Addiction/Substance Use, Stigma, Treatment and Recovery: Impacts, Access and Barriers for Families in British Columbia

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Abstract

This thesis explores experiences of addiction/substance-use, stigma, and addictions-treatment/recovery of families across social locations in British Columbia (BC); illuminating how their experiences reflect Bruce K. Alexander's theory of addiction. Our current addiction-related systemic responses problematically reflect settler-colonial, patriarchal, neoliberal, free-market capitalist, and globalized systems ideologies and values. Indeed, public/private tiered service delivery in BC provides access to treatment according to social locations instead of need. This method of service delivery entrenches stereotypical notions of the 'addict' by shielding those with the privilege of privacy, but ultimately fails many families seeking treatment for addiction in different ways according to social locations. Especially worrisome are systemic barriers for families that perpetuate conditions for both relapse and intergenerational trauma to occur. The aims of this qualitative study are to contribute to a growing body of work that argues for the dismantling of oppressive and exclusionary systems of treatment and argues for the advancement of socially-just and family-accessible responses to addiction in BC.

Keywords: intergenerational impacts of substance-use, stigma, white-settler-patriarchal neoliberal free market capitalist society, family models of treatment and recovery, qualitative research, intersectional theory, dislocation, psychosocial integration,

Dedication

This thesis is dedicated to those, including some of my own friends and family, who are dead or are at risk of dying as this social policy crisis rages on. And, for their children who are left behind.

Acknowledgements

This master's thesis project was researched and written within the traditional territories of the T'Sou-ke, Scianew, Pacheedaht, Wsánec, and Tsleil-Waututh First Nations. I would like to express my gratitude for the opportunity to live, work, learn and play in these beautiful, abundant territories.

While I did not consult directly with the Kackaamin Family Development Centre or the Nenqayni Treatment Centre, my study has been inspired by the incredible healing work these Indigenous organizations are doing with and for Indigenous families.

To the participants of this study, I offer my deepest thanks for so generously and openly sharing such intimate and sometimes painful parts of your lives for the purpose of contributing to this work. I can only hope that my project as informed by your voices can contribute at least in some small way in improving conditions for addiction-affected families in BC.

To my dear senior supervisor, Dr. Maya Gislason, who has so tirelessly taught me, patiently accommodated me, and enthusiastically championed me as I have wrestled for years with these ideas and this work: your example has inspired me more than you could ever know. 'Thank you' will never suffice.

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Preface

The use of the term ‘addiction’ throughout this thesis is not to be conflated with substance use. I have decided to use the term ‘addiction’ because it does not reflect a particular substance, but instead speaks to the condition or state driving the compulsion to use substances or other behaviours in an effort to cope with the underlying causes and conditions that cause harm and although the individual wants to stop they are seemingly unable to do so of their own volition. Additionally, I have chosen to use this term to stay consistent with the work of Dr. Bruce Alexander, who also uses the term ‘addiction’ and whose theory informs my own work. That said, unless otherwise noted, the experiences of addictions I am addressing in this thesis do refer to the problematic use of illicit and/or prescription drugs and/or alcohol. Importantly, however, this approach intentionally resists pathologizing the individual and instead places the person within the social arena where both addiction to and use of specific substances is harmfully mediated by stigmatizing ideologies, systemic responses, and is particularly so for marginalized families.

Not everyone who uses substances is experiencing addiction, but as stated above, the use of substances - especially substances rendered illicit and poisonous by prohibitionist policy – and especially when used by people in particular social locations, can elicit a response by social systems that ascribes to them the label of “addict” or a person with “substance use disorder”. As such, throughout this thesis when it is unclear whether it is truly addiction or simply the use of substances that are resulting in systemic impacts shaping the lives of people, I indicate that this false conflation may be occurring by using both terms: addiction/substance-use.

In this thesis, when I discuss the need for effective and accessible treatment for families, it is for those who use substances in a way that they self-identify as causing them harm (addiction) and who express a want or need for access to treatment. I do not suggest that treatment – even if made accessible to families and delivered using regulated, consistent evidence-based methodologies – is a panacea for ending the harmful experience of addiction. Rather, I argue that such treatment ought to be made available and accessible as part of a multi-pronged approach that also simultaneously demands the dismantlement of oppressive, marginalizing, and dislocating systems, structures and ideologies that have contributed to the addiction/substance use health and social crises that exist now.

Chapter 1.

Introduction

1.1. Background

Addiction and substance use are at the crux of one of the most concerning health crises of our time. For the first time in four decades the average expected lifespan of Canadians has stopped increasing because of untimely deaths due to illicit drug overdose (Young, 2019). And, while this grim reality is due to deaths caused by the unsafe illicit drug supply[1], this evidence does not include the multitude of other deaths, health complications and social harms that result from addiction to prescription drugs, alcohol and a number of other harmful compulsive behaviours[2]. Current policies, programs and systemic responses are clearly failing to effectively address the intersecting issues relating to addiction/substance use in our society. Indeed, multiple and interacting systemic failures are leading to a deepening of the addictions/substance use crisis in British Columbia (BC) for individuals and their families at a time when institutional responses and service delivery options persistently offer inadequate supports and access to effective treatment in particular for addiction-affected/substance-using parents with dependent children. This thesis tackles these unresearched issues in order to draw attention to how existing responses often erect and maintain barriers to recovery for families across a range of social locations; thereby perpetuating traumatic conditions for addiction to continue to arise intergenerationally in our society. Indeed, it is not just individuals, but entire families that are impacted both by an addicted/substance using person's condition and the social and institutional responses they are subjected to as a result. As such, this thesis examines addiction/substance use as a health and social

[1] It is important to note that substances are not inherently unsafe; however, prohibitionist policies exacerbate risk as substances remain unregulated and lethal. Therefore, current drug overdoses (whether the person who died was experiencing addiction or not) are arguably a direct result of policy that could be resolved by legalizing and regulating a safe supply of substances for people to use at their discretion, as they do with alcohol. And as is the case with those who drink alcohol, not all are alcoholics.

[2] For example, gambling, sex addiction, food addiction or other eating disorders, shopping, over-working, over-exercising, etc.

issue located in the context of families and the ways in which ideologies/systems and structures shape their lived experiences.

Individuals are often significantly embedded within their families. Therefore, developing effective strategies, policies and programs to first discern addiction from substance use and second to treat and prevent addiction within family contexts is of the utmost importance. To better understand why our current health and allied social systems are inadequately preventing and treating addiction in families and to identify what might be required to address this dire health and social issue, this study combines desk research with rich interview data to compare the experiences of addiction-affected/substance-using families across four key themes. These themes are: 1. the impacts of addiction/substance use on families; 2. experiences of stigma; 3. access and barriers to addiction-treatment; and 4. access and barriers to "recovery"[4]. These themes enable the exploration and contextualization of experiences shared by working/middle-class parent study participants as well as the systemic responses to addiction experienced by marginalized families as detailed within the literature. The two specific questions that guide this research are: 1. 'how are the experiences of addiction/substance-use, stigma, and barriers to treatment and recovery for addiction-affected/substance-using parents linked across social locations in BC to ideological, systemic and structural forces of white-settler-patriarchal colonization, neoliberalism, free-market capitalism and globalization?' And, 2. 'what changes are necessary to more effectively support recovery in all addiction-affected families in our society?' Ultimately, this thesis shows that the often vastly different experiences of people in different social locations share important commonalties and that the relationship between these experiences points to some of the fundamental flaws in our systemic responses to addiction/substance use in families. Based on this analysis, this thesis contributes to a

[4] The term 'recovery' refers to the process by which an individual addresses and recovers from their experiences of addiction. In the context of this thesis, all the participants practice an abstinence-based method of recovery from substance use, and attend/have attended 12-step support groups as part of their 'recovery'. That said, it is important to note that many people believe 'recovery' does not necessarily require abstinence, but instead speaks to steps taken to improve one's quality of life, whether or not that includes ongoing substance use. Also, there are many other models for pursuing 'recovery' beyond 12-step support groups. The diverse and sometimes conflicting concepts of what qualifies as 'recovery' is explained in more detail in the chapters ahead, but it is important that readers know from the outset that this thesis does not subscribe to any particular method of recovery and rather argues that people, regardless of social location, should have access to recovery methods and models that they identify as appropriate for themselves.

growing body of work that argues for the dismantlement of oppressive systems while also proposing alternate programmatic approaches that would promise to eliminate key barriers for addiction-affected families in BC.

I have narrowed my focus to the experiences of addiction-affected/substance-using families in BC for two reasons. First, in Canada, each province has its own unique health, justice, social development, and child protection ministries responsible for the delivery of health and social services. As such, the experiences of every addiction-affected/substance-using family in BC will be shaped, albeit differently according to their unique social locations, by these overarching systems. Second, my career is in the addictions/substance-using harm reduction, mental health, housing and family support services field in this province. In my role as Operations Manager for Sooke Shelter Society, not only do I serve individuals experiencing chronic, street-entrenched homelessness and addictions/substance use, I also serve a rapidly-increasing number of families who are precariously housed and/or are experiencing other various risk factors, including addiction/substance-use, in our community. Because I live in a small community[5], we are one of very few social service agencies available to all people across social locations who need supports in this community. In my role, I daily witness and support a range of people interacting with the systemic responses to addiction/substance-use (whether it be ministries of health, justice, social development, and/or child and family development). As a result, not only is my work in this study informed by fifteen years of frontline experience, in addition to my own lived experience of addiction and recovery, but my work in policy and program development is informed by all the learning I have done while conducting this research. As such, limiting my focus to the ways in which the province of BC shapes the policies within these ministries and systems keeps this research relevant to the work that I do to support my community members who are affected by addiction/substance-use as effectively as possible.

This research, and novel responses to the current problems described are urgently needed as the children of addiction-affected parents are especially vulnerable to risk. One reason for this could be genetic risk. Paraphrasing Smoller et al (2019), Kendler et al claim: “Family, twin, adoption, and molecular genetic studies have demonstrated that almost all psychiatric and substance use disorders are influenced,

[5] Sooke is considered a rural community with an estimated population of 15,083 in 2020.

often substantially so, by genetic risk factors." (2021, p. 1). For example, even when all else remains equal, there is substantial evidence that shows children who grow up in addiction-affected homes are more likely to develop addiction themselves (Henry, Kimberly L. et al. 2018; Kerr et al., 2012; Campbell et al, 2013). Campbell states: "Estimated rates of alcoholism, smoking, illicit drug use, and gambling reveal that male and female children are more likely to have a father and/or mother who also demonstrate such behaviours compared to offspring in the general population" (2013, p. 313). But as we know, 'all else' rarely is, in fact, equal, and socioenvironmental factors are also linked to and shape an addiction-affected person's experience of their condition, as well as the experiences of children growing up in addiction-affected environments. Cosanella et al claim: "Studies show that people who have experienced one or more adverse childhood experiences (ACEs) prior to age 18 are at a higher risk for substance use, as well as numerous negative mental and physical health outcomes." (2019, p. 2229). Given that parental addiction can be a reason for experiencing ACEs, addiction represents not only a threat to individuals, but is an intergenerational threat to the health and wellbeing of families in our society. While I do not argue that genetic predisposition to addiction may be a contributing factor to the intergenerational occurrences of addiction in families, in this thesis I focus on contributing socioenvironmental factors that can lead to addiction, and what might be done to address such factors. Specifically, I identify, investigate, analyze and discuss the ideologies, social and economic systems that shape how we collectively view and respond to addiction/substance-use in BC and how these may be contributing to both the perpetuation of conditions for addiction to arise, and also failing to resolve addiction in affected families.

Indeed, our society is made up of people reflecting many different backgrounds, histories of immigration, Indigeneity, sexual orientation, gender identities, education, family contexts, financial stability/insecurity, and differing abilities as is reflecting in literature on the social determinants of health (Braveman and Gottlieb, 2014) and social inequities in health (Sharek et al, 2013). Many of these demographic indicators reflect cherished identities grounded in generations of family tradition and/or contemporary cultures. However, in the context of our broader western society, these categories have historically, and continue to be, used to construct and maintain social hierarchies of privilege and power based on the meaning and value that has been unjustly attributed or

denied to people according to one's "race"[6], Indigeneity[7], gender, class and many other indicators (Acker, 2006). In this thesis, I have chosen to use the term 'social location' as an umbrella term to draw attention to the ways in which people are positioned within, read as, and navigate through the world which is contoured by white-settler-patriarchal-colonial categorical constructions such as "race", Indigeneity, gender and class. More descriptive than 'socio-economic status', which typically only indicates a person's education, employment and household income (Deutsch, 2017), the term 'social location' goes beyond those measures to also capture indicators of gender, "race", sexual orientation, age, ability, geographic location etc. (Williams et al 2013). While every person's precise social location is unique, the term is appropriate in the context of this thesis because common experiences expressed by addiction-affected/substance-using people and their families may be attributed to shared aspects of their social locations.

Though all social indicators are likely to reveal distinct associated impacts related to addiction/substance-use, it is beyond the scope of this research to analyze them all. Rather, this thesis examines the ways in which the impacts of addiction/substance-use, stigma, access and barriers to treatment and recovery are racialized/colonized, gendered, and classed experiences. I have chosen to focus on these indicators because, as I discuss at greater length in *Chapter 3: Literature Review*, when consulting the literature, it is very apparent that racialized/Indigenous mothers living in poverty are a population frequently scrutinized in research focusing on addiction in families in BC, while the experiences of white, middle-class addiction-affected parents – and fathers especially -, are largely absent from the literature. As this thesis will show, analyzing the similarities and differences in experiences of addiction/substance-use related systemic responses as they can be linked to the social indicators of "race"/Indigeneity, gender and class is important for understanding how current systems may be failing families, and what might be necessary to improve outcomes.

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[6] The term "race" is placed in quotation marks throughout to disrupt the false and harmful notion that "races" are anything other than social constructions created for the purpose of attempting to justify the exploitation and oppression of some peoples for the benefit of those who invented and attempted to reify the term "race".

[7] I list Indigeneity as well as "race" here because it is important to highlight the distinct dimensions of racism that have been suffered by Indigenous Peoples as a result of colonization.

Indeed, in sharp contrast to what I have read in the literature, the parents who volunteered to participate in this study are all white or white passing parents of female and male gender identities (60% mothers and 40% fathers) and who are working/middle class (10% identify as working class, 80% as middle class, and 10% as upper-middle class.)[8]. As *Chapter 4: Findings* will show, the experiences addiction, stigma, and access/barriers to treatment and recovery expressed by this study's participants are quite different from those reflected in the literature. This difference in experiences suggests that overlapping indicators of "race"/Indigeneity, gender and class are significant determinants of health and social wellbeing for families affected by addiction. As such, when it comes to understanding and addressing the experiences addiction-affected parents, it is important to be able to distinguish between what results from addiction itself and what results from the racist, sexist, colonizing and classist ideologies, policies, programs, institutions, systems and structures that shape the social locations people inhabit.

The absence of middle-class addiction-affected parents from not only qualitative intersectional studies, but also addiction literature in general, is problematic for at least two reasons. First, as previously discussed, it gives the incorrect impression that working/middle-class families are not impacted by or vulnerable to addiction, which is clearly not the case. Secondly, using an intersectional lens to investigate a health issue experienced by both people who have access to unearned privileges as well as those who suffer unjust oppression is important:

> If the problem was viewed not only as [a problem for people marginalized by unjust systems], but also …the unjust social structure that gives unearned disadvantage, then a different set of solutions could follow, such as changes to policy and law to create safeguards against discrimination produced by the system of inequality. (Nixon, 2019. p. 3)

It is this gap in analysis that is exactly what this study aims address. This thesis argues that investigating the ways in which social systems and structures negatively impact populations who have access to unearned social privileges as well as those who have been unjustly oppressed in different ways is an important step toward effectively addressing and treating addiction across our society.

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[8] More details see Appendix A: Participant Social Indicators

To unpack the ways in which experiences of addiction-affected/substance-using parents are shaped by social constructs of “race”, Indigeneity, gender and class, my primary framework for analysis in this thesis utilizes Kimberlé Crenshaw’s theory of Intersectionality (1989). This theory accounts for the ways in which people simultaneously embody multiple categories of “race”, gender and class and speaks to the complicated and layered ways in which these intersecting social constructs shape the contexts in which people live. Intersectionality also explicitly positions individual experience within the context of social structures and institutional practices’ thereby laying the foundation for an equity informed analysis of individual experiences within the fabric of social life (Crenshaw, 1989). Gislason explains: “The concept of intersectionality was originally developed for understanding how different personal identities or groups to which a person could belong could yield impacts in terms of marginalization that are either magnified or substantially different at intersections of those identities” (2016, p. 10). As such, when considering the experiences of addiction-affected/substance-using parents in the context of their social locations, the theory of intersectionality is a strong and important analytical tool in my framework of analysis.

Indeed, as this thesis will explain at length, for families who are marginalized because they embody and/or occupy these intersecting social locations, the experience of addiction/substance-use is compounded by the ways our society currently frames and responds to addiction/substance-use. On one hand, “substance use disorder” is clearly listed as a mental health condition in the DSM-5 (2013); yet, in marginalized populations the social determinants of health and the legal consequences of possessing illicit substances render many of the behaviours inextricably linked to addiction/substance-use, illegal (Pierce et al., 2017). The slippages between defining addiction/substance-use as a health issue and penalizing addicts’/substance-users behaviour through the legal system leads to tragic outcomes. Marginalized families are at an escalated risk for interventions by child welfare agencies and incarceration (J. Murray & L. Murray, 2010) despite the ever-increasing body of literature that speaks to the intergenerational incidence of trauma (Novac et al., 2006), addiction (Patterson et al., 2015), ill-health (Clarkson et al., 2015), domestic violence (Johson-Reid et al., 2006) and criminal outcomes (Reilly, 2003) that are linked to state-apprehension of children. The result is the ongoing systemic construction and maintenance of both “at risk populations” and

"risk environments" (Rhodes, 2009) as well as the reproduction of a range of serious institutional failures for marginalized families affected by addiction.

Attention to the 'causes of the causes' of addiction is critical as it draws attention to upstream factors, including the identification of how racist, colonizing, sexist and classist social policies and practices impact health. The phrase 'the causes of the causes' refers to the ways in which the determinants of health are the conditions and circumstances within which health is produced, including socio-economic structures and social relations. "The social determinants of health are mostly responsible for health inequities — the unfair and avoidable differences in health status seen within and between countries" (World Health Organization, 2014). Increasingly, social exclusion is being identified as a social determinant of health (Benbow et al., 2015). Marmot explains the link between the social determinants of health and 'the causes of the causes':

> the causes of excess morbidity and mortality in socially excluded populations (i.e., the social determinants of health) are not much different from the causes of health inequalities more generally but differ in their degree. Multiple intersecting causes and multiple forms of morbidity characterise social exclusion. The result is people with little hope or prospects and considerably shortened lives. (2018, p. 187)

Indeed, public health and epidemiological researchers have made tremendous contributions in identifying 'the causes of the causes' of such risk environments that can effectively predict addiction and addiction related harms for families in populations that are socially excluded because of unjust policies, systems and structures. Such research nuances our understanding of context and informs the development of effective interventions and supports that reduce barriers and save lives within those contexts. However, these studies do not tend to explain why addiction is also a prevalent concern in families within populations who enjoy many social privileges. One need only consider the fact that treatment for addiction is a multi-billion dollar/year industry with thousands of opulent facilities accessible only to those with ample resources to recognize that this grave malady impacts people at all levels of society (Munro, 2015). Therefore, while some families are more vulnerable to addiction/substance-use because of the ways in which they have been marginalized by racist, colonizing, sexist and classist policies, systems and structures, social privilege alone is clearly not enough to protect families from developing devastating addictions, nor does access to these exclusive treatment modalities appear to be an effective long-term answer.

To understand how these vastly different experiences across social locations in BC might be linked, I have drawn on Alexander's framework that identifies free-market capitalism, neoliberalism and globalization as 'the causes of the causes' of addiction (2008). Alexander claims that these economic, political and cultural ideologies, systems and structures are responsible for creating conditions of widespread and excruciating experiences that result from a lack of psychosocial integration and in response, people attempt to self-soothe in ways that often result in debilitating addictions and compulsions. Alexander draws from Polyani's definition of dislocation that results from free-market capitalism: "Free-market society fragments culture of every sort, breaking the social, and economic links that have traditionally given people a sense of belonging, meaning, purpose, and identity. People find long-term dislocation from cultural support unbearable." (Alexander, 2012, pg. 1476). I find Alexander's framework compelling – at least within the context of western societies that operate through these economic, political and cultural systems and structures[9] – because unlike a medicalized framework of addiction, it looks beyond individuals and holds harmful ideologies, systems and structural inequalities accountable for this phenomenon of suffering that even the most privileged populations cannot necessarily escape. Alexander asserts: "dislocated people suffer even if they are rich capitalists." (2012, p.1476). As such, social epidemiologists and public health researchers are correct in that trauma, often resulting from environmental conditions, lead to addictions – but it is not only because those populations are relegated to oppressive environmental conditions – it is also because living in a society that pits its citizens against each other in a culture that values profits over people and competition over cooperation reduces everyone's innate human worth to a mere calculated economic value thereby putting us all at risk of dislocation. While addiction itself may not be a medical condition, there is great value in treatment that is accessible, responds to the trauma experienced by families affected by addiction and equips families with alternate healing and strengthening strategies for coping could be of value if part of a multi-pronged approach which is designed to mitigate the harms of addiction, if not addiction itself.

[9] This said, Alexander (2008) explains how dislocation is a globalized phenomenon even in countries that operate using different social and economic systems, though it is beyond the scope of this research to get into these details here.

In addition to free-market capitalism, neoliberalism and globalization being listed as ‘the causes of the causes’, throughout this thesis I also explicitly list white-settler-patriarchal-colonialism as a contributing ‘cause’. As this thesis will show, colonial and patriarchal aims entrenched in historic and current ideologies and systems play no small part in upholding the social, cultural, political and economic status quo in this country. However, while Alexander regularly points to the impacts of these structures, he does not explicitly name white-settler-patriarchal-colonialism alongside free-market capitalism, neoliberalism and globalization in his own analysis, so it is important to note that these are my own additions.

If Alexander’s theory of addiction is correct, this might explain why rates of addiction and addiction-related harms continue to rise instead of resolving addiction. Indeed, current models of addiction treatment could be failing to reduce the impact and prevalence of addiction in society for at least two reasons. First, the overwhelming majority of programs are offered almost entirely through individualized approaches. The individualized model of residential addiction treatment is problematic as it perpetuates the dislocation that Alexander identifies as the cause of addictive behavior in the first place. Regarding the individualized response to substance-use, McNeil and Small state: “Notably, individually-focused interventions often overlook contextual forces that constrain individual agency and shape the production of drug-related harm” (2014, p. 151). Indeed, removing an addiction-affected/substance-using person from their family and environment for treatment implicitly and perhaps falsely locates the entirety of the affliction and the power to arrest it within that solitary being, when in fact addiction, as Alexander suggests, might be a symptom of a more complicated, underlying social malady: dislocation.

Furthermore, a significant barrier to overcoming addiction for many parents is separation from their children when attempting to access residential treatment programs because an overwhelming majority of such centres admit individuals only. For marginalized parents, who do not have the means to provide safe, alternative childcare, this often means surrendering their children to child welfare agencies and unsurprisingly, few choose this option willingly (Isaac and Poole, 2002). Instead, some may opt for harm reduction programs, and/or attempt to hide and control their addiction for as long as possible. Therefore, parents living in poverty who remain in active addiction because they do not want to risk separation from their children almost inevitably become

separated because addictions often progress (Brower, 2006). And again, as addictions progress, risky behaviours – especially within a prohibitionist context - including engaging in drug-related crimes, intensify (Jenkins & Cook, 2012). Ultimately, an individualized residential treatment model can be problematic, and especially so for families, as it not only perpetuates the dislocation Alexander identifies as part of the cause of addiction, but also contributes to the creation of 'risk environments' linked to addiction in marginalized families.

Secondly, and as this thesis will explain in greater detail in the chapters that follow, even for more so for socially-privileged families, access to residential treatment presents a significant financial barrier. While marginalized parents who receive social assistance can often access funding for treatment through the Ministry of Social Development and Poverty Reduction, people who do not receive social assistance must fund their addictions treatment privately – a reflection of free-market capitalism and neoliberalism which are two of the main forces that Alexander cites as central to causing the dislocation that causes addiction. Even if treatment is paid for through their employee benefits, these parents still must ensure their normal costs of living and the needs of their family is provided for while they are at treatment and unable to work. As this thesis will show, these costs can be prohibitive for many high-income earners. Ultimately, this two-tiered delivery of individualized treatment through public and private channels continues to put families at risk for a multitude of intersecting reasons.

While it is certainly not the only avenue to addiction recovery, residential addiction treatment remains a popular option for those who aim to achieve abstinence from alcohol and drug use. For example, residential treatment removes clients from environments in which their addiction related behaviours have most recently been entrenched. This puts some distance between the people recovering from addiction and daily places and routines that might 'trigger' them (Passeti et al., 2011, p. 13). Indeed, being able to set aside regular, everyday responsibilities and obligations and focus on recovering from addiction makes residential treatment an appealing option for some.

As such, a family-model of residential addiction treatment could present an attractive solution for addiction-affected parents. Such a model would not only provide an alternative to child-apprehension for families marginalized by social location, thus potentially removing a significant cause of the intergenerational cycle of trauma as noted

previously. Additionally, this sort of programming could also help address the dislocation that may impact any addiction-affected families if its philosophy enables and encourages psychosocial (re)integration within family, cultural and community groups.

In BC, there are already two residential treatment centres with the mandate to deliver residential treatment in ways that keep and treat families together as well as seek to reintegrate addicted individuals as parents and link them back to culture and community. Located in the small forestry-based city of Port Alberni (pop. 17, 336), on Vancouver Island in BC, Kackaamin Family Development Centre[10] is a not-for-profit organization developed to assist Indigenous[11] families (mothers and/or fathers and their children of any age) living with addiction, enabling them to heal together. Full funding is provided for people who have status[12], while those without must secure their funding through alternative channels. The second family-model program is offered through Nenqayni Wellness Centre[13], located in another forestry-based city of Williams Lake, BC (pop. 10, 605), which also serves Indigenous clientele and similarly admits entire families. Nenqayni Wellness Centre is governed by the Chiefs of the 15 local bands who elect the board of directors which represent the 3 nations: Secwepemc (Shuswap), Tsilhqot'in (Chilcotin), and Dakelh (Carrier). The fact that these facilities are already in operation in Indigenous communities validates not only Alexander's theory of dislocation as an underlying cause of addiction, as dislocation was often the express intent of policies imposed upon Indigenous Peoples throughout colonization, but also demonstrates that family models as designed by Indigenous leadership through Indigenous epistemologies could point the way to a new paradigm for understanding and treating addictions in families.

It is important to explain that while Alexander's theory posits that all people are vulnerable to dislocation given the over-arching culture of neoliberal values that pervade our society in BC today, as contemporary public health research shows, these processes have directly impacted some populations more than others. For example, in

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[10] Retrieved from: http://www.kackaamin.org

[11] The use of the term 'Indigenous' throughout this thesis includes all people who identify as being of First Nation, Métis, Status or non-Status Indian, and/or Inuit heritage and identity.

[12] The term "status" refers to individuals who are recognized as "Indians" under the Indian Act of 1876 and are registered to a particular band.

[13] Retrieved from: http://nenqayni.com

Canada, throughout the ongoing history of colonization, Indigenous Peoples have been dislocated from their families, communities, nations, cultures, languages, traditions, land and entire ways of living. These dislocations were the result of premeditated and socially sanctioned practices enacted by colonizers who were authorized to take land and exploit natural resources across Turtle Island. These acts are widely documented forms of structural violence that include but are not limited to the Indian Act, the Reserve System, the Residential School System, the Sixtie's Scoop and the ongoing over representation of Indigenous children within the foster care systems and Indigenous adults within the corrections systems today.

In keeping with Alexander's theory that dislocation causes addiction, it should come as no surprise that the population of the neighborhood with the most visible and documented challenges stemming from addiction in Canada, the Downtown East Side (DTES) of Vancouver, is 40% Indigenous descent (Robertson, 2007) while Indigenous people make up only 4.3% of the Canadian population overall[14]. Furthermore, Indigenous women are statistically overrepresented compared to non-Indigenous Canadian women in prisons[15] while their children are disproportionately represented in foster care[16], and most of such cases are linked to drug use and drug related offences (Allen et al., 2010). While instances of drug/alcohol addiction/use, poverty, and child-apprehension have been shown to perpetuate intergenerational cycles of trauma, abuse, addiction, and criminalization in all populations (Turpel-Lafond, 2014), these patterns disproportionately affect Indigenous families and represent the ongoing colonial project (Denison et al,. 2013). The fact that current systems and institutions have been shown to cultivate abuses by perpetuating cycles of trauma, violence, addiction, and child-apprehension generation after generation demonstrates that an individualized treatment model is part of the problem and simultaneously suggests that family models, that foster interconnectedness and interdependence within and across family systems, could present an effective solution.

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[14] Retrieved from: https://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-011-x/99-011-x2011001-eng.cfm

[15] Retrieved from: http://www.statcan.gc.ca/pub/85-002-x/2015001/article/14163-eng.htm

[16] Retrieved from: https://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-011-x/99-011-x2011001-eng.cfm#a7

Indigenous organizations such as Nenqayni Wellness Centre and Kackaamin Family Development Centre believe that Indigenous families should have the opportunity to recover together as they have been disproportionately impacted by dislocation because of the horrors of colonization. For many, without access to their cultures, languages, traditional territories, and having been stripped of their children by the residential school system and 'child protection', using substances has been the only available method for coping with these many traumatizing experiences. To enable effective healing from such experiences and from addiction, these family-model programs offer the opportunity to families for psychosocial reintegration with each other and with their cultures, traditional practices and beliefs.

While there are also a few non-Indigenous[17] residential drug and alcohol treatment programs in BC that permit children to attend, including Peardonville House[18] in Abbotsford, Rose Harbour in Campbell River[19], and the Karis Support Society[20] in Kelowna, these are designed for women only, and often have an age limit on the children who may attend with their mothers. Though these programs are incredibly important as they reduce barriers for women; they do not enable entire families to begin their recovery together in a safe, supervised, and guided environment the way that Nenqayni Wellness Centre and Kackaamin Family Development Centre have done, and they leave non-Indigenous fathers without any option for attending residential treatment with their children and/or partners.

Throughout this thesis, by comparing and analyzing the experiences of addiction/substance-use, stigma, treatment, and recovery in families across different social locations, I discuss how these experiences point to fundamental flaws of our overarching social organization, indicating why current services are failing families across social locations in different ways. Ultimately, I draw from both the literature as well as participant recommendations to argue for accessible, holistic services for

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[17] This is not to suggest that these organizations do not accept Indigenous clientele, nor hire Indigenous employees, only that they are not owned or operated specifically by Indigenous organizations.

[18] Retrieved from: http://peardonvillehouse.ca

[19] Retrieved from: https://www.annelmorehouse.ca/rose-harbour

[20] Retrieved from: https://karis-society.org

addiction-affected families that include family models of addiction-treatement and recovery services.

1.2. Structure of this thesis

To review, the research questions that guide this thesis are: how are the experiences of addiction/substance-use, stigma, and barriers to treatment and recovery for addiction-affected parents linked across social locations in BC to ideological, systemic and structural forces of white-settler-patriarchal-colonialism, neoliberalism, free-market capitalism and globalization? And, what changes are necessary to support recovery more effectively in all addiction-affected families in our society? To answer these questions, this study utilizes a qualitative methodology to interview ten working/middle-class parents in recovery in BC, Canada. Participants share their experiences relating to the four key themes of this thesis: parenting in addiction and/or[21] recovery; how they have been impacted by and navigate addiction related stigma; the benefits and barriers of residential treatment; and/or the benefits and barriers to recovery programs. Additionally, participants imagine and explain what sorts of services might better serve them while recovering from addiction in the context of their family lives.

Following this introductory chapter in *Chapter 2: Methodology*, I describe and justify my qualitative methodological design and present the intersectional, comparative, decolonizing, and self-reflexive theories and tools informing my analytical framework. I also introduce the critical narrative literature review method I apply in my literature review (Chapter 3) and detail the specific methods I have applied throughout this project.

Next, in *Chapter 3: Literature Review*, I provide a critical narrative review of the literature. This method is a good fit for studies that introduce a new topic to the literature such as mine, as it draws from several contributing concentrations of study to illustrate how this new topic addresses an existing gap. My literature review delineates strengths and limitations of the literature from those related subjects and shows how my research makes a meaningful contribution by underlining the importance of community consultation when considering the social determinants of health-related issues.

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[21] Some participants did not have children until they had already begun their recoveries. For more information, see Appendix A: Participant Social Indicators

Chapter 4: Findings details the experiences of the working/middle-class[22], white/white-passing[23], cis-het/cis-het passing[24], male and female parent participants of this study and is organized according to the four themes of this thesis. While the participants each have different personal histories and experiences, the shared aspects of their current[25] social locations and related social privileges offer valuable insights into a population understudied in addiction literature.

In *Chapter 5: Analysis*, I take my findings from Chapter 4, and compare them to the systematic responses to and experiences of marginalized addiction-affected families detailed by secondary sources, again organizing this chapter according to my four overarching themes. Here I show that while the 'causes' of addiction and harm that families experience are often drastically different, their experiences tend to be rooted in the same 'causes of the causes', or ideologies, systems and structures of white-settler-patriarchal-colonialism, free-market capitalism, neoliberalism and globalization.

In *Chapter 6: Discussion*, I bring the conversation back to Alexander's dislocation theory of addiction, revisit the idea that ideological, political, cultural and economic forces are 'the causes of the causes' of addiction and argue that our current two-tiered public/private systemic responses to addiction reflect and uphold these oppressive systems and structures and do not adequately treat or prevent addiction. I then present ideas for programs and policies proposed by my participants that would reduce the barriers to treatment and recovery that they continue to confront. Finally, I discuss key changes to our current cultural, economic, and political paradigm that would be required to implement such ideas.

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[22] 9/10 of my participants described themselves as middle or upper-middle class, while one participant identified as working class. For more detailed information on participants, see Appendix A: Participant Social Indicators

[23] 8/10 of my participants described themselves as white/Caucasian/European descent, while 2/10 participants identified as having Indigenous ancestry (1/10) and Japanese ancestry (1/10) in addition to European ancestry. For more detailed information on participants, see Appendix A: Participant Social Indicators

[24] 9/10 of study participants identify as heterosexual, while 1/10 participants identify as bi-sexual and is currently in a hetero-sexual marriage. For more detailed information on participants, see Appendix A: Participant Social Indicators

[25] Social locations are not fixed: for example, several participants have historically experienced street-entrenched addiction, though are now situated as middle-class.

Lastly, *Chapter 7: Conclusion* summarizes my thesis and provides my concluding thoughts and ideas of how to move forward to address the complicated issue of addiction/substance use.

By considering why current responses are failing to effectively address addiction in our society and by examining this problem through a broad lens that explores family experiences across social locations in this province, this thesis brings to light patterns in our systemic organization and service delivery that might be missed by a narrower focus. While this study and its resulting thesis are built from a small but representative sample, the findings, analysis, and discussion herein offer insights into and critiques of our current responses to addiction/substance-use. In addition, by considering these intersecting problems from a new perspective this thesis builds an understanding of what might be required to develop holistic, effective, family-based treatment and recovery models accessible to all addiction-affected families in BC. Ultimately I argue that despite the many ways that more socially privileged people unjustly benefit from current oppressive ideologies, systems and structures, and unquestionably escape many of the more devastating impacts of addiction/substance-use endured by marginalized populations, they and their families will also continue to be at risk of suffering the agony of dislocation and many intergenerational harms of addiction, and will also continue to struggle to access effective treatment and recovery when needed or wanted all the while these systems and structures continue to shape not only our responses to addiction, but our society at large.

Chapter 2.

Methodology

2.1. Introduction

In this chapter, I begin with a description and explanation for my choice in using a qualitative methodological design. Next, I describe the intersectional, decolonizing, comparative and self-reflexive theoretical tools that underpin my framework of analysis and justify why each is appropriate for addressing my study questions. In the following section, I describe and detail my use of the narrative critical method used for conducting my literature review. Finally, I list, detail, and justify the specific methods I have employed to produce and work with my data, delivering the resulting findings, analysis, and recommendations within this master's project. Despite its limits in scope given this project's qualitative structure, these methodological tools have enabled a solid study that can provide a foundation for future inquiry.

2.2. Methodological Design

The topic of this study is sensitive. The ways in which families experience and are impacted by addiction/substance use remains highly stigmatized. As such, choosing a methodological design that honours and respects the various contexts and processes families must navigate in their journeys with addiction/substance use and recovery is important.

In fact, people who use substances have been quite vocal in their desire to be consulted when substance related policies and programs are developed and implemented to ensure their usefulness and accessibility. For example, the slogan "nothing about us without us" abounds in grassroots organizations on the Downtown East Side (DTES) of Vancouver[26] - a neighbourhood known for its population disproportionately impacted by addiction/substance-use. This sentiment reflects at least in part "the imposition problem" (Mejia, 2004) meaning that research questions can

[26] Retrieved from: http://www.carnegieaction.org/wp-content/uploads/2019/07/DTES-Vision-for-the-100-Block-Final-1.pdf

largely reflect researcher biases which may not reflect lived experience. In such cases, information critical to the affected population might be missed simply because the necessary questions are never posed; whereas a qualitative design is more likely to capture information that participants value. While not a community-based participatory research project, the study design has been through consultation with addiction-recovery community members as well as is informed by best practices detailed in the literature (Hacker, K. 2017; Greer et al, 2018). My enduring goal has been to develop a qualitative methodological approach that ensures as much participant-lead discussion as possible in order to honour the sensitive material – and the people - it reflects.

Due to the depth and nuance they offer, qualitative frameworks make important contributions to health research. O'Cathain et al. describe qualitative methodological designs as being excellent for:

> explaining how mechanisms work in a theoretical model, developing good recruitment and consent procedures…drawing attention to outcomes important to patients and practitioners, communicating findings… understanding why an intervention was or was not successful, optimising the implementation of an intervention in a pilot trial and challenging the underlying theory of the intervention. (2014, p. 1)

A study that examines how social locations shape experiences of addiction/substance use, stigma, access and barriers to residential models of treatment and recovery programs for addiction-affected/substance-using parents in BC is an understudied topic of inquiry in the literature. As such, it is important to approach this research qualitatively because "one of the key objectives of qualitative social research is to explore, unravel and explain the complexity of different social worlds." (White et al., 2003, p 287). Therefore, employing a qualitative methodological design for this study has enabled an inquiry into the fabric of lived experiences that has provided a rich understanding of how which parents, under what circumstances, are able to access residential treatment, and what recovery from addiction makes possible for them in the contexts of their family lives.

2.3. Theoretical Tools and Frameworks

In this section, I introduce intersectional, decolonizing[27], comparative and self-reflexive lenses and tools of research analysis. Here I describe why each of these lenses are complimentary to my overarching qualitative research design and I explain how each of these tools have been crucial for not only producing but also for understanding the data resulting from this research project.

To begin, the "Theory of Intersectionality" is a revolutionary theoretical framework developed by Kimberlé Crenshaw in 1989, to bring attention to the experience of sexism and racism in the face of middle-class white feminist activism. In short, Crenshaw explains the theory of intersectionality "account[s] for multiple grounds of identity when considering how the social world is constructed" (1991, p.1245). Applying an intersectional lens when conducting research reveals the ways in which institutions, systems and systemic structures perpetuate a culture and society that categorizes, ranks, includes and excludes people in all aspects of their lives based on the intersections of their "race", gender, sexual orientation, religion, age, economic class status, etc.

Of particular interest in research that uses an intersectional lens to investigate addiction in BC – which remains largely conducted on unceded First Nations territories - is 'Red Intersectionality' developed by Clark to explain how violence imposed upon the bodies of Indigenous girls and women is inextricably tied to violence inflicted upon the land. Clark explains a Red Intersectional framework "helps us to understand and address violence against Indigenous girls since it foregrounds context, which in Canada's case has to include gendered forms of colonialism, and the dispossession of Indigenous lands" (2016, p.51). Importantly, Clark explicitly discusses that her Red Intersectional framework centres Indigenous girls and women as agents of change and resistance to the colonial violence imposed upon them.

Indeed, intersectional frameworks of analysis have radically changed the way in which social and health issues can be understood. In Rutherford, McCall claims:

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[27] It is important to note that though this study does not employ a decolonizing methodology, given the disproportionate impacts of addiction experienced by Indigenous Peoples and families as a result of colonization, learning from Indigenous scholars, and citing their studies that do employ decolonizing methodologies and frameworks is an important aspect of this thesis.

“Intersectionality has been hailed as the ‘most important theoretical contribution that women’s studies, in conjunction with related fields, has made so far’”(2018, p. 631). Intersectional analyses render visible the ways in which social determinants profoundly impact and shape how people experience health and their interface with associated health systems and institutions.

As such, it is vital to examine theories of addiction through an intersectional lens that recognizes the specific challenges and barriers confronted by addicted people as a result of their sex, gender, sexual orientation, race, ethnicity, class, language, educational level, age, and a host of other determinants. Indeed, Macrory and Boyd explain: “Because drug use is mediated by these factors, the consequences of drug use are not the same for all women. We have come to recognize that double standards of morality, reproduction, mothering and legal and social inequality shape women’s experience” (2007, p.119). Like many other health-related conditions, the symptoms and impacts of addiction in the lives of women manifest very differently from each other, as well as from men, thus research related to addiction and treatment as experienced by parents will be enhanced using an intersectional lens in my framework of analysis.

Applying an intersectional lens of analysis is particularly complimentary to a qualitative research design because it centralizes the experiences of people who are positioned at intersections of social identities/statuses that have been historically marginalized, or otherwise stigmatized, blamed, and excluded from public dialogues, narratives and decision-making processes. Christensen and Jensen describe qualitative intersectional analysis: “intersectionality is an analytical concept that is useful for analysing and understanding differences and multiple inequalities in contemporary societies at both the macro- and the micro-level” (2012, p. 121). By considering the experiences of individuals at the micro-level embedded within their particular social locations, an intersectional analysis reveals patterns and points to systemic causes at the macro-level that are beyond individual circumstances and choices.

While an intersectional analysis renders visible systemic causes of oppression, it also simultaneously highlights the ways in which some benefit from having access to a host of unearned social privileges. Nixon claims such people “are..[privileged], by definition, because they happen to be able-bodied, settlers, white, straight, cisgender, or other aspects of their social identity that they did not choose, but which nonetheless

align with historic planes of domination and subordination" (2019, p. 5). While the participants for this study do embody certain social privileges given their shared 'working/middle-class' socio-economic status, this thesis will show that these privileges have not spared them from experiencing and suffering from addiction and associated stigma, though in typically less traumatizing and more private ways than typically experienced by their counterparts living in more marginalized social locations. While a qualitative design enables a deeper, more nuanced understanding of individual experiences, an intersectional framework of analysis demonstrates how all these experiences are shaped by overarching social systems and structures.

To improve my understanding of how systems and structures have impacted families affected by addiction in BC, in addition to intersectional analyses, I have also extensively consulted literature that applies decolonizing methodologies. Indeed, drawing from studies that employ decolonizing frameworks has been incredibly important for understanding how systems and structures impact Indigenous Peoples from Indigenous perspectives and through Indigenous epistemologies - and for ensuring that my own research does not contribute to perpetuating harms for Indigenous Peoples through acts of erasure or misappropriation.

Decolonization in practice is the returning of land, resources and political and cultural autonomy to a People who have been subjected to colonization (MacGregor et al. 2018, p. 9). In the context of research, a decolonizing methodology functions similarly: it is the act of 'researching back' – a reframing and reclaiming of Indigenous histories, experiences, and knowledges (Smith, 2012, p. 9). As colonized Peoples, what has been known about Indigenous Peoples – and 'justification' that ensures their ongoing oppression and subjugation – has and continues to be written into the 'research' and policy by and for colonizers. Smith claims "Western research… brings to bear, on any study of indigenous peoples, a cultural orientation, a set of values, a different conceptualization of such things as time, space and subjectivity, different and competing theories of knowledge, highly specialized forms of language, *and structures of power"* (emphasis mine) (2012, p. 44). Part of constructing a decolonizing methodology involves answering the following questions satisfactorily: "Whose research is it? Who owns it? Whose interests does it serve? Who will benefit from it? Who has designed its questions and framed its scope? Who will carry it out? Who will write it up? How will its results be disseminated?" (Tuhiwai Smith, 2012, p. 10). Again, while my study does not claim to

utilize a decolonizing methodology, these questions have remained with me as part of my self-reflexive practice to enable me to remain cognizant of the fact that I have been conducting this work as a white-settler in a white-settler colonial context. Ultimately, because this study was originally inspired by the ways in which Indigenous communities have responded to addiction crises within their Nations and communities, I have consulted several studies that apply a decolonizing methodology and framework of analysis and these are discussed in the literature review in Chapter 3.

Due to the flexibility enabled by the qualitative methodological framework I applied, the focus of my research was able to shift as needed as it progressed. Lewis and Ritchie explain: "a key strength of qualitative research in particular is that it can explore unanticipated issues as they emerge" (2003, p.47). As described in Chapter 1, this study was inspired by the family-models[28] of residential treatment created by Indigenous organizations for Indigenous clients. When I set out to conduct my study, my intention was to learn whether a family-model would appeal to my participants who would hopefully reflect a broad range of socio-economic locations. My hypothesis had been that a model of this sort could eliminate barriers that individualized residential treatment models may present to addiction-affected parents seeking recovery. I wanted to know if and why, or why not, a parent would choose a residential treatment facility that would accommodate their children, and to consider how their responses might be linked to their social locations.

However, once I sent my recruitment posters out into the world, my study shifted in two significant ways. First, as I already touched upon previously in *Chapter 1: Introduction*, the participants that self-selected for my study did not represent as wide a range of social locations as I had hoped - especially in terms of their socio-economic status[29]. In fact, they all identified as currently being working/middle/upper-middle class[30]. Second, because all the participants share this socio-economic position, a

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[28] A treatment model that enables entire families to live and participate in therapy, instead of the individualized model.

[29] See Appendix A: Participant Social Indicators

[30] It is important to emphasize that this is their current status. As explained when theorizing socio economic status, some aspects of a person's social location are not fixed – class being one of them. As the findings section shows, several of my participants experienced poverty while in active addiction and have only accessed the privileges of middle class since recovering from addiction.

pattern linked to that position emerged, revealing a more pressing and interesting concern to address in the body of this thesis. What I heard repeatedly from most of my participants when I asked whether they would attend a family model of residential treatment was not that they *would* or *would not*, but that given their financial position, they *could not*. This surprised me. My expectation had been that given their working/middle-class status, their answers would have related more to their values and philosophies as parents, rather than their financial limitations. Indeed, participants, socially-located as they are, seem to represent western ideals of 'success' – people who had 'made it'. They all are/were[31] highly trained and educated, gainfully employed, living in nice neighbourhoods – achieving and earning all the things we are taught to want in our society - and yet if needing treatment for the life-threatening condition of addiction, they claim they are barely, or completely unable, to afford access. As such, this emerging pattern lead me to question which parents, under what conditions, can access residential treatment and recovery programs as they are currently organized and delivered? And, how are their families impacted by the process?

To answer these questions, a comparative analysis became a necessary part of my research framework. The basic premise of any comparative analysis is to extrapolate meaning from the differences and similarities that exist across a set of data (Palmberger and Gingrich, 2014: chapter 7, p. 97). Although I only interviewed participants who identify socio-economically as working/middle/upper-middle class, I was well informed of the experiences of marginalized families because of my prior review of the literature as well as from my own work, the contrast across these sets of experiences was immediately obvious to me. As I continued to consider my data and findings through an intersectional lens of analysis, the more I became attuned to common underlying causes for the differences in these experiences as being bound by the limitations of particular social locations. As such, I expanded my methodology to include a comparative analysis that draws from secondary sources focussed on the experiences of addiction-affected parents living in marginalized social locations (see *Chapters 5: Analysis* and *6: Discussion*). Employing a comparative analysis of my emergent themes between my own data and findings from the literature has enabled a more robust intersectional analysis that identifies how one's racialized, gendered and classed position influences

[31] 1/10 participants is retired. For more information, see Appendix A: Participant Social Indicators

what one's experiences of addiction/substance-use, stigma, access/barriers to treatment and recovery as a parent with dependent children might be. Social locations influence a range of experiences, supporting the observation that social identities and experiences are both rooted in and perpetuate the values and practices which reproduce white-settler-patriarchal-colonialism, free-market capitalist, neoliberal and globalized systems and structures, as observed by Alexander (2012) as causing such rampant dislocation and thus addiction in our society.

Finally, self-reflexivity is a practice in research that acknowledges that researchers come to their studies and questions from within and informed by their own unique and internalized socio-economic-cultural-political positions and biases while arguing that this explicit acknowledgment can strengthen a study's analysis. May and Perry state: "Authors, writing from a feminist perspective, have argued that a critical and insightful gaze does not come from a position of disinterest from which the researcher works, but that interest itself comes from the advantage of 'being engaged' (Hartsock, 1987)." (2014, p. 1). Utilizing self-reflexivity has been an important aspect of engaging with this material for me given my own lived and professional experience as discussed in *Chapter 1: Introduction*. Utilizing self-reflexivity practices throughout, including the use of a field journal (detailed in the methods section of this chapter); as well as through conversations and consultation with my supervisory committee, my professional teams, and my own recovery community, I have been supported in identifying and addressing my own biases and thus providing a more objective empirical analysis herein.

This section has introduced the intersectional, decolonizing, comparative and self-reflexive analytical lenses applied throughout this study from the study of secondary sources presented in my literature review as well as when analyzing my own findings. I have demonstrated how these frameworks and tools can be utilized concurrently for the purpose of my analysis, as well as how they are compatible with my overarching qualitative methodological design. In the section that follows, I describe and explain my use of the narrative critical method I applied when conducting my review of the literature.

2.4. Narrative Critical Literature Review Method

To prepare for this study, I decided to utilize a narrative critical review of the literature. Rother describes a narrative critical review as "publications that describe and

discuss the state of science of a specific topic or theme from a theoretical and contextual point of view" (2007, p. vii). This method draws information from several selected sources to critically analyze different aspects of an issue and to identify gaps in knowledge. In this section I describe the process I undertook when identifying each of the areas of inquiry for conducting the narrative critical literature review laid out in *Chapter 3: Literature Review*.

The narrative critical review method is well suited for reviewing the literature in this study given the widely varied and intersecting issues that give rise to the questions: 'how are the experiences of addiction/substance-use, stigma, and barriers to treatment and recovery for addiction-affected parents linked across social locations in BC to ideological, systemic and structural forces of white-settler-patriarchal-colonialism, neoliberalism, free-market capitalism and globalization?' And, 'what changes are necessary to more effectively support recovery in all addiction-affected families in our society?'. As Jesson and Lacey state: "a good [narrative critical] review will be more than descriptive. It will be original, perceptive and analytical…" (2006, p. 142). I have selected this method because of its compatibility with the intersectional, decolonizing, comparative and self-reflexive frameworks I have drawn from and applied in an effort to grapple with what is known about the current social, political and health impacts experienced by families living with addiction/substance-use. In fact, frequently associated with these lenses of analysis are qualitative research methodologies that consult directly with populations who have suffered unjustly because of social constructs and marginalizing process with the explicit goal of disrupting the status quo in attempts to achieve social justice.

To begin, this method is applied by first identifying resources for analysis and sorting them into themes related to the issue or question at hand. The themes that I selected to examine in my review are: qualitative and/or intersectional and/or decolonizing frameworks for understanding the social determinants and impacts of addiction/substance-use; theories for conceptualizing the phenomenon of addiction; and, family models of harm reduction, residential addiction treatment and recovery programs.

While qualitative, critical, feminist, and anti-colonial insights are playing an important role in advancing health research in the Canadian context (Richardson, L., Murphy, T., & Canadian Electronic Library distributor, 2018; Nixon, 2019), there are still

few studies directly related to my questions; therefore, I have selected and analyzed studies that investigate a wide array of topics and issues. Where possible, when reviewing the literature related to marginalized addiction-affected families, I selected articles that similarly utilize intersectional and/or decolonizing lenses, theories, and qualitative methodologies.

Indeed, it was important for me to narrow my focus to studies that employ intersectional and/or decolonizing frameworks and qualitative methodologies as these are compatible with my own methodological design. Applying a qualitative methodology when studying the experiences of a population that has been historically and systematically marginalized, silenced and erased – or for those who have access to more social privileges: hidden - is a particularly effective way to disrupt the status quo as it will amplify and centralize their voices. Indeed, as Choo and Ferree state: “only by inclusion of the perspective of these groups could the political issues emerging from their experiences be addressed by movements, law or policy-relevant scholarship” (2010, p. 132). By highlighting the issues and barriers as identified by the people who are occupying stigmatized positions, this review method tailors the information gathered to reflect the information deemed relevant to their expressed experiences and goals.

Once themes have been identified and arranged for the narrative critical review, articles and resources are either included or excluded from analysis based on their relevance to the research question. It is important to note that due to the broad scope of this critical narrative review, several studies were necessarily left out of my analysis. For example, studies that met my criteria for exclusion were those that focused on specific substances, for example, harm reduction in relation to the use of crack cocaine. Because studies such as these focus more on harms related to specific substances and less on the larger social dynamics that impact families. And, when consulting the literature related to international practices of harm reduction, I only reviewed studies that focused on the general reasons harm reduction practices were put in place (rising rates of HIV, etc.) and that offered data to reflect the positive outcomes of such programs.

Finally, the narrative critical review method requires an analysis of the information compiled within each theme or topic. Read together, a broad strokes picture comes into view, illustrating the many moving parts creating the context for the problem at hand. In this case, my selected themes reflect the intergenerational impacts of

addiction/substance-use across social locations in BC, and highlight the importance of learning how we might provide effective, accessible, culturally safe, family-oriented treatment and recovery options in BC for addiction-affected families.

There are short-comings to using a narrative critical literature review, however. For example, Stratton (2019) explains: "Narrative reviews often include an author's assumptions and biases and generally cannot be replicated (as with systematic reviews)" and further notes "critical reviews don't include the rigorous study design of a systematic review and are a form of narrative review." However, Stratton also lists strengths of this style of review to include "justifying a research topic" and "developing perspectives on a topic" (p. 349). My research questions could not be answered by any one body of literature. As discussed, there are various moving parts that create the contexts in which different families in different social locations across the province of BC experience addiction/substance-use, stigma, access and barriers to treatment and recovery in so many different and yet connected ways. To truly grasp the nature of this connection, utilizing a non-systematic, but still rigorous narrative critical review of the literature was the most appropriate method for my task.

Indeed, by employing the narrative critical literature review method I have consulted many studies reflecting a multitude of theoretical frameworks for understanding the phenomenon of addiction. I have read various, qualitative, feminist/intersectional, and decolonizing studies that render visible the social determinants of addiction/substance-use. I have studied statistical reports and policy papers that demonstrate the need for various options for treatment and harm reduction, and articles that discuss the necessity of incorporating culturally safe practices in addiction response programs for Indigenous clientele. I have scoured databases for studies that focus on family-oriented treatment models locally, nationally, and internationally, as well as for any study discussing addiction in the context of families with working/middle/upper-middle class socio-economic status, an understudied population, as my review will show. As a result, this method of reviewing the literature has enabled me to understand the tremendously unjust cycles of trauma, addiction/substance-use, incarceration, and child-apprehension perpetuated by social constructs erected to marginalize those who fail to meet hegemonic expectations of parenthood while also recognizing that despite the privileges that certain social statuses enable, privilege alone does not prevent addiction itself or many of its harmful,

intergenerational impacts. Ultimately, by assessing trends within and across these themes, I built the narrative analysis found in *Chapter 3: Literature Review* that identifies the gap in knowledge that this study attempts to address.

In the following section, I list, describe and explain my choices in each of the practical methods I have applied to conduct my research for this thesis.

2.5. Methods

This section provides a chronological list and description of each of the steps I have taken in this research project. Each of these practical methods were selected as extensions of the theoretical and analytical frameworks embodied in my overarching research design to generate relevant and appropriate qualitative data in answer to my study questions. Furthermore, this section notes the ways I have adapted my methods as new information became available through this process to complete this thesis.

2.5.1. Field Journal/Self-Reflexive Framework

While not an ethnographic study, I have employed the use of a field journal and have kept field notes. Writing consolidated field notes is the habit of recording observations and related thoughts and notes after spending time in the field – or in my case, after conducting an interview or other research related sources. As noted in the section on my self-reflexive research, this practice has been an important process for distinguishing data from my own inherent biases. Madden explains:

> fieldnotes are, among other things, personal documents, and it is not a conceit or a slip into problematic subjectivity to consider one's own personality or foibles in finalising a note-taking strategy, rather one needs to employ a rigorous reflexivity to find a balance between the forces of 'self that will always intrude in some way into ethnographic projects, and the forces and demands of professionalism and ethnographic information-gathering that require us to pay attention to validity, faithfulness and efficiency of information-gathering and recording. (2010, p. 122)

As a self-reflexive researcher, writing in my field journal has been an important practice throughout the completion of this project.

2.5.2. Ethics Approval

Ethics approval was necessary in this case, as this research project requires the involvement of human participants. Furthermore, participants who have experienced addiction can be considered vulnerable given that addiction remains a stigmatized experience. This highlights the necessity to anticipate and mitigate any possible harms that could result from participation to the furthest extent that I am able, and to ensure that all participants were fully informed of any such potential harms prior to giving consent to participate. Given that the self-selected participants in this study have been in recovery from addiction for several years, this study received "minimal-risk approval" by SFU's Office of Research Ethics and ethical approval was granted on November 21, 2018.

2.5.3. Participant Recruitment

This study required participants who identify as being 'in recovery' from addiction and are parents, or, are partners to and co-parents with people who identify as being in recovery. To recruit participants, I used a snow-ball sampling method. Snow-ball sampling is defined as:

> a technique for finding research subjects. One subject gives the researcher the name of another subject, who in turn provides the name of a third, and so on. This strategy can be viewed as a response to overcoming the problems associated with sampling concealed hard to reach populations such as the criminal and the isolated. (Atkinson and Flint, 2001, p. 1)

Snow-ball sampling as a method for recruiting participants is important in qualitative research, especially when working with marginalized or stigmatized populations. Woodley and Lockard explain: "To further the idea that social justice—and in particular womanist, feminist, and multicultural—researchers must "find ways to frame scientific study in a way that legitimizes cultural knowledge," we propose that there is a critical need for the use of strategies such as snowball sampling in qualitative research" (2016, p. 323). Given that my project addresses the stigmatized experience of addiction/substance-use, this recruitment method held the most promise, and was

ultimately successful in recruiting six mothers and four fathers to make the ten study participants[32] who met my inclusion criteria.

I posted my recruitment poster[33] from my personal social media platforms where I announced my research project to my personal contacts and requested that they privately forward my study and contact information to anyone they know that may fit the inclusion criteria of this study. When making my announcement, I explicitly stated that confidentiality would be maintained at the public level and urged potential participants to contact me exclusively via email/telephone or private message (on social media platforms such as Facebook) to maintain their confidentiality. Though every conceivable precaution to maintain confidentiality has been employed, there are certainly unavoidable risks of disclosure that exist when participating in any study, and especially in one that utilizes social media as a recruitment tool. As such, and to enable as strict confidentiality as possible, my study participants were made fully aware of the known risks of participation and have all been provided with pseudonyms within the body of this written work.

To minimize potential imbalances of power, I did not conduct interviews with anyone for whom I have provided counseling or other professional services. Though some of my participants may be personal and professional acquaintances, such relationships are horizontal, not vertical (i.e. co-workers, not clients).

2.5.4. Pre-Interview Contact

Prior to conducting interviews, I sent each participant the participant information and consent form[34] and topic guide with semi-structured interview questions[35] to prepare for our interview. Once each participant verified ongoing willingness to participate in this study, interview dates, times and locations were arranged.

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[32] See Appendix A for Participant Social Indicators

[33] See Appendix B for Recruitment Poster

[34] See Appendix C for Participant Information and Consent Form

[35] See Appendix D for Topic Guide with Semi-Structured Interview Questions

2.5.5. Conducting Interviews

For this research project I utilized a qualitative methodology that employs the use of face-to-face semi-structured interviews because “one of the key objectives of qualitative social research is to explore, unravel and explain the complexity of different social worlds” (White et al., in Ritchie and Lewis, 2003, p. 287). By conducting these interviews, participants’ narratives of their lived experiences provide nuanced details grounded in their social contexts that a less intimate method, such as a survey, might have missed.

Interviews are a preferred method for those wishing to conduct anti-oppressive research that is committed to disrupting power imbalances between people in positions of, and under, authority. Hand explains: “the interview is the ‘site for the construction of knowledge’ which implies that the context of the researcher and informant is central to the process of data collection” (2003, p. 17). By recognizing interviews as a research method in this way demonstrates how its data are more than the sum of their parts. Through interviews, the researcher becomes a complicit contributor to, and is responsible for, the information conveyed by their findings, and is never simply an unbiased arbiter of any sort of universal truth.

Indeed, consulting with the population most affected by an issue can provide invaluable information for effective program and policy development. Maina et al. explain: “Community engagement … begins with the identification of stakeholders based on community interests so that those who are affected are given a platform to have a say in shaping better health outcomes, health services and systems” (2017, p. 82). By using this approach, the participants in this study have shared in detail the impacts that they and their families have experienced because of addiction, as well as expressed the benefits of and barriers to treatment and recovery in the context of their own family lives.

I conducted each interview face-to-face because so much information conveyed is not done through verbal or written means. Irvine, Drew and Sainsbury explain: “Opdenakker draws particular attention to face-to-face interviews’ distinct advantage in providing ‘social cues’ such as voice, intonation and body language. Opdenakker notes that these aspects can ‘give the interviewer a lot of extra information that can be added to the verbal answer of the interviewee’.” (2006, p. 201). Given that much what is

communicated is non-verbal, to catch all the information that has been communicated, and not only the words that are spoken or written, a researcher must be present with the participant in the time and place of communication.

At each interview, I employed the use of a topic guide[36] with semi-structured interview questions that served to remind me of themes and questions but also enabled a more organic process to occur as each interview unfolded. As Arthur and Nazroo (2013, p. 109) note, a topic guide is usually used in place of a list of questions, but in my case of relatively little interviewing experience, I found it helpful to combine a topic guide that addresses overarching themes, as well as listing questions. I also decided to include specific questions in my topic guide as an act of transparency with my participants so that they would be fully aware of the sorts of information I would be asking them to divulge.

As mentioned in the methodology framework section, because of the flexible, qualitative design of this project it was during the interview process that the focus of my research was able to shift from “would you attend a residential treatment program with your children” to what became a more pertinent question “what barriers to treatment and recovery do you confront because you have dependent children”. Because I chose face-to-face, one-on-one interviews that were loosely guided by semi-structured questions in a topic guide, my participants were able to direct the conversation. As a result, I was able to glean more important information about our current systemic approach to drug and alcohol treatment options for families in this province than I was aware of at the outset of this project. Each interview lasted between 25-90 minutes and was audio-recorded using a password protected smart-phone.

2.5.6. Interview Transcription

I personally transcribed each of these interviews as this process assisted me in becoming more intimately familiar with the nuances of themes within and across the interviews as I listened to each intently. This was a laborious process given the number of interviews, but was worthwhile, nonetheless.

[36] See Appendix D: Topic Guide with Semi-Structured Interview Questions

When transcribing, I used the naturalism method "in which every utterance is transcribed in as much detail as possible" (Oliver et al., 2005, p. 1275) in order to best capture the unspoken communication referred to previously. This transcription method was useful in maintaining an accurate memory of the context of what was said and the mood or emotion with which statements were uttered. However, to conserve space in this thesis, I contracted quotes wherever necessary and appropriate. Indeed, the purpose of retaining these details within the transcripts was to enable myself to remember the tone of the conversation more fully and to stay true to context when applying these quotes to the arguments and observations I deliver in the body of my work.

To ensure confidentiality, pseudonyms were assigned to each participant by randomly assigning names pulled from a baby name generator online.

2.5.7. Coding for Themes

Utilizing a thematic analysis approach to coding, my focus was to identify commonalities as well as the spectrum of difference among participants related not only to their demographics, but their common and/or range of experiences, perspectives, challenges, assets, access to resources and barriers faced while in attendance at treatment and/or in recovery in the context of their role as a parent. It was during this process that I recognized common, overlapping social locations shared by my participants. Indeed, a thematic analysis was ideal for this project as such an approach focuses "on meaning across a data set … [allowing] the researcher to see and make sense of collective or shared meanings and experiences" (Braun & Clarke, 2012, p. 57). Applying a thematic analysis allowed me to recognize the ways in which common participant experiences of addiction, stigma, access and barriers to treatment and recovery are tied in unique ways to shared social locations and thus created the foundation for this thesis.

Additionally, rather than employing the use of software, such as NVivo, to code the transcripts, I decided to work with hard copies. Given the qualitative methodology of this research, transparency, self-reflection, and my own subjective position within this project is an important piece that I have attempted to keep front and centre throughout. By physically printing the transcripts, reading and re-reading, colour-coding that is

organized by a codebook, highlighting sections and jotting my own notes (usually rife with emphatic punctuation and underlined portions), physically cutting, and organizing sections of the transcripts together (while keeping intact copies close by for the purpose of maintaining the integrity of the context in which information was generated). This way, sections of my findings for my thesis materialized and I felt more engaged with the data I have produced than I might have felt if I had used a less tangible approach.

Finally, as I began to identify my themes (the impacts of addiction/substance-use, stigma, treatment, and recovery expressed by participants), I could not help but consider how these findings were so different from the experiences described in the literature. It was then that I began to consider how these experiences of addiction/substance-use and stigma, and various pathways to treatment and recovery are rooted to social locations and as such, appear to function to achieve the same aim: maintain the socio-economic status quo in our broader society.

With this new hypothesis in mind, I returned to the literature for closer examination. I drew mostly from the secondary sources I had already identified when conducting my literature review, returning to the SFU Library website when necessary, searching for articles related specifically to my identified themes. Then, I used the intersectional, comparative, and self-reflexive frameworks described previously to build my analysis and arguments laid out in *Chapter 5: Analysis* and *Chapter 6: Discussion*.

2.6. Conclusion

In this chapter I have presented and explained my choice of designing a qualitative research methodology underpinned by intersectional, comparative, and self-reflexive analytical lenses, and informed by decolonizing methodologies, as apt for the research questions at hand. I have also described and justified my choice in utilizing a narrative critical method to review the literature and have listed all the practical methods selected and applied in the creation of this thesis. Finally, I have explained how all these choices have enabled the flexible research design that was able to adapt and change with me as I listened and learned, and observations came to the fore that I had not originally hypothesized at the beginning of this scientific undertaking.

Ultimately, this research intends to contribute to the current body of literature that recognizes the immense value and far-reaching benefits of parent-child attachment and psychosocial integration for improved health and social wellness (Suchman et al., 2012). In the context of addiction/substance-use, stigma, treatment, and recovery, what remains to be seen in the literature is an intersectional, comparative analysis that links the experiences of addiction-affected/substance-using parents at intersections of gender, Indigeneity, "race" and class across social locations in BC. Given the main objective of this research project is to add to a new dimension to addiction/substance-use literature, the qualitative methodology described herein is fitting for beginning a conversation that centers the experiences and voices of addiction-affected/substance-using parents to understand how their experiences of addiction/substance-use, stigma, treatment and recovery are uniquely rooted to their social locations but are all ultimately shaped by the same overarching systems shaped by white-settler-patriarchal-colonialism, free-market capitalism, neoliberalism and globalization regardless of social location.

Chapter 3.

Literature Review

3.1. Introduction

As discussed in *Chapter 2: Methodology*, I have employed the use of a narrative critical method to review the literature for this research project. Recall, when there is not yet a body of literature to address a particular research topic directly, the narrative critical review method is an excellent method for situating and justifying a newly emerging topic of study by identifying themes of literature related to the new topic or study at hand, and critically analysing those bodies of literature.

This method of literature review requires selecting sources from a wide array of literature covering several topics as they relate to a research question and ties them together through a narrative analysis. As a reminder, my study questions are: 'how are the experiences of addiction, stigma, and barriers to treatment and recovery for addiction-affected parents linked across social locations in BC to ideological, systemic, and structural forces of white-settler-patriarchal-colonialism, neoliberalism, free-market capitalism and globalization?' And: 'what changes are necessary to support recovery more effectively in all addiction-affected/substance-using families in our society?' To understand where these questions might be answered in the literature, I identified three themes for the sorts of studies I would need to consult: 1. theories for conceptualizing what addiction is; 2. qualitative and/or intersectional and/or decolonizing frameworks for understanding the social determinants and impacts of addiction/substance-use in families in differing socio-economic locations; and 3. family models of harm reduction, addiction treatment and recovery programs.

I begin by fleshing out the competing frameworks for conceptualizing addiction and introduce Alexander's theory of dislocation which I have applied and build on throughout my thesis. Briefly, this theory posits that dislocation resulting from the white-settler-patriarchal-colonial, neoliberalism, free-market capitalism and globalization that shape our society are the "causes of the causes" (Marmot, 2018) of addiction. Given its orientation and scope, this theory fits well within intersectional and decolonizing frameworks that locate addiction/substance-use and its outcomes within the social

constructs through which they arise and are met, and explains why addiction is a concerning problem for diverse populations, including those with access to more social privileges. In the next section, I share the findings of current intersectional and decolonizing theories and studies which I have used to unpack the social determinants of addiction/substance-use in our Canadian context. Finally, throughout the remainder of this chapter, I consider the strengths and limitations of existing studies related to family-oriented and culturally safe harm reduction and treatment programs in Canada to understand what services are currently available and how these options may be falling short of meeting the needs of some families.

3.2. Theories for Conceptualizing Addiction

To understand why individuals and families have such varied experiences with addiction, treatment, and recovery, I needed to understand the competing frameworks for conceptualizing addiction itself. Having a basic understanding of these varied frameworks is important because even though addiction can affect people of all contexts and backgrounds, social locations largely shape the impacts and outcomes that individual addiction-affected people experience. Therefore, to reduce bias and to better familiarize myself with the frameworks of addiction that inform the policies and laws I searched the SFU library catalogue for literature using the terms “models for understanding addiction”; “theories of addiction”; and “theories of substance use disorder”. I also read several books that theorize addiction (Mate, 2008; Alexander, 2008; Greaves et al., 2015; Lewis, 2015; Szalavitz, 2016). From that original search, I decided to focus on books and articles that conceptualize addiction through the following frameworks: a brain disease/mental illness; a response to trauma; and/or a coping mechanism to soothe the agonizing experience of dislocation people suffer from because of the current social and economic paradigm shaped by white-settler-patriarchal-colonialism, free-market capitalism, neoliberalism and globalization. After considering the strengths and limitations of the previous frameworks, I argue why I have chosen to utilize Alexander’s theory of dislocation as the framework within which to understand the findings of my own research.

Exacerbating the impacts of addiction outcomes today are the remnants of how addiction has historically been framed as a moral issue and its presence as an indication

of moral deviance. Referring to the temperance movement in the early 20th century, Alexander states:

> All drug addicts were said to be dishonest and ruthless in the single-minded pursuit of their drug, somehow becoming criminal masterminds despite the profound brain damage that the drugs inevitably produced. People hooked on drugs were given labels like 'drug fiends', 'junkies', 'opium drunkards' and 'hopheads', as well as drug addicts. Such people were often understood to be possessed by a demonic intoxicant, and to be 'lost' 'hopeless', 'ruined', or 'doomed' … The word 'addiction' has come to evoke these powerful images reflexively. Even in scholarly settings where 'addiction' can be carefully defined at the beginning of a discussion, cultural conditioning often prevails and many people's understanding of the word reverts to the dramatic images of addiction by the end. (2008, p. 32)

With all this graphic imagery continuously recycled through the usual channels of media and popular culture, it becomes difficult to see, let alone treat, each person buried within the caricature of the 'addict' that society has collectively imagined (Taylor, 2008). Furthermore, for those affected by poverty and who thus experience addiction more visibly, it becomes clear how the links between social locations and addiction are still very much informed by this anachronistic framework of addiction.

In my review of the literature, I found that currently addiction, or "substance use disorder", is most commonly conceptualized using the 'disease' or 'medical' model as supported by its definition found within the DSM-5. And while this theory has advantages as it helps to reduce the stigma of addiction by shifting the theory of addiction away from personal choices and failings and can secure more funding for research and supports by calling addiction a 'disease', this model for understanding addiction also has several concerning limitations. For example, explanations of addiction using a medical model primarily focus on how substance use and misuse interacts with various neurological and/or epigenetic functions which problematically leave out important information. In one example, Volkow et. al claim:

> The increasing strength of conditioned responses and stress reactivity, which results in increased cravings for alcohol and other drugs and negative emotions when these cravings are not sated; and the weakening of the brain regions involved in executive functions such as decision making, inhibitory control, and self-regulation that leads to repeated relapse. (2016, p. 363)

Indeed, it is not a question of whether drug use activates a neurological response that alters neuroplasticity and chemical responses within the brain. In fact, it is widely known that not everyone who uses substances becomes addicted. This is an important limitation to the medical framework because the research that subscribes to addiction-as-disease theories do not adequately address what drives people to use substances in the first place. By focusing almost exclusively on mechanisms in the brain and how they change to explain addiction and how it progresses, my findings in this literature review suggest that the disease model could be missing the opportunity to address the causes of addiction. A frequent narrative shared in meetings of Alcoholics and Narcotics Anonymous could hold a clue to what researchers might need to explore more deeply: many addicts explicitly describe the use of substances as a response – a solution, even - to other, separate and pre-existing conditions that without the buffer provided by the substances, had made life unbearable.

According to decolonizing studies, the suggestion that addiction could ever be reduced to a disease in the purely physiological sense is a move towards absolving colonizers of responsibility for the soaring rates of addiction found within Indigenous populations (LaVallie and Sasakamoose, 2021; Deleeuw et al, 2010). If addiction is simply a disease, the link between the horrendous ongoing acts of colonization and disproportionate rates of addiction in Indigenous populations are reduced to being merely coincidental. Thus, not only does the disease model potentially threaten to absolve colonizers of responsibility for the devastation wrought on Indigenous populations, but if widely accepted, would also reinforce the oppression of many other groups as well. Metzel and Hansen explain:

> A host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication “non-compliance,” trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health. (2014, p. 128)

Ultimately, I have found that the ‘addiction as disease’ framework risks blaming people for ‘poor life choices’ when it is imperative to acknowledge deeply embedded structural inequalities at play as well as to reflect on the role of overarching social and cultural harms as they are also important sites from which many cases of addiction emerge.

A key contribution I found that feminist scholars have made to the literature has been in identifying and studying the link between trauma and addiction within contexts of structural inequality. Niccols et al. affirm: “substance abuse has been identified as a means for women to cope with distressing situations in their lives, including emotional pain, distress, violence, and trauma” (2010, p. 322). And, specifically in the context of Indigenous women, “trauma is implicated in the etiology of Aboriginal mothers' substance use, which suggests both addressing trauma healing in addiction treatment” (Niccols et al., 2010, p. 331). By recognizing this link, once again, the stigma of addiction is reduced because the trauma informed framework of addiction advanced by these feminist scholars enables readers to understand the use of illicit substances as sometimes being the only option available for some people to ease their own suffering – especially in contexts of extreme social marginalization.

Furthermore, the work of Dr. Gabor Maté similarly concludes that unresolved trauma from childhood and even stress endured in utero is frequently the cause of addictive behaviours in adults. Maté explains: “Studies of drug addicts repeatedly find extraordinarily high percentages of childhood trauma of various sorts, including physical, sexual and emotional abuse… nearly two-thirds of injection drug use can be attributed to abusive and traumatic childhood events” (2012, p. 192). Citing specifically the population that he works with on Vancouver’s Downtown East Side (DTES), he goes on to say: “With my patients, the childhood trauma percentages would run close to one hundred” (2012, p. 193). For Maté, understanding the interactions between people and their environments, particularly those they experienced when young and powerless, holds the key for understanding and ultimately treating addiction.

Through feminist and decolonizing lenses, arguably one of the most important contributions the trauma framework makes to the discussion around addiction is the use of qualitative methodologies – often lacking in studies produced through the medical or disease framework. By explicitly contextualizing the experiences that participants share within the colonial histories and social structures that specifically impact women, all Indigenous people and especially Indigenous women, and people living in poverty, researchers and policy makers get a better understanding of what is needed and wanted by these populations. Ultimately, the trauma framework, when described through feminist and decolonizing lenses of analysis disturb ideologies that impose responsibility

for addiction upon suffering individuals and succeeds in demonstrating how the personal is political and vice versa – one of feminisms' central tenets.

Taking the trauma framework a step farther, Alexander posits his theory of dislocation which claims that the advent and evolution of free-market capitalism, neoliberalism and the resulting phenomenon of massive dislocations of people around the world (literally as well as figuratively through massive shifts in cultural behaviours) causes the conditions that lead to the need for self-soothing and ultimately addiction for some people – which he explicitly defines as a behavior in and of itself that can manifest not only through the use of substances but many other compulsive acts as well. Alexander states: "global free-market society inevitably mass-produces dislocation and … chronically dislocated people manifest their misery in depression, anxiety, irresponsibility, violence, suicide etc" (2012, p. 1476). He goes on to say "dislocated people strive to compensate for their agonizing lack of psychosocial integration by clinging desperately to the best substitutes that they can find. For many people, addictive involvements with drugs and countless other habits serve this compensatory function better than any other achievable alternatives" (2012, p. 1476). Within the white-settler-patriarchal-colonial, free-market capitalist, neoliberal and globalized paradigm held by the western world as the pinnacle of social evolution, some forms of addiction, such as over-exercising and 'work-aholism' are praised rather than discouraged, despite resulting in some similar harms as the compulsive use of substances, including, unsurprisingly, neglecting relationships to the point of ruin.

Indeed, Alexander's theory points to 'the causes of the causes' as discussed in *Chapter 1: Introduction*. While Alexander convincingly claims all people living in our society are vulnerable to suffering with addiction because of the ways in which addiction results from and perpetuates dislocation, or, 'social exclusion', due to racist, sexist, classist and colonizing policies rooted in social ideologies, systems and structures, the impacts suffered by addiction-affected people are not the same across the board. As such, white-settler-patriarchal-colonialism, free-market capitalism, neoliberalism and globalization can be framed as 'the causes of the causes' of addiction because in order to function, these systems require and, first, 'cause' dislocation by creating a hierarchically arranged social environment along lines of "race"/Indigeneity, gender and class that requires social inequality and glorifies individualism, competition and consumption. Thus, creating an environment that dehumanizes and threatens everyone

to greater and lesser degrees. Then, those who become addicted in their efforts to cope with the dislocation they experience from living in an inadequate or, in some cases, even hostile social environment, are then subjected to the vastly different 'causes' or, social determinants of addiction depending on their own particular social location, historical and current context/circumstances and access to resources.

Indeed, the dislocation framework squarely allocates the etiology of addiction within the white-settler-patriarchal-colonial, free-market capitalist, neoliberal and globalization processes that reduce people to discrete individuals, largely alienated from each other in a hollow culture of commodification, consumerism and materialism. Citing Alexander's addiction theory of dislocation, Adams (2015) also supports a "social interpretation" of addiction (p. 87). Adams explains: "in a social frame, addiction is positioned within this nexus of meaningful connections" (p. 88). As such, this framework is highly compatible with an intersectional lens that similarly identifies current socio-cultural-economic processes within this paradigm as highly problematic. Complementarily, a feminist intersectional framework emphasizes the relevance of relationships, often shaped by dynamics of uneven power distribution within social constructs and institutions, making it highly compatible with the framework of dislocation.

Perhaps most importantly, for my purposes, the dislocation theory is highly compatible with considering addiction in the context of family-life. Adams explains:

> A social interpretation of addiction offers up a different way of looking at treatment interventions. … The addicted self is unlikely to relinquish its attachment to the addictive object unless alternative relationships have strengthened or look like strengthening. Accordingly, service interventions need to focus on activating the opportunities for quality relationships within what remains in that social system. (p. 88)

This suggests the reason that people become addicted is to cope with the trauma caused by the ways in which contemporary white-settler-patriarchal-colonial, neoliberal, global economics and politics have damaged traditional human social patterns from roles within families and broader communities, at least in BC.

Importantly, an Indigenous model for recovering from addiction that is highly compatible with and supports the dislocation theory is called "Spontaneous Recovery" and is described as "an awakening – usually triggered by a traumatic life event [that] leads to abstinence… In the model, the embracing of Aboriginal traditional culture

contributes to SR and sustained well-being" (Tempier et. al, 2011, p. 1). A key aspect of Indigenous culture as described by Tempier et. al involves reintegrating within one's nation, culture and community; herein, the dislocation that Alexander identifies as having caused addiction is addressed and addiction is largely resolved through SR.

In conclusion, this section has reviewed several competing frameworks of addiction discussed in the literature and, ultimately argued that rather than an individual ailment, addiction is in fact rooted within larger social processes and presents as a response to 'dislocation' as posited by Alexander. I have also shown how this view is highly compatible with both intersectional and decolonizing lenses of analysis and as such, is the theory of addiction that I use to frame my own research. And while the point of this thesis is to neither prove, nor disprove any particular theory of addiction, Alexander's partial explanation of the phenomenon of addiction provides a compelling framework because it not only lays out convincing reasons for addiction to arise in all social locations, but it also explains why our current responses are failing to adequately address the problem, with significant and long lasting consequences for addiction-affected families.

3.3. Qualitative and/or Intersectional and/or Decolonizing studies: Social Determinants and Impacts of Addiction in Families in Differing Social Locations

As already discussed, my study employs a qualitative methodology, intersectional analysis, and frequently draws from decolonizing literature that considers the relationship between acts of colonization and addiction in Indigenous and non-Indigenous families and the addiction-related responses offered in the province of BC. As such, I reviewed studies from the SFU library online database using the following search terms[37]: "qualitative addiction families intersectional"; "addiction foster care BC"; "addiction colonization"; "addiction middle-class parents"; "social determinants of addiction families qualitative"; "addiction mothers qualitative"; "addiction fathers qualitative"; "addiction Indigenous parents"; "addiction family decolonization", to learn what aspects of these topics other scholars have studied. On several occasions, these

[37] For the sake of brevity, when searching I consistently subbed out the term 'addiction' for 'substance use disorder' in the following search word sequences in order to capture more studies.

differing searches found the same articles, given the overlapping themes of intersectionality, qualitative methodologies, and decolonizing frameworks that centre the experiences of families impacted by addiction in BC. I also read books related to substance-use policy (e.g. Boyd et al., 2016; Rehm et al., 2018) to understand how current and historic substance-related policies have and continue to shape the impacts of addiction experienced by addiction-affected families in differing social locations. Finally, I also reviewed various government websites that detail the processes, requirements and impacts relating to addictions treatment, child-'protection' (apprehension), and the conditions for receiving various social-assistance payments and supports.

When reading articles related to intersectional, qualitative studies examining the social determinants of addiction, I learned the population most affected simultaneously by addiction and poverty is women in general, and Indigenous women in particular (Torchalla et al, 2015; Allen et al., 2010). For example, Allen et al. claim: "The vast majority of women who are involved in the criminal justice system are poor single mothers, most of whom are serving sentences for nonviolent drug-related offences." (2010, p. 161). And, according to one report, 70% of children in foster care in British Columbia have drug-addicted mothers (Turpel- Lafond, 2014, p. 28). To understand the severity of the issues facing addiction-affected families living in poverty, it has been important to closely examine the systems and institutions that respond to addictions and study the demographics of those processed and contained by such systems and institutions. As such, an intersectional lens of analysis is vital for understanding these trends because such frameworks render visible the social constructs and hegemonic processes that assign value to a range of social identities including gender, "race", Indigeneity, and class.

Indeed, in the grim reality of drug addiction, articles that employ an intersectional analysis are important because such works examine the ways in which addiction/substance-use arises, is experienced differently, and presents different risks for women than it does for men. For example, Torchalla et al. confirm: "Women who use substances generally tend to report more sexual victimization and multitype trauma [15,16] and greater rates of posttraumatic stress disorder (PTSD) [17] than men" (2015, p. 2). And, the literature also reveals that instances of violence and trauma are especially exacerbated for sexual minority women (or, women who are not cis-gendered

and/or heterosexual). In her work with women who use drugs and who are not heterosexual, Braine explains that in comparison with cis-gendered, heterosexual women drug users, “sexual minority women IDUs [injection drug users] experience elevated rates of homelessness, unemployment, health problems, and exposure to violence” (2014, p. 200). Indeed, by studying literature applying an intersectional analysis the forces that shape experiences, risks, and outcomes for people suffering from addiction as reflected by their social locations, became clear. Ultimately, intersectional frameworks are valuable in the study of addiction as they enable the unpacking and render visible the experiences of addiction for women, and as such, can influence the development of effective and relevant programs to serve those who are suffering.

When I realized that I would be changing the focus of my thesis to specifically examine the social conditions and systemic processes by which addiction-affected parents are or are not able to access residential drug and alcohol treatment and recovery programs because of their social locations, I expanded my literature review. To situate my findings, I have scoured the databases for studies specifically related to working/middle-class family experiences of addiction and treatment as these would reflect by own participant population. While none of the articles I reviewed address barriers to treatment specifically, some did address the ways in which socially privileged demographics have historically evaded study given the privacy such social status affords. For example, Granfield and Cloud state: “many drug users and drug dealers avoid detection because they occupy otherwise legitimate social roles and lead basically straight, middle-class lives” (1996, p. 46). Furthermore, Iacobucci and Frieh’s (2018) work that links addiction treatment discourses along class lines within a neoliberal cultural context has also contributed to my own analysis. Iacobucci and Frieh claim: “The goal of addiction treatment… is to return people who are dependent on substances to a state of independence” or, as they explain, to being good neoliberal subjects. They go on to say: “However, who can be expected to achieve independence—from drugs, and from the state—differs along class lines, which transforms the ways in which addiction discourse is deployed for differently socially located populations” (2018, p. 85). Just as I have noted in my research, ideological and systemic responses to addiction differs depending on where and how addiction-affected people are socially located.

In fact, there is so much intensive attention to the experiences of marginalized addiction-affected/substance-using people, that addiction could be wrongly perceived as an affliction suffered only by people who are systemically oppressed. In his article *Redpilling: A professional reflects on white racial privilege and drug policy in American health care*, Lowry affirms: “The commonly held understanding is that Native American, Black, and Latino peoples are the ones abusing drugs, and this perception is matched by a silence equally as intense concerning the pharmaceutical addictions of Whites in health care”(2018, p. 61). This observation suggests it is the unearned privilege of privacy held by white middle-class professionals that creates this illusion of addiction immunity and such unearned privilege evidently does not, in fact, prevent addiction itself.

What appears to be missing from the literature are studies that investigate the experiences of addiction by such socially privileged populations and specifically, parents within that population. When searching the terms: “addiction social privilege” and “substance misuse social privilege”, I did not find any studies that relate to my own. However, when I searched the terms “substance misuse middle-class”, two articles of interest were generated. The first, *Adolescents from upper middle-class communities: Substance misuse and addiction across early adulthood,* by Luther et al (2018) while interesting because of its middle-class orientation, did not fit with my research as it focuses on the addiction of children rather than parents. The second, *Opioid Addiction Stigma: The Intersection of Race, Social Class, and Gender,* Wood and Elliot (2020) did utilize an intersectional analysis of people experiencing opioid addiction stigma across class lines. However, upon reading this article it became clear that the addiction-affected individuals discussed are characters with assigned genders, “races”, and social classes positioned in vignettes developed to measure stigmatizing beliefs held by the study participants who did not identify as addiction-affected themselves. Finally, when I added the word “parents” to my “middle-class addiction” search terms, no relevant literature was generated. Ultimately, what the research shows is that while social location greatly influences the ways in which a person experiences addiction, social privilege does not prevent addiction itself.

While studies using intersectional analyses are valuable for understanding many aspects of the systemic response to addiction, this framework comes up short in some salient ways. For example, when consulting decolonizing literature, I found some would argue that an intersectional analysis is entirely inappropriate for adequately

conceptualizing the unique barriers that Indigenous women, men, and families face when attempting to access treatment for addiction. John explains: “the sentiments of Indigenous women towards feminism are ambiguous; some do not see themselves included by feminists who are unwilling to understand Indigenous women in their full historical and contemporary contexts” (2015, p. 39). Furthermore, given that historically, feminism is grounded as a response to the gender binary imposed by the dominant paradigm from *within*, feminism strikes some Indigenous women as irrelevant as they have been historically and systematically positioned outside, and indeed, in contrast to, the expectations of the dominant paradigm. Houle cites Lindberg’s response to feminism: “Tracey Lindberg asserts that assumptions feminism makes about sexual equality taking precedence over her own Aboriginal history, race, language and traditions are troubling. The experiences of non- Native women and Aboriginal women are too different, and Lindberg finds that when non-Native women assume there is a commonality in the feminist movement for all women, it simply isn’t true” (2012, p. 210-211). Ultimately, feminist frameworks may not suffice when attempting to understand or adequately address issues that impact Indigenous women, particularly the colonial causes and conditions that have led to current rates of addiction, incarceration, and child-apprehension within this population.

It is also important to note that an intersectional analysis - because such analyses frequently arise within a Western ethos - can unintentionally recycle damaging ideas related to hegemonic expectations of gender and parenting. Indeed, only once my search had begun in earnest, did I become aware of my own bias and conditioning regarding the essentialization of women as mothers and my assumption of women as primary caregivers to children that is reflected by the literature. At first, I had taken for granted that family-oriented harm reduction and treatment programs would be designed and developed to focus on the specific needs of mothers (rather than parents in general). Indeed, the highly valuable studies put forth by Macrory and Boyd (2007), Torchalla et al. (2015) and Niccols and Sword (2005) all consider addiction and parenting in the exclusive context of motherhood to the complete absence of reference to fathers. While studies that focus on the unique challenges and barriers faced by addicted mothers are incredibly important because of the difference in experiences for addicted women previously noted, the absence of research on fathers in the context of

addiction and harm reduction literature points to, recycles and re-entrenches social norms that position women as solely responsible for their children.

In fact, it was only when I turned my focus to studies that consider addiction and recovery specifically within an Indigenous context where fathers were considered an integral part of recovery and healing from the trauma of addiction and colonization that I noticed the problematic absence of fathers within western feminist-oriented studies. Ball's article *Indigenous Fathers' Involvement in Reconstituting "Circles of Care"* considers the ways in which western culture imposed through colonization, and particularly through the enforcement of the Reserve Act, which eliminated mobility for many First Nations, rendered fathers' roles of hunting and gathering obsolete and left a gaping hole for fathers no longer sure how to contribute and participate within their communities and families (2010, p.130). Furthermore, this damage was exacerbated and compounded through the propagation of pejorative stereotypes framing Aboriginal fathers as "deadbeat dads" (2010, p. 126). Despite the catastrophic damage colonialism effected upon Indigenous Peoples, Ball's work disrupts these stereotypes by highlighting the importance of fathers in Indigenous families stating: "in a quantitative study of 14 Ojibway fathers, greater father involvement in caregiving was associated with better academic achievement and social development among children, especially boys" (2010, p. 126). Therefore, it is imperative to consult decolonizing lenses of analysis to recognize and understand the ways in which addiction has arisen and perpetuates for Indigenous Peoples in the context of colonization and trauma. Furthermore, such frameworks may also provide an alternative perspective from standard western and even intersectional frameworks to consider and critique current practices, policies, systems, and institutions in place to address addiction for all sufferers.

Because this project was originally inspired by work done in Indigenous communities to address and treat addiction in families as discussed in *Chapter 1: Introduction*, I needed to grasp the reasons that Indigenous families are so disproportionately represented within the population of addiction-affected parents. I consulted various studies and texts related to history, law, social work, and Indigenous theories produced by both Indigenous and non-Indigenous scholars. Considering how the systems and institutions that respond to addiction today are rooted in the ongoing colonial project of Canada is highly relevant to understanding why individualized,

western treatment models can be particularly ineffective when attempting to serve Indigenous populations.

By studying this literature, I have learned rather that programs that are culturally-safe and culturally relevant are of utmost importance. For example, consider Brady's work that states: "Culture provides a pathway out of addiction. I suggest that this development has come about partly as a result of indigenous understandings of the etiology of drug and alcohol abuse among their people, an etiology which stresses the disruption to cultural practices and dispossession brought about by colonization" (1995, p. 1487). By relocating and (re)identifying[38] within an appropriate cultural milieu and relying on culturally relevant tools to recover from addiction, several studies conducted over a considerable length of time have consistently argued that culture can cure (see Brady, 1995; Oetting, 1989; Dickerson et. al 2014; Tempier et al, 2011).

When consulting decolonizing addiction literature, I found that decolonizing methodologies utilized in the study of addiction and treatment programs especially emphasize the importance of family and community identity and connection when recovering from addiction. Tempier et. al affirm that traditional cultural practices are key to maintaining sobriety as participants in their study emphasized the importance of how learning to practice their culture was fundamental to their well-being, including language, songs, legends, prayers, ceremonies, and art. They also shared that cultural practices assisted them with (re)building their identity and (re)claiming a sacred relationship to, for example, their kin, tribe, homeland and the Creator" (2011, p.10). In studies that consider addiction through decolonizing lenses of analysis, it becomes clear why the individually focused mainstream models of drug and alcohol treatment so often fails its clients. A key reason is the failure to acknowledge the trauma related to colonization and the ways in which it has dislocated Indigenous Peoples from their traditions and cultures therefore, the root of addiction, especially in Indigenous populations, remains unaddressed.

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[38] (re) in '(re)identify' appears in brackets here to acknowledge that the damage of colonization within Aboriginal communities is so deep in some cases that many people of Aboriginal descent have been raised in environments completely removed from the culture of their elders and ancestors and that treatment could be the first instance of recognizing and developing an identity within an Aboriginal culture.

One limitation of decolonizing frameworks is the risk of misrepresenting or reducing the scope of First Nation experiences. First and foremost, as Tempier et al. claim: “The Aboriginal community is diverse in Canada” (2011, p. 13), and it would be impossible to develop a decolonizing lens that could simultaneously reflect or represent the experiences, values, or aims of all these Peoples. Another limiting aspect of decolonizing frameworks is that they focus exclusively on the experience of Indigenous Peoples. These frameworks have been developed this way for obvious reasons, namely the historic silencing, oppression, and erasure of Indigenous experiences in the context of various assimilation projects. These issues must be addressed first and foremost. However, the expansion of decolonizing frameworks to include and examine how colonization has negatively impacted all facets of society could prove incredibly valuable in advancing aims of decolonization.

A model that came up in my review which has successfully incorporated aspects of both Western and Indigenous theories and frameworks is called ‘Two-Eyed Seeing’ and was developed by Elder Albert Marshall of the Mi’Kmaw Nation. This approach encourages “learning to see from one eye with the strengths of Indigenous knowledges and ways of knowing, and from the other eye with the strengths of Western knowledges and ways of knowing and using both these eyes together for the benefit of all” (Bartlett et al, 2012, p. 335). This model suggests that though each of these epistemic traditions are unique from the other, they can be used in conjunction with each other, provided the methods and processes of research, dissemination of findings and ownership of studies reflect an ethos of cultural safety and conceptual complementarity.

Regarding my own study, my review of intersectional and decolonizing literature shows that Marshall’s concept of ‘Two-Eyed Seeing’ is valuable in the context of studying addiction. By utilizing an intersectional lens that renders visible dynamics of power, in conjunction with a decolonizing lens that disrupts social norms, readers are reminded that hegemonic expectations related to gender and parenting roles are expressions of Western culture and are not universal. Given that I have been a solitary researcher conducting this study, and am not an Indigenous person, it has not been possible to apply such a framework to my own thesis. However, I think it is important to bring attention to this framework in this literature review as it could lend itself to new understandings of addiction and more importantly, under-studied and perhaps more effective approaches to treating families impacted by addiction.

3.4. Family Models of Harm Reduction, Treatment and Recovery Programs

This section is an analysis of research on harm reduction and treatment programs which are family oriented. This analysis comes both from the academic literature on this subject as well as is drawn from grey literature reporting on programs in BC based on this model. One reason for understanding the importance of family-centered treatment is the disproportionate impact of addiction/substance-use on women as mothers. For example, harm reduction programs such as Sheway are particularly important for addiction-affected/substance-using mothers because such programs frequently include "addiction groups and counselling, nutrition counselling and skill development, parenting education, peer support, and an enriched children's program" (Sword, 2004, p.2). Integrated models of harm reduction such as Sheway enhance the personal agency of mothers who may or may not be ready to address their addiction/substance-use, but who hope to meet the needs of their dependent children, regardless. Indeed, as Macrory and Boyd state: "a large body of research demonstrates that women who use drugs can be adequate parents" (2007, p. 121).

Perhaps one of the most obvious reasons for developing programs that accommodate and incorporate children into the treatment of drug and alcohol addiction in mothers, is that unless their children can attend, they will not be able to attend either. This insight has been articulated for decades; for example, Coletti points out:

> A major barrier to treatment of drug-dependent mothers and expectant children has been the lack of child-care services at treatment facilities. Mothers without access to child-care may have to forego or drop out of treatment. Sutker (1981) has reported that 60% to 70% of women in treatment were mothers who frequently dropped out of treatment because of guilt over not being able to be with their children. (1994, p. 290)

To make treatment accessible to mothers, and especially mothers who lack social and economic resources, their children must be accommodated.

Furthermore, the presence of children in treatment with their mothers has been linked to their ultimate success in achieving recovery from addiction. Letourneau et al. claims: "Existing research has suggested that motherhood status [40], residing with one's children [46], and enhanced social services [40] can each influence treatment success, as can integrating parent and child-focused interventions within substance

abuse treatment for mothers" (2013, p. 7). Not only does including children in treatment programs for mothers make recovery possible, it also increases the likelihood of a positive outcome.

Finally, and perhaps most importantly, because maternal addiction has been linked to several issues in their children, it is highly important that children in these treatment programs are not only accommodated but also experience treatment as well. Letourneau et al., explains:

> Children exposed to maternal substance abuse are at increased risk for developmental problems, such as cognitive deficits, language delays, emotional problems, behavioural disorders, and becoming substance abusers themselves [13, 14]. The increased likelihood of intergenerational transmission of substance abuse is linked to addicted mothers' parenting behaviour, often characterized as neglectful. (2013, p. 1)

By creating integrated programs that address addiction/substance-use as a condition that affects not only women but also their children, improved outcomes are increased for all. Even when mothers continue to use substances, harm reduction has been achieved because they have been given access to tools and resources related not only to recovery from addiction, but that also to enhancing their ability to parent (Milligan et al, 2010).

Unfortunately, and as discussed in section 2, a review of the literature also reveals a troubling theme: the absence and exclusion of men and fathers. Certainly, some would argue that this absence is indicative of progress and positive change for women as the literature is rife with evidence to argue that women require different models of care when recovering from addiction than what has historically been available. As cited above, it is also important to consider how excluding and/or excusing men and fathers from family-oriented drug and alcohol harm reduction and treatment programming risks re-entrenching problematic gender binaries that are harmful to all members of a family and society in general.

In addition, as discussed previously in the section on the social determinants of addiction/substance-use, the experiences of addiction faced by families with access to more social privilege are missing from the literature. Granfield and Cloud assert that in the case of middle-class addiction, many addiction-affected people are simply able to quit without need of treatment or self-help groups (1996, p. 45). This quote, though

dated, was the most relevant article among the few retrieved during my search for "addiction middle-class family". Granfield and Cloud's claim is problematic for at least two reasons. First, this thesis provides evidence to the contrary: working/middle class people do in fact claim to require support in overcoming addiction and maintaining their recovery. And secondly, such inaccurate information can further perpetuate a notion that naturalizes addiction as a problem only experienced by marginalized populations. Perhaps the lack of available literature pertaining to addiction-affected people of more socially privileged positions can be attributed to studies such as these that falsely attach addiction to specific social determinants. Despite a person or family's economic or social resilience, they can still be impacted by the same root causes yet because of unearned social privileges, are able to better cope with them. And, when it comes to the issue of addiction, they have become an invisible group requiring analytical attention.

Ultimately, this is the crux of my findings within the available family models of harm-reduction and treatment literature: the experiences that families encounter when attempting to access treatment and recovery programs for addiction are shaped by their social locations and identities, but those differences – whatever they are – are all linked across social locations to the overarching social systems and structures. As such, my study makes a contribution to the literature by identifying and explaining the implications of those links. Read together, this narrative critical review of the qualitative, intersectional, and decolonizing literature strengthens my contribution to the qualitative addiction/substance-use literature corpus by offering a unique comparative analysis of the experiences of addiction-affected/substance-using families reflecting a range of social locations with insights from the literature. This work reveals patterns that point to problems built into our social systems, structures, and hegemonic narratives as they pertain to addiction treatment response and delivery for families in BC.

3.5. Conclusion

In conclusion, this chapter has provided a narrative critical review of the literature, drawing from several articles related to three themes. These themes are a review of competing theories of addiction; the investigation of qualitative, intersectional and/or decolonizing frameworks for understanding the social determinants of addiction; and a review of studies related to family models of harm-reduction and treatment programs.

In the section that explores various frameworks for understanding addiction, my review of studies that frame addiction as a brain disease/mental illness found that while this theory accounts for some behaviours and patterns, and helps to destigmatize addiction by invalidating the notion that it arises because of 'poor choices', this theory also erases the social contexts in which addiction arises. In my examination of literature that frames addiction as a response to the trauma that results from living within contexts of social marginalization, oppression and colonization, it is unsurprising that people with these experiences might soothe themselves with substance use and in some cases become addicted as a result. While I found that this theory is highly compatible with intersectional and decolonizing studies of addiction, it does not account for addiction in people occupying more privileged social locations. Finally, I justified my choice of using Alexander's theory of addiction as a theoretical foundation for my own study, as it accounts not only for why people in all social locations are vulnerable to addiction, but also suggests why our current responses to addiction are failing to resolve this catastrophic health and social issue.

The section that reviews intersectional and decolonizing studies shows the importance of examining addiction within the contexts of social locations. Intersectional studies demonstrate the ways in which experiences of addiction and responses to addiction-affected/substance-using people reflect the racism, sexism and classism enshrined within our health and social systems and structures. Decolonizing research broadens the scope of understanding by providing a completely different worldview through which to consider the issue of addiction and how it should be treated. These studies ground addiction as a response to the intergenerational trauma experienced by colonization – a process from which the current structures and systems of patriarchal, free-market capitalism, neoliberalism, and globalization stem. Decolonizing studies also decentralize the western notion of families and gender roles, and point to alternate paradigms for responding to addiction.

By consulting the available literature on family-models of harm reduction and addiction treatment, this review has emphasized the importance of providing family-models of care for addiction-affected parents by pointing to the success of women especially when these programs are accessible to mothers. However, that section also pointed to a significant gap in literature relating to the impacts of addiction and barriers to treatment available for fathers, as well as more socially privileged families.

This review has also identified several limitations revealed by the literature including problematic hegemonic concepts of gender norms, roles, and binaries, as well as inherent risks in attempting to use intersectional and decolonizing lenses of analyses concurrently, such as reducing the scope of Indigenous experiences, perspectives and aims that are incredibly diverse, to a singular lens, theory, or framework.

Ultimately, this critical narrative review of the literature draws from the aforementioned three themes to articulate why it is important to have a clear understanding of what addiction is; how it is experienced differently in different social locations because of policies and systems that are shaped by white-settler-patriarchal-colonial, free-market capitalist, neoliberal and globalizing forces; how these forces problematically inform current conceptions of, and responses to, addiction/substance-use in all people, but especially families; and finally, what steps we could take to equitably address this catastrophic health and social issue.

Chapter 4.

Findings

4.1. Introduction

Recall Chapter 3, which offered a critical narrative review of the literature wherein I discussed the ways in which much of the available addiction literature pertaining to addiction-affected or otherwise substance-using parents focuses on the impacts of addiction levied against marginalized families. There I explained how these harmful impacts result largely from policies enacted to oppress and exploit people based on various intersecting social locations of “race”, Indigeneity, gender and class. I also pointed to a gap in the literature pertaining to the experiences of more socially privileged addiction-affection parents. This gap inaccurately implies that addiction is not a concern in less marginalized families. And this gap further inadvertently contributes to the perpetuation of harmful stereotypes that associate addictions-related suffering exclusively with specific social locations.

Though my participants do not represent a homogenous group (see Appendix A), they all currently identify with either working, middle, or upper middle-class, are all white or white-passing and are cis-het/het-passing[39] people. As such, the participants of this study are not people typically associated with addiction. Therefore, grounding the experiences of my participants in the social locations they share is important because doing so highlights the ways in which social structures, rather than addiction itself, often shape the impacts of addiction and stigma, and determine access to treatment and recovery for families in different ways depending on such social locations. Furthermore, while the families represented by this study have had access to social privileges because of their social locations, as discussed in both Chapters 2 and 3, it is important to note that these privileges neither protected them from experiencing addiction[40][41], nor,

[39] Cis-het refers to people who have cis-gender and hetero sexual privilege, and though one participant identifies as bi-sexual, is currently in a heterosexual marriage and is thus attributed the associated heterosexual-passing privileges.

[40] For those participants who were parents during their active addictions.

[41] While it is beyond the scope of this paper to include the family-of-origin stories of each of my participants, it would be disingenuous to suggest that all participants were raised within the same

as this section will demonstrate, entirely shielded them or their children from harmful impacts as a result. To subvert destructive stereotypes and to broaden the scope of what may be required to effectively prevent and respond to addiction across social locations in our society, this chapter presents the experiences and views of the working/middle/upper middle-class, white/white-passing, cis-het/cis-het passing parents-in-recovery who participated in this study.

The data from my study are presented in this chapter by organizing the experiences of participants into four sections that correspond to the four overarching themes of this thesis. Ultimately, by examining the impacts of active addiction, addiction-related stigma, experiences of residential treatment and concepts/modalities of 'recovery' as expressed by the study participants and as framed by common indicators within their social locations, this chapter contributes to broadening the scope of how addiction, and addiction-responses in our society are currently conceptualized and discussed in the literature.

4.2. Participants Report Impacts of Addiction

The impacts of addiction in marginalized communities are so devastating, so violent, and so visible that those images can come to represent what the general public recognizes as 'addiction' (eg. Asbridge, 2004; Elliott and Chapmans, 2000; Erickson and Hathaway, 2004; Huges et al., 2011; Noto et al., 2006). However, as the participants in my study share some of their experiences, it is evident that addiction is a condition that can have lasting, harmful impacts on families in more privileged social locations as well. This section depicts a few of the ways that addiction impacts families in working/middle/upper-middle class contexts.

To begin, consider the basic requirements of parenting small children. Meeting the daily care needs of children can be mundane and exhausting for even the healthiest and most supported parents. However, when a parent is struggling with active addiction, this can add an additional dimension of strain to the already monotonous day-to-day care needs of children. To ease strain and boredom, all parents cut the occasional

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social locations that they now occupy. Briefly, 7/10 reported occupying a similar social location, while 3/10 shared details of their family histories that suggest their social locations have dramatically improved as adults.

corners - doing so even adds an element of fun and excitement to the usual routine. But for parents in addiction, cutting corners can become a day-to-day survival strategy. For example, instead of it being the occasional treat, Harriet, a nurse, remembers: “that last six months we were living off Little Caesar’s pizza, …I didn’t want to cook anymore…” (T2-15). It is important to note Harriet’s reasoning for ordering pizza: as a skilled healthcare professional, she did not lack knowledge or the funds necessary to provide healthy, nutritious food for her children. Rather, by framing her statement when saying “that last six months” Harriet cites the progression of her addiction as the cause of her inability to make good food choices for her children. Therefore, this example demonstrates that parenting while in active addiction can reduce a parent’s capacity to meet the daily needs of their children, even if they have the financial resources and knowledge necessary to do so.

Furthermore, addiction can also impact a parent’s ability to connect meaningfully with their children as addiction preoccupies their minds and attention. Though Reid worked hard to stay active with his son, he remembers how these activities were also overshadowed by the anticipation and repercussions of using substances:

> I tried to keep us busy, so I did things like we went for lots of hikes, we played lots of road hockey, did lots of boy things… and then [my son would] go to bed and I’d get pretty wasted… then I’d be all hung over in the mornings. Mornings were probably rough, I probably put him through a lot of neglect in the mornings when I was like sleeping in and… telling him like ‘go get some cereal’. (T9-11)

Similarly, Amelia recalls: “I was hungover a lot. So there was a lot of laying around in bed. Not participating in my son’s life. My partner… was the one that had to drive to soccer games and take him to school and things like that cause I was not… functioning” (T1-2). Though more socially-privileged parents might still be able to provide the basics for their children, the quality of care that they are able to give when in the throes of active addiction definitely impacts how they connect with and care for their children.

And perhaps more importantly in terms of raising children into adulthood, some of my participants report how active addiction negatively impacted the quality of their relationships with their children and creating an environment associated with the intergenerational cycle of addiction. For example, Paisley admits: “My children grew up scared… they lived in fear… I exploded a lot” (T7-6). Indeed, material comfort is not

enough to raise healthy, well-adjusted children when their parents are suffering with addiction. Parents in this study recognize the ways in which drinking and using other substances impacted their ability to connect with, show up for and emotionally support their children, despite their financial stability.

Though there are many devastating impacts of addiction that these families have not experienced because of the protections their social privilege allows, this section has highlighted a few examples of how active addiction has harmfully impacted the parent-child relationship of participants during active addiction, despite the protections and privileges associated with their social locations.

4.3. Stigma and the Privilege of Privacy

Addiction is a highly stigmatized condition but as this section will show, social location mediates the contexts in which stigma is experienced in significant ways. A common theme that arose from my research data is that while most participants report a fear of stigma in at least one context of their lives (i.e. professionally, or the impact it might have on their children), they consistently expressed their current[42] ability to maintain privacy regarding their history of active addiction and current recovery status. This section will present the ways in which my study participants experience, navigate and frame stigma in the contexts of their lives in recovery from addiction.

For some, concern about stigma is closely related to how participants fear they would be perceived professionally and how that stigma could impact their careers, as well as other aspects of their community engagement. The following quotes demonstrate that while participants often expressed fear and stress related to stigma should their recovery status become known, their words implicitly or explicitly make it clear that they have the privilege of privacy: they can choose to disclose their recovery status or not. As a result of their privilege of privacy, they can successfully navigate away from the impacts of stigma and avoid discrimination. For instance, Clay believes that if the fact that he is in recovery became known, it would limit his ability to advance professionally,

[42] N.B. not all participants in this study had access to the privilege of privacy during active addiction, as some experienced street-level addiction. However, in recovery, all participants have accessed a social status that allows them the privilege of privacy in their current state of being in recovery.

so he does not share this information freely. He says: “I keep [my recovery status] really, really close to my chest… there’s just a lot of old school mentality there that there would be a closed door with certain people, you know?” (T8-18-19). Similarly, Reid reflects on his experience as an executive in his company “a lot of functions revolve around alcohol, and… I was a little worried that [stigma] might hold me back” (T9-14). Harrison also expresses concern about his reputation in a professional context if his clients become aware of his addiction-recovery status. He claims: “I guess I get scared … that my name will travel around and people won’t want to hire me because they won’t trust me…” (T5-18). Stella also expresses that the decision to share her recovery status, or not, has been hers. She says: “I still haven’t come out to – well, only a couple of people are aware … because it is huge stigma. And that’s the way I chose” (T6-3). Meanwhile, Spencer, who is less concerned about stigma in the context of his career, shares one area of his life that he does not volunteer his history of addiction or participation in recovery: “Yeah, that’s one place where I might not volunteer that information… to the parents of the [youth soccer] team that I’m coaching… because I don’t know what their conception and attitudes towards drug users might be” (T4-25). For working/middle/upper-middle class people in recovery from addiction, stigma represents a significant perceived threat to their ability to advance professionally and/or participate fully in their communities, but because of the privilege of privacy tied to their social locations, they are often able to keep this information private and avoid social consequences and discrimination.

Indeed, some participants explicitly recognize that their social location enables privacy in a way that more marginalized addiction-affected people do not have the luxury of accessing. This privilege of privacy can perpetuate the illusion that only marginalized people are impacted by addiction. Lucille admits: “I’m able to keep my recovery private…” (T10-7). Maren also recognizes the privacy her position allows her to have and grapples with the question of whether she can even experience true stigma in her current context:

> I’ve thought a lot about my career path and about my academic and professional life – is [addiction] something I tie to who I am now?... I know there’s huge stigma about it, but maybe cause I’m so far away from it, in appearance-wise anyway, it seems a little easier. … I feel like I get to choose who knows and how I frame it for the most part, so I don’t know if that’s really the same thing because of that choice. (T3-16)

Similarly, Spencer believes that recovery has changed so much about his life that stigma is unlikely to impact him anymore: “to be honest, I think a lot of people… if I were to tell them, being who I am today… about that part of my life, they wouldn’t believe me. They wouldn’t really be able to connect it with who I am today” (T4-25). Here Spencer speaks directly to the stereotypes that are perpetuated about what addiction looks like, and how these perceptions are indeed misguided.

To combat stigma and dispel the narrative that only marginalized communities are vulnerable to the ravages of addiction, some participants are purposefully public with their recovery status. Harriet explains: “I’m very open about it. It’s all over the internet that I’m in recovery and that’s because I know the stigma is perpetuated by hiding it. So, I’m very much ‘I’m a registered nurse, I’m a woman, I’m a mother, I’m in recovery and it’s possible” (T2-10). Because marginalized populations do not have the luxury of privacy that populations in more socially privileged locations enjoy, a myth is perpetuated that addiction only impacts marginalized people. By being open about addiction and recovery, some participants demonstrate that addiction is also an issue for working professionals, and that there is hope for those wanting to recover.

But stigma does not only impact the addiction-affected person. Some participants expressed that they must also consider how their children might experience stigma if their recovery status becomes widely known. Harrison explains: “I don’t want, you know, people to be scared about having their kids over” (T5-19). Lucille also shares this worry: “a lot of that worry for me, is the worry of the impact that would have on my kids… like, what people might think in terms of ‘oh, I’m not going to send my kid over to’ even though [Lucille’s husband’s name] is in recovery…” (T10-6). Because there is a lot of misinformation about what addiction is, whom it affects, and what recovery is about, stigma can have lasting impacts, not only on addiction-affected people but also their partners and children.

Some participants expressed how stigma can impact their health and wellbeing. For example, fear of stigma kept Amelia from seeking help when she realized she had a problem; her suffering was exacerbated due to stigma: “it stopped me from talking about it. It stopped me from getting help sooner” (T1-2). And Maren continues to experience stigma within health services, despite having been in recovery for many years. She explains: “the place where I’ve really noticed it, though, is in the medical profession … if I

go to an appointment with a psychiatrist and that comes up, it has a whole meaning that I know is being attributed that I don't identify with anymore" (T3-15). As was discussed in Chapter 3, there are several different and contested theories and frameworks for understanding addiction, but because of the power that people in positions of authority have (i.e.. medical professionals), some people affected by addiction feel stigmatized when their personal understanding of addiction conflicts with that of the gatekeepers of services.

However, stigma is not entirely negative. Maren also considers how stigma can be useful: "I've watched some of the responses and it's so funny! … I think [stigma is] kind of a good sorter of people I'd like to know better" (T3-15). By listening to the ways in which people talk about addiction and recovery, people impacted directly by addiction can discern safe and informed people from those whose ignorance might cause them harm.

Furthermore, some participants expressed how being in recovery has given them tools to cope with stigma. When asked if she feels stigmatized, Amelia says: "I do, but I feel much more equipped to handle it" (T1-2). And Paisley had this to say about stigma in the context of her recovery: "What [other people] think about me is none of my business" (T7-18). All the while misinformation about addiction continues to circulate, stigma will prevail especially affecting those without the privilege of privacy, but thankfully for some in recovery, tools are available to cope with stigma's harmful effects.

This section has shown that stigma presents a significant threat, not only to people in addiction, but in recovery as well, and not only to themselves, but also to their children. This section has considered a few different contexts in which some parents in recovery are particularly concerned about being identified as such, and the ways in which this fear has impacted them. However, while they have expressed concerns about stigma, the participants in this study also acknowledge that as working/middle/upper middle-class professionals, they have the privilege of privacy and choice when it comes to disclosing their personal information, in which contexts and are successful in navigating away from stigma.

4.4. Treatment: Participants Report Benefits and Barriers

When people have been gravely impacted by addiction and are seeking recovery, they often opt to attend residential treatment programs or supportive recovery houses because of the immersive style these models offer. However, when addiction-affected people are also parenting dependent children, there are many issues to factor in when deciding how to proceed. For some, individualized residential treatment is ideal at the beginning of recovery, despite the barriers it presents, while others believe that recovering within the context of their family ecosystem is their best option within the current addiction treatment/response options available. As such, this section presents the benefits and barriers to residential treatment programs as described by the working/middle/upper-middle-class participants of this study.

To begin, several participants speak to the merits of the individualized residential treatment model. They claim that attending residential treatment or a supportive recovery house was a necessary step in achieving their current state of abstinence-based recovery. Harriet explains: “your life is completely centered around your addiction. Your house, where you sit, where the stores are, your friends, your family, everything… residential treatment plucks you out of that situation, so, you aren’t being triggered every nano-second of the day” (T2-7). Regarding her husband’s needs when addressing his addiction, Lucille agrees that a residential treatment model was a necessary step: “I think there’s a benefit to… be able to pull your head out of some of the lies you’re telling yourself [when living in active addiction]. I don’t think that [my husband] … would have been strong enough to actually get some recovery time without treatment” (T10-19). To begin to recover from what can be an all-encompassing condition, all the study participants agreed that attending a residential model of treatment or a supportive recovery house can be a vital step for some in recovering from addiction.

However, making decisions around whether, or what type of treatment to access can be challenging for addiction-affected parents of dependent children for several reasons. For some participants, there is a fear that accessing help could bring about unwanted state-sanctioned interventions. Amelia explains: “I was afraid [my son] would be taken away from me…. I probably would have gotten help sooner had I not thought he was going to immediately be taken from me” (T1-3). A legitimate fear, given that in Harriet’s case, her daughter was apprehended by the Ministry of Children and Family

Development and Harriet was mandated to attend a residential treatment program for her daughter to be returned to her care. She remembers:

> when I … first was told by the doctor, you know that 'I've called the ministry office, you're going there after my office, today' … I recognized the gravity of what was happening. And so, I did exactly as I was told. I was not going to be belligerent or uncooperative. I knew that being cooperative was the best idea. And so… first it was definitely shock… and, second it was, there was of course anger, … that I reached out for help, … This was all done without my knowledge …It was very very sudden and hard and fast.(T2, 3-4)

While Harriet expressed to me that in her case, the removal of her daughter, who ended up going into her sister's care, was in the best interest of her and her child at the time, the way in which these protective measures are carried out – 'sudden, hard and fast' – create fear in addiction-affected families, particularly if they don't have supportive families prepared to step in to care for their children. Instead of encouraging addiction-affected parents to reach out for help, current practices and policies can prolong their addictions and exacerbate the risks associated with substance use.

Other reasons for hesitating to attend residential treatment programs are related to feelings of grief and guilt they report for having to be separated from their children who remained at home or with other relatives while they were in attendance. Reid says: 'it broke my heart. I thought about [my son] every day. It was the longest I have ever been without him, right? So, it drove me nuts. It drove me nuts" (T9-12). And Stella remarks: "It was hard on me… feeling that I let them down and that I missed out on things" (T6-8). While more socially privileged parents are less likely to face a direct threat of child-apprehension by the state, some still do, and they are all vulnerable to experiencing harmful impacts of parent-child separation as most live-in addiction recovery services continue to lack accommodation for families.

Indeed, some parents claim that not being able to bring their children with them removes residential treatment as an option for them, and therefore they need an option to recover within the context of their family eco-systems instead. For example, when asked if she had attended treatment prior to beginning recovery Paisley answers: "I would have if… I didn't have the kids… one of my kids anyway, had a lot of anxiety…. knowing that I wouldn't be able to talk to him… I probably would have said no to treatment just around that" (T7-10). Similarly, Lucille states: "I wouldn't want to go in

without them period. So I wouldn't have" (T10-11). While these mothers were able to access recovery via alternate routes discussed in the following section, their comments give pause to consider that the barrier presented by individualized treatment models could be preventing recovery for others who would benefit from a residential model to begin their recovery but who will not agree to be separated from their children to attend.

In addition to the trauma that separation of children from their parents can cause as discussed in *Chapter 3: Literature Review*, there are other aspects to attending treatment that make it particularly inaccessible for working/middle and even upper middle-class clients. Particularly, the financial costs of attending treatment can present a significant barrier to contend with. Several of the participants I spoke with described the financial impact they experienced from attending treatment. For example, it took Lucille's family eight years to recover from the financial toll after her husband attended a 3-month residential treatment program. She explains: "We were so broke because we spent the money on going to treatment - even though he chose a cheaper place… we had to pay for it ourselves… there was no way we could access any free services, and we just burned through all of our savings… it's like your drowning" (T10-4). Because their family is middle class, they did not qualify for publicly funded aid. Similarly, Spencer identifies his middle-class status as the reason treatment is not an option for his family at all, not only due to the cost of attending, but the cost of not working while in attendance. He states: "we're middle class, but our financial situation does not allow for me to go to residential treatment. It doesn't allow for me to stop working" (T4-19). Because people are only eligible for state-funded residential treatment options if they are receiving income assistance or disability benefits and are otherwise homeless, the costs of attending residential treatment are prohibitive for many working/middle/ and upper middle-class addiction-affected families.

Additionally, when treatment ends for those who are able and make the choice to attend, there appears to be a gap in services between attending treatment and transitioning back into their lives. Indeed, the participants of this study recognize that clients are typically expected to be entirely responsible for their recovery once they discharge from treatment, regardless of whether it is a publicly funded or a private facility, and that this adjustment to life 'outside' can be jarring. Reid affirms

> that could have been the world's best renowned $500,000 treatment centre … at the end of the day, it matters what you do when you get out of there, right? … Once you get out of there, that's when the shit hit the fan, cause that's when I had to learn how to live. (T9-15)

Paisley agrees: "If someone doesn't have the proper exit plan, exiting treatment, people relapse coming out of treatment right? Cause they're just unprepared for that 'oh my god, real life again'" (T7-21). And Spencer states: "And then you have the mom that's back on her couch with her two screaming kids, you know, yeah she's gonna have a drink again, or that's gonna seem like a good idea, you know what I mean?" (T4-18). Indeed, an abrupt transition from residential treatment back into 'real life' can be problematic for addiction-affected people, thus demonstrating a need for expanded services that extend supports while clients transition back from treatment to their home environments.

In conclusion, this section has shown that while there are many benefits to the current individualized residential model, several participants also identify barriers within the current delivery model that relate to their status as parents. These barriers include fear and emotional suffering due to separation from their children because of the individualized model[43], demonstrating a need for some parents to access treatment and recovery within the context of their family ecosystems. Additionally, the prohibitive financial costs and repercussions related to accessing, and not working while attending lengthy, costly programs that working/middle/upper middle-class addiction-affected parents face were also noted, demonstrating a need for expanded socially funded treatment options for working/middle/ and even upper-middle class parents. Finally, some participants have also pointed to a gap in services between treatment and 'recovery' that leave many people in general, but parents specifically, vulnerable to relapse as they abruptly face the demands of their lives after leaving treatment. Ultimately, these participants have pointed to a need to expand the scope of our current service delivery model to accommodate parents' lived realities according to their family's needs, but instead these choices are being detrimentally constrained by each family's limited personal resources.

[43] As discussed in earlier chapters, there are a few family models, but none of my participants were able to access those services.

4.5. ‘Recovery’: Participants Report Benefits and Barriers

While treatment is a relatively short-term immersive process, recovery is often framed as a lifelong undertaking. Harriet claims: “this is a disease that needs daily maintenance”[44] (T2-23). Maren also views recovery as a time-consuming endeavor, saying: “it’s basically building new neuropathways, which isn’t overnight. …it requires lots of support and learning…” (T3-14). But what is ‘recovery’? And once treatment is over, how is recovery established and maintained?

In fact, as it currently exists ‘recovery’ is a largely informal process for which each addiction-affected person remains individually responsible for defining, identifying and choosing for themselves. And while this autonomy in choosing a modality of recovery that best suits each person is important, as ‘recovery’ is currently framed and delivered, those choices are largely influenced by the resources to which each addiction-affected person has access. For example, while the wealthiest addiction-affected people can access costly therapeutic interventions to resolve underlying issues that the person had previously used substances to cope with, many less financially well-off addiction-affected people instead opt to access recovery through 12-step community support groups for which admission is by donation[45]. Some access a combination of therapies, community and self-help, according to their personal resources. Others believe that abstinence itself is recovery and no further support or action is required. And for others, and particularly for addiction-affected people in marginalized communities, recovery can be less about abstinence and self-actualization as it is framed by various psycho-therapies and 12-step groups and is instead framed as marginally improved quality of life measures accessed through harm-reduction services[46]. This is not to say that there is not overlap between which demographics make which choices, nor even to assign value to one method more than others. The point is that instead of people being able to choose a method of recovery that is appropriate for them based on their experience of

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[44] While this thesis does not intend to promote or validate a medical model of addiction, I do honour the study participants who view addiction through this lens.

[45] “We are self-supporting through our own contributions”

[46] This is not to suggest that abstinence-based recovery has more inherent value than a recovery that involves continued use of substances through Harm Reduction services and measures. Indeed, Harm Reduction is massively valuable for all people who use substances given the harms caused by prohibition and the poisoned drug supply. And as a reminder, not all people who use substances experience addiction.

addiction and personal history, their choices are constrained by their personal resources and again, this tiered model of service delivery/accessibility could be one reason for frequent relapse and ongoing suffering. Ultimately, while what 'recovery' is can have as many answers as there are people who identify as being 'in recovery', in terms of the demographic representation of my study participants, there appears to be some common themes that the following section will explore.

For instance, and interestingly, while all the participants of this study are abstinent from using substances, 'recovery' means so much more to them than just not using their substance(s) of choice and is rather about building new habits and lenses for understanding and engaging in the world around them. Harrison remarks: "abstinence, that wouldn't define recovery. Recovery for me is… doing the things to change like, how I am, right?" (T5-13). Similarly, Harriet claims: "Recovery, to me is more – a whole lot more than just abstaining from my drug of choice. Um, it has to do with … putting in a whole lot of energy to, to filling up my cup essentially – to loving myself, to putting myself as a valuable person on this planet" (T2-1). And Paisley simply states that for her, recovery is "growing up emotionally" (T7-5). Though all the participants in this study agree that abstinence is a necessary qualifier for how they frame their own recoveries, it is only a beginning of a much deeper transformation that involves self-love, self-discipline and developing more mature methods for coping with life than they had previously been aware of or able to access, despite their social locations.

Indeed, seeing as recovery is not simply a passive state of abstinence for the participants, the following paragraph offers examples of activities and behaviours that participants identify as promoting the growth and maintenance of their respective recoveries. For Maren, part of being in recovery is about emotional regulation. She says:

> [I] try and do my best to stay regulated… it's hard being married and… all that intimacy everywhere, it's like, ugh! Yeah, so… it can be difficult, … being in recovery is like watching myself spaz, and then sort of reflecting on what's really going on for me and finding some way, or some person, or some place to pull that into the light. (T3-12)

By pulling what is going on for her "into the light", Maren learns her triggers and can develop new tools to keep her emotionally regulated instead of relying on substances to cope. Paisley has a similar view, she claims: "it's about walking through the feelings" (T7-9). Indeed, as explained at length in *Chapter 3: Literature Review*, people often

ascribe the development of their addictions as initially a response to trauma. Here, participants have explained that part of recovery for them is to learn new strategies for coping when their trauma responses are triggered without using substances.

Other participants indicate that part of recovery is making up for harms done while in active addiction. Reid admits: “I did so many bad bad things, Carla, that I felt like I was not worthy of being on the planet anymore. … so a large part of it for me is giving back and trying to help others where I can” (T9-19). Harrison similarly views recovery as working toward becoming a ‘better’ person than he was when using and shares how he actively pursues this change to his behavior: “I try to, when I wake up most mornings … I try to like sit down and meditate… I’m always trying to actively be, trying to be a better person… actively trying to be a nicer person” (T5-14). Because accessing and using substances in a context of prohibition inherently involves criminal activity to lesser and greater degrees depending on each person’s specific context, and because participants have experienced historic traumas, these statements point to a complex interaction of issues they have had to wade through in their recoveries. Indeed, for these participants, recovery requires learning to feel feelings that may trigger historic trauma, but also having to learn how to grow up emotionally including forgiving oneself for harms done while in addiction. Additionally, for some of the participants, helping others assuages this feeling of remorse and is an important part of their recovery.

In fact, this concept of recovery involving community plays a major part of ongoing healing for all the participants I spoke with. Maren explains: “my very impetus for using things was to soothe that ‘outside self’ – that watching, displaced feeling. Community and connection are like this incredible antidote. … When you find it, wow, it’s really powerful. It takes risk, but it’s powerful” (T3-13). Paisley agrees: “being a part of something like AA and feeling actually connected to people, like, they’re invested in me, I’m invested in them, to some degree, is a game changer” (T7-6). In fact, had the recovery community not been around for Harrison when he began his healing journey, he doubts he would have recovered. He explains: “when I first got sober, that sense of that community was important to develop in order for me to stay sober … because I don’t think I would have kept coming around if I was just still lonely and if people weren’t helping me out and if I didn’t get the opportunity to help people out either…” (T5-7). This community is not just important at the beginning of a person’s recovery, but as time goes by and new people join and begin their own healing journeys, this process of finding a

place within the community and being reminded by newly abstinent members of the suffering of addiction helps to keep people who have been abstinent for a while on track. As Paisley remarks: “when I see people come in that are new, you know, a week or two sober, it helps me to remember…” (T7-17). Additionally, Lucille explains how this connection to other people is made possible in recovery: “It’s allowed me to make more real connections and deeper connections because it has led me to a deeper consciousness of myself and who I am” (T10-16). Ultimately, according to participants, while active addiction had been an experience of profound isolation and disconnection, joining and belonging within a recovery community has enabled healing alongside other people who have experienced similar things and is an invaluable part of building and maintaining recovery.

By starting and committing to their recoveries, participants share the many positive changes to their lives that have come about as a result. For some, these changes have to do with their ability to face challenges. For example, Reid explains: “before recovery, things just held me back, whether it was fear, or um, even my reliability is a big one … cause when I cleaned up and continued on with my career … reliability was not an issue and I kind of started realizing that …anything’s possible, so I started really going for things” (T9-2). Because of his commitment to his recovery, Reid also learned how to apply that commitment to other aspects of his life, including his career, and became able to face and overcome challenges.

In fact, because many recovery programs promote the development of new tools for living, such as self-discipline, these tools are transferable beyond maintaining abstinence and tend to improve their overall quality of life. For example, several participants in this study report how their recoveries and these tools have enabled them to improve their socio-economic positions substantially as a result. In Reid’s case, his newfound self-discipline enabled by recovery improved the conditions of where he lives. He says: “I’m not even close to … the neighbourhoods I’ve come from … I was living in [a town known for violence, poverty and substance use][47] in an apartment in the rough area to living in a better neighbourhood when I moved in with [my wife][48], and then renting in an even nicer neighbourhood and then buying our first home…” (T9-4).

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[47] Name removed to improve confidentiality

[48] Name removed to improve confidentiality

Spencer also remarks: “my ability to… secure and maintain stable employment changed dramatically when I got into recovery” (T4-1). Similarly, for Harrison, being in recovery enabled him to show up for commitments once again. He says: “[going to school] is a big part to do with recovery because… if I wasn’t in recovery, I wouldn’t have the mind set to be able to go and do something like that.” (T5-3). Indeed, five participants who had experienced poverty, in some cases street-entrenched, and/or criminality during their active addictions, all identify now as employed middle-class professionals and claim this improved socio-economic change is a direct result of tools they have developed through their recoveries.

However, it is the impacts on their relationships with their children that participants report that are particularly salient to this study. Indeed, just as addiction has been shown to be cyclical in families, it appears that recovery, or at least its associated social tools, and the sense of belonging within the community that is built also benefit the children of parents in recovery. Clay shares how recovery is helping him to break his family cycle: “I’m very cognizant that I’m very gentle with [my kids]. I won’t put on them what my dad put on me. Because I grew up a violent man, right? I fought a lot. I got into lot of fights, you know, and I don’t want them …to have to bear that, right?” (T8-13). Spencer also wants his children to have a different experience than he had growing up: “I would like my kids to learn how to deal with their feelings better than I did as a kid” (T4-24). Evidently, being able to access and participate in recovery offers parents alternate tools and methods for parenting their children from what they may have experienced growing up.

Indeed, not only do parents report that their children are physically and emotionally safer with them because of their recoveries, but also that their recoveries also equip them with practical social tools for living that they are then able to pass on to their kids. Paisley shares how her recovery informs how she parents: “when they are struggling with something, I share my recovery [tools] with them” (T7-12). And Harrison says: “[my kids] see the things that I do, the things that we do, and they hear the language that we use, with recovery, right? Cause I do know the language that we use is way different than when you’re not [in recovery], right?” (T5-17). Here, the word ‘language’ refers to a way of speaking beyond sounds and symbols, but as the adoption of new choices in how one expresses oneself; in AA this is referred to as ‘The Language of the Heart.’ One example of what this ‘language of recovery’ includes, Maren explains:

“I have some kids that know how to apologize. Like, they know what that looks like and what it feels like and they also are able to really own some of the stuff that isn’t pleasant and why they like it… I love those conversations” (T3-15). Clearly, having parents in recovery gives children exposure to different ways of speaking, coping and new tools for navigating life and social situations than they would otherwise have been equipped had their parents been unable to access recovery.

However, accessing twelve-step meetings, meditation groups, counseling appointments and other recovery-based activities that have enabled such profound improvements for these families can also present challenges for parents with young children. For some, attendance presents a financial barrier. Maren explains the costly endeavor of hiring a babysitter long enough for her to travel to a meeting, attend the meeting and travel home: “If [my husband] and I want to go to a meeting, we have to hire a babysitter. Sixty bucks…. There’s a line where that’s not feasible because you can’t afford it…” (T3-13). Indeed, frequency of access to recovery is dictated, at least in Maren’s case, by how much she can afford to pay for childcare.

To overcome that financial barrier, some parents bring their children to meetings with them, but as many recovery spaces are currently organized, this often doesn’t alleviate the issue. Reid explains: “I’ve taken [my son to meetings] before and I could not focus on what’s going on” (T9-16). And Harriet faces a similar struggle in being able to focus if she brings her daughter along given her daughter’s diagnosis and related behaviour: “I’ve tried bringing my daughter to meetings and she has been recently diagnosed with ADD” (T2-22). While meetings are a fundamental practice and touchstone of community for addiction-affected parents, choosing between the high costs of childcare, or feeling distracted while in attendance can really limit the quality of recovery these parents can access.

Furthermore, not all parents want their children in attendance in recovery meetings. Spencer states: “that can be a pretty loaded environment in a lot of ways, and I would say that today it comes down to me kind of … not wanting my kids to experience that kind of energy on a regular basis…” (T4-23). Additionally, it is a challenge to balance the needs of their recovery with the needs of their family. Spencer explains: “having a role in a family takes up a lot of your time … I think that has an impact on how I participate [in recovery]” (T4-21). Indeed, for Paisley, having children prevented her

from being able to access twelve-step meetings at all. She says: “as a young parent I stopped accessing recovery cause … my husband didn’t want to be home with the kids long enough for me to go out [to a meeting]” (T7-8). Ultimately, attempting to meet the needs of young children while also participating in ongoing recovery activities as they are currently organized and delivered can present quite a challenge for addiction-affected parents.

In closing, this section has highlighted many of the direct and indirect benefits of recovery as described by participants, including benefits they see recovery facilitating for their children as well. It has also shown that while access to recovery is highly important for ongoing wellbeing of participants and their families, financial and time related barriers often limit access to participation in recovery activities for parents.

4.6. Conclusion

This chapter has offered a glimpse into what addiction can look like for working/middle/upper middle-class addiction-affected parents. It has shown that, despite embodying social privileges such as whiteness or white-passing, heteronormativity, education and professional positions, these families have suffered from, and continue to recover from addiction, and face barriers in doing so.

The first section considered some of the harmful impacts of parenting while in active addiction in a working/middle/upper middle-class context. It highlighted the ways in which participants’ wellbeing as well as their relationships with their children were harmed by living in an active state of addiction, despite their social privileges. In the following section, I presented my findings related to stigma as experienced and navigated by participants. This section found that privilege plays a significant role in enabling privacy, hence shielding those occupying social locations of white/white-passing, cis-het/cis-het passing, working/middle-class privilege from addiction related stigma and discrimination. While stigma can have damaging impacts on the lives of addiction-affected people, these participants have demonstrated resilience and discernment in how they navigate stigma and are even able to use it to their own advantage. But again, it is important to recognize the advantages these participants embody as it is these advantages that enable them to navigate stigma more easily because of the privacy their positions enable.

The next section focused on participant perceptions and experiences of residential addiction treatment. That section found that while there are benefits to residential treatment, treatment itself does not seem to ensure long-lasting recovery, and suggests that current models and processes present significant barriers specific to working/middle-class addiction-affected parents. Many who suffer from addiction want to be able to access a residential model of treatment and view it as a valuable beginning to recovery, but there are various barriers working/middle-class families confront. For example, the fear of being separated from their children, concern about state-mandated-child-apprehension, or the limits arising from the individualized model of residential treatment have kept them from asking for help, in addition to for many, the prohibitive costs of treatment.

Finally, the last section of this chapter focused on the theme of 'recovery' and presented definitions, benefits and barriers to recovery as described by participants. Briefly, this last section found that for these participants, access to some form of recovery program or process is an ongoing and enriching endeavor that has had profound, life-changing positive impacts on their lives and the lives of their children. However, just as there are barriers for parents attempting to access treatment, there are also barriers to engaging in active recovery that these parents must navigate on a regular basis and these barriers could result in catastrophic consequences for families given the chronic, relapsing characteristics of addiction. Clearly, to enable ongoing recovery for families, there is important work to be done in providing solutions that remove such barriers.

Ultimately, this chapter has demonstrated that addiction can have serious and intergenerational impacts in families despite working/middle/upper middle-class, white/white-passing and cis-het/cis-het passing social privileges. It has further shown the ways in which the impacts of addiction, and the barriers to recovery these parents have experienced seem to be meted out in specific ways that are rooted to common aspects of their social locations. While social privileges and locations greatly influence the ways in which the impacts of addiction are felt, they also present specific barriers that these parents confront in their pursuit of ongoing recovery.

Chapter 5.

Analysis

5.1. Introduction

In Chapter 4, I presented the four overarching themes that emerged from my data. Recall that these themes are: 1. The impacts of addiction on family life; 2. experiences of, and strategies for navigating addiction-related stigma in the context of family life; 3. benefits of, and barriers to, residential treatment for addiction-affected parents; and 4. definitions of, and methods for engaging in "recovery" and its benefits and barriers in a family context.

This chapter builds on *Chapter 3: Literature Review* as I compare the experiences and views expressed by my study's participants with findings about more marginalized addiction-affected/substance-using parents drawn from the literature. I utilize an intersectional analysis to argue that differences in experiences between these populations, though often stark, are all informed by forces that are rooted in and reflect damaging systemic and hegemonic ideologies experienced at the intersections of "race", Indigeneity, gender and class[49].

This chapter is arranged into two main sections. The first section discusses the first two interrelated themes of the impacts of parenting in active addiction/substance-use and the experiences of stigma as an addiction-affected/substance-using parent. The second section addresses the last two themes: access and barriers along public and private pathways to treatment, as well as definitions of and access/barriers to recovery for addiction-affected/substance-using parents. Importantly, the aim in this intersectional and comparative analysis is not to diminish the complex ways in which some people experience significantly more oppressive consequences of addiction because of sexism, racism, colonization or classism, nor to reduce or conflate the issues and needs confronting many different segments of our population. Indeed, the broad variation in the ways in which people experience violence, oppression and stereotypes is beyond the

[49] Among other social indicators that, as explained in Chapter 1, are beyond the scope of this thesis.

scope of this thesis. Rather, my intention is to argue that our systems, structures and hegemonic ideologies are failing to meet the needs of and are causing harm for even those families whose social locations suggest that they are otherwise 'successful' according to western conceptions of 'success', when they are experiencing addiction and/or seeking treatment and recovery in BC. In other words, the purpose of this chapter is to distinguish addiction from its social determinants by rendering visible the socially constructed processes by which addiction-affected parents are systematically subjected to more or less harmful impacts and stigma associated with addiction, as well as the barriers they confront when attempting to access treatment and recovery. Ultimately, this chapter argues that the impacts of addiction, experiences of stigma, and access and barriers to treatment and recovery programs experienced by the participants of this study as well as more marginalized addiction-affected parents are all meted out by systems reflecting and perpetuating racist, colonial, patriarchal and classist ideologies that are harmful to greater or lesser degrees for all.

5.2. Racialized, Gendered, Colonizing and Classed Systemic Impacts and Stigma of Parenting in Addiction Across Social Locations in BC

For many people experiencing addiction, before treatment or recovery options materialize, other systemic and institutional responses are often encountered first. These can include healthcare systems, the justice system and in the context of addiction-affected parents, child protection systems. As discussed in Chapter 3, the ways in which one experiences addiction/uses substances is to a significant extent determined by the ways in which such social systems are structured to interact with one's specific social location. Indeed, it is social systems and structures shaped by sexist, racist, colonial and classist ideologies that result in "the social determinants of health"; addiction/substance use especially in a context of prohibition and a poisoned drug supply being something that can affect a person's health experience. As a recap of Chapter 3: Literature Review, section 2 that reviews literature related to the social determinants of addiction/substance use, recall that if an addiction-affected/substance-using person is a woman, chances are her experience of addiction/substance use will be different than a man of the same class and "race" because of the hegemonic ideologies and social expectations of gender. Similarly, it has been empirically proven that statistically, substance-using people-of-

colour will experience more oppressive and criminalizing systemic repercussions than those experienced by white people. The dimensions of systemic racism experienced by addiction-affected/substance-using people of Indigenous identity and ancestry reflect this country's horrific, and ongoing, history of colonization. Additionally, socially unjust discrepancies have been noted along class lines as well, disproportionately impacting addiction-affected/substance-using people living in poverty.

While myths and stereotypes related to addiction tend to allocate blame and responsibility for outcomes on the choices made by individuals – these typically being racialized, and gendered people living in poverty - this section will argue that the fact that these discrepancies in experiences of addiction/substance-use, stigma, treatment and recovery exist at intersections of gender, "race"/Indigeneity and class is evidence that it is instead social systems that are largely responsible for creating the contexts in which addiction-affected people endure such experiences. To illustrate these systemic discrepancies, in this section I compare the impacts of addiction/substance-use and experiences of stigma specifically in the context of family groups comparing those expressed by study participants with those relating to the experiences of more marginalized addiction-affected/substance-using parents drawn from the literature. Ultimately, I suggest that as long as sexist, racist, colonial and classist hegemonic ideologies persist, our systemic responses to addiction/substance-use will continue to fail to deliver outcomes that reflect the best interests of families experiencing addiction/using substances, regardless of how privileged or marginalized their social location, though inarguably these outcomes are consistently significantly worse for marginalized families.

To begin, social constructs related to gender-binary roles play a determining role in the ways in which addiction-affected/substance-using people are treated by institutions. Indeed, addiction-affected/substance-using women, and mothers especially, are at heightened risk of poverty, violence and criminalization in systems that structurally marginalize them and socially and culturally penalize them when they fail to embody the hegemonic ideals related to womanhood and mothering. Salmon explains:

> the social construction of mothering has highlighted the numerous ways in which women, and most particularly those further marginalized by race, class and disability, are punished through State-sponsored disciplinary regimes for failing to conform to liberal ideologies of 'good mothering'.

> According to these ideologies, a 'good' mother is self-sacrificing, self-disciplined, morally irreproachable and capable of meeting the needs of her family without assistance from the State. (2011, p. 167)

When women are unable to perform the role of 'mother' as prescribed by such ideologies, they often feel stigmatized and their mental health can suffer. The shame that arises from stigma can have severe consequences of the health outcomes of addiction-affected/substance-using mothers. Benoit et al explain:

> Stigmatizing attitudes have likewise been shown to pose a significant barrier for women accessing services and receiving adequate care [18, 19]. Radcliffe (2011) found that once pregnant women received the label of "substance user", they were often seen by their medical practitioners to be disrespectful, incompetent parents, and untrustworthy [20]. Fear of losing their children through Child Protection Services (CPS) interventions and apprehensions is another major barrier that stops mothers who use substances from reaching out for support, particularly when there are other compounding marginalisations such as lack of housing and racism [17, 21, 22]. (2015, p. 2)

Clearly, when addiction-affected/substance-using mothers are marginalized by stigmatizing ideologies related to "race"/Indigeneity, gender and class held within and perpetuated by social systems, such as health care as well as the justice system, the impacts of addiction/substance-use related stigma that they experience can be severe.

While addiction-affected/substance-using mothers in general often experience devastating social consequences, in the Canadian context, addiction-affected/substance-using Indigenous mothers are especially persecuted. As cited in *Chapter 3: Literature Review*, addiction-affected/substance-using people who are Indigenous – and especially Indigenous mothers - are more likely to be simultaneously impacted by complex health problems, poverty, criminalization, and intergenerational trauma, than any other group in Canada, and again, these impacts result from racist, sexist and colonial systems designed to restrict and oppress Indigenous Peoples.

As previously noted, Indigenous Peoples are still hugely overrepresented within the foster care system as well as the corrections systems, and it is the same system that allocates people to both: the justice system. The Canadian Justice System is based largely on the British Common Law and therefore reflects a British ideological paradigm. Despite Canada's landscape today as being one that is multi-cultural, multi-ethnic, and multi-faith, the same justice system presides over us all. Those who have been most

disproportionately silenced and marginalized by the justice system have been the Indigenous Peoples of Canada. There have been acts implemented that demand special consideration be given when hearing a case involving Indigenous peoples, for example sections 22.1 and 22.2 within the Family Relations Act (1996)[50] pertaining specifically to Nisga'a and First Nation children, but, in her article, "Child Welfare Law", Marlee Kline explains why this is not enough. Though this Act was updated in 2013 with the new Family Law Act[51], Kline's work shows how the court system has historically projected a Euro-centric value system upon Indigenous peoples when deciding their cases by citing how the "best interests of the child" can be perceived very differently depending on whether one is looking through a European or First Nations lens (Kline, 1992). However, it is through the European lens that court orders are delivered, hence the value system of Indigenous Peoples are being ignored or considered irrelevant from a legal standpoint, despite these decisions having detrimental impacts upon them individually and as Nations. It is clear that many Indigenous families are still suffering from the intergenerational impacts of having been discriminated against systematically through the justice system within this province and country, hence their ongoing overrepresentation within both the foster care system and the corrections system.

In addition to structural racism that controls how Indigenous Peoples can parent and even access their children because of the ministries of justice and child and family development, Indigenous Peoples are also often subjected to high levels of social stigma, particularly when experiencing addiction/using substances and these stigmas then inform the care addiction-affected Indigenous individuals receive when accessing other social systems. For example, Goodman et al claim: "racism and stigmatization are identified as being at the forefront of Aboriginal peoples' healthcare experiences" (2017, p.88). Therefore, when Indigenous people suffer from addiction, they confront racism and stigmatization at both systemic and social levels that further increase their likelihood of experiencing violence, criminalization, and poverty thus ensuring conditions of exacerbated addiction-related risks.

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[50] Retrieved from: https://www.bclaws.gov.bc.ca/civix/document/id/consol20/consol20/00_96128_01#section22.1

[51] Retrieved from: https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/11025_01

But even when parents are not racialized and poverty is not part of their lived experience and they have access to the privilege of privacy as discussed in *Chapter 3: Literature Review*, mothers continue to be impacted by sexist, stigmatizing ideologies related to mothering. In our interview, Stella spoke directly to her experience of judging herself as a mother in active addiction: "that's not what a good mother does' you know. Pass out and….[she trails off here]" (T6-5). Because living in a state of active addiction reduces a person's capacity to perform motherhood as prescribed by hegemonic ideologies related to motherhood, addiction-affected mothers who are unwilling and/or unable to conform to these ideals fear and often become, stigmatized and oppressed and are less likely to access help in a timely manner, even when they have access to many social privileges.

And it is not only addiction-affected mothers who experience discrimination in parenting. As stated in *Chapter 3: Literature Review*, the experiences of fathers are often invisible in the literature, which is a reflection of our overarching patriarchal social structures that essentialize women as primary care providers for their children. And while the injustices and oppression women experience because of these sexist systemic impacts are well-known, during our interview, Reid expressed his own frustration with feeling immediately excluded from qualifying as a competent parent and instead felt judged as a "deadbeat" within the family court system because he is a man. He explains:

> I was a guy, and I got the shit end of the stick on everything – the ministry and, I was just, right off the bat without them even knowing who I was, like, I was the enemy. I had to prove myself. …she got away with murder … She could sit there … doing cocaine …right beside the playpen and have all these guys coming and going and selling drugs in the house and collecting welfare and like, just completely raping the system. And here I am like, riding my bicycle to a job because I can't afford insurance and I'm paying her every little extra penny I have even though I pretty much had him [their son] half the time and I paid for all his sports, paid for all his clothes, like I did. I mean, once I started making enough money I just, I was like 'whatever, it is what it is', it's about him, not me, but what pissed me off was that… like, I was the deadbeat. Right? (T9-17)

Reid felt that he was discriminated against by the family court system because of his gender. Indeed, his experience reflects expectations of hegemonic masculinity entrenched within our family court system. Chandler cites Connell who defines hegemonic masculinity as including "valued traits such as strength, power and rationality, and the concept was explicitly tied to understanding and explaining

patriarchal systems of oppression" (2019, p. 1352). As such, Reid's experience suggests that despite the social privilege men experience compared to women, when confronting the court system as an addiction-affected father, this patriarchal system perpetuates harmful impacts in different ways for all members of a family because of hegemonic ideologies related to gender-binary constructs.

This section has shown that the impacts of addiction and its associated stigma experienced by marginalized families are shaped to a large extent by racist, colonizing, sexist and classist systemic processes. It has also shown that participants in this study, albeit to a far lesser extent, have also been impacted negatively by these overarching systems and stigmatizing ideologies. Though study participants embody social indicators that are typically associated with unjust advantages in our society, prevailing systemic and ideological processes – particularly those relating to gender - are also cited here as responsible for shaping some of the harms they and their families experienced while in active addiction, though to a far lesser degree than families marginalized by Indigeneity/"race", and class. Ultimately this comparative and intersectional analysis suggests that first, the impacts of addiction, and the ways in which families are able to navigate stigma, are to a great extent, shaped by racist, colonizing, sexist, and classist ideologies, systems and structures; and second, though largely shielded by the same ideologies, systems and structures that harm their more marginalized counterparts, more socially privileged families do not go unscathed when affected by addiction and confronting our organizing ideologies, systems and structures.

5.3. Gendered, Racialized and Classed Dimensions of Accessing Treatment: Public vs. Private Pathways to Treatment and Recovery for Parents in BC

As explained in *Chapter 4: Findings*, a residential treatment program is often a method of support opted for by people in active addiction who hope to achieve an abstinence-based recovery. Residential treatment is frequently recommended because it removes the affected person from their usual environment, thus limiting triggers and allowing for time, space and support in identifying new skills for coping with their lives. Indeed, several participants attended residential treatment and in *Chapter 4: Findings*, attest to the value of this model for beginning their recovery. However, as discussed there, accessing treatment as a parent to dependent children can be complicated and

even unattainable. In this section, I argue that the current two-tiered, public/private delivery of addiction treatment services are problematically allocated according to one's finances, or 'class' – which, as previously explained, also intersects with and is shaped by one's "race"/Indigeneity and gender, rather than according to one's personal context, history and need.

Even when people have been gravely impacted by addiction and are seeking to attend residential treatment or supportive recovery houses because of this model's immersive style, pathways to accessing treatment are not yet a streamlined, clear-cut process for people in this province. A report titled "Live In Addiction Recovery Services in BC: A Snapshot of the Sector"[52] (2017)[53] by the Centre for Applied Research in Mental Health and Addictions outlines several discrepancies in the industry. For example, the executive summary states:

> The study revealed considerable ambiguity regarding the different levels of live-in addiction services in terms of the criteria that differentiate support recovery and intensive residential treatment beds, which agencies are providing what type of service, and the mechanisms for program access. It was noted that centralized access/intake processes are not consistently in place across health authorities. Further confusion arises from the fact that certain health authorities have redefined their specifications for contracted services as Stabilization and Transitional Living Residences to distinguish them from standard supportive recovery programs.

As such, navigating the system to access treatment can be wrought with challenges for people desperate to survive this often-deadly condition. Compounding the issue is the fact that while some residential treatment programs/beds in BC are publicly funded, licensed and accredited, many are private and unregulated. As a result, this two-tiered system can be confusing and have grave repercussions for its vulnerable clientele. Browne, and author for VICE newsletter explains: "With lengthy waitlists for treatment at publicly-funded facilities, a host of private entities—many not even run by doctors—have opened to fill the void. In most of Canada, there is no government oversight. Anyone with a business license can open a clinic and charge patients whatever they want."[54]

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[52] Retrieved from: https://www.streetohome.org/wp-content/uploads/2017/04/Final-LIAR-Report-2017-May.pdf

[53] Henceforth known as the LIAR report

[54] Retrieved from: https://www.vice.com/en_ca/article/5gqd5a/canadas-private-drug-rehab-industry-is-unregulated-chaos

This blatant lack of regulation and oversight of service delivery combined with exorbitant fees puts some of our society's most vulnerable and desperate people at extreme risk of exploitation and other harms, if they are able to access such services at all given the associated costs.

Furthermore, while participants identify benefits to being able to access a residential model of treatment in the early days of one's recovery, there is no actual data available to demonstrate this model's effectiveness in establishing a foundation for long-term recovery in addiction-affected people. The LIAR Report (2017) further states:

> As a proportion of admissions to residential programs, failures to complete appear to be substantial. Further, formal follow-up with discharged clients is not routine. It would appear that the chronic care paradigm and the accepted practice of monitoring and provision of long-term support have not been adopted across all residential service providers in BC. (p. 8)

Regarding the absence of support reintegrating people back into society after leaving treatment Spencer remarked:

> The supports that are provided by residential treatment are very defined and there's a lot of structure there … everything there is geared towards you being successful, and then you leave and our society is not geared toward you being successful in that way. It's like, ok, you fixed your problem now. Go the fuck back to work. (T4-18)

Despite residential treatment holding the popular opinion as an appropriate response to addiction, given the lack of data and the formidable gaps in services, particularly relating to transitions afterward, whether treatment actually enables long-term recovery, statistically speaking, remains to be seen. This lack of evidence combined with a lack of formal institutional oversight leaves already vulnerable clients in an even more desperate position.

While the Province of British Columbia through the Ministries of Health as well as the Ministry of Social Development and Poverty Reduction funds access to residential addiction treatment programs for addiction-affected/substance-using[55] people, applicants

[55] Again it is important to note that not all people who use substances are 'addicted', however, more marginalized and vulnerable people are perceived and processed as such, often facing 'options' of treatment or jail time for crimes that might have been prevented if not for prohibition of substances and other racialized, classed, gendered and colonizing policies.

must be able to demonstrate financial need to qualify[56]. In fact, it was through this channel that four of this study's participants were able to access treatment, however, these participants are the same four who did not become parents until they had already begun their recovery. Distinguishing between the experiences of participants who attended treatment prior to having children is important to note because while they were able to access treatment via the public channel, they did so without confronting the barriers that parents who require and qualify for publicly funded residential treatment encounter.

Indeed, children present a major barrier to treatment for marginalized addiction-affected/substance-using parents because, as discussed in *Chapter 1: Introduction*, the vast majority of treatment centres do not accommodate children, and the few that do have other barriers to consider. For example, Peardonville House in Abbotsford, Rose Harbour in Campbell River, and the Karis Support Society in Kelowna, are designed for women only, and have age limits on the children who may attend with their mothers. Though these programs are incredibly important as they reduce barriers for some women, they do not enable entire families to begin their recovery in a safe, supervised and supported environment. And, aside from Nenqayni Wellness Centre Society, and Kackaamin Family Development Centre, the two Indigenous family treatment centres also introduced there, these mainstream mother-child models leave fathers entirely without the option of recovering with their children and/or partners. Again, programs for parents that only admit women function to further entrench the gendered trope of women as naturalized care-providers while absolving and denying men that same level of parental responsibility and access to care.

Unfortunately, there are many parents living in poverty that cannot access the programs listed above and who do not have the means to provide safe, alternative childcare when attending a residential treatment program. Therefore, the transactional cost of attending such a program is to surrender their children to the Ministry of Child and Family Development and foster care. As such, most opt for harm reduction programs, and/or attempt to hide and control their addiction/substance-use for as long as possible. Therefore, parents living in poverty who remain in active

[56] Retrieved from: https://www.fraserhealth.ca/Service-Directory/Services/mental-health-and-substance-use/substance-use/residential-treatment-services-and-supports#.Xfk7gWRKiUl

addiction/substance use because they do not want to risk state-mandated separation from their children almost inevitably become separated because the impacts of addictions/substance-use tied to these social locations (Lloyd, 2018; Brower, 2006) often escalate over time, and is particularly risky in the context of prohibition and a poisoned drug supply.

While the barrier to individualized residential treatment is removed when children are apprehended from addiction-affected/substance-using parents, several new barriers arise. To explain: when a child has been apprehended, the social worker acting as temporary legal guardian of that child must create an agreement stipulating the issues a parent must address to regain custody and guardianship of their child/ren[57]. One of the issues in such an agreement usually pertains to providing safe and adequate housing for their children that meet the national occupancy standards[58]. However, for parents surviving on income or disability assistance, when children are removed from their care it greatly impacts their income. As stated on a poverty reduction advocate website: "The amount of assistance you may be eligible for depends on how many people are in your family unit that reside in the house. If you move locations, or a roommate/spouse/partner/child(ren) moves into or out of your home, this needs to be reported to the Ministry."[59] When a child moves out, the monthly payment is adjusted to reflect that, meaning that rent then represents a larger portion of the remaining monthly budget. Furthermore, parents whose children are apprehended also lose the child benefit payment as explained on the Canada Revenue Services Agency website: "Your entitlement to benefit payments stops the month after the child is no longer in your care."[60] Therefore, when a child/children has been apprehended, parents on income or disability assistance are increasingly vulnerable to losing their housing, which is a major requirement of having their children returned to their care.

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[57] Retrieved from: https://familylaw.lss.bc.ca/children/child-protection/staying-out-court

[58] Retrieved from: https://www.bchousing.org/housing-assistance/rental-housing/subsidized-housing

[59] Retrieved from: https://askanadvocate.ca/wp-content/uploads/2019/07/2019-IA-Living-Arrangements.pdf

[60] Retrieved from: https://www.canada.ca/en/revenue-agency/services/child-family-benefits/keep-your-information-date.html#chldrn

Another barrier to treatment and recovery that results from child apprehension is the emotional and psychological impacts such a separation can have on an addiction-affected parent who has lost custody of their children, and as a result their housing, can exacerbate addiction in the process. Zabkiewicz et al. state: “homeless mothers of young children may suffer from unique patterns of mental health problems, including problems with substances” (2014, p. 2). Additionally, for Indigenous parents who may embody intergenerational trauma resulting from impacts of the residential school system and the horrors of the foster care system, the apprehension of their child/ren can trigger terrible memories and fears thus increasing addictive behaviour (Duff et al., 2014). For parents, the failure to achieve these almost impossible aims of abstaining from the only thing that they know relieves their pain and agreeing to attend a mandated program that may have them confront their pain while having no assurance as to the safety and wellbeing of their children often placed in the care of strangers, can clearly lead them to relapse if they go to treatment at all. The delivery of treatment in this way creates this vicious cycle and can almost guarantee addiction/substance use will continue. Furthermore, the failure to achieve these state mandated aims is then internalized through the stigmatizing ideologies described in the previous section, and again, engaging in substance-use functions to cope with that pain and perceptions of inadequacy and internalized colonial violence. Therefore, the requirement of complete abstinence can present a staggering barrier for parents attempting to cope with the emotional and psychological distress resulting from experiencing child apprehension, and as previously explained, the prospects of the children who are apprehended and raised in the foster-care system are similarly dismal. The intergenerational legacy of trauma, marginalization and suffering continues, with a significant body of literature[61] detailing the impacts across the life course of children disproportionately affected by adverse childhood experiences as evidence of this fact.

In addition to the sometimes painful, emotional impacts of separation from their children described in *Chapter 4: Findings*, when it comes to working/middle/upper middle-class parents accessing treatment, the problem is the same, but opposite. I will explain: because these people are currently employed and participating in/contributing to the economy, providing treatment for these addiction-affected people appears to be less

[61] Many examples of which are cited in chapter 3, and throughout this thesis.

of a priority. This lack of priority in providing addiction treatment to those who are gainfully employed is indicated by the financial barrier erected for those who cannot demonstrate 'financial need'. Providing publicly funded treatment only for those who are unable to work suggests that a key motivation to fund treatment is to return a person to work. Since people in these more socially-privileged demographics are already working, they are obligated to go the private route, if they go to treatment at all, because they rarely earn little enough to qualify for public funding, and even when they do, there are still exorbitant costs that can prohibit access to participation, as was explained in Chapter 4. The *Stepping Forward Improving Addiction Care in British Columbia* policy paper on addiction treatment put forward by BC's Physicians in 2009 elaborates on how the issue of financial barriers have been a problem for quite a while in BC:

> It is important to note that even within these public programs, the costs of some services are not completely covered by the public health care system. For example, at BC Women's Hospital, the Aurora program provides both residential and day program beds for addiction treatment. While some of the program is covered under the Medical Services Plan, the 6-week intensive residential treatment program is not and costs $2,730 ($65 per day). It is not unusual for some programs (particularly residential or day programs and methadone programs) to have a per diem or monthly cost associated with them that can be as much as $60 to $90 per day. For example, the Pacifica Treatment Centre, a non-profit society that is partly funded through the Vancouver Coastal Health Authority, has a per diem cost of $90. The BCMA notes that these per diem costs are somewhat unique to addiction treatment, in contrast with other diseases. They are also different than facility fees charged in hospital (i.e., upgraded costs for a single instead of shared room). There are provisions by Health Authorities and other agencies to provide subsidies to assist some low-income clients with these fees.

This two-tiered, public/private approach to our health care response to addiction can present a significant barrier for addiction-affected parents who are still employed/employable. Costs unique to addictions treatment, costs that would not be experienced by people suffering with other ailments, indicates systemic discrimination against addiction-affected people. Maintaining such cost-restrictive barriers for those who are not currently receiving income assistance or disability suggests that providing effective treatment for those who are employed/employable is less of a priority.

Indeed, in *Chapter 4: Findings*, several participants remarked on the prohibitive costs of treatment. Recall Spencer's statement "I said at the beginning of this conversation that we're middle class, but our financial situation does not allow for me to

go to residential treatment. It doesn't allow for me to stop working" (T4-19). And Harrison, who attended a residential program prior to becoming a parent says: "Like, I know I do make a lot of, like a decent amount of money per year, but I can't afford – I can't afford to pay to go to some of those places, right? Part of the reason I got into Turning Point was because I was a fucking bum. And I could get on welfare… That's the only reason that I got to turning point was because I qualified for welfare" (T5-11). These two participants point to the ways in which access to addictions treatment can be prohibitive for people who are employed, but less so for those who are in receipt of Income Assistance benefits paid through the Ministry of Social Development and Poverty Reduction. This two-tiered delivery of addictions treatment services suggests that public funds are currently only allocated to support the treatment of people who are unemployed, but those who are employed – whether or not they can afford to pay for treatment, are expected to fund their treatment through private channels, and as such, many may not be able to access what has been previously described by participants as a valuable, if not vital in some cases, support in recovering from addiction.

Fortunately, some employers will cover the cost of treatment for addiction-affected employees as addiction is recognized as a disability and discriminating against an addiction-affected person is illegal[62]. In fact, it was because of employer policies and benefit packages that three out of the four research participants for this project who attended treatment while parenting, were able to attend. For example, Stella remembers how she came to access treatment: "I went to an addictions doctor, kept relapsing. He reported me to my college of nursing and got all that going and so then I ended up in treatment." And Reid remembers the process he underwent to keep his job: "I get a hold of work and they're like 'you've gotta come in, we need to talk to you'. So I go in and they're like 'do you have a problem?' and I knew if I said no, it was like the last chance that um, they would probably just let me go at that point. But because I said 'yes I have a problem' they were like 'k, you need to go get help' so I agreed to go get treatment" (T9-9). While it is important that addiction-affected people are protected from employer discrimination, it is critical to note that employer-paid treatment still represents the allocation of treatment costs for working/middle/upper middle-class people within the private sphere. However, many employed addiction-affected people are left without

[62] Retrieved from: https://www.go2hr.ca/legal/drug-alcohol-dependency-and-the-employers-duty-to-accommodate

access to treatment as whether or not such a benefit will be offered by an employer remains a private decision.

Furthermore, for addiction-affected parents whose employers use treatment as an ultimatum for remaining employed, this employer-paid and mandated treatment path still represents an outside authority leveraging and shaping one's ability to parent one's children: if the addiction-affected employee refuses the treatment offered, thus forfeiting their current employment, their ability to continue to care for their children is threatened. Unless they can quickly find another source of income to support themselves and their children, they will become increasingly visible to social systems that may forcefully intervene. And, as discussed previously, families that become visible to such social systems often experience exacerbated impacts of addiction/substance-use because of the harms such systems impose on addiction-affected/substance-using people. Recall the fear study participants expressed in Chapter 4 relating to stigma and what might happen to their families if the MCFD became aware of their addiction. When considering all of this, it becomes ever more apparent that accessing addictions-treatment, the channel through which one does so, whether via the publicly funded or employer-paid services, contributes to maintaining the cultural and economic status quo.

While treatment can be accessed, albeit problematically, via both public and private pathways, 'recovery' is accessed almost entirely within the private sphere. Furthermore, because 'recovery' is practiced through a multitude of different avenues, it is beyond the scope of this thesis to engage in an intersectional analysis of each. As such, for the remainder of this section, I will present some of the contentions related to the term 'recovery', and I will consider some of barriers parents confront when attempting to engage with two specific avenues of recovery: 12-step groups, as this is the model of choice for each of my research participants, and harm reduction programs and services, as these have been developed to respond to some of the needs of the most marginalized addiction-affected people in our province.

'Recovery' as a concept remains somewhat nebulous. Recall, 'recovery' as described by participants in *Chapter 4: Findings*, can be understood as an ongoing practice and/or state of being that is achieved once the most troubling aspects of active addiction (for example, craving and detoxification) have been addressed. Furthermore, there exists some debate about what qualifies as 'recovery'. For example, some believe

that to qualify as recovered, one must become and remain abstinent from all substance use. Whereas others believe that improved quality of life and reduced harm from substance use while still choosing to use substances should also be understood as 'recovery' (Bartram, 2020). Models of 'recovery' that exemplify this difference are the 12-step group model which has an explicit goal of achieving and maintaining abstinence; whereas harm reduction programs and services do not expect abstinence. Both models are widely available with little-to-no cost, but as I will point out, are not without significant barriers for parents. And, in the context of this thesis, the concern about what qualifies as 'recovery' is not that there exists a debate, but instead considers the ways access to different forms of 'recovery' for addiction-affected parents can be shaped by a person's access to resources and the contexts of their lived experiences at intersections of "race"/Indigeneity, gender and class, rather than according to their preference or need.

If you will recall from *Chapter 4: Findings*, abstinence is part of the definition that all participants provided when describing their experience and definition of 'recovery'. Indeed, all participants of this study have had lengthy involvement in abstinence-based 12-step recovery groups. In addition to maintaining abstinence, the sense of community that comes from engaging in such groups has been an integral part of how each participant described their 'recovery' experience. Remember though, that many participants also gave examples of how accessing such recovery groups was challenging in the context of parenting. Not all participants believe that 12-step group environments are appropriate for children, while others found their children's presence in these groups to be distracting and still others found the cost of childcare so that they could attend without their children to be prohibitive.

Indeed, for Paisley, the barriers to accessing her recovery program because of mothering young children ultimately lead to a lengthy relapse. She explains: "my husband worked hard and he came home and was like, 'I worked all day, I'm not doing this'. So I wasn't able to assert myself to say 'no, I'm going out and doing something', and so I didn't get to go to meetings" (T7-5). As such, while all participants spoke highly of their recovery experience and also noted the intergenerational benefits that their families have experienced as a result of their recoveries, ongoing access to 'recovery' as my participants practice it, is not without sometimes significant challenges despite the privileges of their social locations.

It is important to note that while this study's participants have all attended 12-step groups, the comparison of models here is not meant to suggest that only working/middle/upper middle-class people access this model of recovery. On the contrary, many people from all walks of life and from all social locations choose a 12-step program model of recovery, though as stated, meetings can present barriers to parents who require childcare to attend. And, for many who have identified that they required treatment before they were able to engage in this model of recovery have confronted the barriers to treatment previously described before getting to the point of attending 12-step meetings.

When it comes to harm reduction models, however, such services are created for and specifically targeted to marginalized populations, populations that, if parents, have likely already had their children apprehended because of the racist, sexist, classist and colonial policies and practices described previously. These sorts of services are typically only accessed by those without better options, the sorts, such as expensive treatments and therapies, that those with more resources, and the privilege of privacy might choose, or if a non-addiction-affected substance user, might never have to encounter. Smye et al. affirm that these services target marginalized populations: "harm reduction opens opportunities for promoting the health of people who often are stigmatized through social responses to problematic substance use" (2011, p. 1). And, while great for people who benefit from and/or want to continue to use substances more safely, harm reduction should not be conflated with treatment or recovery for people who are suffering with addiction, though such programs might be all marginalized people are able to access. Indeed, the current wait for a publicly funded bed in medically supervised detox facilities (medically supported detox is often necessary for alcohol or benzodiazepine dependence, as withdrawal from these can be fatal) are currently around a 13 week wait. When substance-use is resulting in 7 people dying a day in this province, these sorts of waits with only harm reduction options (where accessible) to keep people alive is absolutely unacceptable. As the operations manager of a registered harm reduction site, I fully support ongoing and expanding harm reduction practices that allow people who use substances to use as safely as possible and with dignity and access to any supports as needed but argue that harm reduction is not a replacement for therapeutic interventions and/or treatment. Additionally, neither am I advocating for any one definition of 'recovery' over another, nor suggesting that people would choose

abstinence if given more resources. Instead, my critique here is that harm reduction services should not be the only option available for marginalized addiction-affected people – that other options, if made accessible and available, might prove more successful. Ultimately, I argue that our best option for truly reducing harm is to dismantle the systems of oppression that create the contexts in which people and families have experienced trauma, addiction and that marginalize them in the first place.

5.4. Conclusion

In conclusion, this chapter has presented an intersectional and comparative analysis of the experiences of addiction/substance-use, stigma, treatment, and recovery options expressed by the more socially privileged participants of this study, with the ideological and systemic barriers confronted by marginalized parents as explained in related literature. This chapter has argued that the current responses to addiction/substance-use in BC are all harmfully shaped and delivered through systems that are informed by and perpetuate racist, sexist, classist and colonizing ideologies and policies, though experienced in very different ways depending on one's social location. This chapter has examined and compared some examples of discrepancies in the ways in which addiction-affected/substance-using parents confront social systems and experience addiction-related stigma based on their intersections of "race"/Indigeneity, gender, and class. I have contrasted the impacts and stigma of addiction/substance-use and avenues through which employed vs. unemployed addiction-affected/substance-using parents at intersections of "race"/Indigeneity, gender and class may or may not access public or private options for residential addiction treatment and recovery options – and have alluded to the ways in which their children are profoundly impacted by these various processes. While these experiences vary significantly across social locations, and indeed, from one individual to the next, one aspect of the process of accessing treatment appears to remain consistent: the true test of whether addiction qualifies as requiring state funded intervention is not whether a family is suffering, but whether or not their suffering interferes with a parent's capacity to work.

As such, this analysis argues that it is the racist, sexist, colonizing and classist ideologies entrenched in such social systems as the Ministries of Health, Justice, Social Development and Poverty Reduction, and Child and Family Development that are largely responsible for shaping contexts, determining outcomes, and perpetuating

intergenerational harms associated with addiction/substance-use. And while people with access to more resources and privacy because of unjust privileges tied to their intersections of “race”, gender and class, the participants in this study demonstrate that despite such privileges and to a far lesser extent than marginalized families, they too are harmed by the ideologies entrenched and perpetuated by such systems.

In the next chapter, I discuss the ways in which such sexist, racist, colonizing and classist responses to addiction seem to reflect and even function to maintain overarching structures of white-settler-patriarchal-colonialism, free-market capitalism, neoliberalism, and globalization, and as such, perpetuate the conditions for addiction to arise according to Alexander’s dislocation theory of addiction. There, I argue that since addiction arises across all social locations because it oppresses even those it is designed to benefit, it is in the best interests of people in all social locations to dismantle said systems. I also present the ideas generated by research participants to effectively remove barriers to treatment and recovery for all parents and further discuss the political action and cultural shift that will be necessary to successfully implement such publicly funded, holistic, family-centred healing programs and spaces.

Chapter 6.

Discussion

6.1. Introduction

Recall Chapter 5, where the data and findings from Chapter 4 are compared with the experiences of more marginalized addiction-affected/substance-using families as detailed by secondary sources. The comparative and intersectional analysis in Chapter 5 argues that experiences of addiction, stigma, as well as access and barriers to treatment and recovery for addiction-affected/substance-using parents in BC are shaped in different ways depending on each family's social location, by racist, sexist, colonizing and classist ideologies entrenched in the policies and practices of our social institutions and systems.

When contextualized within our over-arching social structures that are shaped by white-settler-patriarchal-colonial, free-market capitalist, neoliberal and globalizing forces - forces that Alexander argues as being 'the causes of the causes' of addiction - an even broader picture of a troubling pattern in our current systemic responses to addiction/substance-use emerges. Though the impacts of active addiction, experiences of stigma, and barriers to treatment and recovery that families endure can be drastically different depending on their various social locations, my research suggests that current responses to addiction in our province are failing to adequately address this problem for everyone in different ways because these responses are all shaped by, uphold and perpetuate 'the causes of the causes' of addiction.

In this chapter, I discuss the ways in which our current responses to all addiction-affected/substance-using families reflect and centre the very ideologies, systems and structures that Alexander (2012) claims to be significant causes for the widespread experience of dislocation that could be causing addiction to begin with: free market capitalism, neoliberalism and globalization. While the experiences of marginalized addiction-affected/substance-using families cannot be conflated with those experienced by more socially privileged families - as detailed in Chapter 5, the contrast in experiences is stark and clearly unjust - yet, the suffering that is experienced in all addiction-affected/substance-using families can often be traced back along racialized,

colonized, gendered and classed lines to the overarching systems that rely on oppression to function. Given that racism, sexism, colonization and classism are fundamental aspects required for maintaining structures of white-settler-patriarchal-colonialism, free-market capitalism, neoliberalism and globalization, I explain that because our current responses to addiction/substance-use are meted out in racist, colonizing, sexist and classist ways, it follows that they are all rooted in, reflect and perpetuate these systems and ideologies. Ultimately this explains why rather than effectively addressing addiction, our current responses maintain conditions for addiction to continue to arise intergenerationally across social locations in our province.

Indeed, rendering visible these shared roots of addiction/substance-use response and service delivery across social locations is important for several reasons. First, it demonstrates that it is largely social systems and structures that are responsible for the resulting harms of addiction/substance-use – not addiction/substance-use itself. Secondly, by noting the ways in which our responses to addiction/substance-use reflect these systems offers some explanation for their apparent ineffectiveness, given that these response systems are rooted in 'the causes of the causes' of addiction. And finally, by demonstrating that it is these systems that are responsible for not only causing conditions that lead to addiction, but also by noting how they fail to effectively resolve addiction demonstrates that dismantling dehumanizing structures that lead to addiction is more than simply an altruistic and humanitarian endeavor when undertaken by those they are designed to benefit. Rather, to participate in this work is an act of restitution, responsibility and one that this thesis argues is also in the best interests of those unjustly privileged by such systems and structures.

I begin this chapter with a section that briefly explains how white-settler-patriarchal-colonial, free-market capitalist, neoliberal and globalized systems and structures rely on oppression and exploitation of people to function, and that oppression and exploitation is normalized through the perpetuation of sexist, racist, colonizing and classist hegemonic ideologies. I then discuss Alexander's theory of dislocation which explains that living in a society shaped by these systems and ideologies creates conditions in which anyone, regardless of social location, is vulnerable to developing addiction.

In the second section, I discuss the ways in which the impacts of addiction, experiences of stigma, access and barriers that addiction-affected parents confront in pursuing treatment and recovery analyzed in chapter 5 reflect these structures and how the racist, sexist, classist and colonizing delivery of addictions responses and services actively functions to maintain our cultural and economic status quo but fail to adequately address addiction. Next, I present the ideas shared by my working/middle-class participants as programs that would effectively reduce or eliminate the barriers that they themselves confront. Finally, I conclude the chapter arguing that though more socially privileged addiction-affected parents are clearly better situated than those intentionally marginalized by these systems, my research suggests that despite their privilege, families in all social locations will continue to be vulnerable to addiction, suffer from its impacts and confront staggering barriers for as long as we allow our society to be organized by dehumanizing and oppressive overarching structures.

Ultimately this chapter discusses some of the fundamental reasons that addiction continues to abound intergenerationally in all social locations in our society by examining the ways in which our institutional and hegemonic responses and options for addiction-affected/substance-using parents are delivered in such a way that they function to maintain overarching structures of white-settler-patriarchal-colonialism, free-market capitalism, neoliberalism and globalization – thereby upholding 'the causes of the causes' of addiction. By considering the experiences and ideas of people who have lived the reality of parenting in addiction and recovery, this chapter also shines a light on some of the ways we could collectively move forward in developing holistic, accessible family models of addiction treatment and recovery. However, the implementation of such programs and policies could only be achieved by garnering the political will required to dismantle white-settler-patriarchal-colonizing, free-market capitalist, neoliberal and globalizing systems.

6.2. Settler Colonialism, Racism, Sexism and Classism are Required to Uphold Free Market Capitalism, Neo Liberalism and Globalization: 'The Causes of The Causes'

As already stated, white-settler patriarchal-colonialism, neoliberalism, free-market capitalism and globalization rely on the systematic marginalization and

oppression of many people to function profitably for those positioned at the apex of this social hierarchy (Soss, 2011). In this section, I briefly explain the institutional and hegemonic processes by which these political, economic, and cultural systems and structures require racism, sexism, colonization and classism to function, and I discuss how according to Alexander's theory, these are contributing to 'the causes of the causes' of addiction for people living in any social location of our society.

In western societies, the social constructs of "race", Indigeneity, gender and class have been designed and implemented intentionally to control who can occupy which positions in society, and the performances expected of people occupying those positions according to the social constructs each person's social location reflects. Historically imagined by white men in positions of power and influence, through various formal and informal channels, these constructs were institutionalized with their own interests in mind, and were designed to justify the exploitation of women, people of colour, the poor and working classes as well as their genocidal colonial relationship with Indigenous Peoples while naturalizing their own assumed supremacy (Bederman, 1995). While tremendous work has been done through social activism to subvert these damaging social constructs, this legacy continues through the application of unjust policies and practices that we continue to see today.

The subjugation and essentialization of women, and especially women of colour, as entirely responsible for unpaid reproductive labour, the vast majority of domestic labour in the private sphere, and disproportionately undervalued, and overrepresented in 'pink collar ghetto' and low-paid labour markets in the public sphere is a crucial function in maintaining systems of white-settler-patriarchal-colonialism, neoliberalism, free-market capitalism and globalization. Banerjee et. al explain: "With the 'rise' of the service sector and global production chains, there has been growing numbers of women workers in jobs that are less skilled [and] more hazardous…" (2007, p.8). By relegating women to performing these types of private and public work, women (and especially women-of-colour, often in developing nations) are simultaneously unvalued by and invaluable to the ongoing rise of white-settler-patriarchal-colonialism, neoliberalism, free-market capitalism, and globalization.

While women, and especially women-of-colour are the most likely to experience poverty, anyone marginalized by classism plays an integral role in maintaining these

overarching systems and structures. Because the experience of poverty makes people vulnerable and easy to coerce and exploit as they have little power or choice, they are highly valuable in maintaining the status quo. Soss et al explain:

> In capitalist democracies, the poor occupy a position that is both marginal and central to the social order…. They are incorporated in partial ways, through precarious relationships to the routines and benefits that cement social order in the broader society. Yet the contributions of people who live and work in poverty are also essential for the smooth operation of societal institutions. The burdens they shoulder are indispensable for the quality of life that most residents of developed countries have come to expect. (2011, p. 1)

Marginalizing people by imposing poverty through low wages ensured by white-settler-patriarchal-colonial, neoliberal, free-market capitalist and globalizing structures and policies make it possible to exploit people for their labour from which the wealthy benefit. And, these ends are not achieved without the widespread participation in these systems by the people they oppress. Similar to the ways in which mothers are contained (and the poor often are women, women-of-colour and mothers) there is a delicate balance that is maintained. Working people are given just enough opportunity and 'benefits' to remain somewhat pliable and amenable to participating in the current social-political-economic arrangement. They are given just enough hope with the idea of 'trickle down' economics and 'bootstraps' narratives that they might succeed – and some do - that they willingly, if not begrudgingly, participate in these systems. Meanwhile, the erosion of unions and the deportation of labour to offshore factories are just two examples of ways that free-market capitalism and globalization function to further marginalize, divide, oppress and exploit the vulnerabilities of both local and distant workers, while entrenching and upholding the overarching power and influence of the wealthy capitalists at the helms of these systems shaping our society. Ultimately, complex, intersecting factors, including institutional failures and racist, classist and sexist barriers play no small part in keeping most of the working poor both in poverty and participating in the systems that entrench their oppression.

Additionally, ensuring the ongoing oppression and marginalization of Indigenous Peoples is imperative to a settler-colonial, patriarchal, free-market capitalist, neoliberal and globalizing agenda. Indigenous Peoples present a challenge to these political, economic, and cultural forces in Canada given the claims of Indigenous Peoples to their traditional lands and rights for sovereignty. Barker explains: "Canadian society remains

driven by the logic of imperialism and engages in concerted colonial action against Indigenous peoples whose claims to land and self-determination continue to undermine the legitimacy of Canadian authority and hegemony" (2009, p. 332). Given that Canada's economy is rooted in resource extraction, and Indigenous Peoples regularly challenge Canada's authority to access said resources, it seems to be in the best interests of the settler-colonial, patriarchal, neoliberal, free-market capitalist and globalizing agendas in Canada that Indigenous Peoples remain disempowered.

Undeniably, it is those marginalized by racist, sexist, colonizing and classist policies, systems and structures whose lived experiences are the most oppressed, most vulnerable to coercion, who experience the poorest quality of life and suffer the highest mortality rates. These facts are beyond question or debate. For the purposes of this thesis, however, what is important is to recognize is that while the spectrum of suffering is massive, these overarching systems and structures create contexts in which everyone is dehumanized and vulnerable to experiencing dislocation and as such, to developing addiction.

Remember, Alexander's dislocation theory of addiction explains that in a neoliberal, free-market capitalist, and globalized society anyone in any social location can experience dislocation (a lack of an existential experience of wholeness as a person and integration into community). Because neoliberalism promotes individualism and competition, it "abstracts the individual from society" (Augoustinos et al., 2014, p. 276), devalues people and undermines their sense of belonging within society. Additionally, free-market capitalism prioritizes exponential economic growth above all other considerations, including interpersonal relationships, even leading to alienation within communities and significant social and environmental harms (Bone, 2012. P. 655). Furthermore, for countless people, globalization results in many people relocating for work and in doing so physically disconnecting from family, communities, and places meaningful to them, ultimately living a life where the forces that control resources and labour markets trump the importance of social relations and wellbeing (Chacon, 2011). Given that human beings have a deep-seated instinctual need to connect, bond and belong with each other in order to survive (Lieberman, 2014), it is no wonder that when people are separated, ranked and organized in service to economic production and material acquisition – a process that ignores one of our most essential human needs – to connect and belong within our families and broader social groups - it causes many of us,

regardless of social location, devastating pain. Alexander refers to this pain as 'dislocation' and convincingly claims that those affected often turn to addictive behaviours as an adaptation to soothe this need for connection that in this social, political and economic context is often left unmet (2008, p. 154). And again, while it is inarguable that those most marginalized by these systems and structures experience the worst conditions, everyone is dehumanized by living in a society ruled by white-settler—patriarchal-colonialism, free-market capitalism, neoliberalism and globalization as these ideologies, systems and structures reduce our inherent human value to merely our capacity for participation within this overarching paradigm. As such, it is in the best interests of everyone to dismantle such systems.

This section has briefly explained how racism, classism, sexism and colonization are crucial functions in maintaining the political, economic and cultural status quo in Canada. It has also referred to Alexander's work that explains how overarching systems and structures lead to painful states of dislocation that can result in addiction. In the next section, by considering the ways in which families in different social locations experience the impacts of addiction and/or substance-use, stigma, access and barriers to treatment and recovery in our society as analyzed in Chapter 5, I expand on Alexander's work by discussing how these current systemic and hegemonic responses to addiction/substance-use - while failing to consistently and effectively support or heal affected families, and failing to prevent the ongoing, intergenerational occurrences of addiction – they do appear to effectively uphold and perpetuate a white-settler-patriarchal-colonial, free-market capitalist, neoliberal, and globalizing paradigm, thus maintaining the political, economic and cultural status quo while propelling the cycle for 'the causes of the causes' of addiction to continue.

6.3. Impacts, Stigma, Access/Barriers to Treatment and Recovery from Addiction: Operation Status Quo

In Chapter 5, it becomes clear that the different ways in which our society systematically and culturally constructs the impacts of addiction/substance-use experienced by addiction-affected/substance-using parents, stigmatizes them, and determines access and barriers to treatment and recovery in different ways based on their social locations obviously reflects racist, classist, sexist, and colonizing policies and practices. In this section, I argue that delivering services in this way not only functions to

maintain a social, economic, political, and cultural status quo, but as such, fails to address addiction in any sort of effective way; is failing to support or heal families effectively across social locations and rather perpetuates conditions for addiction to arise intergenerationally, all the while deepening social divides. Indeed, by visibly and systemically marginalizing, oppressing, punishing, and exploiting some addiction-affected/substance-using parents for failing to contribute effectively to the economy, or for representing a threat to hegemonic norms, the obedience of others with access to more social privilege is ensured as they bear witness to, and fear the personal and family cost of addiction/substance-use experienced by those without said privilege.

As discussed repeatedly throughout, the impacts of addiction/substance-use experienced by marginalized families are often utterly devastating and unquestionably intergenerational. Indeed, despite the disproportionate experiences of criminalization and child apprehension faced by these populations, these approaches are clearly failing to stop addiction from happening, and instead seem to be propelling addiction forward intergenerationally. For example, in *"Like a lot's happened with my whole childhood": violence, trauma, and addiction in pregnant and postpartum women from Vancouver's Downtown Eastside,* Torchalla et al explain: "Women from the DTES …have high rates of pregnancy and poor pregnancy outcomes [19,20]. Studies among mothers living in poverty found that histories of abuse and maltreatment were associated with greater psychological distress and drug use severity [21], low parenting satisfaction and physical punishment and neglect of their own children [22,23]" (2015, p. 2). Clearly, mothers living in poverty have experienced disproportionate levels of violence and trauma in their own histories and within the context of current addiction/substance-use responses and service delivery and remain vulnerable to perpetuating those cycles of abuse forward with their own children.

While the experiences relayed by participants regarding the impacts of addiction on their family lives were not as dire, they were not without serious implications. Recall the impacts of addiction expressed in Chapter 4 address issues related to some participants' self-perceived ability to meet the optimal daily needs of their children, and they also expressed a lack of ability to maintain positive relationships with their children during active addiction. These impacts of addiction are indeed damaging and represent potential intergenerational consequences given the importance of building secure parent-child attachment for long-term health outcomes of children. According to Haskell

“Children who have experienced ongoing abuse, parental misattunement and neglect develop a view of the world that incorporates their betrayal and hurt” (2012, p. 18). This suggests that the ways in which children experience interactions with their parents shape their expectations for future relationships with others as well as their greater understanding of the world around them. Even within their more privileged social locations, the participants in this study expressed concerning impacts to their parent-child relationships because of addiction. As such, children raised by addiction-affected parents in any social location are more vulnerable to experiencing dislocation and thus addiction in their attempts to soothe themselves, than those who are raised with secure attachments to their parents.

In addition to the systemic and psycho-social impacts of addiction in addiction-affected families is the perpetuation of stigma that clings to populations without the privilege of privacy. An important feature of stigma is that it enables white-settler-patriarchal-colonial, neoliberal, free-market capitalist, and globalizing systems to appear innocuous, naturalizing an us/them dichotomy. ‘Us’ being those positioned to embody and perform hegemonic social norms easily as expected, who use their centralized voices to point blame at those (‘them’) who, for various reasons, do not embody or perform social norms and as such are positioned on the margins. This dichotomy naturalizes the marginalization of populations framed as deserving of their oppression, hence the specific discourses relating to the impacts of addiction/substance-use reserved for Indigenous Peoples, other racialized populations, women/mothers, and those living in poverty. Morone argues, “the divisions between us and them run much deeper than the simple question of citizenship. Cultural images—stereotypes—of criminals, addicts, and loafers identify whole populations as threats to the community. Over American time, the stigmas have been read into race, ethnicity, religion, and class” (1997, p. 994). Indeed, stigma has a profound effect on the experiences of those who have been stigmatized, as well as on those who work to actively avoid becoming stigmatized.

In fact, the way that stigma is generated and perpetuated at a social level toward people who do not embody or perform according to (colonizing, classed, racialized and gendered) social norms, makes it a tool for social control with several effects. First, stigma harmfully naturalizes the systemic impacts and risks of addiction within marginalized populations, such as those described previously, by advancing the

impression that these populations are causing their own problems. Second, this 'naturalization' effect then functions to both justify and divert attention from the ongoing systemic and structural oppression and abuse of individuals within these populations when in fact, stigmatizing ideologies become reified through the colonizing, racist, sexist and classist policies, systems, structures that *actually* create and enforce the contexts that shape the ways in which they perform and experience addiction/substance-use.

Additionally, and as this thesis has shown, naturalizing addiction with specific impacts at particular social locations is a false conflation that perpetuates a misconception about what addiction is, looks and feels like. Addiction can change the social location of the sufferer, for example, a middle-class person's addiction can become so severe that they are no longer employable, and thus become vulnerable to the impacts of addiction associated with poverty[63]. As explained previously, it is the socially constructed position of what it means to be 'poor' that then informs those impacts, not addiction itself. Where it might be the condition of addiction that is, at least in part, responsible for the sufferer's inability to remain employable, our society's overarching systems and structures determine how poverty is experienced and how addiction in 'poor people' is treated. However, Alexander describes addiction as a continuum and explains that people can be suffering invisibly from addiction. He states: "in the middle of the continuum, addicted people strive to maintain a double life, which produces the appearance of normal psychosocial integration more or less successfully" (2008, p. 35). And this continuum is informed and shaped by the causes Alexander cites for addiction: neoliberalism, free-market capitalism and globalization - and as I argue additionally: white-settler-patriarchal-colonialism.

Looking back to the 'Impacts of Addiction' section in *Chapter 4: Findings*, none of the study's participants who experienced active addiction while parenting[64] identify impacts of addiction relating to street-entrenched poverty, homelessness, violence, or

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[63] It is also important to note that the prohibition and deregulation of some substances can also effect people's ability to maintain their lives if the substance they use and depend on (but are not necessarily 'addicted' to) suddenly changes. For more on the differences between 'addiction' and 'substance dependence' see Alexander (2008, Chapter 2: Addiction1, Addiction2, Addiction3, Addiction4)

[64] Remember, some of the participants became parents after beginning their recovery, therefore this statement refers only to the experiences expressed by those who parented while in active addiction.

criminalization. Indeed, the idea of what addiction is, is so often blended within images of poverty, criminality, violence etc. that some participants did not even recognize that they were suffering from addiction. Harriet explains her struggle with identifying herself as an alcoholic when what she was doing did not look like how she had come to expect addiction to present: “I’m not living under a bridge, I’m not drinking at work, I’m not drinking in the morning, I’m not violent when I’m drunk…” (T2-14). Therefore, the conflation of addiction with homelessness, poverty, violence, criminalization etc. not only harmfully perpetuates the naturalization and stigmatization of people experiencing these social conditions, but also harmfully enables ongoing denial in addiction-affected people who are not otherwise socially marginalized; the idea that if a person is still working/employable, they must be fine.

Again, the impacts the participants describe in Chapter 4 relate mostly to their relationships with their children – that addiction prevented them from being emotionally present, and that this harmed their ability to connect with and care for their children in the ways they would have liked. The harmful stereotypes and misinformation related to what ‘addiction’ is, could be contributing to this suffering. Paisley regretfully recalls: “I manipulated them because I always thought that if they would just behave themselves then I would be ok” (T7-6). Because addiction was causing Paisley to suffer, her ability to nurture her children was harmfully impacted, however because of this family’s social location, their suffering was largely invisible and may have been prolonged because it did not resemble the more common and misleading widespread representations of ‘addiction’.

While the impacts of addiction and addiction-related stigma experienced by parents clearly fails to prevent addiction from arising, and rather exacerbates harms by driving families into hiding because of fear and shame, thus increasing the likelihood of intergenerational addiction and harm, the public/private pathways to treatment as described in Chapter 5 make the political, economic, and cultural agendas that shape our current delivery of these services even more obvious. Recall, the participants of this study overwhelmingly express that residential addiction treatment is beyond their means as working/middle/upper middle-class people - unless treatment is paid for by their employer, attending is often beyond their reach. Or if accessed, can lead to years of debt repayment as was the case for Lucille’s family. Meanwhile, though marginalized addiction-affected families can access treatment through the public pathway, often, they

first suffer the painful and traumatic experience of child-apprehension and even homelessness before they can attend. When we remember that experiences of addiction and options for recovery are experienced differently at intersections of “race”, sex and class, and that these indicators are social constructs erected to sustain overarching systems of white-settler-patriarchal-colonialism, free-market capitalism, neoliberalism and globalization, it appears as though the private/public pathways and related experiences of access are shaped as such to serve one of two social functions: 1) parents are able to return to work and thus contribute to the economy with the reward of having their children remain in, or returned to, their care or 2) they are unable to recover, access appropriate housing, employment, or care for their children and thus function as a stigmatized example that keeps less marginalized people obedient to the status quo. Delivered as such, whether by intentional design or not is beyond the scope of this thesis to determine: treatment appears to be less about healing and promoting psychosocial integration, and instead about ensuring obedience to participating in the economy, either directly as a worker, or indirectly as a stigmatized example of what happens to those who are not able to sustain employment and toe the line. As discussed in Chapters 1 and 3, there is substantial empirical evidence of the trauma and harm that children experience and embody because of state-mandated removal from their parents, and that such trauma often leads to intergenerational cycles of addiction. Indeed, the ongoing poisoned-drug crisis, as one example, is ample evidence that current systems and governing bodies that respond to addiction, such as the justice system, child-protection agencies, and the healthcare system itself, are failing to quell the problem of addiction.

And while many people, in all social locations, are able in one way or another to recover from addiction, the barriers to recovery for families remain especially staggering. Because the participants in this study have all attended 12-step programs as a part of their recovery, and because 12-step programs are one of the most accessible models of recovery available, here I will discuss some of the benefits of attending these groups – primarily their aptitude for promoting psychosocial integration, as well as some aspects that make them problematic as they too, at least in some ways, seem to perpetuate the political, economic and cultural status quo.

Founded in 1935, Alcoholics Anonymous began as a peer-led group of recovered alcoholics serving active alcoholics desperate for relief by taking them through a 12-step

program that promises recovery. Briefly, the 12-step program requires participants to admit to their powerlessness over the drug/behaviour causing distress; submission to a self-determined 'higher power'[65]; ongoing self-examination with the aim of developing personal and social accountability; ongoing spiritual connection to said higher power; and ongoing service to other alcoholics/addicts in pursuit of recovery. Since its inception, the original 12-step recovery program has inspired at least 34 other 'anonymous' support group variations, all addressing addictions to particular substances and/or compulsive and destructive behaviours. Because membership is anonymous and the society is largely unorganized by design, it is difficult to determine the success of such groups. However, current estimates put membership at over 2 million people in AA alone[66], and there are approximately 63000 NA meetings in 132 countries. Therefore, this modality of recovery seems to offer something that attracts addiction-affected people in search of aid.

To begin, I will review the concept of psychosocial dislocation and integration. If addiction does indeed result from dislocation, then it naturally follows that an integral aspect of recovery should be psychosocial re/integration. Alexander describes psychosocial integration as:

> a profound interdependence between individual and society that normally grows and develops throughout each person's lifespan... Psychosocial integration is experienced as a sense of identity because stable social relationships provide people with a set of duties and privileges that define who they are in their own minds.... Psychosocial integration makes human life bearable and even joyful at its peaks. Moreover it is a key to the success of the human species, which flourished by simultaneously evolving close cooperation and individual creativity. (2008, p. 58-59)

And while Alexander suggests that ongoing participation in 12-step recovery groups can represent an alternate, though less harmful addiction, rather than a true form of psychosocial integration (2008, p. 341), participants in this study claim otherwise.

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[65] Though AA was inspired by the Oxford Group, a Christian organization, the founders of AA were very deliberate in making AA a spiritual rather than religious program, therefor anyone of any or no religious belief is welcome. And while it is beyond the scope of this thesis to go into detail, it is important to note that echoes of Christian belief systems are evident in the structure and language of the 12-step program, and can often be a site of struggle and even a barrier for incoming members with different beliefs, or for those abused within Christian institutions, for example.

[66] Retrieved from: https://www.aa.org/pages/en_US/aa-around-the-world

Regarding the 12-step program, Spencer states: “it provides people with that connection… that community.” (T4-9). And Maren explains how her connections with others have deepened as a result of being in recovery: “the community I’ve built, …friendships I have now, are sort of prefaced on… vulnerability. When that perhaps before it wasn’t...” (T3-5). For Amelia, membership in recovery groups has brought her a sense of belonging she’s never experienced before. She explains: “Being with people in recovery is a whole different life for me… that stigma is not there at all. The understanding of being similar, or the same as someone else after feeling that I don’t belong for so long… nobody’s better than another in that room” (T1-5). This feedback suggests that 12-step recovery groups, by promoting connection and creating communities of people, at least as experienced by the participants in this study, do in fact enable psychosocial integration and affirm that it is a significant part of maintaining ongoing recovery from addiction.

However, not everything is perfect in 12-step recovery groups. In addition to the barriers of access that result from having children as reported in Chapter 4, participants offered several other critiques of this model of recovery. For example, both Maren and Spencer take issue with 12-step recovery groups conceptualizing addiction through the disease/medicalization model. Maren states:

> the medicalization of addiction, the disease model, although it does access more compassion and it’s a way in, kind of like how getting a mental health label is how you actually get help to access resources. You can’t do it without it... But at the same time, it’s still, it fits into the fucking wheel of now you need an expert to fix you and to give you your medicine, which they’re going to sell you, and now your addiction has become a commodity, and that they’ll sell back to you the solution, which is kind of the problem in the first place... (T3-11)

Though AA does not profit from its services, it’s continued conceptualization and perpetuation of addiction-as-disease framework informs most treatment programs available that do profit as a result, and as such are part of the free-market economic system. To this end, Spencer remarks: “one of my real problems right now is with people who capitalize the 12-step model… I think that really poisons the well” (T4-15). And while Spencer says that 12-step groups played an integral part of his early recovery, the foundational philosophies of these organizations that, in fact, he identifies as neoliberal, no longer fit with his own. He explains:

> 12 step –the disease model of addiction, powerlessness, um, you know the kind of… Christian fundamentalism of 12 step – you know, service, those kinds of things… I believe that that kind of thinking is similar to how drugs had run their course… I believe that kind of thinking has somewhat run its course in my life today… It provides people with that connection …that community. …But that community is predicated on some things that I don't agree with as much anymore. …That idea that if things aren't going well for you, you need to work harder, which are very neoliberal, very much, meritocracy – that kind of thinking, meritocratic thinking. That's part of it – the part that I find it difficult to accept now. (T4-8)

Indeed, the disease/medicalization model of addiction not only perpetuates some of the systematic responses we witness in our systems and structures, as described in Chapter 5, but simultaneously absolves them of contributing to the problem of addiction by individualizing this condition.

Additionally, while the informal and unprofessional peer-led model of recovery has many benefits, including the fomentation of organic communities, uninhibited by the limits of professional ethics, such a model also leaves space for vulnerabilities to be exploited. Unlike others who have found a sense of community and even family in the rooms of 12-step groups, Clay states: "I don't really connect with people in the rooms…. Do I surround myself with people um, in recovery? I'm pretty careful with that. Pretty careful… there's a lot of really sick people" (T8-7). Maren also feels that 12-step groups are not always a safe place to process core issues. She says:

> I hadn't attended open [meetings] for a while just because I think that I hit a point where it got really deep – the stuff I was walking through was quite core and vulnerable. The vulnerability was quite large and I think all those general meetings, as powerful as they were for the beginning, once it started to get truly vulnerable for me – not some drug that was outside of me that I was framing everything through but, me, I found it really hard to participate. I guess I had to make it a little more safe for myself. (T3-12)

As such, though 12-step recovery groups offer opportunities for connections, communities to form, and thus for psychosocial integration to occur as an important aspect of healing for many addiction-affected people, this is not achieved without a certain degree of risk, given the unprofessional nature of such sites, and suggests that safe, professional therapeutic interventions ought to be accessible for people who both need and want them.

As discussed in Chapter 5, 'recovery' does not speak exclusively to the abstinent variety expected by participation in 12-step groups. Indeed, harm reduction models of recovery conceptualize 'recovery' as sustained, improved quality of life regardless of whether substance use has halted. However, this thesis would be remiss if I fail to acknowledge the targeted demographics of such interventions. Indeed, these services have been hard-won protections for those most marginalized and vulnerable to punitive impacts of addiction/substance-use. And while harm reduction services have the capacity to advance recovery for addiction affected people, and are crucial for reducing the many harms of substance use in the context of prohibition, they do not replace evidence-based therapeutic approaches that remain inaccessible to those who lack the personal resources necessary to purchase them. This two-tiered delivery of services once again confirms the overarching ideology that equates human worth and being deserving of health and wellness with one's capacity for economic productivity and social obedience.

To understand how the range of experiences of addiction/substance-use-related impacts and stigma, access and barriers to treatment and recovery endured by addiction-affected/substance-using families in different social locations described in this section are examples of the secondary causes in 'the causes of the **causes**', imagine, if you will, that all these secondary causes exist on a spectrum. At one end are those experienced by the most marginalized and vulnerable populations, and at the other are those experienced by those who have the most access to resources and the privilege of privacy. The spectrum itself exists because of, and is shaped by the primary causes, or, the '**causes** of the causes' of addiction: white-settler-patriarchal-colonialism, free-market capitalism, neoliberalism and globalization. On the marginalized end of the spectrum are the secondary causes resulting from high exposure to social stigma and harmful, exclusionary, and punitive policies and practices for experiencing addiction/using substances while marginalized, and on the other side is often suffering in isolation when experiencing addiction[67] while accessing the privilege of privacy. And while the spectrum is a complicated, nuanced, and intersecting space of various experiences of secondary

[67] I only point to 'addiction' and not 'addiction/substance-use' here to remind the reader that people with social privileges are less likely to experience consequences and suffering from merely using substances in the ways that marginalized populations do whether or not they are truly 'addicted', but that such socially privileged populations do experience the pain of dislocation or addiction regardless of social location.

causes that shape experiences of addiction/substance-use, and while the experiences of the more marginalized end of the spectrum are inarguably and significantly more oppressive and harmful[68] than those who are protected by privilege, it is important to note that while existing on this spectrum, no one is 'winning', and everyone is at some level of risk.

Indeed, despite the ways in which their lives appear to have been *served*[69] - at least in some ways - by systems of white-settler-patriarchal-colonialism, free-market capitalism, neoliberalism, and globalization as working-middle class people, the participants of this study still suffered - and for those who had children during their active addiction: their children still suffered - because of addiction. Despite the various privileges they enjoyed, their families were still impacted by addiction. Their children - though shielded from social stigma, from criminalization, violence, poverty, and homelessness – presumably did not come through entirely unscathed. And while none of these participants are so socially privileged as to identify as 'rich capitalists', Alexander asserts: "dislocated people suffer *even if* they are rich capitalists" (emphasis mine) (2012, p. 1476). At least theoretically, like those in marginalized populations, the secondary 'causes' of their suffering can be traced to the same primary 'causes': overarching cultural, political, ideological, and economic systems and structures. As such, the important distinction this section makes is the different ways in which addiction-affected/substance-using parents are punished and/or rewarded in terms of the social and systemic impacts of addiction/substance-use they suffer and/or avoid based on their ongoing ability to conform to, embody, perform, obey and participate in perpetuating the socio-economic status quo and their gendered social relations within them.

Read together, this section argues that current systemic responses to addiction, the perpetuation of stigma, the options available for treatment and recovery are consistently at best, failing to meet the needs of families, and at worst are actively creating contexts for addiction to flourish intergenerationally in our society. Instead of

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[68] excepting maybe death from overdose, which is happening at all locations on the spectrum -

[69] This speaks especially to my 9 participants who identified as 'middle class', less so for my participant who identified as 'low-income working class' who, rather could perhaps identify more with the section that speaks to poverty as a function of neoliberalism, free-market capitalism, and globalization.

preventing or healing, current systemic responses and models of service delivery appear to maintain a political, economic, and cultural status quo – a status quo that is cited as creating the conditions for addiction to arise in the first place. Meanwhile, research shows that effective harm reduction measures such as housing first initiatives and more funding for biological parents[70] will keep families together and reduce the cycle of intergenerational trauma mentioned previously. This begs the question: why do we continue to fund such institutions that perpetuate these expensive harms? Clearly, our current delivery of addiction/substance-use responses and service options for parents are failing to adequately resolve addiction regardless of social location, but certainly seem to contribute to cementing the social order.

In this section I have teased out the ways in which some of the social determinants of addiction/substance-use play out in the lives of marginalized populations to both maintain their oppression while also maintaining the obedience of more socially privileged populations which in turn perpetuates the production and reproduction of the white-settler-patriarchal-colonial, neoliberal, free-market capitalist, and globalizing status quo. I have illustrated how the oppressive, punitive, and stigmatizing functions of these systems keep more socially privileged people in denial and hidden by their privilege of privacy. And, I have argued that the stigma and structural inequality that cause such devastating and unjust impacts for marginalized addiction-affected/substance-using families, though significantly less damaging for working/middle/upper middle-class families, simultaneously perpetuates the conditions for dislocation and addiction to arise in more privileged populations as well. I have also discussed how the perpetuation of these agendas as central to the delivery (or not) of public and private pathways to residential addiction treatment for addiction-affected parents. I have also considered some of the merits and flaws of the 12-step recovery group modality as expressed by research participants as these relate to issues of psychosocial integration, but also perpetuate ideologies related to neoliberalism and free-market capitalism. I have argued that while these groups promote psychosocial integration for many, they are not without shortcomings. And I have pointed to the value of harm reduction as an incredibly valuable approach to supporting those affected by addiction but maintain that the necessity of such an approach is evidence of the classed, racialized, colonizing and

[70] Retrieved from: https://thetyee.ca/News/2019/06/06/Struggling-Families-Foster-Parents/

gendered systems that divide addiction-affected people according to social location. I have made the link between the experiences of the working/middle/upper-middle classes and marginalized populations clear: as long as we allow systems that prioritize economic gains over the welfare of people, as long as we justify systems that oppress and marginalize people to exist because they benefit some, everyone will remain dehumanized and vulnerable to dislocation and addiction. As such, it seems the best hope for working/middle/upper-middle class people is actually to support social justice aims alongside those marginalized by "race"/Indigeneity, class and sex, as the dismantlement of dehumanizing social and economic structures stands to benefit everyone in our society.

6.4. Participant Ideas: Family Models of Addiction Treatment

The previous section made it clear that current responses to addiction are failing to meet the needs of many addiction-affected/substance-using families in all social locations across BC because, in addition to being largely inaccessible for families, such responses are rooted in the same systems that create the social context for addiction to continue to arise and substance-use to remain dangerous. As discussed in Chapter 2, an important method in developing policies and services for specific populations requires direct consultation with those populations. As such, this section presents the ideas generated by the participants of this research project that they believe, as grounded in their own lived experience, would reduce barriers to treatment and recovery for addiction-affected parents of dependent children. And, these ideas suggest support for a shift away from the current paradigm toward a more socially equitable society.

I begin by identifying the sorts of programs participants would like to see. Next, I discuss policy changes that participant believe would reduce barriers they confront as a result of our current addiction services delivery. However, the reader will note that in the current white-settler-patriarchal-colonial, free-market capitalist, neoliberal and globalized paradigm, these ideas would gain little traction without a significant shift to said overarching political, economic, ideological, and cultural paradigms. However, given that the participants share similar social locations as people who enjoy relative social privileges, and who also, within this thesis have identified how despite these privileges, the wellbeing of their families remain at stake where addiction is concerned, there could

exist a site for solidarity across social locations to unite in a shared effort to dismantle the systems and structures that perpetuate widespread dislocation in our society. As such, following the discussion of participant ideas, I suggest that to effect the changes necessary to create and implement such accessible and family-friendly treatment programs and policies, and to hope to recover from and prevent the ongoing spread of addiction at a widespread social level, an important strategy for the working/middle/upper middle-class addiction-affected families is to support the efforts of existing activist movements that aim to dismantle policies, practices, institutions, systems and structures that perpetuate the oppression of any humans.

In Chapter 4, the barriers to treatment and recovery programs that were often repeated by research participants result around separation from their children, and the cost of attendance. When asked what would make treatment and/or recovery more accessible for them, several participants suggested program ideas that include children and/or childcare. For example, Harper would like to see a recovery community centre implemented with daycare included. She describes her idea as follows:

> a recovery community centre … where people who are in recovery can go and socialize, hang out, have some coffee, maybe go to a meeting – there would be meeting spaces there if they want to go, but really just to go and hang out in a safe recovery area... it would really great to have meetings with daycare …on site… because what will happen is people will bring their children and that child is disrupting the meeting and the mother is unable to get the, you know, the therapeutic value of the meeting cause they're worried about trying to keep the kid quiet the whole time, you know and it's not effective at all. (T2-20-21)

Maren similarly addresses the connection between the demands of parenting, providing, and engaging in recovery and the impact that exhaustion can have on addiction-affected parents. To support parents in meeting these many needs, she also suggested the idea of forming recovery communities:

> I think that, ideally I would love to see, um, communities – like recovery communities, so when you enter, you have that space but then you can integrate your family into your life, but you're still supported and you're still given resources for people to, you know, watch your kids while you go out to the meeting, and you don't have to work so you're gone all day and got nothing for yourself. Like that grind – I'm not saying that you don't work, I'm saying that there's support for people to parent... without getting to that stuck place. (T3-10)

It is very important for the people developing addictions policy, treatment, and recovery programing to understand the weight of the responsibilities that addiction-affected parents to dependent children must balance in their pursuit of recovery. On the one hand, they are in the grips of a potentially deadly condition that requires time and attention to address. On the other, they also have the very immediate needs of their children that require constant attention. As my participants attest: the struggle is real.

Continuing in this vein of considering and including children in programming, several participants specifically emphasize the importance of integrated family programing for effective recovery within the family system to take effect. Paisley imagines a treatment program connected to a supportive housing model in which entire families can recover together over time. She describes her idea here:

> You know… what I would have totally gone for is something like a, an apartment type of complex – the family moves in, there's a common area somewhere in the building where treatment is given, so you come down for meetings…. it's a year program, family moves in and the parents and the kids if they want it, have some sort of learning time, 12 step meetings… (T7-21-22)

In fact, this suggestion closely mirrors the concept already being implemented by the two family-models of residential addiction treatment previously described that are available to Indigenous clientele at the Kackaamin Family Development Centre and Nenqayni Wellness Centre Society. Again, in the case of Indigenous programming they are not only addressing the harms of addiction itself, but the intergenerational trauma and dislocation that Indigenous Peoples continue to suffer because of colonization. Paisley's suggestion addresses two important needs some families seeking recovery confront: a need for safe and stable housing, and the opportunity to engage in treatment and recovery together.

Paisley also suggests a live-out type of psycho-educational program in which all members of an addiction-affected person's family may attend to learn and understand not only what addiction is, but also how to recover from its ravages as a family, and to develop healthier parenting techniques to lay a groundwork for improved parent-child relationships moving forward. She explains:

> [What about] an evening class… Like, something, that it is a treatment program, but it doesn't take me out of my life as it is, but allows me to be somewhere that is safe to learn the things I need to learn to

> understand my disease[71]…. I say that because my children are learning recovery by watching me. … one of my struggles as a parent is wondering if I'm doing it right, - am I being a good parent? (T7-20-21)

And Lucille, whose partner is addiction-affected and attended an individualized model of residential treatment, believes that she and her children would have benefitted if given the opportunity to receive treatment as well. She claims: "if there was a program that all of us could have gone to, and I don't necessarily mean like, with [her partner's name] - like our own program - would have been amazing" (T10-9). Ultimately, though the participants of this research project brought different ideas and conceptualizations of how integrating families into treatment and recovery programs would look, they all agreed that to do so would reduce barriers and relieve the stress of balancing the responsibilities of children with the work of recovering from addiction.

As inspiring as these ideas are, a major barrier to their implementation is not only the cost that such programming would demand, but the necessary shift in social values that would justify the expense. Indeed, our society would have to collectively decide that the wellbeing and healing of families is more important than maintaining our current economic system and distribution of wealth. Maren's comments echo this sentiment regarding what she thinks would be an important shift to our current policy and funding decisions. Indeed, her suggestions for policy changes that would not only significantly improve the lives and chances for recovery in addiction-affected parents, but also the quality of life for all parents. She states:

> I'd like counseling, and counselors and mental health covered by MSP, not just psychiatrists and medical…I'd like that to be ongoing and connected in lives. I'd like to see childcare be completely funded or incredibly affordable. I'd like to see student loan and all that process of education be accessible to everyone absolutely, encouraged, open. I would like to see a living wage be there. Like, really? I would like to see families, instead of tightening the whole stress, pressure, money, noose, I would like to see that expanded to really support a more socialist, social focus. (T3-11)

Here Maren has linked so many aspects of life faced by all young families in our society to addiction. The current lack of accessibility to these basic services and opportunities

[71] While this thesis and some participants reject the medicalized/disease model of addiction, some participants do conceptualize addiction in this way. It is important to demonstrate the scope of self-perception and self-identification related to this issue to adequately capture nuance and respectfully represent its complexity.

encountered by so many families are a result of white-settler-patriarchal-colonial, neoliberal policies, free-market capitalism, and globalization. Maren's statement really paints a picture of the day-to-day stresses parents confront just from trying to get by. As such it is no surprise that many parents use substances and engage in other, sometimes harmful, compulsive behaviours to cope – it has even become culturally accepted, if not expected[72] - and as a result sometimes become addicted. As such, changes to social policies that reduce the costs of childcare, tuition, etc. would not only improve the quality of life for the many families impacted by these staggering costs, but could also reduce the spread, and intergenerational impacts of addiction in families.

However, the political will that would be required to truly institute equitable social and economic policies for families would require a significant ideological, political and economic shift. Maren addresses this issue directly here: "Well, the thing is, I think you don't heal society until you start prioritizing the people in societies, and the earlier you … support [people] the better your outcomes" (T3-10). Indeed, our current social arrangement under the auspices of white-settler-patriarchal-colonialism, neoliberal, free-market capitalism and globalization are failing to prioritize the wellbeing of many people in our society, and addiction appears to be one result.

Ultimately, these overarching systems and ideologies that rely on the racist, sexist, classist and colonizing processes and policies to function are responsible – at least in part - for not only the occurrence of addiction, but also the failure to treat addiction consistently and effectively in families across social locations because of the barriers inherent to these responses as long as they remain entrenched in these systems. In fact, I would further suggest that current addiction responses appear to be responsible, at least in part, for perpetuating intergenerational instances of addiction given the psychosocial impacts that result of the current tiered delivery of services as documented by my research. As such, it seems that an important strategy for long lasting effective change for all families affected by addiction in our society is for working/middle/upper middle-class addiction-affected families is to support the efforts of existing activist movements that aim to dismantle policies, practices, institutions, systems and structures that perpetuate the oppression and marginalization of any

[72] Here I am referring to many tropes including that of moms and wine, ie. 'Wine o'clock' etc. For example, see: https://www.theatlantic.com/entertainment/archive/2016/05/the-women-and-their-wine/482412/

people, and that we ought to demand equitable, accessible, holistic, family-centred options for treatment and recovery for all addiction affected families that want access to such supports.

6.5. Conclusion

In conclusion, this chapter has discussed ways in which sexist, racist, classist and colonizing impacts of addiction, stigma, access and barriers to treatment and recovery for all addiction-affected/substance-using families are rooted to and function to perpetuate the white-settler-patriarchal-colonizing, free-market capitalist, neoliberal and globalizing ideologies, systems and structures that Alexander cites as causing dislocation and subsequently, addiction. I started this chapter by illustrating the ways in which these systems, structures and ideologies require the oppression and marginalization of some to function, and that this marginalization is done at intersections of “race”/Indigeneity, gender, and class. I reminded the reader that because such structures are inherently dehumanizing, everyone, including those unjustly privileged by said structures are rendered vulnerable to experiencing dislocation, and thus addiction as a result.

In the section that followed, I discussed the ways in which families in different social locations experience impacts of addiction/substance-use, stigma, access and barriers to treatment and recovery in ways that fail to effectively resolve addiction, but successfully maintain the current political, economic and cultural status quo. While I have consistently iterated that the experiences of addiction suffered by working/middle/upper middle-class people, such as the participants of this study, are inarguably less dire than those marginalized by these overarching systems and structures, their experiences remain linked as everyone within this paradigm is reduced to a greater or lesser value which is determined by their potential capacity for economic production rather than inherent human worth. In the final section of this chapter, I presented the ideas offered up by project participants as programs that could reduce or eliminate barriers to treatment for addiction-affected families, promote psycho-social (re)integration and even the possibility of intergenerational healing. However, given the economic ethos of the overarching ideologies, systems and structures that currently shape our addiction services, I explained the unlikely widespread implementation of such programs without a radical ideological, political and economic shift. As one

solution, I argue that working/middle/upper middle-class addiction-affected families ought to concentrate their efforts by backing the aims of those actively working to dismantle systems of oppression, as doing so is in their own best interests, despite their access to the unearned privileges attributed to their social locations. As we shift our culture to one that prioritizes the healing, wellness, and value of all humans, we might also implement systems and programming that will support families recovering from addiction and that as a result, may also reduce new cases of addiction from arising.

Chapter 7.

Conclusion

Addiction/substance-use continues to be one of the most pressing health and social concerns of our time. Addiction is a condition that cycles intergenerationally in families, wreaking havoc and devastating lives. But as this thesis has shown, it is not just the condition of addiction itself, but rather the ways in which our ideologies, policies, and social systems have been constructed to respond to addiction and substance use that create the contexts in which much of this devastation in families occurs. Indeed, this thesis has pointed to the sexist, racist, classist and colonizing ideologies, policies and practices that maintain the marginalization, oppression, and discrimination of families in some populations. And, by contrasting these experiences drawn from secondary sources in the literature with those shared by the more socially privileged parent participants in this study, and examining the ways in which families are funneled into a two-tiered public/private addictions response/service-delivery system based on a person's economic productivity, it becomes clear that all of these experiences, though starkly and unjustly different, are all detrimentally shaped by ideologies and policies entrenched in white-settler-patriarchal-colonialism, free-market capitalism, neoliberalism and globalization. By highlighting some of the patterns in the impacts of addiction/substance-use, experiences of stigma, and the access and barriers to treatment and recovery that addiction-affected parents face in different social locations, I have argued that rather than effectively addressing this rampant health and social problem, our current tiered responses to and options for addiction-affected/substance-using parents functionally perpetuate the very structures that Alexander convincingly claims to be causing dislocation and ultimately, addiction, in the first place.

Though my primary data is admittedly drawn from a small number of people, the qualitative methodological design of this study enabled deep conversations with participants regarding their addiction/stigma/treatment/recovery-related experiences that ultimately revealed patterns that appear to be tied to their common social locations. Because all the study participants identify as white/white-passing and working/middle/upper middle-class parents - demographics mostly absent in addiction-related literature - I had the opportunity to view this problem from a unique perspective.

The patterns of experience that became apparent through our interviews were so stark that they shifted the entire focus of this project – a shift made possible by its qualitative design. Rather than investigating the specifics of what new programs might be developed to reduce barriers for addiction-affected parents, what became overwhelmingly clear is that the current barriers to addiction treatment and recovery for families runs much deeper, pointing instead to considerable flaws in our entire current social, political, and economic organization in BC. Though it was obvious that the participants' positions of relative social privilege has shielded many of them from some of the more brutal impacts of parenting in addiction and recovery from addiction, coming to understand how and why that is has enabled an important lens for understanding that it is less that addiction that leads to social harms, and more that it is social structures, maintained by harmful recycled ideologies, that create and maintain the contexts in which these harms are made possible, experienced and perpetuated intergenerationally in families.

By studying the literature related to the social determinants of addiction/substance-use, examining other qualitative studies, learning about the different ways that addiction is conceptualized in the literature and by searching for information and studies related to family models of residential treatment as well as the experiences of middle-class addiction affected families, it became clear that there is a gap in the literature that explains how these experiences are tied, what programs and policies are lacking as well as those that are causing barriers and ongoing harm. In Chapter 4, I presented my findings, which on their own, offer a contribution to the literature regarding the experiences of white/white-passing, working/middle/upper-middle class parents who experience addiction. My findings point to some of the impacts of addiction that are suffered by these families and express the barriers parents confront when attempting to access treatment and/or recovery. This chapter also speaks to the invaluable aspects of recovery that are applied and that seem to benefit families intergenerationally when accessible, thus indicating that there could be tremendous societal value by ensuring that addiction-affected families can identify, choose and access a variety of models of treatment and recovery suited for their personal contexts.

Additionally, by utilizing the combined intersectional and comparative analyses in Chapter 5, I argued that while the experiences of all addiction-affected/substance-using parents are to some extent unique as we are all active agents in our lives, the systems

that shape the contexts of these experiences unquestionably arise from the racist, sexist, classist and colonizing ideologies that inform our current policies and practices, and these have profound impacts on the lives of addiction-affected/substance-using families in different ways across different social locations. Finally in Chapter 6, by pointing to the different ways that these varied experiences are meted out by said racist, sexist, classist, and colonizing systems, I have explained how they interact in different ways depending on social location to uphold overarching systems and structures of white-settler-patriarchal-colonialism, free-market capitalism, neoliberalism, and globalization through punitive, divisive, and obedience/status-quo-maintaining measures. While addiction-affected parents who are socially-situated in positions of privilege inarguably experience less extreme impacts of addiction/stigma and are in a better position to access treatment/recovery with fewer instances of criminalizing and traumatizing systemic interventions, I argue that all the while we continue to participate in and uphold systems and structures that horrifically oppress and marginalize some, and dehumanize us all, we will all continue to be at some level of risk for becoming dislocated and resorting to addictive behaviours to cope.

In conclusion, my thesis has contributed to the body of work that emphasizes psychosocial integration as a necessary aspect of treating addiction and has proposed that family-accessible models of treatment and recovery should be one part of a multi-pronged approach to resolving the addiction problem in our society. By identifying and discussing some of the ways in which more socially privileged families are harmed by current practices, my hope is to contribute to mobilizing the political will to effect change; not by conflating such harms with those rained down upon marginalized families, but by illustrating the ways in which our collective human worth will remain undervalued and under threat so long as we collectively permit the dehumanization of any population.

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Appendix A.

Participant Social Indicators

Gender:

6 Female

4 Male

Economic Class:

1 working class

8 middle class

1 upper-middle class

Sexual Orientation:

9 heterosexual

1 bisexual participant in heterosexual marriage

Marital Status:

8 married

1 common-law

1 single

Ethnicity:

8 caucasian

1 caucasian and Japanese

1 Indigenous[73]

[73] This participant is Indigenous and lives off-reserve and is white-passing, which is important to note in the context of this thesis because though this participant is unquestionably Indigenous, she claimed "I don't feel like I have experienced the trauma that many First Nations people do". Because this thesis analyzes the way in which people's experiences are shaped by racism entrenched within systems, it is important to acknowledge that even when people are not Caucasian, they may have access to 'white-passing privilege' which is what this participant reports.

Participant Age Range:

37 – 61 years

Years in Recovery:

2 – 22 years

Participants with dependent children before recovery:

6 participants had dependent children during active addiction

4 participants had children after recovering from addiction

Participant Number of Children:

5 participants have 3 children

5 participants have 2 children

Appendix B.

Participant Recruitment Poster

MASTERS RESEARCH PROJECT

PARTICIPANT RECRUITMENT

SEEKING:

- parents in addiction recovery (less than 10 yrs)
- partners of parents in addiction recovery
- must be 19 yrs or older

WHAT FOR:

- Master's degree in Health Sciences
- research to develop a Family-Model for Residential Addiction Treatment in BC.

Addiction impacts all members of a family, even if only one person is using substances problematically.

I am seeking feedback:

1. on my family-model of residential addiction treatment, and
2. to understand addiction-affected families can be better served

WHAT:

1 hour interview in person.

Public location of your choice.

WHEN:

summer and fall 2018.

INCENTIVE:

- snacks and juice available
- bus tickets / gas card
- you'll help shape addiction recovery for families
- you'll help create better policies and programs

Contact:

Carla

[…] (text message or phone)

[…]

Appendix C.

Participant Study Information and Consent Form

PARTICIPANT STUDY INFORMATION AND CONSENT FORM

Faculty of Health Sciences
Simon Fraser University
Blusson Hall, Room 11300
8888 University Drive
Burnaby, B.C.
V5A 1S6

Participant Consent Form
"A Family Disease": Understanding Addictions Recovery within the context of Parenthood in BC, Canada[74]

You are invited to participate in a study entitled, "A Family Disease": Understanding Addictions Recovery within the context of Parenthood in BC, Canada that is being conducted by Carla Simicich. Carla is a graduate student in the faculty of Health Sciences
at Simon Fraser University. You may contact me if you have any further questions by email at […]. As a graduate student, I must conduct research as part of the requirements for my Master's of Science degree in Health Sciences. This project is being supervised by Dr. Maya Gislason. You may contact my supervisor at […] or her email at […].

Purpose and Objectives

The purpose of this study is to learn what gaps and barriers to treatment and recovery services exist for addiction-affected parents responsible for dependent children. Through conducting interviews with participants, this project will centre the voices, experiences, needs, wants and beliefs of families who have lived with and are recovering from addiction.

Importance of this Research

Research of this type is important because it shows the importance of talking to people affected by an issue before developing programs and policies to make sure that these programs will meet the needs of the people that will use them. This project hopes to contribute to the development of effective harm-reduction and treatment programs by consulting directly with addiction-affected families.

Participants Selection

[74] This is the original title of my study which has since changed.

You are being invited to join this study because you self-identified as a person in recovery from addiction (and I will ask you what 'being in recovery' means to you), or as the partner of a person who is in recovery from addiction, and who was the parent of a dependent child/children at the time recovery began. Please note that to be 'in recovery' does not mean that you are currently attending a treatment facility or that you have ever attended a treatment facility or program – only that you are not currently in active addiction. In fact, I will only interview people who are NOT currently attending treatment, so please ensure that you are not currently attending a treatment program if you consent to participate in this project.

What is Involved

If you consent to participate in this research, your participation will include a face-to-face audio-recorded interview with me at a time, on a date, and at a location that is convenient
for you. I anticipate that the interview will last no more than one and a half hours. Once I have transcribed our interview, I will email the transcript to you so that you have the opportunity to review it and notify me of any changes you would like to make. Please respond to my email at your soonest convenience if you are indicating that no changes to
the transcript will be required. If I have not received a reply from you within two weeks, I will assume that you are satisfied with the transcript and I will use it as is. Reviewing your transcript and notifying me of any desired changes could take up to another hour of your time. If you do require changes, I will edit the transcript and return it to you for another review. I will not use the transcript unless consent is implied by a lack of response within two weeks, or you have emailed me to let me know that it properly expresses your experiences and views. If I disagree with the changes that a participant requests to the transcript, I reserve the right to not use the transcript for data in my study, however, given that my intention is to learn what it is that participants want to express about their own experiences, I do not anticipate disagreeing with any changes a participant chooses to make to their expression of their experiences, needs and ideas.

Inconvenience

Participation in this study may cause some inconvenience to you, including the time involved in planning, scheduling, and participating in the interview as well as reviewing the transcript if you decide to do so.

Risks

Discussing your experiences of addiction and parenting while in addiction may trigger troubling memories. I hope to reduce this risk by interviewing only participants who identify as being in recovery and as such, have developed/are developing coping strategies for managing emotional responses when they arise. Please be advised that all information shared will be held in confidence and under the terms of this informed consent form with the exception of participants disclosing:
- that a child is currently unsafe
- the intention to cause harm to self or others
If a participant discloses that a child is currently unsafe, I will end the interview and will file a report with the Ministry of Child and Family Development.
If a participant expresses the intention to cause harm to self or others, I will contact

emergency services and remain with the participant (if it is safe to do so) until emergency
services have arrived. If at any time you feel uncomfortable with a question, you may choose to pass without answering and you are free to end the interview at anytime. I will come to the interview prepared with local resources that you may use if you find our interview troubling, including local counseling services as well as a crisis line number. There is also the risk that despite my best efforts to maintain your confidentiality (including the use of pseudonyms and removing all identifying information related to participants from my resulting thesis and any published articles), your identity may become known. Please consider this carefully prior to consenting to participation.

Benefits

Although this research project, as graduate thesis, will likely not be widely distributed, it may be used for the purpose of publishing academic articles. As such, the potential benefits of your participation may include a sense of satisfaction gained from participating in a study that is inspired by your recovery and your input for proposing effective programs and solutions for other families struggling with addiction. Benefits to society and the state of knowledge include the gathering of more comprehensive and inclusive knowledge about family-models of residential addiction treatment.

Voluntary Participation

Your participation in this research must be completely voluntary. If you do decide to participate, you have the right to refuse to answer any question that you do not wish to answer. As you will see on the topic guide for the interview, some of the questions are quite personal and may be emotionally triggering for some participants. Please consider whether you are comfortable covering this material during the interview. In the event that you do become emotionally distressed during the interview, please note that the interviewer is a trained counselor who will support you and will work with you to develop a safety plan. It will be your choice whether to resume the interview at a later date, or not at all. I will also provide the local crisis number to my participants. You may withdraw from the study at any time without any consequence or any explanation. If you do withdraw from the study, the information that you have shared up to that point will not be used and will be destroyed unless you give me written permission to include it in the study.

Confidentiality

In terms of protecting your confidentiality, I will assign you a pseudonym (fake name) when analyzing and describing the interview. Any information that may reveal your identity will be removed, including the name of any treatment program or recovery model in which you participate/have participated, if you wish. This project may lead to academic articles that are widely distributed. While your confidentiality will be protected as much as possible, there are limits to guaranteeing complete confidentiality, due to the intimate and closely networked nature of recovery communities. With this in mind, please indicate your preference below:

____ Permission to refer to the treatment centre/recovery program I have attended/do attend
____ Prefer the removal of all identifying information

Your confidentiality and the confidentiality of the recorded interview will be protected by password protected electronic storage; the consent forms and printed transcripts will be stored in a locked cabinet until after the data collection has been completed. I alone will have access to the recordings and the transcripts. In the process of analyzing the interview, parts of the transcribed interviews may be reviewed by my project supervisor.

Dissemination of Results

It is anticipated that the results from this study will be shared with others in the following ways: I will produce a master's thesis which will be completed in March 2019; the thesis will be archived in Simon Fraser University's database and may be accessed by future students and faculty. This study may also be used for further analysis and consideration in published academic articles.

Disposal of Data

Once the thesis has been completed and submitted, data from this study must be held for
two years according to SFU's regulations. After those two years, I will dispose of the data by permanently deleting the electronic data and shredding the hard copies of the consent forms and interview transcripts.

Contacts

Individuals that may be contacted regarding this study are those who have been included at the beginning of this consent form. In addition, if you have any concerns about your rights as a participant, you many contact Dr. Jeffrey Toward, Director, Office of Research Ethics at […] or […].

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have you questions answered by the researcher, and that you consent to participate in this research project.

_____

Name of Participant Signature Date
A copy of this consent will be left with you and the researcher will take a
copy.

Appendix D.

Topic Guide

Interview Topic Guide

OBJECTIVES

• to identify gaps and barriers to recovery/treatment experienced by addiction affected parents with dependent children
• understand the needs and wants of addiction-affected families
• to better understand the complex social, political, economic, and cultural factors that have contributed to the health/social crisis that is addiction
• to learn whether a family-model of residential addiction treatment is something that families who have experienced addiction need or want and why

INTRODUCTION

• introduce myself and self-locate to participant
• remind participant of the aims of the study; confidentiality; risks; timing; and right to withdraw

1 SOCIO ECONOMIC QUESTIONS

I have constructed these questions as a means of gathering socioeconomic data from my participants for the purpose of identifying patterns and trends.

__Recovering addict __Partner of recovering addict

How do you define recovery and do you consider yourself 'in recovery'?:
Gender:
Age when entering recovery:
Current Age:
Any change to income level since starting recovery?
Any change to level of education?
Number and Ages of Children when entering recovery:
Status of custody of children when entering recovery:
Method of recovery (ie, treatment, meetings, cold-turkey, etc.)
Have you moved since starting recovery? Is your neighborhood/community substantially different from when you were living in active addiction?
Ethnic origin:
Languages spoken:
Sexual Orientation:
Religion/Spiritual identity:
Any change to marital status since starting recovery?
- Discussion of questions above. Does the participant attribute any of the above social indicators as causing/impacting their experience of addiction and or recovery?

2 PARENTING IN ADDICTION AND RECOVERY

• Describe what life was like when you and/or your partner were in active addiction. How did this impact your family life?
• Discuss stigma and how it relates to your experience in active addiction and recovery
• How did you begin your recovery?
• How did being a parent impact your/your partner's ability to access recovery?
• Describe any challenges/barriers to treatment you experienced as a result of having dependent children
• What would have made it easier for you to access recovery/treatment as a parent?
• Were you at any time separated from your children when accessing recovery/treatment? If so, what was that like?
• If given the opportunity, would you have chosen to attend a residential program that would enable you to bring your children and/or your partner so that you could begin recovery as a family?
• Do you experience any barriers or challenges to current and continued access to your recovery as a result of being a parent? If so, what would help?
• Do your children participate in your recovery? Discuss.

3. ADDICTION AND 'COMMUNITY'

There is one theory that claims addiction arises because our modern culture prioritizes individualism, competition, personal achievement and materialism above collaborating/cooperating within and belonging to our families, cultural traditions and communities, and that as a result, people feel socially isolated and turn to substances to cope.

• Discussion of participant's response to this theory and their understanding/definition of addiction
• Discussion of participant's definition of recovery
• Does participation in 'community' contribute to your experience of recovery?
• How does 'connection' with others (partner/family/extended family/friends/coworkers/community etc.) relate to your experience of recovery?

CONCLUSION OF INTERVIEW

• Any other ideas/experiences/opinions that participant would like to express?
• Remind participant of details of informed consent (right to withdraw, right to a copy of thesis/academic articles etc.)
• Give renumeration for participation
• Offer resources for help/crisis resulting from discussing past trauma