Three Mothers’ Stories:
Life experiences with violence, abuse, mental illness, and substance abuse

By
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Abstract

Many women and children in North America and other parts of the world are impacted by male perpetrated violence and often experience responses to this violence in the form of sadness, anxiety, and fear. Some of these women use substances to cope with their frightening and traumatic life situations. These mothers and their children often engage with multiple systems and agencies including, but not limited to, Health Services, Child Protection Services, and Transition Houses. Women often do not receive positive social responses when they seek help from these services. This qualitative research project shares the stories of three mothers with histories of violence, mental illness, and substance abuse. Using Narrative Inquiry the researcher shares the stories as they have been presented by the women, exploring how their life experiences have influenced their sense of identity and choices in seeking support in their communities. Using feminist, mothering, and response-based discourse lenses, the women’s narratives are presented and discussed.
Acknowledgements

This thesis project is inspired by my aunt, Pam Fisher, and the many other courageous, resilient, and strong women that I have come to know through my practice in the field of counselling. These women’s stories of lifelong struggles with issues of trauma due to abuse, mental illness, and substance abuse have demonstrated to me the need for a more holistic approach in the fields of counselling, mental health, and addictions.

I would also like to acknowledge the unconditional and constant love and support of my favourite people in this world. Thank you to my family and friends; Mom, Dad, Grandma, Katie, Gord, Heidi, Kirsten, Candace, Ivan, Kim, Jonny, Kristy, Kim and Erin.

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# Table of Contents

Abstract .............................................................................................................................. iii  
Acknowledgements ............................................................................................................ iv  
Table of Contents ................................................................................................................ v  
Introduction ......................................................................................................................... 1  
   The Power of Stories ....................................................................................................... 1  
   Why Do This Research? ................................................................................................. 4  
Chapter One: Situating the Researcher ............................................................................... 6  
   Constructivism ................................................................................................................ 7  
   Service Provision ............................................................................................................ 9  
   Local Program Development ........................................................................................ 11  
   The Role of Language ................................................................................................... 12  
Chapter Two: Review of the Literature ............................................................................ 15  
   Mothers, Violence, Substance Abuse and Mental Illness ............................................. 15  
   The Psycho-Social Determinants of Women’s Health and Well Being ....................... 21  
   Looking Through a Gendered Lens .............................................................................. 23  
   Discourse ....................................................................................................................... 24  
   The Four Discursive Operations of Language About Violence Against Women ........ 33  
   Woman-Centered Care ................................................................................................. 36  
Chapter Three: Methodology ............................................................................................ 43  
   Narrative Inquiry ........................................................................................................... 44  
   The Study of Experience ............................................................................................... 47  
   Methodological Limitations .......................................................................................... 51  
   Method: How I Proceeded ............................................................................................ 53  
   Analysis ......................................................................................................................... 56  
Chapter Four: The Women’s Stories ................................................................................ 59  
   Daisy’s Story: Discovering Your Power ...................................................................... 60  
   Sandy’s Story: Caretaker, Artist ................................................................................... 84  
   Marla’s Story: Life in a Warzone ............................................................................... 121  
Chapter Five: Discussion ................................................................................................ 145  
   Central Emerging Themes and Influencing Discourses .............................................. 146  
   What Does it All Mean? .............................................................................................. 150  
   The Power of Telling her Story .................................................................................. 153  
Chapter Six: Implications and Future Directions ............................................................ 155  
   Engaging Relationally in Research and Practice ........................................................ 156  
   Women - Centred Care Framework ............................................................................ 157  
   Strengthening Personal Narratives of Dignity, Self-Respect, and Justice .................. 159  
   Researcher Reflections and Implications for my Practice .......................................... 159  
   Concluding Thoughts .................................................................................................. 161  
References ....................................................................................................................... 163
Introduction

“After about a year I wanted to leave because he (my husband) was hitting our daughter and I felt forced to have sex when I didn’t want to. So one day I said I needed to leave and his response was... I don’t know where he got a shotgun, but he sat in the chair for about an hour or so with that shotgun and never said a word. I had no idea what was going to go on and I had already gone through a lot of stuff with him where he said I wasn’t allowed to tell anybody about our problems and so I was silent.

- Sandy

The Power of Stories

Story… is an ancient and altogether human method. The human being alone among the creatures on earth is a storytelling animal: sees the present rising out of a past, heading into a future; perceives reality in a narrative form.

(Novack, 1975, p. 175)

Stories change people. Both storyteller and listener are transformed to some degree with each telling and hearing of a story. Stories can evoke within the teller, listener or reader personal reflection, emotional response, and action. Stories connect us as humans. Within all of our stories we find similarities and ways to relate with our own personal experiences. In the field of counselling, professionals are entrusted with the stories of clients and granted the privilege of entry into their inner worlds. It is through hearing stories, the sharing of personal narratives, that clinicians have the opportunity to appreciate the ways in which clients have made meaning of the objects, events and individuals that constitute their life experiences. Further, Gergen and Warhus (2001)
point out that the therapeutic relationship is like a tango, in that meaning evolves through the development of the relationship. Mahoney (2003) explains how, as a therapist, he is changed to some extent by every client that he works with.

It is argued by many that there can be tremendous healing power in stories (See for example, Connelly & Clandinin, 1990; King, 2003; Malchiodi & Ginns-Gruenberg, 2008). Stories can teach us, inspire us, and empower us. Every recipient of the same story develops their own unique meaning from that story. Stories can be immensely powerful, and the act of telling one’s story if carried out in a safe context, should not be underestimated. Sharing a personal narrative with a safe and non-judgmental audience can also elicit great personal development and healing potential.

**My story.** One of the most profound messages that I have received and integrated into my personal narrative comes from a musical: “When God closes one door he always opens a window”. These are the words spoken to Fraulein Maria by her Mother Superior in the movie The Sound of Music. Excluding the obvious religious tone of this message, I take it to mean that throughout life we are presented with multiple opportunities or options and with every option declined or accepted, multiple other opportunities arise as a result. A life does not follow a straight path, rather “doors” and “windows” are opening and closing in front of us constantly, and through each “door” or “window” lie multiple experiences and realities. Whether they are courses of action or ways of knowing or understanding a particular event, multiple realities are possible. I have often reflected back on the events of my life so far and revelled at how things have rarely turned out the way I imagined, but how things always seem to work out in a way that is satisfying. My
position of privilege and safety within my social location in combination with my life experiences have demonstrated to me that I can accomplish most anything that I set out to achieve, even if it seems impossible at times. My faith in this narrative is what has kept me writing this thesis, even when I wanted to give up. My personal narrative empowers me and challenges me to thrive in this life. It is essential in discussing my personal narrative that I recognize how much of my narrative is born of my socio-cultural position of privilege and power in this world. Being raised in a middle-class Caucasian two-parent family, which was free from any direct experiences of abuse, mental illness, and substance abuse, has most certainly contributed to the positive and empowering tone of my personal narrative.

I began my career as a teacher and after a few years in that role discovered that my passion lay not in the academic aspect of education with children and parents, rather in the areas of personal, social, and emotional development. I was drawn to the students who were struggling because of challenges stemming from issues in their families based on violence, abuse, mental illness, and/or substance abuse. Through my work in the violence against women\(^1\) and mental health I have been struck by the strength and resiliency of the women I have worked with and have been changed by the experience of hearing each of their personal stories. While these stories are fraught with violence, pain, suffering, oppression, silencing, and fear, the stories that I have witnessed have also included examples of resistance, prudence, assertion, and commitment to freedom despite barriers in social/political policy and service structure and provision.

\(^1\) The use of the terms “violence against women” and “woman abuse” are being used in this context to signify the violence and abuse perpetrated against women by their intimate partners, male or female. While violence against women in same sex relationships does exist, the primary perpetrators of violence against women are men (Jahn Moses, Glover Reed, Mazelis & D’Ambrosio, 2003).
Why Do This Research?

If we wish to understand the deepest and most universal of human experiences, if we wish our work to be faithful to the lived experiences of people, if we wish for a union with poetics and science, or if we wish to use our privileges and skills to empower the people we study, then we should value the narrative.

(Richardson, 1997, p. 35).

The complexity of these women’s lives and an interest in the ongoing internalized social expectations that women with histories of violence, abuse, mental illness, and substance abuse utilize to make meaning and create personal narratives is what has drawn me to conduct this research. My aim in conducting this research is to bring forth the voices of these women in order to learn about their experiences, positive, negative, and other\(^2\), when attempting to access services for their complex needs and to investigate the discourses that seem to impact the narratives they construct. Each woman’s narrative provides the listener with the opportunity to understand the ways in which she has made sense of her life experiences. Storytelling is an interpretive practice: It is through a person’s way of constructing reality that the story is being shaped and told for the self and listeners. People’s stories offer a window into their meaning making process and how they experience the world around them and their relationships with others. The notion of meaning making through experience, the process of integration into identity, and both the benefits and limitations of the study of experience will be discussed further in upcoming

\(^2\) “Other” has been identified here to avoid creating an either/or dichotomy of positive or negative experiences in seeking services for the women in this study. A third space, “other”, is emphasized here in an attempt to acknowledge the intersection of “good” and “bad” experiences, where women could encounter both at the same time.
chapters. It is hoped that through the sharing of these mother’s stories the influential
discourses and the social, cultural, political, and gendered theories that depict externally
organized systems will be highlighted. Additionally, it is hoped that these stories will
illuminate the experiences of these women in their unique attempts to gain access to
services for themselves and their children. This could be influential in offering
suggestions for the creation of an improved approach to service provision for women
with challenges of violence, abuse, substance abuse, and mental illness.

For several years, and still today, there exists an ongoing dialogue among the
various professionals who present a link between the service providing agencies and the
women clients. This ongoing dialogue calls for more collaboration between service
providers in the mental health, counselling, and addictions fields. Many of the
professionals in these helping fields recognize that more collaboration is needed to better
provide support to their clients, but there is a barrier limiting the realization of this need
for collaboration.

It has been an honour to have met the mothers in this study and I am forever
grateful for their willingness to share their stories with both me and the readers of this
thesis. Through this process I have been invited by these three women into their hearts. It
is with great respect and honour that I present these women’s stories to you.
Chapter One: Situating the Researcher

My epistemological and theoretical orientation to counselling incorporates poststructuralist, feminist and social constructivist ideas. My orientation has been informed by the work of scholars like Kenneth and Mary Gergen, Michael Mahoney, Donald Polkinghorne, and Chris Weedon. Recently, the local research of Nancy Poole, Amy Salmon, Marie Hoskins, Allan Wade, Linda Coates, Cathy Richardson, Linda Greaves, and Marina Morrow, have influenced my understanding of the issue of women’s health, co-occurring disorders, and violence against women. My practice and epistemological orientation have developed from my life experiences – personal, educational, and professional – and influence the ways that I make meaning of the world and interact in it. Wendt and Boylan (2008) explain poststructuralism as “the academic theorizing and critique of discourse, knowledge, truth, reality, rationality and the subject”. Furthermore, they state that “poststructuralism argues that identity and meaning are rooted in language and so meaning is always provisional and shifting, dependent on features such as context, audience, and experience, and identity is not fixed” (p. 601).

Poole and Isaac (2001) state that poststructural feminist research should commit to “making the invisible visible, bringing the margin to the center, rendering the trivial important, putting the spotlight on women as competent actors, (and) understanding women as subjects in their own right” (p 10). According to Weedon (1987), feminist

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3 The language of “disorder” is problematic as it contributes to the pathologizing, blaming, and oppression of women who in many cases may be responding in very natural ways to trauma, violence, oppression, and abuse with sadness, anxiety, aggression, and stress. The term dis/order implies a deficit (innate inner chaos/disarray) within the person carrying the label. However, the term will be used in this thesis as the writer hopes this document will appeal to a larger audience, including practitioners and clients in the community. It is important that the common vernacular within mental health be utilized to ensure the document’s accessibility and appeal.
poststructural research must “use poststructuralist theories of language, subjectivity, social processes and institutions to understand existing power relations and to identify areas and strategies for change” (as cited in Boonzaier, 2008, p. 185). Poole and Isaac (2001) discuss the role of “research as a vehicle to support change in systems and policies” (p. 12). Based on this concept, research can play an integral role in initiating effective social change when based on ideologies that recognize the diversity of human experiences and the role that language, subjectivity, social processes, and institutions play in those experiences.

\textbf{Constructivism}

This research looks specifically at some of the ways in which the mothers have constructed their identities and made meaning of their individual life experiences. Individuals are continuously interacting with the world around them, and the world is in turn interacting with them. Individual meaning is created through interaction and experience with the world. Construction of meaning and identity from a constructivist perspective includes processes of active agency, order, self, social-symbolic relatedness, and lifespan development. Mahoney (2003) states that “we are moving in the midst of forces far greater than ourselves, yet we have voice and choice within those forces” (p. 5). The women in this research possess active agency in their lives, that is, voice and choice over their lives. However, through no fault of their own, these women met challenges to the scope and success of their control or influence as a result of the oppressive forces that they faced because of violence, as well as social, political, and
cultural pressures and stigmatization. As Mahoney (2003) points out, forces such as these, within which individuals operate, are very strong and often beyond comprehension.

Human beings create order and patterns in their worlds in an effort to respond to and interact with it, and much of this meaning is held in storied form. Interaction with the world includes full integration of, or at least working with, the social stories and theories of the dominant culture that depict externally organized systems, which can include domination, patriarchy, and colonialism. Order and patterns provide perceived security and safety for individuals and “the patterns we develop and the ways we have learned to be are moving with a powerful momentum” (Mahoney, 2003, p. 6). Interruption of this momentum can be problematic. More about patterns in human meaning making will be taken up in future sections of this thesis.

As individuals engage in the meaning-making process they are continuously organizing; building an intra-psychic understanding of the self, the world surrounding the self, and how that self fits into the larger world. Polkinghorne (1996) states that “stories are ubiquitous in people’s lives and include those told by others, and those retained by their cultures in oral and written forms. And from among this array of stories, only a small number of special stories maintained by the culture are meant to serve as sources for personal identity” (p. 365). According to Mahoney (2003) “much of the order we seek and the meaning that we create emerges out of what we feel with one another” (p. 7). Social-symbolic relatedness plays a large role in the way we organize ourselves and our world and so the experiences we have in relationships with family, peers, partners, and colleagues all influence the lifelong process of organizing, reorganizing, and meaning making.
Service Provision

Through my work in the field of counselling with women and children harmed by violence, mental illness, and substance abuse, I have developed a position regarding best practice and service provision for these individuals. The women I have worked with and my aunt have both inspired and informed the selection of this research topic, as well as the choices made regarding the methods and methodology utilized. In the following paragraphs I will highlight some of the main elements of my position in regard to service provision for women who face violence, mental illness, and substance abuse.

The principles I align myself with in practice include the central tenets of the women-centred care model, which include integrated, family oriented, inclusive, relationship focused, socially conscious, and collaborative approaches. I concur with a statement from a Women, Co-occurring Disorders, and Violence Study (1990): “It is now time to find a way to create integrated services that work for women with alcohol and drug abuse issues, mental disorders, and histories of violence and trauma and their children” (p. 11). Their findings fit with the women-centred care notion of practicing in a holistic manner, that works with women in a way to address the multiple and complex challenges they face concurrently. This holistic approach will require a restructuring of some of the systems in place, including social services, mental health, and addictions, and various human services for victims of violence and abuse, who also suffer from mental illness, and/or substance abuse issues. Many of the women I have worked with report their experience with many of these services as increasingly impersonal and often difficult to access. Many have been required to describe their life experiences to service
providers many times over, only to be turned away or referred to another service provider
or agency.

In forthcoming chapters, the women-centred care model will be discussed in
greater detail, as well as discourses related to “women” and “mothering”, as the
relationship between these constructions can be viewed often as mutually exclusive.
Much research points that children can play a key role in the healing process of a mother
and without her children some women will have less of a chance of successful recovery
(Finkelstein et al, 2005; Jahn Moses, Glover Reed, Mazelis, & D’Ambrosio, 2003;
VanDeMark et al., 2005). All children (and mothers) must be provided with the resources
necessary for healthy and positive physical, emotional, and social development. Based on
these ideas it appears that programs for women should be more family-focused and that
these programs can serve as a site and tool for breaking intergenerational cycles of
abuse/trauma, mental illness, and substance abuse.

Women who experience victimization due to abuse, mental illness, and substance
abuse have been studied in the past and their stories have been told, but often through a
lens of blaming, stigmatization, and pathology (Greaves et al., 2002). Much of this past
research has contributed to “public discourse that is fundamentally judgmental, blaming,
and unsympathetic of women and mothers who use substances” (Greaves et al., 2002, p.

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4 “Intergenerational Cycle of abuse/trauma, mental illness, and substance abuse” refers to a pattern that has
been observed by practitioners/researchers (Motz, Pepler, Moore, & Freeman, 2006, in Breaking The Cycle,
p. 68) and conceptualized as a way to predict the future lives of children who have been victimized by
abuse and violence and have had exposure to caregivers suffering with mental illness and/or substance
abuse. While this cycle has been proven to have validity in some cases, the term is problematic from a
constructivist perspective, as it ignores the active agency of the individual child and assumes a causal
relationship between childhood and adult victimization. Childhood exposure to these issues can impact the
development of future victimization, mental illness, and substance use. However, the researcher
acknowledges that various other factors can also influence (e.g., oppression, racism, biology, adult
experiences, etc.).
6), ignore the “social influences that blame women who are victims of violence” (Brewin, 1990, p. 758), and create a “social climate in which women with mental illnesses are viewed as dangerous and incapable of caring for children” (Greaves et al., 2002, p. 8). Through the telling of three women’s stories, highlighting their personal narratives, this research hopes to illuminate some of the complexity that exists at the intersection of these challenges and to underline some of the tensions that exist. Polkinghorne (2005) states that “qualitative methods [such as in-depth interviewing and narrative analysis] are specifically constructed to take account of the particular characteristics of human experience and to facilitate the investigation of this experience” (p. 138). Furthermore, he notes that, “individuals and cultures maintain and communicate their identity answers in storied form and that their members take in and retain them in storied form” (Polkinghorne, 2002, p. 365). For this reason there is value in allowing a woman to tell her story, to articulate the meaning that story possesses for her, and to have that meaning valued as her “truth”.

**Local Program Development**

I work for a local organization that currently provides services to women and children who are victims of violence. Within this organization and other similar agencies, a conversation has begun about the linkages between violence, mental illness, and substance abuse in the lives of women. As an extension of my current work as a counsellor, I am proud to be involved in the development of an innovative project for this

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5 This section does not intend to create a dichotomy between past and present practice or to imply that all past practice was “bad” and all new practice today is “good” because this would be an oversimplification of a much more complex situation. However, I am attempting to point out some of the detrimental ideas, practices, and discourses that have negatively influenced the safety and health of women who face issues similar to the mothers in this study.
region that is modelled after similar programs in Canada. These programs include Maxine Wright and Sheway in Vancouver, British Columbia, and Breaking the Cycle in Toronto, Ontario. HerWay Home (an acronym: Housing first, Empowering, Respect, Woman, Acceptance, Your choice, Health, Opportunity, Mothering, Equality) will be a facility for pregnant and early parenting women that will address the intersection of the issues that a woman fleeing an abusive partner may be facing, including substance abuse, mental illness, and/or trauma through abuse. The program will include several services for women and children including a drop-in centre offering services such as primary health care, counselling support, a community kitchen, child-care, as well as housing units for detox and second and third stage units. A women-centred care approach is being utilized in the development of this project and will be an integral part of the services provided to women and families at HerWay Home.

The Role of Language

When you believe in things you don't understand, you suffer!

– Superstition, Stevie Wonder

Language is a powerful tool used to describe and create meaning. Too often, it is taken for granted that the words chosen by a speaker to describe an experience or idea are understood by others in the way the speaker understands them. Language allows us to engage with one another and to express ourselves in the world. However, language can be used as a way to conceal particular realities, while highlighting others, and for this reason must be considered here. Many words in our language are accepted as appropriate and are actively used without investigation by the speakers into the assumptions, discourses, and
oppressive or otherwise harmful intent that might be inherent and problematic within that language. For this reason, the accepted language utilized by researchers, practitioners, and the general public in the field of violence against women has undergone many shifts through the last two decades. For example, early labels and definitions, such as “wife battering” and “wife beating” focused on legally recognized criminal behaviour taking place within legally recognized relationships. In addition, these terms did not allow for the inclusion of other forms of abuse including emotional, psychological, financial, and so on. This language was replaced with terms like “partner”, “spouse”, “domestic”, and “family” violence. These terms mutualise the act of abuse, implying that both or all individuals in the relationship/family are equally likely to perpetrate and/or experience the violence. However, research shows that women are overwhelmingly the targets of violence. “Intimate partner violence” is a term that has been used more recently, but is problematic because it implies that an abusive relationship is grounded in intimacy rather than oppression. I have chosen to use the terms “violence against women” and “woman abuse” throughout this thesis, as they are the most inclusive terms that describe the experiences of the women in this study. The term “abuse” will be used to describe and encompass multiple forms of violence including woman abuse (physical, emotional, psychological, sexual, and financial abuse) as well as childhood abuse (physical, sexual, psychological, and emotional). “Trauma” will be used to refer to the physical, emotional and psychological effects experienced by a person as a result of victimization or witnessing of violence and/or abuse in any of its many forms.

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6 The use of the terms “woman abuse” and “violence against women” are being used in this context to signify the violence and abuse perpetrated against women by their intimate partners, male or female. While violence against women in same sex relationships does exist, the primary perpetrators of violence against women are men (Jahn Moses et al., 2003).
The language used in the fields of addiction and mental health, also warrant some discussion here. The use of mood altering substances is very common in our society, and the impact of using such substances falls along a spectrum with “problematic substance abuse” at one end and “normal” use at the other end. This thesis will not engage in the question of how much use by the participants is “misuse” or “abuse”, but will accept the participant’s definition of her usage. The term “substance abuse” will be used in this research as it best encapsulates the spectrum of use that women may fall under. Mental health, like substance abuse, falls along a continuum, making it challenging to conceptualize a clear line between mental health and illness. Terms such as “mental illness” and “mental health issues” or “challenges” will be used to describe the scope of experiences faced by women in relation to their mental health.

In the event that any different language is utilized by the mothers I will use their words instead of mine and frequently use direct quotes.

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7 The term “illness”, like “disorder” is problematic as it contributes to the pathologizing, blaming, and oppression of women who in many cases may be responding in very natural ways to trauma, violence, oppression, and abuse with sadness, anxiety, aggression and stress. The term “illness” implies a biological or medical deficit or problem within the “ill” person. However, the term will be used in this thesis as the writer wishes for this document to appeal to a larger audience, including practitioners and clients in the community. It is important that the common vernacular within mental health be utilized to ensure the document’s accessibility and appeal.
Chapter Two: Review of the Literature

This review of the literature looks at current work by researchers in the fields of Social Work, Child and Youth Care, Health, and Counselling. This review highlights some of the current discussions and findings in the field, in regards to mothers facing violence and abuse and dealing with mental illness and substance abuse. The articles used in this literature review were discovered through searching the University of Victoria Library’s journal database. Key word search terms such as ‘violence against women’, ‘domestic violence’, ‘substance abuse’, ‘mental illness’, ‘women’, ‘mothers’, ‘concurrent disorder’, ‘co-morbidity’, ‘language’ were used as well as terms related to theory such as ‘feminism’, ‘post-structuralism’, ‘narrative inquiry’, ‘constructivism’ and finally specific names of authors were entered into the search.

Mothers, Violence, Substance Abuse and Mental Illness

Professionals and researchers working in the field of violence against women are noticing that a significant number of the women seeking services from women’s shelters are also facing mental illness, childhood trauma, and/or issues relating to substance abuse. Bland (2007) states that interpersonal violence, substance abuse, and mental health issues share several points in common. “All involve power and control dynamics, impact entire families, often harming three or more generations, thrive in silence and isolation, carry great societal stigma and shame, and limit freedom for members of our community, resulting in oppression” (p. 1). Violence in the lives of women and children is described by Jahn Moses et al. (2003) as an epidemic. “Interpersonal violence, including physical and sexual assault is so pervasive for women, regardless of cultural affiliation and
socioeconomic class, some consider it a ‘normative’ part of the female experience today” (Salasin & Rich, as cited in Jahn Moses et al., 2003, p. 3). According to Statistics Canada (2007) over 38,000 incidents of spousal violence were reported to 149 police services across Canada in 2006, accounting for about 15% of all reported violent incidents. Women are more likely than men to be the victims of the most severe forms of spousal assault, as well as spousal homicide, sexual assault, and stalking. Sexual assault is one of the most under-reported crimes with fewer than 10% of sexual assaults reported to the police (Statistics Canada, 2007).

The researchers involved in the Women Co-Occurring Disorders and Violence Study (Jahn Moses et al., 2003) in the U.S. found strong associations between exposure to violence and issues related to mental illness and substance abuse in women. Research on exposure to traumatic events among women with mental health and substance abuse issues showed that between 48% and 90% of women with these challenges also have histories of victimization from interpersonal violence (Becker et al., 2005). Jahn Moses et al. (2003) posit that there exists a connection between childhood physical and/or sexual abuse and domestic violence citing that “seventy to 80 percent of women who have experienced domestic violence have also survived physical and/or sexual abuse during childhood” (p. 3). In their study looking at co-occurring rates between violence against women, substance abuse, and mental illness, Miller and Downs (1993) found that 41% of women in alcohol treatment programs reported severe violence (perpetrated by pre-treatment, current, and lifetime partners) and 23% in mental health centers (p. 140).
The responses by women to the social issue of violence against women are unique for each survivor and have been found to include mental illness and substance abuse. I wish to recognize here that the usage of the terms “mental illness” and “substance abuse” in this context are problematic because responses to violence such as sadness, anxiety, and numbing by abusing substances have been pathologized and labelled as mental illnesses and disorders, thereby misplacing the blame for the act by the perpetrator of violence and placing it on the female victim (Coates & Wade, 2007). Usage of these terms has been maintained here to ensure accessibility and appeal to a larger audience of community practitioners.

(Coates & Wade, 2007; Fullilove et al., 1993; Jahn Moses et al., 2003; Soloman, Bassuk, & Huntington, 2002). Jahn Moses et al. (2003) explain that “Chronic physical and/or sexual abuse, have been shown to play complex roles in the development of mental health symptoms, substance abuse, and a wide range of physical health problems” (p. 4). Women with abuse histories and trauma symptoms may face a range of mental health issues including anxiety, panic disorder, depression, substance abuse and dependence, personality disorders, dissociative disorders, psychotic disorders, eating disorders, and post-traumatic stress disorder (Jahn Moses et al., 2003). Duncan (2004) found that responses to violence and abuse in the form of emotional states such as dissociation, depression, anxiety, guilt, shame, and rage are not only experienced by the victim at the time of abuse, but can be experienced continuously or periodically throughout one’s lifetime (p. 269). Fullilove et al. (1993) and Salomon, Bassuk, and Huntington (2002) describe the relationship between violence, mental illness, and substance abuse as complex and multifaceted. They state that victims of violence may respond with substance abuse or develop mental illness; substance abuse and mental illness may put women at greater risk of victimization, and substance abuse and other self-injurious behaviours may result from previous experiences of violence and abuse. Kelly, Blackstein, and Mason (2001) found links between substance abuse and historical or
current trauma through abuse and mental illness, as the substance abuse is often used as a means for coping with these other issues. Furthermore, they state that, “violence, especially in the form of childhood sexual abuse, is acknowledged to have a role in the epidemiology of substance abuse for many women” (p. 290). This growing body of data has “directed the attention of clinicians, researchers, and policymakers to the significant lack of appropriate services for women with these conditions” (Becker et al., 2005, p. 430).

The diversity in experience and needs makes providing effective and respectful support to these women very complex. Historically, the issues that women dealing with mental illness, substance abuse, violence and abuse face have been viewed independently from each other by service providers. However, women with these issues experience their various challenges concurrently, as they are often linked (Breaking the Cycle Compendium, 2007). The researchers and developers of the Breaking the Cycle Program (BTC) in Ontario, Canada, study and report on the complex service needs of substance-involved pregnant and parenting women and their children. Socio-demographic assessment of the active BTC Program confirms that substance abuse problems in women and mothers co-occur with high rates of these experiences: early childhood trauma including sexual, physical, and emotional abuse; psychological and medical problems; and woman abuse and substance abuse by spouses or partners in their adult relationships (Breaking the Cycle Compendium, 2007).

The literature reviewed in the areas of women’s health care, mental illness, violence, and substance abuse repeat a similar theme that implores practitioners to see the interconnections amongst these complex issues facing many women. Some of the
research reviewed for this study demonstrates some shifts in this direction. In her British Columbia research, Morrow (2002a) states that, “researchers and practitioners in mental health are becoming more and more aware of the impact of violence on the lives of women with chronic and persistent mental health problems” (p. 7). Furthermore, trauma informed practices are beginning to be taken up and put in to practice by many service providers working with women in the fields of violence against women, mental health, and substance abuse.

While these appear to represent a positive shift in providing holistic services to women with complex lives, literature found in the area of social responses to violence (Wade, 1997, 2007) advocates for a shift in how violent acts against women and the subsequent responses to these acts by women are conceptualized socially, politically, and amongst front line workers. Additionally, the research of Coates and Wade (2007) calls for further research into the implications for both perpetrators and victims as a result of the language utilized to represent violent acts and how it may be impeding effective intervention. Individuals working with women with histories of violence and abuse, they argue, must acknowledge that violence against women is a complex social issue, embedded in discourses of gender, violence, mental health, addictions, and language, and that the responses by women to violence and victimization be reconceptualized and viewed as strengths, acts of resistance, and coping devices as opposed to deficits and disorders. Wade (1997) states that “therapists have an important role to play in recognizing and honouring the spontaneous resistance of persons who have been subjected to sexualized abuse and assault, battering, humiliation, neglect, and all other forms of violence and oppression” (p. 38).
A lack of collaboration between service providers has resulted in compartmentalization of the woman, who finds herself having to negotiate her way through multiple systems and service providers to receive treatment or reach for help (Benevolent Society Australia, 2009; Breaking the Cycle Compendium, 2007). Clients involved in the Benevolent Society’s program are “often involved with many agencies, (for example one early intervention client family had contact with; drug and alcohol counsellors, police, probation officer, Aboriginal cultural services, social services, employment services, foster care workers, psychiatrist, paediatrician, speech therapist, school teacher, administrators, and counsellors, legal aid, family court and maintenance and individual and family counsellors). Families such as these report that the information which they receive from these agencies feels fragmented” (Benevolent Society Australia, 2009, pp. 8-9). Becker et al. (2005) state that, “there is a growing body of evidence showing that an integrated approach to treatment in which co-occurring disorders are assessed and treated in a coordinated way within a single treatment setting is more effective than treating each disorder separately” (p. 5). According to Stanley and Penhale (1999), breakdowns in communication between key service providers may be “a product of the way in which the problems of mothers and their children are conceptualized by different services” (p. 41). Furthermore, an honest review of the issue of mothers with co-occurring issues and historical trauma through abuse must include some discussion about the ways in which both academic literature, current social constructions, and ideologies position women and mothers in relation to these issues (Greaves, 2000). In addition, the psychosocial determinants of these issues and access to support and treatment for women must be considered (Morrow & Chappell, 1999).
The Psycho-Social Determinants of Women’s Health and Well Being

Many women in Canada today continue to experience inequality in several realms of life in comparison to their male counterparts. Social devaluation based on constructions of gender and the discourses that accompany these constructions have contributed to oppressive experiences of sexism, patriarchy, prejudice, and victimization. Aboriginal women experience these injustices at a higher rate than non-Aboriginal women, as they also face various forms of racism (Greaves, 2000; Ball, 2008). Sex and gender intersect in numerous ways with age, class, ethnicity, sexual orientation, physical and mental ability, gender identity, and life experience and result in different mental health outcomes among women. For example, Kirmayer, Brass, and Tait (2001) found that the legacies of colonization and residential schooling have resulted in cultural discontinuity and oppression in many Aboriginal communities. Further, these legacies have also been tied to high rates of depression, alcoholism, suicide, and violence against Aboriginal women. Roberts, Roberts, and Chen (1997) state that socioeconomic states, race, and gender have been found to intersect, resulting in experiences of oppression and then influencing the presence of depression amongst women. Overall, the highest prevalence of depression is found among Aboriginal women due in part to often impoverished living conditions, experiences of racism and oppression, and negative social responses.

Morrow (2002a) states that there is a need for a “bio-psycho-social model to treatment and support for women” (p.22). She argues that “the social devaluation of women has an effect on their mental health. Women, even if they are in paid employment, continue to bear a disproportionate load of care giving and family
responsibilities and represent the majority of single parents” (p. 9). In Canada the average earnings of employed women remain substantially lower than those of men, and women – especially elderly women, single mothers, and Aboriginal women – are more likely to live in poverty (Greaves et al., 2002). In Canada, 20% of women live in poverty, and women make up 70% of all people living in poverty, poverty being one of the strongest indicators of poor health (Doyal, 1996). In their research, Saraceno and Barbui (1997), find a clear association between poverty and mental illness in particular. In turn, the conditions of poverty often expose women to further harms and stresses. Although all women are vulnerable to physical and sexual abuse, women who live in poverty and who are socially marginalized are particularly vulnerable.

Women’s experiences of physical and sexual violence as children and as adults have a significant impact on their mental well-being (World Health Organization as cited in Morrow, 2002a, p. 9). Differences exist in rates of specific mental health problems between men and women (Gold, 1998). For example, women are almost twice as likely as men to experience depression and anxiety (Howell, Brawman-Mintzer, Monnier, & Yonkers, 2001). Women are more likely than men to be diagnosed with Seasonal Affective Disorder, eating disorders, panic disorders, and phobias, and they make more suicide attempts (Kessler et al., 1994). Richardson and Wade (2008) posit that women are also likely to suffer more greatly than men from negative social responses. These differences have implications for the treatment and ongoing support of women with mental illness. Greaves (2000) posits that, “the health care sector has been slow to recognize the extent and consequences of violence against women and have not viewed violence as an important health issue” (p. 23). Furthermore, social responses to violence
against women and the various discourses taken up in the conceptualization of mothers with challenges resulting from violence must be investigated in the development of programs and services for mothers.

**Looking Through a Gender Lens**

Traditional models for treating and supporting women have often not taken into account the unique psychosocial determinants that stem from conceptualizations of gender. Women’s decisions to seek out support can be influenced by negative social responses to violence against women, mental illness, and substance abuse, as well as numerous discourses related to these same issues, in addition to gender and mothering.

Medical models for treating and supporting women have focused primarily on biological differences between men and women, often ignoring the influences on the life experiences of members of each sex that are based on gender. “Sex” refers to biological characteristics such as anatomy (e.g., body size and conformation) and physiology (e.g., hormonal activity and functioning of organs). On the other hand, “gender” refers to the array of socially and culturally determined roles, personality traits, attitudes, behaviours, values, relative power, and influence that society ascribes to the two sexes on a differential basis (Health Canada Women’s Health Strategy, 1999, as cited in Greaves, 2000, p. 6). As a result of the historical exclusion of women as subjects of research, much of the medical data informing prevention and intervention has been incomplete. Insensitivity in regard to sex and gender in research impairs the ability of clinicians to care for and to advise women patients (Greaves, 2000). There is a need to understand more fully the social determinants of women’s health. Greaves (2000) states:
Women’s health status is affected by a host of social, cultural, political, and environmental determinants attributable to gender. Gender-based discrimination and inequalities are contributing factors in health disparities between women and men. They create disadvantage within health care systems and perpetuate ongoing inequality between the sexes in relation to access and utilization of services. For these reasons the interaction of sex and gender as variables in health research is a crucial dimension in understanding women and men alike. (p. 7)

**Discourse**

“A ‘discourse’ is a way of talking about an issue or practice for a particular political purpose. This ‘way of talking’ is also a ‘way of thinking’ about issues, and even a ‘way of acting’. Discourses can be viewed as constitutive, meaning that discourses ‘build worlds’, or perhaps, more accurately, they build versions of the world” (M. Hoskins, personal communication, April, 2008). A discourse community can be defined as people who share similar thoughts and ideas (i.e., feminist, poststructuralist). Discourse can exist over time and represents the total of all written/spoken/recorded thoughts that each community claims. However, discourses are not unitary. Within any discourse community there exists what could be considered “sub-communities” or pockets of varying discourses which, although they are varied, still ascribe to the central and larger tenets of the larger discourse. Discourse can be elastic to the degree to which a discourse community permits such elasticity.
While many discourses could be seen as relevant to the lives of the women involved in this research, I have limited the discourses explicitly utilized in this project to those rooted in the feminist and mothering literature. This includes, but is not limited to, the work of Mary Gergen, Chris Weedon, Linda Greaves, Amy Salmon, and Marina Morrow, as well as the therapeutic activist work related to social responses to violence and resistance and the Four Discursive Operations of Language of Linda Coates, Allan Wade, and Cathy Richardson. Research found within these bodies of literature has been utilized in the interpretation of the women’s stories in this research project. Within each of these larger discourses (feminist and mothering) are colossal amounts of research and knowledge, only some of which have been accessed in this interpretation. While terms such as “feminist”, “mothering”, “social response”, and “response-based” discourses are put to use in the forthcoming presentations and interpretations, this researcher does not intend to claim linkages with all content within those discourses, but rather with the research found within the sub-communities reviewed within the larger discourse.

Just as biological and social, cultural, political, and environmental determinants often impact a woman’s health and experience, so too do her society’s constructions of what it means to be a “woman”, a “mother”, and a “wife”. The socially constructed meanings ascribed to these terms are derived from numerous influences including historical, philosophical, religious, political, and popular media. Just as earlier accepted terms used to describe issues of violence against women, mental illness, and substance abuse require review to remove potentially inaccurate, misleading, and destructive assumptions⁹, it is necessary also to investigate the socially constructed meaning of the

⁹ This comment is referring to troubling language previously assigned to women with issues relating to abuse, mental illness, and substance abuse such as “domestic violence”, which mutualizes the violence or
terms assigned to women in their various roles, and to reveal the discourses that are taken up in the process undergone to make meaning of these terms.

In reviewing the literature about the social constructions and self-constructions of women and mothers, it is evident and not surprising that the two constructions are directly linked and in many cases viewed as mutually exclusive. Hoskins and Lam (2001), referencing Harre and Gillett (1994), state that, “identities or subjectivities are created from available discourses” (p. 159). Mothering and Feminist discourses are two of the most dominant discourses influencing both the construction of identity in North American mothers, as well as the ways in which knowledge and understanding of “women” and “mothers” are constructed. Both these discourses play powerful roles in the ways in which individuals and systems view and provide services to women and mothers with challenges related to violence, abuse, substance abuse, and mental illness. These discourses, particularly those found within feminist theory, offer commentary, deconstruction, criticism, and alternate perspectives in regard to social expectations and roles related to gender.

**Mothering discourse.** Discourses about mothers have been fraught with popular ideas, expectations, and requirements regarding the meaning of “motherhood” and social conceptions of what it means to be a “good mother” (Ardenell, 2000; Coontz, 2005; Dillaway & Paré, 2008; Hays, 1996; Morrell, 1993; O’Reilly, 1996; Segal, 1988). Ideologies stemming from the mothering discourses polarize men and women into two distinct categories, with motherhood as the central defining characteristic of “women”.

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“disorder”, which implies inner deficits without recognition of typical responses to violence or other traumatic events.
Motherhood is viewed as both a cause and a consequence of differences in men’s and women’s needs, desires, and talents (Morell, 1993).

Since the 1950s, Coontz (2005) states that popular culture characters such as June Cleaver from the television show *Leave It to Beaver* continue to present the “traditional mother” in mainstream North American culture. “Whereas other models, images, and experiences of mothering have existed throughout time, the ‘good’ 1950s post-World War II mother made the ‘stay-at-home mom and apple pie’ the standard model for mothering” (O’Reilly, 1996, p. 89). This powerful social construction has been woven into the ideology enveloping motherhood, family, and the home ever since (Coontz, 2005). According to Hays (1996), while the role of women and mothers in North American society has shifted to include career and work, responsibilities for child rearing remain primarily in the domain of women. Furthermore, Hays (1996) described how mothering ideology is currently defined through so-called intensive mothering. “There are three main tenets of ‘intensive mothering’, to which all women must adhere if they are to be viewed as ‘good’ mothers: (a) child care is primarily the responsibility of the mother; (b) child care should be child centered; and (c) children ‘exist outside of market valuation, and are sacred, innocent and pure, their price immeasurable’” (Hays, 1996, p. 54).

According to Dillaway and Paré (2008), this ideology assumes as its basis that “children require one primary caregiver, which is the biological mother, as a psychological bond exists between young children and their mothers” (p. 442). Furthermore, this ideological framework posits that this “umbilical connection” must remain firmly fastened between mother and child because the mother is ideally *best*
suited to comprehend her child’s needs as she can interpret and respond to those needs intuitively (Dillaway & Paré, 2008). Morell (1993) states that, as a result of the focus on attachment and object relations in 21st Century psychology, “the bond between mother and child has taken on a near-sacred quality and is thought to lead to the fulfillment of both” (p 312). Motherhood as ideology and institution presupposes women’s and children’s interests to be exactly the same: Children’s needs are mother’s needs (Berry, 1993). “Good” mothers are supposed to “subsume their own personality to family”, which means “having no other real interests, but only substitute or contingent ones, depending on other family member’s desires” (Berry, 1993, p. 25).

Salmon (personal communication, February, 2009) describes how when a woman becomes pregnant her body and entire being are often perceived as public property in the sense that it is expected that her issues and needs will be put aside while she carries her child. This type of belief assumes that a woman who puts her fetus and, later, her child at risk based on her unhealthy behaviours rooted in substance abuse, violence, or mental illness is deviant because she is harming her child. This logic is faulty because it ignores the complex lives of women experiencing abuse, substance abuse, and mental illness, as well as the discursive operations of language (Coates & Wade, 2007). Ignoring these features often results in the concealing of perpetrator violence and victim resistance, misplacement of responsibility for violence, and the blaming and pathologizing of women. This popular discourse makes the assumption that a woman with challenges is intentionally harming her fetus or child, not taking into account the barriers that may stop her from seeking help. It presupposes that a woman who uses drugs or who stays in a violent or unsafe relationship places greater value on her drug of choice or violent partner
than her children. This discourse fails to consider this woman’s lack of options and her own assessment of safety. Through their research with substance using women in several British Columbia communities, Poole and Isaac (2001) found quite the opposite to be true and that “mothers who identify as having problems with substance abuse can be both responsible caretakers of their children and in need of care themselves” (p. 17). Poole and Isaac (2001) discerned three reasons why women often do not access treatment services prenatally or when parenting as shame, fear of apprehension of children, and fear of prejudicial treatment on the basis of their motherhood status (p. 12). Strega (2008) states that “the child protection gaze remains firmly fixed on mother's ‘availability’ and parenting skills, while assailants and fathers of the children have been virtually ignored and when men batter mothers, the ‘problem’ is also defined in terms of mother's alleged ‘failure to protect’ rather than in terms of the actions of the perpetrator” (p. 706). Poole and Isaac further state:

Women described their parenting role as one of the most problematic barriers to seeking help for alcohol and drug misuse. Their stories were anguished and poignant, no matter how matter-of-factly a woman related the loss and fears she experienced around childcare and custody. One woman noted: “I was afraid that the people I was talking to would come and take my baby away”. Women’s parenting role had a significant impact on their decisions to negotiate with various services and systems to ensure that their children would be safe and secure in their absence. (p. 17)
The standard which all mothers are measured against is that of the “good mother” who is ever-present, nurturing, connected or bonded with her child, and void of individual interests and activities separate from her position as “mother”. Morell (1993) states that, “there is a need to “fracture the women = mother equation” (p. 307). According to Dillway and Paré (2008), “existing feminist research explains that other types of mothers discussed within popular discourse are characterized as lesser, ‘deviant,’ and/or ‘bad’ when compared to ‘good’ mothers” (p. 443). According to Weedon (1987):

Commonsense values still tie women’s moral development and natural fulfillment to motherhood. But such assumptions involve attributing particular social meanings and values to the physical capacity to bear children. The “essential” biological nature of women guarantees the inevitability that we should fulfill particular economic and social functions which may not be in our own interests. (p. 130)

It is now necessary to reconceptualize the discourses that are taken up to consider women/mothers, substance abuse, violence, and mental health in such a way that the need for health and safety of children and women are no longer pitted against one another (Salmon, personal communication, February, 2009). Morell (1993) states that, “to continue to perpetuate such ideologies is not only theoretically limiting, but is politically dangerous to the broad goal of women’s emancipation” (p. 307).
Feminist discourse.

And once I told them my story, what would they think of me?... Because women aren’t supposed to do this kind of stuff. They’re just not. They’re considered dirty, ugly, filthy. (Poole & Isaac, 2001, p. 14)

Other discourses influencing perceptions of women and mothers, as well as their constructed meanings of self, are illuminated by feminist theorists like Weedon, Morrow, and Morell. Furthermore, Hoskins and Lam (2001) discuss the role of discourse and social positioning related to gender (and other factors) in the available identities for individuals, stating that “agency is possible in that certain positions are chosen and agency is limited in that how one is positioned (including ethnicity, socio-economic status, and gender) restricts certain identities and makes others available (Davies, 1993; Lather, 1991; Weedon, 1987)” (p. 159). Gender influences possible identities for women based on a set of socially constructed gender expectations that have been previously viewed as “common sense” and integrated into the lives of many women (Morell, 1993).

One such “common sense” construction is that of the “good mother”, which is tied into the constructions of the “good woman” and “good wife”. Constructs such as these relate to a larger discourse that constructs women as unique from men, as more innately nurturing, highly relational, and oriented to others. This discourse implies that a woman’s construction of self occurs primarily through connection with others, family and children in particular. In this literature “woman” is positioned as holding moral values that are superior to those of men (Morell, 1993). The idea that women are naturally or innately more relational and nurturing, more oriented to the collective than the individual, and morally superior to men contributes to the role of social conformity in women’s
development. Furthermore, this idea gives credence to the notion that women are gentle and men rough, which can be seen as legitimizing men’s violence against women (Richardson, personal communication, December, 2009). Weedon (1987) states that a kind of “common sense knowledge” seems to dominate many powerful socially accepted ideas about gender and plays a key role in maintaining the centrality of gender differences as a focus of power in society.

The social expectations that girls should be caretakers and look pretty and act ladylike; whereas boys should assert themselves forcefully in the social world are related to boys’ and girls’ future social destinations in a patriarchal society. Dominant norms are constantly reaffirmed as part of the commonsense knowledge on which individuals draw for understanding and guidance. (Weedon, 1987, as cited in Morell, 1993, p. 307).

Combined with life experience, society’s construction of “woman” and “mother” directly influence how she is perceived, treated, and the way in which she constructs her meaning of self as a woman and a mother. Poole and Isaac (2001) found that women made a direct connection between their self-image, societal judgements, and need for support for their individual challenges with substance abuse. While individual women’s responses are thought to be unique to each woman, “there are obvious connections between women’s self judgments and the pervasive ‘common-sense’ attitudes about women and substance abuse [mental illness, violence, and abuse] in society at large” (Poole and Isaac, 2001, p. 14).
The Four Discursive Operations of Language About Violence Against Women

In their interactional and discursive view of violence and resistance framework, Coates and Wade (2007) identify four discursive operations of language which, they claim, perpetuate the oppression of women. Through the utilization of specific linguistic devices they state that language is used “to accomplish four-discursive operations; namely, the concealing of violence, obfuscating of perpetrators’ responsibility, concealing of victims’ resistance, and blaming and pathologizing victims” (p. 511). Furthermore, these authors point out that all individuals are required to participate in the “politics of representation” (p. 512) and use language in the form of accounts to accomplish this. More specifically:

Perpetrators use language strategically in combination with physical or authority-based power to manipulate public appearances, promote their accounts in public discursive space, entrap victims, conceal violence, and avoid responsibilities. These strategies typically are used to compromise victim safety (Coates, 2000b; Wade, 2000). . . . Faced with these circumstances, victims use language tactically to escape or reduce violence, conceal all or part of their ongoing resistance, retain maximum control of their circumstances, and avoid condemnation and social pressure from third parties. In short victims use misrepresentation to resist violence and increase their safety. (p. 512)

Moreover, according to Coates and Wade (2007), violence is often concealed by various individuals including friends and family members, psychologists, psychiatrists,
politicians, advocates, therapists, lawyers, judges, and law enforcement officers by misrepresenting acts as mutual rather than unilateral through the use of mutualizing and/or minimizing terminology. Language is also used to diminish perpetrator responsibility by representing the violence as unintentional (e.g., resulting from the effects of jealously or love). Additionally, the use of particular language in reference to violent acts conceals victims’ resistance. This language often exposes the victim as a passive or even willing participant in the violence, often calling into question the credibility of the victim’s account, as well as her mental status and health. They highlight that “such constructions of the passive or submissive victim exposes victims to that particularly ugly form of social contempt that is reserved for individuals who, when faced with adversity, appear to knuckle under and do nothing on their own behalf” (p. 522). As a result of the concealment of perpetrator violence, suppression of victim acts of resistance, and mitigation of perpetrator responsibility, victims wind up facing blame, stigmatization, and pathology (Coates & Wade, 2007, p. 519).

**Resistance.** Wade (1997) states that therapists supporting women who are victims of violence and various others acts of abuse should utilize stories of acts of resistance in the therapeutic process to illuminate victim’s strengths, resources, and agency. Resistance is defined by Wade (1997) as:

Any mental or behavioral act through which a person attempts to expose, withstand, repel, stop, prevent, abstain from, strive against, impede, refuse to comply with, or oppose any form of violence or oppression, or the conditions that
make such acts possible…Furthermore, any attempt to imagine or establish a life based on respect and equality, on behalf of one’s self or others, including any effort to redress the harm caused by violence or other forms of oppression, represents a de facto form of resistance (p. 25).

Through their research with substance using women in several British Columbia communities, Poole and Isaac (2001) found that “mothers who identify as having problems with substance abuse can be both responsible caretakers of their children and in need of care themselves” (p. 17). From a response based lens, which focuses attention on women’s responses and resistance to violence and oppression, this finding by Poole and Isaac (2001) challenges the idea of being “affected” as a generalized blanket of impact and highlights the importance of focus on women’s responses and the larger social, political, and historical contexts of women’s lives. Response based approaches, such as those of Coates (2002, 2007) and Wade (1997, 2000, 2007) allow space for the investigation of this larger context of women’s lives, as well as the powers of language and representation. The following passage by Bell Hooks (1990) powerfully confirms the worth of focusing on victim resistance:

Understanding marginality as position and place of resistance is crucial for oppressed, exploited, colonized people. If we only view the margin as sign, marking the conditions of our pain and deprivation, then a certain hopelessness and despair, a deep nihilism penetrates in a destructive way the very ground of our being. It is there, that space of collective despair that one’s creativity, one’s
imagination is at risk, there that one’s mind is fully colonized, there that the freedom one longs for is lost. (p. 343)

**Woman-Centered Care**

Over the last decade a number of researchers and practitioners have begun to discuss and attempted to address the need for a more collaborative system, where issues of violence, abuse, substance abuse, and mental health would be dealt with simultaneously as opposed to previous practices of dealing individually with each issue (Bland & Edmunds, 2007; Chartras & Culbreth, 2001; Morrow, 2002b; Poole & Isaac, 2001). “Although the co-occurrence of domestic violence and alcohol abuse is substantial, few counselling programs are equipped to address both issues simultaneously” (Chartas & Culbreth, 2001, p. 3). Collins (1991) as cited in Chartas and Culbreth (2001) further argued that the traditional separation of alcohol abuse and domestic violence treatment facilities has generated deep philosophical differences, which impede the linkage of services (p. 3). “Fusing services could potentially provide clients with treatment that is both convenient and comprehensive. Yet, merging domestic violence and alcohol abuse services may prove highly challenging, largely because of philosophical differences between the fields” (Chartas & Culbreth, 2001, p. 3). Morrow (2002b) states that appropriate service provision for these women has been stalled because of disagreements about the role of violence and trauma in the aetiology of mental illness.

Over the past decade, some notable efforts have been made in Canada to implement more collaborative approaches in the medical, mental health, and addictions
fields. In 2003, “twelve national health organizations came together and formed a consortium to embark on a shared vision: making mental health work” (Canadian Collaborative Mental Health Initiative, 2003, p. 1). This consortium continues to focus on educating professionals about the need for collaborative care between medical and mental health practitioners, as well as providing tools to providers, educators and consumers, families, and caregivers to help them establish and participate in a collaborative care network in their community. The B.C./Yukon Collaborative Care Project, “a current Canadian initiative, is seeking to advance care for persons with concurrent disorders by integrating the expertise of diverse professionals who are active in providing care, but who practice in relative isolation from one another” (Somers, 2008, p. 2). This project involved two of British Columbia’s five regional Health Authorities and inter-professional and multi-agency networks in the Yukon Territory.

As has been stated previously in this review, social responses in the form of oppression based on gender play a key role in the epidemiology of mental illness and substance abuse and violence experienced by far too many women today. In her article *Sex, Gender and Women’s Health*, Greaves (2000) argues that investments in women’s health benefit women by improving their well-being and quality of life, and make the case for the development of policy that takes into account the intersection of sex, gender, and society in women’s health. She calls for programming that is based on the notion of women-centred care (Appendix 1). Further, Greaves (2000) states that such investment and policy alteration would benefit families, communities, and the broader society. To a large extent, the well-being of children depends on the health of their mothers (World Bank, 1994, as cited in Greaves, 2000). International research supports the notion that
direct attention to women’s health research is not solely good for women – it also benefits men, families, and communities (Greaves, 2000). Since many of women’s health problems are caused by or reflect societal conditions, women’s health can often be most effectively promoted through changes in societal institutions and societal attitudes towards women (Matlin, 1998, as cited in Greaves, 2000).

Organizations such as Sheway and Maxine Wright in Vancouver, B.C., and Breaking the Cycle in Toronto, Ontario, are currently providing services for women who face challenges of violence, abuse, substance abuse, and mental illness. These organizations have designed their programs based on the philosophy of women-centred care. Women-centred care is comprised of involvement and participation of women in care planning, empowerment, respect, and safety. Further, they suggest that services that are woman-centred should address the complexities of women’s lives, include a diversity of women, integrate service delivery, respond to women’s forms of communication and interaction, and provide information and education. “Women-centred care is not just about responding to individual needs; it is also about recognizing systemic oppression and its impact on mental health of women” (Morrow, 2002a, p.12). The image below presents a visual representation of the mainstay tenets of women-centred care utilized by the Breaking the Cycle Compendium and program.
The Breaking the Cycle Program (BTC) Compendium describes the women-centred care approach used in their program as based on relational cultural theory, intergenerational transmission of trauma (Motz, Leslie, Pepler, Moore, & Freeman, 2006) and attachment theory (Bowlby, 1988). Relational-cultural theory proposes that relationships that cultivate healthy development are a central human necessity. “It proposes that woman’s substance abuse exists within a larger social-cultural, political, and economic context, and attends to larger systems changes, including reduction of service fragmentation and access issues as part of the solution. Relational theory is grounded in women’s experiences and listening to women’s voices” (Breaking the Cycle Compendium, 2007, p. 26). According to Morrow (2002a) historically stigmatization and discrimination have accompanied mental illness and substance abuse, making it especially difficult for this group of women to receive appropriate care and support. As Harris (1997, as cited in Morrow, 2002a) puts it, “Once we have labelled a woman as
suffering from a major mental illness, whether that label is an accurate assessment or not, we view her reports of sexual and physical abuse through the coloured lens of her diagnosis…The stigma of her diagnosis is often sufficient to call her account into question” (p. 7). Morrow (2002b) adds to this discussion by claiming that “historically, academics, psychiatrists and legal professionals have developed sophisticated ways to discount women’s disclosures of violence and abuse, often through claims that women who report this are delusional or in some way mentally unfit” (p. 9). These historical approaches to women’s health care have been ineffective and so the inclusion of “women’s voices” in program development, as well as services that are based on the nurturing of genuine and non-judgmental/non-pathologizing relationships are key to providing truly women centred care (Breaking the Cycle Compendium, 2007).

Recognition of the power of intergenerational transmission of trauma and former and current relationships, particularly familial attachments, is also said to be of great importance in the provision of women-centred care (Breaking the Cycle Compendium, 2007). Challenges related to abuse, substance abuse, and mental illness, are regularly transferred amongst multiple generations. Experiences of maternal maltreatment and trauma beginning in early childhood, significant histories of substance abuse in families of origin, discontinuities of relationships starting at early age, multiple caregivers and foster-care placements, and high rates of woman abuse, children taken into custody, obstetrical losses, and maternal psychological symptoms including depression are often found influencing and resurfacing in the lives of subsequent generations (Motz et al., 2006, as cited in Breaking the Cycle Compendium, 2007, p. 68).
BTC mothers report current mental health symptomology, which reflects ongoing distress. The severe histories of maltreatment and trauma provide a context for understanding the use of substances by women and mothers. An understanding of the social and psychological context of maternal substance abuse informs the development of approaches, services and policies designed to support women, mothers and children who are substance-involved. (Breaking the Cycle Compendium, 2007, p. 39)

Greaves et al. (2002) identifies further challenges for women-centred care models to ensure that the needs of women’s children and supportive family members are also met. Morrow (2002a) notes: “The needs of women are integrally linked to those of their children and models must reflect these connections without pitting the needs of children against the needs of women” (p. 12). According to the Benevolent Society (2009), an Australian organization that supports substance abusing mothers, in order for women to make real changes in their own and therefore their children’s lives, there must be available adequate support in the form of “skilled, sensitive interventions, which grow from an understanding of all the issues relating to these parents as well as their children” (p. 2).

This review of the literature related to women’s health and experiences with challenges relating to violence, abuse, substance abuse, and mental illness has identified the links that exist most often between and among these challenges. The literature is fraught with criticisms of the historical treatment and service practices for these women, which have tended to ignore the interconnectedness of these issues, compartmentalized
the woman, and privileged the voices of academics and practitioners as “experts” on the lives of these women, as opposed to the voices of the women themselves. The psychosocial determinants of women’s health and some of the common discourses that are taken up in Western cultures to construct women and mothers have been highlighted.

Finally, a review of some of the evolving collaborative and women-centred services being put into place, in some Canadian provinces in particular, have been discussed, as well as the theoretical, philosophical, and ideological underpinnings of these approaches. The Women-Centred Care model and the Interactional Discursive View of Violence and Resistance (Coates & Wade, 2007) have been presented in this literature review as models which seem to be gaining in appeal with today’s service providers when offering support to mothers dealing with violence, abuse, mental illness, and substance abuse. As the stories of the three mothers in this study are presented, I hope the reader will consider the presence or absence of elements of such models in these women’s stories of violence, abuse, substance abuse, mental illness, and mothering, while attempting to access support and safety within their communities. In the final chapters of this thesis, I will return to these models to review how the women’s stories might illuminate or highlight the central elements of the Women-Centred Care model.
Chapter Three: Methodology

Qualitative inquiry deals with the human lived experience. It is the life-world as it is lived, felt, undergone, made sense of, and accomplished by human beings that is the object of study. (Schwandt, 2001, p. 84).

This qualitative research project will explore the stories of three mothers. Through the exploration of these stories I will attempt to identify and explore some of the types of scripts and the overarching narratives that the three mothers utilized to make meaning and to describe and present their stories. Through the analysis of each woman’s interview, these scripts as well as the discourses present in the scripts will be investigated. In this chapter details regarding the narrative inquiry process, using primarily the work of Donald Polkinghorne, Steiner Kvale, and Mary Gergen as guides, will be presented.

The questions that I attempted to answer in this research are as follows:

What kinds of narratives do mothers who have been victims of violence and abuse and who have faced challenges with mental illness and substance abuse utilize to describe their life experiences? In what ways are these women’s narrative constructions about self and life experiences similar or different from some of the ideas found in popular mothering and feminist discourses? Can these women’s stories offer any implications to improving services for women in BC?
Narrative Inquiry

Narrative inquiry is the process of gathering information for the purpose of research through storytelling. The researcher then writes a narrative of the experience. Connelly and Clandinin (1990) note that, "Humans are storytelling organisms who, individually and collectively, lead storied lives. Thus, the study of narrative is the study of the ways humans experience the world" (p. 3). Narrative Inquiry is a means of conceptualizing the storied nature of human development. Further, as Dauite and Lightfoot (2004) point out, “Narrative may be a metaphor for a life course, a developmental theory, a reference to a totalizing cultural force, and/or the method for interpreting oral or written discourse “ (p. x). Narratives provide forums in which we use our imagination and intellect to understand others and even ourselves. Narrative inquiry embodies creativity, allowing researchers and participants to express their stories and make connections by listening, sharing, and interpreting stories being told. Narratives can also provide a source of liberation—a sense of empowerment and freedom to both the researcher and participant (Richardson, 1997, p. 34). Story forms are produced within cultures to make sense of life and can be informed and regulated by numerous forces including practical, social, and psychological influences (Gergen, 2004), as well as dominant discourses. Hoskins (2001) highlights that, “narrative research expands our understanding of how culture works and deepens understandings of the complexities of the self. Stories do not describe experience, they constitute it” (p. 669). According to Polkinghorne (1988), “Storytelling is a mechanism that is used to order experiences into episodes of meaning” (p. 1). Connelly and Clandinin (2006) describe stories as “the portals through which a person enters the world and by which their experience of the
world is interpreted and made personally meaningful”. Hirschfield (1997) explains that as researchers and human beings “stories bring us to a deepened coherence with the world of others and also within the many levels of the self” (p. 26). Dauite and Lightfoot (2004) discuss story:

Scholars have long equated life with the story of life. Epic poetry imposed order in ancient times. The Bible added moral order. The conflict plot prevalent in some cultures integrates temporal and moral presentations; while the spiritual quality of folktales in many cultures, and character-rich moral tales in others, are frameworks for how people perceive and evaluate their lives. (p. xiv)

**Co-construction of the narrative.** Richardson (1997) writes about the power of narrative stating that, “it is a way individuals understand their own lives and best understand the lives of others” (p. 30). Narrative inquiry is a fluid process in which the researcher and informant work together in collaboration (Richardson, 1997). Gergen (2004) suggests that looking at narratives as the construction of a single person, without regard for the outside factors that influence it is too narrow a view for good narrative interpretation of interviews. She proposes that narratives might better be defined as “co-constructions within a context, involving at least two people” (p. 279). Further, she suggests that there are numerous factors that influence the telling of the story. She explains:

If the time, place or actor is shifted, the nature of the narrative is also vulnerable to change. Among the pertinent shaping factors are the identity of the inquirer, the
questions asked, the temporal-spacial characteristics of the interview, and the relationships among these various elements.

(Gergen, 2004, p. 279)

**Narrative validity and flexibility.** The issue of validity in both quantitative and qualitative research is an important one. Kvale (1995) asserts that within current postmodern philosophy, the notion of an objective reality used to validate knowledge has been discarded (p. 19). Furthermore, Kvale (1989) places emphasis on validity in qualitative research as a process of checking, questioning, and theorizing, not as a strategy for establishing rule-based correspondence between our findings and the “real world” (as cited in Miles and Huberman, 1994, p. 279). In current postmodern qualitative research this concept has been “replaced by the social and linguistic construction of a perspectival reality where knowledge is validated through practice” (Kvale, 1995, p. 19). According to Kvale (1995), this perspective rejects the concept that there is one universal truth; rather it accepts the possibility of specific local, personal, and community forms of truth, with a focus on daily life and local narrative (p. 21). This research project seeks to present each of the three mother’s “personal truth” as she conceptualized and shared it. This research will not attempt to apply external validity by asserting that these “personal truths” are generalizeable to a larger population of women with similar life experiences.

Gergen (2004) reminds us that “stories are malleable and multifaceted, not rigid hollow shells shaping the lives of people as had been previously theorized” (p. 274). Narratives are flexible, changeable, and complex. The storyteller has flexibility in how they understand and choose to present their narrative. The teller may consciously or unconsciously modify their story for numerous reasons, including the researcher’s
presence and actions, influences of social and personal discourses, safety, and so on. In the past the use of narratives in research has been criticized as lacking validity for these very reasons. The teller cannot help but share their narrative through the lenses of individual and social influences, bound by available language and within various contexts, and so narratives have been viewed as lacking in internal validity.

Such limitations of narrative research are relevant and worthy of mention here and of further discussion in other venues, however, are not relevant to the trustworthiness of this research for two reasons. Firstly, each mother’s story as she tells it will be viewed and accepted as “personal truth” and will not be judged on its supposed or assumed accuracy or exactness in relation to what actually happened or attempted to be applied to a larger population. Secondly, the researcher acknowledges the fact that each mother’s story content and presentation may be influenced by multiple individual and social elements, but is not concerned with why she chose to tell her story as she did, rather will investigate the specific chosen lenses and involved social influences that are presented in each woman’s story. The term “validity” does not fit with this type of study and so will be replaced with the terms “credibility” and “trustworthiness” in the subsequent chapters of this thesis, as these terms more closely reflect the intent of this narrative study.

The Study of Experience

According to Polkinghorne (2005), traditional attempts in psychology to understand human experience have focused primarily on observable behaviour and were based on the notion that human experience occurs within the “black box” of a person’s awareness and could therefore never be subject to investigation. Some qualitative
methodologies allow the researcher the opportunity to study the experiential life of people and take into account the particular characteristics of human experience, making contact with the complex and fluid layers that make up the contents of the human experience. Polkinghorne (2005) states:

A primary purpose of qualitative research is to describe and clarify experience as it is lived and constituted in awareness. Human experience is a difficult area to study. It is multilayered and complex; it is an ongoing flow that cannot be halted for the benefit of researchers. Unlike the objects in nature, the layers of experience are not rigidly ordered, nor are its moving contents related according to mathematical patterns. (p. 138)

In-depth interviews and narrative inquiry have been chosen for this project as it required a method that sought to capture the richness and fullness of experience as each informant constructed it. According to Polkinghorne (2005) “People have access to much of their own experiences, but their experiences are not directly available to public view. Data gathered for the study of experience needs to consist of first-person or self-reports of participants’ own experiences” (p. 138). In order to study experience the researcher must engage in an intensive exploration alongside the participant. This exploration yields text that is “not simply single words but interrelated words combined into sentences and sentences combined into discourses” (Polkinghorne, 2005, p. 138). Polkinghorne (2005) makes the distinction between qualitative and quantitative “data”, stating that qualitative “data” in their oral or written form are not identical to the experience they are describing. The “data” is the product of the interaction between informant and researcher (p. 138).
Each of the mothers in this research project presented a description of her experience in storied form. Each of these stories can be viewed as an interpretation of an experience. The textual evidence in this interpretation is considered indirect evidence, as the words, sentences, and phrases spoken by each informant and the researcher are only mechanisms to communicate meaning; “the evidence itself is not the marks on the paper but the meanings presented in the texts” (Polkinghorne, 2005, p. 138).

**Are self reports valid?** Evidence about human experience has inherent limitations compared with data about human behaviour. However, in seeking to gain understanding about the lived experience of others self reflection may be the closest one could hope to get to the essence of an individual’s experience. As cited in Polkinghorne (2005) “because experience is not directly observable, data about it depend on the participants’ ability to reflectively discern aspects of their own experience and to effectively communicate what they discern through the symbols of language” (p. 138). It is thought that people do not have complete access to their experience or a clear window into their inner lives (Polkinghorne, 2005) and that people also tend to manipulate their descriptions in order to conform to social expectations. Averill (1983) says that “what a person says is under conscious, voluntary control, and hence is subject to dissimulation and conformity to social expectations… even when a person is not dissimulating in an attempt to present a positive self-image, she or he may not have the ability to report accurately what is taking place internally” (p. 1154). Denzin and Lincoln (1988) state that “any gaze is always filtered through the lens of language, gender, social class, race, and ethnicity…. Subjects or individuals are seldom able to give full explanations of their
actions or intentions; all they can offer are accounts, or stories, about what they did and why” (p. 12). If this is true and humans are inherently unable to recognize or to accurately recollect their own experiences, then self reflection, though imperfect, might be the nearest one could get to understanding the lived experience of another. Churchill (2000) posits that “we are deceiving ourselves (as researchers) if we believe that descriptions, collected from subjects asked to recollect their experiences, will bring us into direct encounter with the original experience” (p. 54). However, there exists a significant connection between one’s reflective self reports and the nature of the experience described. While they are not equivalent, Churchill (2000) espouses that “there is reason to believe that a subsequent reflection (by a researcher) on the reflective consciousness (of the subject) will yield an essential understanding of the experience reflected on (by the subject)” (p. 55).

**Narratives as “more than, less than, and other than what really happened” not as “truths”**. Humans are not static objects that are at the mercy of the world around them, but are agents and players in the interactive process of meaning making. Meaning is constructed through individual experience and human relationships and interactions with other individuals, groups, and institutions (Mahoney, 2003). There is a danger in narrative inquiry to interpret an individual’s story as an absolute and generalizable truth. Each woman’s story may be her “truth”, but cannot be assigned to other individuals no matter how similar the context of their lives may be. Through explorations in narrative research Gergen (2004) espouses that while stories are a basis by which reality is formed and transformed by individuals and groups, each story is produced within a culture and
can be influenced by copious factors (p. 269). She highlights three warning signals about Narrative Inquiry to consider: 1) It is not safe to assume that a life story is comprehensive 2) no one story is accurate as a description of a life and 3) there are difficulties in finding generational or group specific stories (p. 269). In the interpretation of this research I have chosen to take a similar position to Gergen (2004) in that I comprehend the mothers narratives as “more than, less than, or other than “what really happened”” (Gergen, M, 2004, p. 270). I do not regard each woman’s narrative as an “absolute truth” of her individual life, rather as her “personal truth” in that moment, with recognition of the signals identified by Gergen (2004) and the knowledge that her presentation to me is that of her constructed meaning within a particular context at a particular time with a particular conscious or unconscious purpose. From a social constructivist perspective, I “do not require a narrative to be true or false in any absolute sense, rather renditions of events, cohering to certain cultural standards, which make sense to the storyteller in a particular context” (Gergen, M., 2004, p. 270).

Methodological Limitations

In this research there are some conditions or elements that I recognize as beyond my control that could potentially influence my understandings. The issue of power as a researcher and personal characteristics of me, the researcher, could influence each informant’s response and engagement in the study. As an employee of Transition House I could represent the organization in the woman’s mind, which could also limit her responses in the interview process, as she may see me as an authority figure holding

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10 In this context the term “absolute truth” is being used to refer to a comprehensive and accurate description of her life and experience.
power over goods or services, which she has in the past required and/or desired. Or on the other hand she may see me as a safe person or confidant if she has had a good experience with the agency. Furthermore, my age, gender, race, perceived social position, as well as non-verbal factors such as mutual gaze, subtle signs of agreement or disagreement, silences, smiles, frowns, and comments related to shared or diverse experiences all lend shape to the story being told.

Secondly, because I have chosen to work with only three women who are in a state of recovery, I will be gaining perspective on the issue from a specific place in the lives of mothers facing these challenges. I recognize that there may be traits, resources, supports, or qualities that these women may have that assisted them in manipulating the multiple systems successfully that differ from those women who have yet to or who may never successfully reach a state of recovery. The voices of these women may differ from the ones I include in the study and therefore may not be heard.

I acknowledge the limitations highlighted above, as well as those regarding the credibility of self reported data and the restrictions at hand due to the small number of participants. These limitations present some precincts to the kinds of interpretations that can be drawn, as well as the implications for practice that can be pointed to. However, this research does not seek to uncover “truths” about the experiences of all women dealing with violence, abuse, mental illness and/or substance abuse, rather to share the scripts of these three women as they have chosen to construct, reflect on, and share them with me. This research explored these scripts and investigated the discourses taken up by each woman in her narrative expression and the ways in which the scripts were woven through out her story of a life dealing with violence, abuse, mental illness, and substance
abuse and the ways in which she attempted to seek support. Concerns about each woman having complete access to her experience as it actually occurred is irrelevant to this narrative study. Each woman’s story is considered to be her “truth” told within a particular context, influenced by numerous social, political, and practical forces, and told with conscious or unconscious intent. While these women’s stories cannot alone provide evidence for change to services for mothers, they will hopefully illuminate and highlight other possibilities and raise more questions and ideas for future research.

**Method: How I Proceeded**

This research was facilitated by conducting intensive individual interviews with three women in the community, each of whom met the required criterion for participation in the project. The interviews were conducted over two to three one to two hour blocks of time. The researcher recruited mothers through Victoria Women’s Transition House, Margaret Laurence Second Stage Housing, and Bridges for Women, a local organization offering a variety of life skills programming for women. The researcher presented the proposed research during information sessions held at each of the sites. Women who were interested after the information sessions were asked to contact the researcher to discuss potential participation in the project. In addition, the researcher then invited these women and interested staff at these sites to recommend and/or ask other women they knew who might be interested in participating. A snowball effect for gathering mothers to participate was utilized by the researcher.
The mothers. With the hope of recruiting three to five mothers for the study I was successfully able to recruit three eligible women. Criteria for participation in the study included women who have struggled with two of the following three challenges in the past: abuse (in childhood or from a partner), substance abuse, and/or mental illness. The women had to have one or more children who were currently adolescents, teenagers, or adults that they had spent a significant amount of time parenting. For the purpose of the study a “significant amount of time parenting” will be having had regular (at least once a week) contact with her children throughout their childhood, whether the children lived with her, another parent or family member, or were in temporary foster care. Mothers who had permanently lost or given up their children to the care of other guardians through the Ministry of Children and Family Development (MCFD) were not included in the study. Mothers had to be in a state of recovery or stabilization. This included recovery from substance abuse, safety from male partner violence and stabilization of medications for mental illness. In order to decrease the possibility of re-traumatisation or relapse through participation in the study, women had to have been in this state of recovery for a minimum of two years.

Women facing violence, abuse, mental illness, and substance abuse are a complex population. As a practitioner in the field of violence against women and child and youth mental health my experience told me that clients in crisis (who are actively using, experiencing violence and disrespect in an intimate relationship, or who are attempting to gain access to treatment) may not be as capable of being reflexive and/or could be at risk of compromising their safety or health by participating. As the researcher I developed this stringent criterion for recruiting mothers because I was looking specifically for women
who were at a place in their lives where they could be reflexive about their experiences and did not wish to risk compromising women’s safety, health or risk relapse of the participating informants.

**The interviews.** The interviews were conducted in a location chosen by the woman, and in each case the woman chose her home. The interviews were all completed within two to three meetings, with the intention of allowing the women the time that they needed to tell their stories. Additionally, accounting for the possibility that some of the mothers may find telling the complete story in one sitting emotionally exhausting and cumbersome. The interview sessions were audio-taped with each woman’s consent for the purpose of the narrative interpretation. During the interview process the researcher took a position similar to that described by Steiner Kvale in his writing on the qualitative interview. Kvale (1996) posits that the qualitative research interview attempts to understand the world from the subjects’ point of view, to unfold the meaning of people’s experiences and to uncover their lived world prior to scientific explanations (p. 1). The mothers were approached by the researcher with a curious ear. Specific information regarding each woman’s history and attempts and experiences of accessing services was sought after in the interviews. The researcher selected open-ended questions, leaving space for the woman to direct the flow of the interview so she could present her story as she had constructed it. Each interview was unique, as the content followed the direction of the informant’s responses with the researcher asking questions throughout to clarify the meaning that each woman had assigned to her particular experiences and to understand her personal narrative. The purpose of questions is to reveal meaning: “through meaning
questions, we invite people into a reflecting position from which they can regard different aspects of their stories, themselves, and their various relationships” (Freeman and Combs, 1996, p. 136). The following interview questions were used to guide the interview process with each woman:

- Tell me about your experience with violence, abuse, mental illness and/or substance abuse?
- What are your thoughts about abuse, mental illness, and substance abuse? Are they connected?
- How did these experiences influence your role as a mother?
- When and how did you begin to seek support?
- How would you describe your experience of getting support?
- What/who was most and least helpful and why?
- How did your experiences affect other aspects of your life such as parenting, relationships, friendships, finances, health…?
- What advice would you have for helpers?
- What advice would you have for other mothers/women who are currently having experiences similar to yours?

**Analysis**

In light of the methodological perspectives stated above, the reader must know what was important to attend to, and why, during the process of analysing the transcripts. I had three participants, each of whom had two to three interview sessions, which resulted in seventy pages of verbatim conversation. Despite the time consuming nature of the transcription, the end result was beneficial in that the transcribing essentially was the first phase of analysis. As I immersed my self in these women’s words, under the guidance of my thesis supervisor, Dr. Hoskins, initial core descriptions and themes began to emerge, all of which were scribbled in notebooks and on post it notes. These notes essentially
became a list of core descriptions, themes, metaphors, dominant and non-dominant narratives and evidence of particular discourses. Once I had this initial list I created a colour coding scheme, armed myself with multiple colours of sticky tabs and highlighter markers and began my first analytical reading of each of the transcripts. Many of the items from my first list have become integral in the analysis of the women’s stories, as well some additional items were used that were identified during later readings. Connelly and Clandinin (2006) describe story, as it is utilized in narrative inquiry, as “a portal through which a person enters the world and by which their experience of the world is interpreted and made personally meaningful” (p. 477). As I engaged in this analytical process of purposeful reading, it was as though I was hanging out around each woman’s “portal” attempting to interpret her described meaning of the experiences and stories she shared.

The following research strategies were utilized in the analysis of this research: immersion in the data, reading for common themes, comparison between and among interviews, comparison with the research literature, and reflection on my own practice experiences. Self reflection on my own practice was a particularly salient part of this process for me. It has taken me two and a half years to conceptualize and write this thesis, partly because of the time restraints of working full time, but more so as a result of my learning and incubation process. As I immersed myself in the narratives of these three women I was also working with numerous women, children, youth, and families in the community who were dealing with complex issues related to violence, abuse, mental illness, and substance abuse, many of whom have unknowingly contributed to my incubation and learning process. As I began to gain an understanding of the core
descriptions of these women and the similarities and differences amongst them, I began working with the narratives found within the stories in an attempt to comprehend how these narratives had influenced each woman’s perception of self/identity, and the kinds of support she had received. I also explored the discourses that were present within each woman’s narrative and considered what role these discourses seemed to play within the story.

Narrative Inquiry as a methodology suits the intent of this project because: “1) its interpretive tools are designed to examine phenomena, issues and people’s lives holistically; 2) narrative discourse and metaphor are excellent contexts for examining social histories that influence identity and development, and 3) it generates unique insights into the range of multiple, intersecting forces that order and illuminate relations between self and society” (Dauite and Lightfoot, 2004, p. xi – xii). I intend for this research to present and honor each woman’s story as she has constructed it and to explore the social, psychological and cultural discourses that influence the ways in which these women experience and story their life encounters and the impact of all of this on each woman’s construction of self and experiences in seeking support.
Chapter Four: The Women’s Stories

The Women’s Stories:

1) Daisy’s Story: Discovering Your Power

2) Sandy’s Story: Caretaker, Artist

3) Marla’s Story: Life in a Warzone
Daisy has just turned 50. “Wow I made it!” she says with surprise and relief in her voice. Daisy’s story is one of discovering and harnessing personal power. After twenty five years of living with violent partners, trying to suppress and at times process memories of childhood sexual abuse and the witnessing of violence and abuse in her family of origin, raising a son alone, supporting herself and her son financially, and coping with multiple sclerosis, a debilitating and life changing physical illness, Daisy has made it to fifty!

Daisy has recently left what she plans to be, her last abusive relationship relocating to a new city where she lives in a second-stage housing complex (independent housing with on-site counselling support) for women who have fled male violence. Daisy is the proud mother of a twenty four year old son, who lives on his own, and an orange tabby cat, both of whom she adores. Daisy grew up in a family where she witnessed violence perpetrated by her father against her mother and experienced sexual abuse as a girl. Daisy is dyslexic and also believes that she may experience symptoms of Attention Deficit Hyperactivity Disorder (ADHD). Exacerbated by the stress of years of physical, psychological, emotional, and financial abuse, Daisy was diagnosed with multiple sclerosis at the age of thirty and lost the use of her legs for a period of time.

It’s been over thirty six years of abuse from different partners because I don’t know any different; the only thing I am comfortable with is violence. I learned that as a little kid and grew up and thought this is the way you are supposed to live, with violence, with violent people, and violent men. I would get rid of one partner who I thought I’d loved dearly, and then the other partner would come in
and say don’t worry I’ll never hurt you like he’s hurt you. I’ll save you…. yeah right... and I’d say, oh really my knight in shining armor and then he was just as abusive as the last one. We were together for almost 10 years and then Tony came along and he said... he broke your nose, I’ll kill him. I’ll protect you, no, I’ll never treat you like that.... and then he did.

Daisy says she knows now that “watching my parents fight as a little girl and my dad picking up a big pot full of stew and throwing it against the wall” taught her what to expect and accept in her own relationships. “The abuse started when I was 14 years old or so, in relationships, my first boyfriend, I got pregnant, had two abortions and one miscarriage when I was with him. He took my money too and that went on for six years”. In her large family Daisy also recalls experiencing sexual abuse and at the time believing this experience to be “normal” in large families. Daisy’s experiences of abuse and witnessing violence by her father were what she was used to and she says it was not until she began checking in with other people that she realized these incidents were not usual for most families. “I asked her (a counsellor), so tell me does that happen with all families, is there that play thing between brothers and sisters and there was an older male that did something to me too… and I said is that common with big families? She said no and I thought, I just thought it was common and that that’s how families acted, but that’s not how they act, that’s not the safe way to act”. Daisy is haunted today by her memories of childhood sexual abuse, after repressing these memories for years. Today she is getting closer to being able to talk about them. She uses distraction and reassurance of her present and future safety when she is overcome with the haunting memories. “I’m no longer three or four years old and no one will do that to me”, she tells herself.
Narratives and Scripts About Self

Violence and abuse were all Daisy said she knew in relationships. She took up two main narratives in her self construction; Daisy the outgoing, friendly, resourceful, assertive, kind, and benevolent woman and Daisy the weak and abused woman who never believed she was worthy of love, affection, or support. The following statements demonstrate her personal narrative as the outgoing, friendly, resourceful, assertive, kind and benevolent Daisy.

*I’m a nice, caring and giving person you know. I can make friends in a second flat.  
... and the guy before him, he punched me too hard and I thought, you wont do that again, so was only 2 years with him.*

Daisy’s second personal narrative is confirmed in the following statements.

*I wasn’t worth it, I was not important, I was not bloody important.  
I have many acquaintance who are still struggling with stuff and I just think well, so I am very pleased that I am as strong as I am, emotionally, as strong as I am... weak in a lot of other ways.*

Daisy’s two narratives about self, and the interplay between them had influences that seemed to be both advantageous and detrimental to the events in her story. Her construction of self as a friendly and caring woman who protected and nurtured her son, was financially self sufficient, and who left the abusers when the violence became too intense, served and protected Daisy in some ways. This script allowed Daisy to conceptualize herself and her story in many ways that highlighted her strengths. For example, through the utilization of this script Daisy presents her story as one where she kept her son safe, maintained a job, left a number of partners behind when the abuse
escalated, managed her multiple sclerosis, maintained control over her use of alcohol and cocaine as a coping device, and continued to seek help even when she felt she deserved it the least.

*My son’s father, his dad, he died in 1985. Another man I truly loved, another man who didn’t truly, truly love me. One time he slammed me into a wall and broke my nose and so I crawled into the bathroom and had my son in my arms, 4 months old. I had him in my arms so I placed him on the floor and I snapped my nose back into place and then I left that home, left behind another abuser.*

Despite being surrounded by individuals involved with crime and drugs Daisy managed to maintain sobriety and a full time job, while parenting her son alone.

*I was a single mother, so I had to stay alert all the time, so I couldn’t drink more than three glasses (of wine), that was my limit.*

Daisy describes her courageous battle and victory against Multiple Sclerosis as a personal strength.

*I also worked and when I was 30 years old and I ended up in a wheelchair with MS I put myself back through school. I became a bookkeeper and worked for a bar, a couple of restaurants in town and I did their books.*

As a single mother Daisy proudly recalls her ability to keep her son safe from the many abusive partners she had in her life.

*I made sure that when I raised him (her son) that he wasn’t raised around any abuse. I made sure that I didn’t have an abusive partner in the home we lived in. The abusers were kept out, they were kept out, especially the guy who broke my nose. My son needed to live in a fairly safe environment and he doesn’t need to see people bashing me around, he doesn’t need to see that. When he was just a little baby I decided that I didn’t want him to live in the violence, so he never did, I lived in the violence. I went into their homes and lived in the violence.*
Despite the number of abusive partners Daisy had throughout her story, many of her statements reflect dignity, strength in spirit and resilience. While her son was exposed to violence if only through witnessing the aftermath on his mother, Daisy’s story contains a description of her as a mother who felt she put her son’s needs before hers, a mother who did what she could to keep him away from the violence that she chose to live in. Daisy describes her battle with MS and how she dealt with being hospitalized and bound to a wheelchair.

*I remember when I was in the hospital (due to symptoms of the MS) I had strength in my upper body sort of, so I could lift myself in and out of the chair, in and out of the bed, go to the washroom... it was just, I always thought I’m not really disabled, I will get the hell out of this chair, I will get the hell out of this hospital. And I did, I did, I got the hell out of there and then for 4 or 5 years it looked like there was nothing wrong with me.*

While Daisy’s construction of self as the outgoing, friendly, resourceful, assertive, kind, and benevolent mother and woman served her positively in some ways, Daisy also describes how this strength based script was harmful to her in that it stopped her from seeking help for fear of hurting her abusers.

*I went to visit a doctor and he said, you have a broken nose and I said oh shit, and he said someone broke your nose and I said yes. He said do you want to press charges? And I just thought oh no how could I press charges against one of my abusers, how could I do that? I would hurt him, I think he would feel terrible, terrible hurt, that I had hurt him if I pressed charges against him. Now I look back and I think you have got to change your thinking.*

She states that throughout the abusive relationships she maintained a mental script that she could “fix or change his behaviour”. She remained hopeful that he would change and attempted to act in ways that demonstrated loyalty to and faith in her partner.
... and I always thought that when a really bad scenario would happen I would think, I can fix this, I can fix this, I am too darn nice to be treated like that and my partner and I would work on it and he would say I’m sorry I won’t do that again and bla bla bla, yeah right, and I was gonna leave on a number of occasions with whichever partner I was with and they were like no please don’t go and so I stayed and got more abuse.

Daisy states she didn’t believe in violence, yet accepted, but did not condone, intimidating and violent behaviour from the men in her life. Daisy’s values and beliefs in regards to non-violence are demonstrated in the following statement:

I thought, this fellow was violent toward me why do I want to be violent toward something whether it is only a pillow? I don’t want to be violent to anybody or anything.

In her story Daisy describes the interplay between her personal narrative that told her “you don’t deserve this” and that viewed herself as kind, loyal, and non-violent. Daisy had the power to recognize when the abuse was “too much” and the strength to seek some support, mostly medical, and eventually leave, but this narrative of self as the caring, gentle and nurturing woman inhibited her from disclosing the abuse to others, for fear of hurting her abusers. The following statements illustrate the differing scripts Daisy was ascribing to.

I didn’t want to press charges against anyone. I just always thought what a crummy thing to do...
All of these men have a really, really kind good loving side to them and I’ve been on that kind good loving side and I just think I can change that person, I can change the abuser, I can change him.
Competing with the script of self as kind, non-violent, loyal, and caring seems to be an underlying script of self as not being good enough to be genuinely valued by others or worthy of love without abuse or hurt. The combination of these two scripts seems to play out throughout her story, influencing many of her choices and her construction of self and story. The following quotes demonstrate Daisy’s sense of herself as unimportant and unworthy of support and love:

... you are not important, you are not important is the message I constantly gave myself and heard from others.

.... I wasn’t important, someone years ago, a counsellor, said to me. Well you’re pretty, you seem nice, you work in a hotel bar industry so you should be just fine, and I’m just thinking wow you’re a counsellor. I just don’t know how to get beyond stuff like that because I just felt like, excuse me, let’s just put you down here a few more notches, your self worth, do you have any, lets just kick the crap out of it.

Even in her current safe and healthy situation Daisy continues to question why she stayed for as long as she did and says she is “struggling to forgive” herself and to believe that it won’t all come crashing down on her because she believes that she doesn’t deserve a safe and healthy life.

I have this great fear that my nice little life that I have right now is gonna come crashing down and something will happen that will put me right back where I was in the abuse and pain.

I beat myself up emotionally about the things I have experienced. Why did I let myself experience these things and why was I never good enough to myself?
She experiences sadness as a result of the violent and abusive treatment she received at
the hand of male partners who said they loved her. Daisy blames herself for the violence
perpetrated against her by male partners.

**Substance abuse and Mental illness**

Daisy says she was often “attracted to the bad boys”, which to Daisy meant she
engaged in relationships with men who were involved extensively in illegal activities and
were substance abusers. She describes her life as “like living in the Sopranos” and at least
one of her partners as living a “gangster lifestyle”. Despite her attraction to these sorts of
men, Daisy did not describe ever seeking a man who would hurt her. The following two
quotes exemplify Daisy’s description of her ex partners’ involvement in illegal activities,
primarily drugs and violent crime.

*My last partner had spent a couple of years in jail. I think he tried to bring over a
whole freighter of stuff (drugs)... whatever it was I don’t know, don’t care, and
him and a few other people got caught for that.*

*A friend of one of my ex partners had been busted for importing cocaine into the
country and not little bits, but kilos.*

Daisy remained on the periphery of the illegal activities and attempted to ignore the
extent of the criminal acts.

*I didn’t want to know what he did, but I had an idea of what was happening and
stuff. I didn’t really want to know the details, but I knew what was going on and I
saw certain people.*

Being involved with an abusive and violent partner is frightening enough for a woman
and Daisy’s partners were also involved in organized crime, which made the fear of
safety complex. “Yeah, it’s not just the control and violence toward me from him, but on a whole other level. Just watching the violence unfold, you know, wow, kind of scary, pretty frightening”. Involvement with men who belong to these types of circles made coping with the fear of abuse and seeking help extremely challenging, because of the nature of these communities. In the following statement Daisy describes how talking to law enforcement and other professionals posed serious threats to her safety.

_I had a couple of cops come to my door one day and they asked to come in and I said, well sure, a friend of my ex had been arrested for importing illegal drugs into the country. They said to me, do you know anything about that and I said, I know absolutely nothing and we just sat there, and then I got frightened because I thought, if I tell them anything I’m gonna be just buggered because they’ll turn on me and my ex partner will turn on me and who will save me then? I’ll have to save myself._

To cope with being in situations where she felt almost chronically unsafe, Daisy used some substances to manage both her fear about the abuse, as well as her pain as a result of the multiple sclerosis. In the following statements, Daisy describes her substance abuse while in abusive relationships.

_I’ve done a little bit of cocaine here and there, but that was basically just to keep me sober sometimes, and it would keep me sober. Do a line and then I could have an extra glass of wine._

_It’s the coping (substance abuse), its how I coped when the abuse was really bad. I just had to numb, I had to numb myself. It’s like wow... I wasn’t drunk, I was a little high. I could still walk and talk and you know it just numbed the pain._
Daisy’s script of self as a strong woman seems to have influenced her life experience with both substance abuse and mental health. The following quotes illuminate Daisy’s scripts regarding her strength and self awareness when it came to substances and mental illness.

*Oh, it’s easy for me to get addicted, but it’s even easier for me to stop everything.*

*He (psychiatrist) said I can write you a prescription for anti-depressants and I said yeah, thanks, but no thanks, I don’t want anything. I wasn’t depressed.*

Daisy describes her cocaine and alcohol use as a coping device to deal with the abuse and manage the pain she experienced due to the MS. Although her ability to feel good was compromised because of the situations she lived within, she did not believe that organically she had a mental health disorder and so refused medication when it was offered by psychiatrists and general practitioners. Daisy’s mental health was being viewed as compromised for biological reasons by professionals, as opposed to being viewed as a natural emotional response to violence and abuse. However, Daisy believes that her inability to feel good was more so a result of the stress of living in an unpredictable and unsafe environment away from her son.

**Where is my “Knight in Shining Armor”?**

Despite the overarching narrative for Daisy that resulted in a feeling of worthlessness in the eyes of others, her competing narrative of self as a caring and friendly mother kept Daisy searching for the right man, “a man who would truly, truly love me”. Daisy describes her choice of partners as influenced by her attraction to “bad boys”. “…yeah, I’m attracted to the bad boys, the gangsters, the gangster mentality”. With sarcasm in her voice, Daisy recounts her memory of meeting one of her more
deceptive former abusive partners. “I would get rid of one partner who I thought I’d loved dearly, and then the other partner would come in and say don’t worry I’ll never hurt you like he’s hurt you. I’ll save you…. yeah right… and I’d say, oh really my knight in shining armor and then he was just as abusive as the last one”.

Daisy grew up with men in her life who where involved in careers that required strength and are often rewarded for heroic acts. “I come from a family of military and cops”. Although she was raised with exposure to men in the military and law enforcement fields, Daisy says that she was romantically drawn to the “bad boys” or men involved in criminal activity. Some of her comments even demonstrate a feeling of distain towards law enforcement officers. “Anyways, so this one particular day I went to get my nails done or bikini wax or whatever I was doing and I noticed this car following me and so I turned, he followed me. So I pulled over and I just thought you’re a cop I can smell you, I come from a family of military and cops, I can smell them”.

Searching for her “bad boy knight”, Daisy became involved in several relationships with men who mistreated her violently, emotionally, psychologically, and financially. Daisy’s father did not like several of her partners over the years to the detriment of her relationship with her family. “… my dad and my partner didn’t like each other and I figure it was just because they were so darn similar and that’s what I got from that whole scenario”. The turbulent relationship between her parents and her partners resulted in her becoming further isolated into the abuse. Daisy says she constantly sought love, to find that special person who would “truly” love her. Unfortunately, Daisy said that she only found men who mistreated her for many years and in the present has finally realized she “must love herself before anything else positive can follow”.
I always thought will someone ever really totally love me one day? And I don’t know… and I just have to learn to love myself and to be kind to myself. I guess probably I’ve never been as kind as I should have been to myself.

About Seeking Help

Throughout her story Daisy spoke about instances where she had attempted to reach out for help or support and was dissatisfied or, even worse, harmed or re-traumatized by the responses she received. In the following quote Daisy shares why she did not seek help on several occasions.

I never asked for the help, never wanted to say that someone had hit me, abused me, you know yelled at, whatever they did to me. I never wanted to tell anyone that someone had done that to me because I felt such great shame.

The social responses to her experiences and fear of decreased safety held Daisy back from seeking help. When she finally did become involved in community and medical supports, Daisy found further shame and blame in the responses and advice of helpers. Daisy recognized the difference between depression and oppression, even if the professional helpers in her life did not appear to. The quotes below reveal Daisy’s experience with accessing supports through mental health.

In the early nineties I finally went to get some help with it, get some counselling, so I went to a mental health place in town. I went there and I talked to a lady and I went to see her a few times and after awhile she said I can’t help you anymore because you’re not beating the pillow hard enough, and I wasn’t angry enough at a pillow and so she wouldn’t give me any more help.
She put me in touch with a psychiatrist and I told him about the sexual abuse I had as a kid and we talked about it for an hour. Then he said I think you’re just making it up, or you’re hallucinating, or you’re on drugs. I just went wow. He said, I can write you a prescription for anti-depressants and I said yeah, thanks, but no thanks, I don’t want anything. I wasn’t depressed. After him saying that to me I basically shut myself down, I thought I don’t want to, I’m not going to... maybe I am imagining everything. Maybe I am imagining the punching, the strangling.

After experiencing being ignored, blamed, and judged by helpers in her community, Daisy retreated back into herself and back to abusive relationships for several more years. Daisy describes her thoughts and feelings at this time in the excerpts below.

I decided that I didn’t want to have someone from the good side say you’re making it all up. So I shut myself, I didn’t ask for any more help.

I was scared because I was afraid about the judging that would go on from counsellors or psychologists or psychiatrists or whatever. I was just afraid of being judged.

Daisy’s experiences further isolated her from receiving support and colluded with her script of self as no good and not worth it. From her early experiences attempting to seek help, Daisy took away the following messages. “Don’t trust because then the judging starts” and “You’re not bloody worth it”. Her story was minimized and invalidated by several professionals, who she felt did not truly understand her position because no one truly listened or asked her what she needed. Shortly before she left her last abusive partner and relocated to the city where she currently resides, Daisy did recount a positive experience with a helping professional in her life. “The only saving grace I had was a practical nurse, she would come over to assist me when the MS was really bad. She
would come over and I shared stuff with her about the abuse and stuff. She was my saving grace. It was so nice to have someone I could connect to and tell”. This nurse, her son, her father, and an old male friend are the ones Daisy describes who encouraged her to finally leave her violent partner and unsafe life behind. When Daisy escaped to Victoria from her abusive ex partner she describes finding the most support through housing services.

*When I moved here I mainly got connected with supports for the abuse through looking for housing. I did end up getting connected with a counsellor at a local neighborhood house and she also has MS. So I hooked up with her because I thought she should be empathetic because she could understand what I was going through as a person who has gone through the abuse, the MS, the abuse just brings on the MS.*

In her story Daisy also shared what was helpful in accessing and utilizing support. Daisy provided the following pieces of advice to practitioners who wish to reach and support women today who are in situations similar to those she faced in her past.

*...to be available. I’ve never phoned a help line before, just one time in the nineties and that was the only time I asked for help back then. And now I’m here and I’m asking for help. I’ve shared a lot with her (a counsellor who works in Daisy’s housing complex).*

*Just, hey, let’s sit down and have a cup of tea or go to the gym, or whatever, just to have that social interaction, that perhaps you have something in common.*

**Discourses in Daisy’s story**

Woven through Daisy’s story are the ways that she believes she has lived up to the cultural scripts of mothering. Based on her description of her relationship with her son
and the pride she takes in her ability to have kept him safe and the respectful and caring man he has become, it is apparent that Daisy subscribes to some of the concepts of “intensive mothering”. As has already been mentioned, Daisy’s construction of self seems to consist of two competing scripts. Her role as a single mother who was able to provide for and protect her son is central to her construction of self as the strong, self-reliant, and caring woman. Because this particular mothering discourse highlights the “mother = woman equation”, Daisy was able to utilize her strengths as a mother to increase her positive sense of self to some degree. However, in many ways Daisy fractures this equation because she appears to have led two lives, managing to keep her son away from the abusers. “When he was just a little baby I decided that I didn’t want him to live in the violence, so he never did, I lived in the violence. I went into their homes and lived in the violence”. Daisy’s life as a mother differed greatly from her life as a woman in relationship. According to socially accepted expectations of mothers, children’s needs are women’s needs. Daisy put her son’s needs before hers, but accepted treatment toward herself that she wouldn’t accept if it were directed at her son. As she presented her story for this research, Daisy spoke mainly about her son and role as a mother as it related to her sense of pride in the job she did raising him.

Her desire to focus on this piece definitely plays a role in the positive part of her self construction, but is also influenced by the “common sense” social ideas about “good” mothering. One of the most powerful social ideas regarding mothers who deal with violence, substance abuse and mental illness, is that she who stays in drugs or violent relationships is choosing her drug or relationship over her child. While Daisy’s literal description of her story of motherhood would appear to demonstrate the breaking of this
rule from her perspective, it may also be an attempt to compensate or counter this social idea. In Daisy’s story she values her son, but not always herself. Her decisions to use drugs to cope and her inability to leave the abusive partners were impacted by a number of factors, rather than simply a choice to place higher value on her partner, the drugs, or herself than her child.

Daisy’s story highlights many of the socially accepted traditional gender roles of women and the construction of the “good woman”. This construct identifies women as naturally unique from men; as more nurturing, highly relational and oriented to others. It implies that a woman’s construction of self occurs primarily through connection with others, family and children in particular (Weedon, 1987). Within Daisy’s story several elements of this concept are present. Daisy’s search for her “knight in shining armor”, a “bad boy” who would “truly, truly love” her and appreciate her caring and good intentioned nature demonstrates an investment in ideologies about men and women’s roles in relationship. Daisy’s use of the metaphor of a “knight in shining armor” is interesting. Typical qualities of the historical knight include strong, powerful, protective, rescuer, handsome, moral and virtuous, which are qualities extended to the male gender in western society. Daisy’s version of the “knight” in her story was also a “bad boy”. Some of these same “knight” qualities are shared by the typical social construction of the “bad boy” (strong, powerful, protective, handsome). While Daisy sought her “bad boy knight” she also saw herself having those qualities that, according to these gender constructions, are natural for the female gender, that is, nurturing, caring, gentle, oriented to the collective etc. Furthermore, that a woman’s construction of self comes mainly though connection with others; her children who she can nurture and care for and a man
from whom she can seek protection and attention, as well as whom she can care for. Throughout Daisy’s story she searches for a knight who she can nurture. With several abusive partners, Daisy shared telling herself that she could change him or make him a better man. This demonstrates her acceptance in the idea that women are morally superior, at least in relation to her and her partner. Acceptance of this idea could encourage a woman to excuse inappropriate, even harmful treatment, as a means to an end, the end being a man nurtured into kinder more respectful behaviour. The “selfless woman”, “takes one for the team”, ignores mistreatment for the “greater good”.

Combined with this idea for Daisy appears to be integration of discourses related to the “value” of loyalty, hope, and faith in intimate relationships/partnerships. If she views herself as the glue of the unit and as morally superior to her male partner, she then becomes responsible for facilitating and supporting him to change, while also fulfilling her duties as a “good” wife/girlfriend. This thinking further conceals ands obfuscates the male violence, but maintaining attention on the victim’s behaviour, not the perpetrator.

Judgment by others and self judgment are big themes in Daisy’s story. Fear of being judged and blamed by others, particularly professionals were a reality based on multiple experiences for Daisy. This fear and her self blaming resulted in the belief that she wasn’t worth it, as well as threatened her safety and extended the length of time it took her to leave the abusers and seek support. While individual women’s responses are thought to be unique to each woman, the connections between women’s self blaming/judging, the pervasive “common-sense” attitudes in society about mothers, violence, abuse, substance abuse and mental illness and the social responses they are met with as a result are illuminated in Daisy’s story.
Finally, the discourse of gender power and social responses to male perpetrated violence are central in Daisy’s story. The abuser (her “knight”) usurped her personal power using tactics of fear, intimidation and violence. The role of the “knight” as protector implies a power differentiation, with the stronger one, the protector, granted a larger amount of power. Daisy’s most influential supports who encouraged her to flee for safety were men (friend, son, father). A power differential also exists within a relationship where one player (Daisy) is making efforts to change the other (abusers). The decision to change or not to change lies within the abusive partner, despite large or small efforts made by Daisy. “He was an abuser from the very start, and I knew that from the very start and I thought, I’ll be fine, I can change him, no, you can’t change people like that, totally impossible”. Today Daisy feels she has reclaimed or maybe even discovered her power for the first time.

I do have the power. I have the power to create change for myself, do whatever I want.

“My story will help someone, it will help someone”

Daisy provided the following pieces of advice for women and said the main reason she volunteered to participate in this study was with the hope that telling her story would help other women who were facing similar challenges to find ways to take back their power and seek safety and support like she did.

I think that women just have to be patient with themselves and not so hard on themselves. You know and when you talk to yourself, talk nicely. Would you talk to Joe Blow down the street the way you are talking to yourself right now?
Don’t give up, do not give up on yourself, cause I gave up on myself cause I was told that I wasn’t important and you just have to keep phoning help lines, abuse lines, or whatever the avenues you have, talk to your doctor and don’t give up on yourself, do not give up on yourself, cause I did and that’s where the drugs and alcohol came in.

Access those particular people who you trust and who can help you.

Just don’t be afraid of the world. It’s a big bad world but you can always make it a nicer part.

Discussion

When I first met Daisy in her apartment, she welcomed me and although she had volunteered to participate in the study, she seemed somewhat guarded in her responses. She spoke in an upbeat and sarcastic tone, but at times softened and wept as she spoke. Daisy became especially emotional when talking about how she felt about herself and how she never believed that anyone thought she was worth listening to or loving. The sarcasm was particularly noticeable when she described how she had met and become involved with several of her ex partners. “My knight in shining armor” and “he said, oh, don’t worry I’ll never hurt you like he did… bla bla bla” are examples of Daisy’s sarcastic tone. Daisy’s engagement in the interview was genuine and her desire to help others by the sharing of her story was poignant.

The following themes and core descriptions were identified in Daisy’s story: Self blame, fear of judgment, self as worthless and unlovable by others, dignity, negative social responses, taking my power back, mothering and keeping her son safe, gendered discourses and social expectations, and helping other women.
Narrative inquiry is a fluid process in which the researcher and informant work together in collaboration as opposed to traditional research methods in which hierarchical relationships are formed in order to produce objective reality and universal truths that make the informant static and unresponsive (Richardson, 1997). There were several instances during Daisy’s interviews where it was obvious that novel meanings and ways of seeing scripts developed and/or were reaffirmed through the collaborative and conversational nature of the interviews. While posing the essential questions to Daisy throughout the interview I also allowed Daisy to lead the direction of the interview in many ways. At times she added stories or thoughts that weren’t directly connected to any specific question and other times avoided some questions. All of this was necessary for her to present her story as she understood it. Some new and supportive, even therapeutic, meanings came out of the interviews with Daisy. The following excerpt from Daisy’s second interview demonstrates the co-construction that took place at times during Daisy’s interviews.

D - Yes, its healthy, I’m not finding drugs, I have a glass of wine with dinner 3 or 4 times a week, one glass, and umm, I don’t do the drugs, extra strength Tylenol, that’s as far as I go and I just feel I am doing everything I should do at this point correctly, but I’m thinking ok, now what happens to me… what happens to me?

M - What comes next?

D - What comes next? I have this great fear that my nice little life that I have right now is gonna come crashing down

M - What’s different about now from all other times in the pattern before?

D - This place, this place where I am right now and the connections that I have made with counsellors here and just going back to the gym and doing the correct things, yes I am

M - And your future is open for you to choose what you want to have in it. It’s your choice, you have the power...

D - I do have the power, thank you for saying that, I have the power, I do have the power. I keep forgetting that part that I have the power to create change, do whatever I want, thank you for saying that, it just reaffirmed everything that I already knew, but…
M - Well I hear you saying that in a lot of what you have said in your interviews. Because like you said a few times, I thought I could change him, but then as you just said a minute ago, you can’t change another person, the only person you can change is yourself and the only situation you can change is your own, and now you are in the position to do that and you are recognizing that now, so…

D - That’s powerful, and I for some reason think everything is just gonna happen like that, and I shouldn’t think that because life doesn’t happen just like that, I have to learn to be a little more patient with myself.

This example of co-construction in Daisy’s story is demonstrative of the power of narrative and telling one’s story. By pulling out pieces that Daisy had already shared and reflecting back to Daisy how I was making meaning of her scripts allowed us to construct some meaning together and strengthen the esteem building and reassuring parts of her past and present story.

**Personal Narratives**

In her story Daisy offered two overarching narratives about herself, which she believes influenced her life experiences. Daisy describes herself at times as a powerless, worthless, and abused woman and others as a caring, self sufficient, non-violent and strong mother/woman. Her narrative as powerless and worthless seemed to be present and active throughout her story, with the other, more positive, narrative popping up once in awhile. This sadness about self could be the result of a lifetime of being told she was “not worth it” and of violence and mistreatment. While the other narrative revealed could be viewed as moments of dignity and a “celebration in the midst of great sadness about violence and disrespect or a blessing in a sea of woe” (Richardson, personal communication, Dec 2009). Daisy’s sadness represented the years of abuse and degradation she faced, but it seems she never really believed she was worthless, always knowing at some level that we all deserve love and respect and she was mourning its
absence in her life (Richardson, 2009). Throughout her story this narrative gained strength, at times, encouraging her to seek help and try to leave. When Daisy attempted to reach out for a supportive hand she was met with responses from professionals who viewed her through a lens of blame, judgment, and disorder. After a few experiences like this Daisy’s voice of strength and dignity was quieted, granting more power to the narrative of shame and self blame.

**Service Provision and Social Responses**

Daisy’s story highlights several areas where responses and interventions from community supports could have been handled differently, as well as ways in which the system worked for Daisy and helped her to regain her power and transform her life to where she is now. The positive power of telling her story was evident in my experience with Daisy. Through co-construction she was able to create some new meanings around her story, which she described as “empowering”. Daisy was an inspiring participant because she so emphatically expressed her desire to have her story help other women. Daisy’s story also highlights the damage that can be done to individuals who attempt to seek help and are responded to with disbelief or the minimizing of the tellers experience/story. The reality of being judged, Daisy says, played a large role in her apprehension to accessing services or telling others that she was being abused. Some of the judgments faced by Daisy are rooted in social constructions and discourses about mental illness, substance abuse, violence against women, sexism, and motherhood. Experiences with psychiatrists who were quick to identify her as clinically depressed and doctors who questioned her as to whether she was fabricating the childhood sexual abuse
she experienced are examples of instances of this kind of unjust judgmental treatment. From Daisy’s story it seems to be significant that service providers reflect on the meaning they individually ascribe to these constructions and how their individual views and assumptions are evident in their practice.

When Daisy first attempted to seek help 15-20 years ago, the responses she received were not trauma informed and were actually victim blaming and shaming. Daisy attempted to talk about her childhood sexual abuse on at least one occasion and was dismissed and told that she was making it up. Daisy is pleased to know that today many practitioners work from a trauma informed framework (Elliot, D., Bjelajac, P., Fallot, R., Markoff, L. & Glover Reed, B., 2005), and her experience with support around this issue is quite different than 15-20 years ago. The type of relationship service providers attempted to develop with Daisy was influential in her seeking and accessing support. The most supportive helpers Daisy said she experienced in her past were a public health nurse and a counsellor who, like her, was living with Multiple Sclerosis. Both of these relationships were non hierarchical, non judgmental, outreach based (in the case of the nurse), and the helpers themselves had qualities and experiences similar to Daisy, so she felt they could better relate.

Finally, Daisy’s construction of self as caring, self sufficient, assertive, and loving mother/woman deserving of love and respect, while sometimes overpowered by the other narrative of worthlessness, was ever present and seems to represent the resiliency that got her to where she is now, safe and personally powerful. Her experiences with most service providers played into her more saddened narrative, while helping individuals she encountered later (such as the Transition House) approached her with different
approaches and lenses, like trauma informed and woman-centred. These service providers banded around Daisy, assisting her in her transition to Victoria and into the second stage supportive housing she currently lives in. Today, Daisy lives free from violence, drugs, and crime. She accesses the on site counselling support in her building and is adding items to her life, such as exercise, art, and social activities that strengthen her dignified and valuable narrative.
Sandy’s Story: Caretaker, Artist

On a rainy February morning a soft spoken, friendly, and warm Sandy welcomed me into her home to share with me her story. Her small apartment is filled with canvases and art supplies. The walls, decorated with beautiful paintings of flowers, scenes of nature and paintings of women and children. Sandy is an artist. Her story is one that is beset with experiences of neglect, violence, abuse, fear, sadness, drugs and alcohol, challenges of single parenting, intergenerational patterns of violence and abuse and resistance to violence, but also unwitting strength and resilience.

*My story... well let me start with my childhood.... my mother viewed all her pregnancies as punishment from God (laughs). I can remember at four years old going into a foster home with my sister on a farm... kind of being abandoned a bit, treated totally different than her own children.*

Sandy was the second child of five in her family. Her father, alcoholic and violent, left her mother with two daughters when Sandy was only an infant. Sandy doesn’t remember him. It wasn’t long after Sandy’s father left that her mother married another man, with whom she had three more children. “I was terrified of my stepfather. He was always raging, we were hit with a belt if we did anything wrong. We were basically servants to their children, they were privileged and we weren’t. So you had to be on pins and needles and walk on eggshells to ensure he’s not angry”. Sandy describes her step-father as a “terrifying and violent man”, who wanted nothing to do with her or her other siblings who were not biologically his. At one point in Sandy’s childhood her stepfather attempted to murder her and her female siblings.
He started to get more violent, he became really violent and he tried to... well he turned out the pilot light in the furnace and he took my mom and their two boys out for a car ride at night and I guess their daughter, my sister, his daughter, woke up so they took her too, but his intention was to leave her at home as well. Luckily, my sister woke up and smelled gas. She got the neighbours and we got out of the house. After that he was removed from the house, but nothing was talked about except for that my older sisters had mentioned that he was trying to kill us. I didn’t really get it I don’t think, but he was, my mom moved so we moved out of the house, but a couple of months later she started letting him back in and of course we were all in dread... oh God he’s coming back and he was back.

Sandy’s childhood years were riddled with moves, violence, and abuse. She was sent away from her mother’s home by her mother and child protection services at different times to several foster homes, boarding houses, and homes of extended family members. She never stayed in one home consistently. Sandy seemed to be constantly shuffled around sometimes on her own and other times with one or more of her siblings. She talks about those moves in the excerpts below.

So I went to another foster home with my brother and I, while I was there my foster father was becoming inappropriate with me, sexually and I became distressed, wanted to go home. So the Ministry sent me home, which now I don’t think was a wise choice because it was already a violent home. My step father was being removed when he was drunk and fighting a few times before I arrived and then I came home into a system where you don’t talk, you don’t question.

My mom sent my oldest sister and me to a friend of hers who had a rooming house and I stayed there and was befriended by a man there. I guess I was naïve, looking for a father figure and I cuddled up with him on the couch.
At one point I lived with an aunt and uncle. My male teenage cousin, their son, was being sexually abused by his coach, which nobody knew about. So he was basically taking out his frustration on me by taunting me and then at one point tried to make me touch him when he had a hard on.

The experiencing and witnessing of abuse by Sandy and her siblings throughout their childhoods, resulted in increased sibling rivalry, taunting, and abuse between the siblings. “The sister that was just a bit older than me was always taunting, which is exactly what the oldest sister was doing to her and to me. So it’s like, you know, you can’t take it out on the people you need to take it out on so you take it out on each other”.

In her teen years Sandy describes traumatic and abusive experiences at the hands of her siblings, boyfriends, and other acquaintances she met along the way. “For the rest of my teen years it became even more intense (sighs)... yeah, I had a date rape in my teens... One of these people came into the main floor suite where he was staying and started fondling me and I was frozen and kept looking at him to stop it.” Sandy’s stepfather died when she was 12 years old. Much to her dismay and fear Sandy found her mother dating a man who she had been placed with in a rooming house previously who had attempted to sexually abuse her. “He started tickling me and I just thought that was really weird and I said don’t do that, he wasn’t listening so I said I just want to go home and so he took me home and then another time I was at the Stampede grounds with him and we got caught in a rain shower and he was trying to tell me to take my clothes off in the car and I wouldn’t and then he tried to be shaming... you know about being in your wet clothes, you’re being a big sissy”. When Sandy tried to warn her mother about this man and to disclose the inappropriate ways he had acted toward her, Sandy was ignored and blamed. “And I told my mom as she was going on a date... that’s not good, you
know that man touched me, but she and my sisters got mad at me and said that I was spoiling our mother’s chance for happiness bla bla bla… so she dated him for a couple of years”.

“When I was about 13 my sister was finishing up with high school and then brought her drug scene into the family and threw parties because my mom, after my stepfather was gone, she went to work and also to university of some kind.” The accumulation of traumatic and frightening events from her childhood and adolescence led Sandy to begin to smoke pot on a regular basis and spend time with her sister in the “drug scene”. “The rapes and my parent’s abuse really affected me a lot so I smoked pot and I hated school.” It was through her sister’s parties that Sandy met her future husband. “She (sister) had her own place, she had a child, her husband was a pusher in the sixties selling drugs. I ended up with a 26 year old guy when I was 15 and kind of coerced into sex again and not standing up for myself and then I met the man I would marry. He was also my sister’s friend and he was 24 and I was 15.”

“The marriage was, well through the dating it started ok, but then I didn’t want to be around the drugs so I broke up with him and he ended up started seeing someone else, so I think I was probably jealous and I wanted him back. We got back together” and just before her 19th birthday Sandy was married. “On my wedding night he told me that sex isn’t important in marriage and I had to look for work, you know he was working at the post office. Basically I went to bed alone every night and he stayed up all night and then went to his job. It didn’t feel like anything, but like I was just this person there for some reason, like his servant.” Sandy’s relationship with her husband was unfulfilling,
threatening, and abusive. She wanted to leave, but stayed for many years out of guilt and shame.

*He had gone away to work up north and I went out with a friend and ended up having a fling. It was the first time that I actually felt like someone actually appreciated me and I felt like I was connecting with somebody and that’s why I wanted to leave. I thought this marriage isn’t right, I have to get out of this and when he came back I told him exactly what had happened and he told me you know some men will kill their wives for doing things like that or beat them, but I’m not like that. You betrayed me and I wouldn’t have married you if I didn’t believe that you would always be true to your marriage and so I stayed with guilt. So I stayed and I ended up pregnant and he basically went back to drugs.*

While Sandy was not technically a single parent, the responsibility of parenting and home-making was all hers in her relationship. “He didn’t help me with anything, basically I felt alone most of the time. I just had to do everything by myself and so our first child was born and the first thing he says the next day is, this child will come between us and he was angry.”

After the birth of her first child Sandy’s husband’s abusive behaviour escalated. Sandy found herself walking on eggshells to keep the peace in her home and doing all that she physically and emotionally could to protect herself and her children from her husband’s abuse.

*Even at 8 months pregnant, I was the one going out and buying groceries, walking and bringing the Safeway cart while he was having a nap and he’s got a car. I couldn’t leave the house because she (baby) would cry, she wouldn’t take a bottle so he couldn’t feed her, so he was just all frustrated. So I didn’t leave him with her because I was worried.*

Throughout her relationship Sandy made several attempts to try and leave him.
After about a year I wanted to leave because he was hitting her (daughter) and I felt forced to have sex when I didn’t want to. Basically I didn’t love him or feel attracted to him, I didn’t feel like having sex with him anymore and it was always my duty and that was really frustrating cause in my mind you know, are we in the dark ages? He never washed, he was really dirty and stinky. So one day I said I needed to leave and his response was, I don’t know where he got a shotgun, but he sat in the chair for about an hour or so with that shot gun and never said a word. I had no idea what was going to go on and I had already gone through a lot of stuff with him where he said I wasn’t allowed to tell anybody about our problems and so I was silent.

**Mothering Under Duress**

Sandy was forced to stay with him to protect herself from more or escalated violence or potential death. In the end she had three children. Her husband continued to abuse her and the children, her daughter in particular, and offer no support or help to Sandy along the way.

*Finally I had three kids, and you know he socialized with my family all the time and I felt that I was by myself basically, alone, and had to do all of the stuff with the kids. He would stay up all night and read. When I was eight months pregnant with my second child we took a train to Winnipeg to visit his family for Christmas in a day coach. I had my son January 30th. So with a toddler running around, cause she wasn’t quite two and already acting out because of the way he disciplines. The way that she behaved was that she would push the limits and then she got hit and so I would do all this running after her to keep her in line so that it didn’t come to that. I was pregnant and he was reading a book, science fiction books, all day and all night. The next day he slept through the whole day and I was there having not slept through the night, plus constantly running after my child.*
Sandy didn’t have any support people she felt she could rely on. She sees herself now as having been negligent, but explains that she did all she could within the dynamics of her internment by a violent man, her resulting deteriorating mental health, past and current trauma.

When I gave birth to my second son, I had left my daughter with my mother, it was early morning, 6:30, to take care of her while I had the baby. And my mom sent my daughter home with my ten year old sister to take care of her. So when I found that out I went home the next morning and there I was taking care of my husband, my child, the infant and my sister, who is ten years old and smoking with my husband and I was waiting on them, literally waiting on them and I had to go to the store to buy milk and his cigarettes. I was walking past an A and W where people used to go and park and I couldn’t walk. My body froze I could barely move my leg in front of the other to get myself back home. But I did and so I just continued in my silence for another few years and had my third child.

As time passed Sandy became less and less able to cope with parenting her children who were acting out because of the abuse and to continue trying to prevent violence in her chaotic, unsafe and frightening home.

My daughter’s behaviour was starting to hurt her brother, the middle one, and so I was constantly having to intervene and her father was constantly hitting her and leaving hand prints on her bum, like bruise marks off of the hand and popped blood vessels under her eyes and it didn’t matter, I kept saying that’s abusive and you shouldn’t be doing that, it didn’t stop!

One day Sandy realized she couldn’t do it anymore. “I literally stuck my head under the tap of cold water because I thought if I didn’t snap out of it, I wasn’t going to return and that’s when I made the decision and I told him he had to leave and I went to welfare. He
did go work somewhere for a few months and came back thinking that I would take him back and I wouldn’t”.

Sandy decided it would be best to leave the city and move on, as her husband continued to harass her and try to convince her to take him back.

*He came back and said he had cleaned up his act and thought I would take him back and I said no and then I moved to Victoria. While he was gone I had tried to get help from my family to go grocery shopping. It was winter and I had an infant and two kids and all I got was shamed for asking for help. So I thought I’ll just go to Victoria, the climate’s warmer, I’ll be able to manage, you know we’re not going to be stuck in blizzards, so I did that. I went by myself on a train and a ferry with 46 dollars and just a few blankets and came to Victoria and (sighs) then he moved out here too, told me that I should go back to Calgary, that Victoria was his, but I didn’t.*

In Victoria Sandy tried to make a life for herself and her three children. She dated a few men who ended up being abusive in other ways; financially, emotionally, psychologically. Her husband had mainly stopped harassing her and the children, but would run into Sandy from time to time and use intimidation to attempt to continue to exert power and control over her.

*My ex had come by with his car on the street and I could see the rage on his face. I thought, oh my God he’s gonna mow me down, but he just stuck his finger out as he drove by. Another time I was with a friend of mine and we were at my daughter’s kindergarten, my ex was there staring, my friend saw the look on my face and he actually said to me did you ever think about going to Transition House? He said you look absolutely terrified of that man. He said he thought that I must have been abused, because he said the look of horror on your face when you saw him, he tried to get me to connect with a transition house, but at that time*
I don't think I really realized that I had been in an abusive relationship. I probably thought that was normal.

Sandy was struggling to cope with her role as a single parent, her past trauma, depression, and pressure from family and helping professionals that reconciliation with her husband would be in her family’s best interest. “And welfare of course had been trying to convince me that I should stay with my husband and that its better that way and I said no I’m not going to do that.” Her children’s behaviour continued to escalate with problems at home, school, and with peers that was often violent, inappropriate or hostile. Sandy felt she was being abused by her daughter. “I felt abuse by my daughter right from the start, well as a single mom, because of her behaviour.” Sandy also felt a sense of guilt that she could not provide well for her children or manage their emotional needs and at the same time resented them for the blame they placed on her alone for their tumultuous childhood experiences.

We were financially poor and I’d deprived them, was how they saw it. Their father wouldn’t have crumbled and been on welfare and been a substance abusing person if I’d stayed with him, like come on, he was doing all those things and I was carrying the load. But they don’t have anybody mirroring to them the truth, nothing, so I feel like I’ve been abused by them all and could never, and still can’t, figure out through using the system how to get them to see what’s really going on and say it out loud to my own children. You know, you’re not right, you know, when your mom tells you she wants you to help, she has a right to ask for that.

While Sandy continued to try and support and manage her children, it soon became more than she could cope with. “So I started partying with my sister and meeting substance abusers, they would tell you they love you, sleep with you, and then date everybody else.
I had a few sexually transmitted diseases and I got pregnant and had an abortion and then had sex with him within a few days and ended up in emergency”. Just as she had as a teenager, Sandy soon recognized the dangers of the “party world” of her sister.

> Then a light bulb went off and I thought, oh my god what am I doing? I am becoming my mother, being totally victimized and giving her power away. I don’t want to do that and I set a boundary, I ignored people on the street that belonged to that circle, even my sisters, I even had to tell my one sister off.

**Substance Abuse and Mental Illness**

Sandy struggled with some substance abuse and significant mental illness throughout her life. In the statement below Sandy discusses a time of awakening and reflects on her substance abuse and mental illness challenges.

> After having that sort of awakening, you know, what am I doing? I’ve got to get my life back on track. That’s when I started my healing journey, I went to AA (Alcoholics Anonymous) and a mental health centre. I don’t think I recognized mental illness in myself as depression, I can think of many times when my kids were elementary age, where I would let them go and play at a friends place and I would do nothing except sit in my kitchen or my living room and stare at a wall. This was in the first couple of years after my marriage had ended. I literally had nothing, I was drained, I stared at the walls and I was tired (sighs).

Sandy describes her substance abuse as minimal. She described short periods of time that she recalls using drugs or alcohol, but seemed always to have a realization after some time that the substances were not serving her well and so she stopped.
I was introduced to drugs at 13. I was smoking pot and stuff like that from the age of 13 to 16, for myself I found it creating anxiety and stuff so I stopped. Of course, the people I was introduced to were using and that’s how I ended up marrying somebody who ended up having a substance abuse issue.

Sandy made a similar choice to stop using drugs and alcohol in her adult life when “the light bulb went off” and she realized that she was allowing herself to be victimized and was behaving “just like her mother”. Substances seem to be what Sandy attempted to use on more than one occasion in her life to manage her stress and abuse. However, it was not something Sandy ever sustained as a regular coping device. Choosing to avoid substances to cope, Sandy reached out for help for her emotional state, as well as for parenting support.

I’m exhausted and I’m numb and I’m ashamed to go and ask for help. I did go to Eric Martin (psychiatric hospital), I think when they called it EMI, and I spoke to a director there and he kind of gently told me that I had depression, which for me was like, that’s a bad thing. I was very ashamed. I didn’t want to see anybody, I didn’t trust anyone, but he gave me a list of things, like setting up a schedule so I have activity to help me get out of depression.

Sandy experienced suicidal thoughts at times, as well as urges to act out impulses to self harm.

I felt so low and actually had those urges and thoughts, wanting to physically cut myself to release things, I mean it’s not hard to understand how people actually do things that hurt themselves to actually release or get away from that feeling, because those feelings are so terrible.
Seeking Help

Sandy did not give up trying to seek help and better her life and the lives of her children. Emotionally, she struggled to manage day to day and both she and her children continued to be haunted by the effects of past trauma and abuse. On several occasions she felt she was blamed for the abuse and trauma and shamed for her inability to parent her children well on her own. She received pressure from government agencies, such as social services, which tended not to acknowledge the violence she had experienced at the hands of her ex husband and was told numerous times that reconciliation with him was the best way for her to “get her life back on track”. Her parents and siblings blamed her for the state of her family, not believing her about the abuse that she and her children had experienced. One of her sisters even took her ex husband into her home to support him when he was on his own.

Nobody knew because I was supposed to keep everything to myself. I was not supposed to shame him. So in my marriage I said nothing, nobody knew anything, until I left. And then when I left and I said something, nobody believed me. They just totally disregarded as if it had no value and so I didn’t say too much. Well I did ask my family for help when I was forced to go for maintenance from him after we had separated. My sister was friends with him and letting him board at her house and he told her that he would go on welfare or live on the street before he would pay that bitch a cent. I only had one sister that thought his behaviour was wrong and her and her husband wouldn’t have anything to do with him, but that’s the only person. They lived in Australia. And in trying to explain to my mother how hurtful it is her response is to blame me. You’re bitter, you need to get over it, so I’d be blamed.
Her family’s unsupportive responses compounded Sandy’s underlying belief that she was to blame and should be embarrassed and ashamed of herself.

*It was winter and I had an infant and 2 kids and all I got was shamed for asking for help (from family).*

*When I tell them anything they act like I’m just this horrible person.*

Although social services responded to her cries for help with her daughter’s unmanageable behaviour, Sandy did not find their support productive. A missing piece for Sandy was that no one seemed to acknowledge the existence or the impact of the abuse on her as a woman, her mental health or her ability to connect with and support her children. At a psychiatric hospital, Sandy attended a program for individuals affected by depression and anxiety. “I did a day program in 77 or 78. There were parts of it that I felt were really good and parts that I felt really criticized. They didn’t want you to talk about the past, so here you’ve bottled up all this stuff and you are supposed to get healthy without talking about it.” Sandy was further victimized and shamed when she spoke about her trauma and abuse within a mental health setting.

*When I went through the day program at EMI (psychiatric hospital) they never discussed anything about my abuse, nothing about whether I had been abused. At that program they had a group hug on Fridays with this song, but I couldn’t participate, I just balled my eyes out that these people were hugging each other in a circle. I was just; I was like my daughter, why would I trust anybody? Then eventually I started to participate, but when I started to talk about my abuse in my childhood and my marriage I was told that I was in the past and that going into the past, that’s wrong. It was so humiliating. Another woman did too, she went into her father allowing his friend to sexually abuse her in front of him and she*
was put down as well. And I’m sitting there thinking these are the things we should be talking about, these things should be out there, we should be getting help. They basically said, well you have to get outside help for that.

In later years Sandy again sought out help for her mental health and attempted to raise her historical trauma and abuse and was pleased to receive a different message in a group with a focus on parenting.

I did see another psychologist later who did a group thing and a thing on family of origin, a group where you talk, just about the parenting styles. We did a banging thing with a plastic bat on big cushions to get out our anger, and I realized I had all this anger towards that step father who tried to murder us. It was like I realized, I really hated him. I told him (psychiatrist), cause he asked a bit about my life, and I told him that at the EMI program they criticized me for talking about my past and he told me that that was incorrect, that’s the very thing that you should be doing. He said you need to tell your story, you need to get it out there, but he didn’t tell me where to go and access that help. I didn’t know where to get it because obviously the EMI wasn’t going to give it because I’m not supposed to go in with a past.

Parenting Support

Much of the support Sandy received was in the form of parenting support until years later, when her children were all grown up and she was on her own. She described the majority of the problematic behaviours presented by her daughter and didn’t speak much about her sons. Upon reflection today, Sandy is able to see that dynamics of dysfunction and abuse were being recreated in her family with her children and that the abuse and trauma was being transferred down through the generations.
They did a group organized through the ministry with the kids and the moms, parents. I didn’t find it that useful, they said your daughter is so well adjusted, they still don’t get it. The dynamics in the home weren’t working, it’s already been set up, but nobody is addressing it, it’s like it falls on deaf ears. They think well if you would just help yourself, you know, you’ll be alright. Well how am I supposed to do that if I hadn’t talked yet about my abuse, its still down there, most of it? I can’t change the dynamics, I have no family support system, I don’t know how to address the fact that my whole family is recreating it, I hadn’t seen it.

During the interview Sandy shared thoughts and opinions about what was and wasn’t helpful to her during her years actively parenting her troubled and challenging daughter in statements such as this.

I felt there was some help, but I just never felt there was anything that really hit the nail on the head about how to deal with the dynamics that happened between the parent and the child, through the dysfunction that was created in the marriage in the first place. Like her (my daughter) being hit by him and him being really very violent with her and how the dynamics of each individual gets set up by that system, I didn’t feel they gave me tools to be empowered. I just felt that they were saying that you need to change something, but I had no understanding of what that means.

Sandy felt that the system was more willing to respond to her requests for help with her children, but that nothing tried was helpful because it wasn’t addressing her issues and needs as a woman.

Well for the child, I think they understand from the child’s perspective maybe, they want to protect the child and of course they see them in a group and oh, these children have such wonderful skills, well of course they do, their whole life is not bad. I had three really incredibly unique children. Yeah, but the dynamics have already been set up in the home, we’re already in an imbalanced environment. I
didn’t know how to balance it. I didn’t know how to say those words at the time, 
about this imbalance because I was in it. I can’t see the forest for the trees. I just 
know that I had been in this power struggle with my daughter for everything and 
her behaviour was out of control.

Because of her personal trauma and emotional struggles Sandy said that she couldn’t 
recognize the symptoms of abuse and trauma in her own daughter. She, unknowingly, 
turned a blind eye for some time to her daughter’s issues. However, many of her 
statements throughout the interview demonstrated awareness of her daughter’s needs, 
such as the passage below.

I told them at social services that I had problem so they sent a woman to the 
house, the first couple of times that she was there my daughter was flailing 
around like a mad woman and this woman and I literally had to hold her hands 
down so that she could connect to this woman. That’s what made me think, 
something has happened to my daughter in that time period and we’re not getting 
to it.

Sandy felt that much of the advice provided by many service providers and her peers was 
irrelevant to her family’s unique situation and challenges.

I thought it was really beneficial for her, they did give me somebody, some kind of 
respite, but what are you supposed to do with yourself? So I spent a lot of time in 
the museum when it was free. I’d even ask parents who seemed to know how to 
talk to their kids and they’d say, well we don’t use grounding because it’s not 
constructive. Well they have two well adjusted kids who never went through what 
my kids did so of course that works for them.
Sandy continued to seek help and remain open to the suggestions and strategies presented to her by counsellors and other support people, but she felt she was never able to successfully implement them with her children. Sandy says her personal challenges with mental illness and triggers of past trauma prohibited her from better connecting with and supporting her children with their unique and challenging needs. However, Sandy continued time and time again throughout her story to seek help and change this, but felt nothing was the “right fit” for her. Sandy desired a service that would assist her with her children, while attending to her physical and emotional stress resulting from violence all at once. The needs of her children, herself and her relationship with them as their mother appeared to be pitted against each other.

*I had reward systems that a counsellor told me to use. You reward them, put a star on the fridge when they do something good. Tell that to an ADD (Attention Deficit Disorder) person who really hates paper stuff and trying to be organized and you know. And so I couldn’t structure that stuff very well and plus underneath I always felt that everything that I tried, my kids worked twice as hard to disrupt, especially when I went to school and work. Everything at home escalated to more problems, so it actually became harder for me to go out and better myself, it was better to just stay home and stay on top of everything so I could just keep it manageable for everyone.*

Sandy often felt that the help provided only contributed more to her feeling of powerlessness and helplessness. Sandy felt she had to defend herself as a mother and that outside support people were coming in to judge who was right, her or her children.

*Yeah, and I couldn’t protect her (daughter) and I said to these people there was no system coming and helping me, they did send a woman through Child Care, cause I tried that one too, they sent a woman into my home with a tape recorder*
to listen and just record. My kids thought it was an absolute joke and you know I’m telling my side and she is like this vacant person there, just taking the info, but not... Well I think she was going to take it so she could listen to it first, but I’m saying you know, but I need you to give them some feedback, yeah why aren’t you involved here with your family, because you do have responsibilities, but it was just like making me powerless again, like I was just sitting here complaining again and I told her not to come back. So it was helpless.

When Sandy’s daughter got into her teen years she became unmanageable and the signals were present that she was beginning to actively use substances. Sandy says she had to practice “tough love” with her.

Well my daughter wasn’t living at home, I had to practice tough love when she was 16, 17, because she was calling me really rude names, I don’t want to repeat them. Umm and believing she could stay up as late as she wanted during high school and she didn’t have to get up and go to school. So I gave her an ultimatum, you don’t talk to me that way and you either go to school or you get a job and during the weeknights your home at 11 and on the weekends I will waive it because you have to make this compromise with me. She just told me where to go so I had to ask her to leave. I went to a tough love meeting and they scared the hell out of me, because they said, well she sounds like she’s got a drug problem and an alcohol problem and I thought oh my god, because I don’t know because I don’t see, but her behaviour is not different than what its been, its just escalated. So I don’t know if she’s really doing those things.

Drugs and alcohol were never a long lived coping device for Sandy. She ventured down the road of substance abuse on a few occasions in her life, but each time quickly realized that they were only making her life harder. Sandy tried to impart a healthy understanding about drugs and alcohol in her children.
For myself I raised my kids, trying to make them aware of you know, that its ok to use alcohol when you have a family gathering and there is wine at the dinner, but the idea that alcohol is not something to use to make yourself feel good, same with drugs, you know things can lead to problems, so you have to be realistic and of course, kids go through the teens and they try things, but I’m just seeing in my daughter the same patterns of her father and socially needing to drink and she has gone through periods in her life of excessive drinking, and excessive drinking partners, three abortions, she said because she was worried they would have FAS. I don’t see my sons having the same problem, they seem to manage better.

Upon reflection today Sandy says the following about her parenting experience:

You know it’s like, if I look at my behaviour, it’s like I wouldn’t behave like that today. I think I was negligent, I think I was really in a bad place and it hurt my daughter. And you know I just tried to just pick up all these pieces and get help, but you know I didn’t always feel like they understood.

**Dating**

After she separated from her husband Sandy continued to seek out a relationship with a man that would be fulfilling and supportive, but continued to discover that the men she was dating were abusive, mistreating, using and abusing her. Her most recent abusive relationship led Sandy to seek help through the Transition House. Sandy currently lives in a second stage housing unit run by the Transition House.

He was sharing his first, his teenage years, what his life was like and a girl he met and I thought my god, I’m meeting a man who actually shares all of his truths so I shared my date rape and how it had affected me, well that got used against me. He blamed me for it happening and I said that the experience of having him say that was like being raped all over again and I was really angry and it started to
affect the relationship. I don’t want to have sex when I think someone doesn’t think much of me and I told him and then he became really insecure and it didn’t matter what I did to be supportive. I tried to be more sexually engaging and to do things to make him feel that I cared and then that would be thrown in my face, he would call me a whore.

During her time in this unhealthy relationship, Sandy and her partner sought support from a counsellor. This experience, although unsuccessful in “saving” the relationship, was the beginning of Sandy’s journey in finding the eventual support she needed for herself.

He (partner) first set up a counselling appointment before we moved in together, but I didn’t get it, he thought the man should fix me because I’m damaged goods, but he said the counsellor said I’m damaged goods, but actually what I heard the counsellor say was he says your damaged goods. So, I think he thought that I would get fixed and that life would get better, but it didn’t. Then I got myself a counsellor and he yelled at the counsellor, said we were ganging up on him.

Sandy ended this relationship by escaping to a Transition House.

Then I went to Transition House, they told me I was being financially held hostage, I had to leave welfare, I couldn’t get a student loan because he earns money, but he’s not paying for that, so I had to drop that (school) and get a job.

**Personal Narratives**

During the two interview sessions Sandy presented with a soft, gentle, saddened, and somewhat timid or meek tone, mood, and affect. She spoke in a soft and quiet voice and was on the verge of tears throughout most of the interview. Sandy began her story with a statement about her mother, spoken in a sarcastic and hurt tone. “My mother viewed all her pregnancies as punishment from God.” The theme of being a mistake, a
burden, not a person of value, and different than others begins at her conception and continues to be woven throughout Sandy’s story. Being cast out of her family numerous times to unsafe environments, an attempt on her life by her step-father, lack of empathy and support and later judgment and blame by family members, partners, and professionals all contributed to Sandy’s saddened and negative narrative about herself. Sandy’s story also suggests a narrative of self as weak and naive, she sees herself as a wounded little girl, who has grown accustomed to mistreatment and suffering and is searching for someone to take care of her. The following statements from Sandy’s interview highlight this construction of her self.

*It was always all my fault*

*I went to Catholic schools and I was ostracized because my mother was a divorced woman. Kids weren’t playing with me. I wasn’t being invited into other kids’ homes. So I was kind of distressed.*

*It was the first time that I felt like someone actually appreciated me and I felt like I was connecting with somebody.*

*My mom sent my oldest sister and me to a friend of hers who had a rooming house and I stayed there and I was befriended by a man there. I guess I was naïve looking for a father figure and I cuddled up with him on the couch.*

Natural responses to very real traumatic, violent, and degrading events and treatment seems to have translated into this narrative of a wounded, weak, worthless, odd, burden to others serves as one of the core scripts about self that Sandy described. Like Daisy, within Sandy’s story a contrary narrative seemed to emerge and gain strength as she moved forward in life toward more positive and safe situations and relationships. This
script was one of a strong woman, a feminist, a caring mother who was oriented to justice, self care, and to finding a more positive and worthwhile life for herself. On occasion throughout her story Sandy describes situations where she recognized and sometimes even spoke out against treatment she believed to be unfair or activities that she believed were not in her best interest or were unsafe. In the following excerpts from Sandy’s interview transcripts, she shares some of her thoughts and feelings about her experiences that illuminate the existence of this differing narrative.

Basicallly I didn’t love him or feel attracted to him, I didn’t feel like having sex with him anymore and it was always my duty and that was really frustrating cause in my mind you know, are we in the dark ages?

I am becoming my mother, being totally victimized and giving her power away. I don’t want to do that and I set a boundary.

I was 12 and a half and he (the man who had befriended her at the rooming house) took me to the Stampede. And he took me to the fireworks in a car and to the lookout place in Calgary where people go there to neck or to look at fireworks. And he started tickling me and I just thought that was really weird and I said don’t do that, he wasn’t listening so I said I just want to go home. He took me home, and then another time I was at the Stampede grounds with him and we got caught in a rain shower and he was trying to tell me to take my clothes off in the car and I wouldn’t and then he tried to be shaming... you know about being in your wet clothes, you’re being a big sissy and I said I don’t care, I’m gonna stay like this. Then the lights were coming on and I knew that this is really not safe and so I cut off any contact with him

Then one day when I was trying to set a boundary because he (a boyfriend) was shaming me, he raised his fist and a voice came out of me that said you touch me
and you’re dead and I meant it. I was actually shocked at the voice, but I did mean it, no one was going to physically harm me.

He was a workaholic and substance abuser, marijuana and alcohol. So I dated him for two years and realized this is never going to go anywhere, he’s not going to change and I’ve got kids, and I want to have a meaningful relationship with somebody with my kids or not at all.

This narrative was ever present throughout the years of violence and abuse that Sandy endured, but was often overpowered by a need to survive the dangerous, exploitative, and demeaning actions perpetrated against her by partners and family members and the negative responses she met from professionals when attempting to seek help.

I hated him (husband) I just hated him and while I was in Winnipeg I literally wanted to take some money that I had been given to buy Christmas presents and take a plane home, but I didn’t.

I was walking into patterns and recreating patterns, like you know, I didn’t do substance abuse in my marriage so what do I do? I find another person just like my husband. I don’t know how to connect with people that are healthy, I don’t feel good enough. I allow people to put me down, I don’t know how to access things or at least I didn’t, I think I’ve gotten better over the years, but for the most part I always thought, everything is my fault, if I would just do this better.

A third narrative in Sandy’s story is her sense of self as a caregiver and mother figure to others.

My sister’s boyfriend called me, her fiancé, distressed and said can I talk to you and so came over and was talking to me about how troubled he was because he didn’t really want to be engaged etc etc... and I don’t know how we ended up having sex, but for me it was like I’m supposed to take care of people, I’ve
already been used I didn’t think of anything, like this isn’t appropriate or I’m betraying my sister or anything like that, just I’m supposed to be the mother for everybody.

Sandy: Here and Now

As time passed and Sandy’s responsibilities and role as a mother changed she began to experience a strengthening of the strong, caring, feminist woman narrative. She began to assert herself with abusive partners and seek out help and support for herself. She left her violent husband and moved to Victoria and maintained her boundary, denying his attempts to reconcile and his promises to change. Today she lives in a second stage supportive housing complex where she has developed healthy and supportive relationships with other women living in the building, as well as with the counselling staff. She attends a Fine Arts program at the local University and has developed an interest in Women’s Studies. Sandy describes the biggest positive change in her life today as finally feeling that she has a “support system”.

*Ok, I have a support system... I have to say that’s the best thing. I have people who believe in me, even if they are not my close family, there are people that believe in me and are working with me to see that I succeed. I’m really grateful that there is support (weeping). It’s really important because I don’t think that even with all my self care and taking care of myself, I don’t think I could have done it myself, sometimes the negative stuff can be more overpowering, if you don’t have the support systems there. I’m only one human little person, I’m not superwoman; I know I can’t do it by myself.*

Through the support of others Sandy says she has been able to recognize how she was “unknowingly caught in a cycle of abuse” which ultimately stemmed from her early
experiences of abuse and trauma. In the statements below, Sandy articulates her current understanding of how and why she got into and stayed in unhealthy relationships and situations.

*I think we learn what we live and I grew up with alcohol, in an alcoholic home, my father was an alcoholic, my stepfather was an alcoholic and I seemed to, as much as I thought I would be doing things differently, I still repeated the same patterns. I still picked somebody just like that.*

*Now I can look back and see how I was manipulated into becoming a very obedient person.*

*I don’t think I saw it years ago when I was in it, but when I look back now I think oh my God, you think you’re awake and you’re walking into patterns and recreating patterns. I just don’t know how to connect with people that are healthy, I don’t feel good enough. I allow people to put me down, I don’t know how to access things or at least I didn’t, I think I’ve gotten better over the years, but for the most part I always thought, everything is my fault, if I would just do this better.*

Sandy describes most of her past life as just trying to survive. Today, she still feels she is very emotionally and mentally fragile, but says she is now more “mindful and self-aware”. Sandy has had the realization that in the past she had been operating on auto-pilot, simply managing crisis after crisis and putting out fires. Her reality was one of confusion about self and others. What did normal and acceptable behaviour and emotions look and feel like… from a male partner… from children…. from family members… from supposed helping professionals… from herself? Despite this self identified confusion about acceptable behaviour, Sandy demonstrates throughout her story that on some level she recognized that the abuse and poor treatment was not fair or right.
Because of this recognition, Sandy continued attempts to seek help and to resist violence and abuse when she safely could.

_I had always been just in survival mode and having to deal with everybody thinking that you just want a free ride, but what I’m really doing is just trying to survive and stay in tact. I wasn’t able at that point in my life to find resources to value me. When I think about it, I went all those years without any real help for myself._

_I think for all the stages of my life where abuse happened I used to question, am I being triggered by something of my time at this age. How do I separate my triggers from reality? Especially when I sense something is not right, I mean children have lives and get affected by people out there. How do I know when an issue is something for my concern?_  

Sandy says the reason she agreed to participate in this research project and to share her story is because she wants to be able to help other women in situations similar to hers. Sandy wishes to share the following pieces of advice with other women.

_If they are in an abusive relationship, I would probably first want to give them the Transition House phone number and tell them a little bit about my own story. Let them know that through all the years of experience, programs like Transition House and Bridges (a life skills and personal development program for women) have developed in order to help women get out of abusive situations to where they feel they can be their own person. I believe that things have improved since I went through that, just the fact of coming here (second stage housing) and the counselling that is now available to me._  

_I would encourage the person to get that help and to know that there is a way to change things and it’s nothing to be ashamed of, what we have gone through. We are human and...even if you know you’ve made a mistake, there is nothing that_
says you don’t have the right to get help, you do have the right, you have the right to change things, you have the right to make mistakes. The most important part is that when you recognize them to make a change because otherwise you are just going to keep feeling pretty crappy. It’s possible to make a change.

Today Sandy uses several effective and positive techniques and tools to manage and deal with her emotional struggles, past trauma, depression and anxiety. “I use journaling, staying present in my body, reading, talking to counsellors, the art therapy, and making my own art.” Sandy believes that these healthy coping tools don’t make the “crappy feelings and memories” go away, but make managing them and moving forward easier. “Yeah, it doesn’t mean that I don’t have to go through all the crappy stuff and feel all the crappy feelings, but I can’t change what’s happened in my life, I can only learn from it.”

**Discourses in Sandy’s story**

Sandy’s personal narratives and story demonstrate integration of certain ideas from mothering discourses in particular. Within the social organization of mothering extremely high expectations are placed on mothers and the various elements of this organization influence both women’s identities and the conditions in which they perform their mothering (Lapierre, 2008). A woman’s abilities as a mother present a source of positive identity, and as a result can also be an area of vulnerability. There are numerous areas in which mother’s abilities are measured by society and subsequently by themselves. Women facing violent and abusive partners, mental illness, and substance abuse may view themselves as inadequate, deficient, negligent, abusive and non-
responsive or insecurely attached and are often viewed this way by society (child protection social workers, psychiatrists, law enforcement, etc.). Sandy’s role and responsibilities as a mother played a central role in her construction of identity and the way she made meaning of the various events and experiences of her life. From the birth of her first child Sandy was the sole caregiver in the home. Sandy’s husband did not accept any responsibility for parenting or raising their three children, with the exception of “discipline”, which came in the form of violent physical and verbal outbursts. Sandy assumed the role of primary caregiver in order to protect her children from their father. Sandy did not have a choice in taking on this role, as it was required in order to attempt to maintain safety in the home. She reached out at times to family members and community professionals for support, but often was denied, dissatisfied with the service or betrayed by family members who were negligent in their caregiving. It is unclear about Sandy’s position on whether women should serve as primary caregivers, as she had no choice, but to assume this role in her family. Throughout her experience of mothering, Sandy states that she always believed that she wasn’t “measuring up” as a mother, despite the fact that her husband was not “measuring up” or even “showing up” at all. Sandy felt the evidence of her inadequacy could be found in her children’s disruptive and unhealthy behaviour and her declining mental health. Like many women socialized in mainstay North American culture, Sandy ascribed to many of the “common sense” ideas regarding women and mothers. The concept of the “good mother”, the woman who is always available, smiling, calm, successfully managing her children, husband, and home, supportive, put together and made up with an apple pie in hand seems to be the image that Sandy measured herself against. In the context of the violence and abuse she
experienced and her responses of sadness, insecurity, self blame, and coping sporadically using substances, it seems obvious that Sandy could not possibly “measure up”. In fact, few women do. Sandy was operating from a deficit model of mothering that stems from the social discourses ascribed to regarding male perpetrated violence, sexual assault, mental illness, and substance abuse. When she reflected on herself as a mother her focus gravitated toward the things she couldn’t or didn’t do, rather than on the violence of her husband, the ways in which this violence prevented her from meeting the criteria of the “good mother” and the acts of resistance she did enact. Sandy is not alone in her tendency to peer through a deficit lens. Lapierre (2008) states that many of the practices of “helping” government and community agencies that deal with women who have experienced woman abuse, including child protection services tend to work from a deficit model of mothering, which has a propensity to pathologize abused women and their mothering (p. 457). According to Sandy, the “helpers” did not look at the complexity of Sandy’s experience of mothering to find the positive strategies she adopted in often horrific circumstances, rather the emphasis was on her ‘deficiencies’. As Lapierre (2008) argues:

There appears to be no commitment to the development of a holistic understanding of their complex experiences of mothering in these circumstances.

The emphasis is therefore on abused women’s ‘deficiencies’ and they are likely to be seen as ‘failing’ as mothers, regardless of their actions (p. 457).

With such a strong focus by others and Sandy on her deficits in mothering and as a woman it is understandable that Sandy would experience feelings of guilt and shame. Although she was victimized time and time again by family, strangers, and partners, she
somehow ends up being conceptualized as the perpetrator. Sandy’s story fits with the
work of Wade and Coates (2007) on their Interactional Discursive View of Violence,
whereby the use of language and other social responses lead to perpetrator violence being
concealed, victim’s acts of resistance suppressed, perpetrator responsibility mitigated and
victims being blaming, Throughout her story Sandy talks about feeling to blame for the
abuse and talked of numerous attempts to “improve”.

For the most part I always thought, everything is my fault, if I would just do this
better.

Sandy describes herself as a “caretaker” to others. In her story she describes how on
occasion she put the needs of others before her own or others in order to be competent in
the caretaking role. Sandy’s self identified role as the caretaker illuminates the socially
constructed gender roles challenged by feminist theorists like Weedon, Gergen, Morrow,
and others. These constructs result in women being viewed socially as nurturing, gentle,
and highly relational and oriented to others and posit that a woman’s construction of self
occurs through connection with others, mainly family and children (Weedon, 1987).
Sandy says the following about her role as a caretaker:

For me it was like I’m supposed to take care of people, I’ve already been used I
didn’t think of anything, like this isn’t appropriate or I’m betraying my sister or
anything like that, just I’m supposed to be the mother for everybody.

Throughout Sandy’s story she demonstrated that she had constructed her
narratives about self based on her beliefs in the quality of mother/caregiver and woman
she was. To Sandy being a good mother amounted to being a good woman, and vice
versa. Sandy saw herself as a failure in both of these areas. Sandy measured herself in the areas of womanhood and motherhood based on the socially accepted “common sense” qualities related to women and mothers, such as the female qualities of gentle, nurturing, relational, and caregiving. She judged herself based on standards such as the tenets of “intensive mothering”. Just as Sandy ascribed to some of the traditional constructions regarding women, she also accepted or ignored some harmful or disrespectful behavior from men in her life, believing them to be “typical” male traits. Sandy explained the behavior of a male peer who sexually assaulted her as, “like a lot of adolescent males who had no concept of yes and no and what it means, especially in those days, I don’t think people were as aware.” This statement speaks to a social construction of women/girls as objects, which men are entitled to. It amounts to socially-condoned sexualized violence against women and girls.

Discussion

During the recruitment process Sandy sought me out after I had spoken about my research at a morning coffee gathering in her apartment building. She approached me quietly with a soft and saddened expression on her face and in her tone of voice, but an intent interest and a stated desire to tell her story by participating in this research. Throughout the two interview sessions, Sandy’s tone remained generally solemn; she used little humor, and wept often as she spoke about her past. Her tone and affect seemed to clearly match her described sense of self as a weak, damaged, and un-loveable person. Sandy began the telling of her story by stating that her mother believed all of her children were mistakes and punishments. I believe that the choice to begin her story in this way
provides evidence and credibility, from Sandy’s point of view, to her personal narrative as a born victim and worthless woman. Like Daisy, throughout the interviews it appeared to be quite painful, but also empowering for Sandy to share her story. Sandy seemed to be experiencing some sense of relief and satisfaction by having a captive and non-judgmental audience.

The following themes and core descriptions were identified in Sandy’s story: self as a mistake, burden, not good enough, to blame for violence and abuse, patterns and intergenerational cycles, mothering discourses, social expectations based in gender, mother blaming/deficit focused, justice, perseverance, resistance, and negative social responses.

**Breaking Intergenerational Patterns of Trauma and Abuse**

In the telling of her story Sandy provides what she feels is a demonstration of the concept of intergenerational transmission of trauma and abuse. As she sat in her apartment safely reflecting with me about her past experiences with abuse, substance abuse and mental illness, Sandy connected many dots and expressed her belief in the potency of the creation and re-creation of dysfunctional patterns in family systems.

*I think we learn what we live and I grew up with alcohol, in an alcoholic home, my father was an alcoholic, my stepfather was an alcoholic and I seemed to, as much as I thought I would be doing things differently, I still repeated the same patterns.*
In the above statement, Sandy discussed how she feels that she reenacted patterns within herself and her life. She also spoke during the interviews about those patterns surfacing in the lives of other family members, namely her sister and later her daughter.

*I see that pattern repeated in my sister, my oldest sister, as well, even more so. The violence in the home with my stepfather, she eventually, after being with two men that were dealers, her third partner was very violent and sexually abusing her children and I think he was also known by the police as being a rapist and possible murderer. So she brought the same kind of energy and repeated in her own family life. I’m just seeing in my daughter the same patterns of her father and socially needing to drink and she has gone through periods in her life of excessive drinking, and excessive drinking partners. She has had three abortions, she said because she was worried they would have FAS.*

At one point in Sandy’s life she recollected having a moment of clarity about the patterns she was a part of and then made a commitment to change. “I am becoming my mother, being totally victimized and giving my power away.” Sandy saw the pattern and she committed to changing it. Although her story speaks to the power of how violence and abuse can resurface in the lives of individuals who witness or experience it as children, it also demonstrates the agency that individuals, like Sandy, have in changing or breaking these patterns. I am curious about how Sandy came to the conclusion that she was in a pattern. Was it a realization of hers or was it imposed by one of the many professionals she engaged with? Although Sandy says she felt as though she was powerless to change within the immense strength of those patterns, she did.
Personal Narratives

Similar to Daisy, Sandy appears to have had two dominant scripts at play throughout her story as she shared it with me. In response to years of neglect, abuse, degradation and violence Sandy came to view herself as a mistake, a burden, weak, naïve, and to blame for the circumstances of her life. Sandy believes that this narrative placed her in situations where she faced further risks of violence and mistreatment and was responsible for her role and place in “re-creating patterns”. However, while this narrative remained dominant in her story and seemed to gain strength with each incident of abuse, Sandy had a second dominant narrative. As she faced numerous abusers and negative social responses from family and professionals, this second narrative seemed to encourage her to recognize the harmful patterns and resist complete acceptance that her life could never change. Even if this was only a cognitive process, without action, it was her narrative of self as the strong, caring, feminist woman and mother, oriented to justice and change that empowered her to continue moving forward to eventual safety and improving health.

Service Provision and Social Responses

Like Daisy, Sandy’s story illuminates some areas where her interactions and experiences with service providers, particularly in the area of mental health and social services, were both harmful and helpful. Sandy stated that the main barrier for her in choosing not to access help at times was a realized fear of being judged, shamed, and blamed for the abuse she was coping with. These experiences as well as the ongoing forms of violence and abuse perpetrated against her empowered her narrative of self as
weak, to blame, and powerless. The messages received clearly by Sandy from many “helping” professionals like mental health practitioners, social workers, and counsellors were things such as, reconciliation with her abusive partner would be in her family’s best interest and that talking about her past was counterproductive to her present and future health and healing. Scattered amidst these messages were a few “helpers” who suggested opposing views, but those experiences were far fewer. Similar to the experience of Daisy, Sandy was seeking help from systems that at that time were not operating from a trauma informed framework (Elliot et al., 2005, Ko, Ford, Kassam-Adam., Berkowitz, Wilson, Wong, Brymer & Layne, 2008), as well as a time when woman abuse was less recognized and acknowledged as a form of abuse and a social and health problem that required intervention. In addition, professionals and other individuals delivering such messages to Sandy were engaging the Interactional Discursive View of Violence (Wade and Coates, 2007), using language and other social responses resulting in the concealing of perpetrator violence, suppression of victim’s acts of resistance, mitigation of perpetrator responsibility and victim blaming. Sandy talked often about feeling as though she were “stuck in a pattern of dysfunction” that she had inherited as a result of intergenerational transmission. I am curious about whether this idea is Sandy’s alone, or if it had been suggested to her by professionals. The problematic nature of this kind of a model is that, while it may have some weight in that children can learn to perpetrate violence or to normalize it based on their experiences in childhood, it is deterministic and dilutes a woman’s, or any victim’s, acts of resistance and agency. This idea can result in making victims feel powerless and further victimized.
When Sandy discussed the support she did receive in her family she expressed feeling a sense that service providers, while well intentioned, were missing the mark with her family. She demonstrated much awareness when she spoke about her unique “family system”, and how she thought that the support and approaches suggested were very universal and behavioural in regards to managing and supporting her children, rather than family systems oriented.

*I felt there was some help, but I just never felt there was anything that really hit the nail on the head about how to deal with the dynamics that happened between the parent and the child, through the dysfunction that was created in the marriage in the first place. Like she (daughter), her being hit and him being really very violent with her. How the dynamics of each individual gets set up by that system and how I didn’t feel they gave me tools to be empowered. I just felt that they were saying that you need to change something, but no understanding of what that means.*

Sandy was seeking support from someone or some agency that would take the time to develop a non-judgmental relationship with her and her children and through that process, hear their stories and make an effort to understand what it meant to them and to help evaluate how the dynamics of those stories were playing out individually and within the family at that time. Sandy was able to articulate and reflect on this during the interview process, but at the time says she was unable to ask directly for what she needed because of the precarious and tumultuous context that she and her children were living within.

*I had always been just in survival mode and having to deal with everybody thinking that you just want a free ride, but what I’m really doing is just trying to survive and stay in tact and I wasn’t at that point in my life yet where I was able*
to find resources to value me, when I think about it I went all those years without support or help, I was just trying to survive and didn’t have a support system or anyone to believe in me.

Sandy’s story illuminates the difficulties of a mother with a complex life whose attempts at receiving support failed for so many years because the options she had available to her seemed to Sandy to deal only with individual issues, rather than the larger more complex, multilayered and intersecting matter of her concurrent issues. While substance abuse was not a serious issue for Sandy she believes that a woman dealing with concurrent issues should deal with the substance abuse first. “I don’t think you can do the rest without that one (substance abuse) that would have to be really important because you want that person to be able to utilize the gifts, the tools to be able to move forward, but you have to get that one under control first”. Sandy also recalled that it wasn’t until she was removed from the abusive relationships that she could accept support and begin to deal with any of her individual challenges, so perhaps safety and freedom from violence and abuse must come first. Today Sandy is still working her way through some of her past painful and traumatic memories and changing her thoughts and behaviours to better support her health and healing. She states that she has both good and bad days and she has gained several effective tools to cope with and manage the tough stuff.

Yeah, it doesn’t mean that I don’t have to go through all the crappy stuff and feel all the crappy feelings, but I can’t change what has happened in my life, I can only learn from it. You can only change the choices you make now about how you want to move on or which direction you want to move in.
Marla’s Story: Life in a Warzone

Marla, an eighty-one, year old women, participated in this research with both excitement and trepidation. Today, Marla lives alone in a modest apartment where she enjoys freedom and peace for the first time in her life. Marla expresses a keen interest in fashion and design and takes pride in her appearance. Each time I visited her home to conduct the interviews Marla was well dressed and made-up. Marla is a painter, musician, and novice reiki practitioner. While Marla maintains a fairly isolated lifestyle and does not leave her home often, she described a number of friends of all ages who she entertains regularly for tea and/or reiki sessions in her apartment.

Marla was born and raised in Holland and during the interviews recalled her childhood years in Nazi occupied Amsterdam. Married at the age of twenty, Marla did not complete school, and in 1960 immigrated to Canada with her husband and two children, ages 12 and 6. Marla is unique from the other two mothers in this project because of her age, history and status as an immigrant, the traumatic social and political climate of much of her life, the large focus of her story on mental illness, and the challenges of conducting the interviews and Marla’s response to participating in this research. Like the stories of Daisy and Sandy, Marla’s story illuminates the tensions between discourses related to mothering, feminism, violence, abuse and mental illness, and how those tensions affect the scripts mother’s construct about self, as well as how and why they engage in services the way they do. Marla’s story provides somewhat of a contrast to the other two stories, yet the richness and value of her story adds to a developing understanding of some of the ways in which mothers can make meaning out
of their unique life experiences within their complex cultural, social, political, familial, emotional, psychological and social worlds.

Marla described much of her story as one of being controlled and contained. She grew up in an environment where she felt she was under nearly constant surveillance. Marla was the only child of upper class Dutch parents; her father a university professor, and her mother a homemaker with a significant inheritance.

It was never talked about, money. My father had a good salary, but actually the big money came from my mother’s parents, they died very young. When I think back to lifestyle, there was never lack of money. My father had long vacations, so we went always to Europe, it must have cost a lot of money, but we never talked about it.

Despite the comfortable lifestyle that Marla’s family enjoyed, the political and social climate of Holland during Marla’s childhood years created an environment of stress, trauma, and fear in her home, community, and herself. Marla was 12 years old when the Second World War began and in the interviews recalled her experience of feeling constantly monitored and described always having to live carefully and in fear of the Nazi soldiers that occupied the city she lived in.

During the war it was already so difficult to appease the Germans, when we made a mistake you could be hauled off to a concentration camp.

Marla explains that she believes her family to have been much luckier than many other Dutch families during the war because of their financial situation.

All the Dutch people suffered and we were lucky that my parents had money to feed us. They were shot down with low flying airplanes when they went out into the field to look for food. The Germans didn’t like that.
Marriage and Family: Warzones

At the age of twenty, Marla was married to Harvey who was eight years her senior. Although her father was opposed to the marriage, Marla says she didn’t mind entirely because it meant she could stop attending school, one of her least favourite activities as a girl.

I remember my father was not happy about it, for we have in Holland, you call that under marriage, you are listed on the paper officially and it is usually fourteen days before you get married, then we got coupons when you get registered. I was under married for more than a year and then you have to renew it again, but officially, for then you are officially named and then everybody can object to it or comment on it. My father said I am afraid, I am not happy about it. I think that when you are under married you will get married and he wanted me to go back to school, because from under marriage comes marriage, that’s the idea. My husband was absolutely determined to marry me, I had no say in it, but I was happy not to go to school anymore.

After several years of marriage, and the birth of her two children, Marla and Harvey immigrated to Montreal, Quebec. The transition from growing up in a Nazi occupied country to life with her abusive husband in Canada was not that distinctive to Marla. She described Harvey as a strict, harsh, and controlling man by nature. “My husband was half German, he did not believe in the war, but he had that discipline in his blood. Actually if you think about it, it’s really funny. So he didn’t believe in the war, but still that instinct was there”. Marla was made to feel that she was never good enough in Harvey’s eyes and felt she was continuously walking on eggshells with him. “I don’t have a recollection of really when the abuse started, but I was never good enough, I did everything wrong, it was always my fault, but not physically it was never physically, but mental”. Although
Harvey was trained as a professional architect, he rarely managed to hold down one job for any significant amount of time. Marla was not permitted by her husband to work, so was dependent on his ability to obtain and maintain employment.

_He has a knack for never making very much money. He was very good in his profession as an architect, but he never had a knack for making money. That was very trying and he never wanted me to work, so I never worked a day in my life only volunteering I was allowed. So I was not allowed to make any money and it was very difficult for we were very poor, no money at all, that was really a challenge for I’m not raised that way at all and you have to keep up the appearances, parents aren’t allowed to know and all the friends._

Marla described how she was isolated by Harvey from family and friends. In the earlier years when Marla would invite friends over to their home they would always leave with the impression that they had done something to offend Harvey because of his subtle, but controlling behaviours. “I could never make friends. They were always sure that they did it, for my husband would be in the room and then he would leave upstairs so the friends thought that they did something wrong. One by one, isolation, no friends”.

Harvey’s controlling behaviour affected their two children as well as Marla. The children were afraid of their father and did all they could to spend time out of the home with peers. This left Marla alone with Harvey much of the time and created further isolation for her.

_When I am home, you are not safe anymore, anything can happen, he can be very furious with the children, actually he loved his children very much, but very strict. In Canada the young people are way freer than in Holland and in Holland we didn’t even have a fridge, so Harvey would make rope around the fridge, the children were not allowed to get into the fridge, children were not allowed to have_
friends in, that was not allowed. So children usually went to friends, so I was faced with Harvey alone. That was a big challenge to be with him. To please him, to make no noise, to cater to him, to look into his eyes to see if he approved, that was the life.

Marla’s husband did allow her to have volunteer jobs in the community, but closely monitored what the jobs were and what hours she could volunteer. The volunteer jobs were fondly recalled by Marla during the interviews, as they were the only opportunities she had to socialize with people outside of her family and to escape the isolation, even if only for a few hours. “At the volunteer jobs I had contact with other people and that was nice, for when Harvey was home I had to be there, always, so there was no way out. So when he was working, that was helpful, working hours I could see people; that was the only time”.

**Mental Health and Substance Abuse**

Marla’s story does not include any substance abuse, but does highlight much mental and emotional stress and suffering. Through the interviews Marla spoke about several types of mental illness she believes she is or has been afflicted with including depression, anxiety, agoraphobia and post traumatic stress disorder.

Marla believes that her mental illness may have been set off by the escalating level of isolation she was exposed to with Harvey within the larger context of a lifetime of control, fear, and trauma resulting from growing up during the war.

_We came to Montreal in 1960 and from there on the mental illness started really bad for I remember vaguely that I couldn’t listen to noise and I was even disturbed when the birds were singing and that is a fantastic noise, a beautiful_
sound. And my mother made the observation that you must really be sick when you can’t tolerate the singing of the birds and it went way worse, I was totally isolated, but that was... I don’t even remember the year.

Marla recalls living in Quebec and described the personal affects she experienced during October 1970 when the War Measures Act was enacted by Prime Minister Pierre Trudeau in Montreal. The invocation of the act resulted in widespread deployment of Canadian Forces troops throughout Quebec, and in Ottawa gave the appearance that martial law had been imposed, although the military remained in a support role to the civil authorities of Quebec. Marla says that she experienced a “re-traumatisation” at this time. The martial law atmosphere in Montreal at this time in collaboration with Harvey’s mental abuse and isolation contributed to a worsening of Marla’s mental health.

I don’t remember much of it, but we had martial law in Quebec, so probably the war came back really close to home and that triggered it. I had an herb man who handled herbs and he actually told me that it was the circumstances with the politics, when we had the martial law with Trudeau. And he said it is very sad that that coincides with your feelings of the mental illness, you need to see a psychiatrist for I don’t have strong enough medication.

Marla sought support for her mental illness and was prescribed numerous medications over the years that she lived in Montreal, then Calgary and finally Victoria. “The doctor suggested I see a psychiatrist. That was totally useless, I had seventeen of them. They just experimented and nothing worked, I never got well I only got worse and worse. So I was sent to another one and then another one…”.

Marla experienced increasing feelings of “mental distress” for most of her marriage with Harvey, at times leaving her quite debilitated. However, she noticed that
the one and only time that he went away for a significant amount of time that her symptoms seemed to lessen.

Oh and I had one incident when Harvey wanted to go to Holland to celebrate his father’s 80th birthday and we didn’t have enough money and I was very mental ill, very depressed and I said no we don’t have money. I was really scared being alone, I thought I couldn’t function alone, Harvey did everything and guess what, I was totally fine. I was not mentally ill anymore. I went back to the psychiatrist and asked how can that be? And he said you don’t understand that, I had no clue, think about it, he said you were by yourself. It never sank in. So he must of seen something, I was on my own, I was not sick. And as soon as Harvey came back again, boom, mental ill again. So I needed the freedom.

Marla received support for her mental illness from an outreach psychiatric nurse, who she liked very much and whose services she found helpful.

I had a psychiatric nurse, Bianca, she was Spanish, and I asked her how could she help me? Well I take only people I know I can help. She was very helpful, she was very happy that I moved to Calgary and she said don’t tell anybody, not to go into the hospital. She was very practical, she saw that I was very isolated with Harvey and she took me out for lunch, she said you have to go out.

The links between Marla’s historical trauma, abuse from her husband, and mental health were not directly addressed until many years later when she finally left her marriage and sought services from a transition house. Over the years individual professionals seemed to take notice of the connections, but services at this time seemed to be very fractured addressing each individual issue, not the intersections. “She (Bianca) never spoke about abuse, for she was a psychiatric nurse, for she was not trained in relationships, and I was very naïve so who knows what she saw”. When Marla and Harvey moved to Victoria her
new doctor removed her from all medications. “I had a long time of very heavy medication, for we were not divorced at all in 1984. When I came to Victoria the doctor took me off, he said you have 26 years of medication, I will take you off, completely off”.

**The War is Over**

In 1996, after fifty years of an abusive and isolating husband and much mental and emotional suffering Marla divorced Harvey.

*Marrying Harvey was the wrong choice, but I never regretted it, because that was done. Why I waited fifty years, but that was the upbringing, for once married you never get out. I was almost killed so that made me leave and run away, that was the reason. He had to reveal the money situation, he didn’t like that.*

In order to just escape any further involvement with Harvey, and based on the advice of a lawyer, Marla chose not to fight for any money. Marla did not receive any settlement from the divorce, not even that which she had inherited from her parent’s estate in Holland.

*The inheritance, I lost it all totally. I had the lawyer in Transition House who did everything for free, he was so impressed with my case, he was so helpful. He told me it is a big mess when you go after the money and I didn’t want to go after the money. I was lucky I was seventy years old, so I got all the help from the government. For I thought in my feeble brain that I would end up in the street, but the counsellor said no. So I was there seven weeks instead of thirty days and they found this apartment here, so they delivered me totally. And I got the income supplement and I have a little Dutch pension, so I can do very well.*
Marla uses the real experience and metaphor of war throughout her story and shared several times a very impactful statement made to her by her brother in law when her marriage had finally ended.

\begin{quote}
And when I went to the shelter that was in 1996, my brother in law said on the phone, Marla, do you hear me the war is over. Isn’t that striking? So he knew what was going on, he said do you realize, do you hear me, the war is over. That was in 1996 and the war was over in 1945.
\end{quote}

Although she was technically free from Harvey’s abuse and life in a warzone, she said she was unable to move forward. “There used to be a movie with Elizabeth Taylor, I think it was called The Sandpiper. That was about that the cage was open, but they didn’t go out. So I was in a cage with Harvey and now the cage is open and I am too scared to go out”. Today Marla lives freely in her Victoria apartment and has noticed that her mental health seems to fluctuate between times where she feels quite well and others where depression and anxiety seem to overtake her. Marla questions what of her mental illness is due to “chemical imbalance” and what results from a life in warzones.

\begin{quote}
He (brother in law) said Marla do you realize the war is over? But then it doesn’t make sense that now I am free, I should be enjoying going out. It is still in the system and I don’t know if the mental illness is related to that, it must have been a big part of that, but still I know it is a chemical imbalance.
\end{quote}

Marla believes that she currently suffers from Agoraphobia.

\begin{quote}
I know now what it is, I have agoraphobia, I can’t go out, very debilitating. I love to go out, I still long to go out, it is part of my mental illness, this time I am working on it. I am not there yet. I had big difficulties, a little while ago I had counselling for it and they said everyday I have to get out the door to the mailbox
\end{quote}
and to the front door and back. I didn’t do it today. Sometimes I just can’t, I can’t.
I force myself to go to the little Chinese corner store. I am very proud that I did it,
but that is a big hampering. It is stupid, for I am so happy the war is over, that I
can go wherever I want, for all the Dutch people were afraid to go out, maybe it
started there, I have no clue when it started. That’s what the doctor discovered,
but he never knew about it, when I moved to Victoria that was very slightly
known, about ten years or something, so it was never recognized, never
diagnosed, but it has a name, Agoraphobia, and I have that big time.

At the time of the interviews Marla was experiencing a “healthy” phase in her mental
health, experiencing her usual anxiety and fear in regards to leaving her home, but stable
moods and little to no sadness. During the interviews she expressed some fear that her
participation would trigger her mental illness, as it had during an experience she had
when she was interviewed for a story with the local newspaper about violence against
women. Despite her worries about being triggered she continued her willingness to
engage in the interview process. Marla described the oddity she found in the way in
which her mental illness seemed to manifest itself in her experience.

_\textit{I can hide it very well, but inside I’m suffering with the sadness, it is a terrible
feeling. It is a funny illness, when I have it I can’t imagine not having it and when
I don’t have it I can’t imagine having it again, it is a very funny feeling. I can’t
visualise that I could have it again, I am absolutely fine now. I hope that this is it
and I have the right medication now and that I can get off the medication soon.}_

\textbf{Children/Mothering}

Marla spoke very little about her two children during the interviews except to say that
they both “escaped very soon. My son could not handle that I was depressed, he hates
that so much so he left home when he was sixteen”. Marla’s daughter also left the family
as soon as she could, at the age of eighteen. With the children staying out of the home as often as they could and eventually leaving as teenagers or very young adults, Marla felt further isolated.

*I felt devastated, so alone, the children left, they couldn’t stand the tension in the house. Harvey was so strict and my son hated the depression so much, so he stayed with a friend and never came home and my daughter got out when she was nineteen. I felt so alone, so how old was I, I think I was 40, so from then I felt so alone, I felt actually betrayed that my children left, because they couldn’t stand it anymore.*

She describes her current relationship with her son and his family as very strong today. “He is now married, and his wife already had two children and he really loves those children. So my son turned out absolutely perfect (laughs)... nobody is perfect”. Marla’s daughter struggled in the past with “street drugs” and was later diagnosed with Bipolar Disorder. “That is still a very big challenge, but I love her so much. I don’t hear from her that much, but I honour that and I wait until she is ready and she means so well when she talks to me on the phone, she pretends that I am the best mother that ever lived on earth”.

**Personal Narratives**

Marla welcomed me graciously into her home to conduct the interviews for this research. Always fashionably dressed, made up and offering tea and cookies, Marla spoke in an animated and often enthusiastic tone. Her story seemed to focus on three primary themes consistently: the war metaphor, the large role that her mental illness seemed to play in her entire life to date and self as a “con artist”, or as if she were playing a role
throughout her life. These themes seem to be the biggest contributors to Marla’s sense of identity as she has constructed and shared it in this research.

A Victim of a Lifetime of War

Marla sees herself as affected for life by the experience of being a girl in Nazi occupied Holland. Throughout her story she speaks about being regularly triggered by other life experiences such as the abuse of her husband and the martial law experience in Montreal in 1970. Marla shared a theory that her niece had about her mental health that appears to feel somewhat accurate to Marla.

And do you know what my niece says, she tells me, Aunt Marla you are frozen in time, you are still a child. You are frozen when you turned 12 when the war started. You are still 12 and you need post traumatic stress disorder help. But I don’t feel I am frozen. With the Reiki family I learn so much, many new things. But indeed that was a traumatic thing, I was 12 and 19 when the war ended, so that’s lost years and I got married when I was 20. So that was not a good thing. I needed the freedom… from one war to another. Now I understand what my brother in law said, do you realize that you are free… never realized it, maybe, still not.

A victim of a lifetime of war, Marla believes she has been damaged in such a way that even when she was truly free she could not access and enjoy her freedom.

But then it doesn’t make sense that now I am free, I should be enjoying going out. There used to be a movie with Elizabeth Taylor, I think it was called The Sandpiper that the cage was open, but they didn’t go out. So I was in a cage with Harvey and now the cage is open and I am too scared to go out. Maybe it developed like that, but I still have that, that is hampering my freedom, but I went
out on Tuesday, I am very proud when I do it. But I celebrate when I don’t have to go out… I find an excuse not to go out. So when I have to go out, I can go out, but when I stay in too long then it is absolutely a challenge.

Accompanying this script of self as a victim of war appears to be hints of a script about herself where she lacks in personal power and capacity. Marla believes now that for many years she had little to no power or control over her own life as a result of the circumstances in which she lived. She does, however provide a few clues throughout her interviews that she may see herself in a negative light and in some ways to blame for her victim role. Quotes such as the following are suggestive of this type of script:

... I was very naïve, so I never questioned anything.

She (daughter) pretends that I am the best mother that ever lived on earth.

... and I thought in my feeble brain.

These statements provide some clues in regards to a self blaming script, but are not significant enough to be expanded further. A larger culprit warranting blame for her past and present challenges, according to Marla, is mental illness.

**A Mentally Ill Woman and Mother**

Related to the self concept as a victim of war, mental illness appears to also play a large role in Marla’s identity. Throughout her story, she seems to question the root of her mental illness, initially believing it to be the result of years of being controlled, living in fear within different types of warzones, but later questioning this theory and seeing it as
possibly something natural to her individual genetic and psychiatric make-up, a
“chemical imbalance”.

It is actually puzzling because I have now the freedom and I managed to get the
mental illness again, that doesn’t make sense. But at that time I was totally fine,
so that’s when I thought the restriction, at first the war and then with Harvey, that
did it, but I don’t have any restrictions now, so that is still puzzling to me, it
doesn’t make sense?

Despite there being periods throughout Marla’s life where she thought her mental illness
was less prevalent and impactful on her life, she believes it was always still just below the
surface.

To be totally honest now that I have the mental illness back now, I see it has
nothing to do with my ex husband. I would like to blame Harvey, but he is
absolutely not in the picture and I do it now on my own. Or then we would ask is
it a reflection of what had happened before, it had triggered? I don’t think so, I’m
not aware of if it triggered something and then it started again. Not consciously I
can’t put my finger on it. It could be that a trigger point came up for me again
and I am absolutely not aware. Maybe I dreamt about something, for I have no
recollection how it started. Although now that I succumbed to medication again it
is feeling a bit better and the books are very helpful. My instinct is always to get
over it. I want to have a good life with more fun.

Marla made many attempts to rid herself of the illness, but never felt she could
successfully move past it. “So she (another woman in her crisis group) learned how to get
over it, but I never really got over it”. Marla currently remains unclear about the root
cause of her mental illness. She continues to live in fear of its probable return and
subsequent disruption to her life, but actively seeks out ways to avoid this.
A “Con Artist”

Another theme that came up as an extension of the mentally ill woman script was the belief in self as a “con artist”, always putting on a façade and covering up her true situation; be it financial, physical, mental or emotional.

Covering up, yes, because that was in the marriage. I think the most dreadful thing for me was being without money, I wasn’t raised that way. I never talked about it, but then I was thrown in the situation there was no money, so I had to deal with it, so I just pretend that I didn’t show anything with discomfort. I had to cook, I have to get very inventive with the leftovers. My son is still talking about it, you have to make a cookbook. So I made the best, so that is actually covering up.

Part of covering up to Marla was acceptance of the idea that “family matters” were private and to be kept silent from the outside world. It felt important to Marla in the past that outsiders looking in to her family would be met with a vision of organization, financial security, and health. “Don’t talk about it. So reluctantly, we don’t talk about it, we like to forget about it, but it has an influence now I see it must have had an influence on my mental illness and my health”. On one occasion while seeking help for her mental health Marla was advised that upon moving to a new city that she not tell anyone about her illness. Marla shared a belief that talking about her mental illness would make it worse and that putting forth a healthy and safe façade could lessen the symptoms and suffering.

She suggested that when I move out, and we moved out from Montreal to Calgary, and she said it’s a very good move and I wasn’t allowed to tell anybody that I had a mental illness. For the people kept it going, they would ask how is your panic attacks, how is your depression? So I was obliged to explain it all the time, so you
stay in that situation, instead when you don’t talk about it and you don’t tell anybody, then nobody will know because you are just as well as anybody else.

“Covering up”; putting on a healthy disguise and always being ready for danger became a way of life for Marla, so much so that even after she was free and need not cover up any more she still did.

At the shelter I went to the extreme. I would go to bed and I get up 2 o’clock in case there was somebody at the door. Then I have to be dressed. I have to be totally presentable. See I go totally. I had to promise the counsellor that I would stay in bed the normal time, so you see that is always covering up being ready, maybe that is left over from the war, being ready that you had to flee at any moment.

Through Marla’s interviews she demonstrated a commitment to the discourse that mental health manifests itself visually in a stereotypical way. For example, she describes individuals she met in support groups in particular ways and as different from how she described herself. Despite the degree of crisis Marla was in physically or emotionally, she says that she always did her best to cover it up, or play the role of someone who appeared mentally healthy, while in the company of others.

They asked to gather at a certain address and I’m always nicely dressed and I can just act normal and the group was furious, she doesn’t belong here. They were very critical. But the leader said no she does belong here, for we have been surveyed and I answered all the questions, and I qualified. And I had so called treatment. There was also a young girl there who was in an automobile accident. She got it from there, she was so scared to go out, but it was an incident, an accident, so she learned how to get over it, for it was different reason, but I never really got over it. When I was at the crisis group, I was totally dressed and all the
In Marla’s story her mental illness seems to be conceptualized by her as a large and powerful entity that likely resulted from her childhood experiences during the war and was exacerbated by the abuse of her ex-husband. Mental illness has wreaked havoc on Marla throughout her life, with her believing she had little to no control over its presence and power. Despite the grandiose power that she believed that mental illness had over her life, Marla has yet to give up her quest to understand and gain power over it. Marla says, “my instinct is always to get over it. I want to have a good life with more fun”.

**Discourses**

Like the stories of the other two women in this research, Marla’s story has been influenced by sometimes competing discourses. Marla’s story is unique from the other two women in that she focused her story less on her children and role as a mother than the others. Marla presented her story in this research with a heavy focus on her mental illness and trauma and the effects of these on her understanding of self and life experience. Marla spoke of her children and their dislike of being in the abusive family home and her son’s hatred of the depression, stating that “the children left as soon as they could”. Marla experienced feeling betrayed by her children for leaving her behind. “I felt so alone, so how old was I, I think I was 40, so from then I felt so alone, I felt actually betrayed that my children left, because they couldn’t stand it anymore”. Unlike both Daisy and Sandy, Marla did not present a narrative of being a “good” or “bad” mother as a factor in her presentation. Except on one occasion Marla hints that she may be judging...
her self as a mother in a negative light when she spoke of how she believes she is perceived by her daughter today. “She (daughter) pretends that I am the best mother that ever lived on earth”. It could appear at times in her story that Marla sees herself in a child-like role (i.e.: feeling betrayed by her children for their seeking safety, theory that she is frozen at the age of 12 when the war began).

Marla states that she stayed in her relationship with Harvey for as long as she did because “that was the upbringing, for once married you never get out”. Marla identified a belief that she held in her younger life that it was socially unacceptable to leave a marriage and that it was important for a wife to put on her best face and pretend that everything was happy, prosperous, and healthy. “I just pretend that I didn’t show anything with discomfort”. Acceptance and practice of this idea of creating this façade demonstrates integration of some of the tenets of mothering discourse, as well as those discourses that assume particular roles and characteristics as innately based on gender. The concept of a “good” woman within these discourses is enmeshed within the constructions of the terms ‘mother’, ‘wife’ and particular definitions of ‘family’.

Marla’s story demonstrates beliefs and values that are both obliging and contrary to some discourses that identify particular characteristics unique to gender. According to Morell (1993), ideologies stemming from mothering discourses polarize men and women into two distinct categories, with motherhood and particular relational and social characteristics as central defining features of ‘women’. In her work, Weedon (1987) points out some of the particular characteristics that have been assigned to gender and become a part of a “common sense discourse” that play central roles in maintaining the centrality of gender differences in our society. As seen in the cases of the mothers in this
study these discourses can deeply influence the narratives and construction of self of 
women in western society. Based on her beliefs in her earlier life about the role of the 
woman and wife in a family and the commitment to marriage that Marla believed had to 
be honoured, no matter what the situation, demonstrates an acceptance of elements of 
gendered discourse. On the contrary, while Marla recognized the social expectations 
present during the time in regards to gender when it came to the rearing of her son and 
daughter, Marla’s views were somewhat progressive.

_I had a son he wanted to experiment and play with dolls, but I was told you can’t 
do that, for he will turn out gay. My daughter never wanted to play with dolls, she 
never looked in carriages, but my son every time he looked in carriages. He loved 
babies and played also with little cars and trains, but I never forbid him to play 
with dolls._

In some ways Marla’s story stands in contrast to those of Daisy and Sandy, and highlights 
differing tensions and challenges that exist when living with violence, abuse and mental 
ilness and trying to access the most useful help. Elements from discourses surrounding 
women and mothers from both mothering and feminist literature are evident in Marla’s 
story, although discourses of mental illness, trauma, silence/family privacy also seem to 
play key roles. Throughout the presentation of her story Marla spoke often of the role that 
trauma and life in a “warzone” played in her life, as well as mental illness. She seems 
today to remain ambivalent about the connection between these two forces, at times 
stating a belief that the mental illness is an effect of the trauma, while others flirting with 
the idea that it is biological and presupposes the other. Either way, Marla does seem to 
see herself as a product of war, abuse, and trauma, which results in a prevailing victim 
discourse throughout her story. She demonstrates little integration of discourses
surrounding the “good mother or woman” and presents herself as somewhat child-like when she slips into discourses surrounding betrayal and being powerless under the control and monitoring of others.

**A New Script Emerges: The Healer**

Today Marla feels mostly content in her small apartment where she rarely goes out, but entertains numerous friends and Reiki clients. “I don’t come across as a poor lady, no, I feel rich, I am not rich, but I have absolutely everything that I want”. She shared many of the reflections and changed patterns of thinking that she has realized and put into practice. Today, Marla presents an evolving and in some ways novel script. This script deviates somewhat from the script of self as a victim of war and trauma, as well as mental illness continue to play a central role in her story and she continues to grapple with the root cause of her illness.

Eventually you start believing it, for when you are called names, you start doubting, am I that way? For I am reading now that we are already programmed that we are no good, from Louisa Hay, because we heard it over and over again and we have to reprogram the brain and reprogram the tapes that are going in

Marla spends most of her time reflecting on her life, reading self help books, and talking with her friends and clients. She now believes that there are many connections within her story that began as a little girl in Nazi occupied Holland. Scripts about mental illness and the value of covering up are still present for Marla today. As she spoke about numerous topics “mental illness” was almost always raised, as a major entity in her life. At times it seems be conceptualized by Marla as an externalized entity, replacing the war and her ex
husband, that continues to victimize and control her. However, today Marla seems to have waged her own war against mental illness, resisting and fighting back.

My instinct is always to get over it. I want to have a good life with more fun. I just have to get more out, but that has nothing to do with money, it is part of the mental illness. Originally the doctor said I had two things to work on and the agoraphobia that was different, so he was right and it came out way later, it is an official flaw and actually I should pay more attention to that or with more friends it will automatically dissolve itself; if I go out more. The more I go out, the better it is. I know that.

Marla is proud of the work she continues to do to battle her mental illness and discover a life of true freedom, where she controls her journey. “Yes I am working on it, absolutely. It is a lifelong journey, for everybody has a different journey, besides war and other things to contend with, everyone has their own battle or journey or things to overcome. We do that in our own way”. Marla has an interest in social change. She believes a re-education for girls is in order. “We have to start with the daughters because they are programmed by the mothers. We never think about that, maybe the mothers have a task to reinforce the little girls that they are worth a lot and that they are proud of the girls”. The lack of social change today bothers Marla and she spoke a great deal about her beliefs about the status and power of women in current Canadian society.

One thing that I am suffering from is that not much has changed for a lot of women. I want to see big drastic changes in how we can get that. Nothing is happening, not much improvement. We have to start at the beginning with the girls, educate the girls that they don’t take it, they have to fight to be in the rugby team, it is still in this day and age........ We are so intelligent we have all those inventions the ipods and the computers and still the women are suffering that is so
way behind, it’s the same as centuries ago. That doesn’t make sense to me at all that we are so called so enlightened and we are still having women suffering that they don’t earn enough, they earn way less than men, and the men have all the power and everything that women would like to do they can’t do, that doesn’t make sense to me at all, so there is no magic wand, for I want it yesterday, its already way overdue. So how do we address that, is there an answer for that?

Discussion

Marla’s story presents a differing vision in regards to understanding the ways in which a woman might make meaning of experiences with violence/trauma, mental illness, and substance abuse and the discourses that can be taken up in this process. While the researcher had hoped that Marla’s story would present with greater similarities to the stories of the other two informants, the fact that her story stands with contrast to the other two illuminates the possibility of other narratives constructed by women in similar situations. Her story differs and so points out the unique nature of the individual and provides strength to the concept that knowledge about particular types of human experience cannot be viewed as uniform, rather as multilayered, complex, ever-evolving and contingent on multiple factors. Marla’s age, culture, social and physical location are unique to her. I suggest these factors as influences on the discourses she takes up to understand her experience. In addition, because of these differences her story might also be influenced by differing public policy and the types of services available to her.

Of the three mothers, Marla’s emotional state turned out to be the most precarious. The experience of interviewing Marla differed from the others as it was a challenge to maintain her focus on the interview questions. She often spoke on tangents about various topics including her frustrations with her cable television provider, the
personal lives of her reiki clients and other members of “the reiki family”, the self help books she was finding useful, and on occasion attempted to intuit personal details from the researcher’s life and coax her to become one of her reiki clients. After the completion of the interview sessions, Marla continued to make friendly phone contact with the researcher for several months, inviting her into her home. Shortly after the completion of the interviews Marla also made contact to express her declining mental health, which she believed to be a result of her participation. Marla accessed several sessions with a counsellor that was made available to her. The researcher followed up on occasion to ensure that Marla was receiving the support she desired and felt was required.

Of the three mothers Marla appears to continue to be most engaged in her former narratives, experiencing their interference in an emergent fashion on a more regular basis. Daisy and Sandy both presented some emotional and mental distress during the interview process, but to the researcher’s knowledge appeared to contain these states after and move back into their newer narratives as women who felt empowered and/or equipped with tools for coping. While the first two women seemed to be positively influenced by their participation in this research, Marla seemed to experience a negative impact. It is possible that today Marla continues to engage in the ‘victim’ narrative, viewing her life as still under siege by entities stronger than her and whose causes are yet to be understood by her, such as her mental illness. Marla’s narrative as the “con artist” may have been at work during her engagement in the interview process, in that her presentation may have been intentionally or unintentionally constructed to fit what she believed that the researcher wanted to hear. Marla’s story and the process of her involvement in this research illuminates some differing knowledge, discourses, and experiences than the
other two, and raises more questions and possibilities to the researcher than there is data
to directly support.
Chapter Five: Discussion

The questions that I attempted to answer in this research are as follows:

What kinds of narratives do mothers who have been victims of violence and abuse and who have faced challenges with mental illness and substance abuse utilize to describe their life experiences? In what ways are these women’s narrative constructions about self and life experiences similar or different from some of the ideas found in popular mothering and feminist discourses? Can these women’s stories offer any implications to improving services for women in BC?

In-depth interviewing was selected for the collection of research text because it allows researchers and research participants to express their stories and make connections by listening, sharing, and interpreting stories being told. The texts were then interpreted and analyzed for emerging themes, core descriptions and narratives. Also the ways in which the chosen discourses were utilized and offered by the women in the presentations of their stories. This research was intended to present each woman’s story as she had constructed it. It was important to examine the nature of the issues of violence, abuse, mental illness, and substance abuse and explore the social, psychological and cultural forces that influence the ways in which these women experience and story their life encounters.

The issue of credibility in any narrative interpretation must be addressed. During the collection and interpretation of the data, I was aware that each woman was presenting her story as it held meaning for her. The women’s stories may have been influenced by a number of factors related to them individually, individual characteristics
of me, and the relationship that existed and developed between us. For example, each woman’s mood at the time, recent events of the day or week or location/physical space of the interview could have influenced her story, as well as how she perceived me. My age, gender, profession, race, role as a researcher and student, my affiliation with the Transition House, and the questions asked may have influenced the way in which each woman constructed and shared her story. As Gergen (2004) states “stories are malleable and multifaceted, not rigid hollow shells shaping the lives of people as had been previously theorized” (p. 274). As well, stories are often constructed and presented to tell about oneself and the way in which a story is presented is dependent on how the individual presenter sees him or herself, as well as how they prefer to be seen and understood by the listener.

As the interviews unfolded it appeared that relationships were being cultivated between each woman and the researcher. I believe it was because of this relationship building experience that each of the women was able to tell her story as she had constructed it and to experience a sense of relief and satisfaction in sharing, despite the distress of the actual telling.

Central Emerging Themes and Influencing Discourses

The stories of the three women participants offer some central themes, as well as point to some similarities in how elements found in specific feminist and mothering discourses are taken up. While these themes and experiences cannot be claimed as universal for women with complex lives and experiences with violence, abuse, mental illness, and substance abuse, it remains possible that these themes may be shared by other women with similar experiences.
Some of the core themes that emerged in all three women’s stories included underlying but powerful narratives of strength, dignity, and resistance, a fight to regain personal power against extreme odds, and negative social responses from professionals and other people in their lives. Marla’s story stands in contrast from Daisy and Sandy in some ways, as she did not engage in much self blaming in her personal narrative and, although she also received some negative social responses from professionals and other people in her life, she did not present her story with the same narrative of fear of judgment as the other two women did.

One of the most interesting themes that emerged from all three women’s stories is the underlying narratives of strength, dignity, and resistance, which drove each woman to eventually escape her abuser and to continue seeking support despite the often negative social responses they experienced in these endeavors. Amidst environments riddled with violence, abuse, shaming, unfair expectations and sexual assault, each of these women in their own way knew on some level that what was happening was not acceptable and that she deserved to be treated better, with respect, care and fairness. Although this narrative was silenced often by the powerful messages received from their abusers, family members, and “helpers” in their communities, the narrative persevered, thus, the women persevered. I cannot help but wonder how these women’s stories might have been different if someone had acknowledged this narrative and worked with the women to encourage and empower it? The women eventually came to safety in their stories, might they have gotten there more quickly had someone noticed their strengths and connected with their shared human desire to be treated with dignity, justice, respect, and care?
A second very important theme in the women’s stories is their shared experiences of negative social responses by professionals and other people in their lives. Throughout the women’s stories they were met with messages that minimized or even ignored the violence, blamed them, attempted to pathologize their responses to the violence and encouraged them to reconcile or continue to allow their abusers power over them.

Marla’s lawyer advised her that she should just accept losing her entire inheritance to her ex-husband, for it would be less of a hassle. Daisy’s doctor told her she was most likely just depressed and offered her medication to deal with her sadness as a result of the abuse she was facing. And Sandy was told by family members, as well as numerous professionals that she was to blame for her situation. These are only a small sample of the many negative social responses these women met throughout their stories. I wonder if these women’s “helpers” and family members would have responded differently to the women, had constructions about violence and abuse been conceptualized differently?

Would these women have come to safety sooner if the responses of others did not consciously or unconsciously conceal male violence, blame victims, disguise perpetrator responsibility and conceal victim’s resistance and personal narratives of strength, dignity and self respect. This theme illuminates the importance of the work of researchers like Allan Wade, Linda Coates, and Cathy Richardson on the Discursive Operations of Language in regards to violence.

In their own ways each of the women appear to have been subjected to a narrow definition of women and mothering in regards to both the construction of their personal narratives and the abusive, unhealthy, and unsafe behaviours perpetrated against them by their partners. Daisy and Sandy both seemed to define and measure themselves based on
the quality and extent of their mothering and to construct their personal narratives based on this notion as well. Marla stayed with Harvey for fifty years in part because of social discourses about marriage commitments and stigma about divorce and she concealed the violence in the home for her own safety, as well as to avoid public embarrassment. Engrained in most social and cultural institutions and organizations are the “common sense” ideas regarding gender roles and characteristics (Weedon, 1987), deficit models of viewing motherhood (Lapierre, 2008), and the mother = woman equation (Morell, 1993). These institutions along with society as a whole place pressure on women to also accept these ideas for themselves. This is very problematic as can be seen in the case of these women. Acceptance of these concepts put them in situations throughout their stories where they were at risk for and experienced harm.

The stories of Sandy and Daisy contain a theme of fear of judgment from others, shame, and self blame. Just as the women had narratives of strength that seemed to power them to eventual safety, they also had narratives that were fed and empowered by the violence, abuse, and shaming they experienced throughout their stories. These narratives presented them as women who were unworthy of love, weak, odd, damaged, naïve, not good enough, and a burden to others. Life experiences of abuse, emotional suffering, guilt, shaming and judging by others resulted in the reinforcement of this narrative. Although both women live in safety and peace today, each of them articulated that it is a daily battle to disregard these messages that continue to pop up and interfere in their lives, but since they no longer face situations that reinforce this narrative, find it much easier to focus on their strengths and ignore the damaging narrative.
The women experienced fear of judgment from others, but the term ‘fear’ does not embolden the reality of their situations because this ‘fear’ is founded on repeated real experiences of judgment and shaming. Daisy was told by a physician that she was likely imagining the sexual abuse she experienced as a girl. Sandy was shamed while attending a therapeutic group for raising issues of childhood abuse and told she must stay in the present only and look to the future in order to heal and told by a social worker that she ought to reconcile with her husband despite the abuse, as it would be in the best interest of her family. These experiences of shaming and misplaced blame, understandably so, resulted in these women beginning to blame themselves for their situations because the social focus is on questions like: Why did she stay? Why didn’t she stop him? Does she not care about herself or her children? What is wrong with her for choosing a violent man? The blame and focus is removed from the abuser (subject) and she (the victim) becomes the subject (i.e., “He (subject) hit (verb) her (object)”. (Richardson, Dec 2009)). How might the stories of these women have differed if the discursive operations of language in reference to violence were publicly exposed and if society responded to these women as victims in need of protection and deserving of respectful, gentle, and just treatment, as opposed to failing mothers and women in need of treatment for their deficits?

What Does it All Mean?

The stories of Daisy, Sandy, and Marla illuminate important themes that suggest ways in which their experiences could have been different had the social responses to their challenges and discourses about women and motherhood been different. The social
discourses about what it means to be a woman and mother placed pressures on these women which contributed to the violence and abuse they faced and their limited options to escape it. In addition, the dominant discourses that exist in regards to male perpetrated violence and other forms of abuse against women and children influenced the perceived options for safety that the women had and influenced the responses of professionals and other people in their lives. In a way, these discourses and the subsequent responses to these women worked in collusion with the abusers, oppressing and degrading these women further. This process resulted in the women feeling as though they were to blame for the abuse and violence they experienced and they began to see themselves as weak, incompetent, negligent mothers, and deficient women.

They experienced many natural human responses as a result of the abuse and violence such as sadness, fear and anger. These responses were then pathologized as disorders like depression and anxiety by professional “helpers”. The women were then offered medications to manage these “disorders”, which effectively serve to dull these natural responses or it could be said stomp out their natural resistance and strength. Some of the women used substances as a means to cope with the violence and abuse or to numb the effects of these experiences and then risked further pathology as an addict or substance abuser. During her interviews Sandy expressed that while attempting to access support she held a strong desire to find someone or some agency that would take into account her whole story and that of her children; a holistic approach. However, she continuously came across “helpers” that would only assist with one piece of the problem (i.e., her parenting deficits and daughter’s emotional and behavioural problems, but not the relationship between Sandy and her daughter or the root cause of the emotional and
behavioural problems, the violence of Sandy’s ex-husband). Marla’s outreach nurse recognized that she was being abused by Harvey, but focused only on Marla’s mental health because she was a psychiatric nurse.

Each of the women demonstrated strong narratives of strength, dignity that drove them to seek respect, justice and support. Sadly, these narratives were often overpowered by negative social responses, ongoing violence and abuse, and the disconnection between abuse, mental health, and substance abuse service providers. These narratives could have been seen as an untapped resource within the women by “helpers”. Because these narratives are what eventually drove the women into safety, had they been acknowledged and built on with the support of professionals, perhaps these women would have found safety sooner. The themes that were presented in these women’s stories imply that if a holistic, response-based and language and social response conscious approach were used these women may have received the help they so desperately needed sooner.

The quality and value of support services and people appeared to be defined by the participants in terms of the relationship they were able to cultivate with support people. All three of the women have continued support from counsellors involved with a local transition house and two of them currently live in a second stage housing building funded and run by the Transition House. These two women speak highly of the programs offered there based on the personalities and approaches of the counsellors on site who run the programming and offer support. Some of the qualities of a helpful support person were identified by the mothers as being relatable, which would look like a non-hierarchical attitude and approach, having personal experience with the issue at hand, non-judgmental (really hearing and believing the woman), and someone with a holistic
approach, who could see the larger picture and the patterns within a larger family system. Daisy spoke highly of an outreach nurse, stating that her having the capacity for outreach, to meet in Daisy’s home or in the community for coffee was non-threatening, comfortable and like more of an equal peer relationship.

**The Power of Telling her Story**

Some of the most interesting and valuable learning for me with this research came during the interview and transcription process. I was delighted and taken aback by the witnessing of the women’s journeys during the interviews themselves. As has been previously mentioned I was able to both participate and bear witness to the co-construction of some new narratives in the women’s stories, as well as the visually and verbally pronounced expressions of found hope and empathy for other women experienced by the participants. Just as hearing stories can be immensely powerful, the act of telling one’s story should not be underestimated. I believe that sharing a personal narrative with a receptive audience can also encourage great personal development and healing potential. I was the receptive audience for each woman and filled an important role that they expressed was absent from their earlier attempts at gaining support from a captive and non-judgmental audience. Although I was not present as a support person for the women I still presented elements of that role. In addition to articulated and observed relief in sharing their stories, each of the women expressed a sense of pride that the sharing of their stories through this research might contribute to the improvement of services for other women in similar situations and might help some of those women understand that they are not alone.
“My story will help someone, it will help someone”. (Daisy)

The following statement by Novack (1975) illuminates the potential healing power of story that was witnessed in the telling of stories by Sandy and Daisy. “Story… is an ancient and altogether human method. The human being alone among the creatures on earth is a storytelling animal: sees the present rising out of a past, heading into a future; perceives reality in a narrative form” (p. 175). In the telling of their narratives Sandy and Daisy expressed present peace, safety and security achieved from a past of multiple struggles and pain and a sense of hope heading into the future.
Chapter Six: Implications and Future Directions

In this study I have illuminated the experiences of three mothers who have struggled with challenges related to violence, abuse, mental illness and substance abuse. With great measures of courage, honesty, and emotionality, these women shared their personal narratives as they had constructed and made meaning of them. The goal of this research has been to present the stories with integrity and respect. The research was not an attempt to discover “truths” about women’s experiences with these challenges that could be generalized to a larger population. I believe however, that the stories of Daisy, Sandy, and Marla have much to offer in the way of tentative suggestions or considerations for practitioners working in professions supporting women with similar experiences.

Many practitioners today have articulated to me their belief that the approaches utilized by service providers today, supporting women dealing with challenges similar to those of Sandy, Daisy, and Marla, have improved since the time that these women sought support (1970/80’s). Many practitioners use a more woman-centred approach, work collaboratively, are mindfully respectful, trauma informed, focused on the psycho-social determinants of women’s health, and recognize the intersections and relations between these complex issues. Both Sandy and Daisy spoke of their positive interactions with support people and agencies in their recent pasts, based on these newer approaches. The following are possible suggestions or items to be considered for practice resulting from the sharing of Daisy and Sandy’s stories.
Engaging Relationally in Research and Practice

The mothers in this research spoke outright about the value of the relationship between client and clinician/counsellor/nurse/support person, professing the quality of this relationship as the defining factor in determining the support as trustworthy and valuable. A quality relationship to these women involved a non-judgmental, equal, casual, and validating approach. Outreach counselling, home and community visits, seemed to be appreciated and created a more comfortable milieu for these women to open up and reach out for and access support. Utilizing a Constructivist model to relationship, both helper and client engage in a meaning sharing and making process together, as the helper attempts to understand the woman’s story, the meanings she had ascribed to that story, and to work with the client to construct new meanings and new stories for her self directed future. As Hoskins says (1999), “Meanings can only be understood by deeply listening to individuals describe their relationship to various cultural discourses. This process requires a special kind of relationship between individuals.” (p. 77). Creating a venue for building these sorts of relationships requires a shift in allocation of resources, counsellor time, utilization of space and introducing more freedom and capability for counsellors to attend to clients in the community. The drop in centre at Herway Home is designed to provide women with an environment that will be relaxed, non-judgmental, safe, friendly, comforting and functional; a place where a woman can come to cultivate relationships such as those Daisy and Sandy have spoken about and to access supports for multiple issues concurrently.

The positive experience witnessed by the mothers in sharing their stories to a captive and accommodating audience (the researcher) and with the hope that their stories
would help other women in similar situations suggests certain considerations for program
development and funding. Daisy articulated how she felt she could relate best to
counsellors with similar life experiences. Peer support and mentorship programs offer
women the opportunity to connect and establish relationships that can be healing for both
individuals involved. The woman who is in recovery/safety gains the positive experience
of offering her story in assistance to a women in the early stages of seeking support and
working towards recovery/safety, and this woman gains the experience of learning from a
peer further into recovery/safety and through relationship engaging in her change process
with peer support. Peer support and mentorship programs are strongly endorsed by
agencies and programs that work from a Woman – Centred Care framework, which is the
second suggested item for consideration for practitioners ensuing from this research.

**Women - Centred Care Framework**

The Women – Centred Care framework includes the following considerations in
supporting women: participatory, empowering, respectful of diversity, safe, focused on
social justice, individualized, holistic, and comprehensive. Working within this
framework would allow women to feel heard, in control, accepted, involved, action
oriented, comfortable, and understood; all of which were pieces that the mothers felt were
missing from their attempts to gain support and move toward recovery/safety.

By hearing the stories of these mothers as they chose to share them, and by also
considering larger social discourses that may contribute to those stories, I was able to
attend not only to “themes and assumptions underlying the discourse, but cultural and
contextual understandings” that play a role in how violence, abuse, mental illness, and
substance abuse is experienced as well (Hansen, 2006, p. 1063). Engaging clients in the process of drawing attention to, and evaluating social discourses and “common sense” social ideas that impact their constructions of story and self could be a useful tool within a Woman - Centred Care approach to empowering and orienting women toward change and safety.

Addressing issues from a holistic perspective is also a key element of Women – Centred Care and was discussed by the mothers in the interviews. Recognition of the connections between the issues with acknowledgement that a causal relationship may exist, but a commitment to addressing all issues holistically, could be beneficial. Historically, the tendency has been to focus on the chosen “root problem” solely with the intention that addressing this problem would resolve the others. However, in the experiences of Daisy, Sandy and Marla, insistence on only addressing one issue (i.e., mental illness, substance abuse) and ignoring the others resulted in both women feeling blamed, judged, shamed and re-traumatized. Furthermore, as Bland and Edmunds (2007) state the “root problem” is often incorrectly identified. For example, past attempts to support women with complex lives have focused mainly on dealing with addictions or mental health, while ignoring the actual “root problem” for many, which is violence and abuse. For many women dealing with violence and abuse, substance use and emotional responses like sadness and anxiety can be seen as the solution to the problem (the violence and abuse). However, past attempts to support these women have focused on treating her “solution”, as though it is the “problem”. The women’s feelings resulting from these experiences facilitated their withdrawal from seeking support and return to unsafe and unhealthy life situations.
A Women-Centred Care approach seems to have much to offer to women today in situations similar to those of Daisy, Sandy and Marla, and had they been in practice when these women sought help, might have changed their process of seeking and accessing support and safety.

**Strengthening Personal Narratives of Dignity, Self-Respect, and Justice**

A missing piece in the Women-Centred Care Model for me is the use of the practice ideas identified by Wade and Coates (2000, 2002, 2007) calling for more response based work with women, as well as a focus on the acts of resistance that are utilized by victims of violence and abuse. Each of the women in this study shared narratives of strength and resistance that were present throughout their stories, although sometimes quieter than others. Helpers have an opportunity to work with women to acknowledge these types of narratives and support women in empowering these narratives. This approach, by philosophy tends more to areas of strength and resourcefulness in a client’s story, as opposed to those of weakness or deficit. If practiced in the case of Sandy, Daisy or Marla, it is possible that each woman’s strength narrative could have been explored, sanctioned, and put into action earlier on in each woman’s story, potentially impacting the course of each woman’s story in an affirmative manner.

**Researcher Reflections and Implications for my Practice**

The topic for this research project was born out of my experience and interest working with women and children at a local women’s shelter. The idea to address this topic as my graduate thesis project was conceived after some very important and
intriguing conversations with staff and managers working in the field of violence against women regarding the complexity of the lives of women and children accessing shelter services, most of whom had histories or violence and abuse, mental illness and/or substance abuse issues. I was invited as a representative from the shelter to attend a community forum organized by the Queen Alexandra Foundation for Children’s Health and Blanshard Community Center’s Birth Project. This forum was organized in order to discuss the issue of substance using pregnant women in our community after service providers, social workers, and other health officials began to notice the staggering statistics of how many new born infants were being apprehended from their substance using mothers directly from the maternity ward at the local general hospital.

My knowledge and interest in the topic of women/mothers and violence, mental illness, and substance abuse was expanded at this forum and I excitedly joined the team of community members to begin the development of an agency that would provide a unique kind of service to these women and children. As the last year and a half progressed, I had completed my graduate coursework and began this research while working full time in the field of Child and Youth Mental Health, casually at the Transition House, and continued as a member of the team working to develop this new program in Victoria, which had been dubbed Herway Home. Herway Home is unique from its inspiring sister programs in Vancouver and Toronto because it is a collaborative community initiative with a network of service providers from many existing programs serving women, children, and families in Victoria, including the Ministry of Children and Family Development (MCFD) and the Vancouver Island Health Authority (VIHA).
My graduate coursework, employment experience and involvement in the Herway Home project have informed this research project, just as this research and the stories of Daisy, Sandy, and Marla have informed both my work and my theoretical, philosophical, and practical framework in the field. I have begun to integrate some of the ideas based in the ideologies of Constructivism, Feminism, and Post structuralism, as well as Narrative, Response-Based and Women Centered Care practices into my work. For example in my work today I find myself practicing in some of the following ways, as well as advocating and educating colleagues about the value of these practice frameworks. In my counselling work I attempt to honour the client’s personal narrative without blame or judgment and encourage her to take charge of her process as an expert on their own life. I also focus with the client on the social and cultural discourses that impact and influence choices, experiences, and meaning making processes. In opposition to a strict medical/pathological inspection/view, I consult with the client holistically, mindful of the biopsychosocial determinants of health. In addition, I prefer, with the client’s permission, to work collaboratively with other involved service providers (Integrated Case Management Teams) and the woman to ensure that her unique and often complex needs are being met without over-servicing, which may result in re-traumatisation through the telling and retelling of her story.

Concluding Thoughts

The process of attending graduate school and the culminating experience of conducting and writing about this research has truly been a transformative journey both personally and professionally for me. It has tested my motivation, discipline, and forced
me to critically evaluate and shift some of the “everyday” attitudes and practices in all areas of my life. When I first came into contact years ago with the ideas of Post structuralism and Constructivism I recall the sensation of the very foundation of my world and knowledge being rocked; a satisfying, frightening and life changing experience. I often reminisce over a joke amongst other students at that time sharing the same experience. Once you had learned about these ideas, there was no going back, try as you may. I have learned a great deal from this process through the reading of great scholars, support by skilled and knowledgeable faculty members, and most of all through witnessing the hearts of Daisy, Sandy, and Marla. They, along with the many women I have worked with in the field throughout my career so far, have so generously shared their stories with me and you, the reader.
References


British Columbia Centre of Excellence for Women’s Health Publications. (n.d.).

Boonzaier, F. (2008). “If the man says you must sit, then you must sit”:
The relational construction of woman abuse: Gender, subjectivity and violence.
Feminism & Psychology, 18(2), 183–206.


Alaska Network on Domestic Violence and Substance Abuse workshop based on
research: Women Talk about Substance Abuse and Violence. May 2007 in Victoria,
BC.

November 17, 2008 from http://www.mothercraft.ca


Offender Counselling, 22, 1-10.


