before now. They all explained that it was important to them to see their life events written down in chronological order and felt it gave them an opportunity to talk about these events. Some said they remembered things that had happened a long time ago and had subsequently forgotten.

I endeavoured to ensure that each participant was okay prior to leaving and in view of the potentially sensitive nature of the study, all participants were given information regarding organisations within their locality that offered advice if required (Appendix 12). In addition, all participants were reminded that they could access support from their specialist substance misuse midwife if required following participation. Participants were also provided with contact details for the Director of Study and for

the independent advisor appointed to this study. All participants were asked if they would like a copy of their LHC and interview transcript for verification and a summary of the study findings when available. None of the participants requested a copy of their LHC, but they did all request a copy of their interview transcripts for verification. They all requested to be sent a summary of the study findings when available.

3.9.2 Midwife participants

Participants were asked about their experiences and perceptions of supporting PWMS. My professional experience and clinical expertise helped me ensure that interviews with all participants were carried out sensitively and in a non-judgemental, empathetic manner. Whilst none of the midwives became visibly upset during data collection, they did recount detailed, positive and negative experiences and perceptions of supporting PWMS, their babies and their partners. Some of these experiences had occurred some time ago, but where recalled with clarity and were shared in depth. I endeavoured to ensure that each participant was okay prior to leaving and in view of the potentially sensitive nature of the study, all participants were given information regarding organisations within their locality that offered advice if required (Appendix 13).

Midwife participants were reminded that they could access statutory supervision if required following participation. In addition, participants were provided with contact details for my Director of Studies and for the independent advisor appointed to this study.

3.10 Risks to the researcher

Potential concerns of risk to myself had been discussed during supervisory meetings prior to and throughout data collection. These centred round possible risks through lone working. In order to overcome these, I followed Edinburgh Napier University Lone Working Policy and carried a mobile phone with me at all times. Pregnant participants where either met in a private room within a local authority building where staff were present in the areas outside the interview room, or during the later stages

of data collection, interviewed in their own homes in the presence of their specialist substance misuse midwife. Additional plans were put in place, for example; the specialist substance misuse midwives accompanied me to the interviews that took place within PWMS own homes and stayed, with permission from the participants, in the house throughout. The risks to myself whilst interviewing midwives were considered minimal and they were interviewed in a private area in their place of work or in their own homes.

My supervisory team were available to provide support to me, should I feel this necessary and time was taken during my supervision meetings to allow me to reflect on the participants lived experiences. My research diary also helped as a method of debriefing. I found that writing down my thoughts and feelings helped me consider what the participants had told me.

3.11 Reflexive diary

Researcher reflexivity is an iterative and continuous characteristic of good research practice (May and Perry, 2014). Kleinmann and Copp, (1993) advise that as researchers “we do ourselves a favour” if we reflect during the research process as reflection allows the researcher to consider who they are and what they believe in. It allows us to capture our part in the research process and acknowledge that our actions, omissions and views may shape the story we are trying to capture and tell. This is particularly important within IPA (Smith et al, 2009). Furthermore, reflection helps the researcher focus on aspects of the study as it progresses (Kahn, 2013). A reflective diary was therefore kept throughout the study. This was used in order to allow me to consider and reflect upon many aspects of the study, including the study design, the participants, conducting the interviews and thoughts about issues of validity and authenticity.

Many aspects of the interview process, including the impact I may have had on participants were documented. For example, attention was given to whether knowing that the researcher was a midwife influenced data collection with either set of participants. Additionally, the possible influence I could have as a white, educated

woman. I considered whether different aspects of the interview process mattered i.e. did it matter what I wore?; did my accent or the words and terminology I used matter and to whom did it matter?.

Reflexivity also allowed acknowledgement of the emotional work involved in the research process, for example, as a novice researcher, I was initially very nervous regarding data collection. Furthermore, uncertainties and insecurity over my ability to undertake this piece of work were also recorded. Some of the stories from both sets of participants were hard to hear and it became important to me to acknowledge both positive and negative feelings that data collection brought up. Writing in the reflective journal therefore became important in two ways. It enabled me to acknowledge and recognize my professional and personal thoughts and feelings prior to, as well as during, data collection.

As previously noted, it also became a source of debriefing for me. This process enabled me to recognise and acknowledge that my prior knowledge and experience may result in bias (Kleinmann and Copp, 1993), thereby influence data collection and analysis. The diary therefore kept my thoughts and feelings visible, acknowledging that I could not bracket out my assumptions and thereby encouraged transparency (Ortlipp, 2008, Smith et al. 2009). This is discussed further in my Reflexivity Chapter.

3.12 Data collection measures

3.12.1 Mapping out life events and substance use

Life history calendars (LHCs) are a well-established means of collecting accurate, detailed, retrospective data and have been shown to improve recollection of complex life events (Axinn et al. 1999, Caspi et al. 1996, Freedman et al. 1988, Gramling et al. 2004) and allow understanding of how and if, participants current behaviours and attitudes were influenced by past events (Hagemaster, 2006). These were important considerations for this study, therefore an adapted LHC was utilised. Similar to the LHC used by Sierka, (2015), the LHC was adapted to use “years of age” as units of time in order to capture the order of life events and substance misuse.

LHCs have previously proven to be a sound method of collecting retrospective data. They were employed by Martyn and Belli, (2002), who explored risky behaviour amongst adolescents and by Benjamin et al. (2008), who explored psychosocial processes amongst women with a family history of breast cancer. Furthermore, Sierka, (2015) used a LHC in an IPA in order to chronologically map out female offenders experiences of offending, IPT and substance use. As far as I am aware however, this is the first IPA to use a LHC to collect details regarding memorable life events, past negative life experiences, first use of substances and past substance use with a sample of UK based pregnant women with problematic substance use.

Pregnant participants' memorable life events, past negative life experiences, first use of substances and past substance use were chronologically mapped out in order to explore possible relationships between these. First of all, I asked participants to indicate if they had experienced significant life events, for example, when they left school/home, when they had their children. These experiences helped to act as reference points for negative life events and substance use/misuse and addiction. I then asked participants to indicate what substances they had used and when they used them. Following this, they were asked to indicate if they had experienced different types of interpersonal trauma.

Although I had previously advised all of the participants that that they did not need to provide any details of their experiences during completion of their LHC, all of them did. They were all found to provide vivid and detailed accounts of a variety of events and experiences in their lives. In addition, some of the participants created striking imagery at this stage of data collection. I did not want to lose this data, therefore in order to more fully capture how women recounted their life stories, I made additional field notes and wrote down direct quotes on the individual LHCs of some of the details that were given, with each participant's permission. This will be explained further in the results chapter.

The length of time for completion of the LHC varied between participants, however was found to take up the majority of time spent with participants. Following completion of the LHC, participants were offered a comfort break. When participants indicated that they were ready to carry on with data collection, I explained that with their

permission, a recorded in-depth semi-structured interview would take place, in order to further explore their experiences, including their journey to motherhood. I explained that their LHC would be utilised, with their permission, to guide some of the interview questions in order to facilitate interpretation and reflection of events in their life story.

3.12.2 Semi-structured interviews

Semi-structured interviews are the primary way of collecting data in qualitative research (Dew, 2007, Thompson et al. 1998). They permit flexibility, therefore help the researcher achieve greater insight and depth into participants views (Britten, 2006) and allow for important areas to be covered whilst allowing for spontaneity (Rees, 2012). Moreover, they are seen as the exemplar of data collection for an IPA as they facilitate the participant's disclosure of their lived experience (Smith et al. 2009). They were therefore used for this study. Participants were met on one occasion. A second interview may have proven valuable in order to provide participants with a period of reflection after their first interview (Kahn, 2013) however, given the time constraints and anticipated difficulties with recruitment of pregnant participants, in particular, this was not feasible.

Due to the problems that were encountered during recruitment, telephone interviews with PWMS were considered. Although not commonly used in qualitative studies, this method was discussed during supervision meetings as a possible way to increase participation. However, I chose not to use this method for a number of reasons. First of all, given the subject matter of the interviews, I was keen to capture the participant's body language when responding to questions as I felt this was valuable and important (Bryman, 2012). Furthermore, it was important to capture the participant's verbal, prosodic and paralinguistic components of their interview (Kowal and O'Connell, 2014). Moreover, within an IPA, the participant talks and the researcher actively listens and directly responds (Smith et al. 2009). These would not have been achieved or captured fully using telephone interviews. Additionally, the anticipated length of interview time as well as privacy for participants were considered and may have proven problematic during a telephone interview.

The semi-structured interviews with PWMS aimed to cover histories of substance use, as well as significant and negative life events and their experiences of pregnancy and motherhood, thus reflect the sections of the LHC. The semi-structured interviews with midwives aimed to shed light on their experiences and perceptions of supporting PWMS. In order to help guide the interviews, an interview guide for each set of participants was developed prior to ethical approval (Appendix 14 and 15). Advice was sought from the specialist substance misuse midwives who were helping with recruitment regarding the interview guide for the pregnant participants. Likewise, advice was sought from two experienced midwifery colleagues regarding the interview guide for the midwife participants. These consultations were undertaken in order to ensure that the questions were open, non-judgmental, could encourage dialogue and were considered appropriate in terms of asking participants about potentially highly sensitive aspects of their lives. The interview guides were discussed and checked with my supervision team. No changes were made to the original format of the questions.

3.12.3 The interview process

Prior to data collection, all of the participants were advised that the methodology and the methods being used recognised that they, the participant, are the expert, and as such this study aimed to gain insight to their thoughts, feelings and perceptions. This was important as I wanted to hear each particular individual's particular experiences and perceptions. I advised participants that there was an interview guide of open ended questions (Appendix 14 & Appendix 15) which may facilitate interpretation and reflection of events in their lives. However, to embrace the uniqueness of each individual participant and allow the unexpected to be uncovered (Smith et al. 2009), this would not be used in a rigid manner. I advised the participants that the interview may seem more like a one sided conversation as they would be doing most of the talking. They were also advised that I may, at times, ask what would seem like 'silly' questions, but that this was to enable me to clarify and capture their thoughts, feelings and perceptions more fully.

As a novice researcher, the interview guide was initially very helpful, however, as the interviews progressed I found that I referred to the guide less. As I gained experience

and confidence during the interviews, I found it more appropriate to follow the participants own rhythm in how their individual lived experiences emerged. Moreover, they were found to spontaneously raise most of the questions that were on the original guides without prompting from myself. All participants were however, asked the first question on the appropriate guide in order to maintain consistency in the interview process. The participant's experiences and perceptions were found to tumble out quickly at times. They provided rich depth and detail of their experiences, at times in a hurried manner. At other times they spoke quietly and with apparent careful consideration of their experiences, carefully reflecting upon how they felt and how they now feel in relation to their lived experiences.

The pregnant participants were found to often refer back to their LHC's during their interviews, for example, when asked if they were happy to provide more detail about the negative events that had occurred in their lives, they would look over the LHC and pick a period of time they wished to talk about. They often asked which period of their lives I was interested in, however, I advised them that I was interested in the periods of their lives that they wanted to talk about. In this way, the LHC was found to complement and enrich the interview data.

Many of the events that the women had described during completion of their LHC, their childhood experiences in particular, were however, not returned to during their interviews. The participants instead tended to focus on events that were relatively recent, perhaps suggesting that talking about some of their experiences during completion of their LHC was enough. This could also suggest however, that more recent traumatic events and substance use were upper-most in their minds at that time. I did not pressure any of the participants to discuss any aspects of their lives. If they indicated that they did not wish to discuss an event that they had disclosed during completion of their LHC, we moved on without further probing.

As we came to the end of each schedule, each participant was asked if there was anything that they felt was important to them that had not been covered. In this way, they were given another opportunity to tell their story and remain central to the interview. Again, this helped me remain mindful to the fact that what transpired from

the data may be very different from that which was anticipated at the outset (Smith et al. 2009, Bryman, 2012). None of the participants added any more at this time.

It was anticipated that data collection with the pregnant participants would take no longer than sixty minutes. The interviews varied in the length of duration and ranged from twenty to fifty minutes. It was anticipated that data collection with the midwives would take no longer than sixty minutes. The interviews varied in the length of duration and ranged from thirty to ninety-five minutes.

3.13 Confidentiality and anonymity

No identifiable data were recorded on the pregnant participants LHC's. The participants were all assigned a number for identification by myself. Their year of birth was recorded in order to gather information about their age, but their full date of birth was not recorded. Some of the experiences and details that the participants provided during completion of their LHC's and their interviews were considered by myself and my supervision team as perhaps making them identifiable within their own and the wider community, therefore these are not disclosed or reported on during the findings.

All of the interviews were recorded using a digital recorder, with permission from all participants, in order to achieve an accurate account of the interview. Additionally, in view of the potentially sensitive nature of the data being collected, I wanted the participants to know that they had my full attention. Recording the interviews thereby facilitated my involvement in the interview process (Cohen, 2013). The original voice recordings were transferred onto an Edinburgh Napier University password protected computer and were deleted from the digital recording device. All voice recordings held will be destroyed within 12 months of completion of the study.

All data collected was anonymized and names were substituted with a participant number at the point of transcript in order to protect confidentiality. All participants were then given a pseudonym. The data was transcribed verbatim by myself and a copy of the transcript was sent to each participant to verify the contents as requested, the method of which was agreed with each participant following data collection. The

pregnant participants could therefore have their transcripts sent to their home address or to their specialist substance misuse midwife, who would hand deliver these to participants as soon as possible after receiving them. They were advised that these would be sent in a sealed envelope marked private and confidential.

All of the participants requested a copy of their transcripts and for these to be sent to their specialist substance misuse midwife. No comments were received from them. Likewise, the midwife participants could receive their transcripts at their home or work addresses. Two of them requested a copy. These were sent to their NHS password protected email addresses as requested. No comments were received regarding these.

3.14 Analysing the data

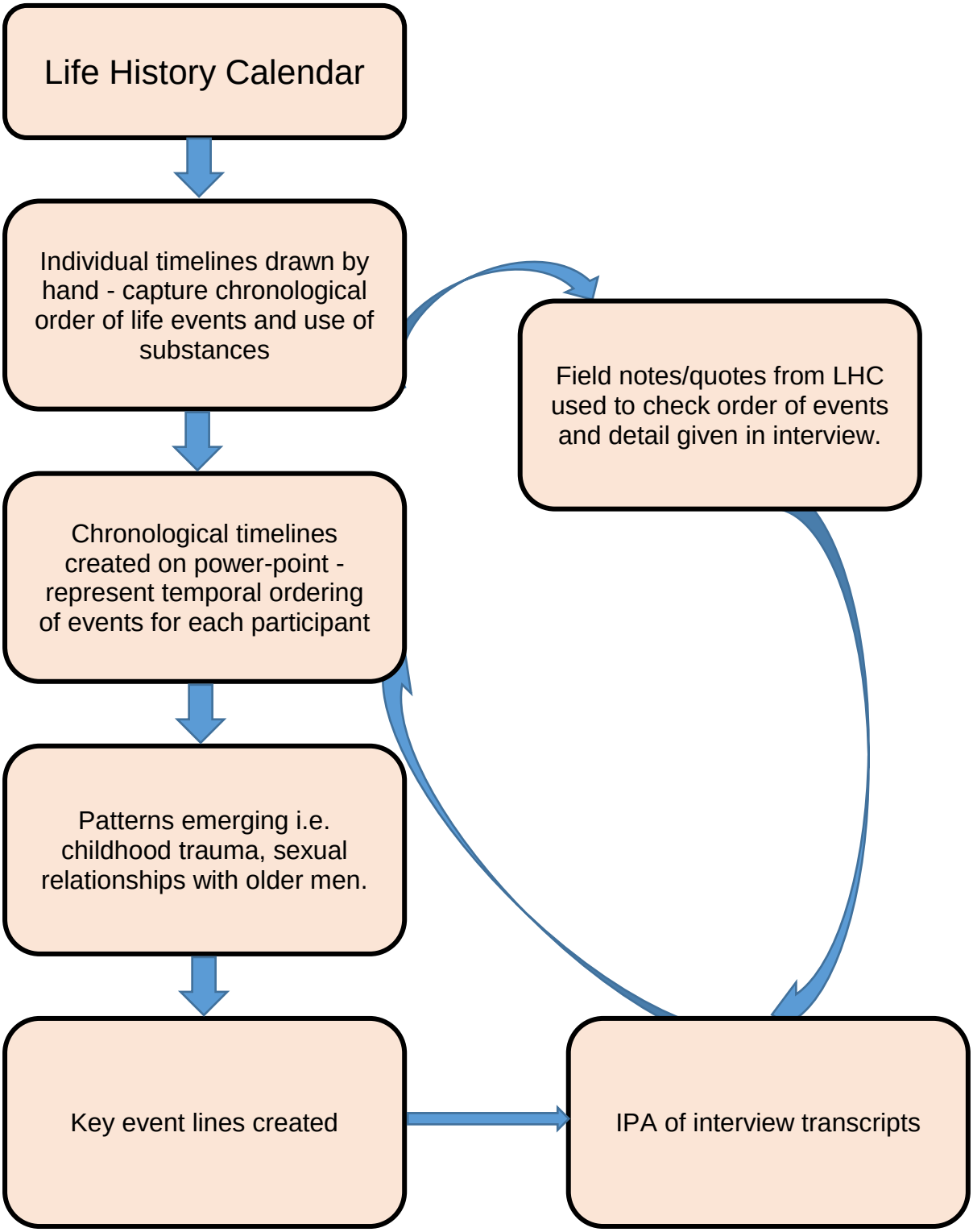
3.14.1 The Life History Calendars

First of all, the data from each LHC was analysed, in order to help establish possible relationships between trauma and substance use. The data were then mapped out by hand into timelines in order to help me consider how to accurately represent the chronological order of the participant's life experiences and their use of substances (Appendix 16 – hand drawings). These were then converted into chronological timelines using power-point and represent the temporal ordering of participant's significant life events, negative life events and use of substances. Additionally, participant quotes and field notes that I had documented on the individual LHCs were later reflected upon and proved pertinent in providing a more complete picture of the participant's lives. In light of this, a pertinent quote made be myself upon their LHCs was added to their chronological timelines. Each chronological timeline is presented in Figure 3-7. Participant quotes and field notes were later incorporated into the IPA of the interview transcripts. Quotes taken from the LHC are indicated within the IPA in order to clarify where and whom they originated from.

The LHCs were found to not only identify individual events and experiences that had occurred in the participants lives, they also revealed a number of significant similarities and differences between the participant's life histories in the early stages of analysis.

A summary of these are presented in Table 13. The information from the participant's chronological timelines in Figure 3-7 presents a complex picture of life events and substance use. I considered this and aimed to present this data in a manner that more clearly displayed the chronological order and interconnectedness between these events. The similarities and differences in the participant's experiences are presented in their key life events lines in Figure 8, which are presented in the pregnant participants findings in Chapter 4. The steps taken during this stage of analysis are presented in the following page on Figure 9.

Figure 9 Steps taken during analysis of LHCs:



3.14.2 The semi-structured interviews

First of all, each interview recording was listened to on my return home. Each interview was transcribed verbatim by myself as soon as possible after each interview took place, thereby keeping my focus on individual participants lived experience. Each transcript was then re-read in order to capture verbal, prosodic and paralinguistic components in order to further enhance the meaning behind the participants accounts and bring the transcripts to life (Kowal and O'Connell, 2014). Copies of the first anonymised midwives transcript and the first anonymised pregnant participants transcripts were sent to members of my supervision team in order to check the appropriateness of the interview questions and the flow of the interviews. Prior to being sent to participants for verification of the contents, all the transcripts were re-read for typing errors.

Initial analysis took place using pen and paper, following the basic steps recommended by Smith et al. (2009). Transcribed interviews were printed out and initial observations of the interview and potentially distracting ideas and thoughts were recorded, in order to bracket these off and help keep my focus on the data rather than my thoughts and perceptions. Transcripts were read and re-read whilst listening to the audio-recordings. This process allowed an overall mapping of the structure of the interview and the narrative, thereby providing me with a mental model of each person and the content of their interview. This also helped ensure that each participant was "the focus of analysis" (Smith et al. 2009).

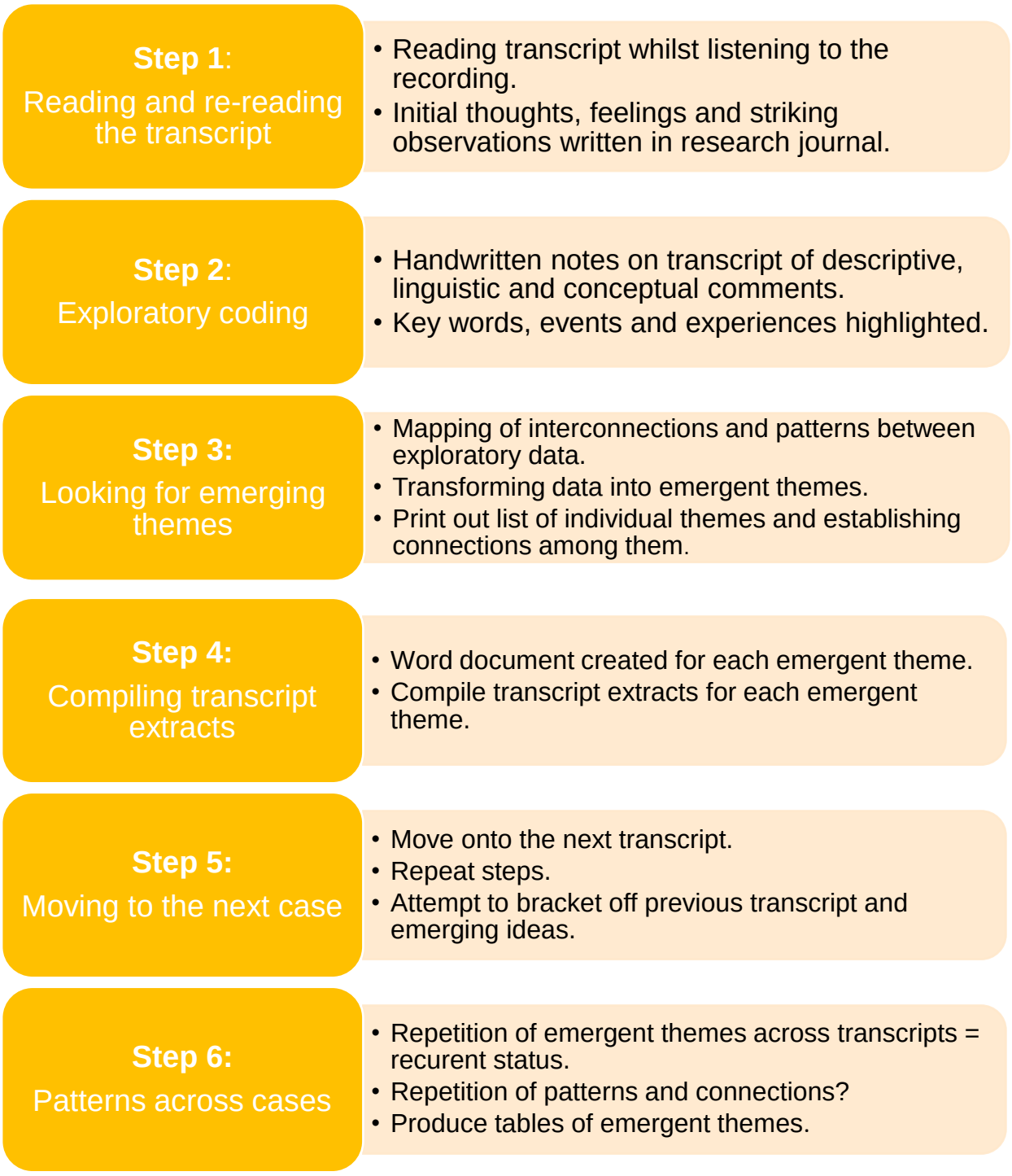
Key words, events and experiences were underlined or circled. Handwritten notes were made on each transcript regarding the semantic, linguistic and conceptual content. This line-by-line process allowed me to begin to identify the specific ways each participant talked about, thought about and understood their experiences. These explorative notes were then re-organised into emerging themes. These included the participants' words and my interpretation, therefore followed the hermeneutic circle, whereby the individual parts were interpreted in relation to the whole and the whole is interpreted in relation to its parts (Smith et al. 2009). These were highlighted and typed into a list and printed. Patterns and connections amongst the emerging themes were then explored. Similar emergent themes were then

grouped together, edited and combined. For example, emergent themes within the pregnant participants extracts around social norms/culture, choice, siblings, stigma, influence of older peers/older partner and lack of adult/parental interest and guidance were re-classified into the super-ordinate theme “Dabbling to addiction”. Quotes which exemplified the themes were then taken from the transcript. This process was repeated with each transcript. Themes identified for each participant were laid across a table and I searched for connections across cases. This allowed me to gain an overview of the convergence and divergence across individuals. Quotes were then spread across the floor in order for them to be displayed clearly and allow identification of the main themes across the cases. This systematic, iterative method allowed each participants account of their interpretation of their own experiences and perceptions to be considered on an individual level and as part of a whole (Smith et al, 2009). The super-ordinate themes and sub-themes are presented in a table of themes on page 103 & 154. The individual steps taken with Interpretative Phenomenological Analysis are graphically represented in Figure 10 and an audit trail of the analysis of two transcripts is presented in Appendix 15.

Each step of analysis was discussed and checked by the members of my supervision team who are familiar with IPA. Copies of anonymised transcripts were selected to be analysed at IPA study days and seminars, which helped me ensure that my data analysis was systematic, the emergent themes were appropriate and that a deep level of analysis was being achieved. Furthermore, I sought regular advice and assistance from IPA experts at Glasgow Caledonian University.

This chapter aimed to describe the research methods employed in the study and the rationale for employing these methods, in order to answer the research questions set out in Chapter 2. The use of qualitative methodology was justified and the research process, including ethical considerations, sampling, recruitment and data collection were explained. The challenges faced during this process and how I attempted to address these were also described.

Figure 10 Individual steps taken with Interpretative Phenomenological Analysis



Chapter 4 – Findings

4.1 Pregnant participants

4.1.1 Introduction

Five eligible pregnant participants were recruited from two NHS Health Boards within Central Scotland. The participants were recruited with the assistance of their specialist substance misuse midwives. An adapted life history calendar (LHC) and in-depth, semi-structured interview were completed with each participant. These data collection methods were employed in order to chronologically map out their individual experiences of interpersonal trauma, their use of substances and gain a unique, deep insight into their lived experiences. Two of the interviews took place within private areas of the participant's children's nurseries. Three of the interviews took place within the participants own homes in the presence of their specialist substance misuse midwives, as requested by the participants.

During completion of the LHC, participants were asked to indicate their significant life events, negative life events and their use of substances. The five participants were found to experience a series of complex, interconnected life events which spanned from childhood through into adulthood. During completion of their LHCs, all of the participants provided such detailed, insightful accounts of their lives that additional notes and some direct quotes were made by myself on individual LHCs, with the participant's permission. This was carried out in order to capture as much depth and detail as possible and therefore prevent valuable data being lost.

An interview schedule was devised in order to allow me to focus on the key aims of the study, however, in keeping with an IPA study, this was not used in a rigid manner. The participants often referred back to their LHCs during their interviews, for example, when asked if they were happy to provide more detail about the negative events that had occurred in their lives, they would look over the LHC and pick a period of time they wished to talk about. In this way, the LHC became inextricably linked to the interview data. Many of the events that the women had described during completion of their

LHC, their childhood experiences in particular, were however, not returned to during their interviews. The participants instead tended to focus on events that were relatively recent, perhaps suggesting that returning to some of their earlier experiences may be too upsetting. This could also suggest however, that more recent traumatic events and substance use were upper-most in their minds at that time.

I did not pressure any of the participants to discuss any aspects of their lives. If they indicated that they did not wish to discuss a previously disclosed event, the interview moved on without further probing. Some of the experiences and details that the participants provided during data collection were considered by myself and my supervision team as perhaps making them identifiable within their own and the wider community, therefore these are not disclosed or reported on during the findings.

4.1.2 The Life History Calendar

First of all, participants were asked about events that had occurred within their lives that they considered to be significant, for example, who they lived with when they were children, when they left school, when they left home. These events appeared to act as signposts around which the participants were able to build a picture of their lives. All of the participants quickly went beyond indicating events and described in great detail and depth, various experiences and perceptions from their early childhoods through to the present day.

None of the participants were found to recount their experiences of trauma or substance use in a chronological way during completion of their LHC. Instead, they jumped from event to event, often from their very early childhood experiences, to that of their own children and on to recent events, possibly in some way reflecting the chaos that appeared to consume their lives at various times. The LHC therefore proved to be an invaluable tool. It captured the fabric of the participant's individual lives, their individual experiences and nuances, without which, I would not have been able to capture the depth of data, or the detailed chronological order and sequencing of events with-in the participants lives.

The LHC also gave context and meaning to the interviews, often acting as a prompt for further discussion. Some of the participants however, were unable to discuss particular experiences or their perceptions of these further during their interviews. The findings of the LHC and the interviews therefore emerged as being inextricably linked. Analysing each separately was found to lose depth, quality and description and therefore the data from the LHC and the interviews were synthesised in order to more fully capture and report the lived experiences. Direct quotes that were documented by myself during completion of the LHC were used as part of the IPA. These are indicted in the IPA in order to clarify where and whom the quote originated.

Most of the participants became tearful at various points during completion of their LHC. This was most notable when talking about their pregnancies and the removal of their children into the care system, suggesting their recognition and deep regret regarding the impact of their actions and inactions on the lives of their children. Some of their experiences appeared to pour out, as if they needed to get the information out quickly. Perhaps they needed to do this before they changed their minds about talking about it.

Some of their experiences however, were spoken about very quietly, with apparent careful consideration, perhaps because what they were describing was so sensitive, intimate and very private. This was found to occur mostly when they were describing experiences from their childhoods. The three participants who were interviewed in their own homes, in the presence of their specialist substance misuse midwife, were found to provide more detailed accounts of their life histories than previously disclosed to their specialist substance misuse midwives. This was particularly so for two of the participants who had very recently been advised that health and social care workers had serious concerns about where their unborn babies should be placed following delivery. All of the participants expressed a sense of wanting to accept responsibility for their actions and that no matter what had happened to them, they had made a series of choices at various stages over their life course.

None of the participants had completed a LHC before taking part in this study. They all appeared to find this valuable and most said they wished they had had the opportunity to do this before. Jenny in particular took some time to look over her LHC

once it was completed, stating that seeing her life in black and white confirmed just how bad it had been at times. She said she often thought nothing much had happened.

The majority of participants were found to recognise that there was a link between what had happened in their lives and their use of substances, but they all appeared shocked when these mapped out so clearly on their individual LHC, further highlighting the LHC as a powerful data collection tool. The participants were asked if they would like a copy of the findings from their LHC, all of them declined this. The findings of the LHCs are presented first, as follows:

- First off all, hand drawings of what the individual chronological timelines could look like were made by the researcher. Examples of these are shown in Appendix 16, in order to show how these progressed and developed during the process of analysis.

- Chronological timelines were developed from the early illustrations and are presented in Figure 3-7. These clearly capture the sequencing and timing of events and experiences within individual participant's lives. A quote from each participant that was captured during completion of the LHC, has been added in order to further capture a sense of the participants lived experience.

- A table of the data from the LHC's was then devised in order to compare and contrast the participant's main life experiences and use of substances and is presented in Table 13.

- The findings from each individual timeline were then synthesized. This was carried out in order to capture the full detail of the women's collective accounts. From this representation of the data, a number of themes emerged and are presented as a narrative in Table 14.

- A number of significant key life events were found to emerge from the participant's accounts - All of the participants had experienced trauma within their childhood; Most of them used substances from a very young age; In their

teenage years, the majority of participants met men significantly older than themselves who were substance misusers/substance dependent; All of the participants experienced domestic violence; All of the participants had had children removed into the care system; All of the participants considered themselves to be clean at the point of interview. These are presented as key life event lines for each participant in Figure 8.

4.1.3 Figure 3

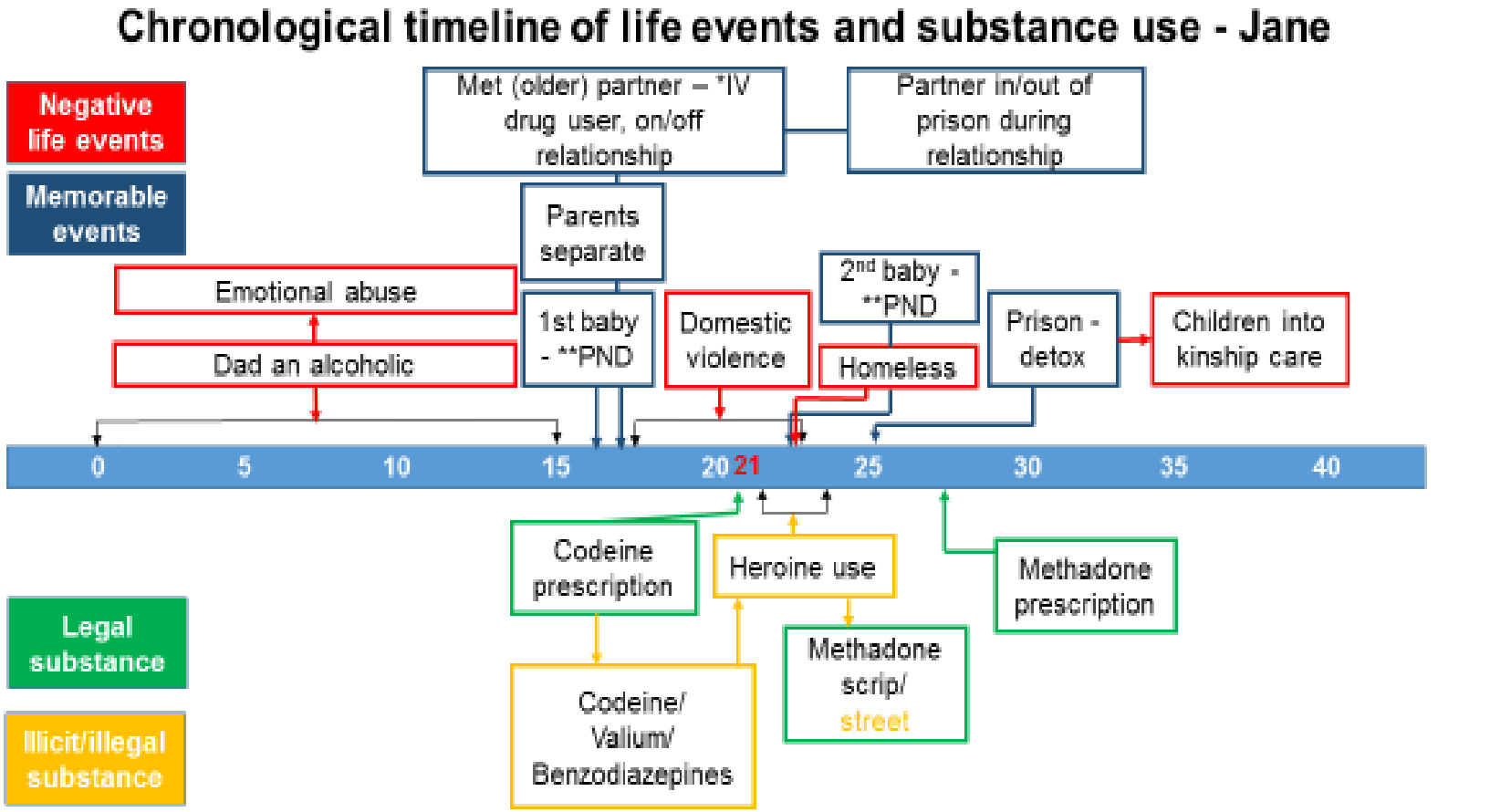

Chronological timeline of life events and substance use - Jane
Negative life events
Memorable events
Legal substance
Illicit/illegal substance
Met (older) partner – *IV drug user, on/off relationship
Partner in/out of prison during relationship
Parents separate
Emotional abuse
Dad an alcoholic
1st baby - **PND
Domestic violence
2nd baby - **PND
Homeless
Prison - detox
Children into kinship care
0
5
10
15
20
21
25
30
35
40
Codeine prescription
Heroine use
Methadone prescription
Codeine/ Valium/ Benzodiazepines
Methadone scrip/ street
21 = substance dependence
* Intravenous ** Postnatal depression
"my dad, stoating down the street drunk ..... I was mortified" Jane

Figure 4

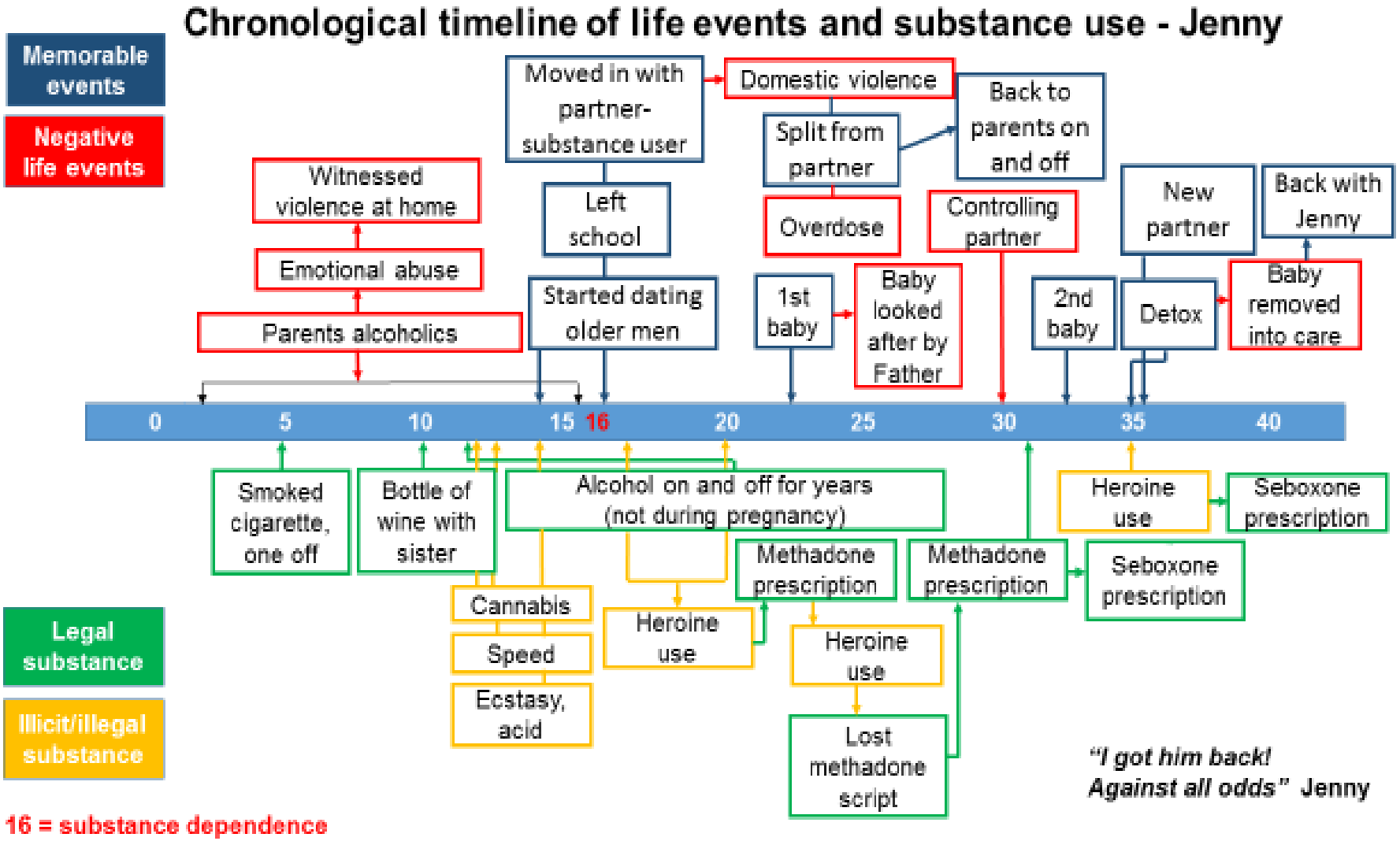

Chronological timeline of life events and substance use - Jenny
Memorable events
Negative life events
Legal substance
Illicit/illegal substance
Moved in with partner- substance user
Domestic violence
Back to parents on and off
Split from partner
Witnessed violence at home
Left school
Overdose
Controlling partner
New partner
Back with Jenny
Emotional abuse
Started dating older men
1st baby
Baby looked after by Father
2nd baby
Detox
Baby removed into care
Parents alcoholics
0
5
10
15
16
20
25
30
35
40
Smoked cigarette, one off
Bottle of wine with sister
Alcohol on and off for years (not during pregnancy)
Heroine use
Seboxone prescription
Methadone prescription
Methadone prescription
Seboxone prescription
Cannabis
Speed
Ecstasy, acid
Heroine use
Heroine use
Lost methadone script
"I got him back! Against all odds" Jenny
16 = substance dependence

Figure 5

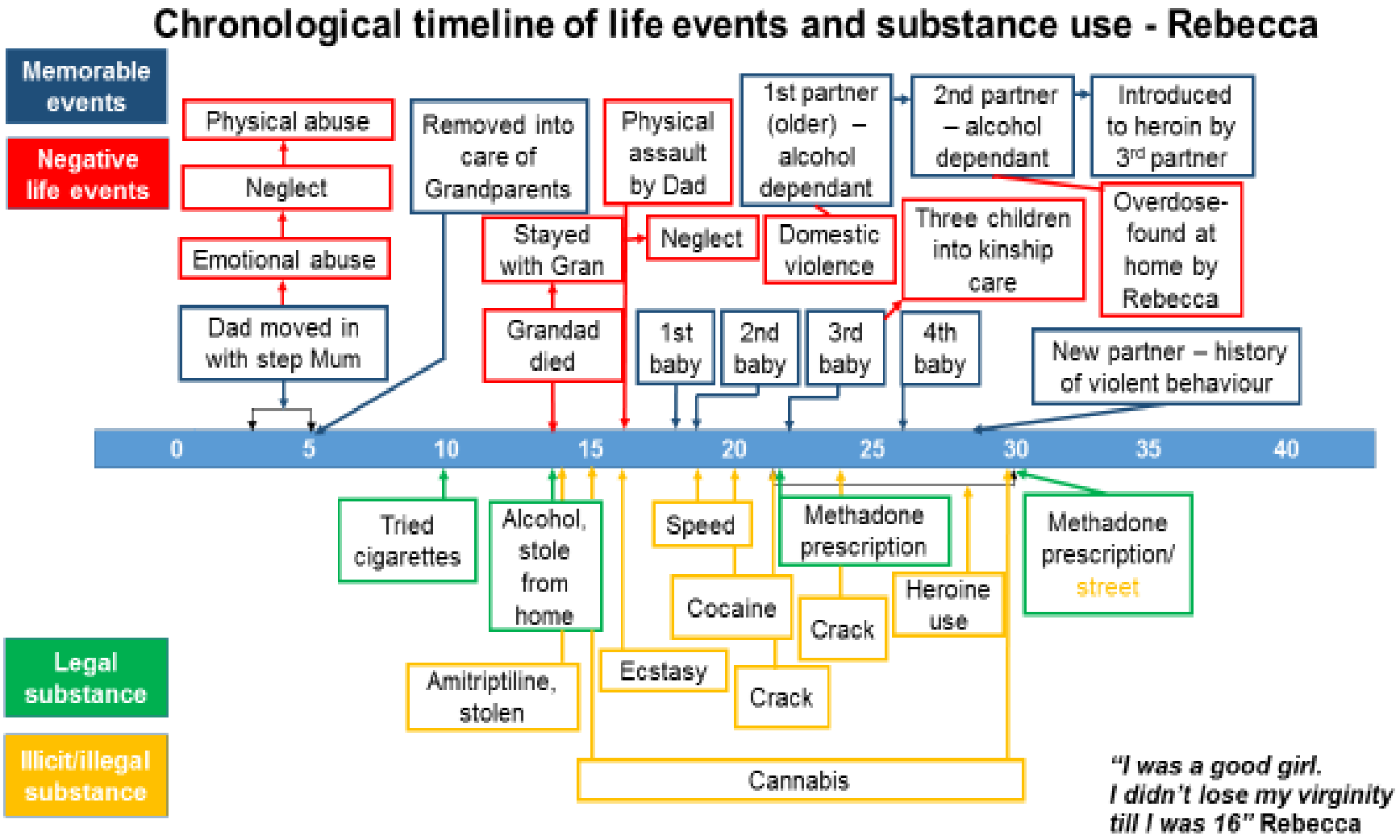

Chronological timeline of life events and substance use - Rebecca
Memorable events
Negative life events
Physical abuse
Neglect
Emotional abuse
Dad moved in with step Mum
Removed into care of Grandparents
Stayed with Gran
Grandad died
Physical assault by Dad
Neglect
1st partner (older) – alcohol dependant
Domestic violence
2nd partner – alcohol dependant
Three children into kinship care
Introduced to heroin by 3rd partner
Overdose- found at home by Rebecca
1st baby
2nd baby
3rd baby
4th baby
New partner – history of violent behaviour
0
5
10
15
20
25
30
35
40
Tried cigarettes
Alcohol, stole from home
Amitriptiline, stolen
Ecstasy
Speed
Cocaine
Crack
Methadone prescription
Crack
Heroine use
Methadone prescription/ street
Cannabis
Legal substance
Illicit/illegal substance
"I was a good girl. I didn't lose my virginity till I was 16" Rebecca

Figure 6

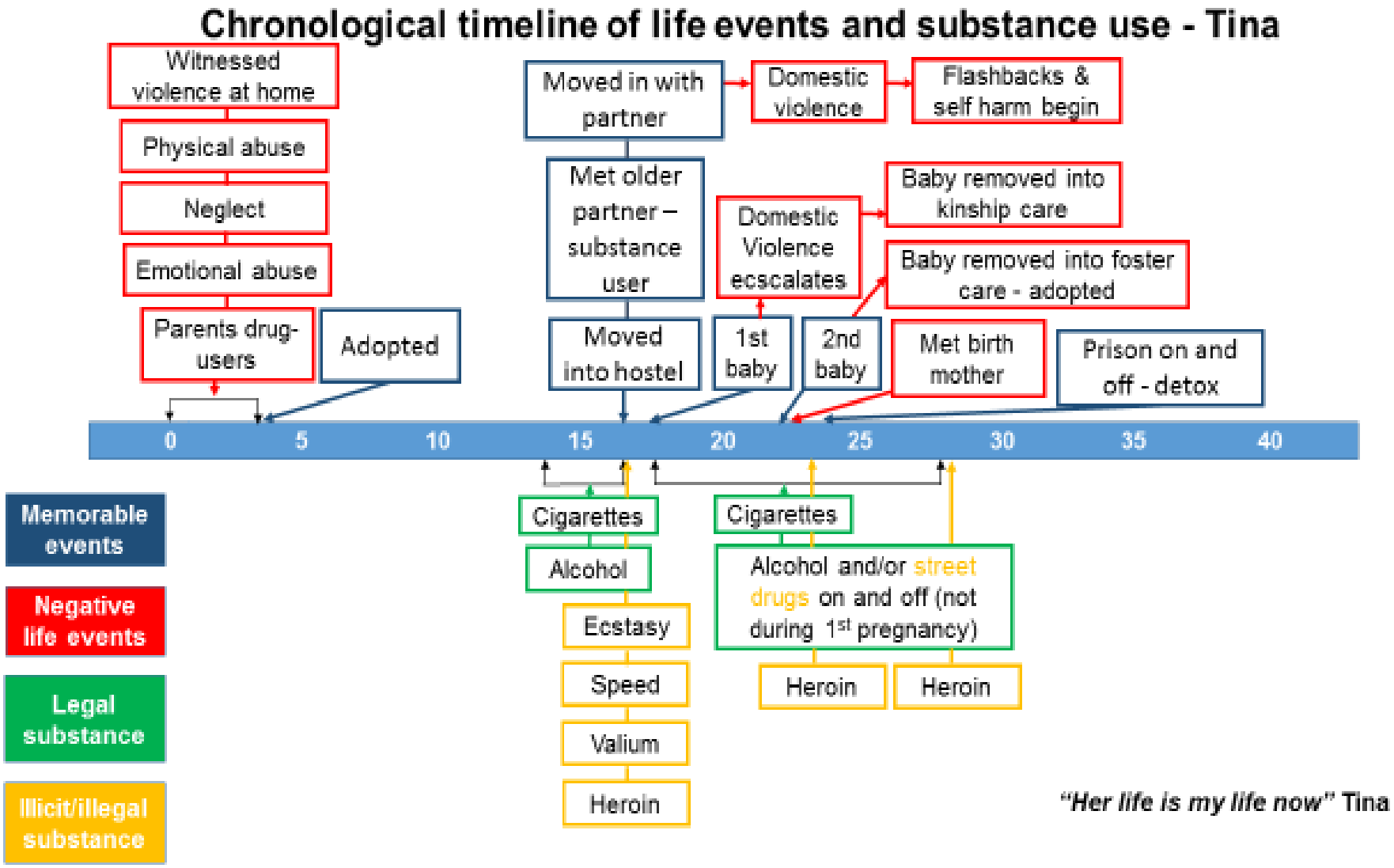
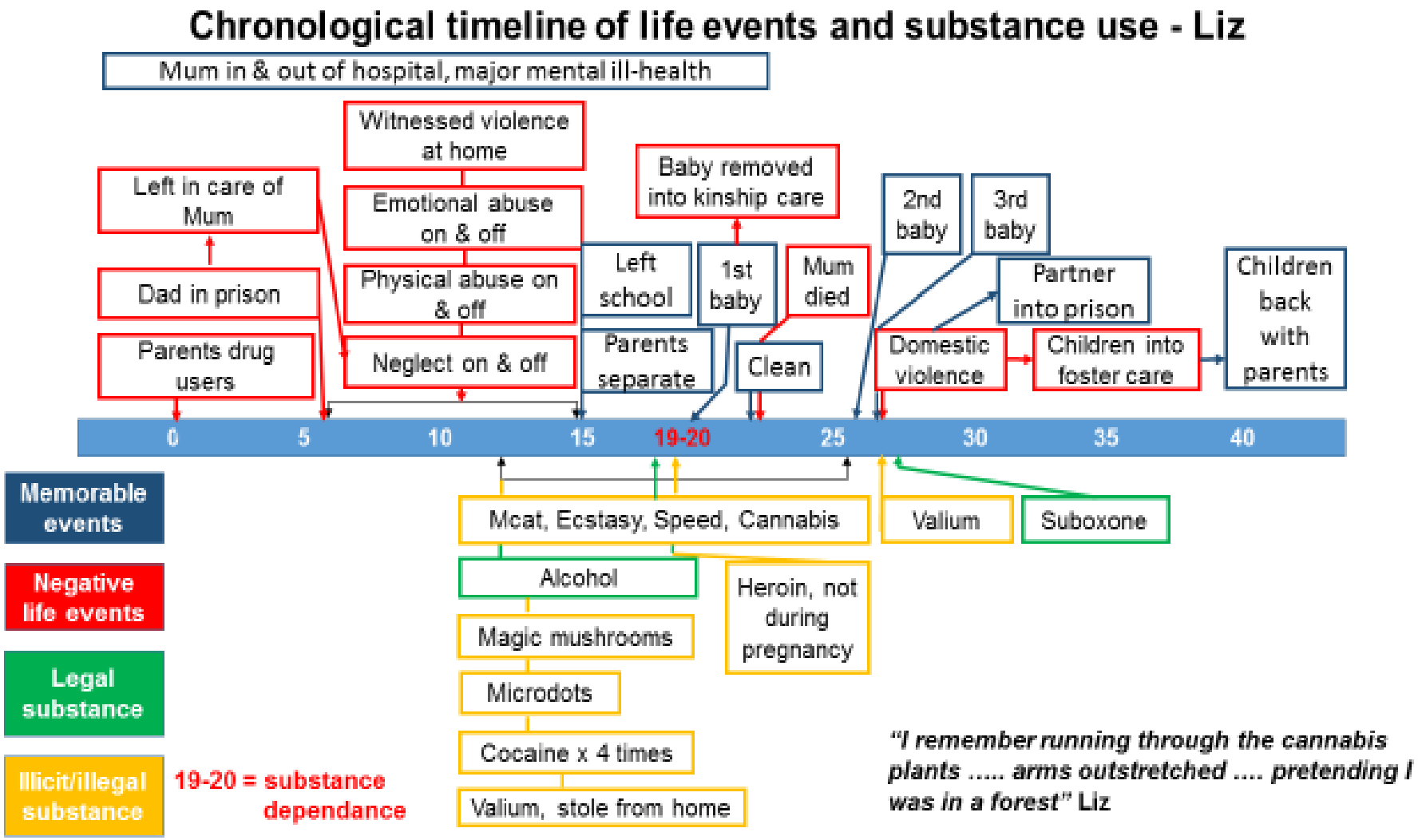

Chronological timeline of life events and substance use - Tina
Witnessed violence at home
Physical abuse
Neglect
Emotional abuse
Parents drug-users
Adopted
Moved in with partner
Domestic violence
Flashbacks & self harm begin
Met older partner – substance user
Moved into hostel
Domestic Violence ecscalates
1st baby
2nd baby
Baby removed into kinship care
Baby removed into foster care - adopted
Met birth mother
Prison on and off - detox
0
5
10
15
20
25
30
35
40
Cigarettes
Alcohol
Ecstasy
Speed
Valium
Heroin
Cigarettes
Alcohol and/or street drugs on and off (not during 1st pregnancy)
Heroin
Heroin
Memorable events
Negative life events
Legal substance
Illicit/illegal substance
"Her life is my life now" Tina

Figure 7


Chronological timeline of life events and substance use - Liz
Mum in & out of hospital, major mental ill-health
Witnessed violence at home
Left in care of Mum
Emotional abuse on & off
Baby removed into kinship care
2nd baby
3rd baby
Left school
1st baby
Mum died
Partner into prison
Children back with parents
Dad in prison
Physical abuse on & off
Parents drug users
Neglect on & off
Parents separate
Clean
Domestic violence
Children into foster care
0
5
10
15
19-20
25
30
35
40
Memorable events
Negative life events
Legal substance
Illicit/illegal substance
19-20 = substance dependance
Mcat, Ecstasy, Speed, Cannabis
Valium
Suboxone
Alcohol
Heroin, not during pregnancy
Magic mushrooms
Microdots
Cocaine x 4 times
Valium, stole from home
"I remember running through the cannabis plants ..... arms outstretched .... pretending I was in a forest" Liz

	Jane	Jenny	Rebecca	Tina	Liz
Childhood abuse: Emotional- Physical- Neglect- Sexual-	 Yes No No No	 Yes No No No	 Yes Yes Yes No	 Yes Yes Yes No	 Yes Yes Yes No
Parental substance use	Yes	Yes	Not disclosed	Yes	Yes
Into care as child	No	No	Yes	Yes	No
Drug use by peer group	No	Yes	Yes	Yes	Yes
Older partner	Yes	Yes	Yes	Yes	No
Teen pregnancy	Yes	No	Yes	Yes	Yes
Polysubstance misuse	Yes	Yes	Yes	Yes	Yes
Heroin addiction- Alcohol addiction-	Yes No	Yes No	Yes No	No Yes	Yes No
Ongoing abuse: Emotional- Physical- Sexual- Controlling-	 Yes Yes No Yes	 Yes Yes No Yes	 Yes Yes No Yes	 Yes Yes No Yes	 Yes Yes No No
Children removed into care	Yes	Yes	Yes	Yes	Yes
Prescribed substitute medication	Yes	Yes	Yes	No	Yes

Table 13 Table of findings from life history calendar

4.1.4 Narrative account of the Life History Calendars:

A number of broad themes emerged during analysis of the LHCs. These are presented in the order these came to light: Childhood trauma and current family/intimate relationships; Substance use and addiction; Ongoing trauma; Pregnancy and motherhood.

4.1.4.1 Childhood trauma and current family/intimate relationships

The majority of the participants grew up in households with substance dependent parents. For instance, Jane grew up with an alcoholic father, Jenny's parents were both alcoholics and Tina and Liz's parents both had substance use disorders. Rebecca however, did not mention her mother throughout completion of her LHC or her interview and she did not indicate substance use or misuse in relation to her dad, her step mum or her grandparents who subsequently looked after her.

While all of the women experienced emotional abuse, only some experienced neglect. All of the women provided graphic accounts of these experiences. Rebecca, Tina and Liz also experienced physical abuse and neglect, but none of the women disclosed histories of sexual abuse in childhood. Arguments, shouting and physical violence were commonplace in the participant's childhood homes. Jenny recalled being frequently involved in splitting her parents up from physical fights and Tina and Liz remembered very violent fights between their parents. These experiences led Tina and Rebecca to be removed from their parents as very young children. While Tina was placed in foster care and was subsequently adopted due to the abuse she was subjected to, Rebecca was removed from her mother's care, by her father and step mother. From there, she was further removed into kinship care due to physical and emotional abuse from her step mother, which was ignored by her father.

All of the participants experienced periods of instability and a lack of parental/adult guidance from one or both or their parents or caregivers and a sense of routine and boundaries appeared to be largely missing at various points in the participant's childhoods. Interestingly, although parental absence was commonplace for a variety of reasons, it was not always viewed as negative. For example, due to her mother's

serious mental ill-health problems which required frequent and prolonged admissions for psychiatric help, Liz had periods of care from her substance addicted father. She remembers spending a lot of time visiting her mother whilst in hospital, but remembers feeling safer and better cared for by her dad, compared to her mum.

The LHCs also revealed participants' current relationships with their parents and childhood carers. Jane has a close relationship with her mother, but has no contact with her father due to his alcohol addiction. Interestingly, Jenny's parents no longer drink alcohol and are no longer violent towards each other. She has a close relationship with them, in particular her mother. Rebecca did not talk about her mother throughout her interview. She currently has no contact with her father, her step mother or her grandmother. Tina is very close to her adoptive mother. She met her birth mother once, a number of years ago, in order to try to understand the reasons behind her maltreatment as a child. Although the meeting had very negative consequences, she would like to meet her mother again as she has many unanswered questions. Liz's mother died suddenly and unexpectedly a number of years ago, but she remains close to her father.

Three of the participants were in intimate relationships at the time of interview. Two of the participants reported that their siblings also had substance use disorders.

4.1.4.2 Substance use and addiction

Four out of the five pregnant women began experimenting with substances from a young age, mostly during their early teenage years. All of the participants had histories of poly-substance misuse and reported periods in their lives when alternative substances were used in the absence of their preferred substance. For instance, at the height of her alcohol addiction, Tina would drink 9 litres of cider every day and if she could not get alcohol, she would take whatever substances were available.

Most began their experimentation with alcohol and quickly moved on to illegal drugs, which appeared to be easily available and widely accepted within the communities where they lived. For example, Liz remembers buying ecstasy from a neighbour, without any questions being asked despite her only being thirteen at the time. Four

out of the five participants reported enduring problematic heroin use and they had all progressed from snorting heroin to injecting it. This was mostly because as their dependence increased, their tolerance to the drug and the amount they needed to buy increased and it became increasingly difficult to afford.

The LHCs revealed the participants' different attitudes towards and experiences of heroin use. Jane initially didn't like injecting heroin herself so her partner did it for her. Jenny reported initially finding injecting heroin *"traumatic"* as she had *"terrible veins"*, however she persisted *"out of necessity".* Liz began injecting heroin out of curiosity, boredom and because her peer group were all *"jaggers".* At the time of completion of the LHC, Jane, Jenny, Rebecca and Liz were all taking prescribed opiate substitution therapy and considered themselves to be clean. Tina reported problematic alcohol use, which she felt was mostly due to its convenience and low cost. However, she reported that she had been abstinent for a number of weeks at the point of the interview. Tina also reported that when abstinent from alcohol, she would often take heroin as she believed this to be less addictive and problematic for her. All of the participants were clean at the time of interview.

4.1.4.3 Trauma in teenage years and into adulthood

All of the participants reported experiencing prolonged periods of abuse. Jane, Jenny, Rebecca and Tina began dating men significantly older than themselves in their mid-teens, all of whom were poly-substance users' dependant on alcohol or drugs. Some were intravenous drug users. All four participants stated that they were unaware of this at the beginning of their relationships. Jane, Jenny, Rebecca and Tina subsequently left home in their teenage years to move in with their older partners who provided them with class A substances, leading to their subsequent addiction to heroin.

Four out of the five participants experienced domestic abuse from an early stage in their relationships and Jane, Jenny, Rebecca and Tina went on to live with a series of violent, abusive men. The violence that Tina was subjected to escalated after she had her first baby. Liz however, described her experience of domestic violence as a one off event, for which her partner served time in prison. Women's past partners

were in general, described as *"very violent"* and *"controlling"*. Physical and emotional abuse, controlling behaviour and coercion became daily experiences for the majority of participants who were shouted at, spat on, pushed, bitten and punched. Jane was told what to wear, when to leave the house and who she could to talk, whilst Tina could only open the curtains in her house when her partner gave her permission to do so and was made to witness violent acts on a regular basis. None of the women disclosed experiences of sexual violence in their adulthood.

4.1.4.4 Pregnancy and motherhood

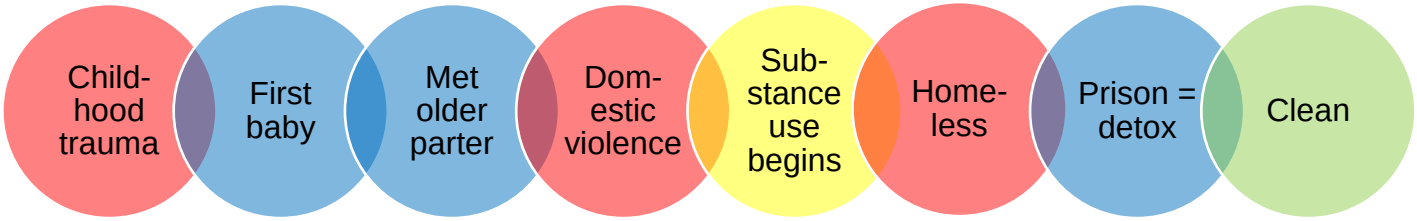
All of the participants were in the third trimester of pregnancy at the time of their interviews. None of their current pregnancies were planned and all of the participants had had more than one child. Some of the participants had experienced substance related problems during their previous pregnancies and some had seen their babies withdrawing from substances. All of the participants tried to remain stable and clean during their previous and current pregnancies. All of the participants had had children removed into the care system, some on a temporary and some on a permanent basis. Not all of the participants whose children had been removed into either kinship or foster care had regular access to their children. Tina and Jenny had both had children removed from their care on a permanent basis. All of the participants tried to remain clean or present themselves as such when gaining access to their children, fearful of what their children would think.

4.1.4.5 Figure 8

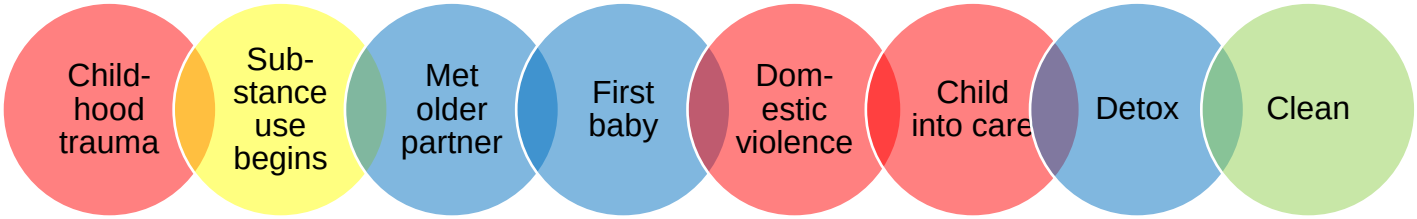
Participants key life event lines from the chronological timelines

Key - = negative life events
= significant life events
= illicit/illegal substance use
= prescribed opiate substitution/abstinence.

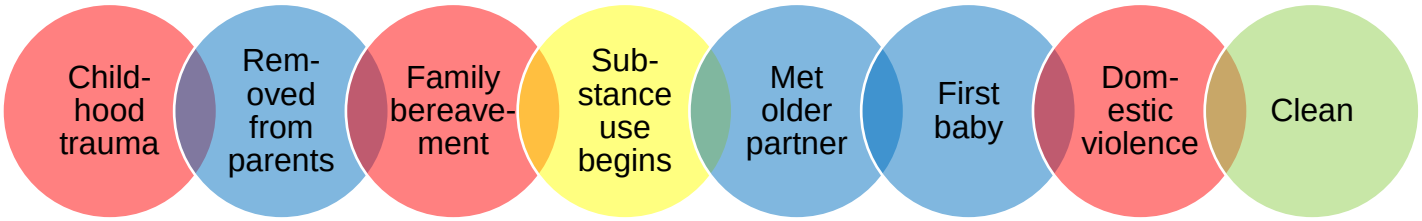
Jane



Jenny

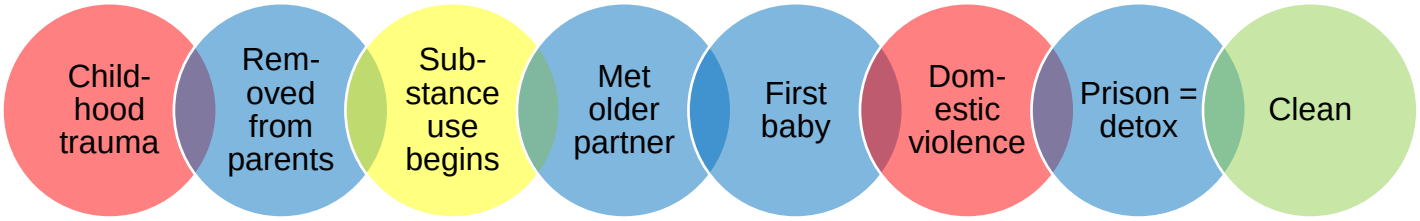


Rebecca

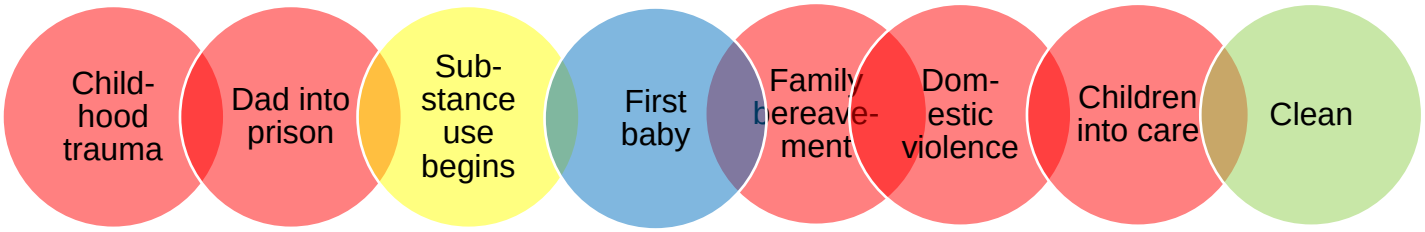


Participants key life event lines (cont)

Tina



Liz



Following the early stages of analysis of the interview transcripts, it became apparent that very similar themes were emerging to that from the LHC. The findings from the LHC, my field notes and direct quotes captured on the LHCs and the interview transcripts were then integrated in order to capture in depth, the participant's experiences and perceptions more fully. Three major overarching themes were identified within which there are eleven sub-themes:

Super-ordinate themes	Sub-themes
Psychological trauma	- Childhood trauma - Ongoing trauma - Substances to block out the pain
Dabbling to addiction	- Dabbling - Addiction - Stigma - Positive impact of prison - What it means to be clean
Addiction and the identity of pregnancy and motherhood.	- Pregnancy - Motherhood - Relationships

4.1.4.6 Interpretative phenomenological analysis of interview transcripts - Pregnant participants' super-ordinate themes and sub-themes

4.1.5 Super-ordinate theme - Psychological trauma

This first major theme captures the participants' meaning-making of some of the traumatic events that occurred at different times in their lives. Within the LHC, participants tended to discuss their childhoods first. Within the interviews however, they were found to concentrate more on recent or current events in their lives first of all. Most of them did not return to talking further about their childhoods during their interviews. This may have been due a number of factors, such as not wishing to discuss their earliest memories in any more depth or recent events in their lives being upper most in their minds, perhaps in relation to their children or current pregnancy.

Data from the LHC and the interview transcripts were combined to present a fuller picture of the participants' experiences and perceptions of the events that had taken place within their lives. Within this first overarching major theme Psychological trauma**,** three sub-themes emerged. The first sub-theme, childhood trauma, focusses on the participants' early experiences of interpersonal trauma. The second sub-theme, ongoing trauma, represents the participants trying to make sense of the trauma they continued to endure into their teenage years and on into adulthood. The third sub-theme, substances to block out the pain, sheds light on some of the strategies the participants used in order to try and cope with their experiences of trauma.

4.1.5.1 Childhood trauma

"I was always left in the pram to cry" (Tina):

During data collection, the deep significance and ongoing effects of interpersonal trauma in childhood emerged for all the participants. The first significant finding was that the majority of the participants grew up in households where either one or both of their parents were addicted to alcohol or drugs. Participants could recall in detail, specific aspects of their parents substance use, appearing to capture the participants' acute awareness of times their parents had used or were under the influence of substances. For example, Jane never saw her mum drink alcohol but during completion of her LHC, she described her dad as "*a drinker*" (LHC quote). When talking about her childhood, she revealed what appeared to be her deep feelings of embarrassment about her dad's very public display of alcoholism:

"*Standing at the living-room window, feeling mortified ... watching him stoating down the street*" Jane

Within the LHC, alcohol was also found to have played a significant part in Jenny's childhood. Her mum drank every day and she described her dad as a "*binge drinker*" (LHC quote). Her childhood memories appeared to be overshadowed by unpredictability and inconsistency, in particular regarding her mum, which was a collective experience amongst the participants. One gains a sense of her feelings of fear and dread as she returned home after a day at school:

"*the smell of alcohol on my mum's breath … her moods if she had been drinking (pause) or not drinking (pause) when I came in from primary school*" Jenny

Substance-related behaviour and activities appeared to be accepted and normalised within the participant's families, the extent to which was captured by Liz. Her early childhood memories centred on what turned out to be her dad's criminal activity of drug production. Although she unaware of this at the time, there appeared to have been no sense of secrecy about this within the family home, highlighting the sense of acceptability of such activities. She recalled during completion of her LHC how her dad:

"*converted the living room into a cannabis farm … I must have been about four at the time*" Liz

At times, Liz's dad was her main carer as her mum endured severe mental health issues which required frequent and prolonged periods of hospitalisation throughout her childhood. She appeared to associate him with feelings of love and nurture as she *"felt safer and better looked after"* (LHC quote) by him than her mum. Her sense of love and attachment to her dad came across very strongly during completion of her LHC. Nonetheless, the subsequent quote taken from her LHC captures the psychological damage of growing up in an environment surrounded by illegal substances and the extent to which this was normalised amongst the participants:

"I remember running through the plants (pause) touching the leaves of the plants (pause) pretending I was in a forest" Liz, (LHC quote)

One gains the sense of a child full of fun, innocence and naivety regarding her parents' activities, particularly as when talking about her dads cannabis farm, Liz stretched her

arms out wide, flung her head back and laughed making the sense of fun and elation she associated with this time tangible. This was a common theme among most of the participants.

Tina however, did not elaborate on her parents substance used disorders. She indicated during her LHC that this had been problematic and was one of a number of issues that led up to her removal and subsequent adoption when she was four. Her only mention of this was when, during completion of her LHC, she described meeting her birth mother who had finally *"got herself sorted"* (LHC quote). The majority of participants were found to clearly recall childhood memories of parental substance use. Rebecca was the only participant who did not discuss substances in relation to any of her carers during childhood.

The extent to which the participants talked about their parent's substance use and addiction during completion of the LHC, appears to reflect the extent to which it dominated their childhoods. During the interviews however, a couple of the participants seemed to have attempted to minimize the effect this had on them. This perhaps in some way highlights their continuing struggle in coming to terms with what their parents' actions and what they were exposed to on a daily basis. It may also shed light, once more, on what seemed to have been an unspoken tolerance of parental substance misuse and addiction during their childhoods, within their families. It seemed that as long as day to day life was not impacted to a great extent and if families and children were still *"provided for"* (Jane, LHC quote) and still *"got things"* (Jane, LHC quote), alcoholism and drug addiction and therefore the behaviours that came with these, were perceived as manageable and were largely overlooked. It seemed that the participants still felt cared and provided for at times which perhaps helped make their lives more tolerable. As Jane says:

"like I said I had sort of quite a good childhood. My dad was an alcoholic but he was still always he was an alcoholic but was still no every day he was steaming drunk it gradually it got worse over years obviously (pause) but em but it ken like we were taken places we got to get things that we wanted" Jane

Nonetheless, Jane appears to illuminate the dichotomy of living with addiction in the family. On the one hand, she clearly remembered feeling *"deeply ashamed"* (Jane,

LHC quote) of her dad as a child, yet she seems to value him for his ability to work and provide for the family. One cannot help ponder over the confusion she felt as a child, growing up with someone whose actions negatively impacted her family, yet life carried on regardless. This sense of appearing *"normal"* (Jane, LHC quote) seemed to be echoed by Jenny who described her parents as being "*very strict about smoking and especially if we got into trouble at school"* (Jenny, LHC quote), suggesting that bad behaviour must remain hidden within the family and out of sight of outside agencies in particular.

Some of the participants, however, did allude to their parents as being distracted and deeply troubled adults, appearing to have been attuned to this even as young children. Some seemed to reflect on this with forgiveness and compassion towards their parents, seeming to understand their parents' addictions within the wider cultural context at the time and perhaps in relation to their own personal struggles:

"they were just adults with their issues you know. Em (pause) at a totally different time when alcohol was such a big thing eh and you know it wasn't an issue to sit in the pub with your kids during the day you know?" Jenny

There was however, a sense of the participants' growing insights that their experiences as children were far from *"a normal childhood"* (Liz, LHC quote*),* yet it seemed they could not fully perceive this reality based on their own memories. For example, Jane described recently searching through family photograph albums and video footage for *"evidence"* (Jane, LHC quote) of her dad's behaviour, suggesting she needed more tangible proof that her memories were correct. Her growing feelings of sadness and disappointment emerged as the physical evidence was found to *"prove"* (Jane, LHC quote) that her dad was undeniably *"obviously drunk in all of my childhood photos and videos"* (Jane, LHC quote)*.*

It seemed that the participants' families tried to maintain a public persona and they emerged as leading childhoods shrouded in secrecy. The problematic nature of trying to contain or disclose deeply engrained family secrets emerged within the interview transcripts of two of the participants. Even when help could have been available from social services, the over-riding fear and anxiety the participants felt regarding

separation from their parents appeared all-consuming, even when they knew deep down, that problems existed:

"*I can remember us em (pause) being so defensive (pause) so defensive of our mum and dad. Cos it it you know at the same time em (pause) they weren't doing anything to hurt us physically … I think even then I knew then em (pause) it wasn't you know they their problem it was between them and it was just that their issue (pause) and their issue then spilled out into our lives … they did try to give us you know a a a stable home you know they did try to make it as normal as possible em (pause) … so we never em (pause) you know we would say (pause) there was nothing going on (pause) everything was fine em (pause) because we didn't want to go you know."*
Jenny

Jenny seemed to be desperate to protect her parents' from judgement for their failures and terrified at the prospect of being removed from their care and her poignant quote captures the participant's central concern of attachment and tremendous loyalty to their parents. It seems as if she felt that if there was no physical pain inflicted, emotional maltreatment was somehow more acceptable. This seems to be echoed by Jane who felt that *"things could have been a lot worse"* (Jane, LHC quote).

Liz, however, recalled what appeared to be frantic attempts of trying to get help on two occasions. During completion of her LHC she explained how aged six, she stole a piece of one of her dad's cannabis plants and took it to her primary school in her pocket as she *"knew by this time what they were doing wasn't normal"* (Liz, LHC quote). She described being *"desperate for one of the teachers, anybody, to find it, but they never did"* (Liz, LHC quote). Her second attempt at seeking help came in light of what appeared to be very dramatic and deeply traumatic events that took place during a family holiday when she was eight. She could vividly remember that her parents had both taken speed. She remembers sitting *"terrified"* (Liz, LHC quote) on the back seat of the car, her dad *"tripping out"* (Liz, LHC quote), her mum *"vicious, clawing at his face"* (Liz, LHC quote):

"I wrote help me on a piece of paper and held it up to the back window in the car hoping someone would see it but they never noticed" Liz (LHC quote)

One gains a sense of the terror, desperation and vulnerability she must have felt being left in the care of parents who seemed to be out of control and unsafe. There is also

a deep sense of her feeling alone in the world and her despondency at not being rescued from this horrific ordeal.

The majority of participants talked about their parents' addictions and the many ways in which this impacted their day to day lives as children. Neglect and abandonment emerged as daily occurrences and were spoken about in great depth during completion of their LHCs. An apathy, lack of consistency and overall absence of reliable authority figures within their childhoods emerged:

"just I I don't you don't I don't also know if it's just because you know em (pause) my mum and dad were so kind of wrapped up in their own stuff" Jenny

Jenny's acute awareness of her parent's complete absorption in their addictions emerged and yet she seems somewhat uncertain about why they failed to meet some of her needs. A sense of feeling abandoned and lacking parental guidance and support was commonplace for all of the participants, and appeared to leave them feeling that they were left to fend for themselves during their childhoods.

Some of the participants were left in the care of older siblings or grew up in environments where parenting was the responsibility of one adult. The participants reflected on these times and seemed almost awe of the parent who *"was left to struggle"* (Jane, LHC quote). Their own experiences of being left on their own at times with their own children perhaps resonated with their parents experiences, as Jane repeatedly said:

"I just don't know how my mum did it, how she managed with us and my dad" Jane (LHC quote)

Some spoke of missed opportunities and a theme of what appeared to be a lack of parental or adult involvement and encouragement with educational attainment and extra-curricular activities emerged among other participants. It seemed that their talents and passions went largely ignored. It's as if everything else was obliterated in light of their parent's absorption in their addictions, leaving no room for the participant's interests and endeavours. Jenny for example, excelled at music and loved playing the violin, yet *"no-one questioned me when I gave this up"* (Jenny, LHC quote) in her early teenage years. Rebecca won disco dancing competitions which she appeared

to recall with great fondness, laughing, as this was something she *"was really good at"* (Rebecca, LHC quote). These times were recalled as *"very positive experiences"* (Rebecca, LHC quote) yet again, no-one seemed interested when she gave up a much loved activity. All of the participants were found to have left school at a young age and it seemed that no-one was interested or cared enough to intervene.

Their experiences however, appear to emphasize yet another failure on the part of many adults in the lives of these, by then, very vulnerable children. This is highlighted by Liz who visibly shuddered whilst talking about some of her experiences during completion of her LHC. As she did so, it was as if her body was recalling the severe neglect she endured, highlighting the extent of the physical and psychological imprint of abuse on a young child. Left mostly in the care of her substance addicted mum, who had co-occurring major mental health issues, Liz remembered:

"the feeling of head lice running down my neck and arms" Liz (LHC quote)

She seemed to recall feeling puzzled, bewildered at what seemed an obvious disregard and lack of acknowledgement of her neglect by educational professionals:

"nobody did anything about it, even when I turned up at school obviously dirty" Liz (LHC quote)

Liz was not alone in describing experiences of cruelty and neglect during completion of her LHC. Rebecca lived with her dad and stepmother as a very young child and never talked about her mother during the interview. She was keen however, to talk about her memories of her step mother *"washing my mouth out with soap"* (Rebecca, LHC quote) and *"force feeding me"* (Rebecca, LHC quote) when she was very young. She offer to show me deep scars on her legs, which she is sure are a result of being *"beaten with the buckle end of a belt"* (Rebecca, LHC quote) as if in some way, needing to show the lasting physical evidence and perhaps seek validation of the deep psychological trauma she feels.

Arguments and shouting emerged as commonplace in all of the participants' homes and the frequency and almost expected nature of these experiences appeared to add to the distress they already felt. Jenny and Liz in particular, regularly witnessed

physical violence between their parents. Jenny "*was regularly involved in splitting them up from physical fights"* (Jenny, LHC quote), whilst for Liz, domestic violence was directed by her mum towards her dad. She remembered her mum *"throwing cups of hot tea at my dad"* (Liz, LHC quote). Rebecca was the only participant who did not recall witnessing domestic violence as a child, however as she spoke of *"feeling"* (Rebecca, LHC quote) an ever present threat of this, directed from her dad to her step mum, one is left to ponder what caused this fear.

In contrast to the rest of the participants however, Tina, remembered very little about her childhood until she was seventeen. Her memories returned in the form of disturbing and highly distressing flashbacks when she became involved with a *"very violent man"* (Tina, LHC quote)*:*

"em (pause) just em my dad battering my mum eh like (pause) strangling her eh (name of brother) my big brother (name of brother) (actions as if scooping her up) having to run to my Gran's (pause) she stayed over the road (pause) to phone the police (pause) having to put me in the bedroom to keep me safe (pause) while he went out em just constant fighting (pause)" Tina

Tina's flashbacks capture the clarity with which all of the participants could remember very specific traumatic events from their childhoods and embody the enduring psychological impact and imprint these have made. They all spoke very quietly when talking about their childhood trauma, acquiring almost childlike qualities. It's as if in recalling their fear, they returned to the age they were at the time of these terrifying events during their interviews. Tina in particular, used very specific actions and gestures which seemed to embody the acts of love and kindness the participants experienced from significant people who helped keep them safe and rescued from the terrifying situations they had to endure.

In addition to witnessing extreme violence, Tina remembers, with clarity, how her parents showed favouritism towards her brother:

"I was always left in the pram to cry (name of brother) was always (pause) always neatly dressed (pause) always got the attention (pause) and I was just like pushed away aside em pushed away aside and left in a wet nappy damp clothes stuff like that" Tina

Her feelings of neglect and abandonment at a very young emerge as she remembers feeling quite literally cast aside in favour of her older sibling. The depth of the trauma she has experienced are clear as she remembers the feeling of being left uncared for and dirty and seem to add to her deep distress. The physical evidence of her psychological trauma from many years of self-harming were obvious to see. Like all of the participants, most of Tina's childhood memories are of when she was very young and most of the participants were found to have very few positive memories from much of their childhood.

Tina however, emerged as the only participant to talk about being treated differently from her siblings. The rest of the participants appeared to feel that they were all treated the same as each other and that what had occurred was a shared, rather than ostracising experience. This was suggested in the way they spoke about themselves during these times. For example, Jenny rarely spoke of herself in the first person when talking about her childhood. She spoke of *"we"* appearing to refer to events as collective ones, which may in some way represent an enduring bond with her siblings. Perhaps the participants felt a level of protection afforded by siblings, in that no one child was singled out for abuse. Additionally, their siblings could be relied upon to rescue them from distressing situations.

Removal from their childhood homes however, did not always secure a future with nurturing caregivers and it seemed as if some of the participants never felt they were ever truly wanted or accepted. A great sense of further rejection and subsequent loss emerged as they appeared to continue to feel *"let down"* (Rebecca, LHC quote) and their feelings of abandonment by significant adults at key times in their lives surfaced:

"I think that my gran only took me because my grandad made her you know what I mean? My papa just showed more attention (pause) more love you know (pause) was gentle with me. Came out the bath and I used to have hair down to my bum and my gran used to she'd be like (mimes brushing hair roughly) whereas my papa would be nice and gentle (mimes brushing hair with great care and attention) ... so I liked being round my Papa more than my Gran" Rebecca

It seems that Rebecca always felt like a nuisance and never truly accepted by her gran, which appears to have been in direct contrast to her grandad who appeared to

welcome and accept her within their family readily and easily. Perhaps her feelings of rejection were so deep as she was being rejected once more, by yet another significant woman in her life. Bonding and attachment to a significant adult appear to be hugely significant and influential. Furthermore, not unlike Tina, it seemed that actions could convey better and in more depth, what she was trying to express. It's as if the gestures and actions she remembered reflected deep feelings of love and affection. Again, acts of kindness and love appeared to become metaphors for the care and attention her grandad showed her in general.

The damage of losing the only positive influence in her childhood was significant for Rebecca and echoed the loss Liz felt when her dad served a prison sentence for dealing cannabis. Both of these participants were found to have been left with women that they knew were incapable of looking after them in any meaningful way. Both described themselves as feeling *"lost"* (Liz, LHC quote), invoking images of feelings of ensuing bewilderment, disorientation and fear.

In summary, this theme has highlighted the various negative experiences, forms of abuse and neglect and a general lack of early positive relationships in the participant's childhoods. Within the interviews, a number of important issues appeared to be a common occurrence; the importance of boundaries in childhood; the significance of feeling rejected by a care giver and the importance of bonding to a significant adult. There was a shared experience amongst all participants with the ongoing struggle of how to take in the meaning and impact of how they were treated as children, often as the result of their parent's addictions. Some of the participants were subsequently removed from their parents and placed into kinship care or adopted. Being removed from an abusive household however, did not always ensure a stable, loving environment and participants were left feeling rejected and abandoned once more. An absence of parents who were reliable, nurturing and trustworthy had long lasting effects on all the participants, leaving them feeling unworthy, unsupported and rejected. A lack of boundaries led to increasing vulnerabilities for all the participants. From there on, they continued to experience adversities.

4.1.5.2 Ongoing trauma

"you're no fucking going out wearing that" (Jane):

Most of the participants appeared to fall in with a large group of peers with whom they began experimenting with substances. Their teenage years seemed shrouded in secrecy as they were *"telling lies"* (Liz, LHC quote), keeping *"secrets"* (Jenny, LHC quote), mixing with people who were *"bad influences"* (Rebecca, LHC quote)" and making *"bad decisions"* (Tina, LHC quote)". The sense of there being a complete absence of adults they could depend upon appeared to continue throughout their childhoods:

"if I had maybe felt I had somebody I could turn to other than I mean my sister was only three years older than me you know she she wasn't really in a position to be the adult (pause) although she tried her best to keep us from whatever em she wasn't really any older. She was just a child herself. So em (pause) yeah I I think if I if I if maybe (pause) somebody had known a bit more about what was going on in our lives or em like my mum and dad … maybe we it (substance use) would never have happened or (pause) you know we might have spoken to somebody about it. But it was just it was never questioned it never even got questioned (pause) nobody knew" Jenny

The above quote from Jenny encapsulates the participants' realities of having no-one listen or care for them and the consequences of being left in the care of siblings, barely old enough to look after themselves. The participants appeared to feel drawn into these worlds, with little volition of their own, but desperately missed adult guidance and supervision. Perhaps most of all, it emerged that they longed to have someone that cared enough to set clear boundaries for them.

The following quote further captures the sense of ever increasing vulnerabilities within the lives of the participants:

"Just em well after my papa died I just started drinking more using drugs eh when you take away somebody that that's sort of the head of the house that has control over you then you've got a free run on everything. Giving that just to a teenager is a bit mad (laughs) you know what I mean yeah so I didn't have anyone to well I did I loved my Gran but I didn't respect her so when she was telling me to stop doing it is was just like mmmmmmm just noise so (trails off)" Rebecca

Being left with adults who did not seem to notice or care what was taking place in their lives became a common feature within the LHC's and interviews. For Rebecca, this became more so after the death of her dearly loved grandad, after which time, she felt even more rejected by her Gran who *"gave up, lost interest"* (Rebecca, LHC quote) in her. Even though Rebecca had deep feelings for her gran, it appeared that the loss of her grandad meant further rejection for Rebecca. Losing the only authority figure in her life appeared to be more than she could bear as she seemed to lose her sense of bearings and spiral out of control.

During their teenage years, the majority of participants became involved with older men who were themselves poly-substance users or had substance use disorders, of which the participants were unaware at the time. The sense of security they felt with these men emerged as they described them as *"reliable"*, *"kind"* and *"wise"* (Tina, LHC quote)*".* Jenny described feeling *"loved and cared for"* (Jenny, LHC quote)*"* in her early to mid-teens by men in their twenties who *"had nice clothes and a good job"* (Jenny, LHC quote)*.* Given the ongoing abandonment and lack of nurturing they were experiencing at home, it is little surprise that they seemed to be very impressed by these men. One gains the sense that they felt looked after, taken care off, feelings that were missing in their lives at home with their parents, who were again, notably absent from their lives. Perhaps they even felt some sense of liberation, of being freed from their difficult lives at home.

Although by this time, most of the participants had experimented with a variety of substances, their older boyfriends quickly introduced them to a range of highly addictive substances:

> *"It wasn't till I met this guy (points to LHC) (pause) that I then tried like (pause) cocaine and (pause) crack and and (pause) heroin and em (pause) you know and was just too young too young to kind of realise what I was really getting myself into"*
> Jenny

The level of trust they had in these men emerged as significant as they appeared to take these substances without question or hesitation. It seemed that it was only after they become further immersed in drugs and alcohol, that they realised the life changing impact of these decisions. Their innocence and youth at the time of making these hugely significant choices is highlighted.

They appeared to feel that these men were their saviours and were blinded to the true nature of these relationships. Tina for example, felt *"rescued"* (Tina, LHC quote) by a man much older than herself who she met when she entered a homeless hostel, aged 16. It seemed that she felt he was saving her as he *"got her off alcohol"* (Tina, LHC quote), however this was replaced by introducing her to drugs. Jane was also *"no longer addicted to codeine"* (Jane, LHC quote)*"* when her significantly older, intravenous drug using partner brought heroin home for them to share, when he couldn't *"score vallies (Valium) for me"* (Jane, LHC quote).

Although none of the participants indicated or spoke about early experiences of sexual violence in their lives, one ponders about the possibility of this as there was often a sense of foreboding in the language they used. Showered with affection and perhaps feeling some sense of freedom, escapism from what was happening at home, Jenny indicated a few *"physical incidents"* (Jenny, LHC quote) on her LHC when she was 16. She now appeared to feel very different about the relationship she was in at that time with a significantly older man. She thought that now *"he was probably a paedophile"* (Jenny, LHC quote*)* seeming to suggest that she now felt the relationship had been coercive and abhorrent and that he had not been the *"perfect man"* (Jenny, LHC quote) she thought he was:

"em (pause) it was when I met this gentleman (emphasises word) (points to LHC) eh when I was 16 (pause) eh that he then (pause) like cos I had tried you know (pause) by that point I had em (pause) alcohol speed cannabis ecstasy but and and and and em (pause) acid but nothing harder than that" Jenny

Most of the participants swiftly moved in with their older partners. Addicted to substances, the majority found themselves going on to experience increasing levels of control and isolation within their lives. Acts of coercion appeared to consume their day to day lives, although they appeared unaware of this at the time. For example, Tina's partner *"wouldn't let me open the curtains"*. He grew increasingly possessive, began *"calling her names"* and *"cut me off from all my friends"*. Jane's partner made visitors *"feel uncomfy … it was no longer after I met him that they all stopped coming".* These acts of abuse however, seemed to initially be mistaken by the participants as a reflection in some way of their partner's wish to protect them.

The extent of what the participants thought *"was normal"* (Tina, LHC quote) emerged as an important theme. Within their accounts, it becomes clear that they did not feel or realise at the time that what they were experiencing were not loving, caring relationships, but damaging, insidious domestic violence:

"*Uhuh (pause) like spitting on me and saying things to me like (pause) just stupid things like "you're no fucking going out wearing that" or like just just silly things … Em I wouldn't say majorly but … definitely (pause) now if I looked back (pause) that were emotionally (pause) mentally sometimes as well (pause) … maybe he'd slept with one of my pals or something stupid like that em and then obviously that would be going through my head … he'd come back and he'd be like "no, I never but the last time I speaking to her and you weren't there, she said she doesn't know why she's pals with you anyway, you're a mess" … so I pushed everyone away (pause) everybody stopped coming that was how was how he liked it"* Jane

Their vulnerability became ever more apparent as they did not seem to realise that their partners were belittling and manipulating them into disbelieving their own feelings and memories, which in turn made them question their own actions rather than their partners. It seems only now, that the participants feel the true extent of what they endured and are able to consider the insidious nature of abuse and resultant isolation they had experienced.

Obvious acts of domestic abuse quickly followed, by which time is seems as if the participants' felt powerless and defenceless. During completion of their LHC's some of the participants described being *"kicked"* (Tina, LHC quote), *"punched"* (Jane, LHC quote) , *"bitten"* and *"dragged around by the hair"* (Liz, LHC quote) by their partners, very often in the presence of their babies and young children. It seemed as if it was the physical violence that came to define their lives. As if to highlight the trauma associated with these brutal attacks, many of the participants could remember exactly when the physical abuse began:

"I remember at mother's day (pause) and em (first baby) (pause) I had just had (first baby) … but he was staying at my mothers the night before …..and it was just me and (name of partner) in the flat. So on mother's day (pause) I got up [pause] got myself ready (pause) was going out the door and he had says to me em "am I not coming with you?" and I was like well "no, cos it's still really early, I'm going up to my mums"… well he didn't like that (pause) so that was the first time really (pause) I'd say he used his hands (pause). He pushed me (pause) and em I fell backwards over the couch" Jane

This is captured by Jane, remembering the first of many brutal attacks by her partner, perhaps made more significant by the timing of events. Now a mother herself, she was physically attacked on what should have been a day of celebration and joy.

Most of the participants were by now experiencing a series of negative and inter-connected negative life events. Tina's partner, for example, became increasingly violent after the delivery of their first baby when she was 17, which triggered flashbacks of the abuse she had experienced as a young child. *"Terrified"*, *"isolated"* and *"feeling a bit mad"* (Tina, LHC quotes), her feelings of distress appeared to be compounded by living with a *"very violent man"* who, in addition to being violent at home would also become involved in *"unprovoked fights against other men"* (Tina, LHC quote). She recounted the details of one such occasion when he "*made me watch as he attacked another man he didn't even know, with a hammer"* (Liz, LHC quote). She began many of her sentences with *"oh when he was angry… "* seeming to provide a chilling, poignant indication of his apparent inability to control his emotions or anger.

Living with increasingly violent and unpredictable men, the participants also found themselves living in unstable environments:

> *"I was back and forward but moved up to (name of town) eh and before I had (pause) before I had my daughter eh and moved back to (name of town) and then I moved back up to (name of town) when I was about 25 and just got in with the wrong crowd and em sort of drinking and getting in trouble and like couple times (pause) the police would just tell me to go home but cos I was totally drunk I'd lash out at the police and then attacking them … I woke up in the cell and I didn't know what I had done and supposedly I'd attacked this lass (pause) this girl and the police officer (pause) and I got put into the prison for eh first one was 4 months"* Tina

Periods of instability, escalating violence and further immersion in their local drug culture were collective experiences that they could not seem to escape, which further added to the sense of hopelessness and loneliness the participants appeared to feel. As they spoke, their negative life events appeared to spill out in quick succession. Their lives seemed to lack stability and they appeared unsettled and further drawn into chaos. They appeared to be caught on a trajectory which they could not control or escape and the sense of disarray and despondency became tangible as they continued to spiral out of control.

No longer the reliable men they thought they were, the participants were let down on numerous occasions, in numerous ways. Often homeless and with no money, it seemed like they felt consumed by a series of ever increasing negative events which further enforced their feelings of low self-worth:

"Em negative things would be [pause] probably em my drug use domestic abuse we became homeless em we became homeless when I was pregnant (pause) … It was winter (pause) it was winter and our landlord was bankrupt. There was no heating or hot water for months so we were moved into a bed and breakfast hostel sort of thing em … We moved to the flat em (name of partner) started taking em selling the drugs (pause) but em started taking them em heavily (emphasis on word) taking them and em we didn't split up but I asked him to leave em so we were still in a relationship but … basically it's a horrible thing to say (pause) but I was basically (pause) but I was with him basically cos what he was giving me" Jane

It seemed like the participants felt that unacceptable behaviour from their partners was tolerable in certain situations and seemed to resonate to their childhood experiences. This is highlighted by Jane as seems to echo back to her earlier quote regarding her family's attitude to her alcoholic father's unacceptable behaviour in exchange for goods.

Liz, on the other hand, denied any long term history of domestic violence with her long term partner. She maintained that he was normally a *"very placid, gentle guy"* (Liz, LHC quote). Given the severity and brutal nature of an attack she had recently endured, one can't help but wonder just how placid and gentle he really was. Moreover, within her account, there was an over-riding sense that she felt that his behaviour could be explained, was almost justified, as it occurred shortly after she told him about *"a wee habit"* (Liz, LHC quote) she had developed through *"dabbling with vallies (Valium)"* (Liz, LHC quote) shortly after the sudden and expected death of her mother.

The participants continued to live with violence, often from various partners, for many years. It seems that any personal feelings of self-worth, self-belief or self-determination had been eroded by their lifetime of abuse as their lives continued to spiral out of control and that staying in these terribly abusive relationships often felt like the only option for the majority of participants who reflected, with regret, on their actions and omissions during this time.

"He'd come back and ken he'd say like (pause) he say he was sorry and it wouldn't happen again and em. Ken what? I felt sorry for him because his mum and that wouldn't take him in (pause) like when I put him out … he was staying in other people's houses that were dirty (pause) minky and I'd feel sorry for him (pause) cos I know that's no the way he is … I felt sorry for him in some ways and I'd let him back" Jane

They appeared to feel so completely terrified, downtrodden and worthless that they thought living in intolerable circumstances was all they deserved. Even when separated however, their ex-partners still exerted huge pressure and control over the participants. Furthermore, as highlighted by Jane, they seemed to feel in some way responsible for their partners, highlighting their feelings of vulnerability in what seemed to have felt like inescapable situations.

In doing so, however, they were no longer protective factors for their children as they appeared to be unable to provide safe homes for them:

"it was just just a vicious circle round and round and there was like at one stage I got my wee laddie back and I was back there and my wee laddie got took off me. It (pause) back then (pause) it was like he had dragged me down to the lowest point that I thought I was worthless and nobody was there that would love me and that's why I kept going back there. You know? Yep" Tina

They seemed to feel caught in inexorable situations over which they had no control as they spoke about being in *"a vicious circle"* (Tina, LHC quote), which aptly captures the participants feelings of entrapment and desperation, even when their children were removed from their care and is encapsulated in the above quote from Tina.

Some of the participants recognised the similarities between the lives they were now leading and those of their parents. They seemed aware that they were now in turn traumatizing their own children, in many of the same ways that they had been traumatized:

"for a while there I was totally in danger of becoming like history repeating itself em because em although I was trying to protect (first child) from seeing things (pause) he was still seeing things and em witnessing stuff that I know had an effect on me growing up (pause) so I'm sure it would have an effect on him you know eh" Jenny

It seemed like the participants felt that they were following an unavoidable path as Jenny appeared to feel that she has in some way followed a predetermined path to

traumatize her own children and now everything that had happened before, was happening over again.

Tina however, appeared to feel that there was a genetic element to the life she was leading and as such, she was now replicating the life her mum had led:

"Just like my birth mum she was in a violent partners and em I've been there eh roughly my kids have been placed with my mum my other one went for adoption at the same ages that I was with my brother eh just violent partners eh my dad was always in and out of prison I've been in and out of prison eh drink and drugs that was a big part in my birth mum and dads past eh so I picked that up eh so like everything that's happened has has been happening over again" Tina

It's as if she finds solace in this, perhaps some kind of validation, that what was happening was unavoidable, rather than of her doing.

In summary, the majority of participants escaped from hostile, abusive childhoods into the arms of older, abusive men. Their feelings of helplessness and rejection, engrained during childhood, became further embedded by living with men who mistreated them on many levels over prolonged periods of time. The participants mistook their partner's age for maturity and security, their initial actions for love and safety. Any feelings of self-worth were eroded and their feelings of worthlessness and rejection emphasised by their partners. Living with abusive, substance addicted men, the majority of participants found themselves yet again, in hostile, unstable environments, mirroring the environments they had tried to escape. However, with no apparent way out, they found other ways to deal with what they were experiencing.

4.1.5.3 Substances to block out the pain

"living in the moment" (Rebecca):

The majority of participants became addicted to substances very quickly after becoming involved with older men. Their main reason for taking substances now was to stave of withdrawal, rather than experimentation. This was described as *"the rattle"* (Liz, LHC quote), a phrase which aptly captures the physical and emotional anguish that came when substances were not available.

In addition to this however, an underlying element to their substance use unfolded. The participants reflected on the ways in which they felt substances helped them deal with difficulties and distress at various points within their lives and it became apparent that they had also discovered the anaesthetic qualities of substances:

"I think well I think em I'm I'm such an emotional person (pause) and eh (pause) I think for me it was like a form of escapism em (pause) whether that be from (pause) escaping from the crap that was going on at home (pause) with my mum and dad eh (pause) or just kind of escaping my own sort of inner feelings cos it for me I've I've kind of recognised that it's when I tend to feel like that I can't cope inside em I can't (pause) I don't like that feeling and so I'd rather feel nothing I'd rather feel numb em (pause) not feel anything than to feel (pause) so horrible inside. So yeah for me I think it's an escapism from em (pause) from my emotions and and and how I felt about myself" Jenny

They seemed to gain a sense of reprieve from both mental and physical pain, from negative thoughts and feelings and in this way a complete avoidance of the harsh realities of their internal and external worlds. This appeared interwoven throughout their accounts.

For others, substances at times appeared to take on almost magical qualities that could ameliorate all aspects of the participant's lives that they could no longer tolerate. Substances appeared to give them a sense of wellbeing, removing their feelings of isolation:

"it made me feel good (pause) yep (pause) it just it took away the loneliness (pause) the way I was feeling in the house the like away from my mum. I did miss being there eh just made me feel great that every problem that I had just was wished away" Tina

None of the participants were found to disclose experiences of sexual violence during their adulthood. Perhaps, however, sex was used as a means of survival, in order for the women to be able to obtain substances from their partners. It was however, clear that the participants came to rely on substances to help them escape the physical brutality that existed within their lives:

"So aye it just (pause) just oblivious (pause) a lot of things I was blocking out (pause) like when (name of partner) when (name of partner) was using heroin (pause) that was like when the abuse started. Well (pause) the physical abuse anyway (pause) started so a lot of it was just kind of (pause) I was under the influence. I wouldn't feel it half as much as I would have if I had been straight. So so it sort of blocked some of that out and if I was under the influence (pause) guaranteed he would be because I wouldn't be without him (pause) … So he would be more relaxed and sort of just sitting back and taking it easy so it was an easier life for me basically ... " Jane

Jane captures the coercion and control that all of the participants endured from violent partners and their recognition and acceptance of their search for escape from the realities of living in unbearable conditions.

Substances therefore appeared to be a readily sought escape route and was the only way the participants felt they could alleviate feelings of distress. Often living a hand to mouth existence with young children, oblivion appeared to become more and more desirable and became an inherent and accepted part of day to day life:

"I've used drugs to block things out I've used drugs to cope when I've not been coping in life. I've used them just when I'm bored. I've used them if I've been ill (pause) just seems to help everything really it does (laughs) If you've got an ache or pain and you take a bit heroin you don't feel that pain eh if you've got any worries (pause) take heroin (pause) don't have worries it's weird it's really weird" Rebecca

Substances seemed to bring a sense of quiet calmness within their lives, a cure all for all physical and mental sensation that they wanted to avoid. It is noteworthy that again, the participants very often did not refer to themselves in the first person at this time. They often spoke as if these experiences had happened to someone else, perhaps helping them avoid very painful memories. Perhaps however, speaking in general terms removed the participants from being the focus of attention and helped them feel less overwhelmed, less vulnerable.

The participants were however acutely aware that they were using substances to try to help them cope with terrible situations, even though the relief they felt was transient:

"Yeah em I did it for the abuse to block things out em to numb the pain and stuff but when you're in that situation you canny get out of it so you try and find another coping way and drink and drugs was my choice to take ... when I was straight I'd feel it a lot more but then after he had hit me I'd just I'd top myself up with more drink and more drugs yep" Tina

Liz however, rejected the possibility that she used substances for their numbing qualities:

"I wouldn't personally (pause) I wouldn't blame that (interpersonal trauma). It has been my own decisions. But like professionals and other people would maybe say well that probably has got a lot to do with it you know (pause) why she took that (emphasis on word) road (pause) but personally like I've said eh all the previous things that have happened in my life (pause) that's the only life I've known so to me that's normal" Liz

Despite describing drugs as helping to make one feel *"so good about yourself"* (Liz, LHC quote) and identifying times of distress on her LHC when she had used substances, it appeared that she could not fully contemplate or identify with using substances to block out the pain. Her apparent insistence on considering her life to have been *"normal"* (Liz, LHC quote), in particular her childhood, is noteworthy as is the suggestion by health professionals that she may use substances to cope with her reality.

All of the participants, however, appeared keen to accept responsibility for their actions and not lay claim to using them exclusively to block out their distress. They all spoke of their substance use as being *"my own choice"* (Jane, LHC quote), as *"nobody forced me"* (Jenny, LHC quote). They spoke about *"knowing it was bad, but doing it anyway"* (Jenny, LHC quote). This may have been as a result of the long term consequences that they now recognised as occurring in part, due to their addictions. It may also have been due their stage of recovery from addiction as the participants all described themselves as *"clean"* (Rebecca, LHC quote) and had undertaken some work with professionals and voluntary agencies.

In summary, this theme highlights how the majority of participants used substances as a means to escape many aspects of their lives. The participants found relief, albeit temporarily, from violence, control, debt and isolation. Overwhelmed and vulnerable, these participants sought solace in substances. Substances helped them avoid withdrawal but also their unbearable memories of their childhoods and the pervasive domestic abuse they were experiencing as adults. Their shared experience of feeling that substances were their only means of escape underlines their overwhelming,

growing vulnerabilities. The deeply traumatized children had now become deeply traumatized adults.

4.1.6 Super-ordinate theme - Dabbling to addiction

This theme captures the participants' experiences and perceptions of their journey into substance misuse and addiction. It focuses firstly on the beginnings of their journey; from the initiation into their local drug culture and their subsequent experimentation with a variety of substances. It then explores their experiences and perceptions of the journey through addiction and how this influenced their lives. Two of the participants served prison sentences for substance-related offences. These sentences had such a profound effect on them, that their lived experiences are explored. Finally, their experiences and perceptions of what it means to be clean is captured.

4.1.6.1 Dabbling

"you didn't even really know what you were dealing with" (Jenny):

It became very clear during the completion of the LHCs and their interviews that the participants all grew up in areas where substances were readily available. The participants seemed to feel an inevitability regarding their substance use. Within their interviews substance use emerged as being unquestioned and deeply entrenched within their neighbourhoods, even amongst children and young adults:

> *"I I started dabbling in drugs at a young age when (pause) you didn't even really know what you were dealing with you know em (pause) drugs were quite a big culture for me eh and my friends where we were growing up you know (pause) we were surrounded by them em … from us me being like 10 and my little sister being 6 to (pause) em folk of like 18 19 and that (pause) em and (pause) so you know they would obviously be trying things (pause) dabbling in things and em (pause) and they would then (pause) find their way to us"* Jenny

There was real sense of innocence and naivety amongst the participants about this time in their lives, as if they somehow stumbled onto these paths without question or volition and of feeling that what they were doings was normal. They all spoke about *"dabbling"* (Jenny, LHC quote), suggesting that substances were thought of as a play thing and not felt to be very serious or out of the ordinary in their environment.

All of the participants' peers seemed to exert a huge influence on them. It seemed that they almost fell prey to older drug users who in some way sensed their vulnerabilities:

"I was just I was young I was in a a hostel em loads of other people were doing it I started doing it em it was like my freedom at my mums I had like that roof over my head and that like love and care but when I went into a hostel it was like I was on my own and just the people surrounding like you used … Yep. A lot of them were older than me I was like the youngest one in there I don't know yep … it made me feel good (pause)" Tina

Tina appeared particularly vulnerable to the influence of others. Having lived what sounded like a protected, sheltered life with her adoptive mum, she seemed suddenly surrounded by older addicts from whom there was no escape.

Liz however, appeared to have felt that she needed substances in order to maintain her reputation and persona:

"well to start with when I was younger I was trying to like be cool like cos I always wanted to sort of be like the cool one eh? Em so yes it was like trying to keep up to this sort of image that I'd set for myself. Cos like I a I was like a party animal I was like one of the lads and that back in the day and so it was just sort of keeping that up" Liz

There seemed to be a sense of bravado and gregariousness around this time in her life. It's as if using substances had become the only way she could maintain the identity she had built for herself and perhaps the only way she could feel in control of those around her.

Within this shared experience of early initiation and use of substances emerged a sense of belonging to their peer group, a camaraderie and sense of fun and the participants appeared to work their way through an exhaustive list of substances:

"Em well like I said ecstasy and that from 13 em smoked a lot of cannabis from 13 probably through to about 20 em experimented with all the others drugs like em magic mushrooms and acid and speed and cocaine em prescription sort of pills all through that sort of time between 13 and 19 20 em but then the my drug of choice was sort of heroine at like 19 onwards" Liz

Perhaps Liz's account was a reflection of what was available to her at that time, yet there was a suggestion of the participants progressing through a hierarchy of substances considered to be of less harm i.e. alcohol and cannabis to cocaine and heroin. There was no sense of their recognition of perception of some the dangers inherent in their experimentation and risk taking behaviours. Neither did they express

any perception or awareness about the illegality of what they were taking at this time, which seemed to further highlight the level of acceptance and normality of substance use amongst their peers and communities.

The purchasing of drugs appears to have been a simple, straightforward transaction which seemed as normal as going shopping. This is captured in another extract from Liz:

Liz: *"em every just dealers you know you know people talk and stuff so you know where to get them from but yes em there was always like a local dealer so and at 13 and that I was getting like acid and pills and all that like no bother at all. Just I would just chap the door and I would get it"*

Researcher: "*It sounds like it was quite easy to get it?"*

Liz: *"Oh yes oh yes I mean like my ecstasy my ecstasy dealer she sold acid as well she just stayed over the back from me so so yes it was easy to get a hold off"*

One considers again, the apparent lack of adults who questioned what was going on in all of the participants' lives as substances could be purchased without question or interference, even when it was from dealers within their local neighbourhoods who most likely knew they were selling to children. Her actions appear daring and blasé, perhaps in response to what she was experiencing at home.

The majority of participants appeared to speak of their early days of experimentation with a notion of nostalgia, usually laughing and speaking fondly of their drug use. Liz in particular talked of *"back in the day"* (Liz, LHC quote), appearing to consider herself as leading a *"party lifestyle"* Liz, LHC quote), when ecstasy provided *"the best feeling"* (Liz, LHC quote). They seemed to associate this time with fun, friendship and belonging. Jenny did, however, allude to the fact that she knew what she was doing was wrong. This seemed further enhanced by her feelings of a lack of parental supervision and guidance:

"I don't know if it was just because everybody else was you know em and obviously because I was younger and I'm looking at older people you know the cooler ones em (pause) and that's what they were doing em (pause) it just I I don't you don't I don't also know if it's just because you know em (pause) ... we didn't have that sort of (pause) adult guidance or that (pause) that person to turn to that we could talk to about possibly you know the fact that we were being offered this stuff and not sure whether we wanted to take it or not. You know what I mean? There was just nobody really to police it just you know (pause) we were we were able to get our hands on it (pause) and so we did" Jenny

One gains a sense that some of the participants longed for some intervention in order to help them escape what was readily available and stop them from being drawn into an underworld where there was nothing else to do and no-one to stop you. It seemed they may have made different choices if someone had shown an interest in what was going on within their lives. Their youth and naivety emerged as well as a desperation to fit in.

Jane's early use of substances differs somewhat from the rest of the participants. She was introduced to harder, illicit drugs by her significantly older, intravenous drug using partner, when she was withdrawing from prescribed and street bought analgesia:

"cos he couldn't get Valium (pause) that's how I started cos cos I was withdrawing from the codeine (pause) the Valium (pause) I wasn't addicted to it then but (pause) if I couldn't get codeine it would be something that I would use. Em (pause) so he said he couldn't get them and he came back with the heroin (pause) obviously (pause) well (pause) I took half of it. We were taking it on his em he was on leave from prison ... he didn't force it down my neck (pause) but think if I hadn't been with him in that situation I probably wouldn't have used heroin but I did (pause) I chose to use it " Jane

It seems that this was a particularly coercive act, on the part of her partner who appeared to prey on her vulnerability at this time. From this point onwards, Jane's partner made heroin readily available to her, however she readily accepts her part in this.

Although they did not all become addicted to heroin, all of the participants reached a point where they began taking it. One ponders this juncture that appears to have occurred in the lives of all the participants as they were all found to progress from

smoking it, to snorting it before finally injecting it. This occurred even when they didn't like injecting, highlighting what Jenny called the *"pull"* (Jenny, LHC quote) of the drug. The participants by this point in their still young lives, were so consumed by getting their next "*fix"* (Jane, LHC quote), it appears they would stop at nothing in order to do this and they talked readily of these experiences during completion of their LHC's. For example, Jane gradually learned how to inject herself after initially being injected by her partner. Jenny initially found injecting *"traumatic"* (Jenny, LHC quote), as she had *"rubbish veins"* (Jenny, LHC quote), however persisted and learned to tolerate this as *"needs must"* (Jenny, LHC quote). Liz felt she never enjoyed heroin. She began using it out of *"boredom and curiosity"* (Liz, LHC quote) after she began associating with intravenous drug users. Hanging around with *"jaggers"* (Liz, LHC quote), she *"ended up where I was having to take it because I had a dependency, I was not well without it"* (Liz, LHC quote).

In summary, the majority of participants grew up in areas were drug use was rife and substances were easy to come by. Having no guidance at home, they appeared to be easily influenced by their older peers and did not appear to sense much, if any, danger about what they were getting involved with. Although some of the participants knew what they were doing was wrong, they carried on as no-one questioned their actions. Perhaps finding themselves in yet another situation where nobody cared about what they did, drove them further into these groups where they felt some sense of belonging and acceptance. Taking substances and mixing with older peers, in turn, led to increasing vulnerabilities. For the majority of participants, this led to them meeting and becoming involved with men much older than themselves, who were themselves alcohol or drug dependent. For most of the participants, this signalled a shift from dabbling to addiction.

4.1.6.2 Addiction

"I never had any of my friends then" (Jane):

The ways the participants described their experiences and perceptions of addiction appeared in sharp contrast to how they spoke of their early days of drug use. The initial camaraderie they had felt they shared with fellow users in the time before they

were addicted, appeared to have disappeared as there was no talk of friends and even less talk of their extended families:

"Pals (pause) I didn't really have a lot of pals to be honest when I was using it was just acquaintances em people that I would maybe like buy drugs of or people in the drug scene that I would maybe sit and have a smoke with (pause) if I couldn't do it in the house or anything (pause) or just other users that I wouldn't talk to otherwise" Liz

Liz sounded as if her life was bleak, lonely and sad and she appeared to have few, if any, meaningful relationships. Liz captures the participants sense of hopelessness and perhaps shame, of having nobody out-with their drinking and drug culture in their lives, compounding their feelings of marginalisation.

It seems as if at this time, they were just surviving. They appeared to exist in a sub-culture, as the lives they had portrayed seemed so far removed from ordinary day to day life. Their lives seemed like a series of transactions, whilst surrounded by relative strangers:

"I had my lowest eh I was sick of being in and out of hostels eh the hallucinations cos I couldn't keep the drink down cos I burnt all my insides em just taking drugs got to the stage I couldn't I couldn't afford it and it got to the stage that I ended up sitting in the streets just to get money or hanging about with people I didn't even like (pause) just to use" Tina

Echoing Liz, Tina sounded so completely alone, sad and desperate. It seemed that even when struggling with poor health, the participants spent their time with strangers, their "*acquaintances"* (Jane, LHC quote) or "*associates"* (Tina, LHC quote), but again, never friends.

The following extract from Jane captures how being a *"drug user"* (Liz, LHC quote) came to define the participants and their recognition of how different their lives had become:

"I never had any of my friends then … all my friends that I had I mean none of them have become drug users.... all the friends that I had (pause) it's not the sort of way they've went. They've went the other way and now (pause) ken I've been probably been too out my face to contact them and they've probably seen me and the way I was and thought ken (pause) it's not the sort of thing I want to be around and I lost all my pals basically" Jane

It's as if they felt there were only two choices to take, but that the path they had taken left them feeling and being seen as socially unacceptable and unable to conceive mixing with previous friends. It seemed that they felt unable to comprehend why their friends would want to associate with them anyway.

Perhaps adding to their increasing sense of isolation, there seemed to be little or no sense of purpose or structure within their lives that did not centre round substances:

"Em like the heroin sort of use just there was no sort of purpose to it was like waking up in the morning finding like like having to find your next fix just constantly chasing like they drugs and your life's just you just have no purpose really just it's scummy when I think about it just that's not it was just like I say chaotic eh whereas now I've got routine there was no routine in my life even well in fact there was routine in my life and it was getting up chasing the drugs" Liz

Liz highlights how the priority and purpose for her at that time lay in *"getting a sort out"* (Rebecca, LHC quote). The participants' sense of shame and guilt about their actions is revealed along with their knowledge that their behaviour was so out-with cultural norms, they were only really accepted within the drug scene at that time.

In summary, at the depths of their addictions, the participants all spoke of what appeared to be a life spent in a series of superficial meetings with people that meant very little to each other. There is no sense of camaraderie, companionship, love or friendship. When they were at their most vulnerable, when they could have benefitted from having positive relationships, their lives appeared bleak, empty and consumed by a desperation to meet their next fix. Perhaps even if they were in a position to have meaningful friendships though, they wouldn't have been able to maintain these as they were so absorbed in getting and taking drugs.

4.1.6.3 Stigma

"you're like the scum of the earth" (Liz):

Isolated from friends and family, the participants' thoughts turned to their feelings of marginalisation and stigmatization from society. Their low self-worth and low self-esteem seemed to be captured as they described themselves using highly negative and evocative language such as *"scum"* (Liz, LHC quote) and *"junkie mothers"* (Liz,

LHC quote), seeming to set themselves apart from everyone else, all the while suggesting they felt the lowest of the low and unworthy creatures.

Liz in particular was very expressive when talking about her feelings of stigma. She sounded defensive, angry at times and feeling she continued to have to prove herself to be a good upstanding citizen, a reformed character. Her extract below evokes her lasting struggle of how she felt society perceived her as morally unjust, with criminal intent, which was a common theme among the participants:

"Och when you use heroine you're a dirty junkie a wrong one. You're a smack head you're this you're that you're like the scum of the earth (pause) you rob your granny's apparently ... Oh I knew people thought that about me. I knew it. It made me feel like really low. Today I still get really worried about people are thinking smack head useless junkie and it does come about and it's always going to come" Liz

The participants seemed to be revealing their deep rooted anxiety that no matter what they do now, they will always be judged on their previous actions and behaviours, for which they will never be truly accepted again. It seems that they felt they could never rid themselves of their drug user identity which Jenny described as the *"junkie mentality"* (Jenny, LHC quote).

Jenny felt she had only recently become accepted where she lived as her current partner did not use drugs. In spite of feeling stigmatized within her local community, she appeared to struggle to come to terms with this:

"I think we're our own worst enemies and we can make ourselves feel awful over things … whether it's just in our own heads or whether we are actually stigmatised I don't know" Jenny

It seems as if she was trying to make sense of whether the stigma she experienced was in fact real or imagined. Like the rest of the participants, it seems that her feelings of self-worth were so damaged, she was unsure how anyone could feel anything else about her. Perhaps this also highlights the feelings of detachment the participants experienced when addicted, that they couldn't completely comprehend their thoughts and feelings, what was real and what was not. Rather than talking about her own personal feelings however, it's as if Jenny is talking about a collective experience, for all drug users.

Rebecca spoke about herself during most of her interview as a *"junkie"*, and described some of her lived experiences of this time in her life. She appeared to capture fittingly, the realities of the lives most of the participants were leading, that of being so completely wrapped up in addiction, they failed to notice what else was happening in their lives and nothing else seemed to matter:

"when you're a (pause) when you're a user and or when you you've got a habit then I suppose you don't really care about what people think because you're too busy trying to fund your habit. It's afterwards you think oh my god I used to walk about dressed like this and no makeup on and my hair not done and stuff like that and it just (pause) it it takes away your confidence being a user will (pause) once you've been a user you start with no self-esteem and no confidence and you need to build yourself back up" Rebecca

Their days appeared so consumed with negotiating and getting drugs that everything else lost all meaning, even down to how their basic needs. Rebecca touches on the long lasting emotional and psychological impact of addiction and one wonders about how this impacts their perceptions of themselves as mothers. Rebecca echoes what other participants described as *"hitting rock bottom*" (Tina, LHC quote) and highlights what seemed like the long, painful journey away from addiction.

The participants described heroin and street bought methadone as *"dirty".* For some of the participants, this was in relation to it being *"cut"* with other substances. It seemed though, that despite their best attempts, society's perceptions of stigma would still over-ride the lived experience of some addicts:

"Yes yes it's what the drug does to people … like it makes them so thin and makes them lose their teeth (pause) fall out … but see when I had a habit (pause) I lost a lot of weight but I never ever stopped looking after myself. I always looked well and then people say I can't believe you used to take heroine" Liz

Liz's perception however, appeared to be in relation to the physical manifestation of addiction, that being *"dirty"* was directly related to how *"users"* turned out. She seemed proud and keen to set herself apart from this perception, that in spite of using drugs, she still appeared the same as everyone else.

In summary, some of the participants' spoke of feelings of ongoing stigmatization and of their anxiety of never being truly accepted within society again. They used very

powerful, negative words to describe themselves, highlighting their feelings of low self-esteem and self-worth. Personal appearance emerged as important to the participants in their contextualisation of addiction as well as their self-perception.

4.1.6.4 Positive impact of prison

"prison was like my secure place to go" (Tina):

The majority of participants were keen to stress that they did not lead the lives that are often portrayed or imagined with addiction. Some spoke about *"dealing drugs"* (Jane, LHC quote) in order to fund their habit. Others spoke of mounting debt with family members and of spending time with their said *"associates"* (Tina, LHC quote) in order to stave off withdrawal. Their partners also supplied them with substances, but they did not speak of a perception of being used for sex in exchange for drugs.

Two of the participants had served prison sentences and disclosed this during their interviews, without prompting from myself. They seemed initially fearful of prison, reeling from the consequences of their actions. Rather than describing this time as negative however, prison became a life changing experience for them both:

"I got sent to prison (pause) for taking (name of partner) heroin (shakes head) … that was when I withdrew quite bad and it stopped (pause) my habit (pause) stopped. I'm still on my methadone prescription em but I think (pause) if I hadn't got sent to prison I definitely wouldn't have got clean out here. No way. I wouldn't have been able to do it I don't think. I wouldn't have the willpower to do it. It would have been too hard for me (laughs nervously)" Jane

Janes lived experience of prison spilled out in a rush, suggesting a need to get this part of her life out quickly, perhaps through concern of judgement from myself as the extent of her partners control over her becomes evident even when he was in prison. It seems she felt compelled to obey his demands to smuggle illegal substances into him on a family visitation day. It seemed that in order to get off heroin, she needed to be physically removed from heroin and the social environment she lived in. It seems that her life in prison was in direct contrast to her normal life and was a place she could gain a sense of stability, routine and perhaps even purpose and her time in prison was spoken about with great gratitude. Her account highlights the importance of prison in that it finally allowed her to get herself clean.

Tina however, became a recurrent offender and well known to the police for disorderly behaviour and assault whilst under the influence of drink. The meaning of what prison became for her is captured, further highlighting the positive impact of prison:

"my time was getting longer (pause) but I came to the decision that I was getting (pause) I was moving from B&B to B&B every single day ... it got to the stage that my prison the prison was like my secure place to go. I wasn't like drinking in there eh couldn't take drugs in there eh you were getting your meals and stuff and so I think that was how I kept going back there em and when I got out I stayed clean for a couple of weeks then went back downhill (pause) just started drinking again taking drugs yep" Tina

For Tina, prison seems to have become a place she could escape the instability that dominated her life, where safety and routine were ensured. This is captured further as after her release, her life spiralled out of control once more, suggesting she was unable, at that time to survive on her own.

Jane has not used illegal or illicit substances since she was released some time ago. The importance of prison in the lives of Tina and Jane cannot therefore be underestimated.

In summary, in spite of the participant's continual struggle to obtain substances, only two of the participants had served prison sentences. Although in going to these initially frightening places and at great cost to their family lives, prison became a safe place for them on many different levels. It provided routine, comfort, nurturing and most of all, somewhere that was free of substances. In short, it appears to have given them some of the resources and the opportunity they needed to get themselves clean.

4.1.6.5 What it means to be clean

"I'd like to say that I'm clean now but ..." (Liz):

All of the participants reached points in their lives when they tried to get clean. Their attempts to achieve this over the years were most often unsuccessful in the long term. Negotiating "*the rattle"* (Rebecca, LHC quote) whilst remaining in hostile environments with substance addicted partners, surrounded by substances and fellow users seemed an impossible task.

Participants' differed considerably in their perceptions of what it meant to be clean and the following extract from Rebecca's interview provides an interesting insight into this:

"Be off off opiates I (pause) I smoke cannabis quite a lot but opiates is my main problem so to be (pause) when I'm clean I'm off opiates but I'm still taking (pause) I'm still smoking cannabis and and but that's in tobacco I smoke (pause) that's what I mean by clean I mean like eh handing in clean samples. Then being totally cleans when I'm off my meth but just being cleans when I'm just (pause) just on my meth (pause) but totally cleans off everything apart from cannabis (laughs) ... that's like methadone's pure whereas on the street it's not (pause) it's cut by so many different things so it's ken its dirty it's a dirtier habit to have that a meth habit you know what I mean? So I'd say clean as in just taking what I've been prescribed not" Rebecca

Rebecca uses a rather lose definition of what it means to be clean and described herself as being *"clean"* despite continuing to use some illicit substances emerged as differing considerably from participant to participant. Alternatively, however, it perhaps highlighted the participants' perceptions of what they appeared to consider acceptable and unacceptable substances to take when they are trying to recover. Moreover, it captured their enduring struggle with managing withdrawal and of coming to terms with life without substances. It appeared that despite their desire to *"get sorted",* the need to have something to fill the void left by their main substance felt overwhelming.

Liz's meaning making of what it means to get clean, however, differed quite considerably from Rebecca. She took a stricter stance, appearing to think that only abstinence from all substances would suffice:

"Like absolutely nothing I mean to a certain extent well I am clean obviously like I've I've not been using any illegal drugs or like prescribed drugs that get abused or anything the only thing that I take is my subutex and but ideally for me to be completely clean clean in my mind I would be free from the subutex as well. So but yes so I don't think that anybody is truly clean until they've came of their like their methadone or their subutex I don't think like anybody's clean until they've done that" Liz

It seems that she longs for a sense of reality and normality. Within her account, her feelings of entrapment and dependence emerged as she spoke of believing herself to be *"chained, it's like I am chained to it".* Her feelings of being imprisoned by any type of substance are captured in her extract.

It appeared that it was only when *"straight",* the participants gained a sense of focus in their lives which helped them fully comprehend what their lives were really like when using:

"I was like (pause) with drink that was that was my worst (pause) I would waken up shaking like a leaf eh just couldn't do nothing I I couldn't even walk to the shop to get myself a bottle (pause) I had to have to have a bottle in the house for waking up ... when I stood up I was like totally shaking I couldn't even walk down the street eh just to get that bottle so I would have to have a drink in the morning" Tina

Tina's dramatic portrayal of how she felt without alcohol captures the overwhelming, all-consuming nature of addiction and the incapacitating effects of withdrawal.

It seemed that the participants felt detached and disconnected from the world during their addictions, but could only comprehend their reality during their attempts at recovery. The disarray and chaos they lived with emerged as they spoke of how they now felt. For example, Jenny spoke of now having "*a clear head"* of *"clearer thinking"* now she was only taking her methadone prescription and Tina spoke about now feeling *"focused".* Jenny in particular spoke of now *"being back to myself"* leading one to ponder who she felt she was if she was not herself when addicted to heroin. Opiate substitution treatment however was not viewed positively by Liz who felt that she still *"lived in a bubble"* whilst taking this. Being clean also appeared to be the only time that the participants could fully reflect on their own lives and relationships and the impact that their lifestyle was having on their children:

"*definitely made me (pause) more kind of I don't know I don't want (pause) I love my mum and dad to bits but I don't want me and my kids to have the same sort of relationship that I had with my mum and dad because it was so secretive and em I would never have turned to them about anything that was going on in my life and I don't want that I want my kids to be able to turn to me and I want them to come to me if they need anything you know so" Jenny*

Jenny captures the participants' strong desires to now try and ensure that their children are able to have carefree childhoods, with trusting, nurturing adults rather than live in the shadows of their parents' addictions as they did.

Despite the participants' attempts to remain stable however, negative life events, particularly if these involved their children, triggered feelings of distress which catapulted them back into substance misuse and addiction:

"I was on like 20ml of meth and then I came down off off that and came off it and everything was fine and then I was drug free for a wee while and then my other kids (pause) their grandad was up at court having like pornographic material and videos of my kids and stuff like that and I went to the court case which I shouldn't have went to and obviously sitting having to listen to that in court about what he all had about my kids (pause) that's what made me use again (clears throat) that's why I'm on a script this time (pause) but eh I was doing well on my script clean and then and then after I found out well (pause)" Rebecca

The terrible irony Rebecca faced due to her own children's exposure to abuse after being removed from her care is highlighted, as is her ongoing vulnerability to substance use as a means to soothe her emotional torment.

Additionally, day to day stressors could also trigger a need to use, highlighting the ever present draw of substances as a means to escape from their internal struggle:

"*it's hard trying to stay away from it when you're stressed (laughs) you know what I mean? When you're stressed and you know that you could just go and have a have a burn and you'd be unstressed you'd be fine relaxed and everything would slow down a bit (laughs) but obviously it's not the way I want to go so"* Rebecca

In summary, being clean appeared to mean different things to each of the participants. Whilst some of them accepted being on prescribed medication, others appeared to feel that these treatments were just as unacceptable as the substances they were trying to escape from and that only complete abstinence would satisfy them. There was a real sense that they had had enough of the lives they were leading as addicts and of their disappointment that either these medications did not work for them as they had hoped or that they continued to need to take them. The participants' ongoing physical and mental struggles with recovery became clear and the delicate balance of remaining clean emerged as events out-with their control threatened to throw them off course, setting them adrift once more into a life of addiction.

4.1.7 Super-ordinate theme – Addiction and the identity of pregnancy and motherhood

This theme captures the participants' experiences and perceptions of their journey to motherhood. It focuses firstly on their pregnancies, highlighting their awareness of the detrimental impact that substance use and addiction had on them all. Some of the participants were more vocal and expressive regarding pregnancy than others and their voices are more visible. The participants' struggles with the incongruous nature of being a substance dependant mother are then considered. Finally, the people and relationships within their journey through pregnancy and motherhood are revealed.

4.1.7.1 Pregnancy

"I'm terrified that my bairns going to come out rattling" (Liz):

All of the participants had histories of unplanned pregnancies. Perhaps this in some way highlights the all-consuming nature of addiction, in that everything other than substances appeared as an afterthought. Even though the participants were now all *"clean"* and appeared to feel more stable within their drug use, they all described themselves as being *"shocked"* at being pregnant again now:

"it really wasn't anything (pause) I wasn't in a sexual relationship with anyone (pause) I went out one night and it happened (pause) it just wasn't (pause) but my mums "well that's all it takes" (pause) well obviously it is (pause) it's happened [both laugh] but em it's just not what I (pause) I didn't expect it (pause) there was no period or anything so I thought I'm not going to fall pregnant but that's obviously not true"
Jane

Jane seems to have been uncertain about her fertility, yet little attention appeared to be given to preventing a pregnancy. One gains a sense of her deep sense of sadness and regret regarding this and her resultant termination.

As the participants reflected back on their lives, pregnancies appeared to land somewhere amongst their already complex and complicated lives:

"Well I didn't really want this baby but I was too late for a termination to tell you the truth but then when I found out it was a boy and everything sort of changed cos I've got girls and I was like oh finally my boy (laughs and rubs bump) I've been dying for since since my first one I wanted my first one to be a girl and then a boy but didn't work that way (laughs) so" Rebecca.

And yet pregnancy was spoken about with great surprise and joy, but also sadness and most often regret. It seemed that whilst the participants initially felt great sadness however, their pregnancies became viewed with joy and a chance at happiness. This pregnancy also appeared to bring a period of hope and fulfilment for Rebecca.

Pregnancy also appeared to bring as a time of opportunity and change:

"Yeah aye I looking forward to it (arrival of new baby) I'm in my time now ... I'm just doing my relapse prevention work eh just everything to keep this bairn safe ay? ... but aye I'm just aye I really feel ready I've got my head screwed on I've got my house eh I've got family family support so I I am just very focussed just now ay just ready to be a mum" Tina

It seemed that now pregnant, Tina recognised the opportunity for change and wanted to try and recover. It's as if the participants felt a sense of hope, recognising that with a new baby, came new prospects and perhaps a fresh start. Perhaps for Tina, it felt like a chance to reclaim motherhood and make up for her past losses.

For others though, even when pregnant, increasing tolerance to substances and addiction obliterated any chance of recovery and is highlighted by Jane:

"Em (pause) I was just smoking it (pause) then I fell pregnant with my second son (pause) em I started snorting (pause) it because it wasn't working and em soon after I had him I started injecting it. Em I got a methadone prescription em and I was using on top after I had had my second son" Jane

It's as if she is in some ways downplaying the addictive nature and detrimental impact of smoking heroin rather than injecting it, but Jane also highlights the overwhelming pull of addiction that all of the participants face, even in the face of motherhood.

It became clear that the participants were very aware that the time and circumstances their babies were conceived and the circumstances in which their babies were born were far from ideal. Rather than being able to look forward to impending motherhood, pregnancy appeared overshadowed by substance use:

"Och when I first found out I was pregnant I was ah shocked … I was absolutely devastated ... because I had social work involvement and like I was on obviously I was on a script and I was just like I shouldn't be pregnant (pause) this isn't fair. So I was terrified to tell social work and I just didn't know like if if my baby was going to be born like like rattling all these sort of things were bothering me" Liz

Liz appears to struggle with guilt regarding her babies' exposure to substances, her fear of social work and is clearly anxious regarding the possibility of her baby withdrawing from substances. One ponders if this is what she considers *"unfair"*, that she would have preferred to be abstinent when pregnant and therefore cannot relax and look forward to the arrival of another baby.

Most of the participants were found to have experienced problems during their pregnancies that were rooted in their substance use, which they now deeply regretted. Many had experienced obstetric emergencies which resulted in premature delivery of their babies:

"When I was pregnant with (second baby) and I was using I was ken like people were saying to me who knew I was using, "aw you shouldn't be using when your pregnant" and I'd be like "Oh the bairns alright, the bairns alright" whereas now when I look back (pause) there's no way I would touch drugs when I was pregnant … if I had knew how that pregnancy was going to turn out and that (name of second baby) was going to cos (name of midwife) told me that was be one of the reasons that he was born early (pause) the abuse I was putting my body through em ..." Jane

Jane appeared immensely pre-occupied with regret regarding the damage substances had wreaked on her and her last baby and of her failure to listen to advice. It seemed that she had felt somewhat blasé regarding the likely consequences of her substance use, perhaps in denial in spite of all the warnings. The very obvious physical differences between her first and second baby emerged as having had a huge impact on her:

"My first pregnancy was brilliant (first baby) he was 8lb 4oz when I had him. He was a big healthy baby whereas (second baby) he was totally different. Seeing him just 2 pound 7 … I tried breastfeeding with (second baby) em to help in-case (name of baby) was withdrawing but it only lasted a couple of weeks (pause) but then I was using everything (emphasis on word) ken it was stupid to (pause) the days I would use (pause) I wouldn't express. (name of specialist midwife) was like it's in your system anyway. I wasn't making (pause) wasn't helping myself so ... " Jane

It seemed she did not really believe or fully comprehend the effect her substance use had had on her unborn baby until presented with the undeniable physical evidence. Even when faced with this reality however and possibly in some way related to this, the overwhelming pull of substances led her back to chaos and her attempts to do the best for her baby were short lasting, highlighting the power of addiction at all times.

It seemed that no matter what the participants did now, their fear and guilt regarding their substance use appeared to run deeply within all of their stories. Even though they had made different choices during their current pregnancies, avoiding on the whole, illicit drugs, their feelings of shame and trepidation about the effects on their babies emerged:

"I'm terrified that my bairns going to come out rattling like (pause) I'm absolutely terrified of that (pause) but like I don't use any other drugs (pause) I don't even smoke or that eh" Liz

One gains the participants' sense of panic regarding the very real possibility of their babies withdrawing from the substances they were taking. The participants did not seem to have peace of mind regarding their babies withdrawing, even when they were stable and on opiate substitute medication prescriptions.
And:

"I'm no using near as much this time (pause) but like (name of midwife) says (pause) that doesn't matter. There are people on the tiniest wee bit and their babies withdraw … thinking about it all the time (pause) with her going to full term (pause) is she more at risk of withdrawing from it because she's been getting it for longer" Jane

Whilst premature delivery was a concern for the participants, Jane highlights the potential difficulties associated with longer term exposure to the fetus of substances including methadone, in-utero. Her pre-occupation and anxiety, perhaps also guilt, capture the real worries of the participants over their unborn babies.

In summary, rather than pregnancy being a time of delight and positive new beginnings, it was shown to remain a time of uncertainty and distress for the participants, even when they were on prescribed medication. They reflected on their past with deep regret and shame, knowing that their substance use had had significant effects on the health and wellbeing of themselves and their babies. It appears that it

is only now they are clean, that they can look back and consider their previous actions. Just like other times within their lives, the pull of substances underlined this period of their lives and they struggled with the impact of substances on their pregnancies and unborn babies.

4.1.7.2 Motherhood

"at times just it … it took over" (Jenny):

Whilst pregnancy clearly presented dilemmas for the participants, motherhood presented them with similar difficulties. In fact, in some ways, it appeared even more difficult as the participants seemed to live in constant fear of judgement and removal of their children into the care system. They had all had children removed from their care, some permanently, therefore they knew this was a very real possibility. All of the participants described these times as having the biggest effect on them:

"I would say that my papa dying had the biggest impact of it all and then my kids getting taken away em yeah … yeah like my other kids it (heroin) takes away thoughts of my other kids" Rebecca

Rebecca's despair of the loss of her children was such that she turned to the very thing that was implicated in losing them in the first place. One gains a sense of the utter devastation she felt at these times and that her only way to cope was to seek oblivion through heroin use. Liz further captured the participants feeling of absolute loss when their children were removed into the care system feeling it *"totally killed me"*.

Some would only ever see their children again if they came looking for them when they were older and the participants' sorrow and remorse regarding this emerged:

"I just I I wish I could change the past for my two other kids but I can't it's too late eh I still get to see them and that's a good thing em but ... " Tina

Tina's deep heartfelt regret and guilt at having to live with the aftermath of her past is clear. It's as if she consoles herself that she still gets to spend some time with them, perhaps feeling lucky that she is allowed to do this based on her previous actions and omissions.

The threat of removal however, appeared to be a double edge sword for the participants and highlights that the participants had additional worries to other mums:

"I suppose also the problem about being a mum is that there's always this fear that by putting your hand up and saying I'm struggling (pause) social work are going to take your kids and that's that was the bit I couldn't get my head around for ages. I fought them (pause) I lied to them I you know em (pause) because I thought if they knew the truth (pause) if they really (emphasis on word) knew the truth (pause) they're going to take them" Jenny

It appears that the threat of removal of her children was so harrowing, it turned out to be the one thing that could help Jenny them change her behaviour and lead to positive change within her life. Yet like the rest of the participants, Jenny felt she must hide her ongoing battle and shame of the consequences of addiction on her children and lived in a state of fear of the consequences.

It seemed that the participants really valued and could not function without the identity of being a mother, or without being present for their children. The knowledge of their children being cared for and perhaps coming to see another adult as significant within their lives seemed unbearable and inconceivable for Liz in particular:

"when they told me that the bairns would go into the care system forever (pause) like I just I couldn't let like that happen (pause) I just wouldn't let that happen (pause) and never see my bairns again? Or see them once a month like supervised once a month? Plus another woman bringing up my kids? So like that just wasn't an option. So it's definitely been like like my kids have been like ... but I mean the main fit up the bum for me was like my kids definitely and if I didn't have them I I'm saying I would be using (pause) but no I don't think I would" Liz

One imagines Liz standing at the edge of an abyss, the threat of never seeing her children again providing a point of no return, whereupon she finally realised that she needed to change her behaviours. There was also the suggestion that without her children, she had little reason to stay clean and her life would spiral out of control once more.

For Jenny however, it appeared that being a mum was not enough of a reason for her to try and recover from addiction:

"it wasn't you know it wasn't enough to keep me clean em or I didn't I don't know if it wasn't enough to keep me clean … it was really (second child) going into foster care and the fact that I could lose this child for good … I've no longer got social work involvement now em but I don't think I don't think having them like changed things for me in any sense. Em I I think that em (pause) you know my addiction at times just it it took over and it didn't matter what was there and it wasn't until I I took it right to the brink of losing everything before I was like what am I doing? you know em so I don't know I don't know if it changed anything really in terms of my addiction" Jenny

It seemed that she needed the shock and panic that came with the threat of permanent removal of her baby, in order to get her *"act together"*. Again, one pictures her standing on the edge of an abyss, a point of no return before she could really comprehend the seriousness of the situation she was in. Perhaps having previously had a child removed from her care on a permanent basis made her realise that the threat of this could very quickly and easily become a reality.

With motherhood, the added worry of trying to protect their children from their substance use emerged as the participants tried to present themselves as *"normal"* (Tina, LHC quote) mums for their children:

"in the past I like (pause) even in my addiction I've never once never (pause) went to see my kids and I would never go and see them drunk eh I think they seen me once drunk em but contact (pause) I've always went to contact and been steady through my contact with my kids" Tina

At the height of her addiction to alcohol, Tina was consuming nine litres of cider per day. In spite of this, she always attempted to appear sober. The shame she feels regarding the impact of her alcoholism and her knowledge of how she must appear on the outside is highlighted.

Again, the long lasting, distressing imprint of growing up with substance addicted parents seemed to play on the participant's minds:

"for a while there I was totally in danger of becoming like history repeating itself em because em although I was trying to protect (first child) from seeing things he was still seeing things and em witnessing stuff that I know had an effect on me growing up so I'm sure it would have an effect on him you know" Jenny

This was particularly clear for Jenny, who hints at how she remembers her parents when she was little and the long lasting detrimental impact this has had on her. Over

time the participants appeared to realise and make conscious decisions about what they were exposing their own children too, suggesting their awareness of intergenerational trauma.

Their children appeared to represent something positive in the lives of the participants. They were all found to speak about their children with great love and affection. There was a sense of humility as they spoke of them, seeming delighted for their children's achievements at school and nursery, capturing the meaning of motherhood for them. Those whose children were nearby were eager for me to see and meet their children before I left. They spoke of them as being *"something I've done right"* (Jane) capturing their sense of pride and achievement. Their constant worry regarding their children's exposure to substance use and addiction was also captured as they said *"see, he looks okay doesn't he?"* (Jenny). The participants who did not have their children present, enthusiastically showed me photographs of their children or gifts their children had made for them.

Additionally, the participants were all found to all spend most of their interviews rubbing their bumps protectively and affectionately. Tina in particular appeared to be in a place where she could contemplate the possibility of a positive future and new possibilities, presumably as she had been abstinent from alcohol for a number of weeks:

"em aye I'm settled now I'm ready I just I've got my head screwed on eh I'm even thinking into the future and that when the wee one gets a wee bit older and at nursery get myself a wee part time job and that's I mean that a big step for me too em I'm doing recovery work … I enjoy that but I want to even just a wee job … maybe a wee shop or something a couple of days a week. I'm just I'm ready ay I can feel it … " Tina

In summary, the participants all placed great value on pregnancy and motherhood, yet addiction was found to challenge the very nature of motherhood for them all. Addiction appeared to have completely taken over at times, leaving little of the participants to provide safe nurturing homes for their children. Addiction appeared to be so overpowering and all-encompassing that even in the face of having lost other children, the participants did not appear to be able to fully acknowledge the threat of permanent removal of their children until it was almost too late. Some of the participants were

able to reflect on the similarities between their childhood experiences and their own children and made active attempts to change these realities.

4.1.7.3 Relationships

4.1.7.3 (a) Personal relationships

"I've put them through some amount of shit" (Jenny):

The importance of the current relationships within some of the participants' lives became clear during completion of their LHCs and interviews. In contrast to how they were during their childhoods, their parents' lives had changed dramatically. The participants appeared to have sustained or re-build positive relationships with at least one of their parents, perhaps as now most of their parents no longer used substances.

Jane and her children had all lived with her mum since her release from prison. She appeared to feel safer there, perhaps out of the reach of temptation as in her own tenancy she was *"surrounded by dealers"* (Jane, LHC quote). She was determined to remove herself and her children from the potentially negative impact of this, which seemed to have been reinforced by her prison sentence. She now also actively chose to *"stay away"* from her dad due to his alcoholism and her brother who was an intravenous drug user. During completion of her LHC, Liz talked with great sadness of the sudden and unexpected death of her mother. She vividly remembered the *"shock when the police came to the door to tell me"* (Liz, LHC quote). Even though she insisted that she did not self-medicate, her life had spiralled out of control following this. She remained very close to her dad, describing him as having been a great support to her, especially when her children were removed into care. She felt her dad *"understood"* her, perhaps having an affinity with her dad due to his history of substance use.

Tina seemed to be having an ongoing struggle with trying to come to terms with how her mum, in particular, had treated her as a young child. She *"just can't understand it"* (Tina, LHC quote) and talked of having *"many unanswered questions"* (Tina, LHC quote) regarding her childhood. She seemed hopeful about meeting her birth mother again. She remains very close to her adoptive mother, who she seemed to feel was more of a friend than a mum:

"my mums a good support eh she takes me to a few of them like my scan she comes along she's going to be my birthing partner for the first one but she's a good support but if she's no there my other pal she's another good support ay" Tina

Jenny appeared to have made the most peace with her parents. She spoke of them, and her mother in particular, with great affection and admiration, perhaps as they had stopped drinking a number of years ago. In addition, they were no longer violent towards each other. She sounded remorseful when talking of how she had "*given them some amount of shit over the years"* and how they have *"never turned their back"* on her:

"my my mum and dad have supported us through everything (pause) eh and now like even now we we talk (pause) we talk quite openly and honestly about what went on in the past and em (pause) … I think you know my mum my mums apologised to me before (pause) you know for for and I think my dad has even as well you know. Questioning (pause) whether you know (pause) my issues with heroin … you know some of that they played a part in you know in how (pause) how we've all kind of turned out (pause)" Jenny

It seemed like she finally felt what it is like to be surrounded by the unconditional love and attention she missed as a child. She appears to feel that their relationship is now in complete contrast to that of her childhood. Where she once felt that her life was filled with secrecy and abandonment, she now has an open, honest relationship with her parents who she feels have taken some responsibility for their actions. Perhaps in some ways, this has healed some of the pain from her childhood.

Rebecca, in contrast to all the other participants, did not have any contact with her gran, her dad or her stepmother.

Most of the participants were in intimate relationships at the time of their interviews, but Jenny was the only one to talk of her partner in any depth:

"yeah (partners name) a really nice guy (smiles) and he's been great he's been great for eh (second child) you know he's gave (second child) something that I never thought he'd have and that's a dad eh and he's em you know he's just supportive he's just everything you know that I would want in a partner. He's not perfect he's a pain in the bum at times (both laugh) but he's he's we've got a good relationship ... we communicate and em you know and it's just nice it's the most normal relationship I've had ever in the whole time cos for most of it I've been out my face or you know blinded by other things you know so yeah it's it's nice to feel a bit kind of settled for a change and to know that and know that we're going to be okay that that actually I do think we will make it you know?" Jenny

She seemed to feel grateful and content as if her life had completely changed since meeting her current partner, who did not have a substance use disorder. Her face lit up when she spoke of him. It seemed he had helped give her and her children the sense of security and stability that had been missing from their lives and a sense of self-worth and value that had been absent from all her previous relationships.

In summary, the significance of having developed positive relationships with the participants' parents emerged. Having previously felt unsupported and *"in the wilderness"* (Jenny, LHC quote), they now appeared to be enjoying the feeling of being loved and nurtured. There was a sense of resolution of some of the pain of childhood for some, but not all, of the participants. Ongoing support from parents appeared to be helping some of the participants chose and maintain positive choices in respect of avoiding the lure of substances. Intimate relationships were also important for the participants, but not often talked about. The positive influence of partners in the lives of the participants and their children was recognised and welcomed.

4.1.6.3 (b) Professional relationships

"I've never been made to feel I'm a bad person" (Jenny):

The participants appeared to have mostly positive expectations and experiences of the health and social care workers they had met during pregnancy and motherhood. They did not seem to expect professionals, particularly those who had specialized in this area of work to show negative feelings towards substance misusers. For instance, Jenny's expectations were that people who work in this area "*genuinely care and understand".*

The participants had all had a number of pregnancies and so were able to reflect on how their perceptions of the support they had received had changed over time:

"to start with if you'd asked me that a few months ago (pause) I'd have said I'm getting too much people (pause) too much help (pause) but no (pause) definitely not (pause) I think I get what I need (pause) aye what I need basically (pause) but I definitely appreciate it all cos I know some of it is voluntary I get. Some of the people I've seen (pause) some of the things (pause) so I definitely appreciate it" Jane

Jane appears to have felt, at times, fearful and overwhelmed by the involvement of various outside agencies. This was apparent amongst all the participants as they spoke of feeling *"scared"* (Tina) and of being *"bombarded"* (Jane) with information and appointments. It seemed that these initial feelings about any intervention or support clouded their judgement towards the true nature and intentions of these workers, as they now welcomed their input and recognised and appreciated they were there to meet their needs rather than merely interfere. Above all they seemed to now see that intervention could be beneficial.

The participants' overall experiences of the maternity services were seen as good. Ultrasounds scans for growth were spoken about as giving the participants *"peace of mind"* (Jane), especially for participants who had had major obstetric problems and babies that were small for gestational age. They appeared a much anticipated chance for reassurance, to *"see how the wee one's grown"* (Tina). Rebecca however, appeared to feel dismissed and not listened to, perhaps even humiliated at times as she was often exposed to unnecessary attempts at invasive, painful procedures:

"If they're going to (looks at arm where recent blood sample had been taken from) it's (bruising) all went away now (pause) if they're going to take blood from me and they don't go where I tell them to go cos I used to inject so when I tell somebody to go here and they choose to go here here here there and there and there and miss then I get a bit frustrated (laughs) so … I know what trickles and what doesn't and what's hard and what's not … and they think oh there's a little bit bounce in there we'll just go and I'm like aaarrrgghhhh in tears and they're like I'm sorry and I'm like well just go here" Rebecca

One ponders if these times were reminiscent of other times in her life when she had felt out of control and distressed by events going on around her, but no-one seemed to notice, listen or care.

Midwives, but moreover specialist midwives, were spoken about with great affection, perhaps as these were the professionals seen most often during pregnancy and early motherhood. The participants *"loved hearing the baby's heartbeat"* (Tina). The care and support they received was described as *"phenomenal"* (Jenny) and *"brilliant"* (Jane) and the participants' perceptions of them as trustworthy, reliable, supportive and nurturing emerged as they spoke of them *"always being there"* (Jenny) and *"being there for me"* (Liz).

The fact that these professionals were often deeply involved in the decision making processes regarding child protection issues was never raised by any of the participants. Instead of feeling resentment towards them or judged or stigmatised by them, the participants appeared to consider their specialist midwives to be their allies who had their best interests at heart:

> *"They've been really helpful and even when I was going through all that with the social work the midwives where still like a you know they were still a base that I could turn to I felt that they were kind of on my side if you know what I mean? Social work were on my side but I was seeing them as not you know as them being against so no it was nice to feel that I had somebody on my side … definitely the midwives are brilliant and even (pause) even the normal midwives on on the wards when you're in having your baby (pause) I've never felt like em I shouldn't be there or or I'm doing something wrong"* Jenny

The feeling of a special connection between the participants and their midwives is captured in the above extract from Jenny. They appeared to feel a deep, meaningful connection with their specialist midwives, seeming to reveal the level of trust they felt within these relationships. Above all, it seemed that non-judgemental care and being treated like any other mum was important.

The participants appeared to have built meaningful relationships with their midwives over time. The seemed to value the frequency of midwifery input and the continuity of having one particular midwife throughout:

"I see (name of midwife) the drug liaison midwife on a fortnightly basis and she's gave me a lot of support as well. Em applying for things and em helping me out (pause) like (pause) she's sort of (pause) she got me a baby chair and things from other mums and I've sort of (pause) things that I had from (name of child) … I gave her my pram (pause) things like that (pause) so aye (pause) I've had a lot of support from them" Jane

Reciprocity also appeared to be meaningful for Jane within this relationship as well being able to access much needed practical help with day to day life and preparation for her new baby.

Jenny in particular was very keen to talk about her experiences of midwifery care and the importance of the unique relationship she had developed with her midwife emerged. She spoke of her midwife as "*a sort of friend"* who *"supported me throughout":*

"I came off my script half way through my pregnancy but (specialist midwife) supported me right through em and were fab you know I just think you know they're a brilliant support actually and it's nice. Do you know what? You already feel bad about the fact that (pause) you know you're you're pregnant and you maybe haven't always been behaving yourself and all the rest of it but they never make you feel like you're awful for doing that you know what I mean? I've never been made to feel like em like I'm a bad person I suppose which I suppose is really important when you're pregnant" Jenny

Jenny appeared to capture what was crucial for the participants, what they needed from the specialist midwife/mother relationship – knowing that they were being accepted for who they are and what they are doing now. She also captures the participants poor sense of self and their knowledge that they that they have not always acted in acceptable ways.

Liz however, seemed at odds. She felt *"professionals wouldn't show it (stigma)",* yet seemed convinced that she would still be judged by them. Her deep rooted guilt and anxiety regarding taking opiate substitute medication during her current pregnancy emerged and she seemed overwhelmed with anxiety:

"this time I'll be like what are they going to think of me?… I I probably will feel like they will something of me. Em so I yes I I probably but that's just me though I'm a worrier and I always feel like people are judging me and I always feel like (pause) so I'm going to feel like maybe some of the nurses or midwives might be well like she's had a baby knowing that her baby could come out rattling. It's going to bother me" Liz

She clearly feared she would be seen by maternity care workers as nothing more than a drug user who had little regard of the impact of her opiate substitution medication on her unborn baby. This seemed far from her truth as she appeared pre-occupied with worry over what people thought about her.

Some of the participants received additional support from other agencies and it appeared that this practical, long term support was invaluable - highlighting that even when clean, taken for granted aspects of day to day life were often difficult for the participants to initiate, organise and maintain independently. They received help with shopping, guidance in prioritizing what to spend their money on and perhaps most importantly, how to negotiate their days without substances. As a previous offender, Jane and her children received extra support from a specialist agency:

"when I got out she was the one that would sort out my appointments (pause) my diary em make sure I was spending my money on what I should (pause) … Like (name of child) was needing to be registered with a dentist. When we went to that (social work) meeting yesterday (pause) so she's (pause) she sorts all that out for me em my money (pause) like I had a bit of a problem with my money getting sanctioned (pause) missing appointments and so she's sorted all that … And the help from her has been unbelievable" Jane

The extract above highlights the positive and life enhancing impact she feels her key worker has made on every-day, otherwise taken for granted aspects of family life. It seems that this assistance is support is needed for the long term good of Jane and her family, suggesting that even when clean, the impact of substances continues to be felt.

As the participants reflected on their previous and current experiences of pregnancy and motherhood, their thoughts turned to events that led to them being involved with social workers over the years. Their perceptions regarding this professional group were startlingly different from that of the rest of the professionals they had met:

"social work yes yes 100% totally judged by them … the social worker that I had to start with she she sort of looked down her nose at me. I didn't like that ... " Liz

It seemed for Liz, her previous experience with social work had been so negative that it undoubtedly coloured her feelings towards them, which seemed hard for her to shake. This was particularly so for Liz, but the rest of the participants also held long held anxieties about their involvement with their families. Social workers appeared to be initially thought of as *"only being there to take away your baby"* (Tina). Participants spoke about *"hiding the truth"* (Jenny) from them and *"not trusting them"* (Liz), revealing the level of caution and suspicion they had felt towards them.

One ponders if this was in some way related to their own experiences and perceptions of social work when they were children. Having previously spoken about being fearful of being *"taken away"* (Jenny, LHC quote) from their parents, perhaps it was difficult for them to perceive social workers in any other way:

"I used to think they used to speak down to me cos I was using and drinking… thought they were better than me but now realised they were just there to help me and back back in the time I didn't used to take the help and this time I'm willing to take all the help. Yep. Just need that wee aye help ... there's loads of support out there for me I've got my friends I've got (substance misuse midwife) I've got (social worker) I've got loads of people I can phone but yep in the past I didn't" Tina

Tina appears to highlight her feelings of low self-esteem and perhaps guilt in talking about how she felt she was perceived by social workers. Over time however, her perceptions of them changed and they appeared to be seen as one of a number of people who were available and willing to help, rather than merely judge her.

Liz, however, returned to her previous experiences, highlighting the impact these have had on her and her family. When her children were removed into care following her partner's arrest and imprisonment for domestic violence, she seems to have felt that despite her best attempts to do whatever was necessary for her children, nothing changed in the eyes of her social worker:

"at the time I just felt like she just trying to take my bairns off me and she didn't want me to have my bairns … I had been doing all this stuff to get like clean samples for months and months and months (pause) going to all my appointments (pause) I was doing absolutely everything I was told to do but that particular social worker wasn't even giving me overnights to my bairns … but as soon as I had the new social worker (pause) … worked with me for about six weeks and she was like why why are you not getting overnights?" Liz

It seems she felt that rather than helping her work positively for the future, social services could not see past her history of substance use. She appears to have felt judged, stigmatized and extremely let down by social services. She did however, capture the positive impact of having a meaningful, trusting relationship with her new social worker. Knowing that their social workers considered them trustworthy and valued them as people emerged as significant for all of the participants. They seemed to want and value deep relationships with their social workers:

"when the new social worker came everything changed … she is absolutely amazing (pause) she is actually (pause) I see her as a a pal like … I was quite happy for her to come out every month to visit me and the bairns cos we'd get a wee blether … she's she's so nice and for like me having the bairns she knows (pause) I'm not a bad mum" Liz

For Liz, it seemed vital that she be treated as an equal by social workers, but above all that she was seen and believed to fit the role of a good mother, that any harm to her children was without malice or forethought.

In summary, the relationships that the participants developed with health and social care workers emerged as significant. Although sharing some of the responsibilities of social workers in terms of child protection decision making, midwives were thought of much more positively than social workers. The participants' feelings towards social workers did however, appear to have become more positive over time. The need for additional practical support emerged and highlights the participants' ongoing search for more positive choices and routine in their lives. Experiencing positive, affirmative relationships with professionals and voluntary sector workers helped the women feel supported and cared for. This in turn helped the participants build trusting, reciprocal relationships which provided them with a sense of stability and confidence to cope with their ongoing struggles and vulnerabilities.

4.2 Midwife participants

Three major over-arching themes were identified from the interview transcripts within which seven sub-themes emerged:

Major themes	Sub-themes
Psychological trauma	- Trauma histories & disclosure - Vicarious traumatization
Stigma	- Stigma in the maternity setting - Personal attitudes towards PWMS
Managing unmanageable situations	- Chaos in the maternity setting - Something's missing - Relationships

Interpretative phenomenological analysis of interview transcripts - Midwife participants' major themes and sub-themes

4.2.1 Super-ordinate theme - Psychological trauma

This superordinate theme aims to capture the participants' knowledge and understanding of the possibility of trauma histories amongst PWMS. First of all, the participants' awareness of the potential for interpersonal trauma within the lives of the women they support is considered. Consideration is then given to the participants' experiences and perceptions of disclosure of trauma by the women they support.

4.2.1.1 Trauma histories and disclosure

"I find that they've always had quite a hard life" (Jen):

All of the midwives appeared to show a heightened awareness of the impact that interpersonal trauma (IPT) may have had in the lives of the PWMS. It seemed that their knowledge had come with clinical experience or through their own personal interest, rather than an area that had been covered in either pre-registration of post registration education and training. It emerged that substance use was viewed as something that would not simply have been stumbled on by women. It appeared with experience the participants felt they had developed a hunch that *"something had happened"* (Jen) in the lives of some of the women they supported:

"there's always been (pause) I find with mums that misuse in their pregnancy (pause) do do always have (pause) bad childhoods (pause) like a traumatic lead up to the (pause) it doesn't it doesn't seem "oh I got in with the bad crowd and got into drugs" (pause) there always seems to be a history (pause) from previous social or you know (pause) they do always have a story to tell you know (pause). That's how I've (pause) I've always found ... I find that they've always had quite a hard life" Katie

It's as if Katie almost expected childhood abuse histories to be at the root of substance use amongst the women she has met in clinical practice. Within this knowledge however, her true feelings about substance use emerges as it seems as if she simultaneously accepts substance use, yet associates it with unscrupulous, dangerous people.

Nonetheless, the participants did appear to value women's lived experiences. They emerged as exploring the wider issues within women's lives and considered the

possible mechanisms underlying someone's use of substances. This is best captured by Samantha:

"there's a saying (pause) and it's an old saying (pause) and it's more to be pitied than mocked and I think although that sounds hard it's not (pause) it's actually a really compassionate saying cos it's saying they've had a hard life (pause) there are things that have happened to that wee scone (pause) that you don't know what made her like that (pause) she wasn't born to be like that" Samantha

It's as if Samantha has learned to suspect or anticipate that something significant must have occurred within a woman's life that was out of her control. A great level of compassion is revealed and like the rest of the participants', she appeared mindful that trauma may alter many aspects of a survivor's life to an extent that may be beyond understanding by practitioners and perhaps even survivors themselves. Within this their feelings of deep empathy regarding trauma histories emerged.

The participants also appeared to grasp the powerful influence of growing up with substance addicted parents:

"and there is sometimes generally (pause) you know … family history of like way way back of drugs so she's brought into that. It's just like everything else (pause) if you're brought into that (pause) you kind of do that don't you" Karen

Children's innocent observation and experience of substance addicted parents appears to be considered highly influential by Karen, that this may in some way shape their future decision making and attitudes towards substances and behaviour. She appears to perceive that substance use may be a learned activity, something which was widely accepted, unchallenged and experienced as routine and the cultural norm within families.

Jen in particular seemed to feel that the implications of trauma on survivor's health and wellbeing were complex and multi-factorial and captured the participant's awareness that substance use was not in isolation, but something they viewed within the context of inter-related and inter-connected life events:

"The toxic triangle … And if you start to dig (pause) you usually find that there's domestic violence or there's something else going on. Or mental health. They're usually all linked together though it doesn't just come (pause) by itself. And it just depends (pause) the violence (pause) it could have been childhood or currently" Jen

Jen's extract in particular leads one to imagine a series of highly sensitive, harmful, intertwined and complicated circumstances that are enmeshed within the survivors psyche. It seemed that all of the participants had developed this view though clinical experience as they all spoke of this in relation to women they had met.

The mental health needs of PWMS were also considered by participants:

"... there's too many pathologies … what I was thinking (pause) that's not just a drug user (pause) that's someone who's got a serious or appears to have a serious psychy illness which they use drugs to either medicate or the drugs have caused but those are like the ones that you can't just say …" Samantha

It seems as if Samantha recognises the complexities of mental ill-health and perhaps feels that these needs are way beyond her level of competence and knowledge. She also has an understanding that some survivors may use substances in order to cope with an underlying comorbidity, or that some may have long term psychological damage as a result of their chronic use of substances.

The participant's appeared to perceive that survivors of childhood trauma may grow up to be vulnerable young women and these perceptions permeated their accounts. This is highlighted by Jen:

"It's been a partner [pause] they've not maybe realised it at the time (pause) but thought it was love (pause) it was the real thing. But they were basically given drugs in return for sex and (pause) and not realising that and then how that affects them in life … I couldn't really say I've ever met someone who's just started using drugs just because they wanted to. It's usually (pause) they've been introduced by someone who is an important person to them in their lives. They've trusted that person. Em and then for whatever reason things have fell apart or (pause) or that's what (pause) they've just had to keep going with that" Jen

Vulnerability seems to be equated with susceptibility towards involvement in risky situations with risky people and Jen's consideration of coercive control as powerful, destructive and hugely influential emerged. This was a common theme amongst all of the participants. Their feelings appeared to stem from clinical practice as none of

them spoke of having undertaken any education or training in this area, instead, they reflected on women they had met in clinical practice.

Samantha also highlights the participants understanding of the complicated nature and stark reality of living with an abusive partner:

"uhuh definitely and it's not just the one issue is it? What I mean is like it's quite often not ideal domestic situation they're going home to" Samantha

Intuition in midwifery practice emerged as significant amongst the participants. It seemed that they were talking about feelings they got from certain people as they spoke about a *"gut instinct"* (Samantha), which appeared to be triggered by some of the partners of the women they had cared for:

"there was one (dad) a few years ago (pause) that I had been really concerned about a baby and kept (pause) social work (pause) the dad (pause) his manner was (pause) very aggressive (pause) you know … I was really concerned (pause) I wouldn't have turned my back on that dad" Katie

The power and value of unspoken gestures and mannerisms amongst couples is highlighted by Katie and it seemed that the participants often watched couples interactions with each other, often feeling *"oh that's no healthy, that's not nurturing"* (Samantha) when watching people together. It seems as if they all recognised the power of body language in conveying more than words alone, suggesting their heightened observations skills and feelings of fear and mistrust that perhaps developed in light of their clinical experience and practice.

The participants appeared to feel confident in trusting these skills, which seemed to be felt on an almost instinctive level:

"but just having a feeling that somethings not right and I felt that about that dad and so did other people and highlighted concerns and (pause) but the highlighted concerns was enough for them to at least put them into … and it still happened" Katie

Katie in particular appeared to trust her intuition as she shared her concerns with other health and social care professionals. All of the participants emerged as feeling comfortable about sharing their *"gut feelings"* (Katie), which must have been taken

seriously as they were found to influence the outcome of child protection plans, however, it seemed that even then, abuse could not be prevented from occurring.

Perhaps in light of the very intimate nature of their clinical practice, the participants seemed acutely aware of women's personal space and boundaries. This is best captured by Samantha:

"nobody else is in about your bits and pieces (pause) nobody else is touching your breasts and I think people (pause) see like see if you're getting induced now which lots of people do I'm trying to think what (pause) about 6 VE's (vaginal examinations) maybe in 24 hours?" Samantha

Aspects of Samantha's practice that are perhaps considered routine, were recognised as very intimate and highly sensitive for women. It seems as if these procedures were not undertaken lightly by Samantha as she identified the uniqueness and often gravity of the situations that presented themselves within her clinical practice and the immense vulnerability that women may feel. Moreover, it seemed that although these procedures were part and parcel of her practice, their repetitive and seemingly intrusive nature was uppermost in her mind.

The very personal nature of these procedures seemed to pre-occupy some of the participants, in particular Samantha:

"… like when they're pregnant (pause) when you're doing (vaginal) examinations (pause) I have had some women dissociate (pause) you see them just leaving the building (pause) their eyes shut they go somewhere else you know?" Samantha

It's as if Samantha felt a sense of great moral distress and sorrow, knowing that her practice may leave the women she is trying to support in some way untethered and disconnected from reality and all of the participants concern with the potential to inadvertently trigger trauma memories and deep distress were revealed.

Abuse histories therefore seemed to be at the forefront of the participants minds. In clinical practice however, a reticence to discuss certain types of abuse emerged. Women's abuse histories seemed to be considered at times a Pandora's Box, often referred to as *"a can of worms"* (Sandra) by some of their colleagues. Samantha in particular appeared to feel very strongly about this:

"And the thing is (pause) I have honestly heard midwives saying "I'm not reading that it upsets me" like somebody's sexual sexual abuse or domestic or something like that (pause). You think really?" Samantha

She appears to recall somewhat incredulously, occasions when their colleagues have refused to engage with women's abuse histories, sexual abuse in particular. Her frustration and disbelief at this narrow, closed off attitude is captured. It seems that she finds it hard to accept that some of her colleagues put their own personal needs before their clinical responsibilities.

Sandra however, seemed to perceive that the refusal to talk or even hear women's stories may be more than just reluctance or even distaste:

"but sometimes we (pause) is it just because we think I better not? I better not get into a conversation with you (pause) because you know you might ask something or want something from me and I might not be able to help you. I think people I think people do do that … as far as I'm concerned it think that can of worms has already been opened somewhere along the line and that's what led them to be where they are. That's just my opinion" Sandra

She seems to suggest that some clinicians, perhaps even she at times, may be unable, rather than unwilling, to actively and openly support survivors of abuse due to a lack of knowledge, appropriate skills and confidence. Sandra's sense of futility at this is, however, also captured along with her feeling that her attitude towards this may not be shared by her midwifery colleagues.

The participants seemed to feel that in consciously providing this type of care, women would be supported in a manner that was not women centred, individualised or respectful of the impact of trauma on health and wellbeing:

"So you have to then choose to be not informed and give possibly inappropriate care (pause) … it would just be generic care they just give the same bland non differentiated vanilla care to everybody … Just keep it all to yourself uhuh that's what I think (pause) they'll get over it and then I suppose like your 25 times more likely to become mentally ill after the birth of your first child (pause) and if you're bringing a big bundle of trauma with you and then what are you going to do?" Samantha

It seemed that this level of care was perceived by Samantha as being mediocre at best, disrespectful at worse and inconsistent with women's mental health and wellbeing. Moreover, the vulnerabilities of childbearing women, particularly those who

may have trauma histories was acknowledged. Samantha's great sensitivity was revealed along with her fears of reinforcing some survivors deeply held beliefs around disclosure. The decision to not become engaged with women's trauma histories appears to be considered as a conscious decision to make oneself emotionally unavailable to women's needs, in order for clinicians to appease their own.

The participants appeared to be committed to finding out about possible abuse histories amongst the women they supported. Multi-agency working appeared to be considered valuable and GPs and health visitors were described as often providing useful sources of information:

"It's the first thing that I do (pause) is go and look at all the social things to look back to see "oh okay". We would look at that (routine enquiry into domestic violence) as well and then em obviously get in touch if they've (pause) most of them (pause) do have a social worker. You know (pause) there's been something (pause)… So that that does interest me" Katie

Taking the time to review maternity records and correspondence from other departments, such as psychology and psychiatry, were therefore seen as important. It emerged as particularly important to the participants to routinely check women's notes in order to *"get a heads up on that" (domestic abuse*- Katie). This emerges as a priority amongst the participants, suggesting they attempt to build a more complete picture of the lives of the women they supported.

Furthermore, women's life stories appeared to be valued and treated with great kindness by the participants:

"I think before anybody discloses any info that is precious and difficult to them (pause) they have to know that it is precious and difficult to you… It's a big defining thing you don't want to be labelled a drug user (pause) you don't want to be labelled a sexual abuse survivor (pause) or your partner if its domestic violence (pause) is that alright?" Samantha

Samantha's awareness of the complex nature of disclosure of trauma for women seems to be considered with deep respect, particularly regarding the aftermath of disclosure. It was recognised by all of the participants as a possibly life changing event of great magnitude, almost like a point of no return, for women and perhaps for the participants too.

Timing and approach to asking about abuse histories appeared to be taken seriously, yet varied from participant to participant:

"Would I ask them? em I probably would follow their lead ... " Samantha

Disclosure therefore did not appear to be service led as Samantha seems to suggest that she preferred to wait for cues from women themselves. It seems that with clinical practice and experience, all of the participants had learned to become attuned to women's clues about asking them about trauma. This seems essential for all of the participants practice, as it was never right *"to press her"* (Jen) regarding disclosure.

It seemed that through practice, they had learned to wait until some kind of relationship had been built with women before asking them what they clearly considered to be very intimate details of women's lives:

"I would just think a lot of the time once they start to know who you … and sometimes they'll volunteer even more info like that so I think it's just a case of us being more open allows them to to speak to us but that's like everything though you know there's people that come in and you think everything's find and then you'll just get them on a day when they're feeling really down and they'll tell you something that's happened ... " Sandra

The benefit of continuity of midwifery carer emerges as being valuable for Sandra and she shows great self-awareness regarding how she presents herself and how she in turn may be perceived by women. It seemed that all of the participants felt these to be valuable and powerful for facilitating disclosure. Disclosure emerges as often opportunistic in nature, and moreover, it seems as if the participants were prepared for this to happen when a women decided that the time was right for her to tell her story.

Nonetheless, in order to help facilitate disclosure, the participants seemed to acknowledge that patience and great sensitivity were required:

"Once we've built up a bit of a relationship (pause) I find that they'll tell me that somethings happened. You know they might say it in relation to their baby. They'll say "This happened to me and I don't want that to happen to my baby" and it maybe comes out that way. Em but I would always ask. Later on as well (pause) once (pause) once I felt the relationship was kinda a bit more stable" Jen

It seemed that through experience, Jen had learned that even when a relationship had been built, disclosure may be so sensitive that women may only be able to broach their trauma histories in relation to their child. There emerged a tenderness and a need to tread carefully, perhaps acknowledging that this may be as the women were themselves not always protected and nurtured as children.

Although potentially fraught with difficulty for the participants and the women they supported, it seemed that disclosure was seen as something that the participants actively encouraged and something that they felt was integral to their midwifery practice:

"… they're always asked about domestic violence (pause) well (pause) if they're on their own (pause) if they're with a partner or anybody (pause) they don't (pause) but if the ladies (pause) on her own (pause) I would say "is there any or has there been any" or (pause) "we can give you help if you need it" Karen

It seemed though that this was often difficult and that opportunities may be restricted. It also appears that Karen's central concern related to domestic violence, rather than lifetime experiences of abuse, perhaps suggesting a perception that imminent danger to the woman and the unborn baby from current abuse, rather than past trauma, was seen as a priority within midwifery care. This was also echoed by Holly:

"… we ask all women about it (domestic violence) at the booking appointment and em you know do they feel safe at home?... most women will laugh that off em but obviously for the more vulnerable girls and that's vulnerable across the board (pause) not just drug and alcohol addiction (pause) you know who's your partner? how long have you known them? you know and if they divulged drug and alcohol does your partner take part in that group? Holly

In summary, the participants were all very aware of the possibility of abuse histories in the lives of PWMS. They seemed very aware of, and appeared to suspect the possibility of childhood abuse, yet in their routine practice, it seemed that the issue of disclosure generally centred round domestic violence. Disclosure of abuse was taken very seriously and the participants' appeared to consider asking women a priority. The enormity of what they were asking women was acknowledged. The timing of enquiry of abuse varied from participant to participant, with some waiting until they felt they had built a relationship with women before asking them.

4.2.1.2 Vicarious trauma:

"I do worry" (Jen):

The participants were all found to remember individual mothers and babies they had supported, as well as events that had occurred at various points in their midwifery careers. The participants all began with *"I remember one lady in particular……"* but went on to recount with great clarity, the stories of many women they had been involved with during their clinical practice. They seemed keen to reflect on these incidents, some of which it became clear they had not spoken of for some time. It seemed that they had not been given any opportunity to recount these events or their feelings, even though these remained highly significant and distressing for them.

Events within the maternity services seemed only to be recognised as important and potentially harrowing for staff, if life threatening and dramatic:

> *"the event that happened in hospital (pause) it (debriefing) would be really really useful because it could change the way we look after them because that's the way we deal with everything else … we're talking about these significant events and how important a debrief is so even a debrief after these kind of events it's it's just as traumatic for that midwife as a PPH (post-partum haemorrhage) in the ward but because it's not a physical thing she's no slipping about it or anything (pause) so there's nothing (pause) so it doesn't matter and then then you feel you don't want to be the first person to say actually I feel this really stressful … and I do that as well (pause) so nobody wants to admit or be the first to say actually I'm struggling with this and we're like that with a lot of things but probably with this"* Sandra

It seems that some events are considered real emergencies and expected to be difficult for staff to deal with, whereas others do not register as significant to the wellbeing of staff. It's as if midwives are their own worst enemies and that an enormous amount of shame surrounds certain types of work related stress, which no-one admits to. This seems to have become pervasive and part of the culture within the participants midwifery practice, as if expressing anxiety at work was considered a weakness amongst their colleagues.

It became apparent very quickly that in remembering events and women's histories, the participants remained anxious about what had happened:

"I'm telling you about things that happened years ago. This is the first time that I've actually thought (pause) obviously that has had an impact … so maybe that is a significant thing that has happened to me (pause) I don't know … I remember feeling I was like really quite upset … So I felt awful and I think to this day I worry. You just try and forget about it but you clearly don't because I can still remember about it … I still remember it. I worried about that baby it was wee it was totey and I wondered what if what if? I don't know maybe that baby was alright maybe not I don't know" Sandra

It seems that it was only in talking about these events, at this time, Sandra began to fully appreciate the depth of the impact particular women and particular experiences has had on her. She appears taken aback, perhaps frustrated by events and shocked at the detail and clarity with which she found herself remembering. In making sense of their feelings, it seems that most of the participants may have been traumatised by what they had heard or seen within their workplaces and their ongoing anxiety related to these events surfaced.

Supporting PWMS and new mothers emerged as being perceived as difficult and distressing experiences for the participants. In recalling these stories, it was clear that particular events in particular women's lives had a considerable, previously unacknowledged effect and it seemed that they had not fully come to terms with what had happened or what they had witnessed. Some participants remembered a particular woman's actions or behaviour or often the condition of a particular baby. For Karen, it seemed that one particular women stood out to her as very vulnerable due to her age:

"that young girl that I was talking about (pause) I still think about her…Yeah I do (pause) definitely … you just think what life is she leading now? Is she still here (pause) is she still (pause) you know (pause) has she had any more babies? What kind of life has she got now? So you do (pause) fleetingly wonder "God (pause) I wonder how she is?" or if her name crops up (pause) you just think (pause) I wonder how she is em (pause) some do have a big impact on you … I did feel sorry for her. … you still feel for them don't you?" Karen

Karen returned to talk about this one specific client throughout her interview. She seems to ruminate on the woman's lived experience and appears to suggest that she felt anxious that she may not have went on to have any future. Disturbing memories like this were found to be almost inscribed in the participant's minds, emphasising the long lasting impact and stressful nature of their encounters.

Involvement with pre and post birth, child protection plans also emerged as being highly emotive, challenging and a cause of great anxiety for all of the participants. It seemed that being face to face with pregnant women or new parents, made participants feel highly vulnerable and more accountable for the decisions they were required to make:

"That was very difficult when I first started to go to to CPCC because they're sitting across the table from you (pause) but I don't find a problem now it's like everything else you you do it often so it becomes an easier task to do and then I think for me the thing that is paramount is what's this child going to be living with? As much as you like that personality that lady (pause) what is that child going home to? ... But now (pause) now I don't find that decision making problematic because I know that deep down I do it for the right reasons" Holly

The participants' great sense of discomfort and unease with this aspect of their practice is captured along with a sense of them feeling initially overwhelmed by this undertaking. Yet like many other aspects of their professional practice, it seems that Holly learned to cope with these distressing and emotive events with exposure and experience of these meetings. It seems that in order to help appease these feelings, which perhaps included guilt at what she was required to do, she felt she could not allow her judgement of each case to be clouded by her personal feelings or emotions. It seemed all of the participants had to actively remove their feelings about the woman involved and focus entirely on the outcome for the baby in order to be able to cope with these stressful events.

Even after years of clinical practice however, it seemed that feelings of uncertainty regarding their involvement and the decisions made in child protection case conferences remained:

"Ah oh (pause) I think (pause) we had one I had one lady recently and that baby initially they made the decision to put the baby on the CPR at the last week (pause) before she even delivered so before we did the PN discussion they (social work) made the discussion that that baby was going to foster care so (pause) I worried about that (pause) but I think then they kind of looked at the whole background again … and the baby went to foster care and I was very much relieved about that" Holly

Holly highlights the dilemma and uncertainty felt regarding the decision to let a baby go home, which emerged as significant for all of the participants. It seems all consuming at times, as the participants were often unsure the right decision had been

made for a particular baby. Once again, the role of intuition in the participant's midwifery practice emerged.

Stress seemed incumbent with this area of practice for the participants:

"Em well (pause) I do (pause) I do (pause) I do worry. Like (pause) I'll em (pause) I go home at night and think (pause) you know (pause) a child's em (pause) you know if there's been a case conference (pause) have we made the right decision for that baby to go home with person?" Jen

Anxiety peppers Jen's account, perhaps in light of her apparent appreciation of the enormity of what she is required to do as part of her clinical practice. Her worries seem emphasised as like the rest of the participants, concerns regarding the wellbeing of particular babies appeared to spill over and consume her time off.

The participants' worries and anxieties seemed insidious. Thoughts of women and babies were described as being able to *"creep"* (Jen) into the participant's time away from clinical practice. They expressed a sense of dread of going into work, as they often worried about what they *"were going in to*" (Samantha) following their days off and annual leave. None of the participants appeared to perceive much, if any, help or support with this. They spoke of *"leaving their worries at the door"* (Sandra), but neither they nor their colleagues appeared able to do this:

"no one wants to be the first to say I find this difficult … we do that fine fine I'm alright" Sandra

Sandra appears to bring to light once more, a general reluctance to talk openly about difficulties at work. It seemed that the participant's encounters at work were unsupportive, superficial and concerns swept aside as meaningless, which is perhaps why they had learned not to express their feelings anyway.

Different strategies to alleviate their work related stress emerged. Jen seemed to gain some sense of perspective with time and distance from work as she found her *"drive home"* helped reduce her stress levels. It seemed however, that this still spilled into her time off and impacted her home life as she spoke of how her family *"couldn't understand why she worried".* With some sense of irony, colleagues were known to

"get home, shattered, get a wee glass of wine" (Sandra) in order to cope. Place of work did, however, emerge as being significant and is exemplified by Jen as she reflected on her previous hospital post:

*"when I worked in labour ward (pause) as soon as you saw the night shift coming in and you handed everything over and walked out (pause) you know (pause) it was a relief (both laugh)"*Jen

It seems that having someone to hand over the care of a patient to, rather than being the last midwife to look after and perhaps make decisions about a woman, made Jen's role less stressful. Perhaps when working within a team, there was a sense of comfort and she felt less responsible and weighed down with concern and anxiety about what had just taken place during her shift.

Whilst the hospital based staff worried about individual encounters with women, the community based participants caseloads appeared to prey on their minds:

"as a community midwife you are constantly thinking about your caseload and thinking (pause) "oh have I done this? (pause) Have I sent that email? … you then just have that worry of em you know (pause) I've seen her in the house that weekend and I know he doesn't like me seeing her in the house (pause) and is something going to happen to her because of that? Em you know what I mean?" Jen

Jen highlights the perhaps wider and more involved role with women that the community based midwives had, which in turn perhaps brought a greater sense of responsibility. A greater awareness of the wider social and cultural issues involved with their clients emerged, which may not seem so pertinent to hospital based midwives and an enhanced sense of professional autonomy was also revealed.

In summary, all of the participants remembered in great detail, individual mothers and babies they had supported during their careers. They remembered with clarity, particular events that had occurred with particular women and babies. All of the participants remained anxious regarding various women they had come into contact with. Some of the participants recognised that major mental health issues may be the underlying cause of challenging behaviour and distress amongst the women they support. Child protection issues seemed to become easier over time, yet this appeared to be due to the participants making sense of their role in protecting the new-

born baby. Supporting PWMS was found to be highly emotive for the participants, who often spend time worrying about their caseload, or what they would be returning to following their time off from work.

4.2.2 Super-ordinate theme - Stigma

This superordinate theme aims to capture the participants' meanings of their perceptions of stigma within the maternity setting towards pregnant women and new mothers who misuse substances. First, consideration is given to the participants' experiences and perceptions of stigma in the wider context of their working environments. This is followed with an in-depth exploration of their own personal perceptions about supporting this client group.

4.2.2.1 Stigma in the maternity setting:

"They're killing their babies" (Sandra):

All of the participants reported being aware of stigmatising attitudes towards PWMS within the maternity setting. Whilst some reported a positive change over time, mostly due to exposure to, and experience of, PWMS, others expressed a concern about what appeared to be pervasive negative attitudes towards this client group. We begin here by focussing on these deleterious, stigmatising attitudes towards PWMS. Amongst the participants, Sandra was particularly vocal when asked about stigma within the maternity setting. This is therefore reflected in this sub-theme.

Sandra was found to feel that staff acted in a *"weird way"* towards this client group. Other participants described how before even meeting these women, their colleagues would often *"look them up on the computer"* (Samantha) suggesting PWMS reputation often proceeded them. It seemed that their notes and therefore their lives were viewed in a salacious manner by some of their colleagues. The power of non-verbal communication as a means to convey that maternity staff were *"not happy"* (Sandra) was described, suggesting that disapproval and judgement often took place within clinical settings:

"you can put across that you're annoyed about something … there are things that are non-verbal … Standing there with your arms crossed (pause) standing at the CTG (cardiotocograph machine) (draws in breath) you know (pause) the trace is flat and they're feeling uncomfortable and you're thinking mmmm no saying anything. We do it and we roll our eyes do you know so but so we draw a line we've got we've got thresholds with some things but we don't seem to have thresholds about our opinions do we?" Sandra

Sandra suggests that midwives openly and routinely display their displeasure and judgement towards women they disapprove off and seems to occur for a variety of reasons. It sounds like a show of authority, perhaps even malice and reveals a cruel, disregard for women's feelings.

Additionally, it seemed that working with PWMS was, for some midwives, an area of practice they were keen to avoid:

"Nobody really wanted to work with them and (pause) and I was the newly qualified midwife who got sent in to do (pause) you know (pause) and I actually found that if you sat down and spoke to them (pause) they were like women (pause) like me and you (pause) you know (pause) who were in there (pause) they were pregnant. They had the same worries as every other mum and you know (pause) wanted to breastfeed and wanted to have cuddles with baby (pause) but had this horrible feeling that people were talking about them and midwives maybe wouldn't help them as much as the mums" Jen

Jen reveals that in her experience, working with PWMS was almost treated like a forfeit. Taking the time to get to know PWMS was however, found to reap rewards for Jen as it ultimately led her to view PWMS as unique individuals, just like everyone else. What also emerges, is the PWMS awareness that they were being stigmatized and one ponders the level of unprofessional behaviour and discourse they must have witnessed or overheard to make them feel that way.

Very powerful, inappropriate, discriminatory and judgemental attitudes were revealed to exist amongst health care professionals, in particular, by Sandra:

"everybody starts to get a wee bit "oh right any problems with the partner?". Everybody just assumes they'll have this partner that's not going to be allowed in … there's this massive assumption that they're going to have this partner who's in jail and he's going to break out of jail and come to see his baby and the family are going to be a nightmare and it's just it's it's just like a kind of what's the word? It's not a cliché it's like a kind of stereotype" Sandra

Negative and inexplicable, highly disparaging assumptions emerged as being made amongst health care professionals regarding this client group, which Sandra clearly condemns. It seems that within the maternity services, an assumption exists that PWMS survive within a criminal underworld that would wreak havoc within the

maternity setting. Sandra captures the feeling of frustration and anger the participant's felt regarding their colleague's ignorance.

All of the participants could remember over-hearing highly negative, condemnatory discourse which often seemed to take place amongst their midwifery and medical colleagues regarding PWMS. Sandra in particular appeared outraged, defensive and disappointed at the condemnatory remarks she could do little to prevent on one occasion and a deep, possibly engrained and apparently quietly accepted issue of discrimination against PWMS within the maternity setting emerged:

"I had a conversation were I I have said in em the duty room and I've said oh I I quite like these women I feel kind of like I feel I feel sorry for them and that's probably not a good thing either but I do feel sorry for them (emphasis on word) … and somebody else said "oh I don't know why you feel sorry for them they're killing their babies" (pause) but I was like well "how can you say that?" (pause) "well they are they're poisoning their baby em and they're probably smoking as well and they're probably doing this they're probably" and it's just sad it's sad that people have that in that job how they can be so em what's the word discriminatory? ... we wouldn't do that if it was a racist comment we wouldn't think twice about it would you?" Sandra

It's as if PWMS were judged by some health care professionals to be terrible, selfish women who gave no consideration to their babies and were almost akin to murderers. It seems that they were afforded little, if any, compassion and empathy highlighting the vast difference in how this client group are viewed within the maternity services. It seems that the participants valued understanding and empathy, perhaps shedding light on what they feel are key requirements for health care professionals, but which they felt where often lacking.

Moreover, the participants seemed to set themselves apart from this stigmatizing behaviour and they reflected sadly on how they perceived PWMS were treated. They appeared visibly upset when recounting the appalling stories that women had revealed to them:

"a couple had said to me things like the midwife said to them "your babies upset, crying" you know, "what did you expect if you were taking drugs through your pregnancy? Did you think your baby was going to be happy?" and it really affects them. It's horrible (shakes head)" Jen

Insensitive care and victimisation emerges as commonplace and Jen seemed angry that health care professionals displayed such abhorrent behaviour towards the women they were supposed to be supporting. Again it appeared that an emphasis was placed upon the health and wellbeing of the baby as a way for staff to emphasise their feelings towards PWMS.

Participants described how women had told them that their hospital appointments were *"horrible"* (Sandra), of how they had been told everything they had *"done wrong"* (Katie) and of being spoken to like *"a five year old"* (Holly). Moreover, some medical colleagues were described as paying "*lip service"* (Sandra) to the needs of this client group amongst whom, some of the participants felt negative attitudes seemed less well hidden and more pervasive in nature. Sandra felt some medical staff *"acted as if their lives are so far removed"* from their own, seeming to feel that they acted as if they were of a different social class, perhaps even a higher moral status to PWMS:

"the worst the worst thing is medical staffs attitudes … there's there's a variation in how they treat them but I I personally find that em that they are very they are very critical and presumptuous … she was in a lot of pain and when I'd gone to speak to the registrar she was like that well "how could you be in pain with all that that she's taking?" … and then they go along "so right and how are you?" and it's just this kind of false and they must think people are kind of stupid … it's almost like just because you're on the methadone programme you must be absolutely stupid and you can't you can't pick up that I'm no interested in what you're saying" Sandra

This apparent indifference to PWMS needs appears to anger Sandra, perhaps made worse as it seems that PWMS are not fully believed when they try seek help and are merely tolerated at times. Sandra seems to feel angry at what appeared to her to be indifference by medical staff and encounters that were superficial and without substance.

It appeared, however, that it was not just medical staff who were perceived as merely abiding PWMS, with little thought or concern of her needs as a pregnant woman or new mother:

"just quickly get them sorted and get them away if we can and if they go to special care then that's even better because we don't need to deal with the baby and we need to deal with the social aspect who comes in and go goes out and we just need to make sure her check's done and that social work know and that's it because we're like that oh right I can't I can't really get into this but I that's just my personal kind of observation … I think when I've been in that situation I've done the same I've done the same and it's not until you reflect on things like that looking back ... I think probably could have been a wee bit better" Sandra

Sandra reveals that encounters with this client group seem to occur as a series of tasks and physical checks that are required to be undertaken with a level of urgency and complacency. Again, there emerged a sense of superficial, inconsequential encounters with this client group and a sense of midwives inability to make themselves professionally or perhaps more importantly, personally available to PWMS.

It seemed that the only way that staff could deal with PWMS was to prioritise getting rid of them, which was reflected on with guilt and regret:

" … you're really just (pause) waiting for her to go home like you know just waiting for her to go" Samantha

The sense of PWMS being viewed as a nuisance and a commodity best dealt with swiftly and curtly emerges again in this quote.

The participants seemed to question why some forms of stigmatization and victimisation are tolerated suggesting that some kind of invisible line exists were some things are okay to say out loud, yet some things aren't. Yet they could all identify with putting the baby first and foremost:

"I suppose the priority through the pregnancy is to make sure that the mum is well and stable em whatever addiction she has em so that the baby is well at the end of it … but then you have to have another head when it comes to social work and attending the CC's and making reports … the the recommendations that you're making are not the best for the mum but the best for the baby stroke child so I suppose at some point in time you do have to … really at the end of the day (pause) it's no what's best for the mum it's what best for the baby" Sandra

It seems that even during pregnancy, the wellbeing of the baby surpasses the needs of the woman and participants had to make a conscious decision that they were protecting the baby, rather than considering the needs of the pregnant women. In this

way, it seemed that the emotional wellbeing of a mother losing her baby is of little consequence.

Samantha however, appeared to perceive that neither the baby nor the pregnant woman/new mother were in fact the focus of care in the maternity setting:

"a lot of the care is based around care of the drugs not the baby or the mum. Like the least you do for that woman is look after her as a new mum and even when you're looking after the baby you're looking after to see what is the effects of these drugs that you've taken and what is the effect on the baby? How is that effecting the mum? How is it how is it effecting the baby and how is going to affect the whole picture? And we all know it changes it changes I think (pause) the start of her motherhood into an assessment of her fitness it turns it into a test for her rather than you being her caregiver she thinks you're judging her and she's right you are judging her (pause) and she knows that (pause)" Samantha

It seems that it is a woman's substance use and the actions of these upon the baby that take precedence within midwifery practice, which in turn flavours the whole approach to this client group. Sandra reveals a sense of unease regarding what she perceives to be an expectation for her to become a moral enforcer and assessor of a woman's integrity and morality rather than her midwife. It seems that all of the participants felt this anomaly which was counterproductive and at odds with their practice, ultimately changing their relationship with women for the worse.

Some of the participants did however, think attitudes towards PWMS had gotten better over time. Jen felt this had improved with hospital based midwives education, whereas Katie felt that her colleagues had learned to *"accept"* their substance use through experience. Samantha on the other hand did not appear to think that stigmatising attitudes towards PWMS had improved at all. She felt that they have been merely superseded by other challenging social issues such as "*paedophilia and domestic abuse".*

In summary, intolerant, stigmatising attitudes towards pregnant women and new mothers who misused substances appeared to exist amongst midwives and medical staff. The participants appeared angry and frustrated and seemed to feel that there was little they could do to challenge these ideas and behaviours. The attitudes and actions described by the participants amongst the staff they had worked with appeared

to be in contrast to their own and appeared to challenge the very nature of what they felt it means to be a midwife. PWMS appeared to be seen as negligent within the maternity setting, based on a series of negative assumptions. The staff revealing these stigmatising attitudes were perhaps, however, shown to be as negligent to their patients as they perceive the patients to be towards their babies. One is left to question the professional duty of care these professionals have to the women in their care.

4.2.2.2 Personal attitudes towards pregnant women who misuse substances

"I don't judge the mums in that sense" (Katie):

The participants moved on to their own feelings towards this client group. They all felt that their perceptions regarding substance use had changed, again with clinical experience. They appeared to feel they were more empathetic now as they had become *"more understanding of them as people"* (Holly). Familiarity from working with PWMS had led them to find that they were *"women just like you and me"* (Jen). They spoke of *"getting on well with them"* (Karen) of *"wanting to get to know them"* (Sandra) and of their feelings of non-judgement as they felt *"able to put the substance use aside"* (Samantha).

It became clear that they considered themselves to no longer feel judgemental to PWMS per se. However, certain behaviours and characteristics emerged that they did condemn, which they appeared to consider as being inextricably linked to this client group. They spoke of *"being given the run around"* (Karen), of aggressive behaviour and of the *"different agendas"* (Samantha) that PWMS have. Moreover, it seems that they felt somewhat manipulated at times by this client group and a lack of trust within these relationships was revealed:

"I think sometimes they think that you're heads zipped up the back you know?" Katie

These challenging feelings appeared to influence their ability to properly fulfil their roles as midwives. They spoke again of feeling they were party to assessing a woman's capability to be a good mother. Samantha in particular appeared to feel this

as she described how this aspect of her practice *"upset the balance"* of the mother midwife dyad:

"well it takes away the honest open nature of the relationship I think you're used to as a midwife (pause) sometimes they like you (pause) I think they're more likely to go into the drama victim persecutor triangle. Sometimes they really like you "oh you're the one who saves me" "you're the nice midwife you're wonderful" or until you're the one that says "this baby is withdrawing we both know this baby is withdrawing" then you're the persecutor (pause) you're the bad midwife (pause) I like everybody else but you" Samantha

It seems that with other women, Sandra feels she experiences honesty and a more honest, equal role. The impact this had on all of the participants relationships with this client group appeared to affect them on a deep, personal level as they seemed to feel that these encounters were attacks against them as individuals.

The participants' feelings of helplessness and distress regarding the vulnerabilities of babies they had cared for seemed overwhelming at times and baby again emerged as being the focus of care and attention, rather than the woman. They spoke passionately of babies *"visibly vibrating"* (Samantha), who needed swaddled in order to help contain their tremors. They clearly felt for these babies as they were *"wee people"* (Holly) with *"wee scadded bums"* (Samantha) who were *"constantly clawing"* (Katie) and who often became *"too distressed to feed"* (Karen). As much as the participants did find these babies memorable however, they were also found to reflect on the impact of this on the mothers:

"I remember looking after one baby (pause) and he was screaming screaming screaming and it was just such a wee shame. Gorgeous wee boy (pause) in there for about three months withdrawing (pause) and every time the mum came in he was crying and she just (pause) she just couldn't (pause) bear it" Karen

Karen reveals her compassion towards PWMS and an acknowledgement that they must be affected when they see their babies withdraw from substances. Perhaps given the length of time that Karen had been involved with this particular baby afforded her the time to get to know the mother as a person.

The participants also seemed to grasp some of the complexities of the lives PWMS may lead and acknowledge that pregnancy and motherhood may not be the major focus in this client groups lives:

"They've just got a different (shrugs shoulders) look on life (pause) … I think you need look at the wider picture (pause) I mean it's frustrating and stuff but (pause)" Karen

Although admitting the difficulties she experiences, Karen appears to try to look past a woman's substance use, seemingly recognising that there are very often a whole host of complexities underlying the behaviours and actions of the woman standing before her. Nonetheless, openness and honesty from PWMS emerged as significant for the participants:

"I find it easier to communicate with the mums that are em that (pause) that communicate back with you easily you know? Disclose things (pause) take on board that their baby is withdrawing … then I I find it easier to work with them then" Katie

It seems that Karen found it difficult to manage to provide support to women without this. It was almost as if subterfuge and duplicity were felt to be at the core of supporting PWMS, rather than the formation of meaningful, reciprocal relationships. Disclosure of substance use was, however, recognised as being difficult for PWMS and the impact of past experience in the lives of this client emerged as being considered relevant:

"they learned that telling the truth got them into trouble" Katie

Katie in particular brought to light that PWMS actions and omissions may often be based upon fear, rather than bad parenting as prior knowledge and experience with health and social care workers had perhaps had negative consequences in the past.

In summary, the participants felt that through clinical experience they were less judgemental about women's use of substances. They did however, appear to remain judgemental about behaviours that they associated with this client group. They felt a lack of honesty and openness between PWMS and midwives impacted their professional practice and often did not feel like midwives when supporting this client

group. However, within this emerged their own appreciation of the potential impact of truth telling for this client group and that the withdrawing baby affected the mother. Their concern with the baby appeared to overshadow their ability to care for the mother and baby as a unit and the baby's needs were given priority.

4.2.3 Super ordinate theme - Managing unmanageable situations

This major theme encompasses what emerged as the participants overarching feelings of what was currently missing within their areas of practice and how this impacted upon the care they felt able to provide PWMS. First of all, their role within supporting this client group emerged. Their place within inter-agency working is considered as well as their feelings about education and training. The features of care that they feel would be of value in helping them provide adequate support for PWMS is then explored.

4.2.3.1 Chaos in the maternity setting

"nine times out of ten it's a Friday night" (Sandra):

It seemed that the participants identified that the current system which they worked in did not fully meet the needs of PWMS *"chaotic"* (Samantha) lives. Care provision seemed to be perceived as difficult, disjointed and at odds with women's needs as *"we don't tie it all together"* (Sandra). A conflict between different areas of practice within the maternity setting emerged as one area hurriedly passes the newly delivered woman to the next:

"I mean nine times out of ten it's Friday night and then of course the woman delivers and labour when you're in labour ward you pass them "here's your bit of paperwork here you go bye" and you phone the unit coordinator and they'll be like "oh" nightmare for them because I mean again when was the last time they were in postnatal? Probably never. So they're not understanding the impact it has on the postnatal staff" Sandra

Sandra seems to suggest that supporting PWMS is perceived amongst her colleagues as more demanding and time consuming than other women. Moreover, there appears little or no support within clinical areas to help midwives provide adequate care, particularly in the postnatal area, where it seemed more fraught for the participants. It seems that the participants felt that some of their colleagues evaded their responsibility to their colleagues, which in turn left them feeling they were *"getting the raw end of the deal"* (Sandra). They described a perception amongst staff of being *"glad it's not you"* (Jen) that had the PWMS to support and a culture of feeling that time with PWMS drained resources and energy that were already scarce became apparent.

The participants seemed to feel torn between supporting PWMS and other women in their care. The most memorable women the participants could remember supporting were described as the *"flashing light drugs users"* (Samantha), particularly so amongst the participants who were based in the hospital setting:

"shouting, screaming (pause) shouting and screaming in the corridors ... demanding their scripts … spitting (at staff), vomiting … loud and shouting and balling and pulling out their drips" Samantha

Samantha seemed to mostly associate PWMS with crisis and disorder and the sense of emergency, urgency and perhaps confusion, that appeared to surround PWMS when they were in clinical areas was captured. PWMS appeared to be considered as being out of control, yet little consideration appeared to be given to other reasons the woman may be acting in this way.

Flexibility, reliability and continuity of carer appeared essential to the participants, but these seemed currently missing which in turn led to PWMS being let down:

"And I think sometimes it is a bit fragmented because they have this person that person that person and that person and they difficulty with that … girls trying to get to appointments (pause) cos they don't have a of of money (pause) sometimes if they don't turn up for appointments they can't phone you because "I've no credit on my phone". They don't have limitless amounts of money to get to A B C and D em and that can be very difficult" Holly

Holly reveals a good appreciation of the wider social challenges that she seems to have learnt may hinder PWMS from attending routine appointments. She appears to understand that their lives are often complicated by otherwise taken for granted financial stability, which may not be available to them when they need it. This wider perception of PWMS day to day realities seemed more apparent within the community based participants, perhaps as they seemed to have more of an opportunity to get to know women more than some of their hospital based colleagues. They seemed more understanding and perhaps more forgiving of the constraints of these women's lives and it one can see how not grasping these factors could lead to misinterpretation and incorrect assumptions being made about this client group.

Some of the participants recognised that their own personal values influenced their professional practice:

"I've not lived their lives so I can't (pause) I don't know if I would be the same if I was in their shoes … it's easy for me to sit here and say "what are you doing that for" you just don't know (pause) you never know what's round the corner (pause) you just don't know… you can't be judgemental (pause) because you don't know what's walking through the door (pause) and I think part of your upbringing as well (pause) I think (pause) if you're brought up with a family that isn't like that and … you get taught (pause) well you can't judge people (pause) or you know (pause) yeah (pause) you maybe think it's wrong (pause) but you can't hold it against anybody. So I think that's important (pause) em (pause) and that's how I was brought up (pause) so that's had an impact as well" Karen

For Karen, it seemed that she was reflecting on her own settled childhood and the extent to which she felt this had helped shape her personality and her outlook on life. She sounds compassionate, as if she is considering what she could have become if her parents had a different set of values and behaviours. She also seems to acknowledge that life can change suddenly and unexpectedly and that perhaps in light of that, one should not be judgemental as no one can predict their reactions to negative life events and that people should be accepted for who they are, not what they have done.

Equality and diversity study days were offered within the participants' places of work, yet these were seen as *"a management role"* (Sandra) and were therefore perceived as being unavailable for the majority of staff. Furthermore, none of the participants could recall the topics of substance misuse or interpersonal trauma being covered within their pre-registration education programmes. It seemed to have surfaced within their clinical practice, yet they felt untrained and unprepared to deal with the realities of this within the lives of the women they supported. Learning appeared to have been something they undertook due to their own interest in these subjects, rather than being viewed as a priority. It seemed that other issues were deemed more pertinent and pressing within the maternity services:

"there's something missing we skirt round the issues because we don't have enough empathy we don't know enough em so we think well we're we're all up in this sepsis 6 thing everybody study days every other week there are posters everywhere. Not a poster about sub misuse there's not a there's nothing do you know?" Sandra

Sandra highlights that within the maternity services, a greater, perhaps even over emphasis is placed upon subjects considered to be urgent and life threatening in nature. There emerges a gap within the education and training within the participants' places of work, where it seems that physical health and wellbeing are a priority and are concentrated on at the expense of more sensitive issues. It's as if the participants were almost surrounded by reminders of these more important clinical issues, but little attention was paid to anything else.

The participants appeared to be crying out for formal training and guidance rather than being left to learn to deal with wider issues through clinical experience:

"Yeah (pause) you've got a phone number but you're not trained to (pause) and again (pause) I think that comes with experience. If you're doing that (pause) every few months or whatever (pause) it's like everything else (pause) the more you do it (pause) the more experience you get but (pause) no the training isn't very great. Yeah (pause) there's substance misuse days and we have a substance misuse midwife (pause) who goes to meetings and says this is what they are calling this now (pause) but that doesn't help us deliver care (pause) it tells us (pause) what's going on with drugs (pause) but it doesn't help us deliver care. We're never (pause) ever taught any counselling (pause) or anything (pause) so I would say it's a bit rubbish"
Karen

Karen appears to echo Sandra and it's as if she has felt that she has been left to get on with the job and learn as she goes, rather than have formal education, training and support in order to practice effectively and appropriately. She too seems to suggest that there was an overall avoidance in addressing how to support PWMS, but that this is only touched upon, rather than being done any justice. This in turn appears to impact her own and her colleagues professional practice which means they cannot provide holistic care. It seemed that what was in place for midwives was felt to be helpful but ineffective in practical terms and Karen reflected the participants struggle to manage, particularly with issues around mental wellbeing.

Samantha also seemed to feel frustrated at not being able to understand, perhaps even have any sense of control over the difficult situations that arose at work due to a lack of understanding of the full needs of PWMS:

"More behavioural-based. Sometimes I think we have people who think if you were in the psychi(atric) ward you wouldn't get away with half of that (pause) you wouldn't get away with a tenth of that cos they know what to do with challenging behaviour right?" Samantha

In summary, the participants appeared to make sense of the ways in which they felt the maternity services did not meet the needs of PWMS. The participants appeared to feel a lack of support and feelings of conflict between different areas of practice emerged. The PWMS they could remember appeared to be the most chaotic and yet the service provision for these apparently distressed women also appeared to be chaotic. Formal education and guidance for the participants appeared to be missing and they seemed frustrated and disappointed with this as it resulted in a lack of expertise in managing difficult situations within the workplace.

4.2.3.2 Something's missing

"it seems to be whatever the consultant decides" (Karen):

In talking about the type of care that they thought PWMS should be receiving, it seemed as if the participants were in fact beginning to identify a lot of what they perceived to be wrong or currently absent. PWMS were described as being immediately considered *"high risk"* (Katie) by health care professionals due to their use of substances, which appeared to result in their care and management being directed by an obstetric consultant:

"it would depend what plan the consultant makes (pause) what appointments they make. They generally get scans (pause) growth scans em (pause) either 28 or 32 (pause) depends on what consultant. Em they might get Doppler's to make sure em the blood flow to the babies fine (pause) but whatever the consultant says" Karen

It's as if the direction of the physical and emotional care and support of this client group lay in the hands of medical staff, which midwives did not expect to be involved with. It seems that in light of this, most of the participants did not have a real sense of involvement or responsibility towards PWMS. It seems that the participants then took a back seat and went along with the consultant's plan. This emerged amongst the majority of participants regardless of being based within the community or hospital setting.

Added to this, it appeared that no clear care pathway exists for this client group. The participants spoke about the existence of these for women with diabetes mellitus, epilepsy and other conditions that were also considered high risk:

"they come into that kind of category (high risk). What I would say is that there doesn't there doesn't seem to a set sort of guideline (pause) it it seems to be whatever the consultant decides" Sandra

Sandra seems to be suggesting that perhaps PWMS are not really high risk and that whatever care and support this client group is offered is somewhat ad-hoc and at the whim of the consultant the woman was assigned. She seems to identify an ongoing struggle to provide consistent, quality care, whereupon no-one is clear what, why and where packages of care are taking place. This was common amongst the participants as they spoke about needing "*pointers"* (Sandra) and *"dos and don'ts"* (Holly). As such, it could be that they are highlighting a disparity in care.

It seemed that midwives did however feel involved with, and responsible for, the wider social context of the woman, as child protection was part of their role. However, a lack of clarity with what they were supposed to do emerged:

"If we see it if it's written down in black and white we tend to think this this is good we like a plan we all like a plan … I think I find that you get bits bits of paper still coming out from from midwives and some people don't do that and sometimes it's on the computer so then does everything get printed off? So I think up to date information with a system that's accessed by the the different people that need to be involved in this woman's care would be perfect but I don't I don't think it is perfect and that's why there's all the stress" Sandra

Sandra reveals however that this too was conducted somewhat haphazardly and was felt to be confusing at times. There emerged a sense of frustration and anxiety regarding what appeared to be a level of inconsistency and disorganisation within the systems they worked. This seems to be made all the worse by a lack of clear guidelines and procedures which appears confusing for the participants, seeming to add to their feelings of stress.

The participants also appeared to find interdisciplinary working a challenge:

"the thing I think that I find really difficult is em child protection orders (pause) so they must stay for 72 hours and eh so you phone up social work and say this is what's happening and they give you another date and another three days later onto that because they know the child is in a place of safety and there's that definite like there's nobody (pause) no woman wants to stay there that long (pause) so there gets to be them stringing them whatever" Samantha

There was a sense of them floundering, of trying to negotiate within systems and organisations who they felt did not fully understand or appreciate their role. There seemed to be further confusion around what happened to the women after delivery regarding child protection issues and the participants seem to feel caught in the middle of plans and procedures that they perceived to be dishonest and do not have the PWMS best intentions at the centre.

They appeared weary and exasperated when recalling examples of this within their practice:

"I don't know if it's the system of em the communication between social work and midwifery which which on paper is supposed to be robust and it's supposed to be that if this happens you just do this this and this but in reality I don't think that that actually happens because I've been on the phone to social work and "she needs to get this and she needs to get that" and they go "oh well that person not here" and "do you really need to get it done today?" and they must be used to that but we're (pause) this is something that's not happening every day for us and we're getting ourselves all stressed (pause) thinking I need to get this right cos if I get it wrong there's going to be huge consequences so again your stress levels go up again" Sandra

It seemed Sandra was suggesting that the systems that are currently in place are weak and that an overall lack of experience and knowledge affects her practice and her ability to do what she is supposed to do. The paperwork regarding child protection appears to create as much a sense of fear and panic as the actual decision making process amongst some of the participants, due to a lack of clear communication. Most of all, the participants huge sense of responsibility for this area of practice emerged. They seemed to feel vulnerable and immensely fearful of the level of accountability they hold.

Not only did the participants seem to find communicating with other health and social care professionals challenging, communicating effectively with PWMS appeared difficult for most of the participants:

"I think the difficulty is em if somebody walked out in front of a car ten times a day and got hit by the car you'd say to them "you keep you're sore because you keep walking out in front of a car" (pause) but nobody ever says that to someone who's got drug use" Samantha

Sandra highlights the participants' concerns over whether or not they could be, or should be, forthright when talking to women about their substance use. She captures the overall awkwardness and discomfort amongst the participants, who is some ways doubted their responsibility, skills and abilities to do this adequately. It seemed that the lack of honesty they felt within their relationships with PWMS was at the heart of their distress.

In summary, the participants seemed to be able to identify what was wrong or missing regarding the care they provided PWMS. Consultants emerged as being the health care professional to direct and make all the decisions regarding this high risk group of women and the participants appeared to have little sense of involvement or ownership or this client group's care. Care planning appeared haphazard and unclear. Child protection work was found to be challenging and the participants seemed to be caught within systems that were confusing and unclear. The participants appeared exasperated and frustrated and felt a lack of honesty when supporting PWMS.

4.2.3.3 Relationships

"that's their soul food, their main drink" (Samantha):

The participants' relationships appeared to be viewed as very different from the women's specialist workers and a gulf between the participants and PWMS emerged:

"I mean maybe do you know what? maybe that's where I learned a wee bit because they'll (drugs worker) say "come on what is it?" you hear them talking to them "what did you take? have you taken something?" and they'll say yes they have so we know it and they know and they know and eventually they'll say "well I had blah blah blah" … and maybe that's what's missing" Sandra

Sandra appears to recognise the value of multidisciplinary working and the skills and knowledge transfer that occurs within clinical practice. She seemed almost envious of the level of openness and honesty that others workers had with PWMS and tried to emulate this herself in order to have more effective conversations.

Nonetheless, the participants appeared to perceive that women wanted to talk about their secret selves, *"that elephant in the room"* (Sandra), but that this would only be divulged to someone they trusted:

"But that takes a lot for them to tell us that and you need to start it by saying by acknowledging it and I think sometimes we don't even mention it they know that we know and we know that they know (both laugh) but it's almost like How are you? How are you getting on? and I don't want to talk about it so I'll let you go" Sandra

It seems that Sandra wants to be able to have more than superficial interactions with PWMS that avoid what is really happening in their lives and side-step the real issues faced by them. It sounds as if some of her encounters with the client group have felt somewhat ridiculous, meaningless and laden with barriers to insightful encounters.

The participant's uncertainty regarding the standard of care that they provided for PWMS seemed to dominate their accounts and the role of specialist workers was raised by all of them:

"we must get it right sometimes … I think we've got (pause) there's something missing (pause) we have a cleft lip and palate midwife but how many times do we see that?" Sandra

Sandra appears to highlight another disparity in care, perhaps even an inequality in service provision for PWMS. As with the education and training regarding supporting PWMS, she seems highlights another area where she feels this group are not currently seen as much of a priority as other groups within the maternity services.

Specialist midwives appeared to be considered professional, experienced and knowledgeable practitioners who inspired confidence in the women they supported:

"if there was maybe certain midwives that they could go to em who are like (pause) the smoking cessation midwives. They have them for them (pause) so it could maybe be a thing that em cos again once you're doing it day in day out you know (pause) I think it helps. Cos if you're stuttering your way through something (pause) they're going to think "she doesn't know what she's doing". But yeah (pause) experience definitely helps (pause) it could be better (pause) definitely" Karen

It seems that Karen's perception of specialist workers is in contrast to how she feels about her own clinical expertise, due to a lack of experience and education. Her

concern about how this led her to be perceived by women she was supposed to be instilling confidence in was revealed. It seemed that the participants felt that specialist midwives were more able to provide compassionate care to PWMS and whose practice was in direct contrast to their own.

Seeing past the substance use appeared to be, at times, an unsurmountable obstacle for some of the participants, whereas they appeared to feel that specialist midwives would have a more solid, honest relationship with PWMS:

"What they need is dedicated midwives who know them who can I wouldn't say they've got a trust relationship with them who knows? … but kind of like an armed neutrality they believe they believe each other whereas what happens is this one person who is loud and shouting and balling and pulling out their drips and whatever (pause) they're not they're not cared for they get lots of attention but it's not necessarily positive attention" Samantha

A lack of trust was highlighted and it seems that some of the participants could not foresee PWMS doing the right thing. They were therefore regarded with suspicion. PWMS were described as specialist midwives *"soul food"* (Samantha) highlighting the participant's perception that they had an inherent interest and passion in working with this client group that perhaps most of the participants did not.

Nonetheless, the participants did seem to want to do their best and were particularly concerned for the mothers who had had their babies removed into foster care. They appeared compassionate and mindful of remembering *"they're women (pause) and they're mothers"* (Holly) who *"want the best for their babies"* (Jen) but their addiction *"takes over"* (Jen):

"I feel that very often some of the mums are just left dangling because (pause) the babies are born and they are taken into foster care (pause) then they're separated but they might have visiting rights (pause) couple of times a week … she's not picked up by the health visitor (pause) and nobody kind of cares for her (pause) so she's just kind of I mean she'll still have other workers you know … but she doesn't have maybe the emotional support like the health visitors (pause) would give how are you feeling your mental state filling out the PND (postnatal depression) scale further down the line. So who cares for her then? Nobody (pause) and this poor mum is in the wilderness I often feel" Holly

It seems Holly wants to be able to address more than the physical needs of these mothers and is acutely aware of the enormity of what it would feel like to have a baby taken away. She seemed to feel that as well as losing their babies, they lost the after care, support and nurturing that other mothers are given as well as their identities as mothers and were set adrift with little support at a particularly vulnerable time in their lives.

In summary, the relationships that the participants formed with PWMS appeared very different from those that PWMS had with specialist workers. Specialist workers were identified as being more open, honest and clear about their roles. There appeared to be a disparity in the level of specialist midwifery support for PWMS when compared to other groups. The participants identified the unique role of specialist midwives, who they felt were more able to provide appropriate care. The participants' concerns with the after care of new mothers emerged. They appeared to feel these mothers were not adequately supported at a very vulnerable time in their lives.

4.3 Conclusion and synthesis of study findings

Analysis of the life history calendars revealed that all of the pregnant participants had experienced a series of complex, interconnected, significant and negative life events. The LHC were found to visually represent the participants' narratives of their lived experiences. As presented in Chapter 4, the participants experiences of trauma were found to be begin in infancy and persist throughout their childhoods, their teenage years and on into adulthood. The context of abuse and substance use within the lives of the participants was revealed. The thread that ran through all of the participants' lives was the repeated, ongoing and insidious nature of the adversities they all experienced throughout their lives and a series of similarities were identified within their chronological timelines. These were converted into key life event lines and include 1) early initiation and use of substances following childhood trauma 2) the impact of being in coercive, sexual relationships with older, substance using male partners during teenage years 3) living in hostile, unstable environments 4) the positive impact of prison and 5) the loss of children into the care system.

All of the participants' had a unique story to tell. The pregnant participants' life stories illuminated their shared and contrasting experiences of life time experiences of trauma, substance use and misuse as well as their experiences of pregnancy and motherhood. The pregnant participants were able to use the interview to reflect and convey meaning to some of the experiences that they had indicated and talked about during completion of their life history calendar. All of the participants could identify specific time points in their lives when they felt their use of substances had been in direct correlation to their experiences of trauma. Their perceptions of the mechanisms underlying their use of substances was therefore captured.

The midwife participants were able to use the interview to reflect and convey meaning to their clinical experiences and their perceptions of supporting PWMS. Their accounts shed light on their shared experiences of supporting group of women that were mostly found to be associated with chaos and difficulty.

4.3.1 Trauma histories

The first main theme within the analysis of the pregnant participants' data, **"Psychological trauma"**, captures the long term implications of the vast array of significant and traumatic experiences that all of the participants had endured throughout their lives. In the sub-theme **"Childhood trauma"**, the deep significance and ongoing effects of interpersonal trauma in childhood emerged for all the participants. The majority of participants grew up with substance addicted parents and had very clear memories of how their parent's addictions overshadowed their day to day family lives. The extent to which substances and drug related activities took place and were normalised and absorbed into the participants' lives, as children, emerged.

All of the participants reported histories of persistent emotional abuse and neglect during their childhoods. Some experienced physical abuse. Most witnessed violence between their parents and some were regularly involved in trying to split their parents up from physical fights. The dichotomy of living with substance addicted parents was revealed amongst the pregnant participants. Most of the participants appeared to have a strong bond with one significant adult during their childhoods and

remembered feeling very defensive and protective of their parents. In contrast to the rest of the participants, however, Tina had no recollection of the trauma she experienced as a child. She reported that her memories came flooding back in the form following experiencing domestic violence aged seventeen. Since this time, she continues to endure intrusive re-experiencing of the traumatic events and feelings she experienced as a very young child. Rebecca and Tina were removed from the care of their parents on a permanent basis, but this did not guarantee nurturing, meaningful relationships with significant adults. None of the participants disclosed histories or sexual abuse in childhood.

During the pregnant participants' teenage years, the lack of nurturing, interested adults continued and is revealed in the sub-theme **"Ongoing trauma".** The majority of participants became intimately involved with men who were significantly older than they were when they were teenagers. They appeared to readily trust these men, seeming to feel rescued and cared for. These men also used/misused substances or had substance use disorders and introduced the participants to class A drugs. All of these relationships became controlling and abusive. Jenny was the only participant to indicate that she now questioned the motives of the older men she was involved with from the age of fourteen. She now wondered if she had been groomed by a sexual predator, aged sixteen. Most of the participants went on to endure severe domestic violence, often with a series of partners, throughout their adult lives. Liz, however, diverged from the rest of the participants as she denied a long history of domestic violence. Nonetheless, she had endured a relatively recent, severe attack by her current partner. The participants were found to have often lived in unsuitable and unstable accommodation with their young children. None of the participants disclosed experiences of sexual abuse during their adulthood.

Early experiences of trauma amongst PWMS were considered by the midwife participants and emerged within the first major theme, also entitled **"Psychological trauma"**. Within the sub-theme **"Trauma histories and disclosure",** the extent to which they suspected and almost expected trauma histories within the lives of this client group is revealed. They were also shown to perceive the negative implications of growing up with substance addicted parents. They appeared acutely aware of the powerful influence that becoming intimately involved with abusive, controlling men

could have on young women. It seemed that their perceptions were based upon their years of clinical experience, which had led them to be sensitive to the possibilities of PWMS experiencing a series of complicated, inter-connected life events. They appeared empathetic to the significance of trauma within the lives of all pregnant women. The participants appeared to place great value on the potential impact of the intimate nature of the routine aspects of their practice. Samantha appeared particularly sensitive regarding the potential to trigger women's memories of childhood abuse, particularly sexual abuse.

All of the midwife participants appeared to place priority on asking the women they support about their trauma histories and prioritised asking women about their trauma histories when they felt it was appropriate to do so. There appeared an emphasis on asking women about experiences of domestic violence, rather than their lifetime experiences of trauma. Some of their midwifery and medical colleagues however, did not emerge as being interested in women's trauma histories nor encouraging women to disclose trauma. This reticence appeared to be particularly so for childhood sexual abuse.

Additionally, the midwife participants all appeared to have experienced a level of vicarious trauma from events, situations and circumstances they had encountered in their clinical practice. They were all able to recount in great detail, particular memories about particular women that they had met during their clinical practice. Most were found to still feel worried, often many years later, about what had happened to these women and their babies. It seemed that they had not been given the time or opportunity to discuss these events and their anxieties over these events and people remained and that the emotional labour involved within their day to day practice went unrecognised or unacknowledged.

4.3.2 Substance use and addiction

Prior to the pregnant participants meeting older men, most had already began engaging in a series of high risk behaviours. These centred round substance use and are revealed in the second major theme "**Dabbling to addiction"**. Within this theme, the participants were found to associate with substance using peers. Substances

appeared readily available, widely available and would *"find their way"* (Jenny) to the younger members of these groups. Polysubstance use was common. The participants spoke about these times with a sense of affection, camaraderie and nostalgia. Jane however, was found to diverge from the other participants. She did not dabble or experiment with a variety of substances. Her substance misuse began after she became addicted to prescription analgesia when she was twenty one.

The majority of participants quickly became addicted to heroin after becoming intimately involved with older men. Tina became addicted to alcohol. All of their day to day lives became consumed with obtaining substances in order to avoid withdrawal. As highlighted in the sub-theme "**Substances to block out the pain"** the majority also reported using substances in order to escape the emotional and physical pain they felt. The participants appeared to live in altered states of consciousness during this time. Over time, the participants made numerous attempts to try and get themselves clean. Their varied perceptions about being clean are captured in the sub-theme "**What it means to be clean".** For Jane and Tina, getting clean was only possible during their time in prison and is captured in the sub-theme "**Positive impact of prison"**. It seemed that they could only become clean when physically removed from substances, their associates and their violent substance using/substance addicted partners.

As addiction was found to consume the lives of the pregnant participants, it also appeared to consume the midwives' perceptions of PWMS and is highlighted in "**Managing unmanageable situations"**. It seemed that they did not appear to consider that some of the behaviours they associated with PWMS may also be related or compounded by their trauma histories and not exclusively related to their addictions.

4.3.3 Pregnancy

Within the sub-theme "**Pregnancy",** the pregnant participants' feelings of surprise and joy regarding their pregnancies emerged. Most of all, however, pregnancy was found to be a time associated with guilt and regret at the impact that substance misuse/opiate substitution medication may have on their unborn babies. The participants looked forward the birth of their new-born babies, however, their pregnancies were marred

with their fear and dread of their babies withdrawing. They were determined to remain clean now that they were pregnant again.

The midwives' feelings of distress, chaos and difficulty around supporting PWMS is revealed in the major theme **"Managing unmanageable situations"**. They were found to perceive their relationships with this client group as often lacking honesty and openness. Most of the participants appeared to feel less involved with a client group who were automatically classed as *"high risk"* (Sandra). Their distress about caring for withdrawing babies emerged and the unborn and newly delivered baby emerged as being the focus of care and attention. They perceived a culture within the maternity setting that time with PWMS drained resources and energy that were already scarce. The midwife participants were found, in general, to feel poorly prepared and unsupported in their endeavours to support PWMS.

4.3.4 Motherhood

Within the sub-theme "**Motherhood"**, the identity of motherhood emerged as immensely important to the pregnant participants. They wanted to do their best for their children. Motherhood inarguably appeared to provide the participants with the impetus to change their behaviours, however, it did not, in its entirety, help the participants at the height of their addictions. It seemed that it is only now that they are clean, they could truly reflect on the implications of their actions and inactions. They were all acutely aware of the impact that their substance misuse and addiction had had on the lives of their children and wished that they could change what had happened, but reflected with great sadness that it was too late.

Additionally, participants were found to be concerned about what happened to PWMS after they were discharged from their care and were apprehensive about what happened to women whose babies had been removed from their care prior to discharge.

4.3.5 Relationships

Relationships emerged as important for both sets of participants. Within the sub-theme, **"Personal"**, the pregnant participants were found to have maintained a relationship with at least one of their parents, most often their mothers. Others had no contact with any of their childhood caregivers or birth parents. Most of the participants continued to struggle with how they were treated as children. Most of the participants were in intimate relationships at the time of participation. Some of their current partners where substance users and others were not.

As presented in the sub-theme **"Professional relationships"**, the pregnant participant's reflected upon their experiences and perceptions of a variety of different health and social care workers. Voluntary sector workers were seen as trustworthy and valuable. Their perceptions of social workers had changed over time, but they still expected to be judged on their past addictions by them. All of the participants emerged as having positive experiences and perceptions of the maternity services and maternity care workers, particularly midwives. They could reflect on the support they had received from their specialist midwives, often having been supported by the same midwife with previous pregnancies. The participants all spoke about these relationships with great affection. Specialist midwives emerged as being seen as reliable, trustworthy allies.

Specialist midwives were also discussed by the midwifery participants in the sub-theme **"Relationships"**. A disparity in the level of care and support that specialist midwives were able to offer PWMS compared to what they felt they were able to offer was revealed. The participants concern with the after care of new mothers emerged. They appeared to feel these mothers were not adequately supported at a very vulnerable time in their lives.

The pregnant participants' deep feelings of shame and embarrassment were revealed in the sub-theme **"Stigma"**. They used highly negative language when talking about themselves, describing themselves as *"dirty junkies"* (Rebecca) and *"useless scum"* (Liz). They perceived themselves to be considered negatively within society. Liz in particular appeared to feel that society perceived all substances users in this way.

They did not however, perceive themselves to have been stigmatized by health care professionals. In sharp contrast to their perceptions, however, were the findings presented in the main theme **"Stigma"** from the midwifery participants. They revealed a shocking, pervasive level of judgement and stigma towards PWMS within the maternity setting. This emerged amongst their midwifery colleagues, but particularly amongst medical staff. Sandra in particular argued that the level of stigma towards PWMS would not be tolerated with other marginalised groups, yet it remained unclear why this was so pervasive in their areas of clinical practice. Their own feelings regarding this client group varied. They seemed to set themselves apart from negative, judgemental attitudes within clinical practice. Whilst they appeared to feel that with time, they no longer judged women for using substances, it emerged that some of the participants did judge the women on behaviours that they associated with substance misuse.

Chapter 5 – Discussion

5.1 Introduction

In this chapter, the key findings of the study will be discussed in relation to the wider literature. Firstly, a brief reminder of the background to the study and the study aims are presented in order to contextualise the findings. The main research findings are then presented. This is followed by a discussion of how these findings contribute to and extend the current literature. The limitations and strengths of the study are then considered, before discussing the implications of these findings for policy, practice and future research. Finally, the conclusions which can be drawn from the findings are presented.

5.2 Background to the study

Experiences of interpersonal trauma (IPT) are commonplace and remain embedded within global culture and economics, particularly amongst women and children (WHO, 2016). IPT may impact on many aspects of a survivors' life including their relationships, feelings, identity, thoughts and behaviours and adversely affect many systems, functions and responses within the body (Felitti, 2002, Van Der Kolk, 2014). Survivors of IPT may experience post-traumatic stress disorder (PTSD) with resultant re-experiencing of intense fear and extreme psychological arousal long after their trauma occurred (Van Der Kolk, 2014). Multiple or repeated experiences of IPT may lead to complex trauma (Mooren and Stofsel, 2015), whereupon survivors experience a gamut of reactions and symptoms which develop beyond PTSD symptomatology (Courtois, 2004). Furthermore, there is a strong body of evidence supporting associations between IPT and substance use (Afifi et al. 2012, Ahmad et al. 2013, Asberg et al. 2012, Brems et al. 2004, Dube et al. 2003, Freeman et al. 2002, Garland et al. 2013, Green et al. 2012, Medrano et al. 1999, Mullen et al. 1999, Ompad et al. 2005, Shand et al. 2011, Ullman et al. 2013, Wu et al. 2010).

Within Scotland, almost a third of individuals requiring assistance for drug use from 2010-2011 were female and most were of childbearing age (NHS, 2012). Neonatal

and obstetric outcomes are poorer amongst women with problematic substance use (Day and George, 2005, Narkowicz et al. 2013, Pinto et al. 2010, Scottish Executive, 2006, Wright et al. 2007). Moreover, substance misuse is associated with a significant number of maternal deaths in the UK (MBRACE-UK, 2015).

Studies which explore the mechanisms underpinning the relationship between life time experiences of trauma and substance misuse amongst pregnant women are scarce. Few studies have explored life time experiences of trauma and substance misuse (Kvigne et al. 1998, Martin et al. 1996, Martin et al. 2003, Salomon et al. 2002, Tuten et al. 2003) or the relationship between IPT in adulthood and substance misuse (Connelly et al. 2013, Curry, 1998 and Eaton et al. 2011) and the existing literature tends to concentrate on the relationship between childhood trauma and substance misuse (Brems et al. 2002, Haller and Miles, 2003, Horrigan et al. 2000, El Marroun et al. 2008, Fogel et al. 2001, Frankenberger et al. 2015, Nelson et al. 2010). Furthermore, no studies have collected trauma histories in a clear, chronological way and this area of research is dominated by quantitative enquiry. These studies provide valuable insights into the incidence and prevalence of trauma and substance misuse, but do not capture the complexities and nuances of the participant's lives or give depth or meaning to their life stories. This is important in order to give voice to an under-researched group of vulnerable women, which in turn, may lead to better understanding of their lived experiences and the challenges they face. This information can also inform interventions or a means to aid recovery. Additionally, no studies have taken place within the UK.

Although many midwives support PWMS as part of their practice, there is limited evidence regarding their experiences and perceptions of supporting PWMS. Studies to date have mostly explored maternity care workers attitudes towards this client group (Raeside, 2003, Radcliffe, 2011), or the lived experience of specialist substance misuse midwives (Miles et al. 2012). One study has explored UK based midwives attitudes towards this client group (Jenkins, 2013). This study has provided valuable insights into midwives attitudes, but does not fully explore or explain their experiences and perceptions as quantitative methodology was employed. This is important in order to gain a fuller understanding of their lived experiences and the challenges they face in clinical practice. This information may also inform pre and post registration

education of midwives and other health and social care workers, thereby enhance practice and improve outcomes for this client group. This study has therefore sought to start to address this gap in the evidence.

5.3 Aims of the study

The current study was an attempt to address the gaps in the literature and aimed to chronologically map out pregnant women's past experiences of abuse and past substance use in order to illustrate common pathways through which these occur and explore possible mechanisms underlying their use of substances. It aimed to explore the lived experience of pregnant women with problematic substance use (PWMS) use and the lived experience of midwives with experience of supporting this client group.

The findings presented in Chapter 4 emerged from the lived experience of the participants. The use of a life history calendar (LHC) captured in detail, the pregnant participant's experiences of trauma and substance use/misuse in the chronological order in which they occurred. The LHC was found to enhance the representation of the lived experience of the pregnant participants, which was then extended in the interview transcripts. Additionally, the LHC gave context to, and helped validate, the participants' narrative accounts. All interview transcripts were analysed using IPA.

5.4 Summary of main findings

The key findings from this study are presented below. These are subsequently discussed in relation to the research questions and the current literature.

- All of the pregnant participants had experienced a series of complex, interconnected life events and could identify how these related to their use of substances. As presented in Chapter 4, the participants' experiences of trauma were found to begin in infancy and persist throughout their childhoods, their teenage years and into adulthood. The high significance and ongoing effects of interpersonal trauma emerged for all the participants. All of the participants could identify specific time points in their lives when they felt their use of substances had been in direct correlation to their experiences of trauma. The

chronological order of trauma and substance use/misuse was therefore highlighted and the extent to which their experiences of IPT influenced their use of substances. The midwife participants were found to suspect and almost expect trauma histories within the lives of this client group. They appeared empathetic to the significance of trauma within the lives of all pregnant women and appeared to place great value on the potential impact of the intimate nature of the routine aspects of their practice. Additionally, they were aware that substances may be used as a way to block out painful experiences and memories.

- Four out of the five pregnant participants went on to develop sexual relationships with significantly older men when they were teenagers. They appeared to readily trust these men, seeming to feel rescued and cared for. Substances appeared to be readily available, perhaps as these men used/misused substances or had substance use disorders. These participants were subsequently introduced to class A drugs. Most of the participants, did not however, appear to question the nature of these early relationships which all became controlling and abusive. The midwife participants were found to be acutely aware of the powerful influence that becoming intimately involved with abusive, controlling men could have on young women. It seemed that their perceptions were based upon their years of clinical experience, which had led them to be intuitive and sensitive to the possibilities of PWMS experiencing a series of complicated, inter-connected life events.

- All of the midwife participants appeared to place priority on asking the women they support about their trauma histories and prioritised asking women about their trauma histories when they felt it was appropriate to do so. However, there appeared to be an emphasis on asking women about experiences of domestic violence, rather than their lifetime experiences of trauma. Within the wider context of the maternity services, however, an apparent reticence to ask about women's trauma histories was revealed, particularly for childhood sexual abuse.

- The overwhelming power of addiction in the lives of the pregnant participants was apparent. The participants were found to look forward the birth of their new-born babies, however, their pregnancies were marred with feelings of guilt, regret, fear and dread of the impact of their use of substances and prescribed opiate substitute medication. The identity of motherhood emerged as immensely important to the pregnant participants. They wanted to do their best for their children, however, whilst motherhood inarguably appeared to provide the participants with the impetus to change their behaviours, it did not, in its entirety, help the participants at the height of their addictions. It seemed that at these times their lives revolved around getting substances and they lived in a state of altered consciousness. It seemed that it was only when clean they could truly reflect on the implications of their actions and inactions.

- Custodial sentences were found to be hugely instrumental in helping two of the pregnant participants to get themselves clean. It seemed that they could only do this when physically removed from substances, their social environments and their abusive partners.

- The pregnant participants were found to have maintained and place emphasis on the relationships they had with key adults from their childhoods, most often their mothers. Additionally, they were found to hold very different perceptions about the expectations of the relationships they had, or could have, with key health and social care workers. Voluntary sector workers were seen as trustworthy and valuable, whereas social workers were regarded with caution. They perceived social workers as very powerful in terms of removing their children from their care, which appeared to be in light of previous experiences during their own childhoods and with their previous children. Over time however, they were now able to consider them as part of a team that were there to help. All of the participants emerged as having positive experiences and perceptions of the maternity services. Midwives, in particular, specialist substance misuse midwives were viewed as reliable, trustworthy allies. The midwife participants, on the other hand, revealed a disparity in the level of care and support that specialist midwives were able to offer PWMS compared to what they felt they were able to offer. The participants' concern with the after

care of new mothers emerged. They appeared to feel these mothers were not adequately supported at a very vulnerable time in their lives.

- The pregnant participants were not found to perceive themselves as having been stigmatized by health care professionals due to their substance use and addiction. In sharp contrast to this finding, the midwife participants revealed a shocking, pervasive level of judgement and stigma towards PWMS within the maternity setting. This emerged amongst their midwifery colleagues, but particularly amongst medical staff. The midwife participants seemed to set themselves apart from negative, judgemental attitudes within clinical practice. Whilst they appeared to feel that with time, they no longer judged women for using substances, it emerged that some of the participants did judge the women on behaviours that they associated with substance misuse.

5.5 Chronological order of trauma and substance use/misuse: Mechanisms underlying substance misuse

5.5.1 Disrupted childhoods

Given the current estimates regarding women's and children's experiences of childhood abuse (WHO, 2016), the finding that childhood trauma was part of parcel of the participants lived experience may not be entirely surprising. However, the level and extent of physical abuse and family violence the participants endured in childhood may be higher than previously reported amongst PWMS (Brems et al. 2002, Fogel et al. (2001). Physical abuse was previously reported by 49.5% of participants in the study by Brems et al. (2002) and experience of family violence was reported by 60% of participants in the study by Fogel et al. (2001). However, in the current study, all of the participants reported experiences of physical abuse and family violence in their childhoods. Furthermore, the majority of participants in the studies by Brems et al. (2002), El Marroun et al. (2008), Fogel et al. (2001), Frankenberger et al. (2015), Haller and Miles, (2003) and Horrigan et al. (2000) disclosed histories of childhood sexual abuse, but none of the participants in the current study disclosed this. This may be somewhat surprising, given the estimates regarding exposure to sexual abuse in childhood (WHO, 2016). However, given the trajectories of the participants' lives, this

study provides important insight into the long term impact of non-sexual childhood abuse.

Importantly, the pregnant participants were found to have maintained and place emphasis on the relationships they had with key adults from their childhoods, suggesting attachments with a significant adult during this time. For some, this was one of their parents, for others, with the responsible adult who took over their care when they were removed from their childhood homes, suggesting that in spite of the multiple types of abuse they endured, some of their needs regarding safety and security were met as children (Benoit, 2004). Of the three participants who remained with their parents, attachment with their mothers endured. This appears to be in contrast to the findings of Sternberg et al. (2005) who found that adolescents who had experienced childhood abuse, particularly physical abuse, perceived weaker attachment to their parents, particularly their mothers. However, the population in the current study were older than the participants in the study by Steinberg et al. (2015), therefore their perceptions of their emotional connection to their mothers may be influenced by how they feel about them now, as opposed to how they felt about them during adolescence. Furthermore, although this study captured some of the participants' childhood experiences and their perceptions of these, it was beyond its reach to assess what type of attachment was developed between the participants and significant adults within their lives.

5.5.2 Substance addicted parents

The finding that the pregnant participants grew up with substance addicted parents is significant. Their family lives were found to centre round the substance using parent or parents and chaos and uncertainty pervaded their childhoods at times. Kroll, (2004) found that growing up with substance addicted parents left children feeling "invisible". Participants in the current study appeared to have had times throughout their childhoods when they felt bewilderment, embarrassment, fear and shame regarding their parents' actions. The findings therefore echo many of the findings of an earlier Scottish based study of children by Bancroft et al. (2004). The participants in the current study however, differ somewhat as they appear to have felt particularly isolated, with little or no help or support from close or extended family members or

external agencies and it appears that they experienced a series of failures on the part of many adults within their lives. Jenny remembers social workers visiting her house on one occasion during her childhood, but there appeared to be no follow up after this home visit. Liz remembers having head lice and regularly turning up for school dishevelled and dirty, yet no-one seemed to comment or actively do anything to help her. Tina's gran used to be alerted for help by her brother but apart from removing them from the house during fights, did not appear to intervene at other times. Finally, all of the participants gave up personal interests and pursuits and left school early, all of which appeared to occur without question from adults in their lives. It is however, difficult to attribute the participant's experiences of childhood trauma solely to their parent's addictions, as although some were aware of their parent's apparent absorption with their addictions, others were also aware of their parents struggle with mental ill-health It is likely therefore, that the abuse they experienced was due to a number of complex and interconnected factors such as substance use, mental ill-health, poor parenting skills and parenting capacity and exposure to domestic violence (Cleaver et al. 2011).

Some of the participants in this study had experience of the detrimental impact of substance use on their unborn children (Day et al. 2005, Narkowicz et al. 2013, Pinto et al. 2010, Scottish Executive, 2006, Wright et al. 2007). The direct consequences of substance misuse are perhaps easier to report however, a number of methodological difficulties exist in the current literature when determining the direct consequence of parental substance use and addiction on children (Mayes and Truman, 2002). As such the findings of the current study support some of the findings of Semanchin and Logan-Greene, (2016), who found that parental substance misuse existed amongst a series of multiple adversities which led to chaos and disrupted living environments.

The midwifery participants appeared to perceive substance use often resulted from growing up with substance addicted parents and substance using peers. As such, their perceptions appear to relate to aspects of social learning theory, such as reinforcement, vicarious learning and environmental events and influences (Maisto, Carey and Bradizza, 1999). However, they were also aware of the possible impact of peer pressure (Skull et al. 2010) and substance use as avoidant coping (Dube et al.

2003), however, it seems that these ideas were based upon their clinical experience rather than any education or training they had received.

5.5.3 The influence of older men

During the participants' teenage years, there seemed to be a complete absence of adults that the participants could depend upon and trust. At this time, most of the participants appeared to be readily engaging in a series of high risk behaviours previously associated with victimisation, such as drug and alcohol abuse and peer influence (Buist, 2010, Gover, 2004, Osgood et al. 2013, Scaramella et al. 2002). These activities appeared to go unnoticed by a variety of adults within the participant's lives, highlighting a further failing within many systems for these vulnerable young women and what could be viewed as missed opportunities to intervene and provide additional support. It seemed that these behaviours and activities increased their vulnerabilities during this time, which perhaps contributed to the striking finding that the majority met and formed sexual relationships with older, controlling, substance using/substance addicted men when they were teenagers. This is an important finding and was found amongst the participants recruited from the two NHS Boards where recruitment took place, which both cover large geographical areas.

Already bereft of attention and nurturing at home, these vulnerable young women appeared to feel rescued from what was happening at home. It seemed as if these men were able to hone in on their existing vulnerabilities and further exploit them. Of significance, was the finding that one of the participants now wondered if one of her early sexual partners was a paedophile. Amongst the rest of the participants however, there was no suggestion that they felt these early relationships were exploitative. Some of the participants may however, not have recognised that the experiences they endured at this young age where abusive (Bradbury-Jones et al. 2014). It was however, beyond the scope of this study to explore this and is an area that requires further research.

The participants were all subsequently introduced to and encouraged to take Class A drugs by these men. Whilst their peers had clearly influenced their earlier experimentation with substances, which for the most part they reflected on with a

sense of nostalgia, it seems that their older partners were equally instrumental in their use of class A drugs to which they subsequently became addicted. The findings of this study may support existing research as drug use (Gogineni et al. 2001) and women's want and readiness for substance use treatment and recovery has been found to be directly affected by whether or not their partners are using drugs or are in drug treatment (Messer et al. 1996, Riehman et al. 2000, Simmons, 2006). However, the participants in the current study were significantly younger and were therefore perhaps at a different life stage than the participants in the extant literature.

All of the participants experienced severe domestic violence. For the majority of participants, this was frequent, ongoing, unrelenting and took a variety of forms. This included emotional and physical abuse, coercive control and being made to watch acts of violence and aggression against others. The participants were unable to see any means of escape from their lives, feeling downtrodden, helpless and worthless, even in the face of losing their children into the care system, which may have been compounded by their substance use (Baker et al. 1999, Chandler et al. 2013, McLelland et al. 2008, Mosedale et al. 2009, Reid et al. 2008, Richter, 2000, Whittaker et al. 2016).

One of the participants was found to experience PTSD symptomatology or complex trauma. It was beyond the scope of the current study to assess participants for these conditions, however, given the ongoing, pervasive trauma all of the participants experienced at the hands of trusted adults, particularly during their formative years (Mooren and Stofsel, 2015), it may be that at least one of the participants would fit the diagnostic criteria for these conditions. This finding is important for clinicians in order to raise their awareness of the potential for survivors of trauma to experience PTSD symptomatology or complex trauma, how this may impact upon the survivor and how they may present in clinical practice (Courtois, 2004, Van Der Kolk, 2014).

5.5.4 Disclosure of trauma

It is important to note that the pregnant participants went above and beyond what they were initially asked to do during completion of their life history calendars. They all provided rich, deep descriptions of their lived experiences, particularly during the

completion of their life history calendars, rather than indicating that these had occurred. Only one of the participants had tried to disclose the abuse she was experiencing during her childhood, however, no-one appeared to notice at this time. All of the participants had had the opportunity to disclose their trauma histories with their specialist substance misuse midwives and had done so, prior to participation. However, some advised me that as part of this study, they had made new disclosures or gave additional detail than they had previously, suggesting that they found this opportunity valuable.

A number of barriers to disclosure of trauma have been identified in the literature. These include lack of time and preparedness of practitioners to ask (Bachuss et al. 2003, Feder et al. 2006, Hamberger et al. 1998, Hayden et al. 1997, Rodriguez et al. 2001, Simmons et al. 2011). Given the detail and depth of data collected in the current study, it would suggest that the participants were willing and keen to talk about their trauma histories. The literature regarding how pregnant women feel about being asked about their abuse experiences is scarce, however, Stenson et al. (2001) found that the majority of pregnant women in their study found it acceptable for midwives to ask them about possible exposure to violence. Disclosure has been found to be complicated but worthwhile (Gerbert et al. 2008). Brown, (2000) found that on the whole, women felt comfortable about being asked about their trauma histories. A variety of factors have been found to help women talk about their experiences of abuse, including feeling supported and receiving a sensitive response (Hegarty and Taft, 2001, Rollans et al. 2013). A variety of other factors including age, range of abuse experience and fear of partner were also found to positively influence disclosure (Hegarty and Taft, 2001). Nonetheless, participants in a study by Gielen et al. (2000) expressed anxiety and fear about the possible negative consequences of routine screening and Hegarty and Taft, (2001) found that the main reason for not disclosing, was that women felt the problem was their own.

What appeared to help facilitate disclosure during this study was the use of the LHC. It seemed that completing the LHC as the participants and I talked, in some way helped with what they were being asked to do. There was a sense of connectedness between myself and the participants during and after completion of their LHC, that this was a shared activity, rather than questions being directed at them. Although they

were being asked direct questions about abuse, perhaps they felt more in control of this process as they could choose the order of disclosure, see the calendar being filled in, they could touch it and point out and refer back to different events and experiences at their leisure and their choosing. Perhaps it helped that we sat next to each other as opposed to sitting opposite each other, which meant there was very little direct eye contact, unless the participants turned directly towards me, which they often did. This may have felt less threatening or intimidating for them and perhaps for me too as a novice researcher.

Carver, (2016) highlighted the importance of shared activities between young, looked after people and their care givers. "Shared doing" was found to provide opportunities for young, looked after people to talk about difficult issues in a less formal setting. Sharing activities have been found to be meaningful, nurturing and enhance feelings of connectedness amongst male care givers and male patients in clinical settings (Kumpula and Ekstrand, 2013) and amongst males in therapeutic environments whilst undertaking a variety of activities together (Moylan et al. 2015, Sheinfeld et al .2011). The current study appears to suggest that "shared doing" (Carver, 2016) may also be important in the research setting in order to encourage communication and relationship building between the researcher and participant, which may be particularly valuable when exploring hard to reach groups or discussing sensitive issues. Perhaps previously reported barriers to disclosure such as fear, shame, embarrassment and concerns over what may happen to their children and their partners (Simmons et al. 2011) are less apparent in a research setting rather than during a clinical encounter. Perhaps the guarantee of time and privacy during the research process as compared to a clinical encounter also helped (Bachuss et al. 2003).

5.5.5 Asking about trauma

The midwifery participants were all found to be aware of, and have an interest in asking women about their abuse histories, which has previously been found to facilitate disclosure (Henriksen et al. 2017). Not unlike participants in a study by Jones and Bonner, (2002) they reported feeling initially anxious about asking about abuse. However, like some other health care professionals, including general practitioners (Brown, 2000, Gielen et al. 2000), they now felt comfortable about asking about trauma

histories and felt women should be asked. Intuition appeared to play a part in the participants practice around disclosure as they often waited until they felt it was appropriate to ask women about their abuse histories, rather than undertaking this at a particular time during pregnancy. In Scotland, Routine Enquiry (RE) into gender based violence should take place at all pregnant women's first midwife appointment whereby, if appropriate, they are asked about experiences of abuse in childhood and adulthood (NHS Scotland, 2017). The participants in the study however, indicated that this did not routinely take place and recent figures within the study setting area appear to support this finding as RE numbers are very low (NHS Trak, 2016-2017). Intuition was also spoken about, as the participants expressed having 'gut feelings' about women's partners, which they shared with the multi-disciplinary team in order to shape decision making. This sense of knowing more that can be explained can be difficult to explain, however, intuitive midwifery practice and its place within clinical decision making and clinical judgement has been considered in the literature for some time (Davis-Floyd and Davis, 1996, Fry, 2016, Geraghty and Lauva, 2015, Rolans, 2013).

Whilst the participants in this study did not express difficulties in asking women about domestic violence and were found to prioritize finding out if this was part of women's lived experience, it emerged that some of their midwifery colleagues remain reticent to ask women about their adverse life events, sexual abuse in particular. They perceived this as resulting from their colleagues' lack of interest, fear and an inability to deal with abuse disclosures. Previous studies suggest that midwives lack confidence and knowledge about intimate partner violence (IPV), possess attitudes and values that do not help facilitate an appropriate response to disclosure and have limited time, support or resources to respond appropriately to women (Buck, 2007, Eustace et al. 2016, Finnbogadottir and Dykes, 2012, Henriksen et al. 2017, Husso et al. 2011, Lazenbatt et al. 2015, Taylor et al. 2013, Thomas et al. 2016). Midwives own personal experiences of domestic abuse were found to affect their perceptions about asking about domestic violence by Mezey et al. (2003). Jackson and Fraser, (2009) found that the majority of midwives (56%) in their study did not feel adequately prepared to deal with disclosures of sexual abuse and a significant percentage (29%) felt they would be unable to cope with this type of disclosure, which perhaps goes some way to explain why they avoid these issues. Jackson and Fraser, (2009) also

found that midwives based within community settings appeared less anxious about disclosures of sexual abuse than their hospital based colleagues and more frustrated following women's disclosure of trauma. In another study involving midwives, Mollar et al. (2009) found that they felt overwhelmed, stressed and used unhealthy strategies in order to cope with these feelings, such as alcohol use and taking their feelings out on family members. Barriers to asking women about IPV have, however, been found to be similar amongst a number of health care professionals, practising across a range of specialities (Waalen et al. 2000).

Education, training and having access to appropriate tools have been reported to significantly increase screening and confidence in asking about trauma (Baird et al. 2013, Thomas et al. 2016). Moreover, midwives and doctors who have received education and training in advanced communication skills and common psychosocial issues, were found to be more likely to ask directly about domestic violence and sexual abuse and report feeling less overwhelmed with psychosocial issues (Gunn et al. 2006), suggesting the importance of clinical practice underpinned by formal and informal pre and post-registration education. In the current study, however, it seemed that the participant's clinical experience had led to an increase in confidence rather than the education or training they had received. Experiential learning (Eraut, 2004) is clearly valuable, however, this study highlights the importance of the perceived value of the work being undertaken, commitment and self-efficacy (Eraut, 2004), which appears to be the case for the participants, but perhaps not for some of their colleagues. The current study therefore appears to highlight ongoing issues regarding midwives asking women about their abuse histories, within contemporary midwifery practice.

5.6 The journey to motherhood for PWMS and the experiences and perceptions of midwives.

5.6.1 Addiction, pregnancy and motherhood

All of the participants considered themselves to be clean at the time they took part in this study. It seemed that is was only when they were clean and stable, they were able to reflect on their experiences of addiction. Their days were revealed to be consumed with obtaining substances. They only associated with other drug users and

appeared far removed from friends, family and society in general. Their experiences of pregnancy and motherhood were found to be marred by their addictions. The midwifery participants appeared to have some grasp of what addiction meant, however, this did not always appear to translate into their clinical practice and the unborn and new born baby appeared to be the priority of care.

Pregnancy has previously been reported as a “turning point” in their lives of this client group (Radcliffe, 2011b), a “window of opportunity” by Daley et al. (1998) and was found to be the impetus for women to get themselves clean by Hall and Teijlingen, (2006) and Jessup et al. (2005). Therefore this study adds to the previous literature. Motherhood has also previously been described as a “lifeline” for this client group (Hardesty et al. 1999). Nonetheless, although pregnancy and motherhood inarguably appeared to give the participants in the current study the impetus to change, it did not, in its entirety, appear to be enough to help most of them at the height of their addictions.

Their sense of identity around motherhood was, however, very strong and the participants spoke of their anxieties and guilt regarding what they had exposed their children to and their heartbreak at having had children removed into the care system. As such, this study adds to the literature, further highlighting women’s struggle with substance misuse and mothering (Baker et al. 1999, Chandler et al. 2013, Mosedale et al. 2009 and Reid et al. 2008). Of note, this is a previously under researched subject within a Scottish based population of substance addicted pregnant women and new mothers, therefore adds to the findings of McLelland et al. (2008), Chandler et al. (2013) and Whittaker et al. (2016). As far as the researcher is aware however, this is the first study which concentrates specifically on pregnant women.

5.6.2 The importance of prison

Spending time in prison emerged as being associated with positive change for two participants, despite this being at great cost to their family life. Prison has previously been reported as giving some substance users the opportunity to engage in some form of treatment (Stewart et al. 2004, Sacks et al. 2012, Fruedenberg et al. 2011). For the participants in the current study, it seemed that the routine and being physically

removed from substances and their social environments was the only way they could consider getting themselves clean. The current study therefore concurs with previous research (Stewart et al. 2004, Sacks et al. 2012, Fruedenberg et al. 2011), which perhaps highlights that for some, prison provides a physical and social environment where *recovery* is encouraged, rather than a physical and social environment where *substance use* is encouraged.

Intimate relationships have also been identified as one of a number of factors which positively or negatively impact substance use amongst pregnant women. El Marroun et al. (2008) found that the strongest determinant for cannabis use during pregnancy was found to be cannabis use by the babies' biological father, whilst Van der Wulp, (2015) found that intimate partners were influential on women's alcohol intake in pregnancy. Intimate relationships are also recognized as impacting recovery amongst pregnant women and new mothers (Clark et al. 2001, Schonbrun et al. 2013). Of note, of the participants in the current study who were in intimate relationships, none had substance use disorders, suggesting that this may have had a positive influence on the participant's maintenance of recovery.

5.6.3 Relationships

The pregnant participants' perceptions about the different health and social care professionals that they had encountered over the years was striking. Voluntary workers were valued and appreciated. Social workers were accepted over time but still viewed with suspicion. All of the participants initially felt ambivalent towards having social work involvement. One of the participants recounted previous negative experiences with one social worker, but this seemed to have been negated by her most recent positive experience. Nonetheless, the participants did expect to continue to be judged by social work on their past substance use. This study therefore concurs to some extent with previous research which suggests that women feel distressed, stigmatized, vulnerable, marginalized and judged by some staff as a result of their substance use (Chan and Moriarty, 2010, Chandler et al. 2013, Hardesty et al. 1999, Howell et al. 1999, Reid et al. 2008, Stadnyk et al. 2007, Walsh, 2011).

The pregnant participants however, reported good relationships with maternity care workers, which is in contrast to the findings of Morris et al. (2012) and Chan and Moriarty, (2010). Specialist substance misuse midwives were found to be particularly liked, trusted and valued and appeared to be viewed as trustworthy friends and allies. The participants appeared to value their specialist knowledge and their non-judgemental, empathetic approach towards them. These qualities have been reported by PWMS and new mothers receiving care and support from specialist clinics with multi-disciplinary workers, however, studies to date have focussed on their experiences and perceptions of multi-disciplinary clinics (Hall and Teijlingen, 2006, Hines, 2012), therefore this study adds to the literature regarding their experiences and perceptions of being supported by specialist substance misuse midwives.

A vast difference in each group's perceptions and experiences of each other was however, highlighted. Whilst the pregnant participants viewed midwives in a positive light, the midwife participants mostly associated working with this client group as frustrating, distressing and demanding. It also seemed that some of the participants could not associate this client group's behaviour with their ongoing struggle to remain stable and clean, their fear of judgement and anxieties regarding the potential consequences of their substance misuse. For the most part, they did not also appear to equate some of this client groups behaviours with being survivors of trauma (Mooren and Stofsel, 2015). This appeared to be compounded by a lack of pre and post registration education and training, support and feedback regarding supporting this client group. This appears to confirm the findings of a recent study by Whittaker et al. (2016), who found that midwives and other health care professionals expressed anxiety over their responsibility for intervening with a group they perceived to be a 'hard-to-engage' population and raised concerns over resources and a lack of support within the organisations that they worked.

5.6.4 Stigma

None of the participants reported feeling stigmatized by health care workers due to their substance misuse, which is a salient finding. As previously discussed, they viewed midwives, in particular specialist substance misuse midwives positively.

The midwife participants on the other hand, reported deeply judgemental, stigmatising attitudes within their places of work. Howard et al. (2000)a and Howard et al. (2000)b previously reported that significant minorities of health care professionals regard substance misusers as “immoral” and Carroll, (1995), Chang et al. (2013), De Vergas et al. (2008), Harling et al. (2012), Howard et al. (2000)a, Howard et al. (2000)b, Monks et al. (2013), Richmond et al. (2003) and Van Boekel et al. (2013) found that prevailing negative attitudes towards substance users exist amongst some health professionals. Some of the participants in a study by McLaughlin, (2006) were found to view illicit drug users so negatively, that they would go to the extent of rejecting further education and training in order to avoid contact with them. Maternity care workers have previously been found to make negative assumptions and judgements about PWMS (Radcliffe, 2011 and Raeside, 2003). The current study therefore appears to confirm that negative, moralistic attitudes are persistent within the maternity services and as such, adds to the current literature.

Some of the participants in the current study were found to feel manipulated by PWMS, which was previously found amongst nursing staff in a study by Ford, (2009). The midwife participants in this study, appeared to feel less judgmental towards PWMS than their colleagues and it seemed that this had come with years of clinical experience rather than education and training they had received or undertaken. Richmond et al. (2003) and Ramirez-Cacho et al. (2007) found that further education and training may help some health care staff working with this client group. Whereas Puskar et al. (2013) found that whilst attitudes amongst student nurses toward patients who use alcohol became more positive following education and training, this was less so for patients who use drugs. Education and training was also found to have a positive impact of clinicians’ attitudes by Raistrick et al. (2014), however, the findings of their study led them to conclude that effective care for substance users was best provided by specialist practitioners. Personal use of substances also positively influenced health professionals’ attitudes (Richmond et al. 2003). However, these contrast with the findings of Ford et al. (2009) and Mclaughlin et al. (2006), but it is unclear if this is due to professional or personal barriers or beliefs.

Furthermore, in this study it emerged that PWMS are immediately classed as high risk by midwives and obstetricians. Their care was therefore planned by an obstetric

consultant rather than their midwife. It seems that this in some way impacted on the midwife participants perceptions' of professional autonomy, responsibility and interactions with this client group, a finding that has previously been reported amongst Swedish midwives (Berg and Dahlberg, 2001). In addition, PWMS care planning does not appear to follow a clear consultant or midwife led care pathway or set of guidelines which perhaps contributed to participants feelings of confusion and chaos regarding this client group.

5.7 Limitations and strengths

The findings from this study provide insight into PWMS and midwives' lived experiences, however, a number of limitations must be acknowledged. This study was a small, qualitative study therefore the findings are not generalizable to all PWMS or midwives that support them. Nonetheless, pregnant women were recruited from two large NHS Health Boards and recruitment of midwifery participants took place within one large NHS Health Board within Central Scotland, all of which encompass a wide geographical and socio-economic area. Whilst this study does not aim to make generalisations, the pregnant participants' experiences of trauma, substance misuse and their lived experiences were found to be remarkably similar. Furthermore, in order to be eligible to take part in this study, the pregnant participants were required to be receiving support from a specialist substance misuse midwife. Not all pregnant women in Scotland or the UK are however, supported by specialist midwives or specialist addiction services, therefore their experiences and perceptions of the maternity services may be quite different to the participants in this study. However, the participants in the current study had received care from non-specialist practitioners during their current and past pregnancies. The midwife participants' lived experiences of supporting this client group were also very similar, even though some of the participants had a vast range of clinical experience and some had previous midwifery experiences within other parts of the UK. Additionally, specialist midwifery support of PWMS is very limited within the Health Board where midwife participants were recruited, therefore midwives who practice in areas where this expertise is widely available may have different experiences and perceptions of supporting this client group.

All of the data collected for this study was retrospective in nature and therefore the timing of events may not be accurate. However, in order to minimise the risk of recall bias, a modified version of a life history calendar was used with the pregnant participants. These have been shown to be a valid, reliable method for collecting complex, retrospective data (Axinn et al. 1999, Caspi et al. 1996, Freedman et al. 1988, Gramling et al. 2004). Nonetheless, as this was self-report data, the causal relationships between the participants' experiences of abuse and substance use/misuse cannot be established. The results therefore, are a reflection of the participant's perception of the relationship between their experiences of trauma and their use of substances.

Furthermore, whilst the life history calendar proved valuable in collecting the detail and some depth of the pregnant participant's life experiences, some of the participants did not wish to re-explore some of their life events during their interviews. This could have been resolved by combining the LHC with the interview, however, the time taken to complete the LHC did appear to provide an opportunity for the participants and I to build up a rapport. Perhaps completing the LHC and the interview in two separate sessions may also have helped, however, due to constraints of time and the problems encountered in recruitment, it might not have been possible to meet participants on a second occasion. Nonetheless, participants were encouraged to talk about the experiences that were most meaningful to them at that time and these were captured during their interview.

All of the pregnant participants were advised that any disclosures that would suggest either themselves' or their unborn baby were at risk would have to be reported to their specialist substance misuse midwives. Likewise, all of the midwife participants were advised that any disclosures of unsafe practice would be reported to a supervisor of midwives. This perhaps restricted what some of the participants disclosed in terms of their current experiences, for fear of the implications of what they revealed. Nonetheless, all the pregnant participants' revealed complex life histories, often disclosing more than they had previously within their encounters with health and social care professionals and the midwives all went into detail regarding their particular experiences and perceptions of supporting this client group.

Notwithstanding its limitations, this study provides a unique insight into the lived experience of the participants, enhances our understanding of what these experiences mean to them and can add to the existing literature of two previously under-researched groups. It provides insight into the chronological order of trauma and substance misuse and the extent to which IPT influenced the pregnant participant's initiation and use of substances. As far as I am aware, this is first qualitative study to map out PWMS experiences of trauma and substance use/misuse in clear, chronological order. Furthermore, this study sheds light on their experiences and perceptions of their journey to motherhood. It also provides a unique insight into some of the challenges and experiences faced by midwives in their clinical practice and as far as I am aware, is also the first qualitative study to explore the lived experience of UK based midwives with experience of supporting this client group.

5.8 Implications for policy and practice

The results of this study have some potentially far reaching implications for policy and practice within the health and social care settings. The complexities of women's lives, and in particular known vulnerable women's lives, need to not only be acknowledged but continually reflected upon by midwives and other health and social care workers. Health and social care professional's awareness of the extent to which trauma has occurred and may impact upon survivors health and well-being (Courtois, 2004, Felitti 2002, Ferrari et al. 2016, Fuller-Thomson et al. 2012, Janssen et al. 2004, , Kessler and Greenberg, 2002, Martin et al. 2006, Mooren and Stofsel, 2015, Spataro et al. 2004, Van Der Kolk, 2014), including during pregnancy and motherhood (Boy and Salihu, 2004, Howard et al. 2013, Lukasse et al. 2009, Silverman et al. 2006, Yampolsky et al. 2010), is crucial in order to ensure that women receive care and support that is tailored to their individual needs. This approach would reflect a trauma informed model of care, the like of which originated in mental health settings. This is an approach that recognises that people seeking support within mental health settings have histories of abuse and that the organisations in place to support them must know how trauma affects them and provide trauma specific interventions which addresses the aftermath of their experiences (Cutler et al. 2013). This could be adopted and become embedded within midwifery and other health care settings in order to foster a

more holistic approach to care. Additionally, this would take into account how routine, taken for granted practices and procedures within the health care setting may negatively impact survivors of all types of trauma (Leeners et al. 2010), including women's experience of childbearing (Andersen, 2012, Parrat, 1994, Rhodes, 1994, Smith, 1998, Zambaldi et al. 2011) and motherhood (Fujiwara et al. 2011, Seltmann and Wright, 2013, Seng, 2002).

The depth, detail and time that the pregnant participants gave in this study, particularly during completion of their LHCs, suggests that they were keen to talk about their trauma histories. For pregnant women and new mothers, opportunities to talk about trauma histories should take place as a matter of urgency. This should, by now, be embedded within all midwives clinical practice (NHS Scotland, 2017), yet it does not appear to be the case. The finding that midwives appear reluctant to ask about women's trauma histories, sexual abuse in particular, may have implications for the quality of care received by survivors of trauma. Not only could this result in midwives providing inadequate support, they may inadvertently reinforce feelings of powerlessness and trigger distressing memories of the abuse survivors have experienced. Furthermore, disclosure should not be presumed to be the sole responsibility of the midwife at the initial booking appointment. Survivors of trauma may, indeed, want to talk about what has happened to them, but this needs to be facilitated and revisited by competent, interested, compassionate and non-judgemental health and social care workers in a private, unhurried environment in order to encourage disclosure in a way that feels safe for them to do so (Hegarty and Taft, 2001, Rollans et al. 2013).

The use of the LHC proved invaluable for collecting the pregnant participant's complex trauma and substance use histories. A similar tool may also be valuable within clinical practice, however, consideration would have to be taken for those disclosing their life stories and for the clinicians hearing them. Furthermore, it would appear that a review of the current programme of asking about trauma and the education, training and support clinicians receive in order to do this (NHS Scotland, 2017) is required. This could incorporate finding out their understanding of why these questions are important to ask and their perceptions about asking the questions. The professionals who ask about trauma histories require adequate and regular education and training in order to

be able to undertake this effectively. They also need readily available and regular access to support in order to enable them to undertake this role meaningfully. Their own potential to have trauma histories must also be recognised (NHS Scotland, 2017).

A clear pathway of care appears to exist for other pregnant women with complex health needs, such as pregnant women with diabetes mellitus or epilepsy. The midwives in this study expressed feelings of confusion and chaos around supporting PWMS, which may be allayed by the development of a clear, care pathway for this client group. This may help enhance the care PWMS currently receive by providing clarity, consistency and reassurance for women and the clinicians that support them. Midwives have an integral part to play in the care and support of all women, therefore the development of a clear set of guidelines for the care and support of this client group may help clarify their roles and responsibilities to a group of women considered to have high risk pregnancies. An understanding of the powerful nature of addiction may also prove beneficial, in order that midwives and medical staff acknowledge that addiction does not end when a woman confirms her pregnancy and are therefore able to recognise the needs of the woman and her baby. Perhaps through pre and post-registration education, training and continuous professional development undertaken with specialist substance misuse services, midwives and other clinicians could realise that PWMS do value pregnancy and motherhood and have their babies interests at heart, however, when faced with the lure of substances, this may not always be clear. Debriefing, shared clinical supervision and feedback about the care and support provided, as well as significant events within the clinical setting would have clear benefits for all health and social care workers, who could in turn, work towards assessing the effectiveness of the care and support they provide.

The findings of this study therefore have wider implications for all health and social care workers. The incidence of abuse is high (Office for National Statistics, 2014, The Scottish Government, 2010/11, The Scottish Government, 2012/13, The Scottish Government, 2016, WHO, 2016) and therefore may affect a significant amount of women that access health and social care support. The care and support of survivors of abuse during childhood and adulthood should therefore be included in the pre-registration curriculum of all health and social care workers. Post-registration education should incorporate this subject, either as a means to update health care

professionals or introduce the topic to qualified staff. Nonetheless, survivors may be at different stages of recovery and not all survivors of trauma may be ready or wish to disclosure their histories, no matter the time or opportunities afforded. Therefore, what could become embedded within the practice of all health and social care workers is a trauma informed approach to everyone in their care. If all our encounters were underpinned by compassion, kindness and a sensitivity to the possibility of trauma in the lives of the people we meet, this may in turn help survivors of trauma feel safe enough and help prevent further distress by the very encounters that are meant to help them (Cutler et al. 2013).

Finally, it appears that some midwives and medical staff are not immune from having pervasive, negative attitudes as these were found to exist amongst midwives and medical staff regarding PWMS. It seems that their disparaging, unsympathetic responses to this client group are on the whole ignored and unacknowledged, yet no other levels of stigmatisation appear to be tolerated the same way. This is perhaps due to a lack of education and training regarding the trajectories of people's life and what addiction actually means, therefore this requires to be addressed. A clearer understanding of the challenges faced by PWMS (Baker et al. 1999, Chandler et al. 2013, Day et al. 2005, McLelland et al. 2008, Mosedale et al. 2009, Narkowicz et al. 2013, Pinto et al. 2010, , Reid et al. 2008, Richter, 2000, Scottish Executive, 2006, Semanchin and Logan-Greene, 2016, Whittaker et al. 2016, Wright et al. 2007) could lead to a change in the culture of negativity and stigmatization which this study suggests may permeate the maternity services.

5.9 Suggestions for future research

A number of recommendations and considerations for future research can be made from the findings of this study. First of all, this study highlights the difficulties of recruiting hard to reach groups and the necessity of building a trusting relationship with key gatekeepers, without which, recruitment of pregnant participants in this study would not have been possible. This was in part achieved by a shared interest and passion in the subject matter between myself and the specialist substance misuse

midwives. We kept in regular contact with each other and I updated them regularly via face to face meetings, phone calls and email correspondence.

The use of qualitative methodology enabled a deep, rich insight into the lived experience of both sets of participants (Smith et al. 2009), which would not have been possible with quantitative methodology (Bryman, 2012). The apparent success of the LHC in this study may have implications for future studies involving hard to reach groups/participants who have complex life stories that may be difficult to share or disclose. It is unclear if the LHC itself, the sense of doing something whilst talking (Carver, 2016) or a combination of these helped the participants to share their intimate and private life events. This could be explored in future research. Furthermore, future research using similar methods of data collection could combine data collection methods such as a LHC with the interview. This may encourage further depth and exploration of the participant's experiences as participants could be asked to talk about how they feel about these experiences at the time of disclosure rather than asking them to revisit these during their interviews.

Given the evidence of the impact of trauma on the long term health and wellbeing of survivors (Anda et al. 2006, Karr-Morse and Wiley, 2012) and the potential effect of exposure to stress on the fetus during the perinatal period (Fujiwara et al. 2011, Muzik et al. 2013, Ping et al. 2015, Seng et al. 2011), an in-depth longitudinal study with a cohort of trauma exposed women and their infants would be beneficial. This type of study could incorporate assessment of participants PTSD symptomatology or complex trauma, in order to explore the extent to which these impact women and children's day to day life's and their long term wellbeing. Furthermore, it appeared that some of the participants may not have recognised that the experiences they endured with older men in their teenage years were abusive. This is concerning and an area that warrants further research.

Finally, this study raised questions regarding the culture of midwifery. Aspects of clinical practice were found to be challenging and difficult, but it is unclear if this is limited to PWMS. Furthermore, discriminatory and judgemental attitudes were uncovered, but it unclear if these exist exclusively towards PWMS. Midwives attitudes to women they support require further exploration.

5.10 Conclusion

In this PhD thesis, I have presented the findings from LHCs and interviews with pregnant women with a history of problematic substance use and interviews with midwives with experience of supporting this client group. The findings highlight the level of lifetime experiences of trauma that existed amongst the pregnant participants. The chronological order of trauma and substance use/misuse were highlighted as well as the extent to which their experiences of IPT influenced their use of substances. The overwhelming power of addiction in the lives of the pregnant participants was highlighted as well as the extent to which this dominated their experiences of pregnancy and motherhood. Relationships with health and social care workers were found to be important to the participants, particularly those with voluntary sector workers and specialist substance misuse midwives. Midwives were found to be very aware of the potential for trauma histories within the lives of pregnant women, but a reticence amongst their colleagues to ask women about their trauma histories was highlighted. Supporting PWMS was challenging, demanding and unsupported and most often associated with difficulty and chaos. Midwives were found to feel unprepared and unsupported with most aspects of supporting this client group.

This study provides a unique insight into the lived experience of the participants and contributes to the literature in a number of areas. It provides evidence of the complex and interconnected mechanisms underlying substance use amongst a group of vulnerable women. These were found to be a series of ongoing, significant and negative life events which include childhood trauma, the influence of older, substance addicted sexual partners and domestic violence and as far as I am aware, is the first study to achieve this utilising life history methodology with PWMS. The level and extent of physical abuse and family violence the participants endured in childhood may be higher than previously reported amongst PWMS (Brems et al. 2002, Fogel et al. 2001). This study also enhances the literature regarding the impact of living with substance addicted caregivers in childhood (Bancroft et al. 2004, Kroll, 2004).

None of the participants in the study disclosed histories of CSA, therefore highlights the ongoing vulnerabilities of children who have experienced a variety of non-sexual

abusive experiences during childhood. The finding that most of the participants entered sexual relationships with men significantly older substance users/addicts adds to the literature regarding re-victimisation, which survivors may not recognise as abusive (Bradbury-Jones et al. 2014). The participants began using class A drugs soon after meeting these men, therefore this study appears to add to the literature regarding the influence of partners on women's use of substances (El Marroun et al. 2008, Van der Wulp, 2015).

Midwife participants were found to expect and suspect trauma histories amongst PWMS, yet revealed a reticence amongst their colleagues to ask about women's experiences of abuse. This appeared to be due to a lack of confidence, time and resources including education and training therefore compliments the findings of previous research (Buck, 2007, Eustace et al. 2016, Finnbogadottir and Dykes, 2012, Henriksen et al. 2017, Husso et al. 2011, Jackson and Fraser, 2009, Lazenbatt et al. 2015, Taylor et al. 2013, Thomas et al. 2016).

The pregnant participants' lives were complex and had periods of instability and hostility, therefore adds to the literature regarding women's struggle with substance misuse and mothering (Baker et al. 1999, Chandler et al. 2013, McLelland et al. 2008, Mosedale et al. 2009, Reid et al. 2008, Whittaker et al. 2016). However, as far as I am aware this is the first study which concentrates specifically on PWMS. Pregnancy and motherhood were found to provide PWMS with the impetus to change, therefore this study adds to the findings of Hall and Teijlingen, (2006), Hardesty et al. (1999), Jessup et al. (2005), Radcliffe, (2011b). Nonetheless, although pregnancy and motherhood did help, it was not, at times, enough to help the participants in this study sustain change at the height of their addictions. Spending time in prison gave two of the participants a chance to begin their recovery. Therefore this concurs with the findings of Landale and Best, (2012), Longabough et al. 2010 and McIntosh and McKeaney, (2002).

The midwives in this study were found to feel a huge sense of responsibility when supporting PWMS, this has been reported elsewhere (Berg and Dahlberf, 2001). Nonetheless, they were empathetic to their needs. Negative, pervasive and stigmatizing attitudes towards PWMS were, however, revealed amongst their

colleagues and therefore adds to the literature surrounding stigmatisation of substance users by health care professionals (Carroll 1995, Chang et al 2013, De Vergas et al 2008, Harling et al 2012, Howard et al 2000a, Howard et al 2000b, McLaughlin 2006, Monks et al 2013, Radcliffe 2011, Raeside 2003, Richmond et al 2003, Van Boekel et al 2013). With regards to midwives attitudes towards substance misusers, as far as I am aware, it is the first study to explore their experiences and perceptions of supporting PWMS using qualitative methodology.

Chapter 6 – Reflexivity

6.1 Introduction

This chapter aims to clarify my personal and professional biases and shed light on the reflections I have undertaken throughout my PhD journey. First of all, I start with an introduction about me, which is followed by my reflections on various aspects of the study. I have chosen to use Gibbs' reflective cycle (1988) in order to consider and reflect upon my experiences throughout this study.

6.2 Potential biases

In order to be transparent within this study, I would like to start this chapter by giving the reader an insight into my possible personal and professional biases within this study. On a professional level, I have worked within the NHS since 1991. I have been interested in the impact of trauma on the health and wellbeing of survivors for many years and can trace this back to a placement on an acute psychiatric ward as a student nurse. During this placement, it seemed that many of the in-patients had histories of trauma and I remember feeling very shocked by this and my interest grew from there. After this placement, I became aware that it was not just patients receiving support in psychiatric wards that had trauma histories and over time, it seemed that patients in various areas I worked within wanted to talk about their experiences or their behaviour suggested that perhaps something had happened to them that still affected them on some level.

As a midwife, supporting one woman in particular had a significant effect upon me. She disclosed her history of childhood trauma and her fears of how this may impact her labour, delivery and breastfeeding experience. This was some time before we asked women about trauma histories. I just felt so glad that she felt she could tell me what her anxieties were. We worked together in the weeks before her expected date of delivery, during which time she talked about her fears and wrote a birth plan in order that the midwives supporting her during labour knew about her history and she did not

need to keep explaining to everyone she met about her trauma history and her fears which resulted from that.

On a personal level, I spent most of my childhood in a single parent home. My mum felt a huge sense of shame about being on her own and my siblings and I were told not to talk about it outside the house and to explain my dad's absence as work related. I remember feeling relieved when my parents decided to get divorced as it would put an end to the toing and froing of my dad. Both my parents were remarried when I was a teenager and what followed were years of fractured relationships. The aftermath of a bitter separation and divorce lasted many years and the reverberations can still be felt in some of my family relationships.

I do not consider my childhood to have been traumatic. We always had food, a warm comfortable family home, routine, boundaries and love. I grew up blissfully unaware of the many challenges that my mum must have faced as a single parent and was surrounded by strong women. Alcohol and drugs were unheard of in our home, particularly for my mum who never smoked or drank alcohol.

6.3 Recruitment

Recruitment of PWMS proved a real challenge. With hindsight, I did not fully consider the difficulties that transpired when arranging to meet the pregnant participants. Even though I knew from my own clinical practice and from spending time with the specialist midwives this client group may experience difficulty with appointments and transport, I hadn't fully realised that they could not, or perhaps would not, get to the sites I had planned to see them in.

First of all, as they were all being supported by specialist midwives, their antenatal care took place within their own homes. This meant that there was no obvious place I could be visible to them prior to recruitment, for example a health centre based midwife-led antenatal clinic. I therefore had to rely solely on the specialist midwives and even though were exceptionally busy most of the time, they were always keen to help me. With hindsight, I should have offered to see women in their own homes

from the beginning. This did seem to help, but I did question if this may impact on the participant/researcher dynamic (McCosker et al 2001, Sherry 2008). My concern centred round my perception that participants may have felt reluctant to fully engage with data collection in the presence of the substance misuse midwife. However, this did not appear to be the case.

6.4 Data collection

With regards to actually collecting the data, I realised that I had not fully considered what I was asking the pregnant women to do. Not only was I asking them to divulge personal, sensitive information to a complete stranger, I was expecting them to travel to meet me and do this without any incentive.

I found myself continually reflecting on many aspects of the data collection process. This ranged from what to wear (too casual - perhaps participants would think I wasn't taking this seriously but too formal may create a barrier), how to speak (accents may reveal many things including where we are from and our social class), what language to use (choice of vocabulary in order to create a balance between understanding without being patronising) and whether or not researchers can create a completely equal, non-hierarchical relationship. I thought about what participants may want to know about me and what information should I offer about myself, if any. I was asking them about their lives and was concerned that it would be dishonest of me not to tell them about mines.

I considered the transferrable skills I have from my clinical practice. Whilst I felt confident in history taking and discussing sensitive issues with women, my experience had been in clinical settings not research settings. I am confident in my knowledge of pregnancy-related issues and I enjoy being a midwife. However, I realised that my own professional experiences and perceptions may colour my interpretation of participant's stories. This would be true for all the participants. I also realised that my own personal experiences and perceptions may colour what I thought and felt about our interactions.

I wanted all participants to feel safe and okay with the interview process. I did not lose sight of what I was asking them to tell me. For the midwives, I was asking them to tell me how they really felt about supporting PWMS, which could lead to many thoughts and feelings being revealed. For the pregnant women, I was asking them to recount very personal life events, some of which they may not have fully discussed with anyone else. I remained concerned about how a researcher obtains relevant information whilst ensuring the wellbeing of their participants.

Whilst some of the issues that arose ran across both groups of participants, some appeared to be specific to each group and will now be considered.

6.5 Pregnant women

I was unsure whether or not to tell the pregnant women that I was a midwife. I was unsure if it would matter to them, if perhaps their previous encounters with midwives may affect their perceptions of me. Most of all if I was concerned if this may create a power in-balance between us. Knowing I am a midwife may have affected many aspects. It could have affected what they told me about their experiences of their journey to motherhood, including their encounters with staff. They may have told me what they think I wanted to hear. They may have portrayed a better story or perception about themselves to me because I was midwife. The specialist midwives however, told them that I was a midwife who was undertaking a piece of research and so were aware of this from the outset. I felt and still feel okay about this. It would not have felt honest for them not to know this. I didn't want it to seem like a betrayal to them if they were not aware of this and they found out at a later date. I did and still consider the influence this may have had on them wanting to take part and their answers.

I felt that in order to get around some of my concerns, it was important that I ask all participants if they had any questions, anything they would like to know. I asked this before we started the interviews, but then perhaps I should I have left this to the end. Perhaps what I told participants about myself influenced what they then told me during our time together.

The pregnant women asked if I was a midwife. I told them that I was a community midwife and that I had taken a career break in order to study full time. Two of the participants appeared to visibly relax when I explained that my background was in midwifery. One told me that was good, she felt it would be okay to talk to me then. One told me this made her feel better as she felt that this meant I had may have some insight into her life. She said she felt this meant I would be caring and care about the subject in hand. They knew I had travelled some distance to meet them, but did not ask where I lived. I was prepared for them to ask me personal details i.e. did I have children, but they asked nothing further about me. Maybe they thought it was too personal to ask me this. Maybe they simply didn't want to know. Maybe it just didn't matter to them.

Whilst I anticipated that some participants may become upset during our time together, I still felt mixed emotions when it occurred. On reflection, this was probably due to what I thought would be upsetting for the women to talk about and what actually was upsetting for them to talk about. For example, Jenny appeared to talk quite easily about her childhood, where she provided rich detail about growing up with parents who were alcoholics. Although she appeared to recognise the effects of her parent's lifestyle on her, she said she did not blame them at all, she had made her own choices. She in fact, became upset when discussing the impact her life choices have made on her parents and when talking about the impact of her substance use on her children. I was surprised at this, this made me think about a few things – was my perception that people would blame or not be accepting responsibility for their choices – possibly and if so, why did I think this? I must also be honest, I thought "I've blown it, we have to stop" but she wanted to keep talking about it, which again surprised me.

In addition, whilst she appeared to be aware of the influence an older boyfriend had had in terms of introducing her to a variety of illicit substances at an early age, it was only as she was talking that she realised that he had also exploited her sexually. Again, this reiterated to me how significant my encounters with women would be and how privileged I was to be allowed an insight into their lives. This also made me think again what I think and what perhaps society think IPV actually is? How many women have been in situations and not actually realised that what was happening was wrong? How many other women have been in abusive situations and accepted what has

happened as normal? What did this say about what we, as a society and as professionals think is acceptable? What (especially as women) are we led to believe is ok/acceptable behaviour towards us? I realised how angry I felt about IPV against women and children. It made me angry about societies apparent acceptance of what can happen to children and women in their lifetimes. It led me to read more around IPV.

I learned that whilst I felt I understood about the power in-balance and bullying that can go on in families and intimate relationships, I too, in the past, hadn't fully considered the impact of more insidious acts of control and violence over women and children. Whilst I realised that I had become more aware of the full extent of violence against women and children in my time as a midwife, I felt ashamed that I had previously considered IPV to be acts of obvious brutality. I also became more aware of my feelings towards women who remained in violent, controlling relationships. I had to acknowledge that I had, in the past, asked myself why women stay in abusive relationships. I reflected on my clinical midwifery practice and hope that I did not minimize or dismiss what women were trying to tell me.

One of the many considerations I made during writing up was the language I was using to describe each set of participants, particularly the pregnant women. After much consideration, the pregnant women were described as PWMS or "pregnant participants". I use PWMS interchangeably throughout the thesis for pregnant women who misuse substances/pregnant women with problematic substance use/are substance dependant and at times for newly delivered mothers. I gave much consideration to using the abbreviation PWMS. I found that I initially felt uncomfortable using words such as misuse, addict, substance user and found myself reflecting on the terminology used within my clinical practice. I realised that I found these words difficult and worried about them sounding judgemental. However, after immersing myself in reading and attending substance use and addiction working group meetings and conferences, I was reassured that these words formed part of the discourse around this subject matter. Moreover, the participants in this study talked of their addictions and their lives as addicts, therefore I consider the terms I chose to use as appropriate.

6.6 Midwives

The midwives all knew from the outset that I am a midwife. I felt it was important for them too, to ask any questions they may have. They all asked where I practiced and what I planned to do after completing the PhD. I told them all that quite honestly, I had no idea what I would do after this and that in fact, my goal was just to try my best and actually finish the PhD. I was aware that it may be difficult for them to tell me what they actually think or feel. As a fellow midwife, I could be judgemental about their actions or inactions with regards to their experiences and perceptions of supporting pregnant women who misuse substances. I prepared myself for keeping my responses internal and realised that I may have to check myself for potential judgements, biases and to be ready be surprised by what they were telling me. I do not think my midwifery background hindered me. However, I do reflect if I could have explored more thoroughly what they said. We had a shared understanding of what it is like to be a midwife therefore perhaps I may have unknowingly relied on my own perceptions and understanding of what the job entails. Perhaps I could have asked for more explanation and clarification about different aspects of their day to day job.

I wanted to make the process as easy as possible. I wanted to ensure all participants knew what we would be talking about and that they had the option to decline to answer. I was careful to explain that the study was specifically about their experiences and perceptions therefore there would be no right or wrong answers. I also had to be careful with this. If the midwives disclosed unsafe or unprofessional practice, I would have to discuss this with a Supervisor of Midwives. If the pregnant women disclosed any illicit drug use, illegal activity or anything that would at that time put them or their baby at risk, I would have to inform their specialist midwife. This posed a dilemma for me as I felt if they were allowed to talk to me about these issues, it may provide different data/insight into their lives, however, the Research Ethics Committee where very clear about this. This perhaps limited what participants told me, therefore could be considered a limitation to the study.

During the interviews with the midwife participants, I found myself surprised at their clear memories of women they had met in clinical practice. As they reflected about

particular women and particular experiences, I did too and wondered how many midwives have been traumatized by events and people in the workplace and how we expect each other to keep going afterwards. I also reflected upon my clinical practice and realised that I had not always been the flexible, non-judgemental knowledgeable practitioner I thought I was.

As the participants talked of their frustration regarding PWMS, I remembered women I had felt frustrated and perhaps even angry at too. I realised that I had not fully appreciated women using substances in order to numb their emotional and physical pain, moreover, I had not fully comprehended what having an addiction meant in the long term. I reflected on what I realised may be a perception that all the unhealthy, poor choices we make in life are expected to stop as soon as a woman becomes pregnant, but that this is perhaps a very unrealistic ideal that many women cannot sustain with proper help, support and compassion.

6.7 LHC

The concept of the LHC was first explained to me by Anna Higgins (nee Sierka) who had used a LHC to collect retrospective data about trauma histories and offending amongst incarcerated women in Scotland. I heard her present her findings at an Edinburgh Napier University student conference and was fascinated by the data she had collected. Having listened to and taken note of trauma histories over many years within clinical practice, it really struck a chord with me. I recalled how most people recounted their history almost in a jumble and that it was unusual for them to recount what had happened in chronological order. Not only that, often people had remembered events as they were speaking and tried to remember where these memories fitted in with the order of other things that had occurred in their lives, often in relation to significant life events or places.

It seemed to me that using the LHC would be important for my study. I liked how it enabled people to indicate what had happened and when it happened, but they did not need to provide any details. I liked how it provided rich detail that may be missing from interviews alone and I imagined how I might represent this data if I was allowed

to use it. I felt it could provide a striking visual representation of someone's life history. Anna very kindly allowed me to see her amended LHC and agreed that I could adapt it in for use in my study. I am truly indebted to her for that as it became a very valuable and powerful tool.

First of all, it felt I was finally getting to do some research. It felt good to be out and about meeting participants and putting all that I had read and practiced for into doing it for real. During completion of LHC, I was always anxious about how the LHC would be received by participants. I explained the matrix to them and most said they didn't know where to begin. I would first of all take them to the significant life events section and say that perhaps this would help get them started. I would ask if they would like to put in things like who they lived with, when they left school, their first boyfriend, when they left home as ways to open the dialogue. I found that all the participants started off slowly, perhaps being cagey with what they were disclosing. After all, I was a complete stranger asking them to share their potentially very private and sensitive memories. I found however, that after indicating a couple of things, the life events came flooding out.

The women mostly did more than indicate what and when things had happened. They went on to describe often in great depth their life events. I realised that I may not capture all of this rich data with crosses and marks on the calendar alone and asked if I could make addition notes on the calendars too, if there was something that I was worried I would miss when writing these findings up at a later date. In this way, I think I was able to capture the very visual images the participants provided for me of themselves as small children and adults.

Completion of the LHC varied amongst participants but often took up to an hour. Some of the participants became upset during its completion. It was emotional for me too. Here I was, collecting this very sensitive information from women I had never met before. I felt overwhelmed by their honesty and the generosity. Prior to data collection, I knew that I was in a privileged position, to be entrusted with these stories, but the LHC really brought this home to me. It was very powerful to me during completion and I considered how useful using a LHC could be in clinical practice. After its completion, the participants and I would share a drink and a snack. This proved a

welcome break and felt like a time for the women to bring themselves back in to the present. I thought at this time, the participants may ask me questions about myself, now that the interview was over, but none of them did.

When the LHC's were all completed, I was left with a huge amount of data. I drew out timelines by hand, fiddled about with word documents, then decided to plot them out using power-point. These took a long time to do, but I am pleased with the result. I have shown them as part of presentations and they appear to really stand out and grab the audience's attention. Many people have told me how shocked they are when they see the participant's life's recorded in this way. The results from the calendar are shocking and even after thinking about them, drawing them and feeling that I have seen them in my sleep, I still feel shocked by the complexities of the women's lives. They succinctly show the order of events as well as the complexity and enduring nature of what the participants have experienced over their lives to date.

The LHC proved to be invaluable. On reflecting on its use however, there are a number of important considerations; I think it provided the women with a time and place to mark down their memories, it undoubtedly helped them remember the order or bring about the order of their life events; it allowed the collection of detailed, complex retrospective data; I think it allowed the women and I time to build up a bit of a relationship; I think it gave us a chance to relax and get into the subject matter; I think it perhaps gave the women a chance to feel that they could trust me a little bit with their personal, sensitive information and provided a gateway into the interviews; I think perhaps the act of doing something whilst talking was a factor in them completing their LHC.

When we looked at their LHC, they looked over their lives and expressed their surprise at how it looked when it was written down. Some said that my goodness, their life had been "shit", that looking at what had happened it was no wonder they had turned out the way they had. None of the women had done anything like this before. Some said that in their years of drugs work and therapy, they wish they could have done this at some point, that seeing it all written down in some way validated how they felt.

6.8 Interviews

Whilst I felt less anxious with each interview, I remained nervous. This was due to a number of things – I was confident and experienced at seeing women and asking them about themselves in clinical practice, but this was different. These encounters were not therapeutic, I was not in a position to comment or make suggestions to the participants, I was there to just listen. Whilst this felt strange at first, I quickly realised a sense of freedom within this. I was not being expected to give advice, discuss recommendations for care or current evidence within midwifery practice. I questioned how many times in recent years I had actually had the opportunity to *really* listen to what people were telling me. It made me reflect on many of the clinical encounters I have had with women and midwives who were probably trying to tell me something but perhaps I had missed.

It made me consider how open and honest our encounters really are, how meaningful a twenty minute appointment really is. Are we (midwives) just really getting through the necessary tasks and ticking the necessary boxes in women's notes? Are we really listening to what women are telling us? Do we have time to consider hidden meanings and pick up hints and clues in what they are saying? Do we really listen to each other as clinicians? Do we consider ourselves as more than midwives, that we are mostly women who have other lives and issues ourselves and how that may impact upon our clinical practice?

In July, I returned to my part time community midwife post. I have enjoyed being back in clinical practice and feel that the education and training I have undertaken as a PhD student has enriched my clinical practice, perhaps in light of enhanced critical thinking (Banning, 2006). Whilst I feel that I have always taken a step back to reflect on aspects of midwifery practice and how these may impact upon women, I think that I do this more so now. I also think the time away has allowed me to return with a slightly different perspective and a fresh set of eyes.

As with the LHC, I felt a huge sense of responsibility. I was being entrusted with the details of participants' lives and wanted to capture these accurately and sensitively.

Although I had a list of questions to guide the interview, it became clear that these would be a guide only. After all, the whole point of this was to collect their stories, it should be their agenda, what was important to them, so some of the interviews were really unstructured and we went wherever the participant took us (Smith et al, 2009). I felt more confident with this as time went on, realising that this was the important thing, not necessarily what was on my list.

As much as I enjoyed data collection, I came away from the interviews exhausted. I found them challenging with both sets of participants. I was worried about participants becoming upset, of doing some harm to them. I was worried what they would tell me – would they tell me the truth? Would they try to portray themselves as someone else, paint themselves in a better light? How would they respond to me? Did it help that they knew I was a midwife? What if I got upset? What if I didn't agree with what they said, if it challenged my personal beliefs or values or clinical practice? What if they disclosed current danger within their lives? What if they disclosed unprofessional practice? Did it matter where we met? Did it matter what I wore, how I spoke, that I had a wedding ring on my finger, that I was a midwife? Did the participants imagine that my life, experience and opinions would be very different from their own? Did it matter that I was a midwife?.

6.9 Analysis

I initially thought that the data from the LHC would be left as a set of chronological timelines, however, once I had made these, I realised they provided much more than I had originally thought. Making up the timelines was time consuming but allowed me to become immersed in the women's life stories. I was keen to show the detail of their lives and capture just how much had happened. It became clear that most of the participants had shared a number of key life events which appeared to jump out at me from the timelines. I felt that this data could not be left out therefore converted each timeline into a list of key life events which I think are as striking as the chronological timelines.

The IPA was a real challenge and took much longer than I had originally anticipated. It took many re-writes and reflections before I could consider how to write it in a way that would shed light on the lived experience of the participants. It seemed obvious to me that the pregnant women would be described as the “pregnant participants” and the midwives would be described as the “midwife participants”. I considered changing the “pregnant participants” to “pregnant women”, however, as they were required to be pregnant in order to take part and were obviously women, I decided to stick with the original description. Likewise, I wondered what else I could call the “midwife participants”. If I renamed one group of participants in relation to their gender, I would have to be mindful of this with both groups as they were both comprised of women. That left me with the question of how I would then describe them; “professional participants”, but then that would perhaps make this group of participants sound somewhat elite.

I think at times, I could have gone deeper in the analysis, but had to be mindful of time and the fact that I had eleven participants’ data to analyse. I often felt overwhelmed with the amount of data I had and thought that I perhaps should just have recruited one set of participants in order to concentrate more fully on their experiences and perceptions. In the early stages of this study, I did consider focussing on PWMS only. However, given the anticipated difficulties recruiting PWMS, I was concerned that if I concentrated on this group only, I may be months into data collection with no data collected. Furthermore, I became increasing interested in the voice of the midwife and felt that important insights could be gained from exploring two sets of participants who share a unique time together. Whilst I do think I made life much more complicated for myself, I think collecting data from both set of participants provided a unique and fuller picture of their lived experiences of the maternity services.

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Appendix 1

Table 2 Excluded studies – No pregnant participants (1 of 1)

Authors	Title of study	Aims of study
Correa et al. (2015)	A content analysis of attributions for resuming smoking or maintaining abstinence in the post-partum period.	Examine attributions of smoking relapse or maintained abstinence in post-partum women.
Davis and Yonkers, (2012)	Making lemonade out of lemons: A case report and literature review of external pressure as an intervention with pregnant and parenting substance-using women.	Present a case report of a postpartum woman with substance misuse.
Ingersoll et al. (2008)	Risk drinking and contraception effectiveness among college women.	Understand relationships between risk drinking, unprotected sex and STI exposure amongst college women.
Letourneau et al. (2007)	Timing and predictors of postpartum return to smoking in a group of inner-city women: An exploratory pilot study.	Examine the timing and predictors of returning to smoking after pregnancy.
Linden et al. (2013)	Addiction in Maternity: Prevalence of Mental Illness, Substance Use and Trauma.	Further explore the history of mental illness and trauma in post-partum women who had a substance use problem while pregnant.
Minnes, (2008)	The association of prenatal cocaine use and childhood trauma with psychological symptoms over 6 years.	Determine if prenatal cocaine use identifies women for ongoing risk of psychological symptoms.
Pace et al. (2014)	Postpartum changes in methadone maintenance dose.	Examine doses among methadone-maintained women during postpartum period.
Stotts et al. (2000)	Postpartum return to smoking: Staging a 'suspended' behavior	Examine factors related to postpartum smoking abstinence.
Torchalla et al. (2015)	Substance use and predictors of substance dependence in homeless women.	Explore the history of mental illness and trauma in women who had recently given birth and had a substance use problem while pregnant.

Table 3 Excluded studies – explored other factors associated with the use of substances by pregnant women (1 of 3)

Authors	Title of study	Aims of study
Ball and Schottenfield, (1997)	A five-factor model of personality and addiction, psychiatric, and AIDS risk severity in pregnant and postpartum cocaine misusers.	Explore relationship between addiction severity, psychiatric symptoms, AIDS risk behaviours.
Behnke et al. (1999)	Characteristics of homeless and low-income women.	Examine the characteristics of homeless and low-income housed women.
Bendersky et al. (1996)	Characteristics of pregnant substance abusers in two cities in the Northeast.	Examine drug use patterns of pregnant women in two inner city sites, with a known high prevalence of cocaine use.
Blechman et al. (1999)	Prosocial coping and substance use during pregnancy.	To describe the coping strategies of pregnant women who live in an inner-city where drug use is prevalent.
Hanson et al. (2015)	Importance of social support in preventing alcohol-exposed pregnancies with American Indian communities.	Explored the role of social support in preventing alcohol-exposed pregnancies.
Hohman et al. (2003)	A comparison of pregnant women presenting for alcohol and other drug treatment by CPS (Child Protection Service) status.	Describe variables of alcohol and other drug treatment seeking women. Also compared women on variables based on CPS status.
Meshberg-Cohen and Svikis, (2006)	Panic disorder, trait anxiety, and alcohol use in pregnant and non-pregnant women.	Examine rates of panic disorder and trait anxiety, alcohol use among and whether pregnancy status moderates these associations.

Table 3 Excluded studies – explored other factors associated with the use of substances by pregnant women (2 of 3)

Authors	Title of study	Aims of study
Huizink, (2012)	Prenatal factors in temperament: The role of prenatal stress and substance use exposure.	Explore 'prenatal programming' effects that may result in long-term effects on a wide range of outcomes for the child.
Lange et al. (2015)	Alcohol use, smoking and their co-occurrence during pregnancy among Canadian women.	Estimate the prevalence of smoking, investigate association between smoking and alcohol and examine predictive risk factors.
Miles et al. (2001)	Psychopathology in pregnant drug-dependent women with and without comorbid alcohol dependence.	To measure psychopathology in alcohol-negative and alcohol-positive pregnant women.
Moylan et al. (2001)	Clinical and psychosocial characteristics of substance-dependent pregnant women with and without PTSD.	Compare psychiatric and psychosocial functioning in pregnant opiate and/or cocaine-dependent women with/without a comorbid diagnosis of PTSD.
Namagembe et al. (2010)	Consumption of alcoholic beverages among pregnant urban Ugandan women.	To use screening tool in order to predict alcohol consumption.
Olson et al. (2015)	Pregnancy, caretaking and substance use disorders: A 12-year longitudinal study of delinquent females.	Examine prevalence rates of substance use disorders (SUD), pregnancy and caretaking (2) describe the association between SUD and periods of pregnancy and caretaking.
Ondersma et al. (2010)	External pressure, motivation, and treatment outcome among pregnant substance-using women.	Explore threat of incarceration, loss of child custody, and/or loss of subsidized housing and the key outcomes of retention.
Patterson et al. (2012)	Neighborhood safety as a correlate of tobacco use in a sample of urban, pregnant women.	Examine effects of self-reported neighbour-hood violence/perceived safety on tobacco use.
Shannon, (2010)	Examining differences in substance use among rural and urban pregnant women.	Examine differences in substance use among pregnant women from rural/urban areas.

Table 3 Excluded studies – explored other factors associated with the use of substances by pregnant women (3 of 3)

Authors	Title of study	Aims of study
Terplan et al. (2009)	Pregnant and non-pregnant women with substance use disorders: The gap between treatment need and receipt.	Examine differences in pregnant women's alcohol and drug use, substance treatment need and treatment receipt.
Van Der Wulp et al. (2015)	Partner's influences and other correlates of prenatal alcohol use.	To identify correlates of prenatal alcohol use, including perceived and reported partner norm partner modelling and partner support.
Vega et al. (1997)	Perinatal drug use among immigrant and native-born Latinas.	Examine patterns of drug exposure among pregnant immigrant and native-born Latinas in the United States.

Table 4 Excluded studies - evaluated treatment/service provision (1 of 4)

Authors	Title of study	Aims of study
Alvik et al. (2006)	Alcohol consumption, smoking and breastfeeding in the first six months after delivery.	To study alcohol use and smoking after delivery, and to relate this to breastfeeding.
Calabro et al. (1996)	Pregnancy, alcohol use and the effectiveness of written health education materials.	Determine whether health education materials were more effective when written at a lower rather than a higher reading level.
Ceperich and Ingersoll, (2011)	Motivational interviewing plus feedback intervention to reduced alcohol-exposed pregnancy risk among college binge drinkers.	Measure the rate of risk for alcohol-exposed pregnancy, the rate of risk drinking the rate of pregnancy risk.
Corse and Moon, (1998)	Reducing Substance Abuse During Pregnancy. Discriminating Among Levels of Response in a Prenatal Setting.	Report the results of the ANGELS Program, a program of enhanced prenatal care designed to reduce substance use among pregnant women.
Crandall et al. (2004)	Does pregnancy affect outcome of methadone maintenance treatment?	Examine treatment outcome between pregnant and non-pregnant participants in a metropolitan methadone-maintenance program.
Dunnagan et al. (2003)	Support for social norms programming to reduce alcohol consumption in pregnant women.	Examine differences between the amount of alcohol consumption and alcohol consumption perception.
Erickson, (2012)	Therapist effects in a NIDA CTN intervention trial with pregnant substance abusing women: Findings from a RCT with MET and TAU conditions.	Investigate whether treatment outcomes among pregnant substance abusers could be attributed to therapist effects.
Freda et al. (1995)	What do we know about how to enroll and retain pregnant drug users in prenatal care?	Integrate literature review.
Grant et al. (2004)	A Pilot Community Intervention for Young Women with Fetal Alcohol Spectrum Disorders.	Describe a 12-month community pilot intervention with young women with Fetal Alcohol Spectrum Disorders (FASD).

Table 4 Excluded studies - evaluated treatment/service provision (2 of 4)

Authors	Title of study	Aims of study
Haug et al. (2004)	Motivational enhancement therapy for cigarette smoking in methadone-maintained pregnant women.	To compare motivational enhancement therapy for reducing smoking during pregnancy with standard-care practitioner advice in a 2-group randomized design.
Hauge et al. (2015)	Establishing survey validity and reliability for American Indians through “think aloud” and test-retest methods.	To use a mixed-methods approach to determine the validity and reliability of measurements used within an alcohol-exposed pregnancy prevention program for American Indian women.
Hughes et al. (2009)	Inconsistent report of pre-pregnancy-recognition alcohol use by Latinas.	Compare two different methods of data collection, in attempt to identify opportunities for improved screening.
Hutchison et al. (2012)	The efficacy of escalating and fixed contingency management reinforcement on illicit drug use in opioid-dependent pregnant women	Study efficaciousness of contingency management in a population of opioid-dependent pregnant women.
Ingersoll et al. (2005)	Reducing alcohol-exposed pregnancy risk in college women: Initial outcomes of a clinical trial of a motivational intervention.	Assess effectiveness of a randomized controlled trial of a one-session motivational interviewing-based intervention.
Jones et al. (2004)	What if they do not want treatment?: Lessons learned from intervention studies of non-treatment-seeking, drug-using pregnant women.	Examine two types of brief drug use intervention models for attracting and retaining pregnant women in drug abuse treatment.
Jones, (2012)	Acceptance of naltrexone by pregnant women enrolled in comprehensive drug addiction treatment: An initial survey.	Explore potential interest in naltrexone treatment by pregnant women enrolled in comprehensive treatment for substance use disorders.

Table 4 Excluded studies - evaluated treatment/service provision (3 of 4)

Authors	Title of study	Aims of study
Kruk and Banga, (2011)	Engagement of substance-using pregnant women in addiction recovery.	Examine the experiences and recovery needs of substance using pregnant women, with a primary focus on women's engagement by child protection services (CPS) in addiction recovery programs.
Leeners et al. (2010)	Pregnancy complications in women with childhood sexual abuse experiences.	Investigate pregnancy complications in women exposed to childhood sexual abuse.
Luty et al. (2003)	Is opiate detoxification unsafe in pregnancy?	Investigate the safety of methadone detoxification.
Marcellus et al. (2015)	Re-envisioning success for programs supporting pregnant women with problematic substance use.	Follow formative development stages of a community-based program, identify key evaluation indicators and processes.
Messer et al. (1996)	Characteristics associated with pregnant women's utilization of substance abuse treatment services.	To gain a better understanding concerning the characteristics of pregnant substance-using women related to their decisions regarding treatment utilization.
Midanik et al. (1998)	Alcohol and drug CAGE screeners for pregnant, low-income women: The California perinatal needs assessment.	Evaluate a revised CAGE and a new drug version of the CAGE as screeners for risk of heavier or problem alcohol and/or drug use among.
Montag et al. (2015)	Preventing alcohol-exposed pregnancy among an American Indian/Alaska Native population: Effect of a screening, brief intervention, and referral to treatment intervention.	To determine if a culturally targeted screening, brief intervention, and referral to treatment intervention may reduce risky drinking and vulnerability to alcohol exposed pregnancies.

Table 4 Excluded studies - evaluated treatment/service provision (4 of 4)

Authors	Title of study	Aims of study
Sairam et al. (2012)	Enhancing the effectiveness of community drug and alcohol teams working with opioid-dependent pregnant women: Results of an audit.	To evaluate the quality of services offered by community drug and alcohol teams to pregnant women in substitution treatment.
Seybold et al. (2014)	Evaluation of a training to reduce provider bias toward pregnant patients with substance abuse.	To provide an initial framework for designing a training workshop to enhance health practitioners' knowledge regarding substance abuse treatment and to decrease their bias toward substance-abusing women.
Tassiopoulos et al. (2010)	Substance use in HIV-infected women during pregnancy: Self-report versus meconium analysis.	Evaluate prenatal substance use.
Tuten et al. (2012)	Contingent incentives reduce cigarette smoking among pregnant, methadone-maintained women: Results of an initial feasibility and efficacy randomized clinical trial.	Examine the feasibility and efficacy of behavioural incentives for reducing cigarette smoking among pregnant methadone-maintained patients
Vicary et al. (1996)	A community systems approach to substance abuse prevention in a rural setting.	Evaluate a community-wide campaign addressing prevention of alcohol, tobacco and other drug problems.
Yonkers et al. (2011)	Self-report of illicit substance use versus urine toxicology results from at-risk pregnant women.	Compare the urine toxicology screens and self-reported use of marijuana or cocaine for women enrolled in an integrated obstetrical/substance abuse treatment program.
Coleman-Cowger et al. (2013)	Comparison of the Addiction Severity Index (ASI) and the Global Appraisal of Individual Needs (GAIN) in predicting the effectiveness of drug treatment programs for pregnant and postpartum women.	Compare the ASI and the GAIN to assess change in alcohol and other drug treatment outcomes.

Table 5 Excluded studies - focussed on the rates of IPV amongst pregnant women (1 of 1)

Authors	Title of study	Aims of study
Ntaganira, (2008)	Intimate partner violence among pregnant women in Rwanda.	To identify variables associated with IPV among Rwandan pregnant women.
Robbins et al. (2015)	Multilevel correlates of broadly- and narrowly-defined intimate partner violence among pregnant women in Los Angeles.	To compare correlates based on two IPV definitions: broad (physical, sexual, or psychological violence) and narrow (physical or sexual violence only).
Velez et al. (2006)	Exposure to violence amongst Substance dependent pregnant women and their children.	Examine rates of domestic violence amongst substance abusing pregnant women.
Wilson et al. (1996)	Antenatal psychosocial risk factors associated with adverse postpartum family outcomes.	To determine the strength of the association between antenatal psychosocial risk factors and adverse postpartum outcomes in the family, such as assault of women by their partner, child abuse, postpartum depression, marital dysfunction and physical illness.
Yang et al. (2006)	Physical abuse against pregnant aborigines in Taiwan. Prevalence and risk factors.	Estimate the prevalence of, and to investigate the risk factors for physical abuse against pregnant aborigines in Taiwan.

Table 6 Excluded studies - examined the prevalence of alcohol consumption (1 of 1)

Authors	Title of study	Aims of study
Balachova, (2012)	Women's alcohol consumption and risk for alcohol-exposed pregnancies in Russia.	Examine drinking patterns among pregnant and non-pregnant women of childbearing age in Russia.
Morris et al. (2008)	Exploring pregnancy-related changes in alcohol consumption between Black and White women.	Explore differences in drinking cessation between Black and White women who become pregnant.
Muckle et al. (2011)	Alcohol, smoking, and drug use among Inuit women of childbearing age during pregnancy and the risk to children.	To provide prevalence data for alcohol, smoking, and illicit drug use before, during, and after pregnancy among Inuit. Factors associated with alcohol use are also identified.

Table 7 Excluded studies - explored women's knowledge and attitudes towards substances (1 of 1)

Authors	Title of study	Aims of study
Castro et al. (1995)	Indicator of lapse/relapse in stimulant users: A lifestyle perspective.	Explore indicators of lapse/relapse in stimulant users.
Dunnagan et al. (2007)	Support for social norms programming to reduce alcohol consumption in pregnant women.	Examine the difference between the amount of alcohol consumed by pregnant women (actual norms) and the amount they perceived was consumed by other women of their same age (peer norms).
Stutts et al. (1997)	Females' perception of risks associated with alcohol consumption during pregnancy.	Examine women's perceptions of risk associated with drinking alcohol during pregnancy.
Toutain, (2013)	Alcohol and pregnancy in France: A new-survey from Internet forums in 2009-2010.	To highlight the recent preoccupations of pregnant women expressing themselves on internet forums in 2009–2010 regarding their alcohol consumption during pregnancy.
Wigginton and Lafrance, (2014)	'I think he is immune to all the smoke I gave him': How women account for the harm of smoking during pregnancy.	To examine how women accounted for their smoking and identities in the light of implicit but discourse that smoking in pregnancy harms babies.
Witbrodt, (2008)	Under-estimation of alcohol consumption among women at-risk for drinking during pregnancy.	To see if women could identify differences between their actual and standard drink sizes.

Table 8 Excluded studies - explored obstetric/neonatal/childhood outcomes (1 of 2)

Authors	Title of study	Aims of study
Branco, (2001)	"IF IT BURNS GOING DOWN…": HOW FOCUS GROUPS CAN SHAPE FETAL ALCOHOL SYNDROME (FAS) PREVENTION.	To provide a more in-depth understanding of how at-risk women regard and emotionally react to warnings about drinking alcohol during pregnancy.
Caldwell, (2002)	Impact of life events, trauma**,** interpersonal conflict and substance abuse on pregnancy outcomes of inner city women.	Explore the impact of life stress, trauma**,** interpersonal conflict and substance use on pregnancy outcomes for women living in an inner-city.
Chen et al. (2015)	Comparison of adverse obstetric outcomes and maternity hospitalization among heroin-exposed and methadone-treated women in Taiwan.	Identify sociodemographic and clinical factors predicting overall risk of adverse obstetric outcomes and the length of maternal hospital stay.
Comasco et al. (2012)	Alcohol consumption among pregnant women in a Swedish sample and its effects on the newborn outcomes.	Part of ongoing study about effects of low levels of maternal alcohol intake on the neuropsychological development of the child. Presents the data on demographic variables, maternal alcohol use and birth outcomes.
Hjerkinn et al. (2009)	Neonatal findings among children of substance-abusing women attending a special child welfare clinic in Norway.	To describe neonatal findings among children of substance-abusing women.
Kearney et al. (2004)	Health Behaviors as Mediators for the Effect of Partner Abuse on Infant Birth Weight.	To explore the role of substance use, health behaviours and demographic risk factors as potential mediators of the relation between recent partner abuse and infant birth weight.
Kiblawi et al. (2014)	Prenatal methamphetamine exposure and neonatal and infant neurobehavioral outcome: Results from the IDEAL study.	To explore how methamphetamine use during pregnancy affects neonatal and infant neuro-behaviour.

Table 8 Excluded studies - explored obstetric/neonatal/childhood outcomes (2 of 2)

Authors	Title of study	Aims of study
Larroque, (1995)	Moderate prenatal alcohol exposure and psychomotor development at preschool age.	Investigate the effect of moderate prenatal alcohol exposure on psychomotor development of preschool-age children in a longitudinal study.
McCall, (2008)	The interaction between selected maternal factors, parenting stress, and infant development for a sample of women who consumed alcohol during pregnancy.	Examine specific interactions and relationships amongst maternal factors, mother's reported stress, her alcohol consumption patterns and the infant's developmental outcomes at 14-months of age.
Piper et al. (2012)	Executive function profile in the offspring of women that smoked during pregnancy.	Evaluate if the offspring of smokers show abnormalities in maternal ratings of executive function, prevalence of Attention Deficit Hyperactivity Disorder and academic performance. A secondary objective was to determine the utility of online data collection.

Table 9 Excluded studies - explored other factors associated with either substance use or IPT (1 of 4)

Authors	Title of study	Aims of study
Baldwin, (2000)	Alcohol and a risk factor for HIV transmission among American Indian and Alaskan Native Drug Users.	Explore relationship between alcohol and HIV transmission.
Crawford et al. (2011)	Pregnancy and mental health of young homeless women	Explore pregnancy and motherhood in unaccompanied homeless young women.
Davie-Gray et al. (2013)	Psychosocial characteristics and poly-drug use of pregnant women enrolled in methadone maintenance treatment.	Describe obstetric, socio-familial and mental health needs of women in methadone maintenance treatment during pregnancy and the extent and pattern of maternal licit and illicit drug use during pregnancy.
Dietz, (1999)	Unintended pregnancy among adult women exposed to abuse or household dysfunction during their childhood.	To assess whether unintended pregnancy during adulthood is associated with exposure to psychological, physical, or sexual abuse or household dysfunction during childhood.
Eggleston et al. (2009)	Suicidality, aggression, and other treatment considerations among pregnant, substance-dependent women with posttraumatic stress disorder.	Examine the association of PTSD and other Axis I comorbidity to the clinical presentation at intake in a sample of treatment-seeking, pregnant, substance dependent women.
Erickson and Tonigan, (2008)	Trauma and Intravenous Drug Use among Pregnant Alcohol/Other Drug Abusing Women: Factors in Predicting Child Abuse Potential.	Address associations between trauma, route of drug administration (IV use), and child abuse potential in pregnant substance abusers.

Table 9 Excluded studies - explored other factors associated with either substance use or IPT (2 of 4)

Authors	Title of study	Aims of study
Furono, (2004)	Cigarette Smoking and Low Maternal Weight Gain in Medicaid-Eligible Pregnant Women.	Examine if cigarette smoking during pregnancy was associated with low maternal weight gain independent of caloric intake.
Massey et al. (2016)	Maternal personality traits associated with patterns of prenatal smoking and exposure: Implications for etiologic and prevention research.	Examine the relationship between novelty seeking, harm avoidance, and self-directedness and (a) abstinence from smoking during pregnancy and (b) average daily cigarette consumption during pregnancy.
Ismayilova and El-Bassel, (2014)	Intimate partner physical and sexual violence and outcomes of unintended pregnancy among national samples of women from three former Soviet Union countries.	Examine the relationship between intimate partner violence and unintended pregnancy.
Jackson and Shannon, (2012)	Barriers to receiving substance abuse treatment among rural pregnant women in Kentucky.	Explore barriers for rural pregnant women seeking substance abuse treatment.
Khajehpour et al. (2013)	Health status of women with intended and unintended pregnancies.	To compare the health status of women with intended and unintended pregnancies in Iran.
Kelly, (1999)	A framework to examine women's success in a substance abuse treatment program.	Examine societal factors that influenced completion of a substance abuse treatment program for a population of low-income pregnant minority women.
Kuo et al. (2013)	A qualitative study of treatment needs among pregnant and postpartum women with substance use and depression.	Explore factors impacting treatment outcomes and needs.

Table 9 Excluded studies - explored other factors associated with either substance use or IPT (3 of 4)

Authors	Title of study	Aims of study
Lobato et al. (2012)	Alcohol misuse among partners: A potential effect modifier in the relationship between physical intimate partner violence and postpartum depression	Evaluate if probability of postpartum depression increases with increasing physical intimate partner violence during pregnancy and if substance use by one or other of the couple changes this relationship.
Loxton et al. (2013)	Acquisition and utilization of information about alcohol use in pregnancy among Australian pregnant women and service providers.	Explore how pregnant women and service providers acquire and utilize information about alcohol use during pregnancy.
Messaadi et al. (2014)	The continued care of pregnant women receiving opiate substitution treatment by midwives.	Determine whether midwives are used to accompanying women taking opiate substitution treatment and to determine their level of knowledge and investment in this area.
Mullen et al. (1999)	Success attributions for stopping smoking during pregnancy, self-efficacy, and postpartum maintenance.	Explore success attributions for stopping smoking.
Namyniuk et al. (2001)	Ethnic differences in substance use patterns in a sample of pregnant substance-using women in treatment.	Investigate whether ethnic differences exist regarding drugs of choice, frequency and recency and severity of use.
Ortendahl, (2008)	Coping mechanisms actually and hypothetically used by pregnant and non-pregnant women in quitting smoking.	Investigate pregnant and non-pregnant women's various coping techniques when attempting to refrain from smoking.
Roberts et al. (2015)	Receiving versus being denied a pregnancy termination and subsequent alcohol use: A longitudinal study.	Examine the relationship between receiving versus being denied termination and subsequent alcohol use.

Table 9 Excluded studies - explored other factors associated with either substance use or IPT (4 of 4)

Authors	Title of study	Aims of study
Seng et al. (2004)	Abuse-related post-traumatic stress during the childbearing year.	To increase familiarity with the post-traumatic stress disorder diagnostic framework by illustrating the symptom categories and associated features with women's descriptions of the symptoms from qualitative interviews.
Stine et al. (2009)	Characteristics of opioid-using pregnant women who accept or refuse participation in a clinical trial: Screening results from the MOTHER study.	Compare the characteristics of opioid-using pregnant women who did and did not consent to enrolment in a multicentre clinical trial of agonist medications.
Terplan et al. (2009)	Gestational age at enrollment and continued substance use among pregnant women in drug treatment.	To determine whether gestational age at entry into treatment (specifically first trimester enrolment) was associated with lower risk of continued substance use
Tuten et al. (2012)	Lessons learned from a randomized trial of fixed and escalating contingency management schedules in opioid-dependent pregnant women.	Explore efficacy of contingency management strategies.

Author	Aims	Methodology	Sample	Findings	Critique
Kvigne et al. (1998)	Demographic and patterns of substance use among women who did not consume alcohol during pregnancy were compared to women who did consume alcohol during pregnancy.	Quantitative. Self-administered screening questionnaire.	N=177 Northern Plains Indian women attending prenatal care at an urban clinic in a rural state.	Women who drank during pregnancy: - consumed more alcohol more frequently pre-pregnancy. - had experienced more relationship breakups and physical and emotional abuse. - were more likely to smoke cigarettes, use illicit drugs and report parental alcohol use. - were more likely to be single, have less education and were less likely to have transport-ation than the women who did not drink. - felt they drank the same or more than other pregnant women.	- Sample not ethnically diverse, limits generalisability and transferability of findings out-with study setting. - No use of tool which would help accurate recall of events. Possibility for under-reporting of the use of substances. - Particular focus on alcohol.

Appendix 2 - Included studies - Interpersonal trauma and substance misuse studies.

Author	Aims	Methodology	Sample	Findings	Critique
Martin et al. (1996)	-Were women who experienced various types of IPV more likely to use alcohol or illicit drugs compared with women who did not experience such violence? Among the women who drank alcohol, did those who experienced various types of partner violence drink more frequently and have a greater number of alcohol disorder symptoms compared with women who did not experience such violence? Among the women who used illicit drugs, did those who experienced various types of partner violence use drugs more frequently and have a greater number of drug disorder symptoms compared with women who did not experience such violence.	Quantitative. Initial screening of women's clinical records and their experience of physical abuse. Structured interview included enquiry of women's socio-demographic Characteristics. Conflict Tactics Scales 2 (CTS2). Alcohol intake enquired about. Short-form of the Michigan Alcohol Screening Test (SMAST-13) used. Drug use enquired about. 20 item version of the Drug Abuse Screening Test (DAST) used.	N=85 prenatal patients attending North Carolina prenatal clinics.	- Physical assault associated with alcohol and illicit drug use. - Women who experienced all types of violence evidenced a greater number of substance disorder symptoms. - Association between IPV and use of substances became stronger in pregnancy. - 65% drank alcohol prior to pregnancy. - 20% (n = 17) drank during pregnancy. - 38% used illicit drug before pregnancy. - 15% (N=13) used during pregnancy.	-Relatively small convenience sample of predominately low-income women limits generalisability and transferability of findings out-with study setting. - No use of tool which would help accurate recall of events. Possibility of recall bias and under reporting of experiences and the use of substances.

Author	Aims	Methodology	Sample	Findings	Critique
Martin et al. (2003) US	Describe women's use of alcohol and illicit drugs before and during pregnancy in relation to experiences of various types of IPV.	Quantitative. Structured interviews. Modified version of the Conflicts Tactics Scales used to assess male partners violent behaviour Alcohol users completed version of Michigan Alcohol Screening Test. Illicit drugs completed modified Drug Abuse Screening Test Tools assessed behaviours in previous 12 months and during pregnancy.	Pregnant women recruited from prenatal care settings between six and seven months gestation (n=85). For every woman reporting abuse, a women disclosing no abuse was recruited.	- Women reporting physical violence before pregnancy were more likely to drink alcohol and use illicit drugs. - Any type of violence during pregnancy associated with alcohol and illicit drug use intake. - Link between IPV and use of substances appeared to become stronger during pregnancy. - 25% drank alcohol during pregnancy. -13% continued to use illicit drugs during pregnancy.	-Small sample of low income women that was not ethnically diverse, limits generalisability and transferability of findings. - No use of tool which would help accurate recall of events. Possibility of recall bias and under reporting of experiences and the use of substances.

Author	Aims	Methodology	Sample	Findings	Critique
Salomon et al. (2002) US.	Examined contributions of adult partner violence, childhood physical abuse and sexual molestation, PTSD and partners' substance use on poor women's use of addictive substances.	Quantitative. Unmatched, case-controlled design. Long-itudinal data set used. Data collected at three points – initial visit to family centre/ after being in homeless accommodation for 7+ days, one year, and then two years. Structured interviews with original questions and existing measurement tools used. Chi-squared tests, Odds ratios and Walls tests used.	Homeless mothers/pregna nt women (n= 200) randomly enrolled from all nine emergency and transitional shelters and two welfare motels in one area of Massachusetts. Low incomed domiciled mothers/pregna nt women (n= 216) randomly selected from women attending Public Welfare Department. Final sample reported on due to missing data – Homeless women n= 132, domiciled women n=146.	- Women with history of IPV almost three times as likely to be using illegal drugs, but not alcohol at follow-up. - CSA predicted development of drug use. - Women with history of IPV were more likely to report PTSD and drugs/ alcohol use by their partner. - Women with history of IPV were more likely to have experienced physical/ sexual abuse as children. - 62% reported history of physical violence from male partners.	-Sample not representative of US in general. - Unclear how many of the women were pregnant/how many were already mothers. - No use of tool which would help accurate recall of events. Possibility of recall bias and under reporting of experiences and the use of substances. - mechanisms underlying substance misuse not explored.

Author	Aims	Methodology	Sample	Findings	Critique
Tuten et al. (2003) US.	To compare pregnant drug-dependant homeless/domiciled women at treatment enrolment on initial psychosocial functioning and treatment outcomes.	Quantitative. Semi-structured clinical interview completed within 72 hours of admission – assessed recent and lifetime functioning in drug/alcohol, medical, legal, employment, family/social, psychiatric. Treatment out-come variables assessed by clinical treatment bills – number of days in residential unit, total no. of days in treat-ment, total no. of admissions in current pregnancy.	Homeless women (HW) (n=117), domiciled women (DW) (n=118). Women selected from admissions to centre for addiction and pregnancy in Baltimore.	Homeless women were found to: - be more likely to have experienced higher rates of physical, emotional and sexual abuse than domiciled women. - report significantly higher ongoing physical and mental wellbeing problems. - report more problems with close family relationships. - spend more on cocaine and alcohol than domiciled women. - stay in treatment for less time.	- Sample not ethnically diverse, limits generalisability and transferability of findings out-with study setting. - Clinical treatment bills were used to compare treatment outcome variables – question validity of this. - No use of tool which would help accurate recall of events. Possibility of recall bias and under reporting of experiences and the use of substances.

Author	Aims	Methodology	Sample	Findings	Critique
Curry, (1998) US	To describe the association between abuse during pregnancy and substance use and psychosocial stress.	Quantitative. Abuse Assessment Screening (AAS) tool used.	Women attending urban prenatal clinics (n=1937)	Abused women were more likely to: - report drinking alcohol and smoking tobacco. - report higher stress levels, less social support and lower levels of self-esteem. - 25.7% reported physical abuse. - 4.5% reported sexual abuse within the past year. -10.5% reported physical abuse during pregnancy. - Adolescents were more likely to report abuse than adult women.	- Ethnically diverse sample, although based within area of known low income families. - Focussed on alcohol and tobacco only. - No use of tool which would help accurate recall of events. Possibility of recall bias and under reporting of experiences and the use of substances.

Author	Aims	Methodology	Sample	Findings	Critique
Eaton et al. (2012)	To examine how pregnancy, for both men and women, is related to alcohol use behaviours and IPV.	Quantitative. Anonymous surveys. Demographic details collected. Experience or perpetration of IPV within last four months enquired about. Alcohol use enquired about.	N=2120 men and women attending drinking establishments in the Western Cape of South Africa. N= 1210 men. N= 910 women.	-13.3% reported being pregnant (n = 119). - 12.0% (n = 144) of men reported having a pregnant partner. - 61% of pregnant women reported attending the bar that evening to drink alcohol. - Experience and perpetration of IPV associated with alcohol use among all participants, except for men with pregnant partners. - Binge drinking was reported twice as often amongst pregnant women than non-pregnant women.	-Limited to men and women attending Shebeens in South Africa. - Large sample, however, smaller sample of pregnant women. - No use of tool which would help accurate recall of events. Possibility of recall bias and under reporting of experiences and the use of substances. - Limited to physical and sexual abuse. - Limited to alcohol use - Cross sectional data, therefore causal findings cannot be reported.

Author	Aims	Methodology	Sample	Findings	Critique
Connelly et al. (2013)	Examine the relationships of sociodemographic, psychosocial and behavioural characteristics with perinatal depression in a large and highly vulnerable sample of economically, educationally, racially and ethnically diverse pregnant women receiving perinatal care in community-based obstetric clinics.	Quantitative. Screening tools used - Edinburgh Postnatal Depression Scale (EPDS), Abuse Assessment Screen (AAS) Tolerance, Worried, Eye-opener,Amnesia,K/Cut down on consumption (TWEAK), Short Drug Abuse Screening Test (DAST-10) and the Partnership for Smoke Free Families (PSF) Health Survey for New Moms–Tobacco Use Questionnaire.	N=1868 women. N=1819 pregnant. N= 49 postpartum women receiving routinely scheduled obstetrical services any time throughout pregnancy or the 6-week postpartum visit. Recruited from 10 community obstetric/gynaecologic clinics.	- Women reporting substance use problems and IPV had higher odds for depressive symptoms. - 20.4% of participants screened positive for depressive symptoms. - 36.7% reported one or more psycho-social issue during the perinatal period. - 20.9% reported harmful drinking. - 4.3% reported drug use. - 23% reported substance use problems. - 3.5% reported current or recent IPV.	-Majority of participants pregnant. -Sample not ethnically diverse, limits generalisability and transferability of findings. - No use of tool which would help accurate recall of events. Possibility of recall bias and under reporting of experiences and the use of substances.

Author	Aims	Methodology	Sample	Findings	Critique
Brems et al. (2002)	Confirm links between childhood abuse and substance misuse.	Quantitative.	Pregnant women in substance misuse treatment (n=192).	- Physical violence in childhood appeared to have strong association with ongoing problems in adulthood. - Women reporting abuse were significantly younger at age of initiation of substance misuse, used substances more frequently and disclosed more psychological problems. - 49.5% reported experiencing physical abuse in childhood. - 119 of reported experiencing sexual abuse. - 15.6% reported all forms of abuse.	-Ethnically diverse sample. - Suggests women used substances at younger age as means to cope but mechanisms not explored. - Unclear why physical abuse had stronger association with substance misuse than sexual abuse, but mechanisms not explored. - No use of tool which would help accurate recall of events. Possibility of recall bias and under reporting of experiences and the use of substances.

Author	Aims	Methodology	Sample	Findings	Critique
El Marroun et al. (2008)	To determine demographic, emotional and social determinants of cannabis use in pregnancy.	Quantitative. Self-report questionnaires including Brief Symptom Inventory, short version of Childhood Trauma Questionnaire and Own memories of parenting questionnaire, used to collect information including demographics, psychopathology, drug use and relationship difficulties.	Mothers enrolled in Generation R Study in pregnancy who answered questions about their own substance use their partner's substance use before and during pregnancy (n=7531)	- Cannabis use during pregnancy associated with being younger, marital status, childhood trauma, educational attainment and delinquency. - Strongest determinant for cannabis use was found to be cannabis use by the babies' biological father. - Cannabis users more likely to smoke tobacco, drink alcohol and use other substances. - 3.2% reported use cannabis before pregnancy. - 2.9% used cannabis before and during pregnancy.	- Large, multi-ethnic sample. May not however be representative of region, limits generalisability and transferability of findings. -Missing data on substance use (14.3%). - No use of tool which would help accurate recall of events. Possibility of recall bias and under reporting of experiences and the use of substances. - Cross sectional data, therefore causal findings cannot be reported.

Author	Aims	Methodology	Sample	Findings	Critique
Fogel et al. (2001)	Explored pregnant, incarcerated women's experiences of childhood violence and substance use, parenting attitudes and psychological health.	Quantitative. Structured interviews. Questions were read to women in view of identified literacy problems.	Incarcerated women in the third trimester of pregnancy (n=63).	- Substance users were twice as likely to have experienced physical violence in childhood. - All of the women reporting sexual abuse in childhood were using substances. -60% reported experiencing family violence during childhood. - More than 70% reported experiencing major depressive symptoms. - Almost half reported using substances within the last year and during the current pregnancy.	-Relatively small sample for methodology. -High incidence of literacy problems. Structured questions – perhaps problems with understanding, disclosure of abuse and use of drugs when in face to face interview. - No use of tool which would help accurate recall of events. Possibility of recall bias and under reporting of experiences and the use of substances.

Author	Aims	Methodology	Sample	Findings	Critique
Frankenberger et al. (2015)	Test the hypothesis that there is a dose–response relationship between adverse childhood events (ACE) and alcohol use during pregnancy that is independent of pre-pregnancy alcohol use and other covariates.	Quantitative. Telephone interviews. Included standardized national questions, optional modules, and state-added questions to assess emerging public health issues.	N=1987 adult women.	- Pre-pregnancy drinking strongly associated with alcohol use during pregnancy. - Increasing ACEs were positively associated with higher odds of alcohol use during pregnancy. - 6% reported drinking alcohol during pregnancy.	- 51% response rate. - Representative sample of women in Nevada but may not be generalizable out-with study setting. - Did not use a validated measure of alcohol use/frequency to document pre-pregnancy alcohol use. - No use of tool which would help accurate recall of events. Possibility of recall bias and under reporting of experiences and the use of substances.

Author	Aims	Methodology	Sample	Findings	Critique
Haller and Miles, (2003)	(a) What is the prevalence of past 30-day victimization and perpetration among perinatal substance abusers entering drug treatment? (b) What patterns of victimization and/or perpetration are evidenced by this population? (c) What factors predict victimization and/or perpetration during pregnancy and the early postpartum period in drug-abusing women?	Quantitative. Structured clinical interviews and psychological tests - CPA intake form, Addiction Severity Index (ASI), Minnesota Multiphasic Personality Inventory (MMPI-2), Millon Clinical Multiaxial Inventory (MCMI-III) and Aggressive-Acts Questionnaire (AAQ).	N=77 pregnant substance admitted to the Centre for Perinatal Addiction which is a Substance Abuse Mental Health Services Administration–funded residential treatment program for pregnant and postpartum substance abusers and their neonates and other preschool age children.	-High rates of victimization. - High perpetration incidence. - 34% were on probation or parole. - Vast majority of women used cocaine (88%). - 81% were drug dependent. - 25% were alcohol dependent. - 72% were nicotine dependent. - Psychiatric comorbidity was common.	-Small sample, comprised mainly of poor women of colour. Representative of area of study, but findings not generalizable or transferrable out-with study setting. - Number of pregnant participants small. - No use of tool which would help accurate recall of events. Possibility of recall bias and under reporting of experiences and the use of substances.

Author	Aims	Methodology	Sample	Findings	Critique
Horrigan et al. (2002)	Identify behavioural traits and life events most strongly associated with substance misuse in pregnancy.	Quantitative. Women registering for prenatal care asked about medical and social history. Women were asked to take Substance Abuse Subtle Screening Inventory (SASSI)	Pregnant women (n=271).	- 55% positive to SASSI. SASSI positive women more likely to: - report history of severe depression - report physical and sexual abuse. - smoke cigarettes, drink beer, smoke marijuana or use cocaine. - report more concerns re: ability to care for baby than women not positive.	- Physical and sexual abuse history not defined as occurring in childhood or adulthood. - No use of tool which would help accurate recall of events. Possibility of recall bias and under reporting of experiences and the use of substances.

Author	Aims	Methodology	Sample	Critique	Findings
Nelson et al. (2010)	To examine the association between experiencing childhood physical and childhood sexual violence/rape on health status and high risk behaviours among young, pregnant urban women.	Quantitative. Urine samples collected to measure for substance use within previous 72 hours. Demographic data collected. TWEAK scales used to identify harmful alcohol intake. Psychological measures were taken.	All women (aged 14-40) attending for emergency room treatment who were identified as being <22 weeks gestation (n=1536).	-Women reporting childhood violence were twice as likely to be experiencing current violence. - Women reporting any childhood violence and current violence were five times more likely to report depressive symptoms and recent cocaine use. - Women reporting sexual violence and no current experience of violence reported higher psychological distress, problem drinking and smoking cigarettes in pregnancy. - 29% reported at least one incidence of physical abuse. - 14% reported at least one episode rape.	- Conducted 1991-2001. - Sample not ethnically diverse, limits generalisability and transferability of findings out-with study setting. - No use of tool which would help accurate recall of events. Possibility of recall bias and under reporting of experiences and the use of substances.

Appendix 3

Table 10 Excluded studies – did not include midwives (1 of 2)

Authors	Title of study	Aims of study
Agrawal et al. (2010)	Medical student views of substance abuse treatment, policy and training.	Examine the impact of medical education on students' views of substance abuse treatment, public policy options and training.
Allen and Beech, (2010)	Exploring factors that influence nurses: Judgements of violence risk in a female forensic population.	Examine how nursing staff in a secure forensic unit make judgements about female patients' level of risk and whether a patient's lack of engagement in therapy was a salient factor.
Brown et al. (2012)	Differing attitudes toward fetal care by pediatric and maternal-fetal medicine specialists.	Compare pediatric and obstetric specialists' attitudes regarding whether and when pediatrics consultation should be offered and their views about seeking court authorization to override maternal refusal of physician recommendations.
Croff et al. (2014)	Provider and state perspectives on implementing cultural-based models of care for American Indian and Alaska native patients with substance use disorders.	Assess provider and state efforts to increase client engagement and to improve the quality of care through culturally relevant interventions.
Dekker et al. (1993)	Prevalence of smoking in physicians and medical students, and the generation effect in the Netherlands.	Investigate smoking habits and attitudes towards smoking in general practitioners, consultants at a university hospital, medical students and students of health policy and management.
Gallant, (1990)	Problems in alcoholism treatment: Labeling and negative stereotyping.	Examine labelling and negative stereotyping amongst staff.
Heather et al. (2004)	Implementing routine screening and brief alcohol intervention in primary health care: A Delphi survey of expert opinion.	To obtain a consensus of expert views on how best to implement screening and brief intervention (SBI) for excessive drinkers in a routine and enduring fashion in primary health care throughout England.

Table 10 Excluded studies – did not include midwives (2 of 2)

Authors	Title of study	Aims of study
Hohman et al. (2008)	A concurrent validation study of the Alcohol and Other Drug Identification (AODI) Scale.	To measure the concurrent validity of the Alcohol and AODI scale, a measure of barriers to social workers addressing substance abuse issues with their clients.
O'Loughlin et al. (2001)	Smoking cessation counseling practices of general practitioners in Montreal.	To determine if general practitioners followed current practice guidelines.
Moore et al. (2004)	Characteristics of Opinion Leaders in Substance Abuse Treatment Agencies.	To test the effectiveness of technology transfer approaches related to evidence-based treatment of co-occurring substance abuse and mental health disorders. To specifically examine characteristics of "opinion leaders" as technology transfer agents.
Shields et al. (2008)	Primary care physicians' willingness to offer a new genetic test to tailor smoking treatment, according to test characteristics.	To assess physicians' willingness to offer a new test to individually tailor smoking treatment according to specific test characteristics
Wadd and Galvani, (2014)	Working with older people with alcohol problems: Insight from specialist substance misuse professionals and their service users.	To develop guidelines for health and social care workers on what intervention strategies are likely to work best with older drinkers.

Author	Aims	Methodology	Sample	Findings	Critique
Jenkins et al. (2013)	To explore midwives attitudes towards caring for pregnant drug users. To examine the relationships between midwives attitudes, experience and formal education in caring for women who abused drugs in pregnancy.	Quantitative. Self-report questionnaire. Comprised six demographic questions and 20 five-point Likert rated statements. 50% positive and 50% negative.	Convenience sampling to recruit 180 midwives from one NHS Trust. 73% response rate N=133 midwives.	- Midwives overall showed positive, non-punitive attitudes. - More recently qualified midwives displayed more positive attitudes. -Midwives with a formal education regarding substance use in pregnancy were significantly less likely to agree with negative statements.	-Took place in England. One site only. - Convenience sample. - Vast majority of participants (90%) had little recent clinical experience of supporting this client group.

Appendix 4 – Maternity care workers attitudes towards pregnant substance users/misusers

Author	Aims	Methodology	Sample	Findings	Critique
Miles et al. (2012)	Develop a deep understanding of the experiences of midwives who work with pregnant women who use illicit drugs, and identify the key components employed by midwives to manage when working with pregnant women who use illicit drugs.	Qualitative. Interviews. Thematic analysis informed by hermeneutic phenomenology was used.	N=12 midwives from three states working specifically with pregnant women who used illegal substances.	Three major themes identified – “making a difference”, “making partnerships” and “letting go”.	-Australian-based study. - Sample size appropriate for methodology used. - Focussed on midwives who had received education regarding substance use in pregnancy and who specifically supported this client group.

Author	Aims	Methodology	Sample	Findings	Critique
Radcliffe, (2011)	Examine the reproduction of stigma in maternity services by exploring the workplace discourse of antenatal staff in three hospital trusts. Part of a larger study into the experiences of substance-misusing women of antenatal services in three hospital trusts are	Qualitative. Semi-structured interviews, focus groups, field notes and observation of clinical encounters.	22 antenatal staff across the three hospital trusts. Participants included community midwives, specialist midwives, postnatal ward staff and sonographers.	-Midwives were found to negatively characterize substance-misusing and women prescribed methadone. - This was more apparent for midwives with little experience of supporting this client group. - Specialist midwives and drug workers were more likely to have an understanding of the organizational demands that are made on drug-using women. - Suggests midwives lack of clinical experience of working with this client group effects their perceptions and attitudes but this remains unclear.	-Study took place in England. - Aims to explore staff working in the antenatal areas' attitudes, but it is unclear how many of the participants were midwives.

Author	Aims	Methodology	Sample	Findings	Critique
Raeside, (2003)	To explore the influence of education and experience on the attitudes of neonatal nurses/midwives when caring for mothers and infants affected by substance abuse.	Quantitative. Self-report questionnaire. Comprised six demographic questions and 20 five-point Likert rated statements. 50% positive and 50% negative.	N=50 nurses/midwives.	-Attitudes of nurses/ Midwives' was generally negative/judgemental. - The most experienced staff generally had a more negative attitude than those with less neonatal experience. - Knowledge base was low. Formal neonatal education did not appear to have a positive effect on knowledge base or attitudes. - Results suggest mildly positive effect on attitudes from in-service education on substance abuse.	-Scottish based study. - Small sample in one unit based in area reported to have high rates of substance use. Generalisability and transferability of findings is therefore limited. - Unclear how many participants were nurses and how many were midwives.

Appendix 5

Participant Information Sheet and Consent Form

Interpersonal Trauma, Substance Misuse and Pregnancy

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Contact us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

The project is looking at the association between negative life experiences and drug use in pregnant women. I would like to hear how you think your experiences have affected your life. I would also like you to share your experiences of pregnancy and having a baby and hear your views about the care you have received during pregnancy and the early postnatal period.

Why have I been asked to take part?

You have been asked to take part as you have been attending the Specialist Midwife for East and Mid Lothian for antenatal care and support. The Specialist Midwife is giving this information to eligible pregnant women.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. Deciding not to take part or withdrawing from the study will not affect the healthcare that you receive, or your legal rights.

What will happen if I take part?

If you would like to take part in this study, please give permission for me to contact you and provide your Specialist Midwife with a suitable way for me to do this. We will meet on one occasion. With your permission, we will complete a “Life History Calendar”. This will allow us to record when you used drugs/alcohol and any negative life events you may have experienced (eg physical, emotional abuse, domestic violence). This will be followed by an interview where I will ask you about your drug/alcohol use, negative life experiences and how you think these have affected your life. I will ask about possible links between drug/alcohol use and negative life experiences. I will ask you about your experience of being pregnant and how you feel about your journey to motherhood.

Interviews will last a maximum of ninety minutes and can be stopped at any time by you. You do not have to answer questions if you do not want to. It will be recorded using a digital audio tape. The recorded interview will be transcribed by myself, immediately after the interview. You can withdraw from the project at any time without giving a reason for doing so.

All information collected will be kept in a secure place that will only be accessible by myself. Participation is voluntary and I will ask you to provide written consent when we meet. I have attached a consent form so you know what I will be asking you to sign. I will let your Specialist Midwife know that you are taking part.

What are the possible benefits of taking part?
You may/may not get a direct benefit from taking part in this study. There are no direct benefits to you taking part in this study, but the results from this study might inform on the future healthcare of other patients.

What are the possible disadvantages and risks of taking part?
It is not thought that there are many disadvantages; however, it is possible that we may discuss sensitive subjects. You do not need to provide any details of your experiences and can refuse to answer any questions you do not want to answer. We will meet on one occasion, for a maximum of ninety minutes. I will provide contact information for organisations that can offer further information and support regarding some of the issues we may speak about. Your Specialist Midwife will also provide support to you if required.

What if there is a problem?
If you have a concern about any aspect of this study please contact Professor Thanos Karatzias at t.karatzias@napier.ac.
In the unlikely event that something goes wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against NHS Lothian but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate).

What happens when the study is finished?
At the end of the research we will destroy all identifiable data collected.

Will my taking part in the study be kept confidential?
All the information we collect during the course of the research will be kept confidential and there are strict laws which safeguard your privacy at every stage. Study researchers will not need access to your medical records in order to carry out this research. All personal, identifiable data will be destroyed immediately after

completion of this study. With your consent we will inform your GP that you are taking part.

To ensure that the study is being run correctly, we will ask your consent for responsible representatives from Edinburgh Napier University, to access the data collected during the study, where it is relevant to you taking part in this research. The Sponsor is responsible for overall management of the study and providing insurance and indemnity.

All information collected will be treated with the strictest confidence, but if you disclose that you or your baby is in immediate harm (for example, if you tell me you are currently using street drugs, if you disclose child protection issues, if you tell me you are concerned about your safety or if you disclose involvement in criminal activities) I will have to report this to your Specialist Midwife.

Everything you tell me will be anonymized. All names will be replaced with a number to ensure you cannot be identified in any way. If I quote something you have said in my project or any publication, I will not use your real name and will remove any personal details that may identify you in any way.

What will happen to the results of the study?
The study will be written up as PhD Thesis. Results of the study may be published in a journal article and/or presented at a conference. *You will not be identifiable in any published results.*

If you would like a copy of your transcribed interview and/or a general summary of the findings, this will be made available to you. I will send these to an address of your choice or hand deliver a copy to your Specialist Midwife to give to you. Copies will be in a sealed envelope marked with your name. The envelope will be marked private and confidential.

Who is organising the research and why?
This study is being organised/sponsored by Edinburgh Napier University. The study is funded by Edinburgh Napier University.

Who has reviewed the study?
The study proposal has been reviewed by the FRECG Committee, School of Nursing, Midwifery and Social Care, Edinburgh Napier University. All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee. A favourable ethical opinion has been obtained from South East Scotland REC. NHS management approval has also been obtained.

If you have any further questions about the study please contact Naomi Waddell via email at: 40103888@live.napier.ac.uk

If you would like to discuss this study with someone independent of the study please contact: Dr Barbara Neades at B.Neades@napier.ac.uk.

If you wish to make a complaint about the study please contact NHS Lothian:

NHS Lothian Complaints Team
2nd Floor
Waverley Gate
2 - 4 Waterloo Place
Edinburgh
EH1 3EG
Tel: 0131 465 5708
craft@nhslothian.scot.nhs.uk

Thank you for taking the time to read this information sheet.

CONSENT FORM
Interpersonal Trauma, Substance Misuse and Pregnancy

Participant ID:

Naomi Waddell
Tel: 07704861047
Email: 40103888@live.napier.ac.uk

Please initial box

1. I confirm that I have read and understand the information sheet (as specified in this document header) for the above study and have had the opportunity to consider the information and ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from the Sponsor (Edinburgh Napier University), from the NHS organisation or other authorities, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

4. I agree to my General Practitioner being informed of my participation in this study ☐

5. I agree to take part in the above study ☐

_____	_____	_____
Name of Participant	Date	Signature

_____	_____	_____
Name of Person taking consent	Date	Signature

Appendix 6

Notes taken from reflexive diary regarding cancelled appointments with pregnant women

19.02.16 – Fife woman, texted to say too emotional to take part at the moment. She requested that she bring someone with her as she finds it difficult to talk about her drug problem. I had said that would be okay. Happy for me to contact her again in the future.

15.03.16 – Edinburgh woman (prepare team). Interview was to take place in her own home with substance misuse midwife present (woman had requested home visit and presence of midwife). Text from substance misuse midwife an hour before meeting to say the participant had been in touch with her to say she felt too emotional.

12.04.16 – Edinburgh woman (east and mid). Interview was to take place in patients primary care centre at 10.00. I had texted night before to confirm and participant said yes (although she said she had it in her diary for Thursday). Participant texted me in the morning (whilst I was on city bypass) to say her youngest child had had a fall that day. Texted her back to say no problem and could I get in touch with her again – no reply as yet.

26.04.16 - Edinburgh woman who had rescheduled from 12.04.16. Interview was to take place in primary care centre at 10.00. Texted her last week to confirm date, time and location. She texted back, very keen to meet. Texted again night before to double check. She texted back this am to say she has been unwell and won't make it. Says she has been unwell throughout pregnancy and has let many people down. Says very embarrassed. Texted her back with well wishes and asked if perhaps seeing her at home would be better for her when she feels well enough. I have asked her to let her midwife know if she would like this.

09.05.16 - Edinburgh woman who had rescheduled from 26.04.16. Interview was due to take place today 10.00-11.30 in her own home, with her specialist midwife present. I contacted her by text message yesterday to confirm our meeting. She texted back to say she had a meeting and was worried she may not make it back in time. I suggested we change the time to 11.00 but she did not text back. I texted this am to see if it would be okay for her midwife and I to come at 10.00 as arranged and that we would wait outside for her if she was late. I then received an email from her specialist midwife to say that the woman had been in contact with her to say that the meeting was causing her some distress and so she felt it was best to cancel today. Specialist Midwife said that woman would still like to take part and that she will contact her this afternoon to get a date arranged ASAP.

17.05.16 – Planned to meet woman from Fife. Email from Specialist Midwife to say participant can't make it. Has to attend group work and will be excluded if can't make it to them all. Woman happy to reschedule.

07.06.16 – Email from Specialist Midwife re: need to cancel apt with woman from Fife for 7th. This was a re-scheduled apt as woman was required to attend a group on the original date. I emailed the Specialist Midwife to see if the potential participant would

like to meet me first so that she can find out more about the study, but Specialist Midwife says the woman not scared about taking part.

08.06.16 – Met woman from Edinburgh today who had rescheduled before. Potential participant had asked her Specialist Midwife if I could meet her for an informal chat. Talked for ages (two and a half hours). Very open about her childhood and her experiences in adulthood. Multiple traumas in her lifetime. Remembers arguments between parents during childhood. Described vivid memory of sitting on stairs listening to argument then hearing tremendous crash – terrified – turned out her dad had lifted cutlery drawer and smashed it through patio doors in the kitchen. Remembers her brother rescuing her from the stairs and carrying her to her bedroom for safety. Says never felt loved by mother, always felt a distance. Big gap between her and her siblings, always felt they got more attention than her. Mum and dad split when very young. Remembers series of boyfriends and one she described as "old pervert"? hinting at CSA which she later disclosed. Mum and boyfriends never in, always out drinking therefore left at home under supervision of brother most of the time. Introduced to alcohol and drugs by brother and his peer group. Says she felt he was looking after her, never felt vulnerable, he took good care of her. Says was always very popular girl at school, was very pretty, had lots of friends. Enjoyed being in brothers friends company, made her feel grown up (says brother would leave her downstairs with his friends whilst he was upstairs "being naughty" with his girlfriends). Met guy at school, he too popular but turned out to be unkind. More drink and drugs. Missed opportunities from school. Homeless as a teenager. Has both children. Drink and heroin both problematic. On meth programme, doesn't know when to stop when drinking alcohol, has always been able to drink a lot, says must be genetic. Says it was inevitable that she would have issues with alcohol due to her mum being the same. Series of violent men in life. Different partners for each child, both violent. Good partner now. Good relationship with dad, trying to rebuild relationship with mum now. Polysubstance use. Feels dirty, contaminated due to drink and drug use. Hates being on meth programme. Hope I have allayed some of her fears. She says she will definitely take part now. She was very surprised that these issues are under researched and says that she thinks that talking about it all will help in her recovery although she appreciates that I will not be providing any counselling etc. Fingers crossed she will see me again. Plan to meet on 16.06.16.

16.06.16 – Due to see woman from Edinburgh today. Texted her last to confirm and all okay. Text message from her this morning. Very apologetic. Received bad news about a family friend late last night and therefore doesn't feel able to take part.

27.06.16 – Email from Specialist Midwife – Fife woman who had to reschedule has delivered early so no longer eligible to take part.

05.07.16 – Due to see woman in Edinburgh today (rescheduled from 12.06.16) but got text from Specialist Midwife last night to say woman is unable to make it due to childcare difficulties. I have asked her to see if the women would be happy to do telephone interview.

Version 1 12.06.15

Appendix 7

Interpersonal trauma, substance misuse and pregnancy – A phenomenological exploration of pregnant women and midwives in Scotland

Midwives: You are being invited to take part in a research study.

What is the purpose of the study?

The project is looking at the association between negative life experiences and drug use in pregnant women. It will explore Midwives experiences and perceptions of supporting pregnant women who misuse substances. It will explore Midwives experiences and perceptions of what this client groups' journey through pregnancy and the early postnatal period may be like.

If you are interested in taking part in this study please contact:

Naomi Waddell
PhD Student
Edinburgh Napier University
40103888@live.napier.ac.uk
07704 861 047

Appendix 8

Participant Information Sheet and Consent Form
Interpersonal Trauma, Substance Misuse and Pregnancy

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Contact us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

The project is looking at the association between negative life experiences and drug use in pregnant women. It will explore Midwives experiences and perceptions of supporting pregnant women who misuse substances. It will explore Midwives experiences and perceptions of what this client groups' journey through pregnancy and the early postnatal period may be like.

Why have I been asked to take part?

You have been asked to take part because you are employed as a registered Midwife within Maternity Services in NHS Lothian. If you have experience of supporting pregnant women who misuse substances and are able to give independent informed consent, then you are eligible to take part in this study.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. Deciding not to take part or withdrawing from the study will not affect you or your legal rights.

What will happen if I take part?

If you would like to take part in this study, please contact me and provide a suitable way for me to get in touch with you to arrange at suitable time to meet with you. I would like to carry out face to face interviews in a place of your choice. The interview will last approximately sixty minutes and can be stopped at any time by you. You do not have to answer questions if you do not want to. It will be recorded using a digital audio tape. The recorded interview will be transcribed by myself, immediately after the interview. You can withdraw from the project at any time without giving a reason for doing so.

All information collected will be kept in a secure place that will only be accessible by myself. Participation is voluntary and I will ask you to provide written consent when we meet. I have attached a consent form so you know what I will be asking you to sign.

What are the possible benefits of taking part?

You may/may not get a direct benefit from taking part in this study. There are no direct benefits to you taking part in this study, but the results from this study might inform on the future healthcare of patients and future education and training of health care staff.

What are the possible disadvantages and risks of taking part?

It is not thought that there are many disadvantages; however, it is possible that we may discuss sensitive subjects. You do not need to provide any details of your experiences and can refuse to answer any questions you do not want to answer. We will meet on one occasion, for a maximum of sixty minutes. I will provide contact information for organisations that can offer further information and support regarding some of the issues we may speak about. You can also can access support through statutory supervision if required.

What if there is a problem?

If you have a concern about any aspect of this study please contact Professor Thanos Karatzias at t.karatzias@napier.ac.
In the unlikely event that something goes wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against NHS Lothian but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate).

What happens when the study is finished?

At the end of the research we will destroy all identifiable data collected.

Will my taking part in the study be kept confidential?

All the information we collect during the course of the research will be kept confidential and there are strict laws which safeguard your privacy at every stage. All personal, identifiable data will be destroyed immediately after completion of this study.

To ensure that the study is being run correctly, we will ask your consent for responsible representatives from Edinburgh Napier University, to access the data collected during the study, where it is relevant to you taking part in this research. The Sponsor is responsible for overall management of the study and providing insurance and indemnity.

All information collected will be treated with the strictest confidence, but if you disclose unprofessional practice, I will have to report this to the on-call Supervisor of Midwives. Everything you tell me will be anonymized. All names will be replaced with a number to ensure you cannot be identified in any way. If I quote something you have said in my project or any publication, I will not use your real name and will remove any personal details that may identify you in any way.

What will happen to the results of the study?
The study will be written up as PhD Thesis. Results of the study may be published in a journal article and/or presented at a conference. *You will not be identifiable in any published results.*

If you would like a copy of your transcribed interview and/or a general summary of the findings, this will be made available to you. I will send these to an address of your choice. Copies will be in a sealed envelope marked with your name. The envelope will be marked private and confidential.

Who is organising the research and why?
This study is being organised/sponsored by Edinburgh Napier University. The study is funded by Edinburgh Napier University.

Who has reviewed the study?
The study proposal has been reviewed by the FRECG Committee, School of Nursing, Midwifery and Social Care, Edinburgh Napier University. All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee. A favourable ethical opinion has been obtained from South East Scotland REC. NHS management approval has also been obtained.

If you have any further questions about the study please contact Naomi Waddell on: 07704 861 047 or email: 40103888@live.napier.ac.uk

If you would like to discuss this study with someone independent of the study please contact: Dr Barbara Neades at B.Neades@napier.ac.uk.
If you wish to make a complaint about the study please contact NHS Lothian:
NHS Lothian Complaints Team
2nd Floor
Waverley Gate
2 - 4 Waterloo Place
Edinburgh
EH1 3EG
Tel: 0131 465 5708
craft@nhslothian.scot.nhs.uk

Thank you for taking the time to read this information sheet.

CONSENT FORM

Interpersonal Trauma, Substance Misuse and Pregnancy

Participant ID:

Naomi Waddell
Tel: 07704861047
Email: 40103888@live.napier.ac.uk

Please initial box

1. I confirm that I have read and understand the information sheet (as specified in this document header) for the above study and have had the opportunity to consider the information and ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that relevant data collected during the study may be looked at by individuals from the Sponsor (Edinburgh Napier University), from the NHS organisation or other authorities, where it is relevant to my taking part in this research. ☐

4. I agree to take part in the above study ☐

_____	_____	_____
Name of Participant	Date	Signature

_____	_____	_____
Name of Person taking consent	Date	Signature

1x original – into Site File; 1x copy – to Participant

Appendix 9

Notes taken from reflexive diary regarding cancelled appointments with Midwives

Cancelled appointment's – midwives
04.03.16 – Participant off sick.

04.04.16 – Participant has had to change shift.

Have had interest from three midwife's who haven't got back to me after I have sent them the participant info. Sheet. Frustrating and difficult to know how many times to approach someone – have decided that after three tries, I won't contact them again. Frustrating, but not as much as the pregnant women!!

Appendix 10

Definitions of abuse

NEGLECT

Neglect means not getting the basic things you need. This may include not having access to:

- Clean, warm clothes or shoes
- Comfort and affection
- Enough to eat and drink
- Protection and guidance to keep you away from dangerous situations
- Somewhere warm and comfortable to sleep
- Help when you're ill or you've been hurt
- Support with getting your education

PHYSICAL ABUSE

Physical abuse is when someone deliberately hurts or injures you. Physical abuse can involve:

- Hitting and smacking
- Slapping
- Punching
- Pinching
- Kicking
- Shaking or suffocating
- Scalding or burning
- Hair pulling
- Someone deliberately making you ill

EMOTIONAL ABUSE

Emotional abuse is when someone says or does something that makes you feel bad about yourself, scared, sad, upset or worthless.
Emotional abuse could be:

- shouting at you, calling you names, putting you down, humiliating you
- saying or doing things that make you feel bad about yourself
- pushing you away or not showing you affection
- putting you in dangerous situations
- making you see things that are distressing, like domestic violence or drug/alcohol misuse
- stopping you from having friends

SEXUAL ABUSE / ASSAULT

Sexual abuse involves forcing or tricking someone into taking part in any kind of sexual activity. This can include kissing, touching genitals or breasts, vaginal or anal intercourse or oral sex. Sexual abuse can involve:

- being touched in a way you don't like without giving permission or consent
- being forced to have sex (rape)
- forced to look at sexual pictures or videos
- made or forced to do something sexual

DOMESTIC VIOLENCE

Domestic abuse means experiencing harm from a current or former partner and can involve:

- Physical violence
- Sexual violence
- Threatening to hurt you
- Financial abuse – not allowing somebody to spend their own money or not giving them money for basic things
- Stopping someone from going to work

WITNESSING VIOLENCE

Witnessing violence means seeing other people being hurt or assaulted. This can include:

- Witnessing domestic violence
- Witnessing physical abuse or assault, e.g. someone being beaten up or threatened
- Witnessing sexual abuse or assault
- Witnessing emotional abuse

(Adapted from NSPCC. (2009). *Child protection fact sheet. The definitions and signs of child abuse*. April. WHO. (1999). *Report of the Consultation on Child Abuse Prevention*. 29-31, March. Women's Aid. (2014). *What is domestic violence?)*

Edinburgh Napier UNIVERSITY

Version 1 23.04.15

Appendix 11 Life History Calendar

Born *[year]*	**Age**	**1**	**2**	**3**	**4**	**5**	**6**	**…**	**…**	**42**	**43**	**44**	**45**
Memorable events	*Living arrangements*												
	[Event]												
	[Event]												
Drug/alcohol use (inc tobacco)	Alcohol												
	Drug *(type)*												
	Drug *(type)*												
	Drug *(type)*												
	Alcohol Dependence												
	Drug Dependence												
Negative life experiences	Neglect												
	Physical abuse												
	Emotional abuse												
	Sexual abuse/ assault												
	Domestic violence												
	Physical assault												
	Witnessing violence												

Version 2 12.06.15

Appendix 12 – Debriefing sheet for pregnant women (Lothians)

Thank you for taking the time to take part in this research study. Please find below details of organizations that offer further information if needed. Your Specialist Midwife will also provide support to you if required.

www.survivorscotland.org.uk

www.gbv.scot.nhs.uk

Edinburgh Women's Rape and Sexual Abuse Centre

1 Leopold Place

Edinburgh

EH7 5JW

Email: support@ewrasac.org.uk

www.ewrasac.org.uk

0131 556 9437

Health in Mind

40 Shandwick Place

Edinburgh

EH2 4RT

Email: contactus@health-in-mind.org.uk
www.health-in-mind.co.uk

0131 225 8508

Open Secret

98 Thornhill Road

Falkirk

FK2 7AB

Email: info@opensecret.org
www.opensecret.org

01324 630100

Samaritans

08457 90 90 90 (24 hour support for anyone experiencing distress or suicidal thoughts)

Rape Crisis Scotland

www.rapecrisisscotland.org.uk

08088 010302 (free helpline every day 6pm till midnight

Victim Support

www.victimsupport.org

0845 30 30 900 (Mon-Fri 9am-9pm, Sat & Sun 9am-7pm)

Provides support and information for people affected by crime including rape and sexual abuse.

NAPAC (National Association for People Abused in Childhood)

Email: support@napac.org.uk

napac.org.uk

0800 085 3330

Provides information, advice and support for adult survivors of any form of childhood abuse.

Scottish Domestic Abuse Helpline

0800 027 1234

TANSAL (The Abuse Network Survivor Aid Links)

Tansal.50megs.com

Provides information on literature, links and UK based events for survivors of any form of childhood abuse and those supporting them.

Refuge

Email: info@refuge.org.uk

www.refuge.org.uk

0808 2000 247 (24 hour national domestic violence helpline)

Broken Rainbow

Email: help@broken-rainbow.org.uk

www.broken-rainbow.org.uk

0300 999 5428 (Monday 2pm-8pm, Wednesday 10am-5pm, Thursday 2pm-8pm)

Support for lesbian, gay, bisexual and transgender people experiencing domestic violence.

Counselling Directory

Connecting you with Professional Support: http://www.counselling-directory.org.uk

SAJE Scotland

Group work intervention designed to empower women to make positive choices about their lives.

Freedom Project: www.sajescotland.org

Scottish Women's Rights Centre

Partnership between Rape Crisis Scotland, Strathclyde University Law Clinic (SULC) and Legal Services Agency. Provides helpline for women experiencing gender based violence to have access to legal information. Helpline staffed by volunteers from SULC with support from a qualified solicitor.

Tel: 08088 010 789 open every Wednesday 13.30-16.30.

Appendix 12a – Debriefing sheet for pregnant women (Fife)

Thank you for taking the time to take part in this research study. Please find below details of organizations that offer further information if needed. Your Specialist Midwife will also provide support to you if required.

www.survivorscotland.org.uk

www.gbv.scot.nhs.uk

Fife Women's Aid

Email: info@fifewomensaid.org.uk

0808 802 5555 (24 hour helpline)

Suite 1

First Floor, Saltire House

Pentland Park

Glenrothes

KY6 2AL

Fife Rape and Sexual Assault (FRASAC)

182a Esplanade

KIRKCALDY

KY1 1RE

01592 642336

E-Mail: info@frasac.org.uk

Office Hours - Monday-Thursday 9am till 4pm, Friday 9am till 12noon

Rape Crisis Helpline: 08088 01 03 02 open daily 6pm - 12noon

Support in Mind Scotland

John Hunter House

Hunter Street

Kirkcaldy

Information line: 0131 662 4359

Tel: 01592 268388 or 01592 649785
email: fifeservices@supportinmindscotland.org.uk

Open Secret

98 Thornhill Road

Falkirk

FK2 7AB

Email: info@opensecret.org

www.opensecret.org

01324 630100

Samaritans

08457 90 90 90 (24 hour support for anyone experiencing distress or suicidal thoughts)

Rape Crisis Scotland

www.rapecrisisscotland.org.uk

08088 010302 (free helpline available every day from 6pm till midnight)

Victim Support

www.victimsupport.org

0845 30 30 900 (Mon-Fri 9am-9pm, Sat & Sun 9am-7pm)

Provides support and information for people affected by crime including rape and sexual abuse.

NAPAC (National Association for People Abused in Childhood)

Email: support@napac.org.uk

napac.org.uk

0800 085 3330

Provides information, advice and support for adult survivors of any form of childhood abuse.

Scottish Domestic Abuse Helpline

0800 027 1234

Counselling Directory

Connecting you with Professional Support: http://www.counselling-directory.org.uk

SAJE Scotland

Group work intervention designed to empower women to make positive choices about their lives.

Freedom Project: www.sajescotland.org

TANSAL (The Abuse Network Survivor Aid Links)

Tansal.50megs.com

Provides information on literature, links and UK based events for survivors of any form of childhood abuse and those supporting them.

Refuge

Email: info@refuge.org.uk

www.refuge.org.uk

0808 2000 247 (24 hour national domestic violence helpline)

Broken Rainbow

Email: help@broken-rainbow.org.uk

www.broken-rainbow.org.uk

0300 999 5428 (Monday 2pm-8pm, Wednesday 10am-5pm, Thursday 2pm-8pm)

Support for lesbian, gay, bisexual and transgender people experiencing domestic violence.

Scottish Women's Rights Centre

Partnership between Rape Crisis Scotland, Strathclyde University Law Clinic (SULC) and Legal Services Agency. Provides helpline for women experiencing gender based violence to have access to legal information. Helpline staffed by volunteers from SULC with support from a qualified solicitor.

Tel: 08088 010 789 open every Wednesday 13.30-16.30.

Appendix 13 Debriefing letter (Midwives)

Thank you for taking the time to take part in this research study. Please find below details of organizations that offer further information. You can access support through statutory supervision if required.
If you would like any information regarding this study, please do not hesitate to contact me at 40103888@live.napier.ac.uk or my Supervisor Professor Thanos Karatzias at t.karatzias@napier.ac.uk.
Dr Barbara Neades is the independent advisor for this study and can be contacted at B.Neades@napier.ac.uk. Dr Neades is not directly involved in this study and can give you further information regarding the research process if required.

www.survivorscotland.org.uk

www.gbv.scot.nhs.uk

Edinburgh Women's Rape and Sexual Abuse Centre
1 Leopold Place

Edinburgh

EH7 5JW

Email: support@ewrasac.org.uk

www.ewrasac.org.uk

0131 556 9437

Health in Mind

40 Shandwick Place

Edinburgh

EH2 4RT
Email: contactus@health-in-mind.org.uk
www.health-in-mind.co.uk

0131 225 8508

Open Secret
98 Thornhill Road

Falkirk

FK2 7AB

Email: info@opensecret.org
www.opensecret.org

01324 630100

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Rape Crisis Scotland

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08088 010302 (free helpline every day 6pm till midnight

Victim Support

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Provides support and information for people affected by crime including rape and sexual

abuse.

NAPAC (National Association for People Abused in Childhood)

Email: support@napac.org.uk

napac.org.uk

0800 085 3330

Provides information, advice and support for adult survivors of any form of childhood abuse.

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0808 2000 247 (24 hour national domestic violence helpline)

Broken Rainbow

Email: help@broken-rainbow.org.uk

www.broken-rainbow.org.uk

0300 999 5428 (Monday 2pm-8pm, Wednesday 10am-5pm, Thursday 2pm-8pm)

Support for lesbian, gay, bisexual and transgender people experiencing domestic violence.

Appendix 14

Proposed Interview Schedule for Pregnant women

1. How do you feel about being pregnant/becoming a Mum? *(pregnancy,motherhood as a motivator to make changes/perception of care given/involvement of multi-agencies/support network)*

2. Can you tell me a bit more about when you started using alcohol/drugs? *(first experiments/who introduced/why started using/why continued using/how did it make you feel/quantities)*

3. How did taking drugs/drinking alcohol make you feel?(*coping mechanism, block out trauma)*

4. Can you tell me if you think that there are links between the negative things that have happened in your life and taking drugs/drinking alcohol? *(associations between trauma and sub misuse,coping strategies)*

5. Would you feel comfortable telling me a bit more about the negative experiences that have happened in your life? *(perpetrator/frequency/support network)*

6. Can you tell me a bit about the care you have received during pregnancy/motherhood?*(good experience?/bad experience?/what helped/didn't help)*

Is there anything else you would like to add that you feel is relevant but hasn't been covered?
Thank you for taking part in this study.

Version 1 24.04.15

Appendix 15

Proposed Interview Schedule for Midwives

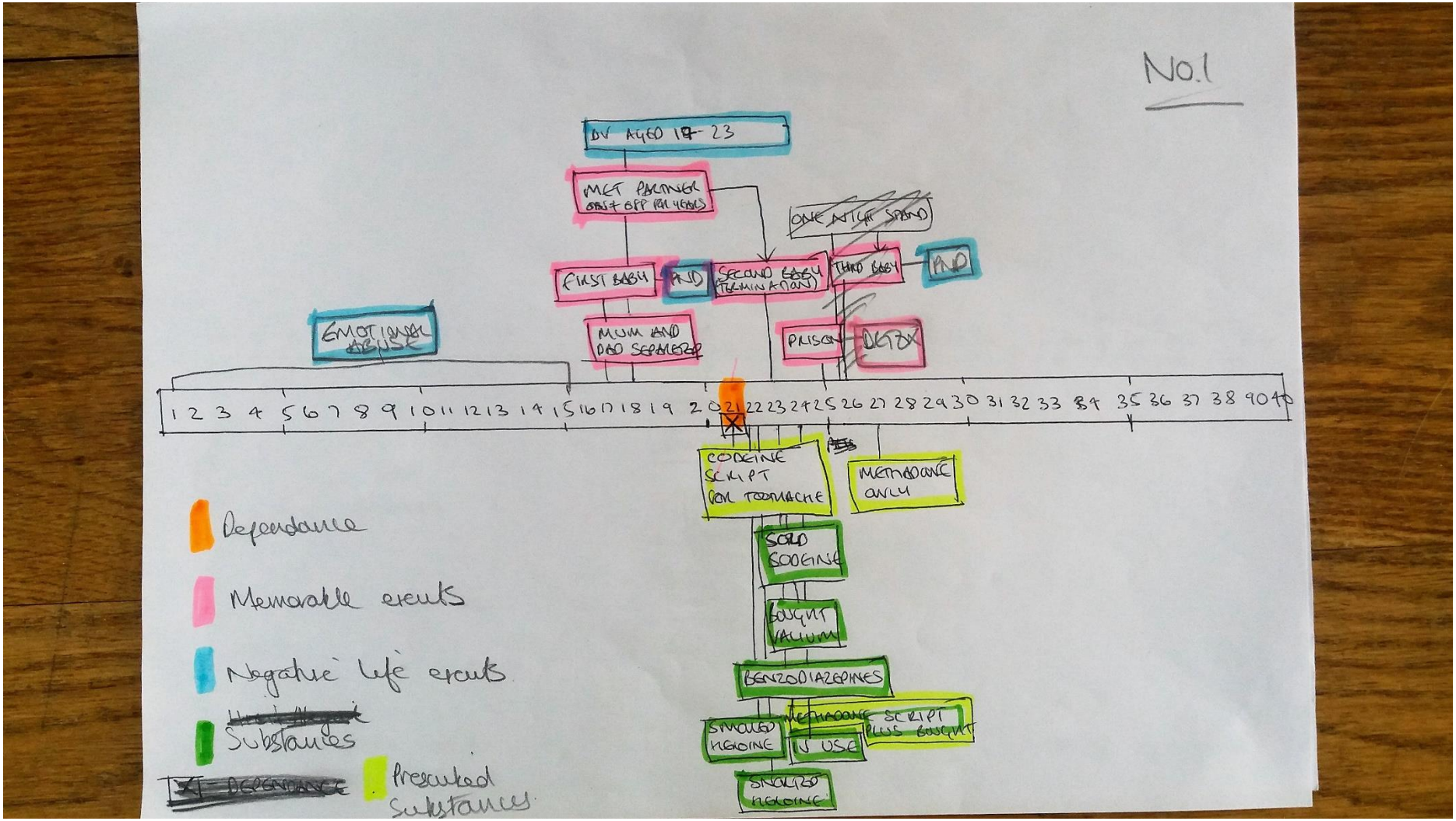
1. Can you tell me about your experiences of looking after pregnant women/new mothers' who misuse substances?
2. Do you think alcohol/drug dependence impacted, if at all, on their experiences of pregnancy/motherhood?
3. How do you feel about supporting pregnant/new mothers' who misuse substances?
4. Have you received any education regarding substance misuse?
5. Can you tell me if you consider the impact a history of interpersonal violence may have had in the lives of pregnant women who misuse substances?
6. How do you think pregnant / new mothers who misuse substances can be best supported?
7. Do you have any examples of good practice you would like to share with me?

Is there anything else you would like to add that you feel is relevant but hasn't been covered?

Thank you for taking part in this study.

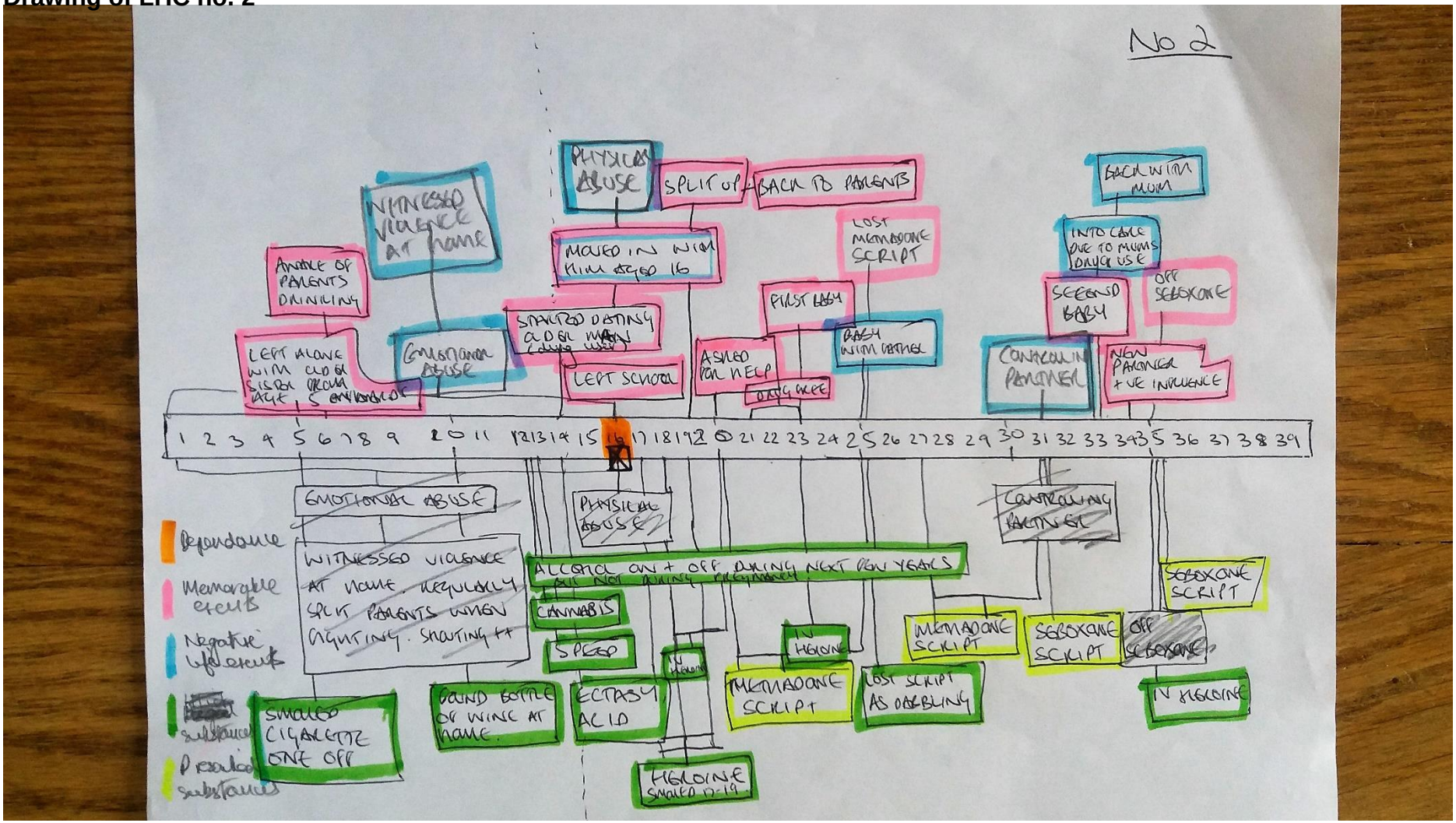
Appendix 16

Drawing of LHC no. 1



Appendix 16

Drawing of LHC no. 2

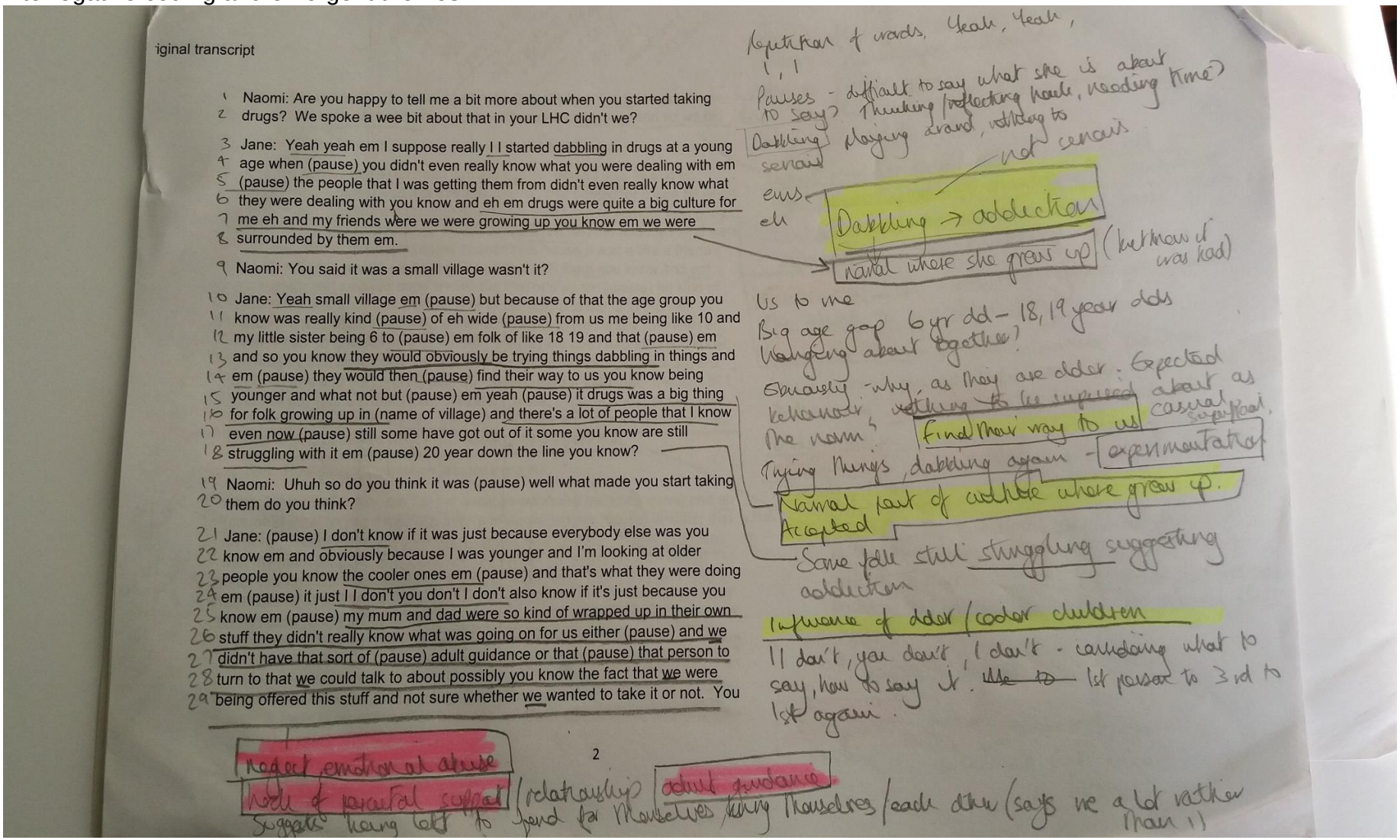


Appendix 17 Example of analysis of transcript – pregnant participant

Such a sad story, seemed like she really wanted to talk about her experiences. Very articulate woman. I thought she may stop interview after she became tearful when talking about her children being taken into care, but happy to start again. Says found this really helpful, has had counselling in the past but not done anything like LHC before, says it really helped her, seeing it all written down in order (? sense of validation that it has been bad/hard, can see the order of trauma and substance use more clearly when it's in black and white?). Keen for me to meet wee boy, kept saying "he looks okay, doesn't he?", suggesting she still worries about impact of substances on him? Very proud mum. Mixture of emotions for me – shock, sadness, anger at missed opportunities and can't help but wonder what her life would be like now if her parents had been more available when she was a child.

Extract from reflective diary (written in car after interview)

Appendix 17 Extract from pregnant participant interview showing description and content, language use, conceptual and interrogative coding and emergent themes.



iginal transcript

1 Naomi: Are you happy to tell me a bit more about when you started taking
2 drugs? We spoke a wee bit about that in your LHC didn't we?

3 Jane: Yeah yeah em I suppose really I I started dabbling in drugs at a young
4 age when (pause) you didn't even really know what you were dealing with em
5 (pause) the people that I was getting them from didn't even really know what
6 they were dealing with you know and eh em drugs were quite a big culture for
7 me eh and my friends were we were growing up you know em we were
8 surrounded by them em.

9 Naomi: You said it was a small village wasn't it?

10 Jane: Yeah small village em (pause) but because of that the age group you
11 know was really kind (pause) of eh wide (pause) from us me being like 10 and
12 my little sister being 6 to (pause) em folk of like 18 19 and that (pause) em
13 and so you know they would obviously be trying things dabbling in things and
14 em (pause) they would then (pause) find their way to us you know being
15 younger and what not but (pause) em yeah (pause) it drugs was a big thing
16 for folk growing up in (name of village) and there's a lot of people that I know
17 even now (pause) still some have got out of it some you know are still
18 struggling with it em (pause) 20 year down the line you know?

19 Naomi: Uhuh so do you think it was (pause) well what made you start taking
20 them do you think?

21 Jane: (pause) I don't know if it was just because everybody else was you
22 know em and obviously because I was younger and I'm looking at older
23 people you know the cooler ones em (pause) and that's what they were doing
24 em (pause) it just I I don't you don't I don't also know if it's just because you
25 know em (pause) my mum and dad were so kind of wrapped up in their own
26 stuff they didn't really know what was going on for us either (pause) and we
27 didn't have that sort of (pause) adult guidance or that (pause) that person to
28 turn to that we could talk to about possibly you know the fact that we were
29 being offered this stuff and not sure whether we wanted to take it or not. You

2

Repetition of words, Yeah, Yeah, I, I

Pauses - difficult to say what she is about to say? Thinking/reflecting back, needing time?

Dabbling

Dabbling → addiction

Natal where she grew up

Big age gap 6 yr old - 18, 19 year olds hanging about together?

Sexually - why, as they are older. Expected behaviour, nothing to be surprised about as the norm?

Trying things, dabbling again - experimentation

Find their way to us casual

Natal part of estate where grew up. Accepted

Some folk still struggling suggesting addiction

Influence of older/cooler children

I I don't, you don't, I don't - struggling what to say, how to say it. ~~like to~~ 1st person to 3rd to 1st again.

neglect, emotional abuse

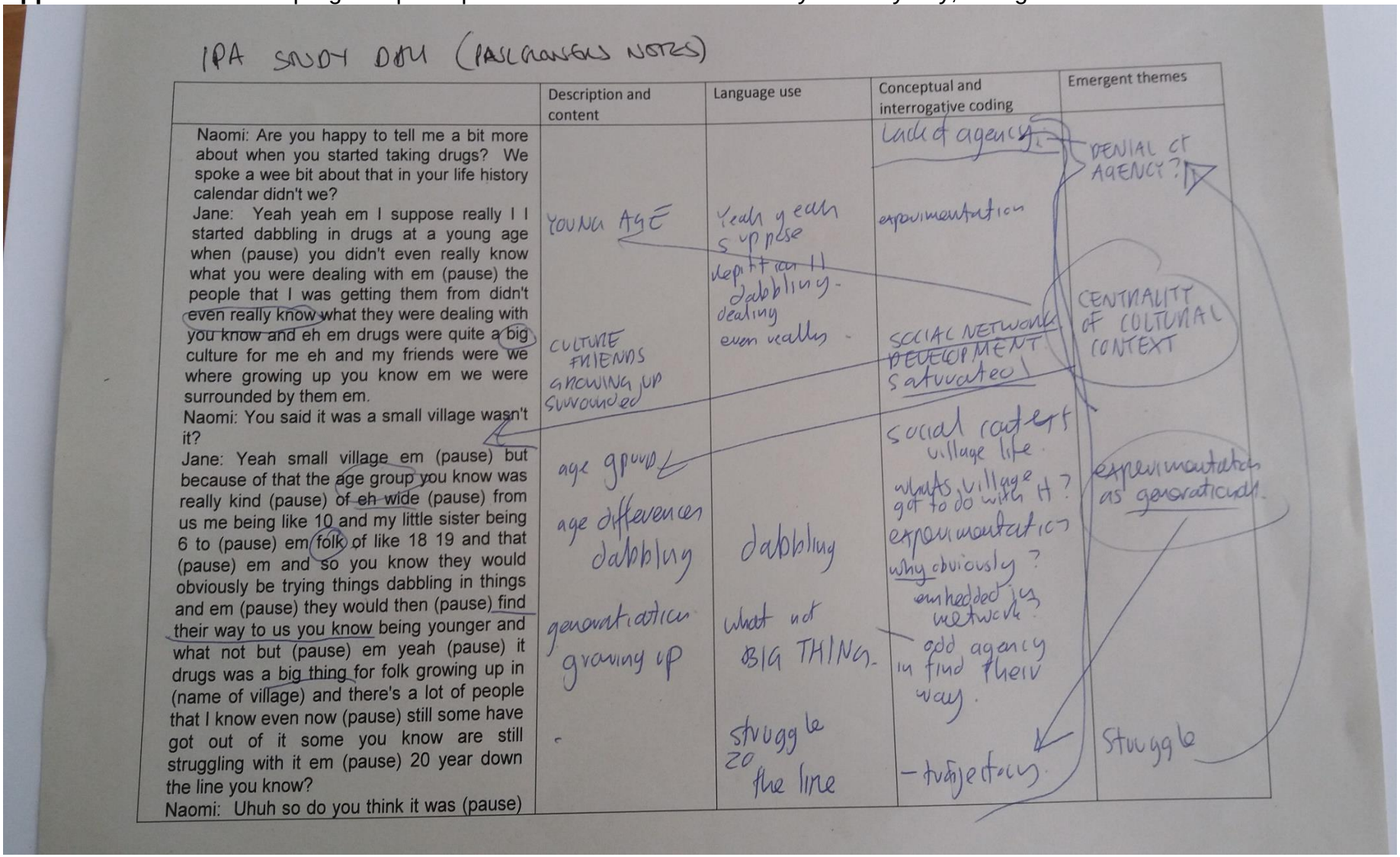
Lack of parental support

Suggests having left to fend for themselves/having themselves/each other (says me a lot rather than I)

adult guidance

relationship

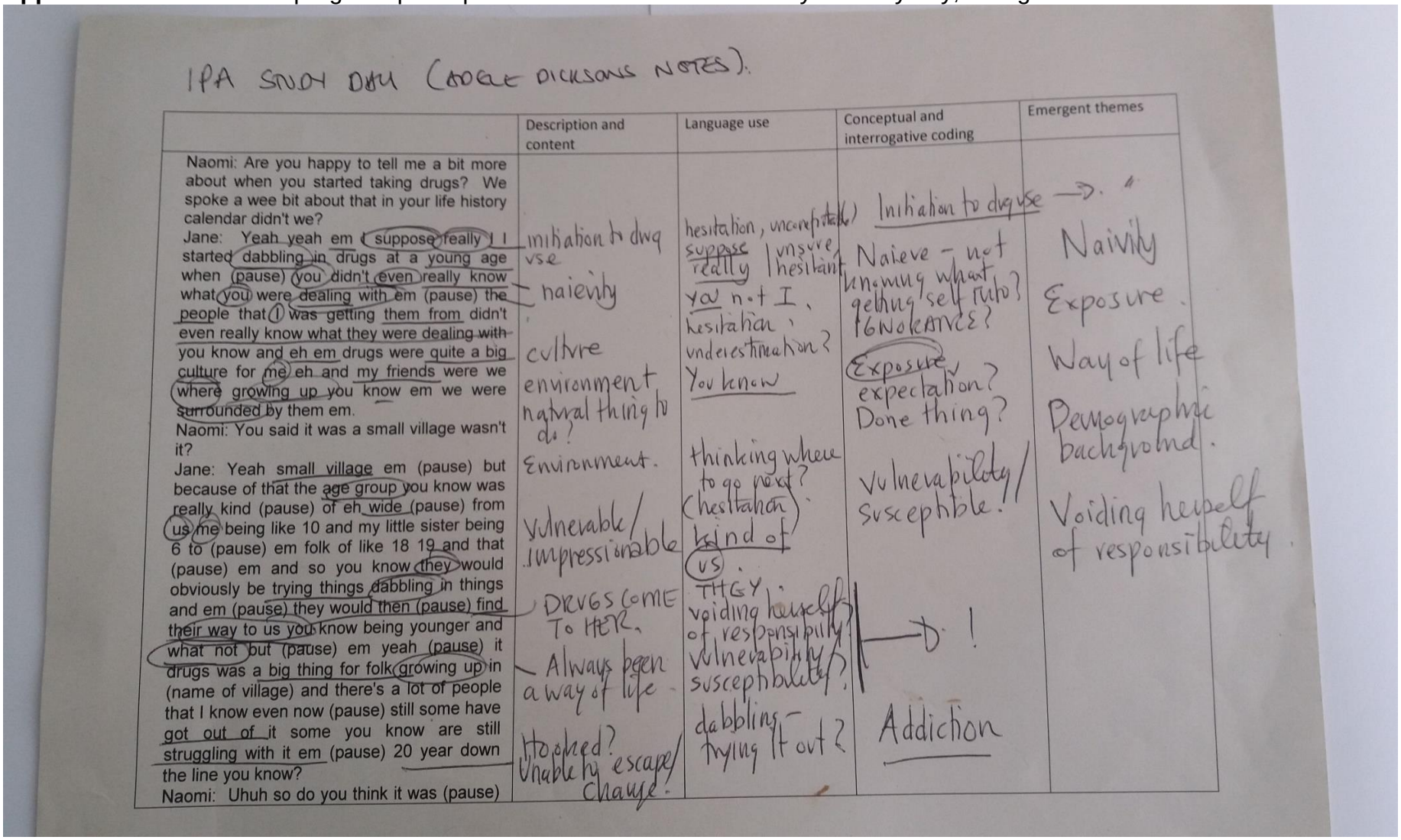
Appendix 17 Extract from pregnant participant interview used at IPA analysis study day, Glasgow.



IPA STUDY DAY (PASCHANGES NOTES)

	Description and content	Language use	Conceptual and interrogative coding	Emergent themes
Naomi: Are you happy to tell me a bit more about when you started taking drugs? We spoke a wee bit about that in your life history calendar didn't we? Jane: Yeah yeah em I suppose really I I started dabbling in drugs at a young age when (pause) you didn't even really know what you were dealing with em (pause) the people that I was getting them from didn't even really know what they were dealing with you know and eh em drugs were quite a big culture for me eh and my friends were we where growing up you know em we were surrounded by them em. Naomi: You said it was a small village wasn't it? Jane: Yeah small village em (pause) but because of that the age group you know was really kind (pause) of eh wide (pause) from us me being like 10 and my little sister being 6 to (pause) em folk of like 18 19 and that (pause) em and so you know they would obviously be trying things dabbling in things and em (pause) they would then (pause) find their way to us you know being younger and what not but (pause) em yeah (pause) it drugs was a big thing for folk growing up in (name of village) and there's a lot of people that I know even now (pause) still some have got out of it some you know are still struggling with it em (pause) 20 year down the line you know? Naomi: Uhuh so do you think it was (pause)	YOUNG AGE CULTURE FRIENDS GROWING UP SURROUNDED age group age differences dabbling generation growing up	Yeah yeah I suppose dabbling - dealing even really dabbling what not BIG THING struggle to the line	Lack of agency experimentation SOCIAL NETWORK DEVELOPMENT saturated social context village life what's village got to do with it? experimentation why obviously? embedded in network add agency in find their way - subjectivity	DENIAL OF AGENCY? CENTRALITY OF CULTURAL CONTEXT experimentation as generational Struggle

Appendix 17 Extract from pregnant participant interview used at IPA analysis study day, Glasgow.



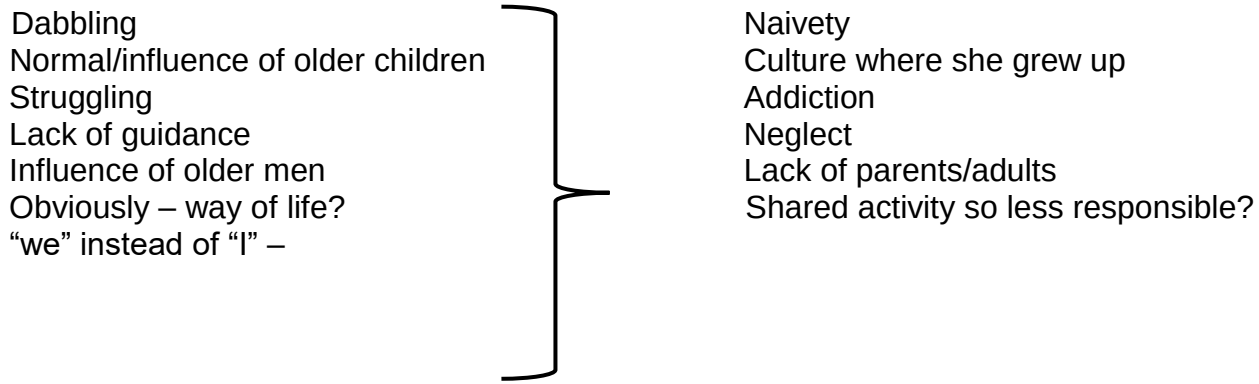
IPA STUDY DAY (GOOGLE DICKSONS NOTES).

	Description and content	Language use	Conceptual and interrogative coding	Emergent themes
Naomi: Are you happy to tell me a bit more about when you started taking drugs? We spoke a wee bit about that in your life history calendar didn't we?				
Jane: Yeah yeah em I suppose really I started dabbling in drugs at a young age when (pause) you didn't even really know what you were dealing with em (pause) the people that I was getting them from didn't even really know what they were dealing with you know and eh em drugs were quite a big culture for me eh and my friends were we where growing up you know em we were surrounded by them em.	initiation to drug use naievity culture environment natural thing to do? Environment.	hesitation, uncomfortable suppose really | unsure | hesitant you not I. hesitation, underestimation? You know	1) Initiation to drug use → Naieve - not knowing what getting self into? Tolerance?	Naivity Exposure. Way of life Demographic background.
Naomi: You said it was a small village wasn't it?				
Jane: Yeah small village em (pause) but because of that the age group you know was really kind (pause) of eh wide (pause) from us me being like 10 and my little sister being 6 to (pause) em folk of like 18 19 and that (pause) em and so you know they would obviously be trying things dabbling in things and em (pause) they would then (pause) find their way to us you know being younger and what not but (pause) em yeah (pause) it drugs was a big thing for folk growing up in (name of village) and there's a lot of people that I know even now (pause) still some have got out of it some you know are still struggling with it em (pause) 20 year down the line you know?	vulnerable/ impressionable DRUGS COME TO HER. Always been a way of life Hooked? Unable to escape/ Change.	thinking where to go next? (hesitation) kind of (us). TITGY: voiding herself of responsibility? vulnerability/ susceptibility? dabbling - trying it out?	Exposure ✓ expectation? Done thing? Vulnerability/ Susceptible. → D ! Addiction	Voiding herself of responsibility.
Naomi: Uhuh so do you think it was (pause)				

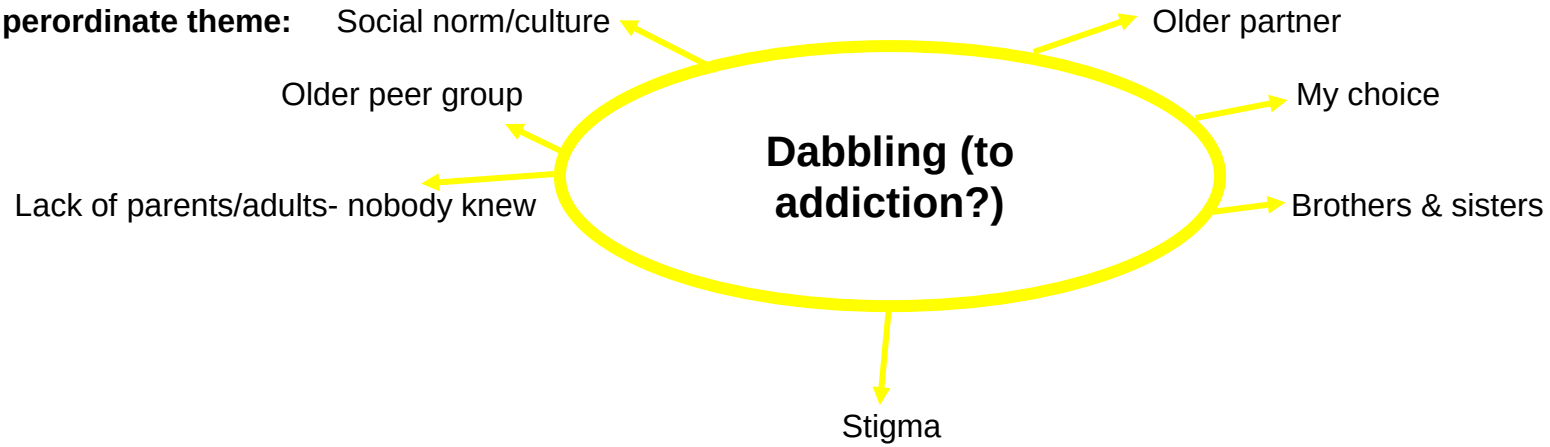
Initial thoughts following first reading of pregnant participant transcript

Older, on opiate substitution script, was initially on methadone, now suboxone as felt "stoned" with methadone. Has lost script in the past due to heroin use. Very aware of past events on current life, particularly her childhood. Parents both alcoholics, do not drink alcohol now ? has this made a difference to their relationship. Talks of parents, in particular mum with great affection, feels dad doesn't remember things quite as they really were when she was a child. Close relationships although still has secrets. Lack of supervision -> mixing with older children -> alcohol -> drugs -> older men -> more drugs - polysubstance but heroin main substance – too much, too young. Long sad story of abuse in childhood and beyond, although ?normalised childhood "wasn't too bad". Realization during interview re: older man going out with 14 year old, sounded very sad at this. Felt used? Abused again? Mistook sex/drugs for love. Abusive controlling men during adulthood. Substances to block out the trauma, would rather feel numb. On being a mum – did it help? (substances), she thinks it didn't, very honest. Low self-worth – done lots of work, feels knows herself now. Looking to the future. New partner does not have sub use disorder, kept saying he's a nice guy. Devastated at loss of children, not all returned to her care full time but she sees regularly. Very negative view of social workers initially, better now, would not admit to them before she had problems, wonders why now although perhaps due to fear of removal of children/stigma/being seen as bad mum/person. Says had brilliant relationship with midwives. Overall picture of sadness during interview - related to being older?, involved with drugs longer?, more trauma?, more time to reflect on life?

Development of emergent theme for pregnant participant (from extract provided and rest of transcript)



Superordinate theme:



Quotes:

Social norm/older peer group/naivety

“I I started dabbling in drugs at a young age when (pause) you didn't even really know what you were dealing with em (pause) the people that I was getting them from didn't even really know what they were dealing with you know and em because of that the age group you know was really kind (pause) of eh wide (pause) from us me being like 10 and my little sister being 6 to (pause) em folk of like 18 19 and that (pause) em and so you know they would obviously be trying things dabbling in things and em (pause) they would then (pause) find their way to us you know being younger and what not but (pause) em yeah (pause) it drugs was a big thing for folk growing up in (name of village)” page 2, line 10-16.

Peer pressure/culture/naivety

“I don't know if it was just because everybody else was you know em and obviously because I was younger and I’m looking at older people you know the cooler ones em (pause) and that's what they were doing em (pause) it just I I don't you don't I don't also know “ page 2, line 21-24.

Lack of parents/adults - Nobody knew (neglect)

“There was just nobody really to police it just you know (pause) we were we were able to get our hands on it (pause) and so we did. We never told anybody what what we were doing because we knew (pause) we shouldn't be doing it. We knew it was bad em (pause) but we wanted to I suppose in a sense so yeah no I never told anybody (pause) and I I you know the (pause) the secrets that I suppose (pause) probably even now my mum and dad probably don't know what went on for us when we were in our (pause) early teens (pause) you know there's probably loads they don't know” Page 4, line 71-77.

My choice/normalising parents behaviour

“but at the same time you know eh I don't I don't blame my parents cos I know you know at at some point I became an adult and I’ve got the choice then to either continue down that path or or to change it and so em (pause) you know they were just adults with their issues you know. Em (pause) at a totally different time when alcohol was such a big thing eh and you know it wasn't an issue to sit in the pub with your kids during the day you know? Em (pause) so (pause) yeah I think em (pause) I don't blame them at all. Not at all. I just know that (pause) certain situations and what not it just it didn't help (pause) it didn't help” page 5-6, line 119-127.

“I had you know I em an addicts mind-set is very much it's everybody else’s fault and it's you know it's em I I was blaming everybody else when really all I needed to do was say this is you that's doing this and only you can change it”

Older partner

“yeah (pause) eh I met him em (pause) when I was 14 and eh (pause) I em (pause) well this this was the one that I dated for a wee bit when I was 14 em (pause) and (pause) he was (pause) I can remember telling my mum I was going to stay at my friends and em (pause) me and my friend were actually going to this guy’s house. It wasn't his house it was a like a friend’s house and em (pause) we took acid and that with them you know and em (pause) eh and smoked dope and all the rest of it so em (pause) he kind of introduced me. That was the first time I tried acid and that”

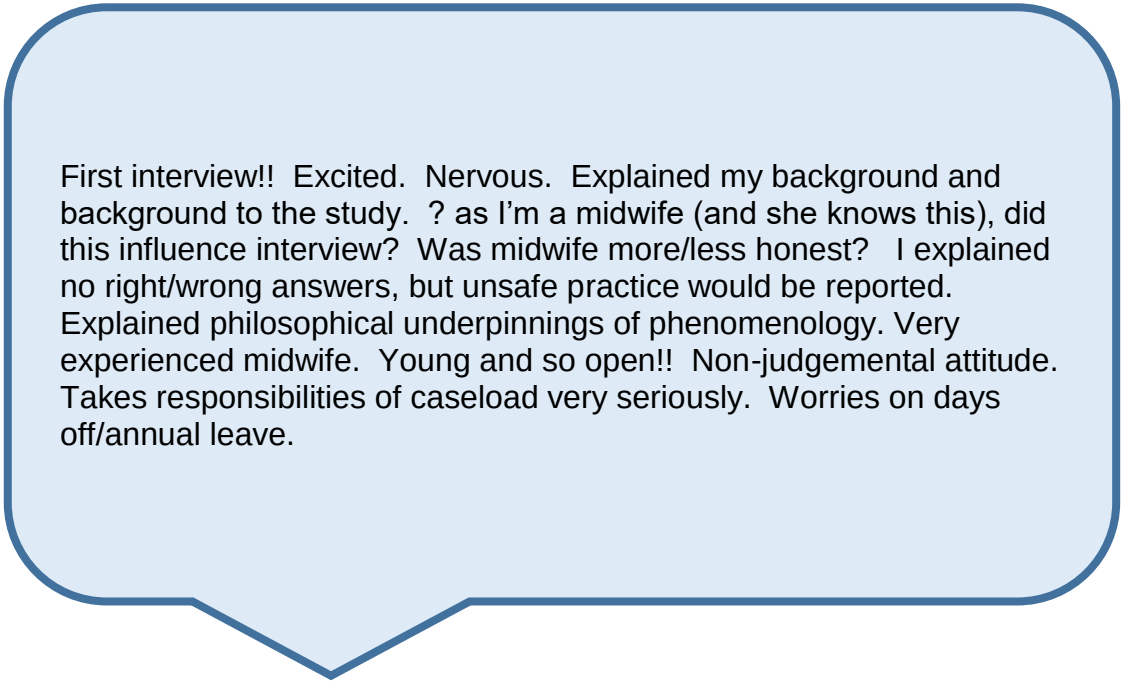
Brothers & sisters

“I’ve got issues with heroine but my younger sister also at a completely separate time and place got into heroin (pause) and em my big sister (pause) has a bit of a drink problem so em they sort of question (pause) whether (pause) it’s what went on in the past for them is how it then it's led on to affect us em (pause)”

Stigma

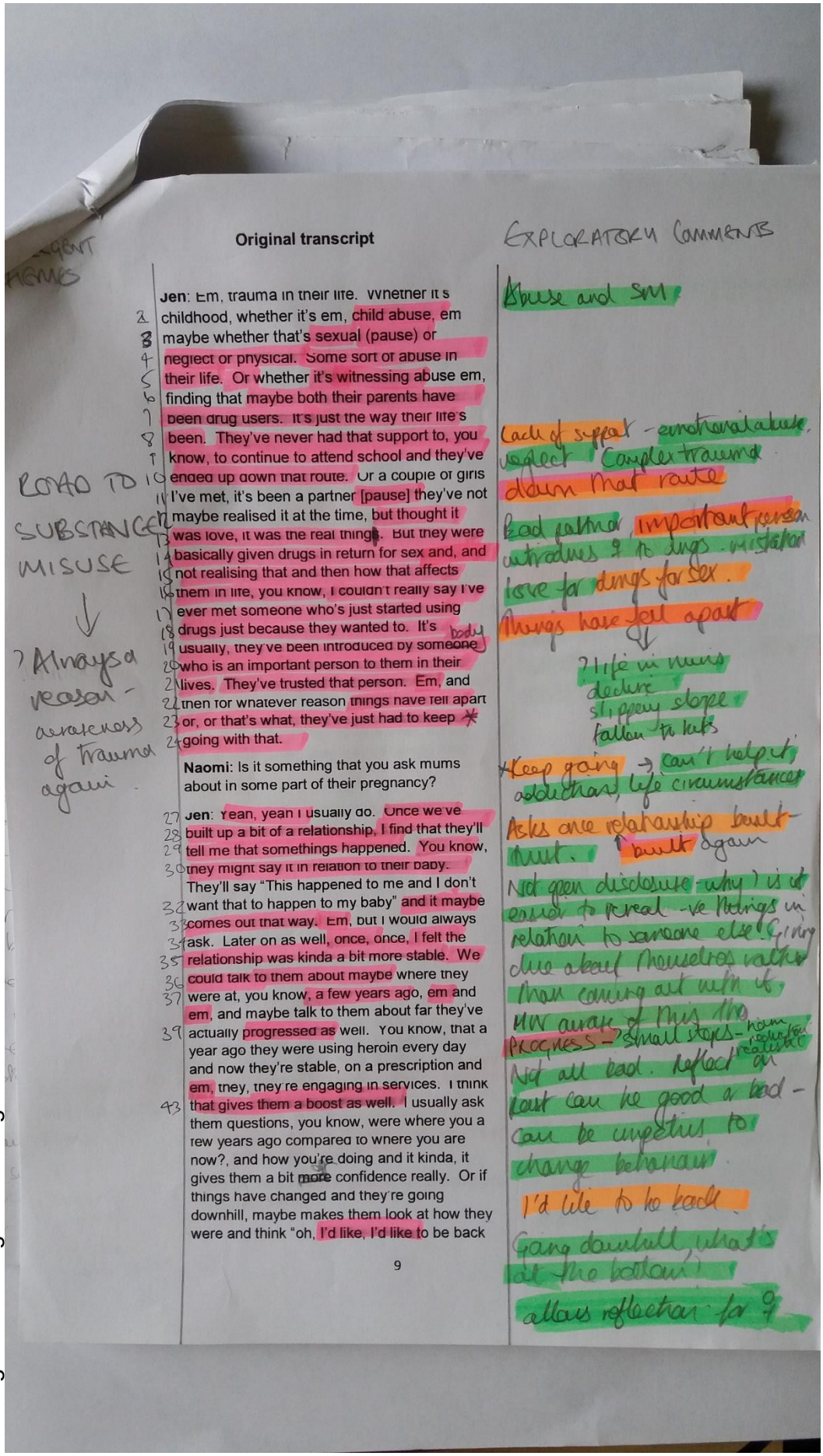
“Em not by the professionals that I deal with not at all em you know (pause) it I I think if folk that are working in this area knows you know you don't really get into a job like that unless you genuinely care and understand I think em I think it's more just society really eh and what they would think about em (pause) pregnant mums with substance use or even what we think of ourselves I think we're our own worst enemies and we can make ourselves feel awful over things ….. but you know definitely (pause) whether it's just in our own heads or whether we are actually stigmatised I don't know” page 11, 270-278.

Appendix 17 Example of analysis of transcript – midwife participant



Extract from reflective diary (written in car after interview)

Appendix 17 Extract from midwife participant interview showing description and content, language use, conceptual and interrogative coding and emergent themes.



Original transcript

Jen: Em, trauma in their life. Whether it's childhood, whether it's em, child abuse, em maybe whether that's sexual (pause) or neglect or physical. Some sort of abuse in their life. Or whether it's witnessing abuse em, finding that maybe both their parents have been drug users. It's just the way their life's been. They've never had that support to, you know, to continue to attend school and they've ended up down that route. Or a couple of girls I've met, it's been a partner [pause] they've not maybe realised it at the time, but thought it was love, it was the real things. But they were basically given drugs in return for sex and, and not realising that and then how that affects them in life, you know, I couldn't really say I've ever met someone who's just started using drugs just because they wanted to. It's usually, they've been introduced by someone who is an important person to them in their lives. They've trusted that person. Em, and then for whatever reason things have fell apart or, or that's what, they've just had to keep going with that.

Naomi: Is it something that you ask mums about in some part of their pregnancy?

Jen: Yean, yean I usually do. Once we've built up a bit of a relationship, I find that they'll tell me that somethings happened. You know, they might say it in relation to their baby. They'll say "This happened to me and I don't want that to happen to my baby" and it maybe comes out that way. Em, but I would always ask. Later on as well, once, once, I felt the relationship was kinda a bit more stable. We could talk to them about maybe where they were at, you know, a few years ago, em and em, and maybe talk to them about far they've actually progressed as well. You know, that a year ago they were using heroin every day and now they're stable, on a prescription and em, they, they're engaging in services. I think that gives them a boost as well. I usually ask them questions, you know, were where you a few years ago compared to where you are now?, and how you're doing and it kinda, it gives them a bit more confidence really. Or if things have changed and they're going downhill, maybe makes them look at how they were and think "oh, I'd like, I'd like to be back

Initial thoughts following first reading of midwife participant transcript

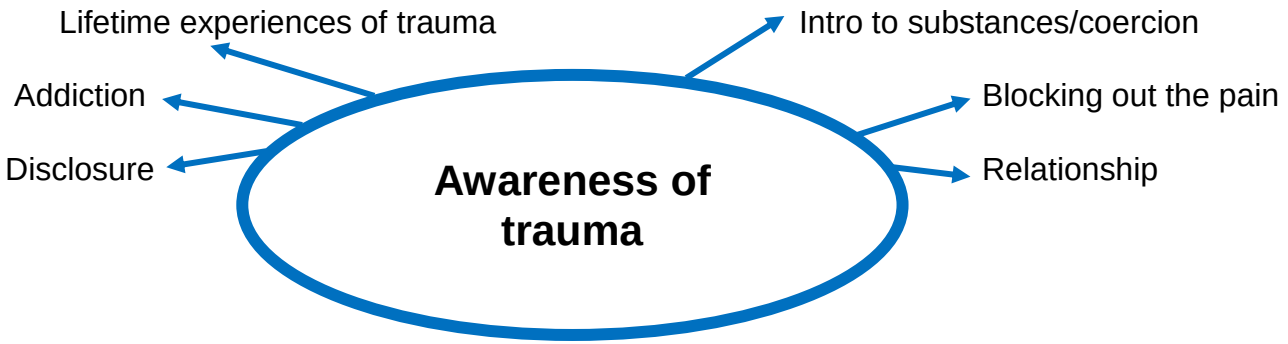
Overall flavour from the interview is that she appears to take her role of women's advocate very seriously (on a personal and professional level) and aims to provide the best care she can. She thinks all women should get the care they are entitled to and her account reflects her strive to provide this. Very open and honest interview including when asked about effects on her professionally and personally. I think the transcript captures some sense of her compassion and feeling of responsibility to the women she supports. She says very simply that PWMS are just like any other woman – most of them aim to do the best for their babies, they want closeness and to bond with their babies just like any other mother. The majority are aware of the risks their lifestyle poses. She is very aware of the impact trauma may have had on their lives and the choices they have made. Her perception is that there is usually something beneath the surface of their decisions, that she has not met many people who get into substance misuse by chance. This may be due different types of abuse in childhood or present. She spoke about a "toxic triangle" of abuse and substance misuse. She acknowledges addiction, illness, recovery which I would consider to be unusual things for a midwife to talk about with any real knowledge. She does not recall receiving any formal education regarding substance misuse during her undergraduate education despite working in an area with a high incidence of this. Jen developed an interest in working with these women when she was newly qualified, mostly due to other staff's disinterest in working with this client group. Is this particular to midwives – the least experienced get the patients who need the most care/support. Being flung into the loins den comes to mind and reminds me of my own early midwifery experiences. She enjoys getting to know the women and values developing good relationships with them. She likes to make herself available to women and support them in any way she can. She still gets shocked by some of her client's outcomes (i.e. back to substance misuse very quickly) and speaks with sadness when recollecting experiences she has had. She speaks about harm reduction which is not something that I would think comes naturally to midwives. Despite negative experiences, her interview gives an overall sense of positivity, she does not appear cynical towards these women i.e. gives the impression that everyone has a choice, everyone has a chance, they are doing the best they can and that we should be realistic with what we are trying to achieve (maybe that's what we need to realise – what is achievable for someone with an addiction? And celebrating their achievements (however small they may seem to us). Speaks about seeing pregnancy as a time of opportunity, a chance for women to make positive changes and for these to be encouraged. She thinks that for some women, more can be achieved during this relatively small period of time than at other times in their lives perhaps because their wish to do well and the opportunity it provides them (coming into contact with midwife, continuity with midwife, access to other services). She perceives stigma within the maternity setting and says she always asks women about their experiences. Her perception is that women are having better experiences but that there will always be stigma as some people can't or won't change their attitudes to PWMS. Her perception is that hospital based midwives need to have more education. She values and sees the benefits of continuity of carer. Her text bring to mind issues around trust, non-judgemental attitudes and of building relationships (perhaps that relationships need to be developed, get to know each other before women trust you, will disclose to you). Recognises the needs of

women, that this needs to be individualised, flexible, accessible. Sense of partnership with the women and of seeing them through i.e. *really* engaging with the women and *really* journeying with them to motherhood and the early days of parenting. Does this really mean building/having meaningful relationships with people? Her concerns about her work creep into her days off and her annual leave. She feels that her family don't understand why she worries. She seems to accept this as part of a job that she loves. She shows a huge sense of responsibility to her caseload, she just wants to do it right, do right by the women, make sure they get the care they are entitled to. She appeared to need time to have a good think when asked about examples of good practice.

Development of emergent theme for midwife participant (from extract provided and rest of transcript)

Impact of trauma histories	Lifetime experiences of trauma
Lack of support/neglect	Intro to substances/coercion
"keep going with that"	Blocking out the pain/addiction
Lack of guidance	Neglect
Build trust with woman	Relationships
Asking about trauma	When appropriate for woman
Clues re: trauma	Disclosure sensitive

Superordinate theme:



Quotes:
Lifetime experiences of trauma

“trauma in their life. Whether it’s childhood, whether it’s em, child abuse, em maybe whether that’s sexual (pause) or neglect or physical. Some sort of abuse in their life. Or whether it’s witnessing abuse em, finding that maybe both their parents have been drug users. It’s just the way their life’s been. They’ve never had that support to, you know, to continue to attend school and they’ve ended up down that route” (page 9, line 1-10)

“they’re using drugs because of a certain reason. Not many people will just start using drugs because they want to try it. There’s other issues going on. And I think once, once you see that and you understand that”

“the toxic triangle and how, you, that there’s always something else behind it. And if you start to dig, you usually find that there’s domestic violence, or there’s something else going on. Or mental health. They’re usually all linked together though, it doesn’t just come, by itself. And it just depends, the violence, it could have been childhood or currently” (page 12, line 10-17)

Intro to substances/coercion

“it’s been a partner [pause] they’ve not maybe realised it at the time, but thought it was love, it was the real thing. But they were basically given drugs in return for sex and, and not realising that and then how that affects them in life …….. I couldn’t really say I’ve ever met someone who’s just started using drugs just because they wanted to. It’s usually, they’ve been introduced by someone who is an important person to them in their lives. They’ve trusted that person. Em, and then for whatever reason things have fell apart or, or that’s what, they’ve just had to keep going with that” (page 9, line 11-24)

Addiction

“They know it’s not the best for their baby, em, but they can’t stop [pause] for whatever reason ……. that’s (coming of meds) a really, really hard task for them. And it’s actually getting through to them, that’s it’s actually [pause] we’re happy if you’re stable and you’re not using anything else and you’re gradually reducing. We’re really happy with that” (page 6, line 11-46)

“when you realised that, that drugs has actually much more control of their life than, than their new-born baby, I think, that is quite eye opening”

Blocking out the pain

“Some women [pause] the guilt makes them use drugs and alcohol more to try and block it out [pause] whereas other women, the guilt, it does make them completely stop” (page 6, line 15-20)

“they need to do that to block out what’s just happened” (page 8, line 8-9)

“it’s, it’s very blatant. You know, she’ll, she’ll talk about the pregnancy sometimes, but a lot of other times she’s just focussing on, she’s maybe kind of, she’s in a bad relationship. She’s got a lot of history of, em, of trauma, basically throughout her life. That she’s got other things to deal with rather than focussing on the pregnancy. She’s just got, she’s just got to get through day to day life” (page 7, line 32-40)

“Some women [pause] the guilt makes them use drugs and alcohol more to try and block it out [pause] whereas other women, the guilt, it does make them completely stop” (page 6, line 15-20)

“maybe things have happened in their lives and they become pregnant and they’ve already got their drug use. Trying to deal with these past issues and they’re dealing with being pregnant, just makes it too much for them and they just block out being pregnant and just get on with things [pause] just to survive really [pause] which is sad” (page 7, line 16-24)

Disclosure

“Once we’ve built up a bit of a relationship, I find that they’ll tell me that somethings happened. You know, they might say it in relation to their baby. They’ll say “This happened to me and I don’t want that to happen to my baby” and it maybe comes out that way. Em, but I would always ask. Later on as well, once, once, I felt the relationship was kinda a bit more stable” (page 9, line 27-35)

Relationship

“I feel that there has to be someone, somebody who supports them through pregnancy and looks after them. Gives them everything that they’re entitled to …….Em, I think that just, I think it depends on the type of person really. Some eh, how can I say this really? I think, I think it’s just the type of person really. Who you are, that you, that you feel you’re capable to look beyond what, what they’re actually doing and, and see that there’s other, there’s other reasons” (page 8, line 23-34).

“trying to meet them as soon as possible….just to start a relationship with them [pause] as early as I can really……but I usually find that if you can engage with them quite early on, from booking or, em, 8, 10 weeks, em that we, we tend to have a quite, a good relationship” (page 2, line 22-43)

“you’re building on that relationship” (page 4, line 25)

Disclosure

“Once we’ve built up a bit of a relationship, I find that they’ll tell me that somethings happened. You know, they might say it in relation to their baby. They’ll say “This happened to me and I don’t want that to happen to my baby” and it maybe comes out that way. Em, but I would always ask. Later on as well, once, once, I felt the relationship was kinda a bit more stable” (page 9, line 27-35)