PSYCHIC RETREATS INTO HEROIN: INSTITUTIONAL TRAUMA AND LOSS

IN THE LIVES OF SUBSTANCE USING MOTHERS

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Abstract

This ethnographic study considers the accounts of 12 new mothers in recovery for heroin addiction. Using structured interviews, it aims to uncover the historical and ideological contexts of their experiences and seeks to understand how these experiences intersect with axes of power, oppression, and structural inequality. The study draws upon object relations, attachment theory, Lacanian analysis, critical theory, theories of liberation psychology, and a biopsychosocial approach to addiction and harm reduction. It asks: in what ways do interactions with oppressive systems of race, class and gender impinge upon substance using mothers? And how do historical and ideological constructions of motherhood and addiction insidiously insert themselves into the mother-infant dyad? The study identifies three areas of institutional trauma: exclusion from language, loss and bereavement, and sociocultural shame. It argues that these combined institutional harms trigger a psychic retreat into the primordial, preverbal, somatic realm of heroin. Interviews reveal how institutional systems of control constrict voice, language, and symbolization, all of which are central to the phenomenology of addiction. They further r show that many women suffer a profound and enduring loss from child removal, which increases their risk of future substance use. Analysis of the child welfare system points to structural problems of race and class bias that lead to excessive child protection enforcement. Interviews show that substance using mothers experience a unique duality of shame: the pathogenic shame inherited from their early traumas *and* a sociocultural shame specific to social constructions of motherhood and to the phenomenology of oppression. The study's findings stress the need to keep mothers and infants together in

drug treatment, and provide strong support for a harm reduction approaches to addiction treatment. It concludes that addiction policy should adopt a harm reduction focus, including the decriminalization of heroin and other drugs, improving access to medication assisted therapy (MAT), and increasing social welfare spending. Finally, the study concludes that therapeutic work with substance using mothers calls for a radical psychoanalysis that bears witness to the trauma of oppression, supports the development of imagination and resistance, and advances the goals of psychic *and* social liberation.

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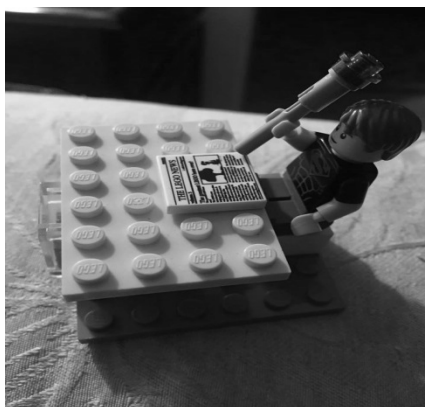
"Mom, this is me writing my dissertation."

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Introduction: Rethinking Ideologies of Motherhood and Addiction

The rationale for keeping mothers and babies together in drug treatment is well established in the literature. A mother's relationship with her baby "reorganizes the addictive reward system" in the early phases of motherhood (Pajulo, Suchman, Kalland & Mayes, 2006) and better outcomes are achieved when this relationship is leveraged in addiction treatment (Bromberg, 2010). There is a growing body of literature that speaks to the centrality of relationships in the recovery process and these have generated interest in attachment and mentalization-based interventions (Leigh & Borelli, 2010; Nardi, 1998; Söderström & Skårderud, 2009; Suchman, DeCoste; Thorberg & Lyvers, 2010). Furthermore, new research in neurobiology, reveals that those areas of the brain associated with pain are also those associated with social separation (Banks, 2011), highlighting the role of oxytocin in the mediation between social attachment and addiction prevention and treatment (Tops, Koole, Ilzerman & Buisman-Pijlman, 2014).

While the transition to motherhood is an opportunity for reorganization and therapeutic intervention (Cohen & Slade, 2000), the social stigma of motherhood and addiction, as well as punitive policies and practices, pose significant barriers for treatment. Our culture remains deeply entrenched in prohibitive policies and abstinence-only models of treatment. Much of addiction treatment remains wed to now-outdated methods, including the use of punishment, humiliation and shame. The child welfare system impinges upon the lives of substance using mothers in ways that cause long-lasting trauma and harm. Ultimately, institutional traumas and entrenched historical ideologies operate to undermine healing.

The 'crack baby' phenomenon of the 1980s was particularly instrumental in vilifying low-income drug using mothers. Analyses suggest that media coverage and the subsequent public panic had racist and classist origins and ultimately lacked empirical evidence (Flavin, 2009; Humphries, 1999; Klee, Jackson & Lewis, 2002). Although the problem was initially presented as a medical one (as in, the impact of crack cocaine on the developing fetus), it was largely socio-political in nature and resulted in punitive sanctions against poor and working class women. Many of the statistics and prevalence rates from this era were grossly exaggerated and evidence for a direct causal link between crack use and developmental damage remains scarce. In reality, socio-demographic contributions such as poverty, education and unemployment play into negative outcomes as much as, if not more than, maternal addiction (Lyons & Rittner, 1998). Dorothy Roberts (1997) in *Killing the Black Body*, gives a poignant account of the victims of the policies that arose out of this era, exposing the disproportionately punitive sentences of pregnant women, the criminalization of reproduction, the strategic focus on crack versus cocaine as a classist distinction, and the bureaucratic regulation and stigma of black motherhood.

These earlier social constructions should alert us to the cultural narratives and ideologies present in the media portrayals of today's "opioid epidemic." Although current discourse would have us believe that we have entered into an exceptional and unprecedented time, the so-called "opioid epidemic" is far from the first and only heroin scourge in our recent history. Similar to the ways in which racism played a large role in the drug policies and media representations of the 1980s, race is central to our new and urgent resolve to treat the rising tide of predominantly white opioid users, with care over

incarceration. Furthermore, even though an increase in opioid prescribing is undoubtedly part of the picture, the focus on opioids as the causal agent of addiction, shifts attention away from the real reasons people are overdosing at record rates. Obscured by language such as "opioid crisis" or "opioid epidemic" (which narrows our associations with addiction to images of white pills seen on covers of Time magazine) are causes such as prohibition, the criminalization of drugs, the unintended consequences of opioid prescribing restrictions, and rising social dislocation, as people across the country find themselves less secure in their jobs, families, and communities.[1]

One does not have to look far to also find that mothers are reentering public discourse. Images and circulated videos of severe cases of Neonatal Abstinence Syndrome (NAS) reinforce the idea that perinatal drug use is cruel and abusive.[2] Articles with titles such as "Born Addicts", "Saving the Babies of the Opioid Epidemic", or "The Tragedy of Opioid Addicted Babies" continue to vilify mothers and fuel child removals. Newborn infants are referred to as "addicted" (instead of the more accurate term "dependent"), perpetuating the myth that these infants are irrevocably damaged and that the mothers at fault have set in motion a powerful trajectory of intergenerational pathology. Most of the articles bemoaning the child victims of the opioid crisis call for expanded resources for foster care as the solution, rather than for resources that would

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[1] It's telling that the leading edge of this wave of opioid addiction spread out from socioeconomically savaged or failing areas of the country like rural Appalachia– areas associated with high job loss, uncertainty, hopelessness and lack of identity.

[2] In an analysis of the historical and cultural contexts of Fetal Alcohol Syndrome, Armstrong (2003) reminds us that medical diagnoses often shape the social order. Diagnoses do not exist in a vacuum, but are informed by the zeitgeist, history, politics and the morals of the time. The question is not whether or not the condition exists, but why and how it becomes so prevalent in common parlance, and in our social fabric. Why has it become so prominent compared to other social problems linked to negative developmental outcomes? After all, the main threat to the developing brain is not crack or heroin, but poverty.

keep mothers and their infants together. They often paint a simplistic picture of the incompatibility of addiction and motherhood, without drawing attention to the nuances of the mothers' experiences, to treatment barriers faced by pregnant women, to the institutional harms caused by the child welfare system and to the larger impacts of drug prohibition and criminalization.

Prior to embarking on this research, I was less aware of how these narratives and ideologies construct our understanding of addiction and of maternal drug use. Not unlike most psychologists, I had received little training in addiction. I had therefore not developed much curiosity beyond what I knew of mainstream theories, primarily the disease model. This research has led to radical transformations in my understanding of addiction and motherhood. Over the course of my research, I learned about the phenomenology of heroin: what it was, what it felt like, what it represented: a soothing mother, a retreat from the world of relationships, a feeling of omnipotence and resilience, a way to ease the pain of agonizing memories or traumatic intrusions, a transient encounter with the oblivion of death. I learned about a disordered and chaotic system of treatment, one in which women perpetually cycle through detox, 28 day programs, and outpatient programs. I learned about the devastation and lasting trauma of child removal, a term which is used casually in the professional circles of social work and foster care, but which came alive in the stories of the women I interviewed. I will never again hear the words "child removal" or "foster care" without being reminded of the despair, loss and heart break of which these women spoke.

A growing number of scholars in sociology and feminist theory have described drug-using mothers' interactions with institutions of authority and systems of oppression

(Boyd, 1999; Gomez, 1997; Humphries, 1999; Klee, Jackson & Lewis, 2002; Murphy & Rosenbaum, 1999), but psychological analyses have failed to fully integrate this aspect of their experiences. Dyadic psychological interventions for substance-using mothers and their infants have focused largely on mentalization-based treatments and parent-infant psychotherapy, both of which are powerful in their capacity to facilitate attachment and even to change the course of intergenerational transmissions of trauma. But mothers, and their relationships with their infants, risk being inaccurately pathologized if structural influences are not integrated into psychological formulations. If the impact of sociocultural shame is not taken into account, for example, well-intentioned agencies may inadvertently perpetuate a 'deviance' discourse. They may impose an ethnocentric, conservative ideal of family and motherhood (Martin, 2011) or fail to acknowledge the centrality of shame in formulations of parent-infant relational problems. If the structural circumstances and ideologies surrounding child removal are poorly understood, it may be impossible to understand the relationship between the removal of a child and a mother's repetition compulsion to repeat patterns of birth and loss. Psychologists are often hired by systems such as the child welfare system or may feel compelled to align themselves with caseworkers. In order to fully appreciate the ethical implications of our involvement with these systems, we must be equipped with an awareness of historical and political contexts, as well as of the ideological forces that drive current practices.

Two realms of literature have historically dealt with maternal addiction. But the two discourses rarely overlap. In sociological and feminist literature, there is a paucity of information on infant subjectivity because of how this might inadvertently suggest complicity with the politics of 'fetal personhood'. On the other hand, the infant mental

health field, in which infant and parent subjectivities have primacy, the literature has not

adequately integrated aspects of larger systemic influences. And, while there are many

studies that speak to the role that oppression plays in shaping behavior and mental health

(Duran, Firehammer & Gonzalez, 2008 Ratts, 2009; Jacobs, 1994;;), little scholarship

places the parent-infant relationship in a sociopolitical context.

In order to impact change in both community and clinical settings, a deep

understanding of the psychological lives of substance-abusing mothers *in a socio-

cultural-political context* is needed. There is a need to understand the ways in which

internalized shame and oppression impact upon parent-infant attachment and upon the

capacity for intersubjectivity, mentalization, and affect regulation. There is also a need to

understand ways in which drug policy and theoretical models of addiction impact upon

healing and stability.

This study is an intersectionality-informed ethnographic inquiry into the lived

experiences of mothers who are in recovery for heroin addiction. It seeks to uncover the

historical and ideological contexts of these women's everyday lives and to understand

how experiences of oppression and suffering influence a mother's caregiving relationship

with her infant. Drawing upon theories of liberation psychology, it seeks to *de-ideologize

everyday experiences* by challenging 'objective realities' about maternal drug use

(Adams & Kurtis, 2012). It exposes the socially constructed perceptions and ideological

undercurrents that drive policy and treatment, and it aims to *recover historical memory*

from dominant narratives (Adams & Kurtis, 2012). Drug using mothers do not exist in an

ahistorical vacuum. In this project I ask the questions: in what ways do interactions with

oppressive systems of race, class and gender impinge upon drug using mothers? How do

historical and ideological constructions of motherhood and addiction insidiously insert themselves into the mother-infant dyad? And finally, what can we do as a society to reduce the harms of drug use, particularly for mothers and their infants?

This dissertation brings into conversation several disciplines: psychoanalysis, addiction research, critical theory and public policy. It is perhaps unusual to see psychoanalysis and public policy side by side, but in the world of addiction, the social and the psyche become very blurred. It became impossible to think about the women's inner lives without considering the internalization of oppression and trauma. It also became clear to me that the rationale for policy and political change was strengthened by psychoanalytic theories that explained seemingly unjustifiable patterns of behaviors. Ultimately, it is my wish to convey that the inextricability of the psychological and the social is not unique to the field of addiction, but to all facets of human life. I hope to illustrate the value of a psychotherapy that not only acknowledges the social, cultural and political etiology of symptoms, but that also uses this lens to reframe individual pathology, to foster the development of critical consciousness, and to support dignity, empowerment and experiences of collective action.

Chapter 1 explores the phenomenology of heroin and the ways in which it evokes a return to the very first, primordial stages of psychological life. Employing Lacanian psychoanalytic theory, I illustrate ways in which suppression of voice prevents the women I studied from joining the Symbolic order, keeping them locked in the preverbal, amorphous realm of the Real - the realm of heroin. I link failure to symbolize and mentalize experience with a retreat into the body. This chapter provides support for the

importance of environments that facilitate language, narrative and mentalization in the healing of addiction.

Chapter 2 links inner experiences of traumatic loss with the social context of institutional harm and the child welfare system. It places child removal in a historical context, exploring issues of class and race, and it exposes ideologies that reinforce our culture's knee jerk response to remove children from poor mothers. First-hand accounts of child removal expose devastating trauma and a sense of powerlessness that triggers schizoid defenses and escalated drug use.

Chapter 3 explores shame as a central affect in the lives of substance using mothers. It considers the unique phenomenology of a duality of shame: the pathogenic shame resulting from early trauma and the sociocultural shame of stigma and social oppression. It emphasizes the relevance of shame to the perpetuation of both addiction *and* parent-infant relational disturbances.

Chapter 4 addresses the models of addiction that dominate treatment discourses and that operate on the day to day lives of the mothers and their children. It chronicles the history of addiction paradigms and explores our burgeoning understanding of addiction as a socially-mediated adaptation. This chapter provides strong support for a harm reduction approach to addiction treatment and policy. It highlights the approach's pragmatic value and, in the context of our current epidemic rates of overdose, insists that harm reduction is a public health imperative. It also provides a psychological rationale for the use of harm reduction in the context of the parent-infant relationship. This chapter draws on object relations theory, in particular the notion of a Winnicottian potential

space, to illustrate the ways in which harm reduction, as a philosophy and as a practice,

maps onto the particular developmental and attachment themes of addiction.

Health policy and treatment interventions for substance-using mothers have

largely ignored the input of the recipients of interventions (Klee, Jackson & Lewis,

2002). The exclusion of the perspective of substance using mothers from psychological

research further contributes to a power-over stance that marginalizes and infantilizes

them. This study represents one way to capture and reflect the subjective experiences of

mothers within a socio-cultural context. It aims to inform drug policy, drug treatment

programs and to contribute conceptually and practically to a model of psychotherapy

informed by feminist critical theory and scholarship.

Methodology

This chapter begins with a brief description of the overall design of the study, and the rationale for choosing a qualitative approach. It next addresses the methodology based on the following: 1) *Participants;* 2) *Materials;* 3) *Procedures* - recruitment of participants and interview scheduling; 4) *Data Analysis*; and 6) *Ethical Considerations* - informed consent, assessment of risks and benefits of research, and safeguards to well-being of participants. I will also discuss the methodology's relevance to feminist theory.

Type and Design of Study

The study's participants include 12 female residents of a 'Mommy and Me' substance abuse treatment program in an urban area on the east coast. I will be referring to the facility as HDT. Wine (1985) emphasizes that methodology should flow from what a researcher needs to know, rather than itself dictate knowledge. With this in mind, I selected a qualitative methodology that would best capture the lived experiences of its subjects, as well as acknowledge the complexities of overlapping systems of oppression. My methodology is ethnographic, inspired in part by the feminist critique of the dominant positivist framework, but mostly by my sense that it would be able to capture the complex and insidious nature of oppressive systems. A qualitative ethnography is best able to give voice to a group that, historically, has been marginalized and stigmatized. For a group that is seldom depicted as heterogeneous, it was important to select a methodology that would not lead to reductive assumptions and that would uncover differences between the women. Moreover, qualitative research is best suited to explore

nuanced categories such as race, gender and class, and the ways in which they intersect with axes of power and systemic oppression (Trahan, 2011). Finally, qualitative methods also allow for a stance of reflexivity that minimizes power asymmetries between researcher and subject (Eagly, Eaton, Rose, Riger, & McHugh, 2012).

Along with observation and informal interviews, I used a long interview format (McCracken, 1988). My methodology blends these various sources of information, with the aim of capturing a holistic understanding of my topic (Padgett, 2011).

Participants

All data was collected with participants at a parent-infant residential substance abuse treatment facility. Women were asked to voluntarily participate and 12 women were interviewed. One hundred percent of the participants were women. Approximately seventy-five percent of women were ethnic minorities. Only women who had been formally admitted and had resided in the facility for no less than three weeks were interviewed.

Materials

The Long Interview

This interview format is outlined in McCracken's (1988) book *The Long Interview* and is inspired by anthropological, ethnographic methodology. It is designed to enter into the phenomenological experiences of respondents and to capture the nuances of their lived worlds. The interview is designed to be as unobtrusive as possible and create a space in which the respondent can tell their own story on their own terms.

The questions that make up the long interview have been termed "grand tour" questions (McCracken, 1988). They are nondirective and open-ended. The structured nature of the questionnaire does not restrict the participants' narratives as the name might imply, but represents a way to be present and attentive to the informants' stories. McCracken (1988) denies that the structure in a questionnaire should limit the open-ended quality of the dialogue that can happen within the confines of the structure. The open-ended invitation to reflect on the topic was facilitated by what McCracken calls "floating prompts" (such as the raising of an eyebrow or a repetition of a word to elicit further elaboration) in addition to probes that pulled for key categories and terms, if these did not emerge spontaneously.

McCracken (1988) describes a line that the researcher must walk between using the self as a tool of inquiry and "manufacturing distance" necessary for clear understanding. One way he suggests to do this is to, in advance, examine one's own cultural assumptions and the ways in which one's own subjectivity might identify with that of the interviewee. On the other hand, banishing one's subjectivity completely in the name of objectivity is, according to McCracken, neither realistic nor desirable. Therefore, the interviewing calls upon one's clinical skills to achieve a delicate balance between these seemingly paradoxical stances. One must find ways of slowing down the process and creating a space for questions such as: "how can my experience by helpful here? How might my experience muddy the waters?"

McCracken does not restrict the concept of "manufacturing distance" to the interviewer. The claim is that in order to be fully attentive to the material, one must actively encourage the interviewee to "see familiar data in unfamiliar ways". In an

interview, one is asking participants to report on material that is routinized and taken for granted in their lives. Unobtrusive prompts and well-constructed questions serve to free up participants to think intentionally about specific aspects of their lives. This is consistent with the tenets of liberation psychology which would support women in their resistance to domination by challenging the social and historical constructions of everyday experiences.

Procedures

The principle researcher introduced the study at a group meeting. The researcher handed out a letter describing the study (see Attachment 3). This was not a consent form, but rather a statement of interest. Women were asked to check a 'yes' or 'no', indicating interest. The researcher facilitated the recruitment, and staff members left the room. This was designed to minimize the risk of coercion or any unintended pressure. Their choice as to whether or not to participate was unknown to members of the group because all participants were asked to hand in the form, regardless of which box they selected.

If a person indicated interest in the study, the principle investigator arranged a meeting time directly with that person. At the initial meeting, the researcher conducted a thorough informed consent, reiterating that participation was voluntary and making sure that it was understood that participation (or lack thereof) in no way impacted access to care at HDT.

The researcher used to work at a clinic where many of the women at HDT visited for personal therapy. However, the researcher's former clients no longer resided at HDT. In addition, the women were not recruited through their therapist nor were their therapists

present during the recruitment process. This minimized the risk of the women feeling

pressured to participate for fear of losing access to needed treatment. All interviews were

administered by the principle investigator.

Interviews were audio recorded. The investigator studied the recordings of the

interviews in order to identify important themes. The interviews began in the fall of 2015

and concluded in the summer of 2016. Participants received a gift basket with self-care

items and age–appropriate toys for their infant. They were told that they would receive

this, even if they chose to withdraw from the study. However, none withdrew.

Data Analysis

Prior to analysis, all of the interviews were transcribed verbatim. Identifying

information was removed, and numerical codes and pseudonyms replaced the actual

names of the participants in the transcripts and subsequent analysis. I used an inductive,

thematic analysis approach. Themes emerged, but were mediated by interpretation.

Braun & Clark (2006) remind us that data are not coded in an "epistemological vacuum"

and the researcher should make explicit his or her theoretical stance. Themes were

informed by and interpreted through the lens of attachment theory, liberation psychology,

social constructionism and a critical theory/feminist perspective.

Current feminist scholarship emphasizes the importance of a critical stance that

contextualizes data within gender/power relations, arguing that women become

pathologized when ideologies of gender are not explicitly addressed in research. This

study seeks to understand women's experiences of motherhood and addiction in an

ideological and historical context and is engaged in a critical analysis of social forces beyond the individual.

McCracken (1988) outlines five stages of data analysis that facilitate a recursive process of repeated readings and analysis:

Stage 1: The investigator focuses on the utterances of the transcript without paying attention to larger symbolic significance. Meaning construction is set aside and generalities are postponed. The language of the transcript is taken at face value. The investigator pays attention to how her own subjectivity is "set off" and makes notes of a "stream of associations".

Stage 2: The investigator takes the observations from stage 1 and extends them. She then rereads the transcript using these observations as a lens for this next stage of analysis. Additional relationships or contradictions are noted.

Stage 3: The investigator moves away from the transcript and only uses it to confirm or to disprove possibilities. The investigator develops patterns and themes.

Stage 4: McCracken (1988) refers to this stage as a "time of judgement". It is during this stage that data are harvested and winnowed to produce broad themes. Interrelationships between themes are considered and redundant themes are eliminated. Then themes are organized hierarchically.

Stage 5: The investigator brings themes together into a thesis. The cultural categories from the interview now become analytic categories. There is a move away from individual subjectivity and towards framing the data for the social sciences.

Houghton, Casey, Shaw & Murphy (2013) propose that the credibility of qualitative data is bolstered by (1) prolonged and persistent observation (2) triangulation (3) peer debriefing and (4) member checking. These interviews were a part of the larger context of my own immersion in the setting. Not only did I have access to the transcribed narratives gleaned from the interviews, but I was also able to draw upon many hours of informal conversations and participant observation.

Peer debriefing is another way of ascertaining the integrity of the data. While it may not be as relevant to a researcher whose belief is that there is a unique and irreplaceable relationship between the researcher and the data, it can, at the very least, be useful to audit whether the data labels and the interpretations that led to those data labels seem logical and credible (Cutliffe & McKenna, 1999). In order to do this, I requested that a fellow researcher in the social sciences read clusters of the transcribed data and generate themes of her own.

There are many kinds of triangulation, including data, investigator, theory, method and analysis triangulations. One can also more specifically triangulate across time, space and person (Adami & Kiger, 2005). I attempted to triangulate the data across persons, including women with addiction across varying backgrounds, including age, race, socioeconomic status and sexual orientation. I included all of these variables so as to capture the complexities that may exist. Interestingly, the original conceptualization of

triangulation is to infer congruence among multiple data points and, as a metaphor derived from the field of navigation, aims to distill a discrete concept. But a new conceptualization has emerged in the literature that views it as a way to achieve *completeness*, versus the more traditional aim of achieving *confirmation*. The suggestion is that rather than a validation of a discrete truth, triangulation presents an attempt at in-depth understanding (Adami & Kiger, 2005; Houghton, Casey, Shaw & Murphy, 2013). This approach to triangulation is particularly fitting to the nature of case-study research and therefore was relevant to the project at hand.

'Dependability' in qualitative research is often compared to the concept of 'reliability'. It is what demonstrates a certain consistency in the data. It calls upon the researcher to reflect upon and document how methodological and interpretive decisions were made, and to be continuously self-aware as to how one's theoretical orientation, history and personal interests impact upon data collection and analysis (Houghton *et al*, 2013).

Braun & Clark (2006) argue that the use of self in thematic analysis can lead one into the phenomenon of interest in a useful way, while simultaneously serving as a reminder to bracket self-experiences for optimum understanding. This is, of course, similar to the psychoanalytic concept of *countertransference*. One is aware of it, both as a way to access a resonance with the analysand *and* to alert oneself to possible distortions in one's understanding.

Despite their elusive and philosophical underpinnings, these concepts have pragmatic applications for qualitative research. All of these qualities and ideas about subjectivity, use of self, and distancing fall under the concept of "reflexivity". The

credibility of the research hinges upon the self-awareness of the researcher and, in some cases, on the documentation of this self-awareness. As suggested by Houghton, Casey, Shaw & Murphy (2013), I maintained a reflective diary throughout the process, in which I took note of countertransferential reactions.

Ethical Considerations

The interviews had the potential of becoming somewhat emotionally activating for the women. However, based on conversations with the women about their prior experiences with researchers, they reported that they had benefited from being interviewed and from sharing their narrative. While it could not be guaranteed that every woman would benefit from being interviewed, it was my experience that the women at HDT enjoyed speaking with me.

There was a plan in place should the interviews trigger emotionally activating material. I conducted the interviews on-site where each woman had access to an on-site therapist. The on-site counselors were alerted to the interview process prior to the onset of the research study and were prepared to be available to participants. I conducted interviews during times when on-site counselors were available and was ready to bring the participant to her counselor should she experience emotional distress that could not be alleviated by this writer. I made use of my clinical skills and judgment during the interviews to minimize distress and to end interviews in ways that left participants feeling contained and emotionally regulated.

Also, because I was acutely aware of the women's oppression and societal stigmatization, the questions were designed to minimize judgment and allow for the

women to be heard in a very accepting and non-shaming atmosphere. It was important to me that the interviews not further exacerbate the stigmatization of the participants, but rather convey a stance of non-judgment and empathy.

Overall the value of this research far outweigh its risks. The subjects in this research have contributed to knowledge that could have implications for policy and for intervention. Specifically, this study increases the field's understanding of how ideologies, theories of addiction and various institutional forces impact upon a mother's recovery and upon the parent-infant relationship. It adds knowledge to a dearth of research about the parent-infant relationship in the context of society and larger systemic forces. It also addresses the substance-abuse treatment culture which, since the 70's, continues to engage in shame-based approaches. This understanding informs practices and models of treatment for an expanding mother-infant sector of the addiction treatment field.

Chapter II: Language and Symbolization

"When I cannot see words curling like rings of smoke round me I am in darkness—I am nothing."

━ Virginia Woolf, The Waves

"There's really no such thing as the 'voiceless'. There are only the deliberately silenced, or the preferably unheard."

–– Arundhati Roy

When the women arrive at the HDT facility, they begin at the bottom of a rigid 5-level patient hierarchy. At the lowest level, "border," they are not allowed to speak to other residents, to participate in house meetings, or to make any phone calls. Over time, as women obey the institution's rules they rise to higher levels and gain privileges, but live under the constant threat that infractions will tumble them back down to the lowest rungs of the hierarchy. To even the casual observer, it is striking the extent to which the control of language and communication is at the center of HDT's system of rewards and consequence.[3]

Beyond rewards and punishments, the basic operating procedures of the HDT seem designed to keep residents silent and unheard. Women have to "bridge" staff when they have a question or need, which means that they write down and submit a concern and staff have 72 hours to respond. This system reduces interactions to a problem solving mechanism, in which problems are identified and solved, but where interactions are reduced to a bare minimum of authentic, reciprocal communication. So that while issues

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[3] To be sure, non-language rules and regulations played an important role, as I will discuss in later chapters. For example, residents at lower levels were not allowed to wear makeup or jewelry, not only representing a removal of a physical comfort, but also becoming a very visible marker of stigma.

of the temperature of the room or plumbing issues might eventually get addressed, patients are starved from any kind of actual feeling of agency or connection in their dealings with staff. Similar to "bridging" is a system referred to as "dropping a slip" which is designed to prevent direct confrontation between women. Women can "drop a slip" on someone to report infractions by their fellow residents, but again, this functional exchange of information reduces authentic communication amongst residents and between residents and staff to a bare minimum.

The control of communication is hardly limited to exchanges amongst residents and staff. Phone calls are controlled and monitored. They have to be made on speaker phone and as one moved from level 1, to level 2 and so forth, one is able to obtain more phone call privileges, moving from one five-minute phone call on speaker phone, to two ten-minute phone calls, to eventually graduating to several phone calls without having to use the speaker phone. Not only does this monitoring contribute to a sense of emotional isolation but anyone that has been involved in any kind of bureaucratic system understands that navigating these labyrinths of offices and officials requires significant time on the phone. As the women struggle to secure phone time to contact case workers and legal aids, little time is left for conversing and connecting with the outside world. And when women are disciplined, they often become demoted to the first level, losing what little voice they had.

I observed these to be punitive rather than practical measures that reflected the premise that drug addiction requires chastisement rather than support and care. In a word, these policies are antitherapeutic, so much so that several women who had significant histories of incarceration stated that their experience of this was "worse than prison." I

believe these responses suggest that measures of control limiting agency and voice

fundamentally undermine the rehabilitative goals of substance abuse treatment in a way

that parallels the rehabilitative failures that most criminal justice scholars critique in the

modern carceral state.

Like with dropping slips and bridging, "writing an awareness" is another example

of the way in which language is employed by the institution in a rigid, isolated way that

bypasses the complexities and nuances of authentic communication. Here, Anne

describes her punishment for becoming angry at a caseworker.

> *Respondent: Um well yeah, there is this staff here and I was talking to her*
> *about something. And she took what I said the wrong way and ...trying to*
> *think about what I said. Someone had left here and got high and come*
> *back. So I said, ok well I guess I have to leave and come back in order to*
> *go to a meeting, because I was told I couldn't go to a meeting that night.*
> *She took offense to it and she started saying about her flat screen TV and*
> *at least I get to go home and watch my flat screen TV and at least I can*
> *have visitors whenever I want. as long as they are outside the gate or*
> *whatever. Then I get very angry and I want to lash out back and I have*
> *done that a couple times here. So I did and I got in trouble for it. I just, I*
> *am trying to learn not to say anything to anyone. It's hard to just sit back*
> *and listen. I got wrote up. I had to do an "awareness." You have to write*
> *an essay and you have to clean something like behind the dumpsters.*

The fact that this is called *an* "awareness" suggests that the activity is somehow

framed as a one-time occurrence or an object, rather than an unfolding process or a state

of being. It implies that the complex processes of reflection and awareness can be

achieved in a single exercise, almost by surgically inserting a skill or like giving a pill or

a drug. Within the culture of HDT, there seems to be an unwillingness to engage in the

messy back and forth of real relationships, a fear of the open-ended and a mistrust of all

that is not contained or controlled. In a parallel process of sorts, the lack of confidence

that the institution has in its ability to soothe and contain affect, mirrors the women's own

conviction that they are unable to regulate pain and suffering, without drugs, in their own lives.

Writing, a potentially beneficial activity, is associated solely with punishment for deviant acts. As I spoke to the women, the resentment that they reported feeling in response to these kinds of forced exercises seemed to eclipse any learning or awareness that might have arisen from an otherwise constructive therapeutic medium. Indeed, Anne's response indicates that all she had learned from the process was "not to say anything to anyone." Expression was transformed into both a transgression and a punishment, but not a source of growth and healing. Moreover, the pairing of the "awareness" with a chore such as cleaning behind the dumpsters, so clearly designed to shame, seems almost an unintended conditioning, in which writing, communication and reflection become conditioned aversive stimuli. Much like some of the other practices at HDT, Anne's experience is one of language in isolation of relationship.

Belensky, Cllinchy, Goldberg and Tarule (1986) in *Women's ways of knowing: The development of self, voice and mind* discuss the vital contribution of relationship, dialogue and play to the development of language, capacity for abstraction, and sense of self.

> Language – even literacy- alone does not lead automatically to reflective, abstract thought. In order for reflection to occur, the oral and written forms of language must pass back and forth between persons who both speak and listen or read and write- sharing, expanding, and reflecting on each other's experiences. Such interchanges lead to ways of knowing that enable individuals to enter into social and intellectual life of their community. Without them, individuals remain isolated from others; and without tools for representing their experiences, people also remain isolated from the self (p.26).

Instructions to talk or to write about experiences, such as those demanded of Anne, are not sufficient. It would be difficult for women with significant impairments in emotional awareness to successfully translate acute negative affect into containing narratives and, in the absence of a corrective relational context, these types of exercises are unlikely to support reorganization and integration. Instead, experiences of punishment and control (such as being made to clean behind the dumpsters) are likely to activate trauma-related affect and trigger a repetition of maladaptive patterns (Siegel, 1999).While some of the rules at HDT may have pragmatic rationale and may serve a purpose, it should nonetheless be acknowledged that they also have negative therapeutic consequences for the women and these negative consequences, when paired with more strictly punitive types of regulation, create an atmosphere in which communication is suppressed and regulated in ways detrimental to the women's growth and recovery.

When interviewed, the women regularly complained that HDT rules, regulations, and punishments significantly slowed down the basic processes that were essential for them to make headway in their lives and on their cases. When they were out of something, needed to attend a group, had a question about their treatment, wanted information on housing issues, or had a complaint about something in the facility, they were restrained. But beyond the practical frustrations they initially voiced to me, I increasingly discovered this communicative control had substantial negative consequences on residents' healing, growth, and attachment. In addition to their expressed experiences of powerlessness, subjugation and humiliation, I began to wonder about the significance of this in the context of the women's narratives and began to understand language to be a central theme in the phenomenology of heroin addiction and

of its so-called treatment. The women's experiences in an environment that appeared to

regulate voice, language and communication in such a systemic way, in addition to the

centrality of language and narrative in our understanding of substance use, is the

backdrop to this chapter.

As discourse was central to the methodology of this project, having used an open-

ended long interview format, participants were given an opportunity to tell their stories

from beginning to end in narrative form. Many of them told me that they had never done

this before, that there hadn't been space in their treatment for their stories, or that they

had held back as they hadn't fully trusted that they wouldn't be judged. The regularity of

the women's responses further supported my view that the best path to recovery requires

active and vocal participation in shaping and reshaping one's own narrative. Indeed,

while we all feel a fundamental need to be heard and understood, that need may be

especially central to the marginalized women I encountered at HDT.

Having announced my research topic and conveyed my general irreverence

toward "the system," I sent a signal that their stories and their "word" would mean as

much to me (if not more) than the narratives of institutions with more power. There is a

freedom and an opening up that occurs when one can proceed with the assumption that

one will be believed and trusted. As one can imagine, substance using women are

accustomed to being looked upon with suspicion, assumed to be lying and manipulating.

I believe that implicitly communicating my theoretical orientation and making clear my

interest in external systems of control helped, right away, to depathologize the women. I

wasn't looking for personality deficits. I was making my intentions explicit; I wanted to

hear what had happened to them. I also attempted to be transparent during the interviews,

my intention being that the women should also have access to my own mind if this were to be a truly collaborative effort. While still acknowledging inherent power dynamics, I wanted as much as possible to embrace the concept articulated in feminist scholarship of "mutual empathy." Many of the women became tearful during the interview process, connected with difficult affect and shared painful experiences. Many commented on the interview's therapeutic value, one participant commenting that the interview process was "good for [her] soul."

In this chapter, I will first use a feminist lens to explore the meaning of language, of voice and of voicelessness in invidious systems of oppression. I will then begin to link the social significance of voicelessness with the intrapsychic by providing a Lacanian analysis of women's narratives. This analysis will demonstrate that heroin represents a bypassing of the symbolic order of language and will propose that the integration of language and "putting into words" is central to clinical work and treatment. Finally, I will discuss the significance of language and "putting into words" to issues of affect regulation, the body and somatization, and the capacity to mentalize, all of which are central to the phenomenology of heroin addiction and can inform compassionate approaches to healing.

A strength of my approach in this chapter, and this project as a whole, is that it draws on literatures that haven't been put into conversation by previous scholars. Often, superficial conflicts between the theoretical perspectives I employ have led scholars to see them as incompatible instead of complimentary. This project seeks to layer insights from feminist scholarship, attachment theory, Lacanian theory, theories of child development and psychoanalysis. I justify their integration by arguing that each provides

a different perspective that captures real elements of the same human experience, regardless of their metaphysical disagreements about the "true" nature of the mind. So when Lacan speaks of *jouissance* or of *desire*, we may either see this as a metaphysical statement about the human psyche or we may also see it as a metaphorical description of human experience that well captures real life observations made in my research. The data itself is concrete and unifying, and I have chosen to explore its meaning through these various theoretical lenses.

My hope is that these perspectives will yield practical implications, elucidating the importance of language and voice in the recovery of substance using women and the antitherapeutic consequences of silencing women as a form of control and punishment.

Voice and silence in feminist theory

Voice has long been central to feminist theory and practice. Indeed, voicelessness has often been viewed as a defining condition of oppressed groups – one that serves to maintain hegemonic systems of authority and patriarchal discourses. To be voiceless means that one's story remains untold, that one is unable to contribute to cultural and historical narratives. A group's voice can also be silenced, in insidious and invisible ways by the pervasiveness of dominant narratives. The women at HDT were entangled in narratives that not only perpetuated their voicelessness, but that practically defined their trajectories and futures. Their imposed silence was an uncanny echo of their voicelessness and exclusion from normative narratives of motherhood and addiction. The compounding of individual and social silencing left many of the women feeling fundamentally and existentially misunderstood and unseen.

With her book, *In a Different Voice*, Carol Gilligan (1982) carved out an area of feminism dedicated to the idea of voice and framed women's oppression as a suppression of one's authentic voice. Carol Gilligan was aligned with ideas that were at the time emerging from a group of feminist researchers at Wellesley, later organized into Cultural-Relational Theory. This brand of feminism emphasized *difference* and argued that women's innate nature is wired to value connection and relationships.[4] While traditional views of psychological development emphasized autonomy, aggression and separation, Gilligan and others in the Cultural-Relational movement proposed that female development was driven by connection, care, human attachment, non-hierarchy and mutual empowerment and empathy. These feminine traits amounted to a "different voice" which Gilligan argues has equal normative value to the traits highlighted in male-dominated society. The devaluing of the female voice functions as a central force of patriarchy by pathologizing female experience.[5] Gilligan aims to recast the struggles of women as a symptom of disconnection in patriarchal individual relationships and in the larger socio-political context of power hierarchies and systems of oppression.

[4] Gilligan's "difference" feminism can be contrasted to "liberal" or "egalitarian" feminist perspectives exemplified in works like Susan Okin's *Juctice, Gender, and the Family*. This dispute, which dominated much of second wave feminist discourse, centers on the degree to which gender is a product of biology v. culture, physiological construction v. social construction, nature v. nurture. However, as Catherine MacKinnon so ably points out in works like *Feminism Unmodified*, narrow debates over the origins of female difference often amount to a contrast between biology as destiny and culture as destiny. One might say that differences over gender difference often amount to a difference without distinction. A more fruitful approach recognizes the lived experience of real gendered women as one in which their voices and views are denied agency and power. As McKinnon argues, debates over the origins of gender often mistake cause for effect by seeing our understanding of gender difference as a cause of oppression rather than a result of power inequalities. Likewise, my perspective argues that heroin-addicted mothers are viewed and treated deviant because they are powerless and marginalized.

[5] This feminist perspective is also related to Marxist derived feminist standpoint theory, which makes the epistemological claim that the experience of oppression grants a clearer understanding of the ideologies that structure society. Just as the working class can see the oppressive structures of society through their lived experience in a way the capitalist class cannot, so too can women see oppressive gender structures by reflecting on their lives. As such, the inclusion of women's observations and perspectives provides a more complete knowledge base from which to discuss issues of justice and equality. Such knowledge is hidden from men, rendering the powerful unable to access the standpoint of women, even if they have the best intentions for women. See Nancy Hartsock's *Money, Sex, and Power*.

According to Gilligan, not only do women silence their own voices in relationships in order to sustain connection to others but their experiences as a group have been silenced and their collective voice has not been given legitimacy in intellectual and public discourse. Gilligan promoted the idea of an authentic voice that resides within women and promoted it as a unitary concept and identity. This has been refuted and challenged by postmodern feminism which rejects the notion that there is one way to be, an authentic, underlying sense of self that need only be uncovered. Consistent with relational-cultural theory, the idea is that this authentic voice emerges in the context of real, mutually supportive relationships and that only in the context of these relationships can one find one's voice. The theory posits that one can exist in false relationships in which one's authentic voice is silenced. The women at HDT were unable to experience anything approaching an authentic voice, as they made clear in their emotional reactions to finally telling their own narratives during the interview process.

To complicate matters, Mahoney (1996) considers silence to be a form of resistance against the dominant discourse, problematizing Carol Gilligan's emphasis on the 'politics of voice.' For Mahoney, the withholding of private information about oneself is an act of defiance and a source of agency over one's own personal narrative. It is my story and by withholding it I deny others the power to use, denigrate, or recast it. Thus in some ways, to lose one's ability to remain silent is perhaps an even more destructive and insidious form of oppression than a loss of voice because it operates indirectly and unseen. Silence and secrecy are central to the lives of the women, as they navigate a complex landscape of social workers, lawyers, rules that govern access to treatment or housing, being held to standards of perfection by treatment centers and by the larger

society. Silence and secrecy, while often considered pathological in the context of their

substance abuse, are also a source of power.

Mahoney uses object relations theory to develop this argument, drawing upon

Winnicott to explain how central the balance of being heard and not heard is to one's

sense of self. The Winnicottian 'true self' is a self that is never fully known; it remains

silent. Winnicott emphasizes the duality of sociality and of isolation (both of which

provide comfort) and suggests that perfect communication in fact threatens sense of self

and agency because it doesn't lead to a sense of differentiation. Agency and resistance

are born of imperfect interaction and creativity and resistance comes from a balance of

being heard and not heard.[6]

While Mahoney presents an interesting challenge to Gilligan's argument, the

validity of her objection depends entirely on the ability to *choose* voice or silence, which

is a choice denied to the women at issue. The power of voice is a necessary, but not

sufficient, condition for the power of silence. Consequently, the women at HDT are

denied the power of voice *and* silence. Not only are their voices stifled but their silence

also loses its power. If silence is imposed and controlled, it lacks the agency to function

as an act of resistance and withholding.

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[6] Winnicott's notion of the true self, is at the core of one's sense of self that is kept inside and does not communicate or interact with external reality. There are times when the true self is more or less close to the surface, or times in which the true self approaches the external façade of the false self. However, in essence, the true self is a self of silence, a self that is unfound and essentially unknown. This duality of the primitive wish of merging, of being eaten or swallowed, of being fully known and understood, and of the drive for differentiation and autonomy which reacts to external impingement with a retreat into the self is an important and healthy dialectic. Ultimately to be completely heard and seen threatens one's sense of agency and creativity. This sense of creativity and autonomy emerge from interactions between oneself and others that are imperfect, where one is not completely understood and even from the subsequent feelings of shame that these interactions can lead to.

A significant aspect of Mahoney's criticism--in the spirit of third wave feminism--targets Gilligan's reification of "authentic voice" and "whole self" as essentializing what it means to be a woman. By shifting the feminist focus from a collective expressed "women's voice" to subjective inner voice, Mahoney seeks to open the space for each woman to be a woman in her own unique and individual way. In this sense, Mahoney joins in the postmodern turn in contemporary feminism that rejects binaries and envisions identity as radically socially constructed. For feminists like Judith Butler, gender is constantly being constructed, deconstructed, and reconstructed through discursive and performative acts. Butler argues that language is the source of all meaning and power, and any attempt to wield language necessarily employs and reaffirms the network of social power that surrounds us all. In works like *Gender Trouble*, Butler (2011) rejects the possibility to recast our social world in fundamentally non-oppressive ways, noting that the very act of advocating for "women" reifies the category of women in ways that harm the individuals whose lived experience fails to harmonize with dominant discursive meanings of the category. In the face of this ever-present Foucauldian power, Butler argues that resistance must be reimagined as an individual act in which one performs social roles in mildly unexpected and subversive ways.

While I do ultimately find Butler's arguably pessimistic assertions about the limits of radical social and political organizing, I do find her focus on performance adds an important element to our feminist consideration of voice. Butler reminds us that the way we perform our narratives through language, both verbal and nonverbal, allows the individual to carve out a unique identity within an oppressive world that is slightly more comfortable. In performing our narratives we may not be able to construct our narratives

whole-cloth, but we put our gloss on the hand we are dealt, and in doing so we find a

sense of agency in the life we have been handed. For the women at HDT, who have been

dealt the poorest of hands, the opportunity to perform their narratives may be the only

source of power and control available to them. That space to perform their identity may

be critical for them to forge a livable identity within the social identities of "addict" and

"mother" that are thrust upon them. Performativity is a social act, a discursive act. It

requires a give and take with an audience. As the women of HDT "bridge" and "drop

slips" they are denied any opportunity to perform and are left isolated, with no room to

construct a livable narrative.

Gilligan, Mahoney, and Butler all point to different ways in which voice is central

to constructing an authentic and livable narrative of self. It is therefore particularly

striking that regulation of voice had such a prominent role in the treatment of the women

that I interviewed. In the absence of language and connection, women are left to interpret

the silence. The experience of being silenced triggers women's existing sense of shame,

powerlessness and vulnerability and forecloses opportunity to build language and

reflective capacities.

Lacan, the *Symbolic*, and the *Jouissance* of Heroin

Here I choose to bring in theorist Jacques Lacan, language being central to his

conceptualization of development and of human participation in culture. From a Lacanian

perspective, the use of silencing in the treatment of the women at HDT, replicates a

disruption of an essential developmental process; one which in fact further contributes to

their immersion in a preverbal, primordial "jouissance". Heroin addiction can be seen as

an attempt to access *jouissance* by bypassing the symbolic world of language and of the

Other (Loos, 2002). Using the narratives of these women, I integrate Lacanian and

attachment theory to make sense of their struggles with heroin addiction.[7]

In the beginning, a baby is born in a bath of attunement, a space of perceived

oneness with the mother who contains dysregulated states, flailing arms, hunger, and a

sense of existential timelessness by reflecting back to the baby a state of coherence. Later

on, when the child joins the collective, symbolic order, of language she loses her sense of

omnipotence in the world and is left with an internal sense of 'lack', a void left by the

loss of the primordial, preverbal, state of oneness with the mother. Lacan posits that this

sense of lack is central to human existence and that we spend most of our lives chasing

objects that echo the original lost object. We fall in love, we pursue intellectual

endeavors, we have children, we chase fleeting moments of ecstasy and passion. But

none of these objects ever compare to the original state of sublimeness. While they

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[7] The relationship between Lacanian psychoanalysis and attachment theory has been tentatively explored in several case studies and theoretical papers (Leupnite, 2009; Ruti, 2010; Vanheule & Verhaeghe, 2009; Vanheule, Verhaeghe & Desmet, 2011). In general, many might maintain that these two theoretical orientations are basically irreconcilable. One upholds a notion of a True Self while the other views self as an illusion, one emphasizes growth and integration while the other emphasizes lack and alienation, and one makes room for the bolstering and shoring up the ego, while the other specifically denounces ego psychology and blames the allegiance to an illusory ego for trapping subjects in fantasies that divert them from the truth of their desires (Ruti, 2010). However, there are some overarching points of connection worth considering in the context of addiction. First, there is a parallel between Lacan's mirror stage and Kohutian 'mirroring' in that both underlie a socially and linguistically mediated development of self. Lacanian stages of development (from the Real, to the mirror stage, to the symbolic castration and the entry into the world of signifiers) require a social mediation by the Other. Even though the Other, and the rupture from the ethereal world of the Real that it engenders, represents a death or "castration" of sorts, it is necessary for existence in the world. It is what tones down the "too muchness" of jouissance (Ruti, 2012) and keeps us regulated, despite some degree of perpetual existential suffering and dread.

Second, both Lacanian psychoanalysis and attachment theory reject the humanistic notion of a core, stable authentic self, in isolation of representations and signifiers (Sass, 2015;Vanheule & Verhaeghe, 2009). In many ways, Winnicott's notion of a False Self is akin to the narcissistic fantasies of coherence and wholeness of Lacan's register of the Imaginary (Ruti, 2010). Lastly, there are some similarities in what both theories suggest are the goals of analysis. Lacan's emphasis is on the acceptance of the "symbolic castration" and of the sense of "lack". In a way that is not as radically different as one might expect, attachment theory/mentalization-based therapy facilitates the acceptance of (and the subsequent distancing from) internalized representations of the other. Both involve processes in which the subject and the Other are "dynamically intermixed" (Vanheule & Verhaeghe, 2009).

distract us from our permanent sense of lack, the shadow of this existential void is always present, hovering just outside of our awareness.

While this permanent sense of existential lack may seem disagreeable, it is only through this rift that we can fully become cultural, social human beings. We unconsciously sense the loss of a primordial omnipotent state. However, we are willing to trade all of this in for living in the "social space of signification" (Ruti, 2012). In fact, it is often the failure to accept the symbolic order of language and the failure to join collective life, that is at the root of madness and psychosis (Sass, 2009). It is only the space of indescribable lack, left by the murdering of an earlier primordial state by the Symbolic, that makes room for meaning-making and creativity. The Symbolic order may on the one hand represent a patriarchal oppressive hegemony (and Lacan precisely uses *The name of the Father* to describe the symbolic order), but it also presents possibilities for creativity and transcendent experiences of infinitude.

Because the Real cannot be fully symbolized by signifiers, there is always left over *jouissance*, and this leaks into the Symbolic in unexpected ways. This is what Ruti (2009) sees as the basis of 'singularity'; that part of our being that passes through the regularities of our everyday lives in flashes of eccentricity, idiosyncrasies and even defiance. It is the part of our existence that resists socialization. It is the 'stain' that emerges on the landscape of the Symbolic that has within it an agitation and a disequilibrium (Sass, 2003). These threads of jouissance are what keep us from being completely integrated in the world and, within them, is contained a kind of infinitude. If the Symbolic is an illusory, coherent world, then the excess jouissance is what leaks through to remind us that we are not completely closed within the finite (Ruti, 2014). In

sum, when *jouissance* trickles through, it need not be the ominous and unwieldy force that it is when it is in its original, unmitigated, undiluted form. It can in fact inspire desire, creativity and visions of the infinite.

But what if the induction into the symbolic order goes awry? What if the chaos and disjointed experiences of the Real are not put into words and go unsymbolized? Without 'lack', desire, creativity and visions of infinity are stunted. Disruptions in early relationships or early childhood trauma, which all of these women have experienced, may disturb the process by which language intervenes to provide affective and verbal representations. In some ways, this sort of early trauma can be viewed as a "failure to symbolize" (Kirshner, 2015).

Women's descriptions of their subjective experiences of heroin were reminiscent of Lacan's register of the Real and of what Sass (2015) describes as "the more inchoate, intimate, particularistic, and fluid reality of preverbal intimacy with the mother-figure and the world"(p.27). Often the drug seemed to represent a holding environment for which they yearned. One woman described a fear of being without the drug, comparing it to feeling like she was "out in a bay floating around". This is reminiscent of Winnicott's descriptions of the baby that is, psychologically and emotionally, "falling forever" or of Lacan's "corpse morcelle" – the incoherent, fragmented, floundering body of the infant without a holding environment.

> *I felt like nobody could take away this thing that made me feel at ease with myself – frightened that I couldn't cope without it. I couldn't imagine a life without it. It felt like severe loneliness…I felt unmoored, like I was out in a bay floating around and nobody cared. Like I wasn't attached to anything unless I used. It was a security blanket. It felt like that.*

This is further clarified by her description of her recovery as feeling "the good

force of the earth *holding* me"

> *I was very lonely. (tears) Like I heard you say that other*
> *day that you can feel lonely in a crowded room. And now, I*
> *have come to terms with the fact that I do have myself, even*
> *though I have a lot to work on, I do meditate and I do feel*
> *the good force of the earth holding me. And I feel very*
> *grateful about simple things.*

It would be difficult not to perceive the parallels between this woman's

description of heroin and a womb-like, primordial, holding environment. The narratives

also seemed to reflect the Winnicottian concept of "going on being"; a timeless state

experienced by the infant before he/she develops a subjectivity and is still essentially

merged with the mother.[8] Heroin seems to approximate a state of "going on being."

Women described experiences of time stopping and of feeling like every need had been

met with ease. This woman described a euphoric state in which she had eaten, without

ever having moved, as if it had happened seamlessly, and without effort.

> *I was laying down on my couch and I had a very vivid lucid*
> *dream, I wasn't asleep but I wasn't awake either and in the*
> *dream I was hungry, I got up made myself a sandwich, ate*
> *it, watched a whole tv show. And then I opened my eyes and*
> *I realized that I had done none of it and I was in this very*
> *euphoric, comfortable state and I remember that one lucid*
> *dream more than any other time. I just felt very warm,*

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[8] The mother engages in what Winnciott decribes as "primary maternal preoccupation", which is itself a
state of timelessness. The mother forgoes sleep, schedules and routines are suspended, day and nights
become irrelevant for a time and the mother's subjectivity joins with the infant so much so that she begins
to feel what the infant feels. This essentially describes projective identification; it is during this time that
the infant is able to project and place her experiences into the mother, allowing the mother to resonate with
the baby and meet her needs. In "good enough" parenting, the baby's needs are predictably met; the baby
feels hungry and milk comes, the baby feels a cold sensation and is changed, the baby's sense of
dysregulation and lack of control is met with swaddling and holding. Without this holding environment, the
baby, in Winnicottian terms, feels an anxiety akin to "falling forever" (Ogden, 2004; Winnicott, 1956).

> *relaxed and very content. It never actually happened but I*
> *felt full and comfortable, like I had eaten the sandwich.*

This woman described the effortlessness with which she moved in the world,

despite conditions of poverty and stress.

> *I felt great, like superwoman. Like all my stress stopped.*
> *And I was able to do a thousand things in one day. I could*
> *do anything without being overwhelmed. I had unlimited*
> *amounts of energy. I felt happy and euphoric and very*
> *"that's fine, everything is cool, no problem. Nothing is a*
> *big deal. Very like, I will deal with that no problem. "Oh*
> *you need me to do one more thing? No problem". I was*
> *relaxed and calm.*

But there was also a death-like quality to their narratives. Without the mediation

of the Other, one does not merely 'brush up against' *jouissance* allowing it to 'leak into

the symbolic' in ways that can produce unexpected creativity, transcendence and

glimpses of infinity (Ruti, 2012). Rather, one is engulfed by it. Zizek (2007) describes

taking drugs as a sort of "*autistic jouissance*": a *jouissance* that detours the Other and

therefore "suspends symbolic castration". In this sense, it is an immersion in the Real in a

direct and deadly way, ominously aligning itself with the death drive (Zizek, 2004).

> *It was as if I was laying on a cloud and sinking into it one*
> *millicentimeter at a time for four hours. I lay there for four*
> *hours sinking into this cloud. It was so serene and peaceful.*
> *All pain went away. I was thinking that if I could die right*
> *now, I would.*

In an introduction to a book on Lacan and addiction, Malone and Baldwin (2011)

cite Laurent (1998) to illustrate the death-like qualities of unmediated *jouissance*.

> The first thing that drug addiction teaches psychoanalysis is that the object is a semblance, not a substance. It is precisely in drug addiction that we can find the most strongly sustained effort to incarnate the object of jouissance in an object of the world. It is precisely here that it may be verified that the object is semblance, and that on the horizon, the true object of jouissance— if that word means anything— is death. (Laurent, 1998, p. 138)

This analysis has implications for the treatment of the women at HDT. Healing from addiction means entering little by little into the shared symbolic order and beginning the process of symbolizing one's experiences in *speech*. This is particularly important for these women, the majority of whom have suffered from *unspeakable* early traumas and abuse. The removal of their "voice" as punishment is not only a shaming stigma, but it further distances women from the shared symbolic order.

Given the women's retreat to a preverbal, primordial jouissance, treatment should be conceptualized as a sanctuary (perhaps one that replaces the sanctuary that heroin once provided) where old attachment injuries and traumas can become symbolized and metabolized through language and metaphor. Lacan did not believe in the corrective experience or relationship in therapy, but he did recognize that, in a rebirth of sorts onto the symbolic order, the analyst could temporarily embody the generalized Other, could take the patient back to the origins of becoming a subject and could begin the process of symbolizing the patient's experiences in speech (Kirshner, 2015).

Reentry into the symbolized order would require the women to acutely feel the sense of *lack* that their drug use once obscured. In my interviews, women spoke about the fear of encountering this sense of lack and many expressed doubt that they could survive it.

> *I am scared. I am scared of what life will be like without it.*
> *That's what stressing me out. I have a lot of worries about*
> *everything. Going home. I am afraid I'm going to use. I*
> *don't want to pick up. Not having nowhere to go.. Just*
> *scary for me. That I am about to actually be out of here*
> *soon.*

Therapy would necessarily include tolerating feelings of incompleteness, longing, and even suffering. But, because there is no desire without lack, patients would also begin to be able to connect with their desires, their creativity and their capacity for meaning making. They would be freed up to search for those objects that not only contain an echo of the Real but that also contain *the other*, experiences such as falling in love. And what better context than the budding mother-infant attachment relationship to discover love and desire?

Treatment institutions often impose harsh and rigid laws, regulations and boundaries in an effort to ground patients into a symbolic order of sorts. Programs are faced with reconciling "the ideal of consumer society" (a jouissance in and of itself) and harsh prohibitions against the "'too much' of jouissance." This leads to treatment that is overly optimistic, directive, scripted, with a focus on the here and now. In my interviews, women seemed well-versed in a rhetoric of personal responsibility and action-oriented, here and now, skills: "working the steps", "people, places and things", "I am accountable for my actions", "I know what I need to do, it's about implementing it and doing it. It's the tools, using the tools that I have." "I am going to do everything that I can to be proactive in my recovery as much as is in my reach. So I have to make the best out of the situation. I want recovery so I have to be responsible for my recovery." Many of the women I spoke to were cautious to draw a connection between their histories of trauma

and their drug use, having internalized the institution's master narrative of "nobody is

responsible but you." Loose (2002) points out that *jouissance* is in fact the only *a-historic*

aspect of the patient's subjectivity and that the institutional denial of a patient's full

subjectivity evokes the very *jouissance* the institution wishes to destroy. The statements

made by the women reflect a continuation of *jouissance*, the ideals of capitalist society

and the values of consuming and enjoyment in excess.

Instead, treatment centers need to be putting as much distance as possible between

the patient and *jouissance* through symbolization of the past, narrative and language. This

should be a slow process, acknowledging that "it is essential that addicts should get the

chance to bring a harmful toxicity within the realm of the signifier in order to be able to

come to live with the facts of who and what they are." Loos (2002) emphasizes that

interventions must start by bringing a patient into the symbolic, "with anything that

incarnates the essence of addiction", including substances such as methadone and

suboxone for stabilization. The most important goal, according to Loos, is to provide

patients with an "opening for the speaking subject" even if, in the process, they must

bring their addictions and their substances, like transitional objects, with them. When the

fear of being without one's main coping mechanism is lifted, patients are freed up to

begin to enter the symbolic realm and experiment with new ways of being.

Language and Self-Regulation

Any parent knows the powerful regulatory function of language. I remember the

way in which my son's hand would come close to pulling my earrings; he would wrap his

little hands loosely around them and, having over time internalized my own language and

prohibitions, would say "don't pull, don't pull, no, no" before letting go. I remember when talking about how delicious the lollipop in the supermarket looked became an acceptable replacement to grabbing it. He had used language to substitute for action, to control his urges and impulses; his social environment, via language, had become his own source of self-control. The most well-known articulation of this phenomenon is by Vygotsky who posited that self-regulation develops as a result of the internalization of cultural and social symbols, the most important of these being words and language. Vygotsky (1986) proposed that social language, eventually becomes "private speech" and then, in turn, becomes completely internalized as thought. He believed that private speech serves a self-regulatory function that children are able to draw upon to plan, manage and regulate their behavior. There has also been the suggestion that this inner voice functions as an "observing ego", which addresses the self from a third-person perspective and facilitates integration and coherence in what might otherwise be experienced as a very discontinuous and fragmented mind and sense of self (Siegel, 1999).

Selma Fraiberg (1959) also contributed to our understanding of the way in which language creates a buffer between urges and desires and impulsive action:

> Words substitute for human acts and the unique human
> achievements of control of body urges, delay,
> postponement and even renunciation of gratification are
> very largely due to the higher mental processes that are
> made possible by language. The human possibility of
> consciously inhibiting an action and renouncing, if only
> temporarily an expected satisfaction, is largely dependent
> upon the human faculties of judgment and reasoning,
> functions inconceivable without language (p.115).

Fraiberg also discusses the way in which language gives us control, invoking the image of a baby who has just learned to wave and say "bye-bye" and who suddenly seems to deal much better with separation or of a child whose "bed-time soliloquy" conjures up objects and people in the darkness of separation. These represent what Fraiberg refers to as the "first triumph of language"; words begin to substitute for people, objects, and experiences as a way of overcoming painful emotions and giving a child control over his circumstances.

From a neurobiological perspective, there is good evidence that affect labeling can exert control over the limbic area of the brain, particularly the amygdala, a brain region fundamentally involved in emotion and attention processing. Lieberman, Eisenberger, Crocket, Tom, Pfeifer & Way (2007) demonstrated a relationship between affect labeling and diminished activity of the amygdala, as well as increased activity in the right ventrolateral prefontal cortex (involved in language processing) and the medial prefrontal cortex (involved in inhibition). Neurobiological studies on these top down, inhibitory processes of the limbic system continue to sync up with the clinical wisdom of psychotherapists who have long trusted in the soothing and regulatory functions of putting feelings into words.

In light of all this, treatment should provide plenty of space to put complicated experiences into words, in the context of authentic relationships. When women were asked to describe helpful components of their treatment, they inevitably referred to informal conversations with caring staff members while on the bus to the methadone clinic, a feeling of being understood by someone, or the act of sharing common experiences with other patients. While "dropping slips", "bridging" and "awareness" are

attempts by the institution to account for the deficits in communication and impulse control that the women might naturally have, they are rigid and end up limiting the very kind of authentic, relationship-based, language and communication that would ultimately support recovery. Most women that I interviewed reported poor self-regulation, stating that it was difficult to control their impulses, contain outbursts or communicate effectively. One woman became tearful after a long disclosure of severe and long standing childhood sexual abuse stating, "I just can't communicate. I am not good at communicating", underscoring the pain of living this way. The ability to regulate affect is the main organizer of an individual's experience in the world. Ultimately, it is necessary for the achievement of a unified and well-integrated sense of self.

The women of HDT have extensive histories of early trauma and are therefore much more vulnerable to developing poor self-regulation and impulse control (Cole & Putnam, 1992). As children, a lack of attunement to their emotional needs may have conveyed that affect could not be modulated (Koplow, 1996). When their affect is not matched by the external werold, children are less able to interpret affective cues in themselves and in others. In two ways this seems to lead to difficulties with impulse control. One way in which the misinterpretation of affective cues precipitates lack of impulse control is the perception by the individual of everything as an attack or a threat. Arousal is interpreted as a stimulus for fight or flight reactions, rather than as a cue to process and assess incoming information (van der Kolk 1994). Cicchetti and Toth (1995) discusses findings that maltreated children often respond with aggression to friendly approaches by peers, distress in other children, or attempts by other children to comfort them. Another way in which ill-attunement to affect seems to coincide with poor impulse

control is the misreading of one's own inner states. The result of a child's inability to

label the internal emotions that may precipitate an eventual eruption, is a tendency toward

seemingly unpredictable and uncontrollable outbursts of distress (Koplow, 1996).

Cicchetti (1995) found that maltreated children spend less time describing physiological

states and are less able to express negative emotions such as hate, disgust, or anger. This

limited ability to express emotions though words may also be an underlying cause of poor

impulse control among children who have experienced trauma. This is further supported

by research that indicates a strong predictive relationship between breadth of vocabulary

and self-regulatory skills in preschool children (Vallotton & Ayoub, 2011). At HDT, we

see a vicious cycle in which the women have outbursts (resulting from a failure to

symbolize in language) and are then punished with a removal of language: the very

language they so desperately need for affect regulation and integration. [9]

Unsymbolized Affect and the Body

We know that substance use is associated with decreased ability to put feelings

into words, to symbolize experience and to regulate affect. Heroin users in particular

have been found to have lower levels of mentalization, abstraction and tolerance of

affect, often suffering from intense depression that they cannot internally regulate.

Atanassov, N., & Savov, S. (2016) found significant differences between a group of

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[9] A responsive caregiver, on the other hand, modulates a child's physiological arousal by providing the child with varying degrees of soothing behaviors and stimulation, simulating the regulation of affect necessary for normal play; a balance between periods of stimulating explorations and periods in which the child returns to their secure base for comfort (van der Kolt, 1994). This, in turn, teaches a child the capacity to modulate affect while providing him with the necessary affective foundations for further explorations and development of self. The consistent experience of being understood by a parent's empathic attunement organizes the child's mind and inner self so that she is eventually capable of autonomous emotional regulation (Siegel, 1999).

heroin addicted patients and a control group on dimensions of affect regulation, verbalization and symbolization. The study hypothesizes that heroin users lacking mentalization capacities have difficulty putting feelings into words and subsequently somatize their emotions and affective experiences. These symptoms are similar to those with alexithymia or somatoform disorders, who also to appear to suffer from deficits in mental state language and histories of insecure or disorganized attachments (Lemche, Klann-Delius, Koch & Joraschky, 2004; Waller & Scheidt, 2006). Without the cognitive and linguistic buffering of left brain processes, those with poor mentalization ability are vulnerable to undiluted, unprocessed affect and fight or flight responses. Without the containment of language, affect is experienced as amorphous, overwhelming and frightening. [10]

To further illustrate the centrality of language to human experience, I am reminded of the patient with schizophrenia whose affective experiences are condensed into visual images and sensations. People with psychotic-level psychologies tend to lack a sense of trust and security in the world and are encumbered by feelings of imminent annihilation (McWilliams, 2011). Their experience can be intensely isolating and terrifying. Being unable to symbolize, express, and communicate subjectivity in language is central to that experience. In the absence of an ability to convey experience in words, psychotic patients must rely on non-verbal forms of communication such as projective identification or what Lotterman (2015) refers to as *emotional induction*. Disowned parts

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[10] Putting something into words adds distance. Rather than being immersed indefinitely in the intensity of the limbic system, using words moves affect to the frontal lobe of language, rational thinking and problem solving. By putting affect into words, one becomes the narrator of one's experiences and, by accessing the 'I', one is able to gain perspective and distance, floating above the experience instead of being painfully immersed in it. Putting words to one's experiences *across time* in narrative form and integrating the 'me then' and the 'me now' supports continuity and integration of the self.

of experience are communicated non-verbally to those around them, who may then, in

turn, experience strong emotional and somatic responses within themselves, as a way of

resonating with or understanding the psychotic experience. With many parallels to

addiction, some have described schizophrenia as a disturbance of symbol use. Thought

and language are replaced by bodily sensations and, through a process of

desymbolization, life is experienced concretely through somatic sensations rather than

through thinking and language. Similarly, the phenomenology of addiction is marked by

a retreat from language into the body. It is marked by a distorted relationship to the

somatic, in which one's body becomes alien, foreign and fragmented; the body is

"perceived" rather than "lived", it is a "thing-body" rather than a "lived-body" (Kemp,

2009).

Here, Vivian's experience of her pregnancy illustrates this kind of disturbed

relationship with the body. She wanted to rid her body of what she perceived as a toxic

intrusion. [11]

> *I was trying to find out how to self-abort. Anything I could*
> *swallow, take, do to myself. Um, I thought it was ruining*
> *my life. It was oh my god it was like, you are the one thing*
> *that would stop it. . It was disgusting but when you get high*
> *and you are pregnant, you have to do an immense amount*
> *more of drugs to feel it because the baby takes a lot of the*
> *drugs. If you shoot dope, you don't really feel it because*
> *you have another person taking part of it. I felt this intense*
> *anger and hatred for this person.*

Vivian was then admitted into the hospital for an acute infection and treated for a

high risk pregnancy. An environment of care and connection facilitated the beginnings of

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[11] As I will discuss in Chapter 2, the traumatic loss of Vivian's two previous children to the state
had much to do with this disturbance and we should be cautious to consider pathological symptoms in a
vacuum, outside of the context of trauma and institutional forms of oppression.

a transition into the symbolic.

> *During that two month period, I had a revelation. I realized that I am going to have the baby. A baby is going to come out. A baby that I made. And I fell in love with my baby. My baby saved my life. And I couldn't imagine not having her. I slowly….that was the first time I started getting prenatal care, I started to see the baby for the first time, I was taking care of myself, I was eating right. I was doing things that moms are supposed to do when they are pregnant. I was seeing a lot of moms with their babies because I was on the place in the hospital where pregnant women are or where women who just have their babies are. So um, you know I was seeing …it was becoming real. I was coming to reality.*
>
> *I was switched to methadone. They helped me, made me very comfortable. They really helped me a lot. They were really excellent. I was getting a lot of prenatal care. I was getting two ultrasounds a week. I was going to three or four appointments a week that I would have with the baby. So it was intense baby, constant baby stuff. I was seeing like images of the baby three times a week, and pictures. It was very real. There was no way for it to not be real at that point. It became a reality and I accepted it. But it became real, that experience in the hospital, my water broke. I didn't have no medicine. I had a natural birth with my daughter. I feel so connected to her. She went through so much with me in my pregnancy. I put her through so much. She is very resilient. That is how I think of her. It was a positive experience. Everything from that point forward, like I said she saved my life. I have been fighting to get her since that point. And i fought for her and I got her and she is the best thing that ever happened to me.*

One way to understand Vivian's relationship to her body is that she translates an unbearable and unspeakable pain into somatic sensations. By reducing that pain to the concrete realm of the body, she gains control over it. By "rendering herself incapable of receiving unpleasurable impulses", she also effectively cuts herself off from the symbolic realm of the other. In an article about the phenomenology of anorexia nervosa Skårderud

(2007) discusses the ways in which *concretized metaphor* is expressed through the body, representing such a regression in representational functioning and an impoverished capacity to symbolize linguistically. Skårderud (2007) conceptualizes this as a symptom of a fragile self-organization: an attempt to shore up the self and to control overpowering affect by grounding oneself in the tangible realm of the body. Similar to what we see in users of heroin, the *concretized metaphor* is what Atwood & Stolorow (1984) define as "the encapsulation of structures of experience by concrete, sensorimotor symbols" (p.85). Painful feelings are reified and translated into objects or things, which can be controlled. In heroin users, this is particularly meaningful. The act of injecting the drug is a ritual that narrows and contains unsymbolized affect to a particular administration on the body; a vein is selected, the drug is prepared, and the body is acted upon. Skårderud (2007) describes a sequence that begins with psychological experience or mental states and is then translated directly into the physical body, without the mediation of the "as if" of reflective functioning. He therefore concludes that concretization can fundamentally be understood as an impairment in the capacity to mentalize.

Mentalization and the Transitional Space

The concept of mentalization is central to our understanding of the interaction of language and affect, as it refers to the capacity to envision and to put into words mental states in self and others (Slade, 2007). It has become an especially important concept in the treatment of substance-using mothers not only because of its relevance to maternal affect regulation and addiction recovery (Söderström & Skårderud, 2009) but also because it has been found to be predictive of parent-infant attachment status and to

correlate with a child's ability to flexibly regulate, develop empathy and have healthy relationships later in life (Slade, 2007).

Mentalization-based interventions (which are fundamentally language-based, left brain-based interventions) are critical for heroin using mothers for several reasons. First, mentalization gives one a sense of self, an 'I' that hovers above one's experience while still being in them, reflecting upon one's own mind and the minds of others. Therefore, with it comes a sense of agency and control (Bateman & Fonagy, 2010) which, as we have discussed, are lacking in substance users who may be chasing feelings of omnipotence and control. Second, mentalization-based interventions shore up parent-infant attachment which is, in and of itself, an antidote to drug use. One of the goals of "mommy baby" drug treatment is not only to protect the mother-infant dyad from any interruptions to bonding and attachment that might have otherwise occurred as a result of traditional drug treatment, but to also leverage the attachment relationship for therapeutic benefit. In a study by Meins et al (2002), a parent's mind-related comments with their 6-month-old was predictive of attachment security at 12 months, highlighting *discourse* and *language* as the central mechanisms. Finally, if we view addiction as a response to affect regulation difficulties, mentalization is regulating at the brain level. It facilitates integration by transforming primary affect into secondary affect by means of a reflective, verbal process (Hill, 2015).

There is also a need to consider how the various institutions with which these mothers come into contact serve to either facilitate or inhibit the capacity for mentalization. A treatment facility in which language and support for reflective functioning is constrained is one that not only undermines the *development* of

mentalization in its residents but which does not itself mentalize. Twemlow, Fonagy &

Sacco (2005) have argued for an expansion of the construct of mentalization to include

what they term "mentalizing communities." They propose an application of attachment

theory to broader social systems and argue the importance of sociocultural context in our

understanding of mentalization and of parent-infant relationships.

> Although mentalizing is developed in the family and
> immediate social environment, including the community of
> the individual, what is known is that social forces that may
> be culturally and politically determined can also affect the
> capacity to mentalize, even in individuals brought up in
> ideally healthy, securely attached mentalizing homes.
> Coercion and humiliation in communities are very
> important in undermining this developmental achievement.
> (p.269)

It is difficult to tease apart the socio-cultural and psychological etiologies of

symptoms, including failure to mentalize. It was evident through my research that the

women I interviewed existed in an environment that was inherently dysregulating and

that, regardless of their own psychological vulnerabilities, undermined their capacity for

affect regulation, self-mentalization and the mentalization of their babies[12]. One of the

ways in which it did this was by constricting open communication, language and 'voice.'

Another way in which the environment undermined mentalization was its use of shame

which, as we will discuss in later chapters, is central to the affective experiences of

substance using mothers.

    As we envision a transition from de-symbolization and the physical body to being

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[12] These are all highly predictive of parent-infant attachment status and should be of interest to institutions
involved in child maltreatment prevention.

able to mentalize the body and the mind through language, it is important to consider the

port of entry as a therapist, as a treatment facility and even as a larger culture. One has to

be willing to initially "feel oneself into the object world of the other" (Altman, 1993) and

to enter into what Ogden (1989) terms the *autistic-contiguous dimension* – a mode

defined by the very beginnings of the body self, prior to any integration or coherence. It

is a mode that necessitates a soothing *other* to contain the anxieties of disintegration and

unboundedness. To not have this 'other' and to remain trapped in a sensory-dominated

world is to be cut off from the possibility of a certain mutuality of experiences or from

what Winnicott called the 'potential space.' It is within this transitional space that one

can work through the anxieties and threats of fragmentation, begin to interact with

psychological material and play with new ways of relating.[13] It is within this space that

one can begin to symbolize.

<div align="center">***</div>

Of course, there is a fundamental rift between lived experience and the capacity of

language to capture it. When one tries to put a dream into words or to observe a psychotic

patient attempting to explain a complicated sensory or existential experience, language

can seem pathetically inadequate. This represents the ever-present Lacanian *lack*, the

distance that we try to bridge between our lives and the echoes of the Real. But while

language is in part responsible for the rupture with the omnipotent state of infancy, it is

also the vehicle of creative expression, meaning, and participation in collective life and

history. Mari Ruti (2013) describes language as "our strongest shield against the demons

of emptiness."

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[13] In chapter 3, I will discuss ways in which harm reduction approaches can open up a space for substance users that parallels the function of a Winicottian transitional space.

Chapter 4: Loss

"The reckless destruction of American families in pursuit of the goal of protecting children is as serious a problem as the failure to protect children. We need to understand that destroying the parent-child relationship is among the highest forms of state violence. It should be cabined and guarded like a nuclear weapon."

-Martin Guggenheim

Hopes and dreams? I got a million of those. I just want to live. Be happy. Make sure my daughter is very well taken care of, god knows it's going to be hard. I want her to bond with her brothers, my sons and be with them and do family things together. Have a day on the beach out. Just be a family. That's what I want. I want a family.

-HDT resident

In the previous chapter, I discussed the ways in which institutional control can stifle voice and language, both of which are integral to the phenomenology of addiction. I also touched upon the ways in which the system places tangible obstacles in the way of recovery and flourishing. In this chapter, I expand upon the ways in which the rules and procedures of the child welfare system prevent healing and induce a form of institutional trauma, which can make failure and relapse virtually inevitable. Before embarking on this analysis, I feel it is important to pause and take an extended look at one of the HDT women's stories. Jocelyn's story puts a face on the trauma discussed in this chapter and shows how various systems of social control intersect tragically in the lives of real women.

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Jocelyn had long, thin, dark hair. On her arms were tattoos of names, symbols of relationships. Her voice was deep and gravelly, yet gentle. She was a large, solid woman. Years of hard living were etched into the lines on her face. There was a quiet steadiness about her. She seemed to convey a certain acceptance of her lot in life that was strong but resigned. We sat together in a small storage room in the annex of the treatment facility. Scattered on the floor were small boxes filled with urine collecting supplies. She told me that her childhood had been hard. Her mother had been into drinking and crack cocaine. Her father hadn't been in the picture. Throughout her childhood, Jocelyn had harbored the fantasy that he would have protected her, had her mother only let him. Her mother used to threaten that she would kill both of them before she allowed Jocelyn to have a relationship with him.

Jocelyn's mother had been severely abused and raped by her stepfather as a child, eventually having a child by him at the age of 13. Jocelyn now believes that this is what sent her out to the bars each night, binging on hard liquor and cocaine and sometimes not returning home for days. Growing up, Jocelyn felt hated by her mother. Jocelyn's mother used to tell her that she wasn't her daughter, that she was adopted, that she was picked up from a trash can.

Jocelyn's first drug was heroin. She was only twelve. Her mother had pushed her out of the house and Jocelyn was forced to sell drugs in order to take care of herself. She lived in the streets, sleeping in cars and occasionally paying people to let her stay in their homes. She spent nights standing in the corner of a smoky pool room selling weed for the lady who owned an afterhours joint. When the lady introduced her to heroin, Jocelyn fell in love with it. It made her feel safe, warm, and content, even as things were falling apart

around her. Feelings of safety and security were scarce and Jocelyn lived one day to the next. Heroin was a constant and dependable companion.

When she became desperate for shelter, she would ask her grandfather to let her stay at his house. He would try to molest her in her sleep. He would offer her clothes, underwear, and cosmetics in exchange for letting him touch her. She would always leave, preferring to sell drugs in the street than endure the abuse.

At 15, she was arrested for bringing drugs to school. She dropped out and entered her first of many inpatient rehabs. Jocelyn got pregnant at 18. She split up with the baby's father right after the baby was born because he was on drugs and she wanted to give motherhood her best shot. But without family support Jocelyn struggled to pay her rent and her bills. She went back to selling drugs and she started getting high again. Jocelyn would bring her son to her father's house so that he wouldn't be around the drugs. She wanted to protect him. She would spend all day with her dad and her son, and would return to her place at night to sell drugs.

One day, Jocelyn sold to an undercover cop. He arrested her on the spot and the courts sentenced her to 4 and a half years. From one day to the next, her little boy had lost his mother, too young to make sense of why. Although Jocelyn's mother had discouraged the relationship, her father had remained in Jocelyn's life, and he now took in her son. Jocelyn described him as a kind, gentle man who had developed a loving relationship with his grandson. But while Jocelyn was in prison, child welfare removed her son from her father's care. They cited a minor drug possession charge from 10 years prior as justification. In prison, Jocelyn felt powerless. "I was in prison so long, they

terminated my rights.", she told me. Jocelyn's son ended up in foster care. She didn't see

him again until he was 16.

When Jocelyn came out of prison, she met a man who fathered her second child,

but who left her to deal with the pregnancy alone. Jocelyn had to leave her job when she

gave birth. What she was getting through unemployment wasn't enough to make ends

meet, so she went back to selling drugs to take care of her daughter. For seven years,

Jocelyn was a parent to her daughter, Monica.

At the time, Jocelyn had a girl living at the house. This girl had been molested by

her father and had nowhere to stay. Jocelyn had seen herself in this girl's story, and

agreed to take her in. During this period Jocelyn was selling drugs to make ends meet,

but made sure never to sell drugs from home. Every day, Jocelyn would drop Monica off

at school and then go to sell drugs on a street corner. One day, Jocelyn arrived home to

find a letter threatening eviction for "illegal transactions" in the house. She discovered

that the girl's boyfriend had been selling out of her apartment. Jocelyn asked them to

leave and gave them 30 days. When the 30 days were up, Jocelyn was firm that they had

to go. The girl was enraged and called child welfare to report Jocelyn. Jocelyn's

response at the time was "Go ahead and call them. What are they going to do? They

can't take my daughter from me. I provide for my daughter. I don't put my hand on her.

She's in school, she's up to date with her shots, I don't abuse my daughter. What are you

going to tell them? There is nothing they are going to do. I have a roof over our heads."

When child welfare came to investigate, Jocelyn admitted to them that she had a

heroin habit. She told them that she never did drugs in front of her daughter. She thought

that by telling them that she had a habit, they would help her. But, that night, they came

to the house at 12:30am to take her daughter. It was dark outside. They were woken from their sleep. The caseworkers told seven-year-old Monica that they were taking her to the hospital. They never told Jocelyn that they were taking her away for good. Jocelyn told me, "I would have done everything in my power to not lose my daughter. Anything. They never gave me a chance."

After they took Monica, child welfare told Jocelyn to go to a rehab. She was in a detox program for 45 days, waiting to get into a "mommy and me" program. After 45 days, she began to wonder why she wasn't moving. It seemed that people who had arrived after her, had already been transferred. She asked one of the counselors why it was taking so long and the counselor looked up her case. It was documented that the "mommy and me" program wouldn't accept her due to a prior felony charge. She was told that it would be hard to get her daughter back.

After Jocelyn's parental rights were terminated, Jocelyn couldn't even stay in her apartment. Everything in her house reminded her of her daughter. Her daughter's dog was there. She would sleep on the streets all night. She started doing drugs she had never considered before. She tried to commit suicide. "I guess I used to wish to overdose. So I didn't have to go through the pain."

When her next daughter was born, she had hoped that the pain would stop. Jocelyn's eyes filled with tears as she told me, "I loved her. I already loved her but I was hoping she would fill the void of my daughter. You know, but she didn't. My daughter, my other daughter, I had her for so long. That bond I had with her was taken away from me in an instant."

When we had reached this point in the interview, the lighting in the room had begun to dim as the day came to a close. I noticed that her daughter's name was tattooed across her collar bone. Her pain was palpable in the room. I realized that this pain was not anything like what we tend to imagine when we think about an addict's child being taken away. This was the pain of a bereaved mother whose daughter had been whisked away in the middle of the night. A bereavement every bit as real as that of parents who lose their children to illness or accident or some other tragedy. Jocelyn's loss was real. Her loss was a tragedy.

Jocelyn continued, "I just know that the only difference I feel is that I am not going to put my baby though what my other kids have been though. She's going to have a mother. I love her. I love that little girl. She makes my day every morning. She keeps me going. That's one thing I know for certain. She's not going to be separated from me again. Ever."

I thought about how uncertain Jocelyn's future was. She told me that she was scared. Once she leaves the rehab with her daughter, she has nowhere to go. She doesn't want to go back to selling drugs. Her felony charge precludes her from public housing and leaves her with few job prospects. TANF will give her 322 dollars a month, the standard amount for an adult and one dependent.

<center>***</center>

Over the course of my interviews, one of the most salient themes was the trauma caused by child removals. Women described it as a pain they would do anything to numb

or deaden. In their narratives, the loss of a child was followed by periods of dissociation, acute intensification of drug use and, in some instances, suicide attempts. The loss of a child, which has been described as "the ultimate loss", is universally considered the most painful of possible life events (Goodenough, Drew, Higgins & Trethewie, 2004). It places parents at risk for complicated grief, heightened suicidal ideation, (Zetumer, Young, Shear, Skritskaya, Lebowitz, Simon & Zisook, 2015) and existential pain, as they struggle with issues of identity and meaning (Keesee, Currier & Neimeyer, 2008).

Even though this trauma emerged as a key theme in my research, and was what many of the women wished to speak about, it is striking how little scholarship exists on the subject of loss experienced by parents in the child welfare system as a result of child removals. Much of the literature focuses on the child's experience of trauma and that of the caseworkers (Mills, 2012). While both of these perspectives are vitally important, the parent's perspective is conspicuously absent. Child welfare research on the parent tends to be focused on assessment, services, and outcomes, with little acknowledgment of the parent's subjectivity or emotional experiences (Battle, Bendit & Gray, 2014).[14] This lacuna in the research likely reflects three cultural, political, and academic tendencies. First, problems and harms suffered by marginal groups are historically understudied in all areas of social policy, and there is clear bias against valuing poor and minority households. Second, the study of, and advocacy for, child welfare is deeply tied to the position that children need more state protection from abusive and neglectful parents. Both social workers and academics were key players in shifting public policy and perception from considering beating a child a private concern of parental discipline to a

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[14] The limited scholarship on the grief of parents whose children are in care comes out of Australia (Burgheim, 2005; Thomson & Thorpe, 2003; Salveron, Lewig & Arney, 2009; Olsen, 2014) due perhaps to its long history of removals of Aboriginal children.

public concern of child abuse.[15] And third, workers and agencies responsible for child removal develop unconscious personal and institutional defenses to shield them from the psychic pain of acknowledging the harms, justified or not, that they routinely visit upon women, children, and families.[16] This third tendency bares further consideration before I turn to the traumas of child removal.

Much has been written about the vicarious trauma experienced by case workers, whose experiences in the system may conflict with the empathy, compassion and moral beliefs that likely led them into the field in the first place (Horwitz,1998; Van Hook & Rothenberg, 2009; Mills, 2012; Haight, Sugrue & Calhoun, 2017). Workers have few ways to process this kind of cognitive dissonance. Individually, they often develop harsh defenses, clinging to the memory of a single case of atrocious child abuse to rationalize applying a rigid, "better safe than sorry" approach. There may also be a reluctance in the scholarship to mentalize the so-called perpetrator for fear of minimizing or invalidating the harms of child abuse and neglect. This victim/perpetrator binary avoids the inevitable self-doubt that comes with acknowledging most family situations as complicated and multifaceted.[17]

Particularly in the context of substance use, we are not far from a time in which addiction was defined as a moral failing, and we are still in a time when the war on drugs dictates punishment over care. The feelings and experiences of drug addicts have no

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[15] See Barbara Nelson's *Making An Issue of Child Abuse* (1986) for an excellent account of how professionals and advocates worked together to put child welfare on the national agenda.

[16] These tendencies are not confined to child welfare, but are clearly more structural. One might easily identify these trends in any public-sector field where state or advocacy organizations are tasked with policing private harms. None of this is to say these fields are unnecessary, nor their workers ill intentioned, but merely to point out that that we should always be on the lookout for structural biases against groups or individuals when advancing state powers.

[17] See seminal paper by Menzies (1960) for a case study in nursing on social and institutional defenses against anxiety. Also see Alderfer (1980). His paper on *underbounded* systems provides a theoretical lens through which to understand the ways in which systems apply rigid procedures.

place in a model that emphasizes punishment and personal responsibility. It is only

natural that child welfare workers internalize this stigma, making drug-using parents easy

to identify as perpetrators. Finally, there has been a shift since the late 1990's away from

family-centered practice in the social work world, motivated in part by a fear that failed

family preservation policies had led to a series of preventable child deaths. This fear is

driven in part by the fact that public, media, and political attention disproportionately

focuses on the most shocking cases of abuse.[18] If you are a worker or agency that

receives little acclaim for preserving families and faces the constant threat of scorn,

budget cuts, or firings from a single mishandled case, it is unsurprising that your

organizational mission will become *removal of children at all costs*.[19]

I turn now to those ignored and overlooked costs of child removal. First, I discuss

the trauma experienced by mothers whose children have been removed. Second, I discuss

the impact of high levels of removal on poor communities with special attention to those

subject to racism. And third, I discuss how removal harms the very children the system is

seeking to protect.

Institutional Trauma and its Sequelae

In his book *In the Realm of Hungry Ghosts*, Gabor Mate (2010) asserts "If I had

to design a system that was intended to keep people addicted, I'd design the system we

[19] Family preservation advocates counter that family-centric policies and practices were never seriously implemented and that policies that masqueraded as "family preservation" failed to address poverty and the material needs of families. Some scholars even argue that poverty is not, for the most part, at the root of child maltreatment but that poverty has merely been *interpreted* as neglect. They demonstrate that the rise and fall in rates of child maltreatment have little to do with the presence or absence of anti-poverty programs but with the fluctuating size of an insidiously coercive arm of child welfare, that has a long history of monitoring the "undeserving poor" while masquerading as "child rescue" (Pelton, 1997).[19]

have," referring to the way in which punishment, shame and disconnection (all central to our current approach) create an affective breeding ground for addiction. Similarly, the removal of infants from drug using women may in fact represent a perfect way to ensure an escalation of drug use. If heroin represents an object-relationship, then to remove a child from a substance using woman is to remove a powerful vehicle for healing. In Chapter 1, we spoke about the ways in which women seek relief from psychic pain by evoking the primordial, omnipotent state of the original mother-infant dyad – a regressive defense uniquely suited to protect against the powerlessness and loss of control that these women experience as a result of state intervention. In fact, heroin use has been described as an attempt to regain control and mastery after an injury to the self (Dodes, 1990). There is perhaps no greater injury to the self than the permanent loss of one's own child and no loss more likely to activate a retreat into heroin oblivion. These traumatic child removals are likely to trigger a parent's own early deprivations and separations, leaving them vulnerable to decompensation and the kinds of maladaptive coping that child welfare then interprets as further evidence of incompetence.[20] This often occurs while mothers are being required by the state to go through detox. The abrupt loss of the drug suddenly empties them of a soothing symbol of attachment--one that has long filled a relational void. It forces them to rapidly give up the one source of regulation that they have, often in the absence of any external supports.

The "termination of parental rights" is permanent and, in all but a very limited number of cases, irrevocable. It marks the end of a legally recognized parent-child relationship. The parent no longer has the right to have any contact with the child, in

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[20] It often seems that child welfare judges the parent's "fitness" based on their ability to survive the intense destabilization that they cause, often pointing to problems judged to be inherent to the parent, that were in fact caused by the environmental stress of being involved in the child welfare system.

person or by telephone, mail, or computer. The parent loses the right to receive

photographs, progress reports, medical information or educational records. The finality

and severity of the termination make it no wonder that the women speak about it as if it

were death.

Many of the women described their responses to such a loss as withdrawing from

the world, disconnecting from their past or from their memories, and retreating to an

inner life in an attempt to protect themselves from unbearable feelings of loss and pain.

Object-relations theorists such as Fairbarn, Guntrip and Seinfeld refer to this type of

retreat as a schizoid defense. Similarly to the Lacanian analysis of Chapter 1, Seinfeld

(1991, 1996) conceptualizes drug seeking as a "return to the womb"[21]--a defense that

allows for a person to retreat into the self, to deny dependency needs, and to rely

exclusively on internal objects, while rejecting the need for the external world

Here, Vivian describes transforming from a "functioning addict" to virtually

obliterating herself with drugs after the removal of her two children.

> *I was on my own, I had lost my apartment, my mom died,*
> *my money was gone. I had no family. I was living in a*
> *motel. No money. I was on welfare, living off of food*
> *stamps, food pantries. So at that point I was an addict, but I*
> *was a functioning addict. I would get my children dressed*
> *and do the necessary things that I needed to do. I wasn't*
> *debilitated. When they took my kids, when they terminated*
> *my rights, I became completely like.....my mind, body my*
> *everything was in the street. Into drugs, into heroin. My*
> *waking up was heroin, my afternoon was heroin, my night*
> *was heroin. Then it was cocaine after a while. I sometimes*
> *would use as much money as I would make. It made me feel*
> *not upset about the pain of losing my kids, my mother. It*

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[21] While he views this as a defense that anyone, at any level or type of personality development, can move in and out of, it is inspired by the phenomenology of schizoid characterology.

made me forget things. Like I wouldn't think about my children. I slowly forgot about them. I forgot their birthdays. It was my defense mechanism. My children were my everything. I was never away from them, ever. They were gone like that. They never came back. That was my only coping mechanism. I didn't know how to cope. After a while, it made me feel better, it really did. It made me the whole while feel better about my children. In the meantime, it was making me deteriorate and making me feel worse, and depressed. Just taking over my everything. I lost everything. I thought it was helping me. I thought it was stopping me from thinking about it.

Maria describes losing her desire for drugs in the presence of her newborn in the

NICU, where she stayed with her for 7 days, not leaving her side, clinging to her up until

the last days before child welfare took her into their custody.

The worker came and told me "you are going to get discharged, but your daughter is not." We are going to put her in Pediatrics. I thought they was lying to me. I thought they thought that I was going to leave her there. I stayed the whole time. I would not go home. I stayed clean the whole 7 days I was in there. I didn't want to get high, I just wanted to be with my daughter. I know I was going to get her taken away from me. It was hurtful. Oh my god, as soon as I had her, they put her on my chest, and I knew they were going to take her from me. I felt like crying. She didn't come out crying and I said please make her cry, please make her cry so I could know my baby is alright. And when she cried, I started crying. Then the second day, I was holding her I would sleep with her and I just knew it. I was getting really really depressed but I didn't want to get depression, so I tried to keep myself happy, not thinking about what was going to happen. And then we had Plan B. My mother in law was going to take her and get temporary custody until I could get her back. I had to go to court on the 4th of December and that's when they took her away from me. They took her from me and the worker had sent an investigator to my mother in law's house to get it approved. Her house wasn't approved. They gave her two lists of things she had to fix, and get put in place before she could get my daughter. So they had another emergency hearing the day before Christmas, and at this point, I didn't

>*want to get depressed, so I just kept getting high. Once she*
>*was taken away from me, I continued to get high. When I*
>*had her, I wasn't high, but when I didn't have her, forget it.*
>*I was out there.*

Nicole describes going from sniffing heroin to shooting it as she experiences the

loss of her mother, her home, her job, and her child. We see aspects of what was

discussed in Chapter 1: a deadly *jouissance* that approaches the death drive and a

yearning for a complete return to the womb- a schizoid defense triggered by loss and

impingement.

>*At that point we had just lost our family home because my*
>*aunt couldn't afford it any more so me and my father were*
>*moving into an apartment. My mother died that January.*
>*And I lost my son two days after we had officially moved*
>*into our apartment. They came and took him. And I had*
>*hopes we could get him back a couple days later. We were*
>*going to court and my father was there to supervise us and*
>*everything would be ok. But then they said "we don't trust*
>*your father anymore because you were using and he didn't*
>*know" and when we didn't get him back that day, it just*
>*gave me more ammunition to want to be high. And then it*
>*became that I didn't want to feel. Anything (tearful). And*
>*when that happened, I really gave up on me. Because they*
>*have made their decision they are keeping my baby. I don't*
>*have nothing left – I don't have my mom, I don't my baby. I*
>*was going through a lot. I lost my mom, I lost our home, I*
>*lost my job, I lost my baby. I had met a girl in IOP and she*
>*said "do you want to go cop?" and I was like "yeah". She*
>*was telling us how she had overdosed a couple weeks*
>*before and had been brought back to life. We told her to*
>*only do one bag but she didn't listen and did two. She did*
>*two bags and she literally stopped breathing, her heart was*
>*not beating. I was in the car with her. But before that*
>*happened, I looked at her and she was so high that I was*
>*like wow, I remember when I used to be like. And I was*
>*nostalgic. And at that point I was so empty and broken. All*
>*I wanted was to be high like that. And after we saved her*
>*life, after my friend brought her back to life, the next day I*

> *started shooting. I saw someone dying, and at the same*
> *time it inspired me. I started doing what she did. .* [22] [23]

The loss of their children to the state also seems to place the women in an ambiguous 'in between' place. They face a unique type of grief which forces them to inhabit a no-man's land between an object world and complete oblivion. Here, Maria's narrative illustrates the way in which losing one's children, while knowing "they are still out there somewhere" represents a trauma that is uniquely painful and difficult to resolve. Maria speaks about the sensation of not knowing where her children are or if they are hurting. She feels the pain of separation acutely, even many years after the loss. Not only must a mother, in this situation, cope with her own pain, but she must live wondering whether her children are suffering, whether they have understood what has happened, whether they blame themselves, whether they feel abandoned, unloved, or scared. She must essentially hold her own grief and that of her children at the same time. In an article on fathers' experiences of court-ordered child removals, Baum & Negbi (2013) reference the importance of achieving a "remembrance formation" (Tähkä, 1984) as one moves

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[22] Interestingly, Guntrip (1992) points out that the behaviors which we label as schizoid defenses are adaptive defenses employed by people who are desperately trying to fight against a complete withdrawal from the object world. Heroin use, while still belonging to a primordial, regressed, infantile world, may nonetheless be a "struggle to stay in the world". After all, a complete regression "to the womb" would ultimately manifest as psychosis, loss of ego, "insanity", or a complete loss of selfhood. At its most extreme, it would be equivalent to psychic death or suicide. Does heroin represent the womb? Or is heroin, despite all of its evocations of the original mother-infant symbiosis, an adaptive attempt to stay connected to the object world? Is it in fact evidence of an active, struggling ego, fighting the "ultimate regressive impulse to return to the safety of the womb?"

[23] In traditional conceptualizations of schizoid phenomenon, articulated by Fairbairn and Guntrip, the schizoid defense stems from attachment disruptions with a caregiver who is overwhelmed by or who cannot tolerate the infant's needs. Discovering that his needs are dangerous and might destroy the mother, the infant over time becomes what Guntrip refers to as a "shut in" individual, denying the need for relationships and seeking more reliable substitutes. A drug is dependable, will not let you down and allows you to feel filled up without having to rely on relationships that one has learned are unpredictable, unstable or frightening. It is not difficult to conceive how a system such as the child welfare system evokes a schizoid response.

through the mourning process. A remembrance formation is a "stable inner image, or

memory, of the lost person, which frees them from continued preoccupation with him or

her." Grieving mothers, whose children are still alive but who have been taken away from

them, are unable to accomplish this. They continue to imagine their children as they

grow, change and develop. They become tormented by thoughts and worries about their

children's continued experiences and feelings in the world.

> *I want to believe that my boys are being taken care of*
> *properly, that nobody's hurting them, that they didn't die. I*
> *need to believe this. I am supposed to register and wait to*
> *see if a child will still find me. I don't think anyone knows*
> *what it's like to look for a child cause that's what I did, I*
> *looked for my kids. And it hurts. My kids are hurt. I don't*
> *know what they feel but I know what I feel. I don't know if*
> *my kids want me. I don't know anything (crying.) It's*
> *something nobody understands. Nobody knows what it's*
> *like to be me.*

In many ways, the experience described above corresponds to what Boss (1988)

calls "ambiguous loss"; a loss that may be non-death in nature and in which a person is

physically absent but emotionally present. One of the reasons *ambiguous loss* is thought

of as the most painful kind of trauma is that it tends to elude resolution.[24] One is

suspended in a frozen state of grief, an infinity of not knowing – a state perhaps more

terrifying than the finality and certitude of death.

Ambiguous loss is also defined by the fact that it doesn't neatly fit into a grieving

process that is culturally and socially sanctioned. There may be an absence of cultural

rituals, in which the loss can be discussed, explored and mourned communally (Mitchell,

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[24] The concept of *ambiguous loss* has been applied to an endless number of issues and phenomenology, including the experiences of military deployment (Huebner, Mancini, Wilcox, Grass & Grass, 2007), chronic illness (Boss & Couden, 2002), parenting a child with autism (O'Brien, 2007), parental incarceration (Bocknek, Sanderson & Britner, 2009), and foster care (Lee & Whiting, 2007; Samuels, 2009).

2016). The stigma of addiction contributes to what Doka (1989) refers to as

disenfranchised grief. The women experience shame connected to the loss of their

children and may feel as though they do not have permission to grieve publically. They

may become isolated and reluctant to seek support from others, who they fear may judge,

reject or invalidate them.[25]

The women of HDT also described the ways in which the ambiguous loss of their

children had a significant impact upon their experience of subsequent children. They

described their relationships with new children as conflicted and painful. Births were

often filled with the hope that the new baby would somehow replace the lost child, but

instead, mothers often struggled to reconcile their love for the new child with their

intense loyalty to the lost child. Moreover, as they tried to build new maternal bonds, they

were haunted by the terrifying prospect of forming a strong attachment to another baby

that would be taken away. The impact of these psychological conflicts upon a mother's

ability to remain strong, to fight for her child, and to survive the assaults of a punitive

system, is surely underestimated. The psychological dimension of cumulative

institutional trauma is rarely considered a source of a parent's "compliance" failures.[26]

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[25] *Ambiguous loss* and *disenfranchised grief* appear to trigger a domino-like trajectory of social isolation. When their grieving becomes "stuck" and chronic, the women may become perceived by others as "grieving for too long". Others may start to avoid them as they also begin to avoid happy family gatherings that remind them of their loss. They feel shunned and misunderstood by their communities and they also actively insulate themselves.

[26] In many ways, the very act of becoming pregnant after having a child removed is considered a form of compliance failure. A repeating pattern of pregnancy and child removal is strikingly common, and is often seen as evidence these women are unfit to parent. After all, if they cannot adequately care for one child, how can they expect to care for several? And if removal is the predictable result, are they not damning these new babies to a life with poor prospects? With these thoughts in mind, case workers can often be heard making comments like, "Well if she has had three babies removed, then…" or "If she lacks the judgment to keep having babies despite having them repeatedly removed, then…". Statements such as these not only ignore the political context of child removal (which we will discuss in the next sections) but are also insensitive to the largely unconscious, psychological sequelae of losing a child. A psychiatrist at a hospital that I worked at used this logic with a patient who had lost several children to child welfare and was at risk of losing another. He inappropriately argued that a mother's therapist should use therapy

The loss of a child to the state is a pain that remains with women, in some form, indefinitely. It has a life of its own; just as intergenerational, unconscious forces find their way into the relationship between mother and baby, so too will the past traumas of child removals. It is a grief that is rarely acknowledged by the child welfare system; parents are rapidly moved into completing concrete tasks such as parenting classes, child welfare 'conferences', court appearances, detox, housing applications, bypassing the affect or the meaning of what is truly a profound and devastating loss. The stories that I have shared in this chapter serve as a reminder of how severe of an impact this type of institutional trauma can have, and also of the likelihood that women will experience long-term repercussions, such as a worsening of their addiction or a repetition of the cycle of trauma with subsequent pregnancies. It also reminds us that drugs do not, by themselves, remove a mother's or father's desire to love, comfort and protect their children. In fact, the women repeatedly challenged the perception of others that addiction had eclipsed their love for their children. They shared that, even in their addictions, these feelings and desires were intact and strong.

> *People have said oh well, when you were using you weren't*
> *thinking about that baby. You know, you can never know*
> *my train of thought, my feelings. Just because my actions*
> *didn't display it, it doesn't mean that wasn't what I was*

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sessions to convince the mother to get a hysterectomy after having written a letter that had triggered and virtually ensured the removal of her baby by child welfare. His actions may have been well-intentioned, but were evidence of an underlying ideological fantasy: move the baby to middle class home, and sterilize the "unfit" mother – a fantasy that has pervaded much of the history of the child welfare system, but which expressed itself most directly during the eugenics movement of the 1930's. Firstly, once a woman is involved in the child welfare system, subsequent births are automatically under intense scrutiny and repeat removals are common. What I also found is that women often seemed to have another child in an attempt to achieve motherhood and to heal from the trauma of a previous removal. I observed a repetition compulsion of sorts- a cycle of pregnancy and loss. Interestingly, one study found that women who lost custody were 2.5 times more likely not to use reliable contraception and to have repeat pregnancies. While pregnancy and the circumstances under which women become pregnant are complex and multiply determined, not only are we far more judgmental of poor women's decisions to have multiple children but we also fail to consider the impact of institutional harms.

> *feeling. Nobody could ever love a child like that actual*
> *child's parent. I don't care what state of mind they're in or*
> *whatever the case may be.*
>
> *I have a good heart. Even in my addiction, I love hard. I*
> *want the best for people. I don't want to see anyone suffer.*

The Termination of Parental Rights

When I began to interview the women at HDT, I was struck by their profound grief and loss. Yet, I could not understand how they could have allowed the state to ultimately terminate their parental rights. How did this happen? What occurred between the time when a child was removed and a court's final decision to remove the child indefinitely? Child welfare would provide the mother with a list of requirements and activities to complete within a certain timeframe in order to get her child back. As I listened to story after story of women permanently losing their children, I wondered, why didn't they just do the things they were supposed to do? Was their addiction so strong that it overwhelmed any attachment yearnings that they would otherwise have had for their child? Women would make comments such as "I didn't get my shit together", or "I didn't do what I needed to do." As they seemed so willing to take on the blame, my immediate assumption was that their addiction was the main barrier to reunification.

But once I dug deeper, I often got a different story, one that pointed to structural barriers to child welfare compliance. In fact, I found that many of these barriers sprang up as a consequence of the removal itself. Often requirements for court appearances, parenting classes, conferences, securing "appropriate housing", drug testing, and visitations became unmanageable, dragging on for years with many women discovering that as soon as they had met one requirement, another would pop up. Go to your court

date, lose your job. Go to your job, miss visitation with your child. Visit your child, miss your doctor's appointment and have your prescriptions run out. Like the Hydra of Greek mythology, cut off one head and two grow in its place. It would feel like a vicious, inescapable cycle - one that intensified feelings of stress and despair.[27]

What often lay beneath superficial statements of "only I can be held responsible" was an initial reluctance to express in language the exasperating process of bureaucracy, institutional rules and barriers, and a belief that no one would believe that they had tried their best. Many of the women had also internalized the doctrine of abstinence-based programs; they would avoid blaming external circumstance and would emphasize the kind of personal responsibility narrative that programs such as AA espouse. As interviews proceeded, however, and as the women felt safe enough to reflect on their experiences, they would begin to make connections between their traumas and drug use. They would disclose in detail the steps between the removal of their children and the termination of their rights. I began to understand the various causes of "non-compliance", not one of which was a lack of devotion or caring as one might suspect at first glance.

Pauline's story illustrates the circular, perverse web of rules and institutional barriers that regularly trapped women in the system. Pauline's newborn was removed from the hospital shortly after birth. The reason cited by child welfare was a positive toxicology screening during a pregnancy six years prior. As soon as her baby was

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[27] Also, requirements of child welfare are in conflict with a harm reduction approach to addiction. More affluent substance users might be able to seek out a harm reduction psychotherapist, make use of suboxone treatment, and continue to parent and function in their jobs while still not completely abstinent. But poor minority women tend to lack access to these services, and risk child removal and incarceration if they seek public help for their substance use. Poor families are monitored in ways that prevent flexibility or integration of a harm reduction approach. They tend to be judged harshly without consideration that there are nuances and a full range of drug use. While middle class families often deal with excessive drug use outside of the purview of agencies with private therapy, poor families are likely to be faced with the threat of losing their children (Lee, 2016). The difference between treatment and incarceration is often primarily a difference of class.

removed, Pauline lost her "mother-child" housing, which she called home. In the midst of

the shock and trauma of having her newborn taken, she was abruptly kicked out of her

home and placed into a very violent and run-down shelter.[28]She was told that, in order to

get her baby back, she would have to find "appropriate housing." *Child welfare was

requiring the very kind of housing that had been taken away from her as a result of their

actions.* Pauline was told at the shelter that the waitlist for housing was six to eight

months long and could sometimes take years, putting her in a precarious position. Child

welfare moves to terminate parental rights one year after removal, and for Paulina, this

clock had begun ticking the day her baby left the hospital.[29] They placed her baby in

foster care two hours away from the shelter, making visitations and traveling to court

hearings, appointments, and required parenting classes difficult. The move also disrupted

access to her doctors and counselors, which were again the very services upon which

reunification was contingent.

      These stories highlight a policy regime that rose to prominence in 1997 with the

passing of the Adoption and Safe Families Act (ASFA). With a growing consensus that

children were spending too long in foster care and with the publicizing of high profile

abuse cases, family preservation was interpreted as dangerous and reckless. Roberts

(2002) documents how the notion of "psychological parent", put forth by Joseph

Goldstein, Anna Freud and Albert Solnit in their 1973 book *Beyond the Best Interests of

the Child*, was used to justify a move away from family reunification and towards

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[28] Keller, (2011) considers this kind of sudden disruption in housing a form of "ambiguous loss" in which there is little opportunity for closure. She discusses the little recognized consequences (psychological and social) of housing disruptions, including loss of place and loss of social network.

[29] Most states have similar termination laws, holding a permanency hearing at 12 months and terminating parental rights at 15 months. As discussed later, these shrinking timelines are part of a focused national agenda to decrease foster care time by increasing adoption speed.

adoption. The book suggested that children, who form a strong attachment with their new

caregiver or "psychological parent" in foster care, are potentially harmed by a return

home to the biological parent. This theory was never well supported by empirical

research, and runs counter to a growing body of evidence that removed children often

maintain a strong attachment to and yearning for the biological parent (Litner, 1975;

Thomson & Thorpe, 2003; Mitchell, 2016; Battle, Bendit & Gray, 2014; Lee & Whiting,

2007; Samuels, 2009; Rivera & Sullivan, 2015). Yet the phrases "psychological parent"

and "in the best interest of the child" were used in hearing after hearing in congress to

support a bill that would ultimately swing the child welfare pendulum in the direction of

removal and adoption (Hansen & Ainsworth, 2011; Roberts, 2002). [30]At around the same

time, several books and newspaper articles came out criticizing the child welfare system

and blaming it for a number of high-profile child deaths. Roberts (2002) also highlights

the influence of family violence advocate David Gelles, whose book *The Book of David:*

How Preserving Families Can Cost Children's Lives pointed a finger at the "reasonable

efforts" clause[31] of the older Child Welfare Act and blamed reunification efforts as the

cause of child deaths. The sentiment was "family preservation kills."[32]

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[30] In a paper on the violation of parents' human rights in child welfare, Ainsworth and Hansen (2011) argue that the "best interest of the child" construct has served to justify increasingly intrusive practices. Parents are left feeling antagonized by workers who, implicitly or overtly, suggest that it is the state that knows, and will decide, what a child's "best interests" are. Rather than support family-centered, relationship-based models, it contributes to a child welfare culture in which the rights of parents and the rights of children are separate and in conflict with each other. It continues to serve as an institutional defense against acknowledging the inevitable paradox of "doing harm while doing good" (Ainsworth & Hansen, 2012).

[31] *Reasonable efforts* is a legal term describing the level of services and assistance that should be offered by caseworkers and child protection agencies to a child and family members in order to facilitate reunification. ASFA made possible exceptions to this mandate, allowing caseworkers to sidestep services and accelerate termination of parental rights and adoption proceedings in certain cases.

[32] The "best interests of the child" construct was vague and it gave judges too much room to be guided by their own values and personal biases when deciding "what is best for this child?" (Mnookin, 1973) Caseworkers were also guided by vague notions and the criteria for "imminent danger" was often assessed with a caseworker's subjective intuition leaving room for bias, racial stereotyping, cultural prejudice, and

The outcome of this particular zeitgeist was a law that made paramount children's safety at all costs, made exceptions to the "reasonable efforts" clause, and put children on the fast track to adoptive homes. The passing of ASFA made available financial incentives for placing children in adoption. Under ASFA, the government began to pay states a bonus for foster child adoptions during the fiscal year that exceeded a baseline of the average annual number of children adopted in the state between 1995 and 1997. They received $4000 per child adopted above the baseline, $6000 per child with special needs and technical assistance to assist states in developing mechanisms to increased permanency through adoption. Agencies were, and still are, ranked according to the number of children that are placed in adoption, and these agencies vie for a good ranking upon which continued funding is contingent. (Roberts, 2002)[33]

The Child Welfare System is far from the only arm of the state placing barriers in front of the women I interviewed. The criminal justice system not only incarcerates men for non-violent drug related crimes, but it increasingly targets a large proportion of women as well. Poor women are more likely to come into contact with the law and what my research found was that incarceration would frequently interact with women's ability to appear compliant.

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the influence of long standing, almost unconscious, myths and narratives about matriarchy, unwed black mothers, absent fathers, and welfare dependency (Roberts, 2002)

[33] The exceptions to the "reasonable efforts" clause had consequences for women in particular. In an analysis on the impact of state and federal laws on children exposed to domestic violence, Matthews (1999) explains that, while a crime against a child does not hold the non-perpetrating parent responsible, a finding that a parent has *failed to protect their child* is easily interpreted as a crime (qualifying it for an exception to "reasonable efforts"). Many states have laws that criminalize omissions, such as leaving a child with a violent partner, failing to rescue a child from abuse perpetrated by a partner, or deciding, despite known dangers, to stay living with an abusive partner. Such laws overlook theoretical perspectives on the dynamics of abuse, as well as research that shows that leaving an abusive partner is dangerous. The intersectionality of gender and class place women at a further disadvantage; women often find themselves in a double bind, knowing that leaving may require them to stay in a shelter, which would subsequently cause them to lose their children anyway. Criminalizing women's role in domestic violence may also deter them from seeking help.

> *I was arrested the night they were removed so I was never*
> *able to return back to them. They were placed in foster*
> *care. At that point, I felt so powerless. I felt completely*
> *powerless. I wasn't allowed to see my children all the time*
> *period I was incarcerated. Then when I came out, I saw*
> *them once a week. Shortly after that, they terminated my*
> *rights. And I felt completely powerless, completely*
> *powerless. Like I had no control. I had a public defender. I*
> *was in a rich county and I felt like I was in a rich town. I*
> *had no fighting chance to get my kids, none.*

In addition to the child welfare system and the criminal justice system, the social welfare system also presents a set of restrictions, requirements, and surveillance that complicate the lives of mothers in recovery. The passage of ASFA came within a year of President Clinton signing the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (also known as the 1996 Welfare Reform Act). Women were forced off of welfare into low wage jobs without subsidized child care, compounding poverty and also increasing the likelihood that their children would be cared for in unstable and unsafe conditions. Welfare reform meant that poor women, already involved in the child protection system, were required to comply with the intensive demands of *two* separate programs. Even though these two arms of the welfare system seem as though they should be able to operate as one, in the service of uplifting those in need, they had become punitive systems of social control. For drug using mothers, who also had requirements for completing detox, one can imagine how easily "compliance" became a bureaucratic nightmare. The documentary *Ending Welfare As We Know It* (Weisberg & Weisberg, 1999), narrated by Meredith Vieira follows the lives of five welfare recipients who, with the passage of the new law, are faced with the new time limits and work search requirements. We watch them spend forty hours a week

performing job searches, taking classes, taking buses to fill out applications, struggling to

find child care, and failing to find jobs. When these women, who express strong desires

to work, do find minimum wage jobs, they are unable to make ends meet. The

documentary expressly makes the connection between welfare reform and child welfare.

Several of the women are forced to move into shelters and lose their children, with

Meredith Vieira stating:

> As welfare rolls plummeted during the past decade, the
> number of children placed in and out of home care tripled.
> Since traditional welfare was criticized for its failure to
> promote intact families, it would be a sad irony if the
> financial stress caused by tough new welfare laws was
> actually fueling the increased placement in foster care.

Community-level Impacts

The forcible removal of children from their mothers or fathers has long been

considered a tool of social control used by the state against minority populations,

communities and groups. In its most extreme forms, child removal, to "civilize"

indigenous children, has been used in efforts to extinguish native cultures - a form of

genocide. The act evokes painful scenes such as that in *Sophie's Choice*, a 1982 film in

which Meryl Streep is forced by a Nazi general to choose which of her children will be

sent to die. Or the poignant scene in the film Rabbit Proof Fence, a film about the policy

of the Australian government between the years of 1910 to 1970 to forcibly remove and

"civilize" half-caste aboriginal children. It depicts the intense grief of a mother wailing

and clawing at a police officer pulling her children into a jeep to take them to an

internment camp, the scene ending with three generations of women laying in the desert

dust, one banging her head with a rock in an attempt to self-soothe.

Dorothy Roberts proposes a theory of *group-based* harm that she argues has

occurred as a result of a child protection system that disproportionally targets poor, black

families (Roberts, 2002).[34] Not only does this system sever parent-child bonds, but the

presence of intrusive state supervision affects black families' status and welfare *as a*

group. Roberts uses a historical frame to contextualize these trends, highlighting that the

removal of children, the destruction of family, and the loss of parental identity were all

central to the trauma of slavery. She argues that the way in which the child welfare

system contributes to community disintegration weakens collective ability, political

power and social capital. Because of the conflation of poverty and 'neglect', poor

communities are targeted and there is a geographical, spatial concentration of state

supervision, resulting in a weakening of social ties.

At the most concrete level, the state chooses not to pay for social services like

food stamps, heath care, housing, and welfare within a community, and instead directs

funds to foster and adoptive parents in middle class communities.[35] At a more indirect

level, community members stop seeking help from state agencies for fear of involving

child welfare services in their lives. Parents may even avoid taking their children to the

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[34] It is well documented that black children are removed at higher rates than white children. While recent years have seen slightly more racial balance in child removal statistics, HHS reports that racial disparities remain a persistent problem that the system has failed to solve. *See* Child Welfare Information Gateway (2017).

[35] For example, New York foster parents are paid up to $1,289 a month per child and $1,953 per child with special needs. In a recent New Yorker article, a foster parent was being paid sixty-two thousand dollars a year for three children who had been removed from their mother for poverty-related problems such as unstable housing (MacFarquhar, 2017).

doctor for bruises or burns for fear of being reported.[36] And at its most diffused, and

Foucauldian, communities, in which child welfare agents are a constant presence, lose

trust in their friends, family, and neighbors, never knowing who might pick up the phone

and spitefully report them, as Jocelyn's house guest did. Who can thrive living in the

Panopticon? From material resources like government benefits to social capital like

community trust, an overactive child removal regime insidiously reproduces social and

economic inequalities by weakening those social ties that are indispensable for a

community's strength, well-being and ability to collectively organize.

Mass child removal parallels the corrosive effects that mass incarceration has had

in communities. In the *New Jim Crow*, Michelle Alexander (2012) argues that the current

penal system and the dramatic upsurge of incarceration since the onset of the drug war in

the 1970s has decimated communities of color. The criminal justice system has created a

second-class citizenry of young men who are not only unable to participate in the legal

economy, but are also indefinitely barred from participating in the democratic process.

Someone that has been convicted of a drug felony cannot find work, is prohibited from

obtaining most professional licenses, can be denied public housing for the rest of their

lives, can legally be turned away by private landlords, is permanently ineligible for food

stamps and is responsible to pay back thousands of dollars in court fees, fines, and

accumulated child support (the payment of which can in fact be a condition of parole). In

fact, people can lose their public housing for having individuals accused or convicted of a

felony at their home. These policies fragment communities and prevent individuals from

accessing resources upon release from jail or prison, pushing them to return to drugs and

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[36] See MacFarquhar, 2017

crime. In the end, communities are left burdened by crime and unemployment, while the

prison industry profits.[37][38]

In a PBS interview, Michelle Alexander (Childress & Alexander, 2013) expresses

the ways in which mass incarceration and the war on drugs have impacted upon those

communities in which arrests and incarcerations for nonviolent drug offenses are

concentrated.

> And in these communities where incarceration has become
> so normalized, when it becomes part of the normal life
> course for young people growing up, it decimates those
> communities. It makes the social networks that we take for
> granted in other communities impossible to form. It makes
> thriving economies nearly impossible to create. It means
> that young people growing up in these communities
> imagine that prison is just part of their future.
>
> And it affects people emotionally. It's growing up not
> knowing and forming meaningful relationships with their
> relatives and parents. But it's also devastating for people
> who come out and want to do the right thing by their family
> and aren't able to find jobs and support them (Childress &
> Alexander, 2013).

The Child Welfare System mirrors the criminal justice system, but it also interacts

with it. The current inequalities and injustices within the child welfare system were aided

by the confluence of the war on drugs, welfare reform, and the passage of ASFA. All of

the women that I interviewed made reference to incarceration, either of themselves, of a

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[37] We know that being involved in long-term support systems has been found to be protective for families (Gray, Cutler, Dean and Kempe, 1977). Social organization theory posits that neighborhoods in which informal community networks and resources are depleted and which have lower levels of social capital may have fewer adults to supervise children and to become involved in social institutions (Coulton, Korbin, Su & Chow, 1995).

[38] This depiction of communities should not be taken as advocating a "culture of poverty" approach to race politics or to black poverty. The culture of poverty approach is one we have been stuck with at least since the Moynihan Report which, while advocating greater federal spending on social welfare supports for inner city minority communities, famously was most influential in spreading a discourse that argued cultural pathologies in the black community would undermine any attempts at targeted economic support.

relative, or of their children's fathers and to the ways in which this complicated the loss of their children and their ability to get them back. For example, recall that Jocelyn's father was unable to take temporary custody of her child because of an old drug charge. In addition, current mandatory minimum sentencing laws operate in non-gendered ways that do not take into account women's disproportionate role in caring for children (Raeder, 1995), leaving an increasing number of children at risk for loss and destabilization.

Similar to those exiting the prison system, women who have histories of child welfare involvement have records that limit their engagement in the world and contribute to their isolation and sense of stigma in society. For example, forty-one states maintain a child neglect and abuse central registry and thirty-one states and the District of Columbia allow or require a check of central registry records for individuals applying to be child or youth care workers. More broadly, information is made available to employers of child care businesses, schools, and the health-care industries (Child Welfare Information Gateway, 2014). Like with felon records, this reporting virtually guarantees women will not be able to find childcare work. Childcare is one of the principle fields open to women without college degrees, meaning these laws deprive women and their communities of vital income.

Equally important is the message that these kinds of laws send to these women and to their communities that they are not capable of contributing. Many of the women spoke to me about wanting to help other women, wanting to open their own "Mommy and Me" programs and wanting to somehow use their experiences to help other struggling women. Most of the women were in fact motivated to tell their stories to me

for that very purpose. By creating barriers that prevent women from giving back to society, the state blocks these women from becoming a resource for their communities. Not only is their productive labor lost, but so too is the knowledge and perspective that only comes from years of navigating the system. Childcare workers who have struggled in their own parenting journey may be better situated to identify and intervene early in the struggles of other parents.[39] Preventing these women from using their hard earned knowledge cuts off a powerful redemptive opportunity. It steals from them the silver lining of their experiences: the chance to transform shame, to restore a sense of dignity and to create meaning of their life histories.

I had first hand contact with the enforcement of this law and with its ramifications beyond those directly prevented from working. One Thursday afternoon, I arrived at the HDT treatment center at my regular time to find that many of the staff I had come to know and trust were gone.[40] I soon discovered that all staff with prior histories of child welfare involvement had been let go. The residents were confused and saddened. Not only did this represent a disruption in the important connections they had formed with this staff, replicating their own attachment histories of sudden loss and unresolved goodbyes, but it also implicitly communicated that they were now part of a separate, stigmatized group, considered to be dangerous to children. Here, Jocelyn describes the incident, drawing out the parallels between the penal and child protection systems. She

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[39] Feminist standpoint theory argues that experiences of oppression and powerlessness give people a unique epistemological advantage in seeing ways in which the world works differently from our idealized conceptions of it. See Hartsock's *Money, Sex, and Power (1983)*.

[40] During my interviews, I worked closely with the staff at HDT. There were two staff members in particular who were very close to the women and who served as inspiration to them because they had also struggled with heroin addiction and had been involved in the child welfare system. Women often spoke about how different it was to speak to those counselors and staff who had a first-hand understanding of their experiences.

describes the way in which these two systems interacted to undermine her family's

stability and its ability to provide social support. Ultimately it was the interaction of these

two systems that led to the permanent removal of her daughter from the family system.

> *Child welfare got rid of them cause they took over this place. This place was under human resources before, and some of the girls that went through the program. Now they get rid of all them. A lot of the workers here are gone. They had child welfare charges from years ago. She'd been through this program 13 years ago and because of that you can't be around kids. That's unfair, very unfair and they got rid of her. Anybody with a case got to go it doesn't matter how long ago. That's the other reason why I'm like so affected with my daughter being taken away, my other daughter because my father tried to get custody of her. And he had a CDS charge for one bottle of cocaine from like 15 years ago and they wouldn't let him take my daughter.*

As I listened to these stories of personal loss and of community disruption, I was

struck by the enormous costs of child removal. Removal and the subsequent terminations

of parental rights seemed an extreme response. Why is this significant loss of rights

unique to the child welfare system? [41] It seemed that the only possible answer was that

children were being saved from great peril. However, it is far from clear that children are

being well-served by removal from their homes.

The illusion of safety: child removal outcomes

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[41] Roberts points out that, as a culture, we allow contact with non-custodial parents in cases of divorce (even, in fact if that parent is deemed "unfit" for custody) and we fully accept that a child would maintain a relationship with a stepparent *and* a parent without the need for one relationship to threaten the other. Roberts proposes that the severing of parent-child bond, unique to child welfare, can be explained by a history of dehumanizing poor, and especially black, families. Policy both creates and is informed by our limited capacity, as a culture, to mentalize the poor and to imagine that poor, and especially black, parents and their children have loving attachments.

So far this chapter has shown that child removal is a devastating trauma for women in recovery, as well as for vulnerable communities. But what if the harms of child maltreatment outweigh the harms of removal? In a system built to protect children, perhaps the benefits to the removed children justify the harms to others. So how do children fare? First, it is unclear how many serious incidents of abuse or death are being prevented because little data exists comparing removal and non-removal decisions *in comparable abuse and neglect situations*. This issue calls for future research, but we do know that children in the foster care system suffer from abuse and neglect, and we also know that the act of removal causes significant and lasting trauma and attachment injuries. The harms are far from short-term and the guarantee of safety is far from certain.

Preeminent trauma researcher and clinician Bessel Van der kolk (1987) reminds us that "the earliest and possibly most damaging psychological trauma is the loss of the secure base"(p.32). Severing the parent-child attachment is an enormous trauma in and of itself. Often, child removals take place without warning, in the middle of the night, and involve the police. Children are forced to see their parents vulnerable to state authority, stripped of their dignity and unable to protect them. The child is placed in an impossible situation; the very person from which the child would ordinarily seek proximity and comfort is herself in danger. Drawing on family violence literature, we now know that to see one's primary attachment figure under threat is a very significant trauma and that outcomes for child witnesses of domestic violence are in fact not significantly different from those outcomes associated with physically abused children (Kitzmann, Gaylord, Holt & Kenny, 2003). Similarly, it has been suggested that the trauma of removal may have equivalent outcomes to the trauma of abuse and may be experienced by the child as

more significant than the trauma of neglect (Rivera & Sullivan, 2015). It has been hypothesized, by Felitti et al (1998) in their theory of Adverse Childhood Experiences (ACEs), that the toxic stress and disrupted neurodevelopment that results from removal leads to a cascade of negative outcomes, including social, emotional and cognitive impairment, adoption of health-risk behaviors, disease, disability and social problems. That children and parents will emerge unscathed from even brief separations of this nature is unlikely.

Sankaran & Church (2016) criticize child protective policies that rely on high levels of short-term removals, in which children are returned home in less than 30 days. While officials employ these removals as if they are harmless, the truth is far different. Referring to these children as "short stayers", Sankaran & Church (2016) describe the "debilitating effects" and long term consequences of these short-term removals, including neuropsychological, attachment, and delinquency outcomes. They capture what it might feel like to be one of these *short stayers*: "not knowing why they are entering foster care, the purpose of foster care, where they will be living, with whom they will be living, when they will get to see their birth family, and how long their foster care episode will last" (p.5). A recent New York Times article called *Foster Care as Punishment: The New Reality of "Jane Crow"* addresses the trauma of such short term child removals, estimated to be 25,000 nation-wide and disproportionally affecting the poor (Clifford & Silver-Greenberg, 2017). Children are described returning to their families with flashbacks, separation anxiety, diminished trust or with the fantasy that they may have been to blame for the separation. These reactions have subsequent impacts upon learning and behaviors in school, in some cases leading to psychiatric diagnoses and medications,

which we know are disproportionately prescribed in twenty to forty percent of foster youth (Lash, 2017). [42][43] Particularly for children who are returned to their homes within thirty days of the removal, these traumas are difficult to justify in light of the overwhelming harm that they cause.[44]

The traumas of removal for children may lead to what some attorneys call a "snowball effect" for birth parents (Barish, 2010). Children develop symptoms, receive diagnoses, and are prescribed medications, all of which creates new responsibilities in caring for them. Parents, who already carry the burden of proof to demonstrate fitness to the courts, must prove themselves capable of dealing with these new challenges created by the removal process itself. The effect is to make it even more difficult for the parents to regain custody. Another recent New Yorker article *When Should a Child be Taken from his Parents?* chronicles a mother, Mercedes, on an odyssey through the child welfare system. Her situation worsens, her life becomes unstable, and her children develop psychiatric symptoms as a result of the separation and an unhealthy foster home. The article ends with Mercedes, having spent two years relentlessly attempting to

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[42] For example, the child may exhibit responses to trauma (affect dysregulation, interpersonal difficulties, sleep disturbance, regression in developmental achievements, aggression and noncompliance) and be given a diagnosis of conduct disorder or ODD (complicated by the fact that Medicaid reimbursement often requires a diagnostic code).

[43] Foster care children are more likely to be prescribed psychotropic drugs. A 2011 Government Accountability Office report looked at five states and using 2008 data found that foster care children were more likely to be prescribed medication than non-foster youth. Percentage ranged from 20-40 percent. Lash (2017) points out that rates are uniformly disproportionate among states, but that there is variability in numbers between states. This may suggest that need for medication may be an artifact of different state systems. Sadly, the problem is often due to a lack of resources to address children's distress in other ways, and well-intentioned efforts to maintain a child in a placement subsequent to removal from the biological family.

[44] Some believe that there are spikes in these sorts of removals following a high-profile case in which child welfare has been blamed for negligence, which suggests that these removals may be socially constructed, rather than rooted in objective evidence of harm.

comply, hopeless in the face of what begins to feel like an impossible, maze of a system. The outcome is poor for everyone involved.

Not only is the removal itself traumatic, but children are likely to encounter further harm within the foster care system.[45] Studies have shown risk of physical abuse, delinquency outcomes, and a high incidence of sexual abuse (Euser, Alink, Tharner, van IJzendoorn, & Bakermans-Kranenburg, 2014; Hobbs, Hobbs & Wynne, 1999). Despite difficulties in parsing out abuse and neglect that predate foster care placements, there have been studies comparing foster youth to children who remained in the home despite similar maltreatment. MIT researcher Doyle (2008, 2013) made use of naturally occurring randomization of caseworkers to child-protection cases and found that children "on the margin" (cases in which caseworkers disagreed about whether or not to remove the child), fared better when they remained in the home. Results indicated that these children had arrest, conviction and imprisonment rates as adults that were three times higher than those children who were not removed and remained in their homes. While there is of course no way of empirically measuring the danger of removal when children are in such danger that all caseworkers agree that removal is favorable, Doyle's research highlights the potential harms and negative life outcomes associated with foster care.

Two of the women that I interviewed, whose children had been removed for drug use, described horrific incidents that occurred whilst their children were in foster care under state supervision. Jocelyn's three year-old son had been found tied up in the closet with his mouth taped shut. Mary's newborn, who had been removed directly from the hospital, had suffered a major seizure and was hospitalized after a foster parent had

accidentally mixed her formula with vodka. While these anecdotes are far from comprehensive data on removal outcomes, I found it striking that these two extreme examples of trauma were among the handful of children discussed in this study.

Children who spend their youth as wards of the state also suffer *long-term* problems beyond the immediate incidents of abuse that they may encounter in their foster care settings. In 2014, Dale Margolin Cecka, at the University of Richmond, wrote a paper called *The Civil Rights of Sexually Exploited youth in Foster Care* and estimated the harm of foster children, as wards of the state, to be "far worse than prisoners and institutionalized adults, in terms of their rights to be free from harm while in custody." She argues that the state bears responsibility for the large number of children who are missing or discharged from the foster care system and demonstrates a direct link between systemic neglect and later sexual exploitation. A 2013 expose in the Huffington Post titled *Stopping the Foster Care to Child Trafficking Pipeline*, cites statistics that highlight the long-term risks and outcomes for children under state supervision (Soar, 2013). [46]

Several papers have also explored the existential, phenomenological experiences of children who have been separated from their parents and subsequently raised in foster care. In her examination of children's acculturation to foster care, Mitchell (2016) explains how children, despite superficial safety, suffer some of the very same pains and

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[46] In 2013, 60% of the child sex trafficking victims recovered as part of a FBI nationwide raid from over 70 cities were children from foster care or group homes. In 2012, Connecticut reported 88 child victims of sex trafficking; 86 were child welfare involved, and most reported abuse during their time in foster care or residential placements. In 2012, Los Angeles County, California reported that of the 72 commercially sexually exploited girls in their Succeed Through Achievement and Resilience (STAR) Court Program, 56 were child-welfare involved. In 2007, New York City identified 2,250 child victims of trafficking, seventy-five percent of whom had had contact with the child welfare system. In Alameda County, California, a one-year review of local CSEC victim populations found that 55% were from foster youth group homes, and 82% had previously run away from home multiple times. In Florida, FBI agent Gregory Christopher (head of Florida interagency rescue and restore law enforcement task force) estimated that 70% of victims identified in Florida were foster youth.

ambiguous loss that the mothers in this study expressed. They struggle with how to reconcile their feelings about their birth parents and their new foster parents. They experience guilt and issues of conflicting loyalties. Many resist adoption; not only do they harbor hopes that their biological parents will return but, to them, adoption represents a symbolic betrayal. Beyond Mitchell's research, there is evidence that children in foster care go to great lengths to maintain ties with biological siblings, run away from their foster homes to reunite with their biological families or attempt to rejoin their families upon exiting the system (Courtney, Skyles, Miranda, Zinn, Howard & Goerge, 2005). Samuels (2009) conducted interviews with young adults who had been raised in foster care and who had recently exited the system; the young adults in his study reported that it wasn't until they were reunited with their biological families, as adults, that they were truly able to put to rest their unresolved sense of loss and grief. Many of these young adults had carried with them a longing for a sense of place, for belonging and for the subjective experience of "being known" (Samuels, 2009). Regardless of whether or not removal is justified, current notions of 'safety' and 'permanency' ignore the more subtle or less easily observed psychological harms, that may be just as detrimental to a child's life prospects.

Directions for child welfare

What the women in my study needed most was material and concrete support upon exiting treatment. They voiced their worries about housing, social isolation, financial support, access to medical care and appropriate treatment. Many feared that a return to the stresses of poverty would undermine their recovery. The services that are

provided by child welfare do not address these needs. Rather, in line with an ideology that supports the idea that child maltreatment is necessarily and completely a personal failing, child welfare contracts with agencies to provide a package of services aimed at changing a mother's behaviors: parenting classes, counseling, psychological testing, and abstinence-focused drug treatment. Often these services are required of parents, regardless of what the allegations or problems are. One mother that I encountered was required to complete random drug screens even though her toxicology screen in the hospital was negative and she did not use substances. Her lawyer eventually fought to get this requirement removed, but this is one of many examples which demonstrates the arbitrariness of the system's requirements. These are also services that typically *add* stress rather than relieve it. Parents must travel to weekly appointments and classes. Psychological testing often leads to diagnoses which further hinder a mother's ability to regain custody and which often lead to an additional list of requirements (Roberts, 2000).[47] [48]

In Macfarquhar's aforementioned New Yorker article, the foster parent that took Mercedes' children was paid between forty-six and sixty-two thousand dollars a year (a sum she would continue to receive up until the children turned twenty-one). Meanwhile, Mercedes struggled to find housing that had been made a requirement of regaining custody. It is difficult to read the article and not begin to think; what if that sum of money were given directly to Mercedes? The women I interviewed jumped through an endless

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[47] The role of psychologists in child welfare is an understudied area of our field and deserves further attention.

[48] While I don't wish to minimize the powerful impact certain therapies can have in the lives of families, particularly family or dyadic parent-infant psychotherapy, I believe that they must be provided in the context of safety and stability and by therapists willing to acknowledge the larger socio-political meaning of symptoms.

number of bureaucratic hoops. Each class that they took, each social worker they meet

with, each packet of paperwork, each court appearance, each evaluation they underwent,

all added costs to the process. One is left wondering what things would be like for the

women I spoke with, were all of those resources diverted *directly* (and not in the form of

additional, bureaucratically cumbersome social programs) to supporting families.

What we know is that when funds are made available for family preservation

efforts, positive outcomes can be achieved for parents and children. There is evidence

that programs that support families practically and *economically* go far in preventing

child maltreatment. There have been several attempts at implementing true family

preservation programs and the research shows that, when families are surrounded by

support and the right kinds of material assistance, that children fare better and are safer

than children who are removed and placed in foster care.

Rivera & Sullivan (2015) describe a demonstration project in Oregon designed to

avoid removal through comprehensive and enriched supports, with a heavy focus on

housing. On the front-end, case workers investigated cases along with "peer assisters"

(someone who was in recovery and who had experience in the child welfare system). The

family then developed a plan with the caseworker which involved *immediate* access to

housing with on-site staff and treatment providers. Parents moved through a continuum

of housing, from emergency, to transitional, to permanent. Support services included

transportation, couples and family therapy, medical care, child care and developmental

services. Substance abuse treatment was relationship-based and trauma-informed. To

reduce the harms of removal, the project also implemented a "Partners in Parenting"

program for those children that required removal. Foster parents maintained open

relationships with biological parents and parents were able to remain in their children's lives in meaningful ways; they were able to meet their children at school in the morning for drop off, attend parent-teacher conferences, and remain involved in their medical care. After being reunited with their parents, the program also supported children and foster parents to remain connected. The treatment group performed exceptionally well on family permanency outcomes, with 91.7 percent of the treatment group being reunited with their family as compared to 51.9 percent in the comparison group. The children in treatment group also experienced lower rates of subsequent maltreatment compared to other studies of general populations.

A pilot perinatal addiction clinic in Hawaii also demonstrated that comprehensive supports, in the context of a harm reduction model, yields positive outcomes for women and children (Wright, Schuetter, Fombonne, Stephenson & Haning, 2012). In the clinic, pregnant women participated in harm reduction treatment, had comprehensive perinatal care, transportation, an array of social services, family planning, and medication. Ninety-six percent of women in the study had negative toxicology screens at the time of delivery, twelve percent of them had preterm infants (equivalent to the state and national average) and, at eight months post-birth, ninety percent of the women had retained custody and were raising their children. The clinic increased referrals from physicians in the community and played a role in normalizing treatment for what would otherwise be a very marginalized and stigmatized group. The authors also highlighted significant cost-saving benefits, citing that the cost of only *one* preterm infant can exceed the annual cost of running a comprehensive family preservation program.

Beyond these more targeted reforms and programs, some have suggested that the child welfare system is symptomatic of larger problems in our socio-political system. In two seminal papers from the 1970s, Mnookin (1973) and Wald (1975) expressed concern over the harms of foster care and argued for very narrow standards of child removal, stating that it should only be enacted in the most serious cases of child injury or "immediate and substantial harm". They highlighted the common conflation of neglect and poverty in neglect cases, criticized open-ended and vague criteria that gave judges excessive discretion in the courts and proposed a system of *voluntary* preventive services. Pelton (2016) continues in this vein, advocating unconditional cash benefits and universal preventive services as a way to reduce child welfare's role – one which he believes should be narrowed to dealing with only the most extreme cases of child abuse. He critiques the neoliberal approach of making cash benefits conditional on services that will mold and change the behaviors of poor families, arguing that these programs remain coercive and punitive by the very nature of their conditionality and ability to withhold. He is particularly critical of the way in which child welfare uses the removal of children as a way for parents to accept services that are largely ineffective and do not address those material needs that are usually at the heart of neglect allegations in the first place. [49]

In the end, advocates from all sides seem largely in agreement that the foster care system visits significant harms upon children. The major disputes are not around the data and outcomes related to foster care, but in how we interpret that data. The standard response to problems in the foster care system has traditionally been to expand it and to apply more funds and more resources to foster families and adoption initiatives. We

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[49] Pelton (2016) notes that parents end up signing "voluntary placement and service plans", blurring the lines between *voluntary* and *coercive* in insidious ways.

could, instead, be asking "how can we support families to care for their children?", but our values as a society dictate the questions that we ask and the actions that we take (Roberts, 2000). Ultimately, our system is grounded in a neoliberal ideology that works from socially constructed ideals of motherhood, ideas about the "underserving poor", and an ethos of autonomy and personal responsibility. Given these values, we are committed to the idea that poor families are the root of the problem, and our inclination is to use foster care data to undermine and eliminate these families. Ideology, not particular statistics, drives policy. And our ideological blinders prevent us from considering policies that help children *because they also help these children's mothers*, the undeserving poor. We appear unwilling to consider solutions that dignify and acknowledge these women.

Moving forward in small ways that challenge dominant ideology inevitably leads us to other conclusions that more significant changes in social supports and entitlements are necessary to advance collective welfare and social justice. Perhaps it is ultimately an unwillingness to look at these grander reforms that keeps us disinclined to take the small steps now that would benefit these women and their children.

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Circa 1940, at a meeting of the British Psychoanalytic Society, psychoanalyst, Donald Winnicott stated "there is no such thing as an infant" (Winnicott, 1960). What he meant by this statement is that a child exits in the context of a relationship with his primary attachment figure and that, similarly, a mother or father exists in the context of their attachment to their baby. The subjectivities of baby and parent are intertwined and

inextricable. To pit the interests of children and parents against each other, as do the child

welfare system and the courts, is to undermine *both* the child and the parent.[50]

It is in this spirit, that we must abandon the binaries of child's rights versus

parent's rights and transform the notion of "in the best interest of the child" to "in the

best interest of the family".[51] While some argue that family preservation efforts are to

blame when the limited services that we provide to families fail, it is clear that as a

culture, we have not done enough to support poor families. Addressing poverty at its core

is what ultimately promises to protect children and preserve families.

In this chapter, I discussed the intrapsychic dimensions of loss associated with

child removal and the termination of parental rights. I considered the significant

community-level impacts and group harms of child welfare policy and practices. And, by

examining research on foster care outcomes, I challenged the illusion that removing a

child from their home guarantees safety. Taken together, these points demonstrate that

our current system is not supporting poor children, because it is not supporting poor

mothers. Substance using mothers are particularly vulnerable to the injuries and traumas

that occur in the child welfare system. They have significant histories of trauma. They

have been injured, hurt or disappointed in relationships and in love; heroin becomes a

defense against the vicissitudes of human connection. Not only is losing their children to

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[50] Some feminist scholars have critiqued the parental rights doctrine as paternalistic and argue that the concept of family and maternal function should be expanded and redistributed to larger society. However, Appell (2000) considers that these criticisms fail to consider the ways in which the dissolution of the parental rights doctrine may in fact harm poor families, who are already excessively in the public sphere.
[51] This kind of polarization also lends itself to the repression of one side or the other, rather than to the development of the capacity to hold both sides at once. For caseworkers, it may perpetuate a paranoid-schizoid position of aligning themselves with only one part of a child's or a mother's experience. The caseworker may be unable to hold that a mother simultaneously hates *and* loves or that a child feels, at once, threatened *and* secure (Mills, 2012). Therefore, not only do these binaries put families at risk practically, but they may prevent caseworkers from conceptualizing cases in complex and nuanced ways. In some cases of extreme abuse, this kind of dichotomous thinking may in fact lead caseworkers to ignore real signals of risk or danger.

the state a profound and enduring loss for these mothers, but the disorder and

unpredictability of the child welfare system itself seems to replicate the very traumas of

their early attachments. The system is experienced as dehumanizing, punitive and

arbitrary, reinforcing feelings of powerlessness and ultimately triggering a schizoid

retreat into further drug use.

Chapter 4: Shame

A Duality of Shame

There is a common thread that runs through the preceding chapters on voice and

identity, loss and the child welfare system, and addiction and trauma. That common

thread is shame. More than any other affect, the women of HDT spoke of shame. When

silenced, women felt shamed and forced to reject significant parts of their identities.

When welfare services monitored and managed women, they felt the shame of failing to

meet social expectations, and when they lost their children to the system they felt shamed

as failed mothers. When trauma and dislocation led to addictive behavior, shame

intensified women's isolation and pushed them deeper into drug use.

Shame is dysregulating and painful. It often feels contagious; talking about shame

begets shame. Shame is an affect without words. It is excluded from the *Symbolic* order

(Lacan, 1957) and from the realm of shared discourse.[52] It resides in the primitive,

preverbal realm of the right brain. It is tied to ruptures in relationship and it threatens our

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[52] Mollon (2005) suggests that, in its most extreme form, shame is implicated in psychosis, which he describes as a "violent expulsion from the symbolic order."

most basic sense of security in the world. Shame is the affect that is "unspeakable" or that "dare not speak its name" (Hill, 2015 p.189).

Shame however was present throughout my interviews with the women at HDT. I encountered histories of complex relational trauma, severe sexual abuse and attachment disruptions. There was a deeply ingrained, pervasive shame that impacted their interpersonal expectations, their capacity for affect regulation, and their ability to integrate experiences into a unified sense of self. There was also a socio-cultural shame that came, not from internal worlds, but from the external social and political contexts of their lives. Addiction, particularly among mothers, finds itself at the intersection of intrapsychic and socio-cultural shame.

Don't they understand? We already wake up every morning
and can't hold our heads up. We don't need to feel shamed.
We already have enough shame of our own.

The mothers at HDT were burdened with a duality of shame: the shame they inherited from their own early traumas, stored in the psyche, and the shame that they experienced at the meta level – at the level of the social.

Pathogenic Shame

Shame in and of itself is not an entirely unhealthy affect. Moderate shaming is central to any parent-child relationship and is, in fact, central to the development of affect regulation and secure attachment. In secure attachment relationships, children learn to regulate shame and self-esteem through patterns of interaction that reassure them that strong negative affect is tolerable and containable. Toddlerhood, in particular, is a time of

prohibition and frequent misattunements, but under ideal circumstances these misattunements are positive developmental opportunities. They are quickly repaired, and shame is modulated, by the restorative reassurances of a responsive parent. The child reaches out to the parent, the parent flashes a disapproving look, the child experiences shame and its related physiological manifestations and the parent pulls the child in lovingly to restore feelings of connection and safety. Repeated misattunement-shame-collapse-repair patterns are encoded neurobiologically over time, providing the infant with the growing capacity to tolerate and recover from negative affect states. Moderate shame is foundational to a child's sense of self, perceptions of their own agency, worthiness, and confidence in their ability to master anxieties and emotions.

But when ruptures are too frequent and too jarring, and when repair does not follow, the child begins to encode a different pattern into what Schore (1994) and Hill (2015) call the primary, automatic affect regulating system. Chronic experiences of misattunement and prolonged states of dysregulation lead to a pervasive and deeply ingrained shame. This kind of shame, which originates in the primordial, preverbal intersubjective space between infants and their early attachment figures, is referred to as *absolute shame* (Ayers, 2003) or *pathogenic shame* (Schore, 1994; Hill, 2015; Fosha, 2002). Unlike the securely attached child, this child has the repeated experience of reaching out to the parent, with the expectation of attunement, only to be met instead with disapproval, disgust or, perhaps most terrifyingly of all, a still face.[53] The primordial

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[53] Barry Brazelton and Edward Tronick, in their seminal 1975 "still face" experiment, were among the first to explore the physiological and psychological impacts of misattunement in the mother-infant dyad. They vividly demonstrated the infant's dysregulation and physiological collapse in response to a mother's lack of affective responsiveness. Mothers were instructed to violate the infant's expectations of responsive, animated interaction by becoming suddenly motionless. After many attempts at soliciting attention and responsiveness from the mother, the infant becomes dysregulated and distressed, "finally withdrawing into

origins of absolute, internalized shame are the unmodulated shame experiences of the

infant who fails to elicit an attuned, mirroring, empathic response from the mother. These

early experiences of unmodulated shame become encoded and internalized over time. In

the end, they become so internalized that the experience of shame does not necessitate the

presence of the other's gaze. In her analysis of the archetypal significance of the eye in

the phenomenology of shame, Ayers (2003) states: "Absolute shame requires no

audience, but occurs through the observations made by a staring, critical internal eye that

objectifies and poisons the other parts of self being scrutinized" (p.11). This quote from

one of the HDT women represents the internalization of this critical eye. Ultimately, her

own face in the mirror, her own gaze, has become the source of shame.

> *The hardest part is having to forgive myself because I hold*
> *so much guilt and shame. I know that if I don't forgive*
> *myself and I can't look at myself in the face, I am never*
> *going to get better.*

Pathogenic shame refers to a self-object which, early in development, introduced

shame through rejection, non-mirroring or punishment. Its etiology is relational. But, in

addition to the shame of interpersonal trauma that these women carry, there is a felt

socio-cultural shame that is specific to the stigmatization of maternal drug use and to

experiences of social oppression.

Socio-cultural Shame

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a state of helplessness, face averted, body curled up and motionless" (Brazelton, Tronick, Adamson, Als & Wise, 1975).

Many substance using mothers internalize a deep sense of shame and a narrative of deviance that is specific to gendered social constructions of motherhood (Martin, 2011). The mothers that I interviewed subscribed to a model of addiction that ignored the intersectionality of poverty, sexism, and racism. Their accounts reflected a belief in their own individual pathology. The various institutions in their lives perpetuated a romanticization of motherhood and a belief that drug-abusing mothers represented the prototypical "bad mother." These social constructions of motherhood and deviance, compounded by dehumanizing experiences with human services and social service agencies, produced powerful feelings of self-loathing and shame. Up against the dominant narrative of motherhood, they were faced with the daunting task of integrating the identities of 'addict' and 'mother' into a cohesive narrative of their own.[54]

Parallel to the shame produced by an early non-mirroring holding environment, substance using mothers are exposed to a sociocultural shame that is specific to the experience of a non-mirroring culture. Oliver (2002) suggests that when one's culture does not contain and reflect loved or lovable self-images, one suffers from what she calls *social melancholia*: the loss of a lovable self. She also describes another way in which those who are subjugated or marginalized by social inequalities are forced to carry a double dose of shame. Not only are they shamed by dominant values but they are also the vessel for the projected shame of those in power, shoring up the power of the privileged by holding their projected unwanted affects.

Shame has been identified as "the emotion of oppression" (Woodward, 2000) and has been described as that which is interiorized psychologically from experiences of race,

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[54] Here we see the deep connection between shame and the problems of voice and identity discussed in chapter 1.

gender and class-based oppression (Bepko, 1991; Watts-Jones, 2002). Drug using

mothers find themselves at the center of various interlinking systems of oppression,

including the war on drugs, mass incarceration, poverty, racism, the child welfare system,

and motherhood ideologies. They find themselves with a unique intersectional identity, in

which their status as mothers fits poorly with other disadvantaged statuses. The

intersection of "drug user" and "mother" is an especially marginalized combination, but

race and class intersections are also significant. There is a shame that emerges from these

chronic experiences of social subjugation and of being coercively controlled. The women

I interviewed were often stuck in a permanent second-class citizenship due to their

criminal records; they were excluded from housing, jobs and other forms of social

integration. Shame is also associated with structural inequality, ideologies of success and

the myth of meritocracy (Comstock, Hammer, Strentzsch, Cannon, Parsons, 2008).

Poverty and contradictions between "dominant symbolic forms of cultural expectation

and lived material existences" cause shame; there is an existential sense of discontinuity

produced by the disconnect between a culture of rabid consumerism and the realities of

structural inequality (Ray, 2014). Shame immobilizes, maintains oppression and

undermines agency (Moane, 2003; Moane, 2006).

　　　　The mothers at HDT experienced a constant barrage of shaming interactions with

figures of authority. The women spoke about the shame of feeling misunderstood, being

labeled with false assumptions and experiencing powerlessness in the face of pervasive

cultural narratives.

> *Sometimes when we worry about our babies here, like when*
> *there is a problem with the heat or something like that, they*
> *will turn to us and say "well you weren't worried about*
> *your baby when you were out there using." And they are*

very off base. I took care of my child, when I had my child. And they made a lot of assumptions that just because we were using, we weren't taking care of our babies. But not all of us were making those mistakes. Some of us did put our kids first even though we were using. We made sure their needs were met, before we met our own needs.

The judge turned to me and said "It's not your son's fault that he was born to a heroin addict and was addicted and taken at birth" She was mixing up my case, I wasn't using when I was pregnant with him and I raised him and my parenting was never in question. They made incorrect assumptions all the time. It made me feel empty and like all the work I had been doing was for nothing. Like no matter what she wasn't going to give me back my baby and I was doing all of this for nothing.

They spoke about the shame of dehumanization, of "being treated like a number",

with all of their varied identities subsumed under the "addict" identity.

You know they categorize like just one whole delinquent type of low life type of people. There are some staff here that remind us of that a lot. Just even words like "you guys", "the way you guys are used to doing", or "the way you guys are used to living". You know they categorize us a lot. It makes me feel outcast. It makes me feel unwelcome. It makes me feel bad.

There was a lot of times in here, when we came into contact with staff who treats us in a different manner. There's staff that's said stuff like "I have to get home. I can't stay here late. I have to get home to my kids or I will wind up like you guys here in the program without my daughter." Just little things like that. They don't seem like a big deal but it makes us feel very separate.

I was sitting in the chair in front of the judge. Basically his words were, she is pregnant and she is still using, she is obviously an addict. It was the way he said it. I felt shamed. He was talking to my worker as if I wasn't there. I was right there. I felt belittled.

Many of the women struggled with how to integrate those parts of self that felt shame into their life story. Some would ask "What will I tell my child?" Others worried about how the stigma and shame associated with addiction would impact their children.

> *I worry about people talking to my daughter, like your mom*
> *is a dusthead, a hood rat, your mom fucking lost when you*
> *were born. I don't want my daughter to be exposed to that.*

Palpable in many of the interviews was the 'unspeakability' of shame:

> *My life was prostituting, getting high, living in the street,*
> *stealing, doing anything any means to survive, anything*
> *necessary, ANYTHING necessary. There is nothing I*
> *haven't done. I did everyday what I had to do in very nasty*
> *parts of the worst parts of town by myself. I never was with*
> *anyone, I was always alone. I have had everything happen*
> *to me. There is nothing that hasn't happened to me.*

This exchange between me and one of the women illustrates that way in which shame even entered into the transferential space of the interview.

> *I know that I am different from you. God made me*
> *completely different from you. I have a disease, an*
> *addiction. And I know you don't have it. Most people look*
> *at us like we are diseased, like we are outcasts, like*
> *somebody they don't….we are not like you guys. I know you*
> *guys feel very different than us. We are lower class than*
> *you guys. The majority of people who aren't addicts feel*
> *that we are those people.*
>
> *Interviewer: I noticed that you referred to me as "you*
> *guys" and I am wondering what this is like for you to be*
> *interviewed by me.*
>
> *The place that you seem to be coming from. You seem*
> *genuinely interested without malice. Like you don't have*
> *preconceived notions. You seem really open. That is how I*
> *feel.* [55]

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[55] During this exchange, I was made acutely aware of the power of my own gaze, particularly because of shame's relevance to the face and to the eyes of others. The gaze of the other had become the gaze of the

The women at HDT also routinely experienced the shame of having to constantly maintain a *false self* exterior. They felt compelled to achieve an idealized form of motherhood. Women feared complaining about their true experience of motherhood or expressing vulnerability. They were criticized for the behaviors of their children (which were often simply developmental in nature) and their parenting practices were scrutinized, making it difficult for them to have authentic interactions with their children or to remain calm and regulated in response to their children's distress. They knew that failing to live up to the ideal had very real consequences for their standing with child welfare agencies and for the treatment center's impression of their progress and compliance.[56]

When the women at HDT strived to maintain an impossible ideal, feeling compelled to perform motherhood in ways that demonstrated to the outside world an unwavering positive attitude, an untiring sense of calm, and total control over a perfectly regulated baby at all times, there were real costs. They forced ambivalent feelings underground and had no outlet for expressing the frustrations, lack of confidence, fear and dread that all mothers of newborns inevitably experience. Maternal ambivalence is a concept well known to infant mental health workers, for whom an ability to accept and express ambivalence is a sign of health and for whom normalizing maternal ambivalence

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ethnographer. My own comment revealed that I was 'noticing' and 'seeing', which may have perhaps exacerbated the focus of the gaze. But shame is a dialectic of being seen and not seen. The primordial origins of absolute, internalized shame are the unmodulated shame experiences of the infant who fails to elicit an attuned, mirroring, empathic response from the mother. My effort at attunement sought to perhaps disconfirm these early relational templates and soothe shame. It also reduced the power of a ubiquitous, all-encompassing gaze by redirecting the interaction to the here and now and by narrowing our focus to the interpersonal space.

[56] The shame women experienced under the scrutiny of child welfare services is evident in chapter 2. This institutional shaming compounds the deeper primordial shame discussed in this chapter.

has been identified as central to child maltreatment prevention work (Raphael-Leff, 2010). Failing to provide an environment in which ambivalence can be expressed, forces mothers to adopt a false self. They adopt an existence made up of reactions to external demands, a disposition of compliance reminiscent of the infant who, as a result of being unable to achieve a state of "going on being", develops a false self to defend against threats of annihilation. There is something shameful about having to hide one's true self, of having to push oneself underground, precisely because it resonates with that object-relational experience. It evokes that moment of reaching out, with joyous spontaneity, of moving with arms stretched out, with the anticipation of being matched in one's exhilaration, only to be deflated by an unexpected disapproval or withdrawal. When the women at HDT must subvert their inner spontaneity and freedom, bury it, and in its place erect a self that is compliant, cautious and subjugated, it triggers primitive and archaic developmental experiences.

Mothers 'in recovery' are in a constant state of performance; they perform treatment compliance, recovery narratives, idealized motherhood, and being clean. Unable to express the ambiguities and inconsistencies of motherhood, to articulate the multiple meanings of their drug use, or to inhabit the grey area between 'clean' and 'dirty', their sense of self is permanently hidden and unmirrored. Gair (1995) argues that, although aspects of hiding the true self are adaptive and essential, the cost of *consistently* maintaining a false-self façade is the feeling of shame. She further articulates that the defenses constructed to ward off the shame of false-self compliance not only lead to self-harm and addictions but they also create limitations and barriers to intimacy, love and attachment. Substance using mothers experience shame, they are coerced into relying on

false-self identities, and they develop defenses which then threaten the protective and vitalizing attachments with their infants. All of this places them at risk for becoming further entrenched in their addictions.

The relevance of shame to addiction and to parent-child attachment

Shame should be of interest to those working with mothers and infants as it has been identified as relevant to understanding relational disturbances and psychopathology. Shame is so painful and paralyzing that it is tenaciously defended against. The classic defense is to hide, but others have proposed that, attempts to disown the painful affect lead to defensive rage, aggression, contempt, envy or depression (Morrison, 1999). Recollections of shameful childhood experiences are correlated with a tendency to externalize blame and violence in assaultive males, leading to a mutually reinforcing cycle of shame, loss of control and anger (Dulton, Van Ginkel & Starzomski, 1995). Shame has been shown to mediate between women's early sexual victimization and later aggressive conflict with intimate partners and family (Kim, Talbot & Ciccheti, 2009). Shame-proneness is independently related to dissociation (Talbot, Talbot & Tu, 2004) and shame appears to play a central role in the development of PTSD (Budden, 2009). In light of these studies, that point to the interpersonal outcomes associated with internalized shame, it seems reasonable to theorize about the impact of shame in the interpersonal space between mother and infant and to propose that an understanding of shame be central to any dyadic parent-infant work, particularly with substance using mothers. Indeed, Hill describes the neurobiological process in which shame shuts down the capacity for dyadic, intersubjective experiences.

> When engulfed by shame, we suffer a profound physiological and psychological collapse. There is a loss of tonus that causes the head to hang involuntarily, eyes cast downward, breaking visual connection with others. The chest cavity contracts, constricting and slowing the heart. Attention is focuses inwardly on a negatively valanced, shut down and shuttered self. Any previous object-oriented intentions are replaced by an all-encompassing sense of aloneness, debasement and wish to hide. The hung head and slumped posture of shame exude a collapse of subjectivity and preclude the possibility of intersubjectivity (Hill, 2015. p.124).

Shame is also relevant to addiction because it is bound up in issues of integrity of the self. In the next chapter, I will speak in more detail about addiction, as a response to fragile self-organization and annihilation anxiety. The regulation of shame is specific to the developmental period in which issues of self–organization and cohesion of self are paramount; shame is directly implicated in subject formation and identity construction (Oliver, 2004) and, because the regulation of shame is central to one's attachment style (Hill, 2015), it is also central to one's sense of self in relation to others. Shame represents a rupture in communication, attachment and connection with those others who are responsible for the mirroring, attunement and empathic holding that support one's sense of 'going on being'. It represents a rupture with those we trust to ward off early anxieties of annihilation and 'falling forever.' The physiological and intrapsychic collapse that shame quickly triggers resonates with a primitive, infantile disintegrative anxiety.[57] Finally, because shame is a theme of early life, the defenses employed against it tend to be primitive (Alonso & Rutan, 1988). Shameful experiences become dissociated and cut

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[57] Not only is shame associated with annihilation, as a result of abandonment or loss of the object, but later in development, it is also associated with the attachment figure's responses of retaliation, withdrawal of love and failure to survive the child's destruction of them (Alonso & Rutan, 1988).

off and shame can trigger retreats into regressive schizoid defenses, one of the consequences of which, as we have identified, is drug use.

Chapter 5: A Theory of Addiction and Treatment

Towards a Revised Theory of Addiction

Contemporary approaches to drug addiction are dominated by two broad models, one *moral* and one *medical*. The moral model views drug addiction as a vice or sin, and sees the suffering of the drug addict as a consequence of wicked or hedonistic choices. Drug use is bad and the addict rightly suffers. The natural solution from this vantage point is to criminalize drug use, and employ the tools of criminal justice to punish, deter, and perhaps reform current and future users. The moral model has found its clearest expression in America's historic temperance movements against alcohol and its ongoing war on drugs, but the model more subtly pervades most aspects of public health and welfare policy.

While the moral model has long been dominant, and stubbornly persists, recent decades have seen its hegemony challenged by the medical model of addiction. The medical model treats addiction as an illness or disease. It is a tragedy that afflicts addicts like cancer or pneumonia afflict the ill. We don't punish those with cancer, we treat them. We don't preach against the spread of pneumonia, we encourage handwashing to kill the

infectious agent. And likewise, the medical model encourages us to treat the addict and control the spread of the chemical agent. The growing influence of the medical model can be seen in many areas, such as the cultural cache of Alcoholics and Narcotics Anonymous, the growing popularity of detox centers and drug courts, and the Affordable Care Act's mandate that all insurance cover addition treatment.

Most of the women at HDT identified strongly with a medical model theory of addiction, though elements of the moral model also colored their thinking. Clearly there are advantages to the medical model. It not only pushes improved access to healthcare services, but it also eases some of the stigma, guilt, and shame that addicts suffer under the moral model. Their flaws are serious, but not their fault, at least not entirely. While the women I interviewed promoted the idea that their affliction was an inborn, constitutional 'disease', they also resented being categorized and expressed ambivalence about their identity as an "addict". The label came with a price, and that price was feeling separated and marginalized. Addicts are seen as broken, and we are a society quick to discard broken things. The disease model is also reductionist and eclipses the personal meanings that substance users may ascribe to their drug use or to their drug. It closes down conversations about how addicts interpret and view their own addiction. Furthermore, it replicates a pattern, familiar to many of the women, in which a false self is maintained in order to access vitally needed care, while other parts of self are split off and pushed underground.

For the women of HDT, the disease model was the only theory which allowed them access to care, compassion and a minimal amount of understanding and nonjudgment. Any theory that was more nuanced risked slipping back into antiquated, yet

still widely held, theories that paint addiction as a moral failing, as hedonistic, or as criminal. They were forced to cling to a theory that, in other ways, undermined the plight of addicts more generally. The disease model, while having been welcomed as a long-awaited and refreshing alternative to models of drug use that emphasized pleasure seeking and delinquency, ultimately allows society to evade the *social causes* of addiction. So, while these women found refuge in the disease model, its larger dominance as a narrative in the field of addiction treatment further pathologizes them and holds them individually responsible. And, as with every theory or cultural narrative, there are policy implications that ultimately determine its real-life merits. In this case, the disease model indicates the need for abstinence and individual treatment, allowing policy makers and governments to conveniently turn a blind eye to social causes and to reject harm reduction policies.

A more recent shift in the disease model highlights the "chemical hooks" that turn users into addicts. As Nancy Reagan's "Just Say No" campaign suggested, exposure to narcotics could turn *anyone* into an addict. Addiction is inherent to the drug itself and resides in the drug's chemical properties or "chemical hooks," not in the user's biology or genetics. This view has gained its loudest voice with President Trump's appointment of New Jersey Governor Chris Christie as the head on his Commission on Combatting Drug Addiction and Opioid Crisis. In 2015, Christie's outlined his views on addiction in a heart wrenching speech detailing the death of his long-time law school friend due to Percocet addiction. His core message was that his friend had the perfect life, yet was overcome by the addictive power of his painkillers. If it could happen to such a successful man, it

could happen to anyone.[58] While the speech itself was compassionate and well-intended, it represents an example of insidious narratives and of the kinds of implications that these narratives have for policy. While on the surface, the speech rallied support for addicts and for addiction treatment, it placed all causal power in the chemical, bringing a renewed commitment to the drug war and abstinence-based prevention and treatment programs.[59]

The pendulum seems to be swinging back and forth between drug addiction as an inherent individual pathology and drug addiction as the result of drugs' chemical hooks. Both seem appealing on the surface because they represent a welcomed respite from the older moral model. And indeed, both versions of the medical model highlight relevant information about the brain and its interactions with chemical stimuli. It would be irresponsible to completely deny biological or constitutional factors. We know that individuals vary temperamentally from birth; children are heterogeneous in their sensitivities to stimuli, sensory experiences and emotional reactivity. We also know that individuals who have differences in executive functioning and attention (those most likely to be diagnosed with ADHD) may be more vulnerable to addiction because drugs can compensate for decreased sensitivity in their dopamine reward circuits. Is it possible that these groups, by the very nature of their genetic and biological makeup alone, are at increased risk for addiction? Of course. But what is missing from mainstream addiction

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[58] https://www.youtube.com/watch?v=FdYMx7sycW4

[59] Another pernicious aspect of Christie's approach is that it plays into the pattern of seeing drugs as a moral problem when associated with poor minority groups, and shifting towards a treatment-based medical model when the afflicted are middle or upper class white folks. While the response to the current opioid problem appears to highlight the racial bias in the policing of crack and marijuana, along with class bias in the policing of methamphetamine, I am by no means advocating a shift towards more punitive policing of opioids in the name of equity. It is simply a shame that reform only comes when those in power are the ones suffering.

research are theories that acknowledge experience, early trauma, social oppression, and

the basic human drive to alter consciousness.[60] [61] [62]

In recent years, a new approach to addiction has gained increasing attention – one

which argues that psychological needs, social experiences, and neurodevelopment all

interact to explain addictive behavior. Not only does this model encourage us to view

these susceptibilities *alongside* the large body of evidence that we now have about

addiction and *experience,* but we are also increasingly finding it difficult to tease apart

experience and the brain. Neurobiology and experience are no longer binaries and the

existence of brain differences no longer negates the possibility of experience-based,

social etiologies. Nowhere is this truer than with trauma and addiction.

In the 1980's, researchers at San Diego's Kaiser Permanente began to unravel the

question of early experience and its association with adult health outcomes. At the time,

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[60] Perhaps one of the most glaring omissions in our addiction discourse is the refusal to acknowledge that people use drugs because they find the effects fun, relieving, or enlightening. Any attempt to understand "the hooks" of drugs divorced from that experiential component will inevitable miss the mark. Journalist Johann Hari goes so far as to note that altering consciousness is a phenomenon found universally across all human societies in all historical periods, and is in fact observed routinely in many other animal species. As Hari notes, "the overwhelming majority of people who use prohibited drugs do it because they get something good out of it--a fun night out dancing, the ability to meet a deadline, the chance of a good night's sleep, or insights into parts of their brain they couldn't get to on their own. For them, it's a positive experience, one that makes their lives better" (Hari, 2015, p.148).

[61] Controversial Terrence McKenna, an ethnobotanist who advocated the exploration of altered states of mind using naturally occurring psychedelics, expresses his view that addiction is inherent to human nature in a video interview…. He insinuates in this quote taken from that interview, that addiction is inherently relational, echoing the links between addiction and attachment referenced elsewhere in this dissertation. "We are addictive animals. We addict to everything. We addict to each other and glorify it as our most noble outpouring of sentiment in the phenomenon of romantic love. When a pair of lovers are parted, the withdrawal symptoms are indistinguishable from heroin. Vomiting, shaking, uncontrollable emotional outbursts, sleeplessness, short temper, hysteria, this is real. What romantic love is, is a pheremonal bonding, an exchange of chemical messengers which takes these two autonomous organisms and welds them into one galaxy of need and intention and understanding and expectation. When you just tear that apart, people are shook up "

[62] It is important to note that societies differentially meet the needs of their members, and much of what we consider "mental illness" – including addiction – is a function of particular configurations of family life, work, community, technology, etc. that fail to meet basic human needs (not only based on class and economic needs).

their obesity clinic was suffering from a 50 percent dropout rate. Vincent Felitti, head of

the Department of Preventive Medicine at Kaiser Permanente, interviewed those who had

left and found that the majority of the 286 people he interviewed had histories of sexual

abuse. This led him to wonder about the relationship between early trauma and coping

mechanisms, such as eating, in response to depression and anxiety. In collaboration with

the CDC, Feliitti went on to conduct what is now considered to be a landmark study in

epidemiological research – one that has produced fifty scientific studies and articles and

over a hundred conferences looking at the prevalence and implications of what they

termed "Adverse Childhood Experiences" (ACEs) (Felitti, Anda, Nordenberg,

Williamson, Spitz, Edwards & Marks,1998). The CDC-Kaiser Permanente Adverse

Childhood Experiences (ACE) Study is one of the largest investigations of childhood

trauma and later-life health outcomes, with enormous implications for our understanding

of addiction.

The original ACE Study was conducted at Kaiser Permanente from 1995 to 1997

with two waves of data collection. Over 17,000 Health Maintenance Organization

members from Southern California receiving physical exams completed confidential

surveys regarding their childhood experiences and current health status and behaviors.

The questionnaires asked about emotional, physical and sexual abuse, domestic violence,

household substance abuse, mental illness in the household, parental separation or

divorce, criminal involvement of a household member, and emotional or physical neglect.

The study's findings were striking. Almost two-thirds of study participants reported at

least one ACE, and more than one in five reported three or more ACEs. Findings

revealed a graded dose-response relationship between ACEs and negative health and

well-being outcomes across the life course. These included, among others, alcoholism, COPD, depression, fetal death, drug use, liver disease, poor work performance, financial stress, intimate partner violence, STDs, smoking, suicide attempts, unintended pregnancies, early initiation of smoking, early initiation of sexual activity, adolescent pregnancy, sexual violence, poor academic achievement and early death. The graded dose-response relationship indicated that the accumulation of childhood stress, and not the impact of a single experience, was decisive in predicting later outcomes. For example, compared to an ACE score of zero, a score of four or more ACEs was associated with double the risk of being diagnosed with cancer, and a four-fold increase in emphysema. Compared to an ACE score of zero, a score of six or more ACEs was associated with a thirty-fold increase in attempted suicide, triple the risk of lung cancer and a three and a half times risk of ischemic heart disease. An ACE score of four was associated with a seven-fold increase in alcoholism. And compared to an ACE score of zero, a score of five or more ACEs was associated with *a seven to ten-fold increase in drug addiction*. While the broad health implications of childhood trauma are remarkable, nowhere is the connection more striking than it is with addiction.

In 2003, Dube, Felitti, Dong, Chapman, Giles & Anda (2003) conducted a retrospective study of 8,613 individuals, in four birth cohorts, dating back to 1900 to examine the relationship between drug use and ten categories of ACEs. The study found that each ACE increased the likelihood for early initiation of drug use two- to four-fold. Compared with people with zero ACEs, people with ACEs were seven- to ten-fold more likely to report drug use problems and addiction. For each of the four birth cohorts examined, the ACE score also had a strong graded relationship to lifetime drug use. The

persistent graded relationship between the ACE score and initiation of drug use for four successive birth cohorts dating back to 1900 suggests that the effects of adverse childhood experiences have persisted regardless of the particular zeitgeist or policy environment; the impacts of early trauma appear to transcend variations in the availability of drugs, social attitudes toward drugs, or expenditures and public information campaigns to prevent drug use (Dube et al, 2003).

The association in the research between trauma and addiction was in fact so strong that it led Vincent Felitti, head of the Department of Preventive Medicine at Kaiser Permanente at the time, to state : *"The basic cause of addiction is predominantly experience-dependent during childhood, not substance-dependent. The current concept of addiction is ill-founded" (Felitti, 2003).*[63]

But how does one get from early trauma to drug addiction and the myriad of health outcomes discovered by the ACE study, including early death? What is the causal connection? Intuitively, the story may appear to go something like this: people experience trauma, they make poor, self-destructive life-style choices and these, in turn, lead to health issues. While there is certainly an element of truth in this narrative, it remains somewhat of a non-explanation. It rests on a view of human behavior as an explanatory black box. While the ACE study presented a striking association between early life trauma and addiction, it still required a theory of addiction that offers a causal explanation for this connection. Such a theory can be found in the biopsychosocial model developed by Vancouver physician Gabor Maté.

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[63] Donald Trump's most recent speech emphasized media campaigns, a resurgence of "just say no" and increased drug policing and prohibition. It is striking that trauma, which accounts for one half to two thirds of serious problems with drug use has not been mentioned as part of national goals for reducing drug use.

Maté's work builds on decades of experience working with "hard core" heroin addicts in Vancouver's downtown eastside. In his major work on addiction, *In the Realm of Hungry Ghosts*, Maté (2010) not only links addiction with early trauma, disruptions in attachment, and stress, but he provides a neurobiological mechanism of action. His theory suggests that these adverse early experiences change the brain in ways that make it uniquely susceptible to addiction. Adults with traumatic childhoods do not have adequate neural networks to produce necessary levels of soothing and comforting neurotransmitters through typical healthy social interactions. This lack of chemical comfort expresses itself as persistent loneliness, anxiety, and depression, leading these individuals to pervasively seek out external stimuli to provide comfort and escape from their existential pain. This compulsive external comfort seeking expresses itself as addictive behavior, be it overeating, compulsive shopping, or destructive heroin use.[64]

Much like the disease model, Maté's approach acknowledges fundamental brain differences between addicts and healthy individuals. But instead of attributing these differences to genetics, he attributes these directly to trauma, stress, and early relational deprivation.[65] These developmental experiences shape the structural development of neural networks and the biochemistry of the neuroendocrine system in ways that are *largely durable*. Developmental neuroscience has increasingly made clear that

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[64] Dr. Daniel Sumrok, director of the Center for Addiction Sciences at the University of Tennessee Health Science Center's College of Medicine refers to addictions as "ritualized compulsive comfort-seeking" and views it as a normal response to early trauma and adversity (Stevens, 2017).

[65] As children grow, ACEs directly interfere with optimal development of the limbic system and alter the functioning of the Hypothalamic-pituitary-adrenal (HPA) axis. Stress-induced cortisol becomes neurotoxic if left in system for prolonged periods of time, impairing myelination of limbic structures, thinning connections between right orbitofrontal cortex and the amygdala, thus reducing capacity to inhibit amygdala responses. We also know that cortisol directly acts on all tissues of the body including the heart, lungs, brain, immune system, bones, intestines. Insufficient early maternal contact leads to permanent overproduction of vasopressin, leading to high blood pressure. Early trauma can lead to permanent decrease in production of oxytocin (the love chemical), making it difficult for people to go on to easily form intimate relationships (Shore, 2001; Hill, 2015; Mate, 2008)

experience-dependent brain development is heavily concentrated in the first five years of life (Siegel, 1999; Phillips & Shonkoff, 2000; Schore, 2001; Perry, Beauchaine & Hinshaw, 2008; Doyle, Harmon, Heckman & Tremblay, 2009). So while continued brain plasticity does offer opportunities to reshape the brain in more healthy ways, Maté's approach concedes that the brain's basic architecture is set in adults. As such, heavy ACE exposure leaves some individuals *permanently susceptible to addiction*, forcing us to shift our focus away from "curing" addiction and towards managing it through harm reduction strategies

Maté's focus on "hard core" users highlights that at least some addictive behavior is likely permanent, yet it is far from a hopeless model. The psycho-social roots of heavy addiction offer us clear opportunities to *prevent* addiction through social welfare measures aimed at reducing child poverty, abuse, and family separation. Moreover, this etiology suggests that the harshest edges of addiction can be addressed making use of the brain's continued plasticity by increasing healthy neural connections with supportive relational experiences in therapy and beyond. What's more, the fungible nature of addictive behavior opens the possibility that healthier addictions to work, exercise, hobbies, etc. can potentially be substituted for more destructive addictions to heroin, methamphetamine, etc.[66] Finally, the population Maté is most concerned with, hard core users, makes up only a fraction of illicit drug use. What does this model suggest for most drug users?

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[66] It is notable that from this perspective marijuana can be considered a healthier addiction. While pot is often depicted as a "gateway drug," the evidence increasingly supports the idea that pot might be an "exit drug" more akin to methadone. Research is showing that heroin overdose rates are dropping in states where marijuana has been legalized (Bachhuber, Saloner, Cunningham & Barry, 2014).

If individuals with high ACE scores are permanently susceptible to addiction, the

converse would seem to be that individuals with low ACE scores are permanently

resistant to addiction.[67] That is to say, children who grow up in loving and supportive

environments should develop a brain architecture that allows them to enjoy drug use

casually without developing an obsessive need to use. And indeed, most drug users are

able to enjoy substance use without it leading to abuse, even with supposedly highly

addictive substances like cocaine and heroin. But what about individuals with low or

moderate trauma histories that do abuse drugs? What about individuals with moderate to

high trauma histories that do not abuse drugs? And what about those addicts that achieve

natural remission without any treatment or intervention at all (Peele, ? Here Maté offers

the answer of "stress" as a trigger variable, but does not fully flesh out his position,

instead remaining focused on his high ACE score hardcore addicts. I am not the first to

find this narrow focus less than fully satisfying.

Stanton Peele, perhaps one of the first addiction researchers to challenge the

disease model of addiction and the hegemony of abstinence-based treatments such as AA,

forces us to reckon with the contradictions between the more deterministic model of Mate

and the evidence that many addicts do indeed recover. Peele notes common life

transitions that appear to trigger natural healing and remission; addicts often return to

lives of sobriety or moderation when they marry, mature, undergo some sort of personal

or religious transformation or gain exposure to alternate social networks. He cites the

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[67] Even as the biopsychosocial approach to trauma and addiction gains support, it remains largely taboo to suggest that most people can safely use most drugs the way alcohol and marijuana are used recreationally (or medicinally). However, the implications of this conclusion undermine the core logic behind drug prohibition and the war on drugs, and deserve greater public consideration.

counterbalancing forces of family, meaningful employment and status in one's community.

In his book *Chasing the Scream*, journalist Johann Hari (2015) relies on Mate's model to make sense of the empirical trends that he observes but, much like Peele, expands it to include research that places emphasis on the adult social environment, with important implications of larger social systems, including poverty and inequality. proves a compelling and comprehensive account on the war of drugs. His broad conclusion is that prohibition and criminalization of drugs only serves to further the harms of addiction; the drug war creates illicit markets controlled by violent criminals and fuels a system of mass incarceration.

Hari takes Maté's view and expands it to include research that places emphasis on the adult social environment, with important implications for larger social systems, including poverty and inequality. He pairs Maté's work in Vancouver with insights gleaned from what are commonly referred to as the "Rat Park" studies. Rat Park challenges classic medical model addiction studies that show rats obsessively self-administering cocaine until they overdose. Such studies purported to show the inherently addictive quality of drugs, but Rat Park revealed that the drug seeking behavior was actually a response to social and environmental isolation. Rats confined to tiny barren lab cages soothed their pain with drug abuse. But what about happy rats? In the late 1970's, in the addiction laboratory of Dr. Bruce Alexander at Simon Fraser University, researchers designed a rat utopia of sorts: the rats had physical comfort, friends, sex, plenty of toys, and activities. What Bruce Alexander and subsequent replications (Schenk, Lacelle, Gorman & Amit, 1987; Solinas, Thiriet, Rawas, Lardeux & Jaber,

2009) found was that these rats tried the freely available drug-laced water, but preferred to drink regular water. What's more, drug addicted rats from barren cages quickly shed their addictions once transferred to Rat Park. Their conclusion? Addiction emerges as an adaptive response to a life of pain, loneliness, and dislocation. And, environmentally-mediated addiction disappears in response to a supportive and enriching environment (Alexander, 2000). Feliti (2003) and Hari (2015) both note that the same pattern can be seen in humans by comparing rates of drug use by soldiers at war with rates of drug use by veterans. In the case of Vietnam, 90% of heroin users kicked their habit without treatment within a year of leaving the hell of war and returning home to their families.

The implications of Rat Park and Vietnam lead Hari to conclude that even adults with low ACE scores are vulnerable to addiction if their social environment is harsh, lonely, and otherwise painful. Does this finding contradict Maté? Hardly. Maté demonstrates that chronic heavy drug addiction is a response to a chronic deficit in feelings of love, support, and connection. Rat Park shows that temporary drug addiction is caused by an acute deficit in these same feelings caused by a current life situation that lacks love, support, and connection. The former is baked into one's brain architecture and persists even in supportive environments. The latter is resisted by a healthy brain architecture and persists only so long as an environment of isolation remains. In both cases, the common denominator is psychic pain. As Gabor Maté is fond of saying, "Ask not why the addiction, but why the pain" (Mate, 2014)?

In truth, Maté and Rat Park do not provide competing models of addiction. Rather, they focus attention on two complementary factors that drive addiction under the biopsychosocial model: childhood trauma and social dislocation. Both of these factors are

present to varying degrees in every individual. Both operate on the same neural

pathways, impacting the levels of rewarding neurotransmitters in our brain chemistry.

Both point to a specific type of psychic pain that drives addiction: isolation. As such,

Hari aptly concludes: "the opposite of addiction is not sobriety, it is connection" (Hari,

2015).

The biopsychosocial theory of addiction endorsed here leads naturally to a harm

reduction focus in addiction treatment.[68] Underlying the Harm Reduction approach is the

assumption that drug use will occur, whether it be occasional, recreational or as part of

entrenched addictions. The goal of harm reduction is not to rid society of drugs, but to

educate, minimize illness or infection, and reduce users' need for contact with violence

and crime. It aims to provide access to treatment and to remove the judgment and

punishment that so often prevent users from getting help. A harm reduction approach

helps users reduce or abstain from use, if that is indeed their goal. But abstinence is only

one option among many. For opioid addiction, other options include opioid agonist

therapies such as Methadone and Buprenorphine. In countries which have decriminalized

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[68] Harm Reduction is a public health approach that aims not to eradicate drug use, but to minimize its harms. It emerged and gained popularity in England during the 1980's when law enforcement and social workers were forced to respond creatively to a heroin epidemic that had swept through the county of Merseyside, home to the city of Liverpool. What eventually became known as the Mersey Model drew upon a tradition of addiction treatment that dated back to the 1920s, when a prominent group of British physicians formed the Rolleston Committee, and concluded that continued drug use was necessary for some substance users to have functional lives. The Mersey Model made injectable opioids available to users, it set up some of the very first needle exchange programs, and it sought cooperation from law enforcement to refer users to treatment (Riley & O'Hare, 2000). In large part, harm reduction efforts gained popularity in the 1980s to check the spread of HIV, a disease that not only struck intravenous drug users but traveled laterally to their non-using partners and vertically to their children. In other words, harm reduction has primarily been adopted to limit collateral damage to the broader community. Particularly in the US, harm reduction was a response to crime, violent gang activity, prostitution, mass incarceration and police corruption, viewed to have largely emerged in reaction to prohibition policies and to the war on drugs.

drugs, options include regulated heroin injection sites and/or prescription heroin maintenance. A recent written statement made to the president by a leading group of addiction treatment, education and research professionals identified these Medication-Assisted Treatments (MAT) as a number one priority, recommending that they be made widely available, without mandatory counseling and regardless of ability to pay (The Center for Optimal Living, 2017).

The efficacy and safety of harm reduction and medication-assisted treatments (MAT) for heroin addiction is well-established in the literature. It is associated with declines in criminal justice system involvement, heroin relapses, and HIV infections, as well as improved retention in treatment and a return to productive employment (Matusow, Dickman, Rich, Fong, Dumont, Hardin & Rosenblum, 2013). MAT is also the preferred treatment for pregnant heroin users; it has been shown to reduce street heroin use, the incidence of maternal death, infection and disease, as well as expand mothers' access to antenatal care and social support (Fullerton, Kim, Thomas, Lyman, Montejano, Dougherty & Delphin-Rittmon, 2014; Matusow, Dickman, Rich, Fong, Dumont, Hardin & Rosenblum, 2013).

Harm Reduction advocates generally criticize the low success rates of abstinence-only treatments, as well as the underappreciated dangers of abstinence for heavy users. The story is all too familiar. Someone goes into a 30-day abstinence-based treatment facility, they leave, they use, and because their bodies are no longer habituated to their usual dose, they die from overdose. A powerful story ran in the Huffington Post in 2015, with the subtitle: *There's A Treatment For Heroin Addiction That Actually Works. Why Aren't We Using It?* (Cherkis, 2015). It documented the story of Patrick, who had

attended a 30-day drug treatment center in Georgetown Kentucky- one which provided "a hodgepodge of drill-instructor tough love, self-help lectures, and dull nights in front of a television" and which scorned all forms of medication-assisted treatments. Much like the majority of heroin treatment in the US, the center's philosophy was not based on what we know about the neurobiology of addiction, nor was it informed by research showing that *90% of opiate addicts in abstinence-only treatments return to heroin use within one year*. In a state where only 38 opiate addicts treated in 2014 were able to obtain Suboxone, Patrick's treatment was not unique in its reliance on outdated methods. Many facilities, much like HDT, are run by poorly trained workers and entrenched in a tradition, harking back to Synannon, of confrontation, hierarchies, shaming and punitive practices. They are not informed by best practices and current research. Patrick graduated from the program after 30 days as an AA-devotee. He was found by his parents, dead from an overdose only three days later.

While the evidence favoring harm reduction policies like MAT, needle exchanges, and decriminalization continues to grow, the addiction treatment community has been slower to apply harm reduction principles beyond drug access policies. However, in 1990s a group of psychologists embraced harm reduction after years of working in abstinence-based models and experiencing first hand, the recidivism and low success rates of programs similar to Patrick's. Tatarsky (1998; 2003; 2007) and Denning & Little (2011) were among those that developed a form of Harm Reduction Psychotherapy: a modality of therapy that created space for drug use and was open to exploring the meaning of a patient's addiction in a nonjudgmental, non-coercive therapeutic environment. It pushed back against a tradition of excluding drug users from

psychotherapy and the idea that abstinence was a prerequisite for insight-oriented

treatments. It also argued harm reduction's compatibility with psychodynamic theory.

Harm reduction offered a space in which to become curious about the multiple meanings

of a patient's drug use. It fit well with the psychodynamic concept of allying with a

patient's defenses (in this case, drug use), until safety was established and the patient had

sufficiently built up other, alternative inner and external resources (Tatarsky, 2007). It

facilitated a mutuality in the patient-therapist relationship and allowed for a treatment that

did not impinge or impose arbitrary goals. [69]

With much of the social work and psychology professions wedded to 12-Step

programs and abstinence-based methods (Bride, Abraham, Kintzle & Roman, 2013;

Fitzgerald & McCarty, 2009; Rieckmann, Kovas, McFarland & Abraham, 2011), a

psychological formulation of harm reduction and Medication-Assisted Treatment (MAT)

is sorely needed. In the following sections, I will expand upon the ways that harm

reduction lends itself to psychoanalytic theory and upon the particular ways in which it

intersects with the psychological and developmental dynamics of addiction. Beyond the

practices that it has become most known for, such as needle exchange or naloxone

distribution, harm reduction holds out hope for healing addiction at deeper levels. I will

use Winnicott's concept of *potential space* as a backdrop for understanding the ways in

which a harm reduction approach is uniquely suited to intervene in the disrupted

attachment histories and traumas that are often central to hard-core heroin addiction. I

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[69] Interestingly, Guntrip (1992) highlighted the importance of this sort of mutuality for the treatment of schizoid defenses and dynamics (often associated with addiction, as discussed in Chapter 2)– impingement being central to the schizoid patient's early object relations. He emphasized a treatment that did not impose "preconceived notions of what should be done".

will also discuss the particular ways in which harm reduction, as a practice and as a philosophy, addresses themes that arise for substance-using mothers.

Winnicott's Potential Space

Winnicott describes a developmental trajectory that moves back and forth along a continuum between union and separation, highlighting the ability to eventually hold and tolerate the paradox of these two poles. At the very beginning of life, an infant is merged with the mother; there is no awareness of the mother's separateness, because the mother's invisible holding environment responds seamlessly to the infant's needs. If all goes well, and in the presence of a "good enough" parent, the infant is unaware of need or desire because his needs are met and contingently responded to. The infant experiences a "continuity of being"; she is kept warm, satiated, regulated and protected from the impingements of the outside world. A well-attuned caregiver engages in a "live adaptation to the infant's needs", bringing the infant into existence by responding to his solicitations and conveying the illusion that outer reality magically matches his inner needs. Winnicott viewed this "continuity of being" or "going on being" as foundational to the development of ego strength (Winnicott, 1960).

Over time, and with the inevitable frustrations of environmental failures, the infant begins to develop a sense of self and of *I-ness* (Ogden, 1989b). He begins to separate, but does not fully have the capacity to hold in mind a mental representation – to carry with him the soothing, comforting image of his caregiver. He does, however, develop the capacity to symbolize the attachment figure using a transitional object, usually in the form of a well-loved blanket or stuffed animal. This becomes the child's

very first symbol - one which allows him to feel connected to his caregiver, even in her absence. It is a symbol that captures the dialectic of union and separation: "unity in separateness" and "separateness in unity" (Ogden, 1989b).[70]

The infant begins to move from an all-encompassing mother-infant union to a world that includes a symbol, the symbolized, and the capacity of the infant to think about and interpret the symbol (Ogden, 1989b). The infant transitions to a "potential space", in which union and separation co-exist, can be explored, and played with. For this reason, the "potential space" is also often referred to as the "transitional space": a space that exists *between* union and separation, where infants can experiment with separation, and simultaneously retain the fantasy of the original union with the mother. It is the closeness and merging with the mother that allows for a space to open up between the baby and the object world (Ogden, 1989b). Paralleling the idea that exploration is predicated upon trust in and access to a secure base, the capacity for envisioning and tolerating *separateness* necessitates *togetherness*.

In order for the transition to go well, the "potential space" must be what its name implies: *potential*. It is a space of hypotheticals and illusion. The infant can play and experiment with the experience of separateness, without committing to it. Games like peek-a-boo or catch the baby are a practicing or mastery of important developmental struggles: disappearing and reappearing, now-here and now-not-here, separation and reunion. They facilitate the mastery of the quintessential anxieties of infancy; they provide glimpses of annihilation and "falling forever" but create, for the infant, the

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[70] I am reminded of my son's transitional object, a blanket knitted for him by his great grandmother. In the end, it became torn up and tattered and had a big knot in it. My son, as soon as he could speak, would hold on to this knot and call it his "strong part." This to me seemed so symbolic of his emerging ego strength, facilitated by the love and security of his attachments.

repeated experience of being found, being caught, being held. Kaplan (1978) describes the tension and fluttering in a baby's body as his mother covers her face in a game of peek a boo; the baby is on the verge of the possibility of falling apart but is restored to a state of harmony once his mother's face, full of delight and excitement, reappears. These games capture the gist of the potential space: mother and infant are one *and* mother and infant are separate. It is defined by a dialectic of oneness and separateness.

Ultimately, the *capacity to be alone*, as is described in Winnicott's (1958) classic paper with this title, is built on experiences of being alone *in the presence of another*. The experiences of being responded to and held, but not impinged upon, create a space in which the infant can experience aloneness in the presence of the mother. It is within this space that the infant can be in touch with parts of his true self; his experiences emerge from his own desire and agency. They are not mere reactions to the external environment or to demands for compliance. The infant ventures into the world with sufficient ego strength and ego-relatedness, having internalized the paradox of the mother-infant relationship: alone yet close.

Under different circumstances, in which a child's only ally in development is unresponsive, rejecting, neglectful or frightening, the infant is left without protection against an anxiety which he believes will persist forever (Lieberman, 1993). Instead of existing in a responsive, attuned holding environment, the infant's experiences are made up of *reactions* to external impingements, experiences of annihilation, anxiety and ego weakening (Winnicott, 1960). Without the boundaries of physical holding and attunement, infants are vulnerable to experiences of fragmentation and annihilation.[71]

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[71] It is important to note that external stresses such as violence or poverty can exert its own pressure on the parent-infant relationship, making it difficult for the parent to "turn inwards."

The somatic experience of feeling held and contained, at the level of the body, provides the illusion of integration and cohesion. Without it, the infant experiences something akin to what Winnicott called "falling forever." Later on, these early experiences of being 'dropped' and uncontained may manifest as a persistent existential anxiety, reflecting a fear of disintegrating or falling apart. One may develop an annihilation anxiety or the subjective sense of not feeling 'put together'; one may feel as though one's body is leaking out into infinite space or that the ground is giving way (Vartzopoulos, 2013).

One way to understand heroin use is that it is an attempt to contain fragmented parts of self, and to attain some semblance of cohesion and continuity of being. Vartzopoulos (2013) proposes that annihilation anxiety triggers a psychic retreat to the body – a regression to the developmental stage in which issues of annihilation and cohesion are most salient [72].

Harm Reduction as Potential Space

Winnicott applied his concept of potential space to the therapeutic milieu; arguing the analyst-patient relationship mirrors the reciprocity of the mother-infant dyad and the therapeutic space is a symbolic, "as if" space for the exploration of transferences and metaphor. Winnicottian theory has also been applied, albeit less commonly, at a meta level to organizational culture and practice. Most notably, Kahn has applied a

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[72] Interestingly, Nancy McWilliams (2011) discusses annihilation anxiety in the context of paranoid personality structure, noting that these patients may be particularly susceptible to drug use. Not only does this kind of anxiety lend itself, psychologically, to the kind of bodily, somatic retreat that heroin provides, but it also places people at risk for addiction, neurobiologically. Unlike separation anxiety, which belongs to the PANIC system and is mediated by serotonin, annihilation anxiety is part of the FEAR system, and developed evolutionarily as a response to the possibility of predation. Unlike separation anxiety, it appears uniquely responsive to "downers" such as benzodiazepines, alcohol, and opiates.

Winnicottian lens to the work of caregivers in the helping professions, emphasizing the

importance of *organizational holding environments* (Kahn, 2004).

Organizations and communities that provide support to addicts are spaces which

may also stand to benefit from an application of Winnicottian ideas. This is especially

true because of addiction's relevance to early object relations. Having described the

pragmatic rationale for harm reduction policies earlier in the chapter, I wish here to

provide a psychological and developmental justification for its usefulness.

Let's take a look at harm reduction, in perhaps its most evolved form. Between

the years of 1994 and 1996, the Swiss government explored the impact of Heroin-

Assisted Treatment (HAT) on one thousand heroin users, in a study that would eventually

be a major influence in drug policy across Europe. Heroin-injection sites were set up and

addicts were able to use medically prescribed heroin under the supervision of doctors and

counselors. Results from the 2-year study found improvements in health (declines in skin

diseases, diseases of the digestive system, malnutrition and anemia), improvements in

mental health, dramatic decreases in the consumption of illegal heroin (down from eight-

one percent to six percent), massive declines in criminal activity (down from seventy

percent to ten percent) and significant improvements in social integration. At the

conclusion of the study, none of the participants were homeless, permanent employment

had doubled and there were significant decreases in welfare dependency (Brehmer &

Iten, 2001). In 1999, strong public support for the initiative lead to the Swiss federal

government establishing HAT as an official treatment option by executive decree.

Currently, in over 23 sites across Switzerland, patients have access to medically-

prescribed heroin (Ochsenbein, 2014). These are located, not on the outskirts of town or

in back alleys with lines around the block, but in the center of towns where people from all walks of life can access care on a lunch break, and in a place that doesn't signal stigma and marginalization (Hari, 2015). They are greeted by doctors who supervise the injection of heroin and are able to speak with on-site counselors and social workers. Those who frequent these clinics are not the faces of addiction that we have become accustomed to, either through real experience with addicts or from what we know of public health media campaigns that show harrowed, gaunt, lesioned faces. Instead, the clinics' clients are well dressed, well-nourished, and largely indistinguishable from other citizens (Hari, 2015).

The professionals and doctors who run these clinics explain that the skin lesions, boils and malnutrition, that we have come to associate with heroin use, are mostly caused by toxins found in heroin that is cut with flour, chalk, talcum powder and other medically impure additives (Hari, 2015). In fact, counter to what one might assume, opioids in pure form have a relatively benign impact on the body, compared to other substances (DaSilva & Haze, 2011; Friedman, 2011; Haber & Batey, 2011; Kwasnicka & Haber, 2011). In addition, drug criminalization leads to poor health and welfare outcomes; when it is harder, more expensive, and more dangerous to obtain drugs, people are driven into prostitution and other illegal activities that undermine their health and access to mainstream care. Criminalization also incentivizes dealers to traffic in more concentrated drugs to maximize profits, leading to dangerously potent and inconsistent products, often laced with fentanyl or ketamine, which greatly increase the likelihood of overdose. In the spirit of harm reduction principles, the goal of these clinics is not to moderate use; users are allowed to request an increase in their dose or a decrease in their dose without fear of

judgment. Contrary to intuition or to what we know about 'developing a tolerance', these clinics report that their users do not tend to indefinitely increase their dose. Instead, it is shown that, after initially requesting a dose increase, most begin to reduce their use over time (Hari, 2015).

From a Winnicotian perspective, these clinics serve as transitional spaces. They offer access to the metaphorical attachment object, without creating fear that it will be abruptly taken away. Patients can depend on receiving heroine every day in a stable environment. Unlike street heroin, the availability of which is precarious and unreliable, the heroin at the clinic provides a sense of safety and regulation to those whose attachment histories have left them bereft of any internalized secure base. These clinics mirror the "in between" nature of Winnicott's potential space. They allow addicts to play with and explore separation, while keeping one foot firmly planted within the orbit of the attachment object. Patients increase their dose, decrease their dose, speak to others, play with ideas, and imagine futures with less or no drug use. They are invited into a space of hypotheticals and illusion so that they can feel out separation on their own terms and in their own time.

In many ways, the potential space facilitates an exploration of what Bromberg (1996) calls a *multiplicity of selves*. It is a space in which a patient's many parts of self can coexist. In these clinics, patients are able to gradually break down barriers that have been erected between the various parts of self- parts that have, up until now, remained unintegrated or dissociated. They are not forced to segregate their identity as a drug user from their socially acceptable identities as workers, students, parents, etc. Not only are the clinics geographically integrated into community life, situated at the heart of cities

across Switzerland, but they symbolize the psychological integration that can occur as a result of harm reduction practices. Harm reduction can foster a "healthy illusion of a cohesive personal identity" (Bromberg, 1996, p.4), while "standing in the spaces" (p.1) between one's separate parts.[73]

Rothschild (2010) explains that addicts generally enter treatment with the expectation that they will be asked to exile the "part of themselves that uses." Unfortunately, their fears are not unfounded, as much of mainstream treatment and culture requires that drug users sever off parts of self. She notes that "all too often, in substance abuse therapy, there is a goal, either implicit or explicit, of silencing or even killing off the aspect of the person that is addicted or enjoys using a substance" (Rothschild, 2010 p.144). In therapy, patients are often sent *out* for drug treatment before being allowed to begin traditional psychotherapy, sending them the powerful message that their using self is not, or should not be, part of who they are as a whole. My experience working on inpatient units and in the psychiatric ER of a small city hospital in the Bronx, served as further evidence that institutions contribute to the addict's fragmented, disjointed sense of self. Once drug use is confirmed in these settings, the patient's psychological distress, personality, and complexities often become subsumed under the narrow category of substance use. Instead of viewing substance use as an integral part of a person's entirety, it is viewed as something that is *overlaid* onto a

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[73] Similar to Winnicott, Bromberg rejects a valorization of integration and autonomy in favor of an ability to play with and reflect upon dialectics. Bromberg belongs to a larger tradition of Relational Psychology which views the mind as "a configuration of shifting, nonlinear, discontinuous states of consciousness in an ongoing dialectic with the healthy *illusion* of unitary selfhood" (Bromberg, 1996, p.3).

person's personality. It is something to be got rid of, so that *real* treatment can proceed.

At best, these patients are referred out by social workers. At worst, they are denied

treatment and then discarded. These patients are treated particularly poorly when it is

found out that they have attempted to conceal or deny their drug use, a defense they may

have justly erected in order to protect themselves from an unforgiving and punitive

system. They are often accused of "malingering", of "only wanting to get drugs", or of

"trying to take advantage of the system." All of this serves to narrow the identity of

addicts and to undermine their strivings to live as whole, integrated human beings. This

demand by institutions to cast out parts of self is particularly insidious and harmful, as it

further contributes to the dissociation and fragmentation that is so central to the

phenomenology of trauma. The institution fails to serve as a holding environment, instead

replicating experiences of disintegration and annihilation.[74]

Even the most well-intentioned therapists and treatment providers may fear that

an expressed interest in a patient's drug use or a curiosity about a drug's meanings, may

inadvertently trigger use or relapse. They may inadvertently communicate a fear or an

anxiety about bringing the patient's using parts of self into the room, unconsciously

reinforcing the disintegration and fragility of self-organization that is likely at the root of

the patient's addiction in the first place. Patients, accustomed to dissociating

unformulated parts of self (as a result of trauma), will often comply with what they

perceive to be the therapist's wishes. Rothschild (2017) discusses the importance of

getting to know the "using self" in psychotherapy – of articulating it and giving it a voice.

She speaks about helping patients understand that "the part of themselves that uses and

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[74] This casting out of parts of self mirrors the casting out of persons. Institutions determine who is human, who is visible, who is unseen.

the part of themselves that wishes to get well are both part of the same self" (Rosthchild, 2017). As was discussed in Chapter 1, trauma undermines a person's capacity to symbolize experience and to self-mentalize. Harm reduction psychotherapists attend to a patient's growing capacity for symbolizing affect in language and support their ability to form a narrative that is integrated and coherent – drawing in unformulated, cut off parts of self. Treatment makes room for the parts of self that use heroin; it welcomes the expression of experiences that illicit shame, as well as those that evoke memories of pleasure and comfort.

In an ethnography of a drug rehabilitation center in Kashmir, Varma (2016) discusses the significance of this kind of psychological integration, in which histories of drug use are woven into poetic and spiritually meaningful narratives. Patients privately challenge the dominant ideology of addiction, despite public "performances" of recovery narratives. Varma criticizes the center's linear model of recovery, in which patients move from addiction to recovery, severing off shameful parts of their past lives in order to commit fully to sobriety. In their minds, patients retain their dignity and engage in a form of private resistance by drawing upon *nasha* – a Kashmiri term that links intoxication to other forms of altered consciousness, such as spiritual experiences with the divine, love and madness. Patients access reveries and tell themselves stories about the experiences of love and loss that led them into drug use. These reveries allow them to access an "in-between temporal state", in which they dip into their pasts, integrate cut-off fragments of their life narrative and recast their substance use as something spiritually and existentially meaningful.

> Through Nasha, patients recuperated intoxication as a
> valuable experience, maintained temporal and

phenomenological links with their past selves and
behaviors and, in contrast to public recovery narratives,
absolved themselves of responsibility for their
addictions[…] Nasha offered patients a discursive and
experiential capsule through which to express and recast
illicit experiences of drug use, love, madness, and jealousy
that are thick with emotion, deeply painful, and otherwise
intangible. Its presence – along with the durability of love
reveries- shows how patients have alternative therapeutic
and narrative resources that those that the clinic
authorized.[…] In contrast to the therapeutic function of
recovery narratives, *nasha* did not force patients to forget
or completely separate themselves from their histories of
intoxications. Rather, the Sufi language of *nasha* absorbed
the negative attributions of drug use into a more
encompassing, positive frame, allowing patients to revisit
their pasts while avoiding shame and stigma (p. 59).

Nasha provides an, in-between potential space to which patients can safely

regress, in order to rework and integrate parts of self. It allows them a way to replace a

social environment of rigid narratives and restrictive representations with a space of

authentic meaning-making and symbolization. Much of traditional abstinence-based

treatment emphasizes a linear process, rigid, discrete identities, and an autonomous,

'responsible for one's own actions' self. In contrast, the practical principles of harm

reduction map onto a psychological *potential space*, defined by dialectic, fluidity and

multiple selves. Union and separateness co-exist and multiple self-states stand side by

side. Previously cut-off, dissociated parts of self are articulated and the shame, that is

inevitably so central to addiction, is soothed and regulated.

While all individuals struggling with addiction need *potential spaces* of meaning

and creativity, the need for such transitional spaces is especially important for substance-

using mothers. The birth of a child triggers themes of union and separation, motherhood

introduces new identities and parts of self, and oppression impinges upon the psychic

spaces of substance using mothers in unique ways.

In the next section, I will describe the transition to motherhood in order to

illustrate the unique challenges that mothers face in drug treatment.

Treatment during the Transition to Motherhood

Drug use aside, the women at HDT are all navigating the transition to

motherhood, carrying with them their own early losses, traumas, and attachment injuries.

Even under the best of circumstances, intergenerational, unconscious forces have a way

of finding their way into relationships between mothers and infants. These unconscious

processes were first described in 1975 by Selma Fraiberg in her seminal paper "Ghosts in

the Nursery":

> In every nursery there are ghosts. They are the visitors from
> the unremembered past of the parents; the uninvited guests
> at the christening. Under all favorable circumstances the
> un- friendly and unbidden spirits are banished from the
> nursery and return to their subterranean dwelling place. The
> baby makes his own imperative claim upon parental love
> and, in strict analogy with the fairy tales, the bonds of love
> protect the child and his parents against the intruders, the
> malevolent ghosts. (Fraiberg, Adelson & Shapiro, 1975,
> p.387)

Fraiberg highlighted the distinctiveness of the early parent-infant relationship in

its unique propensity to trigger a parent's own unresolved attachment histories and to

become fertile ground for projection. The unwanted "ghosts" of a parent's past easily

take up occupancy in the present, particularly at a time in which care, attachment and intimacy are salient. [75]

In their book *Birth of a Mother*, Stern & Bruschweiler-Stern (1998) similarly emphasize the enormity of the transition to motherhood. They describe the "birth of the mother" as a period of crisis, albeit a normative one. It is a period of disequilibrium in which new mothers experience a profound psychic reorganization and a new set of needs, wishes, fantasies, and fears, the collection of which Daniel Stern terms "the motherhood constellation" (Stern, 1995). A mother, for example, may unconsciously harbor the fantasy of unconditional love. She might anticipate that her baby will replace the loss of a loved one. She may believe that the baby will lift her from depression and infuse her with a new sense of vitality. Some babies come embodied with what Daniel Stern refers to as the *projected family destiny*, symbolizing the possibility of a brighter future, change or social mobility. Once the baby is born, the mother is faced with the enormous psychological task of integrating the baby that she may have *imagined* with the *real* baby. All the while, she is negotiating profound identity transformations, as she shifts from identifying as a daughter to identifying as a mother (Stern & Stern, 1998).

In the very first weeks of an infant's life, the mother enters into a state which Winnicott calls *primary maternal preoccupation* – a fugue-like state which "would be an

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[75] Fraigberg put forth a formulation for the parent who eerily appears not to even hear the cries of her own infant and seems "condemned to repeat the tragedy of his own childhood with his own baby in terrible and exacting detail." Fraiberg concluded that these parents had not *processed*, *integrated*, or *'heard'* the forgotten cries of their own distant pasts – cries that had themselves gone unheard and unnoticed. Through Fraigberg's Infant Mental Health program at the University of Michigan, social workers helped mothers to gain insight into the reenactments and repetitions of their own past in the present which, in turn, led to an ability to perceive their infants as a separate beings, with a separate subjectivities (Cohen et al, 1999). Recent research has provided neurobiological correlates of Fraiberg's original conceptualization. It has been found, for example, that unprocessed trauma can result in a dulling of a mother's amygdala responses to her infant's distress (Kim, Fonagy, Allen & Strathearn, 2014).

illness were it not for the fact of pregnancy" (Winnicott, 1956, p.61), of dissociating from

the external world, of turning inwards towards the infant, and of ablating her own

selfhood in order to remain intensely attuned to the subjectivity of the infant. The infant

inhabits what Ogden terms the *autistic-contiguous dimension*- a mode defined by the very

beginnings of the body-self, prior to any integration or coherence (Ogden, 1989). It is a

mode that necessitates a soothing other to contain the anxieties of disintegration and

unboundedness. The parent must feel his or her way into the infant's world in order to

provide the infant with the illusion of 'going on being' (Ogden, 2004). Of course, the

abandonment of self and the passivity that Winnicott's description implies of mothers is

jarring to feminist principles. Essentialist notions of motherhood are also at odds with the

feminist notion that gender is a social construct. The *motherhood constellation* and

Winnicott's *primary maternal preoccupation* have both been criticized for the ways in

which they reify gender differences and solidify gender roles (Kaplan, 1992), as well as

for their inattention to cultural and sociopolitical contexts (Stern & Menzel, 1996). They

nonetheless stress the *psychological* arduousness and complexity of parenthood in ways

that I believe are important to understand. Some feminist scholarship has highlighted the

importance of acknowledging the distinctiveness of a particular motherhood mindset

because of its practical implications for social support (maternity leave, social and

financial support) and because of its critical importance to the well-being of infants in the

first weeks of life (Hollway, 2012).[76]

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[76] One can imagine a broader Primary Parental Preoccupation or a Parenthood Constellation, certainly as men have become more involved in early infant care. We find that men too experience challenges to their identity as they become fathers. Going from an independent, unencumbered identity to a primary caregiver identity is a dramatic and sudden shift in roles. Research and psychological theory has perhaps not given enough attention to the psychic reorganization that may take place for new fathers. Even though my research deals only with mothers, I was often left wondering about the experience of missing fathers.

Indeed, during the transition to motherhood, where much is in a state of flux, a mother's source of regulation must come, to a great extent, from the outside. It is for good reason that many societies view the initial stages of motherhood as a time to surround the mother with great amounts of support. Supports in the immediate family, in the community and in our society as a whole must provide this external regulation, protecting the mother from external impingements, 'lending her an ego' while she attends to the fragile states of her infant. Just as the consistent experience of empathic attunement organizes the child's inner self so that she is eventually capable of autonomous emotional regulation, so do supports surrounding the mother lead to the confidence and strength necessary for parenting.

Adding drug treatment to the initial stages of motherhood adds a layer of complexity to an already challenging developmental moment. The mothers at HDT must provide a protective holding environment for their infants, while struggling to regulate pain that may have arisen from failures in their own early holding environments. They are then told to stop using. They are asked to give up something that provides them with protection, regulation, and predictability– the very things they may have lacked in their own early experiences and that they now desperately need in order to provide "good enough" experiences for their infant.

Harm reduction is not only increasingly being embraced as the safest and most effective treatment for heroin addiction in pregnant women (Ritter, Ritter, Cameron, Ritter, Cameron, 2006), but it also addresses many of the developmental and psychological needs of mothers with disrupted attachment histories. As we discussed in Chapter 1, the compulsive use of heroin can be viewed as a regression to the secure base.

The women repeatedly described the experience of heroin as containing, warm, and embracing. It protected them from the very real impingements of their external environments and from the internal impingements and intrusions of their traumatic histories. In a striking parallel process, they are called upon to protect their newborn infants from the very same threats of disintegration and annihilation that they themselves experience (and soothe with heroin). With this knowledge, treatment should represent a continuation of the initial holding environment with a gradual shift to transitional spaces - spaces between complete dependence and separation, between merging and the capacity to be alone in the presence of another, between a "continuity of being" and the eventual development of ego strength. Abstinence-only approaches defy a developmental model, forcing women to abruptly give up the object before mastering critical developmental tasks. Harm Reduction, as a practice and as a philosophy, replicates the transitional space. It supports development, without skipping over crucial steps. It also creates an environment in which women can connect with parts of their true selves.[77]

Despite a growing body of evidence supporting the medical and psychological benefits of harm reduction, our public institutions have thus far failed to effectively incorporate harm reduction principles into practice. In many cases, even when harm reduction is accepted as a goal, the impact on our public institutions has remained superficial. Often harm reduction is window dressing on a system that is at its core defined by moral and medical models.

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[77] This parallels the connection that Winnicott makes between the potential space and support of an infant's true self. It is only within spaces that are free of impingement that the infant will have experiences that emanate directly from her own sense of self and vitality. If the infant's experiences are mere reactions to a series of environmental intrusions or to a parent's need for compliance, a defensive façade or 'false self' will develop.

The efficacy and life-saving benefits of Medication-Assisted Treatment (MAT) is well established. And yet, there continues to be a significant gap between opioid addiction rates and the availability of MAT (Jones, Campopiano, Baldwin, McCance-Katz, 2015). In the next and final section, I will discuss some of the main factors driving this disparity.

Barriers to Harm Reduction

Public perception and stigma

Public attitudes and social stigma significantly interfere with patients' access to MAT and lead to poorer treatment outcomes, even when MAT is implemented. Much of the public continue to harbor negative beliefs about methadone and its side effects, believing that 'substituting one drug for another' ultimately prevents recovery. These all have a way of contributing to poorer treatment outcomes, limiting access to treatment and leading to counter-therapeutic rules, such as limiting the duration of treatment or imposing ceiling doses (Matusow et al, 2013). In addition, much of the substance-abuse counselor profession is entrenched in the tradition of AA treatment, which promotes abstinence from *all* mind-altering chemicals, including medications such as methadone.

One of the women that I interviewed described the need to conceal part of herself, in order to participate in NA meetings.

> *I have heard people say "that's not being clean", not to me*
> *but in discussions about it. So that's what led me to say, to*
> *decide I am not going to disclose that information to*
> *people. I am still going to be very much a part of NA but I*
> *am going to choose not to disclose that information.*

Not only does the stigma associated with methadone use pervade institutions, but

it also becomes internalized by patients. Many of the women I interviewed wished to

come off of methadone because they themselves did not consider themselves to be

"clean". "Clean", a term widely used in treatment facilities and by treatment providers, is

not a harmless, value neutral term. The women I interviewed often referred to themselves

as either "clean" or "dirty", having internalized a narrative of dichotomous, discrete

identities – one which runs contrary to a harm reduction approach of reducing shame and

of being able to accept and articulate a multiplicity of selves.

One of the women I interviewed had been through five inpatient programs and six

IOPs, never having been on methadone or buprenorphine.

> *Because if you stay on methadone, you are not really clean.*
> *You know what I mean. Not trying to down anyone else.*
> *Like in here, I see a lot of people, I think they are still high,*
> *in a way.*

By contrast, the rare times methadone use was affirmed and normalized, women

were able to make choices without shame. When asked about an experience that felt

nurturing and supportive, this mother spoke about a nurse who had asked openly about

her methadone use and had encouraged her to stay on it.

> *Some of the nurses were nice and some of them would ask*
> *questions. Like, how did you end up on methadone? Some*
> *were very supportive. One of them, I was telling her I*
> *wanted to be clean from the methadone and she told me*
> *"don't you dare rush off the methadone, you do what is*
> *best for you and you don't worry about what anyone else*
> *wants and needs. Because if you rush off, you are going to*
> *pick up. And you are a phenomenal mom and you have a*
> *beautiful baby and don't throw that away because you try*
> *to rush off this methadone."*

> *Interviewer: What was that like?*

*It made me feel very strong. Because of her, I decided to
stop my detox because I was hurting myself. I was trying to
detox before I was ready. Had I rushed it, now that I am
going to be out in the real world, I could relapse.*

Without intentional counter-narratives, women are likely to internalize and accept
the status quo. Environments that do not mirror or reflect positive self-images undermine
the *potential space* that these women need in order to explore their drug use, in all of its
facets, and to make decisions in full awareness, with the engagement of their many parts
of self.

Cost and Insurance

Problems with cost and insurance also frequently interfere with consistent access
to treatments. In certain states, Medicaid has historically restricted access to
buprenorphine, claiming that it is costly and less safe, despite research indicating that the
mortality rate of drug-free treatment is *seventy-five percent higher* than that associated
with medication-assisted treatments (Clark, Samnaliev, Baxter, Leung, 2011). Some have
suggested that the rationing of buprenorphine among Medicaid recipients translates into a
restriction of medication-assisted therapies more generally, resulting in higher mortality
rates among Medicaid beneficiaries with opioid addiction (Clark, Samnaliev, Baxter,
Leung, 2011).

The Affordable Care Act did much to improve access to buprenorphine in the
thirty-two states that expanded Medicaid. Despite increased access however, there remain
large treatment shortages and barriers. Forty-four states require prior authorization for
buprenorphine treatment, nine require documentation of counseling, eleven have lifetime
limits (ranging from 12 -36 months), fourteen have maximum daily limits (which may be

too low for some users), and some states require documentation of several failed

alternative therapies before being eligible for buprenorphine (a system referred to as "step

therapy") (Clemans-Cope, Lynch, Epstein & Kenney, 2017).

Pregnant Medicaid beneficiaries are often faced with changes in their insurance

that can impact access to care. One woman that I interviewed could not find treatment

that would accept her new pregnancy plan.

> *I knew I needed help to stop but my Medicaid changed from being straight Medicaid to a pregnancy plan. I tried to get into IOPs (Intensive Outpatient Programs) but IOPs wouldn't take me because of my Medicaid. I tried getting into 28 day programs but the 28 day programs wouldn't take me because of my Medicaid. So I ended up staying outside, getting high my whole pregnancy.*

Interactions with the Criminal Justice System

The repeated incarcerations that drug-users experience as a result of possession,

dealing, or prostitution also interfere with their access to effective medication-assisted

treatment. Drug users move in and out of a system which in turn, pushes them in and out

of use.

> *I was going home. And most likely because I was such a liability at that point and they didn't want to transport me every day to get my dose. And anything could have happened to the baby at that point. They sent me home. So I went home and I stayed clean for 2 or 3 days and then I started worrying. I wasn't sick. And I was like, it seemed like the baby was ok. I didn't really know. I had never been pregnant and using before because I never thought I would be in that situation. So I thought well maybe if I just stay clean, he will be ok and everything will be ok. Then I just wound up using again.*

It is well documented that release from prison is a time of high risk for addicts; their return to use is rapid and often deadly (Seaman, Brettle & Gore, 1998; Bird & Hutchinson, 2003; Farrell & Marsden, 2008; Krinsky, Lathrop, Brown & Nolte, 2009; Binswanger, Nowels, Corsi, Glanz, Long, Booth & Steiner, 2012). There appears to be no coordinated approach and the random pin balling between heavy use and abstinence that the system creates is not a strategy that an addict should be expected to be able to navigate.

Even when addicts are routed through drug courts, as an alternative to incarceration, they face difficulties accessing effective treatment. In a nationally representative survey of US drug courts (Matusow et al, 2013), fifty percent of drug courts reported that no MAT was available *under any circumstance*, thirty-four percent reported that treatment was available only to those already receiving agonist medication, and *only twenty-six percent made MAT available to pregnant women*. The drug courts attributed the lack of access to funding issues, state policy prohibiting the use of MAT, an unwillingness to begin detoxed clients on new agonist medication, and a shortage of local providers. [78] Many addicts are forced to choose between abstinence and incarceration; both of which are more likely to lead to relapse or overdose.

An emphasis on detox

Many of the women I interviewed described experiences of going in and out of detox, living in a perpetual cycle of alternating abstinence and heavy drug use.

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[78] The Huffington Post story that I reference earlier reported that drug courts in Kentucky forced addicts off of medications, such as Suboxone or Methadone, and into abstinence-based treatment as part of state-wide policy.

> *I would go in and out of detox programs. I'd come out and still want to use and the only place I would know to go is back where I came from because I had cut myself off from everything. And so I would go back to using.*

While largely ineffectual for treatment, detox centers were nonetheless familiar and accessible to women prior to their pregnancies. But the very real dangers associated with detoxing while pregnant often lead detox centers to turn away pregnant women, who are left with nowhere to turn. `

Known to all of the women I interviewed is the evidence indicating that detoxing while pregnant can harm the fetus and precipitate premature labor (Gowing, L., Ali, R., Dunlop, A., Farrell, M., & Lintzeris, N., 2014). Many of the women felt caught between worries about the impact of their drug use on their pregnancies, knowledge that detoxing would harm their babies, and the fear that seeking help would result in being reported to child welfare services. When safe, medication-assisted treatment is stigmatized, difficult to find or unavailable, women often take harm reduction into their own hands.

> *I went to detox and they did two pregnancy tests and told me I was pregnant and they couldn't take me. They told me they didn't understand the dangers of me being pregnant. It was too dangerous. I left crying hysterically. My caseworker told me to go the emergency room to see what I could do. I went to the ER and they said "we can't prescribe you anything. We can't prescribe you methadone, we don't have the right license for that." I went down to the needle exchange because I had started going there from before to get fresh needles, and especially now I didn't want to get Hepatitis C or anything. And they said, "I can't believe nobody can help you, it's dangerous for you to just stop using an opiate. You need to keep using while we find you a methadone program." So I was going to the methadone clinic for a while but it was really hard to get there. It was early in the morning and I had a really rough pregnancy. I was sick all the time. And I was going through it. I was still using, I was scared. I was really scared. At the*

> *same time, I knew that I was doing more damage to the*
> *baby by not doing heroin.*

Ironically, their best attempts to protect their pregnancies and their future infants

are often used against them in court to justify child removal.

> *None of the detox centers would take me and so I was just*
> *going to detox on my own. My caseworker said "if you do*
> *that, you will never see your child because we will take the*
> *baby for abuse and neglect for trying to detox by yourself*
> *from an opiate" But then, later, the methadone was used*
> *against me in court by the law guardian.*

A lack of available treatment

Federal funding cuts have forced methadone clinics to close and time-consuming

federal regulations for the prescribing of methadone deter new providers (Vashishtha,

Mittal & Werb, 2017). Patients can only access methadone at certified clinics which are

often far from their homes or shelters. They must report to these clinics every morning,

often beginning at 5am. Long travel times and long lines interfere with the ability to

retain a job. The constant monitoring and supervision, inherent to methadone

maintenance, reduces the overall acceptability of the treatment.

Another major barrier to MAT access is the dearth of buprenorphine providers.

Buprenorphine (Suboxone) is considered a preferable treatment to methadone in many

ways; it can be provided in an office setting and can be used without supervised

administration in maintenance programs. Physicians who wish to prescribe it must obtain

something called the DATA waiver, which was written into the Drug Addiction

Treatment Act of 2000 and its 2006 amendment. The DATA waiver requires that

physicians take an 8-hour course to be allowed to prescribe buprenorphine. They can treat

thirty patients in their first year of practice and then, one hundred patients per year after

that. There are restrictions as to which pharmacies can dispense medications; only

accredited Opioid Treatment Dispenser pharmacies can fill prescriptions. Many areas

suffer from a dearth of waivered providers, this being particularly true of rural areas

(Andrilla, Coulthard & Larson, 2017). In some areas of the country, patients remain on

waiting lists for years (Sigmon, 2014).

Many have advocated for an expansion of medication-assisted treatments to

primary care (Jones, 2017), arguing that placing primary care on the frontlines of the

overdose crisis is a critical and urgently needed strategy (Saitz & Daaleman, 2017). But

this proposal has been met with significant push back. Physicians report that they lack

addiction expertise and adequate support from allied professionals. They perceive drug

users as having highly complex needs. They express concerns about their careers,

surveillance duties, safety risks and DEA disruptions to their practices (Livingston,

Adams, Jordan, MacMillan, & Hering, 2017). Ultimately, the stigma of addiction remains

a significant barrier; physicians fear attracting drug users to practices that serve families

and middle class professionals (Andrilla, Coulthard & Larson, 2017). [79]

In many ways we face a collective action problem where the burdens of providing

MAT treatment are concentrated on the first medical professionals to enter the space.

With a dearth of providers, those doctors offering MAT are overwhelmed by a flood of

addicted patients. If public policy were to incentivize or mandate broader participation in

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[79] In one study, physicians reported that having more ancillary staff (psychologists and mid-level providers) would motivate them to prescribe Suboxone (Makam, Gevirtz, Branche, Sperber & Alexveev, 2017). There has also been the suggestion that all medical students and residents be required to become providers, in order to expand access (McCance-Katz, George, Scott, Dollase, Tunkel & McDonald, 2017). While this is a pragmatic solution that may in fact be needed, it is consistent with the unfortunate trend of placing patients who have the most need with practitioners who have the least amount of experience.

MAT training and services, the burdens of drug treatment would be diffused and easily

absorbed in most medical practices, as is the case in France (Simojoki, Vorma & Alho,

2008). [80]

Vashishtha, Mittal & Werb (2017) make the claim that harm reduction tends to be

most popular when it is framed as a preventing harm to the larger community. Hari's

description of policy change in Switzerland, which ultimately led to the decriminalization

of heroin and to the establishment of fully sanctioned heroin-injection sites, validates this

proposition. Hari (2015) notes that it was not compassion for drug users that ultimately

swayed Swiss public opinion, but the realization that harm reduction reduced crime,

vagrancy, homelessness, health care costs and the spread of drugs and disease into the

broader community. Therefore, advocates may want to stress that MAT prevents HIV,

not only to users, but to their non-using partners and children, and that those enrolled in

MAT programs are less likely to initiate others into drug injecting (Mittal, Vashishtha,

Sun, Jain, Cuevas-Mota, Garfein & Werb, 2017).

The Swiss example suggests that harm reduction can have significant appeal

across the political spectrum. Some have argued that the pragmatism at the core of the

harm reduction makes it politically and ideologically neutral, and that this neutrality is a

benefit. However, I believe a fuller realization of its principles requires us to embrace a

more progressive set of political beliefs. In the end, the greatest obstacles to harm

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[80] Concerns with widespread availability of buprenorphine included intravenous misuse and diversion. This has been solved in part by a newer formulation consisting of buprenorphine and naloxone in a 4:1 ratio. Nalaxone is an opioid antagonist, which has no effect when administered sublingually but which triggers withdrawal when used intravenously by users of opioid agonists. This newer formulation, which combines two harm reduction medications, has been shown to maintain the benefits of buprenorphine, while minimizing the risk of misuse and diversion (Finch, Kamien & Amass, 2007; Simojoki & Alho, 2008).

reduction are the ongoing criminalization of drugs and the chronic forms of dislocation, alienation and social disconnection caused by global capitalism (Alexander, 2000).

Pauly (2008) argues that the values of harm reduction are consistent with a social justice approach. Conceptualizations of harm should be expanded to include the social concerns and structural inequalities that are at the heart of addiction: social welfare, access to health care, policing, incarceration, employment policy, and housing. The HDT women worried extensively about their return to lives of poverty, housing instability, employment barriers and restrictive, second-class citizenship due to their criminal records. At the end of the day, their greatest fear was that these stresses would, once again, leave them vulnerable to drug use. Bruce Alexander, the original Rat Park researcher, argues that harm reduction does not go far enough. He calls for dramatic social changes on a large scale, stating boldly that more narrow interventions such as rehab, psychotherapy, therapeutic communities and even harm reduction have run their course. He argues that 'dislocation' is the source of addiction, and that this dislocation is rooted in the very structure of our market-based economy (Alexander, 2000).

To more fully realize the promise of harm reduction, reforms need to be made in our approaches to psychotherapy and to our public policy related to drugs and addiction, with moves toward legalization. Ultimately, broader changes to our public institutions are needed. At its fullest realization, I would argue that this looks like a society that is socialist and humane – a society where people are protected, cradle to grave, from life's preventable traumas.

Conclusion

"Ideology is strong exactly because it is no longer experienced as ideology… we feel free because we lack the very language to articulate our unfreedom."

— Slavoj Žižek, In Defense of Lost Causes

"Empowered subjectivity and agency are possible for those othered within dominant culture by virtue of their own resistance and revolt against oppression. This resistance not only brings people together to create meaning for themselves but also begins to provide the social space necessary for empowered psychic space."

– Kelly Oliver, Psychic Space and Social Melancholy

In 2015, I attended a symposium where addiction researchers, experts, and treatment professionals gathered from across the country. Excited to learn about theories that I could apply to my dissertation, I came ready with questions and eager to learn. Having had exposure to theories of harm reduction, ACE research, and the work of Gabor Mate, I was expecting to hear about the cutting edge biopsychosocial work I was sure must be spreading through the field. But as the three-day conference dragged on, I heard no mention of these theories. Most of the workshops were led by researchers who studied

neurobiological processes and who showed little interest in linking the neurobiological with the social. Many workshops seemed inspired by spiritual AA ideology, melding together an assortment of new age practices with little grounding in a cohesive theory of addiction. Even when medication-assisted approaches were mentioned, speakers insisted on legislating mandatory counseling along with it. They treated harm reduction like triage, a temporary solution to move addicts into *real* treatment, which inevitably looked like the same old approaches of detox and abstinence.

On the second day, they announced that there would be a quick harm reduction presentation between sessions, where several workers from a local needle exchange program would come in to speak about their program. They had little time to explain the philosophy and practices of their program and were met with skepticism and distrust from audience members. Not once during the entire duration of the conference was there any mention of political or social policy changes that would reduce addiction or violent crime through the decriminalization or legalization of drugs.

This is the current, mainstream field of addiction research and treatment. We continue to be deeply entrenched in the medical model, and quite frankly, continue to hold on to some of the judgement of the moral model. We are loyal to AA ideology and abstinence-based treatments, despite lacking robust research of their efficacy. I had hoped that my experiences at the HDT facility merely reflected that practice had not caught up with the research. But as the conference came to a close, I was struck by how little harm reduction principles have penetrated the research itself. The findings and theories that I found foundational were being ignored by the best minds in addiction studies. The

insights that I found transformational were not transforming the field. This dissertation is

my own small attempt to push for change.

Perhaps as psychologists we are partly to blame for a medicalization of what is

clearly also a psychological affliction. Psychoanalysis turned its back on addicts a long

time ago, labeling them 'unanalyzable' – a tradition that continues to this day, with most

therapists requiring patients to complete addiction treatment *before* they can be seen. I

completed an entire five years of a graduate program in psychology with not one class on

addiction. In fact, addiction was rarely mentioned at all. And if it was, it was never

articulated, symbolized, or explored. At an institutional level, we exclude addiction from

public discourse. The phenomenology of addiction has been expelled from

psychoanalysis in much the same way that shame tends to be dissociated from the

traumatized psyche. Although the aim of most psychoanalysis is to draw in cut-off,

shameful, unarticulated parts of self, we continue to insist that addiction be left at the

door.

In many ways, the trauma of addiction *is* an exclusion from the realm of language.

In a chapter entitled *Psychic Space and Social Melancholia*, Oliver (2002) argues that

exclusion from the social world of language results in a collapse of psychic space - a

space which would ordinarily support the articulation of affect, the reworking of trauma,

and explorations of creativity and "utopic imagination." The mothers that I met were

undermined by a non-mirroring culture. They had few ways of articulating their losses or

of symbolizing their affects. They carried early trauma which had interrupted their

traversing of a developmental potential space. And now, they existed in a social

environment that further constricted psychic space and undermined opportunities for inspiration, meaning, attachment, and agency.

The women were excluded from the world of language in many ways, one of which was the inadequacy of words to capture the nuances of a disordered social system. What makes this system so destructive is the way in which its insidiousness, invisibility, and elusiveness seem to escape language. One can easily become overwhelmed and even silenced by its absurdity, its paradoxes, and its distortions. Systems such as "welfare", "food stamps", "rehab", "detox" and "shelters" have a very different meaning to those who are on the periphery of them, compared to those living in the realities of these systems. To most of us, for example, "homeless shelter" evokes *a place*. Yet, in reality, it is a complex warehousing *system* in which women and children are given housing one night at a time. They are often required to stand in long lines all day in order to qualify for the following night. A "detox center" sounds like an appropriate setting and one might find oneself wondering why women find themselves having to complete detox over and over again, failing each time. In reality, they are limited 8-day programs that typically turn pregnant women away. Part of the disempowerment that the women feel is the difficulty that they have expressing what it's like to be in this exasperating system. The power of invisible elusive ideology is that, despite its very real practical consequences, it is impossible to pin down or to describe with language.[81]

The mothers were also excluded from language by an imposed identity that rendered their words inconsequential and hollow. They lived with the stereotype of the

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[81] Aldous Huxley (1954) famously argued the inadequacy of language to describe LSD experiences, suggesting the language limits direct experiencing of the world. In light of their exclusion from the realm of language, it is interesting to think about drug use as a retreat to realms in which language may be irrelevant to experience.

"lying manipulative addict". When your very identity is defined by lying and untruth, and when anything you say might be construed as a lie, every interaction becomes strained and intentional. Authenticity is stifled by the other's unspoken skepticism and distrust. The true self is unknown and unseen. Preconceived notions of identity drown out language, and words become divorced from connection and meaning. Identities associated with the disease model of addiction further regulate and constrain language. Women develop practiced scripts or recovery narratives, which not only circumscribe identity, but also prevent them from accessing a rich and nuanced language with which to describe the complexity and multiple meanings of their experiences.

Despite these obstructions to language, it is important to emphasize that the women at HDT were not voiceless. Each day, they engaged in their own powerful and courageous resistance. But they confronted institutions that stifled language and connection, and their voices were silenced by experiences of loss, trauma, shame and social oppression. Beyond the traumas of their early lives, these women suffered the trauma of exclusion from the realm of language, which placed them at increased risk of retreating to the somatic, primordial realm of heroin.

In many ways, addicts hold something for society. Their symptoms are somatized experiences of profound disconnection, dislocation, alienation, loss and trauma. They are the dysfunctions and failures of our society made flesh. Until radical social transformations take place, widespread addiction will persist, whether it be to drugs, food, consumption, work or power. Until our values and institutions fully commit to eliminating trauma, neglect, and inequality, many people will grow up and live with the

pain and loneliness that drives addiction. To fully combat the problems raised in this dissertation, revolutionary charge is necessary.

In my mind, these changes would take the form of a society and culture that valued and prioritized the support and care of all of its citizens – a culture of care which ensured basic needs such as education, housing, health care, child care and meaningful work. Such a system might very well look more socialist than many can imagine America being at this point in time. Still, we need not wait for revolution to make significant improvements. There are important battles to be fought, and changes to be made, within our existing system. A prime example would be drug legalization, which would reduce the harms that mass incarceration places upon drug users, stem the tide of overdoses linked to highly concentrated and impure illicit substances, and allow those suffering from addiction to more openly access harm reduction treatments. Such reforms do not depend on ideology or partisan persuasion, and should be drawing support from across the political spectrum. There are also changes that can be made within our profession and its understanding of addiction, changes which would not only alleviate suffering, but which would also contribute more directly to liberatory social change.

First, addressing the needs of substance users, and in particular substance using mothers, requires us to challenge notions of professional objectivity. Psychological testing batteries, done in the confines of our offices, are used as justification for child removal. The social pathology of the system masquerades as individual pathology. Terms such as "non-compliance" obscure institutional barriers and biases. The presumed pathology of a mother who has had several children removed, back to back, obscures political contexts and the largely unconscious psychological sequelae of institutional

harms. My dissertation illuminates ways in which claims of neutrality, in the context of systems of treatment, child welfare, and entrenched ideological narratives, risk slipping very quickly into complicity with oppressive forces. With a long history of reflecting back society's prejudices with a veneer of objectivity, the field of psychology should now consider critical reflection to be central to responsible professional practice.[82]

Psychotherapists working with substance-using mothers should be equipped to listen for historical and ideological contexts and respond to the psychological interiorizations of gender, race, and class-based oppression. Empathy should include imagining the many ways in which women's narratives include unexpressed, unarticulated entanglements with these systems. Chou, Beeler-Stinn, Diamond & Cooper-Sadlo (2014) specifically call for mother-infant treatment programs that work from a feminist lens and intentionally deconstruct gender roles, stigma and shame, and "oppression identities". Prilleltensky (2003) calls for interventions that have 'psychopolitical validity', which he defines as the extent to which interventions "integrate knowledge with respect to multidisciplinary and multilevel sources, experiences and consequences of oppression." Black feminist theory has advocated for race and gender-based treatment in which clinicians understand and respond to the historical stereotypes that compound internal and external barriers to recovery (Roberts, Jackson & Carlton-LaNey, 2000).

Watkins and Shulman (2008) emphasize the need for communities that facilitate the articulation of oppression, trauma and negative self-perception in thought and

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[82] I am not suggesting that this be at the expense of the intrapsychic explorations that make psychoanalysis so deeply moving and rewarding. Depriving certain groups of experiences of insight and exploration in the name of supportive therapy is a bias in and of itself. And as Oliver & Edwin (2002) argue, "psychic working through is inseparable from social action and social change, *and vice versa*."

language. It is within what they call "public homeplaces" that deep listening, dialogue, dreaming, and creative expression can take place. Through processes of symbolization, members are purified of "toxic internalizations and feelings of inferiority, emptiness and meaninglessness" (p.57). A collaborative group process called *cooperative inquiry* has also been identified as a way to work through shame and internalized oppression. Its curative factors include story-telling, the recognition of shared feelings and experiences, critical reflection, and the use of poetry, art, movement and rituals, as multiple "ways of knowing" (Rosenwasser, 2000). These models correspond to the needs of the women in my research: needs for safety, symbolization, connection, and meaning.

Therapeutic spaces should also facilitate the development of what Paulo Freire (1970) termed *critical consciousness*: a form of knowledge that illuminates contradictions within dominant ideology and allows connections to be made between subjective experiences of suffering and larger historical, social, cultural and political contexts. By beginning to view existence and behavior in larger contexts, individuals gain psychological and emotional distance from what they assume to be individual pathologies and failings. It allows them to understand how particular political agendas or oppressive systems shape their lives and choices. It recasts and questions the meaning of choice and free will. A critical history perspective makes sense of the system's arbitrariness and unpredictability. It provides a framework in which to organize experience and counteracts the dysregulation of shame.

Substance using mothers require environments that facilitate a rebirth into the symbolic order. These are places in which mothers can begin to put experiences into words and can sit with ambivalence, paradox, and loss. These environments should be

free of shame, judgment, and threats of disconnection. They should be informed by an

appreciation of social contexts and an understanding of the sequelae of trauma and

dissociated pathogenic shame. Because self-regulation and shame are so central to their

developmental histories and subjective experiences in the world, substance using mothers

need attuned others to join them in experiences of dysregulation or intense emotion. They

need caring others who are curious and willing to explore and make sense of rage or

anger. Punishment and shame, which are central tactics of many therapeutic

communities, should have no place in addiction treatment.

Whether it be in our offices, in treatment centers, or in public places, space needs

to be created not only for the articulation of affect, experience, and critical understanding,

but also for the articulation of hope, resistance, and creative reimaginings.[83] Drawing

upon the work of Ignacio Martin-Baro, the foundational figure of Liberation Psychology,

Watkins and Shulman (2008) describe the psychologist's role as "that of a convener, a

witness, a co-participant, a mirror, a holder of faith for a process through which those

who have been silenced may discover their own capacities for historical memory, critical

analysis, utopian imagination, and transformative social action" (p.26). Oliver (2002)

describes the healing value of collective resistance in its ability to foster relationships,

generate meaning, and open up psychic space. Our concept of well-being must include

elements of empowerment and social action. After all, Freire emphasized praxis as much

as he did transformations in consciousness:

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[83] Watkins and Shulman (2008) assert that the acknowledgment of psychological symptoms is in itself a transgressive act; it confirms the mark left by oppression on the body and the mind. In this way, psychoanalysis is well-positioned to play a part in liberation and resistance.

> […] activity consists of action and reflection: it is praxis; it
> is transformation of the world. And as praxis it requires
> theory to illuminate it" (Freire 1970, p. 125).

I have demonstrated, throughout this dissertation, the ways in which institutional and systemic forces undermine women's strivings for what we would consider to be the traditional goals of psychanalysis: insight, agency, self-cohesion, identity, love and intimacy, and self-discovery. Our psychological formulations must include knowledge of these systemic forces. They must be informed by critical history and by an understanding of ideology and cultural discourse. We must strive toward a modality of psychotherapy that acknowledges the social and political significance of symptoms and be willing to bring *the social*, beyond superficial notions of group difference, into the therapeutic space.

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The women in this project experienced various interlocking systems of race, gender and class-based oppression. Their words and their stories are acts of resistance - attempts to describe the indescribable, to "articulate unfreedom," and to contribute to counter-narratives about substance using women and their children. I end with the hopeful words of one of the women at HDT. In my mind, this quote speaks beautifully to the curative potential of relationship, love and attachment. It's a narrative that rejects static, prescribed identity, in favor of multiplicity and fluidity. Ultimately, in its imaginative wielding of words, it reveals the power of language and symbolization to recast trauma, rewrite destiny, and envision liberation.

I named her Anastasia which in Greek is resurrection and if you look up resurrection, it means resumption and if you look up resumption it means, to begin again after a long period of pause or interruption. She has helped me to begin to see these last two years as just an interruption in my life. They say you have to hit bottom, well I was so low in my bottom that I didn't know how I was going to get out, but this baby got me out.

APPENDIX A

CONSENT FORM
FOR ANONYMOUS DATA COLLECTION

You are invited to participate in a research study that is being conducted by Cassia Mosdell, who is a doctoral student at the Graduate School of Applied and Professional Psychology at Rutgers University. The purpose of this research is to gain understanding of how to support mothers and babies in substance abuse treatment.

This research is anonymous. Anonymous means that I will record no information about you that could identify you. There will be no linkage between your identity and your response in the research. This means that I will not record your name, address, phone number, date of birth, etc. If you agree to take part in the study, you will be assigned a random code number that will be used on each test and the questionnaire. Your name will appear only on a list of subjects, and will not be linked to the code number that is assigned to you. There will be no way to link your responses back to you. Therefore, data collection is anonymous.

The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law. If a report of this study is published, or the results are presented at a professional conference, only group results will be stated. All study data will be kept

There may be benefits to you for participating, including personal satisfaction from sharing information about your life, and the satisfaction that might come from contributing to research that seeks to improve standards of care for women and families. The risk of participating in this study is that you could become upset or uncomfortable while thinking about or discussing the issues involved. If you do experience emotional discomfort, the interviewer, as a trained clinician, will assist you in dealing with your feelings and will make appropriate referrals to your on-site counselor or dyadic therapist, if necessary.

Participation in this study is voluntary. You may choose not to participate, and you may withdraw at any time during the study procedures without any penalty to you. In addition, you may choose not to answer any questions with which you are not comfortable.

You will receive a gift basket for your participation in the study. Once you begin the interview, you have the right at any time to withdraw from the study, without loss of compensation.

If you have any questions about the study or study procedures, you may contact myself, Cassia Mosdell at cassiachan@gmail.com or at 862-206-9500. You can also contact my faculty advisor Karen Skean, PsyD at kskean@aol.com or 732-247-7489.

If you have any questions about your rights as a research subject, please contact an IRB Administrator at the Rutgers University, Arts and Sciences IRB:

Institutional Review Board
Rutgers University, the State University of New Jersey
Liberty Plaza / Suite 3200
335 George Street, 3rd Floor
New Brunswick, NJ 08901
Phone: 732-235-9806
Email: humansubjects@orsp.rutgers.edu
Please retain a copy of this form for your records. By participating in the above stated procedures, then you agree to participation in this study.

I have read and understand the contents of this consent form, and will keep a copy of this form for my files.

_____   _____
Signature (Participant)   Date

_____   _____
Signature (Investigator)   Date

APPENDIX B

INTERVIEW GUIDE

Interviewer: I want to begin by thanking you again for agreeing to participate in this study, and for making the time to speak with me. I hope that the results will prove helpful to other mothers who are in similar circumstances, and I also hope that you will find some benefit from talking about your own experience, and in sharing your perspective. I'm interested in understanding your experience as much as possible.

I'm going to begin by asking for some basic background information, and then we'll move into talking about your experience. If at any point in the interview you are uncertain about something, would like me to clarify a question, or if you'd like to stop and take a break, please let me know. Before we begin the interview, do you have any questions or concerns?

Demographic Information

1. What is your date of birth?
2. Where did you grow up?
3. How many years of school have you completed?
4. Are you single, partnered, married, separated or divorced?
5. Is your partner male or female?
6. Do you identify with a particular religion? If so, which one?
7. How important is this religion to you? Very important, somewhat important, or not very important?
8. How many children do you have, and what is each child's age and gender?
9. How old were you when you gave birth to your first child?

Early experiences

- Can you tell me what it was like for you growing up?

Experiences with drugs

Now I'd like to ask a bit about your experiences with drugs:

- Can you describe your first experience with drugs?

- How did it feel?

- What was your life like at the time?

Questions about pregnancy

Now I would like to ask you about your pregnancy.

- Before you became pregnant what were your thoughts and feelings about motherhood?

- Can you describe the moment you discovered you were pregnant?

- What thoughts and feelings?

- Did you hope for a son or for a daughter?

- While you were pregnant did you have any thoughts?

Questions about the birth

- Who was present at the birth?

- How were your interactions with the people around you (nurses, hospital staff…)

- Can you remember any thoughts and feelings that you had when you first saw/met/held your baby?

Treatment

- Now I would like you to take a minute to think of a situation in which you felt powerless or put down by a larger system such as DCPP, legal systems or a treatment facility.

  a) if necessary, provide help with choosing the incident.

  b) Get the whole timeline, including what happened just before the incident and the outcomes.

  c) Probe for details on the setting, the situation, who did and said what.

  d) Probe for feelings.

- Now I would like you to take a minute to think of a situation in which you felt supported and respected. Can you describe it to me?

  a) If necessary, provide help with choosing the incident: I am looking for incidents that are evocative of caring and support.

  b) Get the whole timeline, including what happened just before the incident and the outcomes.

  c) Probe for details on the setting, the situation, who did and said what.

  d) Probe for feelings.

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