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Experiences of the Recovering Crack Cocaine Addicted African American Woman Within a Self-care Framework

Submitted by

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DEDICATION

This thesis is dedicated with love and gratitude to my family, my husband Ken, my children Deborah, Angela, and Christina, my parents Donald and Virginia Hauri, and my sisters Janet, Mary, Margaret, and especially Linda. Their support, encouragement and help made it possible to complete this thesis.

Additionally, this thesis is dedicated to the women who participated in this study and who shared their experiences so others could learn and who daily struggle with their recovery.
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CHAPTER I

Introduction

In the last twenty years the United States has experienced an epidemic, an epidemic that is costly, not only to individuals but to several generations. This epidemic is the addiction to cocaine, specifically to crack cocaine. This study examines how crack cocaine addiction affects African American women, 18 to 45 years old, and their ability to care for themselves. This chapter contains the statement of the problem to be explored, the identification of the theoretical framework, the purpose of the study, the research questions, the definition of terms, and the significance for nursing.

Statement of the problem

Historically, addiction has been alternately seen as a problem of the "will" or as an illness or disease. In the 18th century, drunkenness was described as resembling a hereditary or familial disease. However, during Prohibition (1920-1933 in the United States), the view of alcoholism as a disease gave way to the belief that it was a break down of the individual's moral character. With the emergence of Alcoholics Anonymous in 1935 and supported by findings from research, the disease concept is the accepted theory again. (Kinney, 1991)

In 1971 the Substance Abuse and Mental Health Services Administration (SAMHSA) began conducting a series of surveys (National Household Survey on Drug Abuse) to measure the prevalence of use of illicit drugs, alcohol, tobacco, and nonmedical use of prescription drugs in the United States. Annually, from 1994 to 1998, 514,000 to 934,000 Americans tried cocaine for the first time and the number of crack cocaine first time users was 371,000 in 1998 (SAMHSA, 2000). In 2000, the Substance Abuse and
Mental Health Services Administration reported from the National Household Survey on Drug Abuse that 1.5 million were current, within one month of the survey, users of cocaine. The Substance Abuse and Mental Health Services Administration (1995), using one-day census data collected by the Office of Applied Studies in the Department of Health and Human Services, reported that in 1990, on any given day, substance abuse treatment centers in the United States had approximately 768,000 clients, 53.7% were 18 to 34 years of age and 28.4% women. This census also found individuals in treatment to be 21% African American when African Americans are 12% of the general population. An estimated 2.8 million people age 12 years and older received alcohol and or drug treatment in 1998. (SAMHSA, 2000) The Ohio Department of Alcohol and Drug Addiction Services reported that, for the year 1997, 16,506 individuals were admitted to drug treatment units in Ohio for crack cocaine and of this group, 67.1% were African American and 51.5% were women with an average age of 33.8 years (ODADAS, 1998).

The National Institute on Drug Abuse or NIDA (1989) estimated the number of regular users of crack cocaine to be five to six million individuals with approximately 21.2 million having tried crack at least once. In addition, NIDA, estimates that daily 3,000 to 5,000 individuals try crack for the first time. The Bureau of Justice Statistics (1992) identified the fastest growing population of regular crack cocaine users to be young women ages 18 to 25 years of age. The number of new crack cocaine users in 1998 was reported by SAMHSA (2000) to be 371,000 this does not reflect an overall significant change from the annual estimates since 1985 although there was an increase in use by the 12 to 17 year group. SAMHSA also reported that, in 1998, the rate of substance abuse treatment was higher for males (1.7 %) than for females (0.9 %). Within
the general population, women have been underrepresented in addiction literature because of a previous assumption that findings for males could be generalized to include women (Dahlgren & Willander, 1989). Addiction is currently accepted as a disease process. To enter treatment requires the admission of being an addict. Women addicts have been described as social outcasts or as the wife and mother, closely guarded and protected by the family (Gorski, 1989; Naegle, 1988). In both cases the woman is effectively kept from diagnosis and treatment. Lack of diagnosis and treatment allows the progression of the addiction to continue unchecked. Unchecked progression of the disease process of addiction leads to risks that may complicate recovery.

A number of authors (Finkelstein, 1990; Fuchs, et al., 1995; Gorski, 1989; Long & Mullen, 1994; Naegle, 1988) describe the woman entering a recovery program as being more ill, with more complex issues than her male counterpart. Some of the issues facing women entering treatment programs, over and above concerns regarding the addiction itself, are low self-esteem, loneliness, sexuality, problematic personal relationships, and complex health concerns (Long & Mullen, 1994; Nyamathi & Flaskerud, 1992; Wallace, 1990). Often a health concern is what brings to light a woman's need for treatment of her addiction. Health conditions that may accompany a woman entering a recovery program include old and new fractures, burns, depression, panic attacks, eating disorders, migraine headaches, menstrual irregularities, gastritis, hepatitis, injuries from motor vehicle accidents, and pregnancy (Cregler & Mark, 1986; Fuchs, et al., 1995; Unger, 1988). However, there is very little information available regarding the effect of crack cocaine use on a woman's life and her ability to care for herself. What is living with
coca ine addiction like for a woman? What is the recovery process like for a woman? How does addiction and recovery affect the woman’s ability to care for herself?

Identification of nursing conceptual/theoretical framework

This study has as the nursing theoretical framework, the self-care deficit theory of nursing (SCDTN) (Orem, 1995). The self-care deficit theory of nursing assesses what the individual needs to maintain a state of well-being, his or her self-care ability, and directs the nurse to support or enhance the individual’s self-care abilities or to directly meet the needs of the individual when a deficit is identified. The theory’s holistic, empowering, and self-directed approach to health care meets the complex needs of the African American woman addicted to crack cocaine.

Statement of the purpose

The purpose of this study was to explore the experiences of adult African American women, 18 to 45 years old, who are recovering from crack cocaine addiction. The secondary purpose of this study was to explore how the addiction affected the woman’s self-care abilities.

Research questions

The research questions posed for this study were:

1) What is the experience of the African American woman using crack cocaine?

2) Is there a difference in the self-care activities reported by African American women during active crack cocaine use and during recovery?

3) What do African American women addicted to crack cocaine identify as reasons facilitating their remaining in recovery?
Definition of terms

Self-care Activities

Theoretical definition: “Self-care activities are the deliberate actions taken within the context of daily living to regulate internal functioning and development” (Orem, 1995, p. 121).

Operational definition: Self-care activities in this study, are defined as the actions taken by the participants to promote, maintain, or enhance health as related by the participant.

Addiction

Theoretical definition: “Substance dependence is a maladaptive pattern of substance abuse, leading to clinically significant impairment or distress, as manifested by … tolerance, withdrawal, ingestion of larger amounts of a substance over a longer period than intended, no success at reduction or control of substance use, increasing preoccupation with the substance, social, occupational, or recreational activities are negatively affected because of substance use, and/or continued use despite recurrent physical or psychological problems (American Psychiatric Association, 1995, p. 108-109).

Addiction can be described as a healthcare situation in which the focus is oriented to the regulation of a disease that has disrupted human integrated functioning to the degree that quality of life is gravely affected and rational processes may be disturbed (Orem, 1995, p. 135).

Operational definition: In this study, addiction will reflect the participant’s identification of self as dependent on crack cocaine.
Recovery

Theoretical definition: Recovery is a three-phase process of change from active addiction to maintained abstinence (Prochaska & DiClemente, 1986). Phase one is precontemplation, phase two is active change, and phase three is relapse prevention or change maintenance.

Recovery can be described as a health focused process of overcoming or compensating for the effects of a disease (Orem, 1995, p. 134).

Operational definition: In this study, recovery will reflect the participant’s end of active crack cocaine use for at least six months and the participant’s engagement in a sobriety maintenance program.

Significance

The U. S. Department of Health and Human Services (1990) has identified that drug abuse in the United States for both men and women results in an increase in: the number of unplanned pregnancies with subsequent intrauterine fetal drug exposure; the Human Immunodeficiency Virus (HIV) infection rate; the rate of severe crimes resulting in incarceration; and in the utilization of emergency health care services. The results of the study presented here will provide information and direction to nursing that will afford an insight as to the impact of the experiences of a crack cocaine addicted woman on her ability to engage in self-care activities.

Researchers have reported women addicted to alcohol and other drugs to have had one or more negative life experiences. (Henderson, Boyd & Mieczkowski, 1994; Nyamathi, 1991; Zlupko, Kauffman, & Dore, 1995) The experiences included histories of dysfunctional family life and overresponsibility or caretaking in the family of origin.
The women were described as having ineffective or nonexistent coping mechanisms and low expectations for life outcomes. Also described is an increased participation in risky behaviors with high levels of guilt and shame regarding the addiction and poor to crisis-only attention to health care needs by addicted women. Additionally reported were issues regarding childcare ranging from neglect and abuse to lack of a caregiver when the women were ready to enter treatment.

Nelson-Zlopo, Kauffman, & Dore (1995) reported findings that indicate repeated admission to treatment programs are common for women seeking sobriety. Hanke and Faupel (1993) reported that treatment services designed for men typically do not encompass the treatment needs of women, particularly women who are mothers.

Dahlgren and Willander (1989) found that a treatment program specific to women, one that recognized the women’s needs for direction in building and maintaining relationships not found in traditional treatment programs, had women entering treatment earlier in the disease process. Willander further reported the women experienced 50% less relapse and a decrease in mortality where alcohol was the direct cause. Following treatment, these women experienced improved relationships with their children and their relationships with men, spouses, or boyfriends either improved or ended completely. Additionally, Dore and Doris (1998) reported that 69% of the subjects in a study exploring the relationship of parental substance abuse and child abuse had one previous attempt at treatment while 31% had two or more prior episodes of treatment.

The study being presented will provide direction for nurses and other health care providers to increase their awareness and better prepare them to recognize the conditions that may bring the crack cocaine addicted woman to seek health care services.
Conversely, treatment providers in recovery programs can be alerted by the findings to the potential health and psychosocial issues that confront the woman who enters a treatment program. As a result, providers then will be better able to assist the addicted woman to engage in self-care activities that support the development of a recovery plan and facilitate her participation and success in recovery.

Summary

Crack cocaine addiction is a major concern in the United States. Adult African American women are a significant group of crack users. Nurses and other health care providers need to be prepared to recognize the deeply complex issues that surround the experiences of the crack cocaine addicted woman and how these experiences affect her self-care abilities. In this chapter is the problem statement, identification of the theoretical framework and the purpose of the study. The research questions were formulated. The terms, self-care activities, addiction, and recovery were defined. This chapter also illustrated the importance of learning what the experiences of women addicts have been and how identifying and developing programming based on these experiences may contribute to the women’s ability to cope with their addiction and recovery.
CHAPTER II

Literature

This chapter examines the self-care deficit theory of nursing (SCDTN) (Orem, 1995), which provides the theoretical framework for this study. The study will assist the nurse to understand how crack cocaine addiction affects the African American woman’s self-care requisites, basic conditioning factors, self-care agency, the impact on the woman’s self-care activities, and the subsequent impact on the woman’s well being. One specific set of self-care activities to be examined is what factors facilitate recovery. Research literature is then reviewed concerning alcohol and drug addiction and how it affects the self-care requisites of women. Areas explored in this review include: health status as affected by addiction, gender differences in addiction, treatment for the woman addict, and women’s self-care activities related to their addiction.

Theoretical framework

Self-care deficit theory of nursing

Self-care. The deliberate action taken within the context of daily living to regulate internal functioning and development is self-care. (Orem, 1995). Orem further states that self-care behaviors are learned by individuals to direct life functions and development.

Self-care requisites. The SCDTN “guides the nurse in designing a system of care to ensure that the individual’s self-care requisites will be met” (Orem, 1995, p. 160). Within the SCDTN there are three types of self-care requisites: universal, developmental, and health deviation. Self-care requisites are “formulated insights about actions to be performed by or for individuals that are known or are hypothesized to be necessary in the regulation of individuals’ human functioning and development” (Orem, 1995, p. 191).
The universal requisites are associated with life processes, with the maintenance of the integrity of human structure and function, and in general well being. The universal requisites are identified as: sufficient air, water, and food; provision of appropriate actions for elimination; balancing rest and activity, solitude and social interaction; the prevention of hazards; and promotion of normalcy (Orem, 1995, pp. 191-192). The developmental requisites refer to the life events that are associated with the maturation of the human being through the life cycle. Health deviation requisites are associated with alterations in health and also can be related to the diagnosis and treatment of the alteration. Health deviation requisites are further categorized as;

"seeking and securing medical assistance; being aware of and responding to the effects of pathological conditions; effectively carrying out prescribed treatment measures; recognizing and responding to side effects of medical treatment; accepting need for care; accepting health state which may require a change in self-concepts and self-image; and learning to accept changes in life style brought about by a pathological condition" (Orem, 1995, pp. 201-202).

When these requisites are met there is promotion of well being.

Within the SCDTN, what an individual needs to meet the self-care requisites is identified as therapeutic self-care demands. Actions to be performed for the regulation of human functioning and development are self-care activities. When the therapeutic self-care demand exceeds the self-care abilities of the individual a self-care deficit exists.

**Basic conditioning factors.** "Distinguishing features that affect an individual’s ability to engage in self-care activities or the amount of self-care required are known as basic conditioning factors."(Orem, 1995, p. 203) The basic conditioning factors include
but are not limited to: age, gender, developmental state, health state, sociocultural orientation, health care system factors, family system factors, pattern of living, environmental factors, and resource availability and adequacy. The basic conditioning factors of gender, developmental state, pattern of living, family system, sociocultural orientation, and environmental factors affect the therapeutic self-care demand of the woman habitually using crack cocaine. These basic conditioning factors in turn impact the woman’s ability to meet her self-care requisites. The universal self-care requisites that are impacted include: protecting one’s self from hazards and recognizing and seeking care for physical conditions such as pregnancy and sexually transmitted diseases. The developmental requisites impacted include: fully participating in the developmental process of completing adolescence, engaging in healthy adult relationships, and becoming a parent. The health deviation requisites impacted include: securing assistance, awareness and attention to conditions, carrying out therapy, awareness of effects of therapy, accepting of self as an addict, and learning to live with addiction. Self-care requisites set the goal of self-care and are the reason for self-care activities.

Self-care and self-care agency. Self-care is the practice of learned behavior taken deliberately by an individual to maintain well being. Self-care agency is the complex acquired ability to meet one’s continuing requirements for the care that regulates life processes, maintains and promotes integrity of the structure and its functioning, and promotes the individual’s development and well being (Orem, 1995). An individual’s ability to engage in self-care activities is influenced by his or her basic conditioning factors and self-care requisites. The form the self-care activities take depends upon the purpose to which it is directed. The ultimate goal or purpose of self-care activities is to
establish or maintain a state of well being. Well being is the perceived condition of
contentment, state of health, and continued personal development. (Orem, 1995) The
relationship of the basic conditioning factors, self-care requisites, self-care agency, self-
care activities and ultimately well being is shown in Figure 1.

Review of literature

There was no nursing research found that looked at the self-care activities of the
clar cocaine addicted woman. This review is described in relation to the universal self-
care, developmental, and health deviation requisites.

The effect of substance abuse on the universal self-care requisites

Fuchs et al. (1995) explored the health effects of alcohol intake on women in a
prospective study among 85,709 women, 34 to 59 years of age without a history of
myocardial infarction, angina, stroke or cancer, who completed a dietary questionnaire in
1980. In a 12 year follow-up of these subjects, 2658 deaths were found to have occurred.
The relative risk of death in drinkers, after adjustment for other predictors of mortality, as
compared with nondrinkers was 0.83 (95% C.I., 0.74 to 0.93) for women who consumed
1.5 to 4.9 grams of alcohol per day or one to three drinks per week, 0.88 (95% C.I., 0.80
to 0.98) for those who consumed 5.0 to 29.9 grams per day, and 1.19 (95% C.I., 1.02 to
1.38) for those who consumed 30 grams or more per day. Results were determined that
light-to-moderate drinking is associated with a decreased risk of death from
cardiovascular disease and heavier drinking is associated with an increased risk of death
from other causes, particularly breast cancer and cirrhosis.
Figure 1. Relationship of basic conditioning factors, self-care agency, self-care requisites, and well being.
Edlin et al. (1994) explored the idea that smoking crack cocaine was associated with an increase in HIV infection. The study recruited 2323 young adults from the inner city neighborhoods of New York, Miami, and San Francisco who were interviewed and then tested for HIV. Of the 1967 participants who never injected drugs, 1137 were crack smokers. Of these 1137 crack smokers, 15.7% tested positive for HIV compared to 5.2% of the 830 nonsmokers (prevalence ratio adjusted for the city, 2.4; 99% C.I., 1.7 to 3.6). The prevalence of HIV was highest among the women in New York (29.6%) and Miami (23.0%). Crack smoking women had more sexual partners than non-smoking women, 25 versus 5 partners, p<0.001. Edlin, et al. concluded that, in poor inner city communities, young smokers of crack cocaine, particularly women who have multiple sex partners and women who engaged in sex in exchange for drugs, are at high risk for HIV and that crack cocaine use promotes heterosexual transmission of HIV.

DeHovitz et al. (1994), Lindenberg, Reiskin and Gendrop (1994), and Nyamathi (1991) found a strong correlation between stress and high-risk behaviors such as alcohol and drug abuse within the impoverished and homeless populations. Other high-risk behaviors include frequent exposure to unprotected sexual encounters with the potential for unwanted or unplanned pregnancies and the increased risk of sexually transmitted diseases (STD). These studies are now described.

DeHovitz et al. (1994) explored illicit drug use and untreated sexually transmitted diseases in 372 inner-city women. The women were recruited from ambulatory clinics, drug treatment centers, community health clinics, and the community directly. The women were 18 to 50 years of age and reported having sex with at least one male partner in the past year. Excluded were those who gave a history of intravenous drug use or a
previous positive HIV antibody test. Cocaine was the most frequently detected drug used: 14.1% on urine toxicology while 31% reported use in the past year. In the tested subjects, 130 (35%) were found to have an untreated STD, 17 had two STD’s and four women had three STD’s. The sample results showed 61% of crack cocaine users had a STD as opposed to 34% of non-users (odds ratio (OR) = 2.9, with a 95% C.I. 1.6 - 5.5, p = 0.001). The authors also found that 33 of the 36 women who reported having sex with six or more partners used crack cocaine.

Lindenberg et al. (1994) explored perceptions about drug use with 24 Hispanic women from an inner city prenatal. Utilizing a descriptive, qualitative research design, focus groups were engaged to identify themes that trigger or deter drug use for the inner-city Hispanic women. Six themes were identified with either the potential to enhance resiliency against drug use or the potential to increase vulnerability for drug use. Those enhancing resiliency were; family antecedents, the positive socializing of parental and childhood experiences, personal competence reflected the ability to make positive life choices, adult developmental roles, having children, being a role model, establishing personal goals, establishing enduring emotional relationships; economic participation, and access to community resources. The women perceived social pressure or peer influence and stress and environmental deprivation as triggers to use drugs.

Nyamathi (1991) in a study of 581 homeless and drug-abusing minority women who ranged in age from 18 to 69 years old, found these high risk behaviors: 56% reported nonintravenous drug use by; 13% had sexual partners who used intravenous drugs; 33% reported prostitution; and 36% reported a history of a sexually transmitted disease.
Wallace (1990), in a study of admissions to an inpatient detoxification unit over a six month period, described the frequency of dysfunctional family experiences of 61 individuals. The patients were predominantly African American males, addicted to crack cocaine, unemployed, high school dropouts with a mean age of 28 years old. Half of the crack cocaine users were adult children of alcoholics, one quarter to one third gave a history of sexual abuse and other forms of domestic violence prior to age 16, 25% reported experiences of domestic violence, 28% reported sexual abuse, 26% experienced disrupted relationships or traumatic losses such as the early death of one or both parents. Wallace concludes that being the adult child of an alcoholic or the adult child of a dysfunctional family may be an etiologic factor in the development of crack cocaine dependence.

The effect of substance abuse on developmental requisites

Henderson et al. (1994) interviewed a convenience sample of 23 men and 23 women from an inpatient drug treatment center who were 18 to 50 years old. The majority was African American. Most of the subjects were single and unemployed. The majority of men and women reported their first experience with illicit drugs as introduced to them by males, the males as a business interaction, the women as a sexual encounter. This finding regarding women being introduced to drug use through a sexual encounter is supported by Zlupko et al.’s. (1995) review of the literature for gender differences in drug addiction treatment. Zlupko et al. found the female addicts frequently engaged in drug use with an intimate other and then women, as when compared to the men, also reported having few or no friends and a very limited social network. The formation of a social
network based on one to one relationships including mutually respectful intimate and sexual relationships is part of human growth and maturation.

Hofkosh, Pringle, Wald, Switala, Hinderliter & Hamel (1995) explored early interactions between drug-involved mothers and infants in a study of 32 mother-infant couplets out of 144 initial enrollees. The couplets entered the study either at the time of delivery or prior to one month postpartum. The mothers had to meet the criteria for substance abuse or dependency and be enrolled and remain in a home-based clinical intervention program for one year. Maternal and newborn characteristics, interactional measures, and developmental assessments were completed. Mothers were primarily African American, unemployed, single, mean age of 28.5 years old, and involved with a male partner. Only 20% had not finished high school. Results indicated older mothers ($r=.41, p=.04$), mothers of higher parity ($r=.42, p=.02$) and mothers more active in the program ($r=.41, p=.04$) had significantly higher scores on the Nursing Child Assessment Satellite Training Feeding Scale. This finding indicated that mothers who were older, with more children, and who participated in the program had a more positive interaction with their infants during feedings, one of the most intimate interactions between an infant and mother. Mothers who were better educated ($r=.49, p=.009$) and mothers who were more active in the program ($r=.44, p=.02$) had higher scores on the Home Observation for Measurement of Environment scale. The findings indicated that mothers who were better educated and participated in the program had a more stable, child-parent supportive environment. The researchers concluded that substance exposed infants whose mothers received support services, were more organized to support infant development and
performed better on the assessments. Becoming a parent and developing the parent-child relationship is a human developmental step.

The effect of substance abuse on health-deviation requisites

Nyamathi (1991) and Smith, North, and Spitznagel (1993) identified that addicted individuals took few or no preventive measures, rarely recognized or sought care for medical conditions, and frequently failed to follow through with prescribed therapies. Nyamathi, in a study of 581 homeless and drug-abusing minority women, found women who were high in self-esteem and stronger in a sense of coherence, reported less emotional distress and fewer high-risk behaviors. The subjects ranged in age from 18 to 69 years old and, like many of the other studies in this review, were predominantly African American, never married, had one or more children, and were unemployed. The subjects report 12.7% intravenous and 56% nonintravenous drug use. A history of sexually transmitted disease was reported by 35.6%, prostitution by 33%, and 13.4% had sexual partners who used intravenous drugs. Coherence, self-esteem, and support availability accounted for 49% of the variance in emotional distress, with coherence and self-esteem making nearly equal contribution. Coherence, self-esteem, and support availability accounted for 26% of the variance in somatic complaints. The three variables explained 10% of the variance for high-risk behavior, with support availability being not statistically significant.

Smith et al. (1993) studied psychiatric diagnosis and comorbidity in randomly selected 300 homeless women living in St. Louis, Missouri shelters. Subjects ranged from 18 to 64 years old, 90% were mothers with children living with them, 50% had completed high school, and 77% were currently unemployed. The major nonsubstance
psychiatric diagnoses were somewhat overrepresented in the subjects when compared to a randomly selected group of 318 women of low income, that is, having a household income of less than $4,800/household, and living in St. Louis. Depression was twice as frequently reported in the homeless subjects as in the low-income group with 49% of those reporting depression having attempted suicide. Substance abuse was present in one third of the women. Only 12 % of the women with a history of alcohol use disorder and 36% of those with a drug use disorder self-reported ever being impaired by their substance use. This lack of awareness may have kept many from seeking treatment.

Dahlgren and Willander (1989) investigated women’s responses to treatment programs that treat both men and women in an effort to suggest programs that would more adequately meet the needs of the addicted woman. Dahlgren and Willander completed a controlled two year study of 200 women treated in a specialized women’s project for Early Treatment of Women with Alcohol Addiction (EWA). Subjects ranged from 18 to 67 years of age, the majority were employed, living with a male partner, and had partners who were problem drinkers or alcoholics. Subjects were randomly divided into two groups of 100, probands, those entered into the test program, to the EWA unit and controls to the traditional treatment unit. Follow-up found 67% of the probands to be alcohol free at 300 days after treatment and 59% alcohol free at two years compared with 45% and 48% respectively for the control group. This study suggests women treated in an all women unit may have a more successful rehabilitation and social adjustment than those treated on a traditional unit. Zlupko et al. (1995) in their review of gender differences in drug addiction treatment, suggest treatment programs that reflect a philosophy which focuses on the strengths of individuals and uses their past experiences
as learning tools rather than sources of grief and shame, are going to be more successful for the woman addict. The authors further suggest alternative treatment programs for women should incorporate a team approach, utilizing the disciplines of mental health, social work, medicine, nursing, and nutrition. Additionally, the authors recommend that, along with sobriety, the treatment model most beneficial for women, recognizes that the use of drugs for a woman may be a coping mechanism and incorporates other components that provide women with the ability to take charge of their lives and their bodies.

Summary

Although the literature reports on the complex issues that surround individuals who are alcohol or drug addicted, there is very little research that explores the issues of the crack cocaine addicted woman. No research was located that explored how addiction affects a woman's self-care abilities. Research is critically needed to generalize findings to women or suggest differences to assist with the creation of holistic treatment systems for women. Orem's (1995) SCDTN provides a nursing framework to explore the experiences of crack cocaine recovering women and the effect their addiction has on their self-care abilities.
CHAPTER III

Method

This chapter contains a description of the design of the study, the method of obtaining data, and the process of participant selection. Following this, the data collection process, method of data analysis, and protection of human participants are presented.

Design

The design is a psychophenomenological study of the experiences of the recovering crack cocaine addicted woman related to her self-care activities. Data were analyzed by van Kaam’s (1966, 1987) psychophenomenological method. Orem’s (1995) self-care deficit theory of nursing (SCDTN) provided the theoretical framework for the study.

Participants

Target population and setting. The participants providing the data for the study were adult African American women, 18 to 45 years old, addicted to crack cocaine and in recovery for at least six months. A purposive sample of five women was selected from those enrolled in an aftercare phase of a woman’s transitional residential recovery program in Northwest Ohio. The site of the recovery program was a converted home in a neighborhood similar to the areas in which the women lived prior to entry into the program. The site had an average of ten women living in the home at any one time, with eight to ten additional women active in the aftercare program. The women remained in the residence for up to one year. As the women completed the treatment plan and left the residential facility, reintegration into the community was supported by weekly and biweekly attendance at group meetings held at the treatment site.
The investigator was introduced to all eligible women, as determined by the recovery case manager, in a group setting, at the recovery house. During this meeting, the study was described to the group and a letter inviting them to be part of the study was given to each woman (Appendix A). The letter also contained a brief description of the study. The investigator contacted those who indicated interest, either by directly contacting the investigator or by contacting the investigator through the case manager of the program. The investigator provided further explanation of the study and answered any questions the women had. An individual interview was scheduled with each interested woman volunteering to participate. The site for the interview was one that was private and agreed upon by the participant and the investigator. Each participant was informed that she may at anytime refuse to answer a question or end participation without any repercussions.

Materials

At the interview, following the signed consent (Appendix B), each woman was asked to provide demographic information (Appendix C) about their basic conditioning factors of age, education, sobriety date, and type of health care coverage. This information provided the investigator with demographic data on the women’s current resources.

Data collection procedure

After obtaining the informed consent from the participant, the information about her basic conditioning factors was obtained. The audiotaped interview was conducted in a private setting agreed upon by both the investigator and the participant. The recovery program provided a quiet private space as one site. The interview was anticipated to be
approximately one to one and one half-hours in length or until data collection was completed or data appeared redundant.

Three questions were asked of each participant:

1) Tell me your experience with using crack. Start at a point in your life before you started using any substances and continue to your present situation.

2) Now I'd like you to focus on how you took care of yourself while you were using and what is different today?

3) What have you had to call upon to keep you in recovery?

After data were analyzed, a follow-up appointment was made with each participant to confirm the findings.

Protection of human rights

Participation was strictly voluntary and confidentiality was maintained at all times. Each participant was informed that they may at anytime refuse to answer a question or end participation. The information from both the questionnaire and the interview was held strictly confidential. No identifying information appeared on the questionnaires or in the taped interview. Each of the data sources was numerically coded. The participant's name appeared only on the consent to participate. Consent forms were separately stored in a locked file cabinet in the office of the researcher and will be destroyed by shredding after three years. Audiotapes were destroyed after being transcribed into written form. All data were reported as aggregate, no names were used. Verbatims were only made available to the researcher and her committee.
Approval for this study was obtained from the Institutional Review Board of Human Protection of the Medical College of Ohio (Appendix D) as expedited research. Permission was obtained from the recovery program providing access to the participants (Appendix E) prior to seeking institutional approval.

**Procedure for data preparation and method of data analysis**

The basic conditioning factors were reviewed to establish demographic data on the sample. The taped interviews were typed verbatim by a professional transcriptionist. Data from the taped interviews were analyzed using van Kaam’s psychophenomenological method (PPM).

**The Psychophenomenology Method**

The phenomenological method (PPM), is a means to “describe and analyze scientifically the psychological structures of human experience” (van Kaam, 1987, p. 99). Earlier, van Kaam 1966, in looking at the character of human experience, described it as very complex, continually moving with new moments coming continually forward changing the total picture. The phenomenal analyst poses a question carefully aimed at obtaining spontaneous descriptions of a subjective experience. Van Kaam (1966) believed “that potential data be observed as they exist before an attempt is made to interpret them” (p. 295). The question is formulated so that the subjects are able to freely relate a wide variety of situations and the purpose is to discover moments common to all individual experiences of the same kind. This method leads to the description and classification of phenomena that can be affirmed by experts in the same field. Research performed in this method is preliminary exploration, pre-empirical, pre-experimental, and pre-statistical; it is experiential and qualitative.
The procedure for PPM as described by van Kaam (1966, 1987) and further explicated by Anderson and Eppard (1998) was utilized in preparing and analyzing the data of this study. The four phase process follows.

The first phase of the process is analysis. In five private interviews individual descriptions of the three research questions were obtained on audiotape. The taped interviews were transcribed verbatim. The investigator read the transcripts and listened to the tapes to get a general first impression of the structure of the experience. The experiences of each participant were put in table form and organized by question and content. Using the participants' own words hypothetical essential structural elements of the experience were identified. Repeated statements were eliminated noting the number of occurrences. Tentatively, the essential structural elements of like experiences of all of the participants were organized in the table form. Continuing to use the participants' own words, categorical statements were identified as compatible and incompatible giving an indication of the predominant features of the phenomenon. The data was presented to the investigator's chairperson for validation.

The process of methodological reflection reduced the statements of the participants to more precisely descriptive terms further identifying the integral structure of the experience. Continued situational reflection identified the elements essential to all or the majority of the participants.

The second, phase, translation, involved expressing the essential elements in the metalanguage of the science. For this study the elements were translated to the language of the SCDTN. The third phase, transposition, determined the fidelity by presenting the translation to the investigator's committee to assure as much as possible the accuracy of
the procedure. In the final phase, phenomenological reflection, a paradigm of the experience was produced that incorporated the essential structural elements of all three questions. The final paradigm was presented to the participants for verification and confirmation. Completing this phase is a statement of the limits of the understanding of the phenomenon gained through the process.

Summary

The process presented describes the actions to be taken by the researcher to determine the experiences of the participants. The psychophenomenological method (van Kaam, 1966, 1987) was used to establish the essential elements or themes that reflect the experiences of the participants. The essential elements were translated from the words of the participants into the language of the SCDTN (Orem, 1995) to describe the basic conditioning factors and self-care requisites of the participants. Finally, the researcher utilized the basic conditioning factors and self-care requisites to assess the self-care agency of the participants based on the data provided by the participants during the audiotaped interviews.
CHAPTER IV

Results

This chapter presents the results of the data analysis utilizing van Kaam's (1966, 1987) psychophenomenological method. The data for the analysis were obtained from verbatim provided by the participants during private face to face interviews. Essential elements for each of the three research questions were identified from the participants' descriptions of their experiences. The essential elements and supporting participants' statements are presented, as are the experiences of the African American woman who is recovering from crack cocaine addiction. The chapter concludes with the presentation of the paradigm of the participants' experience.

Sample

Participants in this study consisted of five African American women who were in recovery from crack cocaine addiction. The participants, at the time of the interviews, had recovery times of one year and five months to two years and three months and ranged in age from 27 to 44 years of age. Each was capable of verbally sharing their experiences using crack cocaine and their subsequent time in recovery, thus meeting the criteria for participation. The individual interviews were from 45 minutes to two and one half-hours in length and took place at various sites based on the comfort of the participant. None of the participants had completed high school but two had received their GED since entering recovery. All of the participants were receiving medical coverage from the Medicaid HMO program.
Findings

The data analysis began with the investigator reading the verbatim transcription while listening to the audiotapes to hear the experiences as well as read the words. A general first impression of the structure was formulated and written. As the verbatim were reread, significant statements emerged that were recorded as possible structural elements. These steps encompass the first third of phase one of van Kaam’s (1966, 1987) analysis process. The reduction process eliminated repetition with numerical notation of the incidence of the same kinds of statements. Tentative relationships of structural elements were determined and a list of compatible and incompatible statements, in the participants’ own words, were presented to the investigator’s advisor for validation, completing the first half of phase one of the psychophenomenological method (PPM). Utilizing the process of methodological reflection, potential conforming elements were determined and each was evaluated as to necessity in the emerging structure. The investigator then reflected on each element in the participants’ own words to capture the participants’ feelings of the situation. Essential elements were identified for each of the three research questions completing phase one, analysis, of the PPM. The essential elements of all research questions are presented in Table 1.

Research question 1

Eight essential elements were described by the participants’ in answering the first research question, “what is the experience of the African American woman using crack cocaine?” Each participant was requested to respond to the question, “Tell me your experience with using crack. Start at a point in your life before you started using any substances and continue to your present situation.”
Table 1. The essential elements by research question.

<table>
<thead>
<tr>
<th>Research Question #1 What is the experience of the African American woman using crack cocaine?</th>
<th>Research Question #2 Is there a difference in the self-care activities reported by African American women during active crack cocaine use and during recovery?</th>
<th>Research Question #3 What do African American women recovering from crack cocaine addiction identify as reasons facilitating their remaining in recovery?</th>
</tr>
</thead>
</table>
| 1. Feelings of being out of place and alone  
2. Previous experience of drinking and using with family  
3. Missing a positive mother/daughter relationship  
4. Violence from abusive relationships  
5. Feelings of paranoia while using  
6. History of incarceration  
7. Loss of children to county protective services  
8. Self-destructive thoughts and wishing to die | 1. Minimal to nonexistent ability to care for self  
2. Unable to fulfill responsibilities as an adult or parent  
3. Engaged in the risky behavior of multiple sex partners from prostitution, and daily soliciting  
4. Left family for long periods of time  
5. Stole from family and loved ones  
6. Experienced multiple attempts at treatment and staying clean | 1. Identifying and utilizing a sponsor  
2. Connecting with God or a Higher Power  
3. Multiple sources of long-term support are essential  
4. Adopting the Alcoholics Anonymous premises of keeping the focus of recovery on self, looking back, and remembering what it was like while using |
Element 1. Feelings of being out of place and alone

Four of the women expressed feeling lonely, alone, and out of place. In an attempt to become a part of the group or their family, three of the women described early use as a means to be accepted.

- Felt out of place even in my own home…when I would stay up at night and drink and play cards with my family I didn’t feel so alone….I even felt like I didn’t belong in school…when I missed [school] after being up all night I was okay with it.
- Felt alone…unhappy, I was so lonely, just so lonely…drinking I felt… a part of the crowd.
- My mom’s other kids didn’t like me…I think they were jealous. One time I remember I was dressed so pretty and I was happy and proud and when I went for a visit to their place they threw mud on me…at seven years old, can you believe it, I was doing what[siblings] were doing drinking, smoking, and having sex to be accepted.

Element 2. Previous experience of drinking and using with family

All of the women reported using with parents, siblings, cousins and various other family members. Four identified their mothers as addicts or alcoholics.

- The first time I used [crack] I was with my cousins.
- I remember at the age of eight or ten drinking with a friend, my brother, and my sisters…. [first use] crack cocaine with my brother
• I saw my sisters get high...my brother is still getting high...I saw my parents get high....mother was an alcoholic.

• Mother was a drug addict...an IV drug user.

**Element 3. Missing a positive mother/daughter relationship**

All five of the women described poor to nonexistent relationships with their mothers. One witnessed her mother’s death of an overdose and was still angry.

• I wanted to get away from all the arguing and fussing [by mother]

• I had and still have family problems with my mother

• I never had a mother/daughter relationship

• My mother...I remember nothing positive. Nothing....She [mother] died of an overdose in front of my face. I was ten then. I hated her for that.

**Element 4. Violence from abusive relationships**

Four of the women shared experiences of physical abuse by men in their lives. One shared “he [boyfriend and father of her oldest child] was beating me all the time. I never went to the hospital for it so I guess it wasn’t too bad.” A second, “I haven’t forgotten having my jaw broken.”

**Element 5. Feelings of paranoia while using**

Feelings of paranoia while getting high were identified by all of the women.

• while getting high...I was paranoid...I would peek out my window

• I thought I was losing my mind...when I’d get high, I’m running to the windows [looking for the police]...I’m getting paranoid.
• I stayed paranoid all the time while I was high…I even walked down the street at 3:00 in the morning backwards because I thought someone was following me.

Element 6. History of incarceration

Four of the participants shared the experience of being incarcerated, several were repeat offenders for various criminal activities during the time they were using.

• I boosted [clothing or other items are stolen from a store then are returned for cash or if a like item exchange is the policy of the store then a receipt is requested. In a few days the individual returns the item with the receipt for a cash exchange]…my way to Marysville [a state correctional facility].

• found myself in Stryker [a state correctional facility]…picked up for possession [drugs and paraphernalia]

• I went to jail a lot…one time for prostitution one time for possession [of drug paraphernalia]

Element 7. Loss of children to county protective services

The women spoke of hurting their families and those who cared about them. Four experienced the loss of their children to CSB, the local children’s protective services. One mother had all four of her children placed for adoption. One was eventually returned to her and remained with her. The fifth participant was honestly surprised that her children were never taken from her. She stated, “I don’t know why mine [children] were not removed.”
[I was] hurting everybody…who cared about me….I was hurting my house[family]. What am I doing to my babies?

I had him [her youngest son of five children] two maybe three weeks before CSB called [he was then placed in foster care with his siblings]

[The children] were out of my life for so long [a total of 18 months]…[CSB] placed them in foster care just before I went into treatment.

I was sixteen and staying with my sister; me and my two kids. I promised to pay her but hey I never did, so one day she up and says, “CSB is on their way to get your children.” I didn’t believe her until they [CSB] were next to my bed and then I was packing their things and crying with my three-year-old wiping my tears saying, “It’ll be okay mommy, it’ll be okay. Can you believe it this three-year-old was acting like the grown-up? [The children were returned after six months but were permanently removed one year later and were adopted six months after CSB took permanent custody.]

Element 8. Self-destructive thoughts and wishing to die

The women described self-destructive thoughts. The thoughts included wishing to die, not fighting if their life was threatened, and actual suicide. Two of the women spoke about contemplating taking their own life; “I was actually suicidal,” “I was smoking so much…I thought about killing myself.” A third stated, “I just wanted to die. I even prayed for it.” A fourth described how tired she was of the life style and if someone had threatened her she would not have taken action to prevent any harm. She stated, “I don’t think I would have fought for it” [her life].
Research question 2

The participants were then asked, “Now I’d like you to focus on how you took care of yourself while you were using and what is different today?” In response to the second research question, “Is there a difference in the self-care activities reported by African American women during active crack cocaine use and during recovery?”, the participants reported eight elements that described the difference. The first six elements reflected activities during use and the last two described behaviors since entering recovery.

Element 1. Minimal to nonexistent ability to care for self.

Personal care for all of the participants during active use was minimal to nonexistent. Personal care was described as hygiene activities, meeting nutritional needs, laundry, and medical care. One participant in response to the question “How did you care for yourself?” stated simply, “I didn’t.”

- Wouldn’t keep my room clean, barely...clean me...I was drinking 24 hours a day, seven days a week.
- I didn’t take baths...didn’t cook....I’d rather get high than wash...I got dark and real thin. I had burns on my lips from the pipe, and a rash all over...but I kept on.
- In the same clothes for two or three weeks...breath stinking...didn’t even think about a toothbrush.

All of the women had children; two spoke about getting very little or no obstetric care during their pregnancies: I didn’t even get prenatal care, only went to the doctor when I got pregnant...with the last ones...only near the end [of the pregnancy]. None of
the women mentioned routine healthcare activities before or during the period of active use.

Element 2. Unable to fulfill responsibilities as an adult or parent.

The women described their inability to be responsible for themselves, their children, or their homes. The desire for drugs overruled the sense of responsibility expected of an adult and parent.

- I was not responsible for myself, for my kids.
- Responsibilities were last, drugs were first….we never had lights….or gas over 30 days. I was a 30-day woman. [refers to having utilities on for short periods of time then turned off for failure to pay the bills]
- I never did that [care for my children]….didn’t pick up my son’s machine when it busted [aerosol machine] or his seizure pills….kids didn’t go to school.

Element 3. Engaged in the risky behavior of multiple sex partners from prostitution and daily soliciting.

The women engaged in the hazardous behavior of multiple sex partners. All of the women reported that they prostituted for money as well as for drugs. Soliciting exposed the women to several hazards: pregnancy, sexually transmitted diseases, physical abuse, and arrest.

- I would walk the streets, walking up and down the street at 3:00 and 4:00 in the morning
- I was sleeping with people for money….I was soliciting on a day to day basis.
• I was watching them [other women] in the houses doing all kinds of degrading things and I was saying, “If I ever do that I hope I die”…two years later I’m right there.

Element 4. Left family for long periods of time.

Being absent from the home for a long period of time was common; all of the women reported these absences. The trips away from home to procure drugs or to use were called “missions”. The mission could be for a few hours to days or weeks or longer. One woman left on the first of April and did not contact or return to her family until December. All of the women reported going on missions. Three of the women described these absences.

• I would be gone for weeks and weeks at a time. When I got back it was understood not to ask about where I’d been…I wouldn’t or couldn’t tell them anyway.

• Nobody has seen me because I’m on “a mission.” Now I look at those poor souls out there, you can tell they’re on “a mission” by the look on their face and sometimes what they got on, how you dress sends a message….I’m thanking God everyday I don’t have to do that any more.

• I stayed on the street for days…sometimes two weeks. After the kids were gone I left for over three months.

Element 5. Stole from family and loved ones.

Prostitution was only one means of supporting the drug habit. All of the women shared how they stole money, clothing, gifts, and food stamps.
• I stole money from my mother.
• I sold the kids’ Christmas gifts. One time it was after they had opened them.
• I traded the kids' new shoes to the dope man...I had been good for two weeks [sober] and I had promised the kids new shoes (I actually remember making the promise). We went and bought them and that evening I returned two pair to the store for cash. The other kid knew to wear hers and so I started a fight with her, took the shoes off her and traded them to the dope man.
• I blew whole checks [government assistance checks] and all the food stamps on drugs.
• I boosted clothes [clothing or other items are stolen from a store then are returned for a cash exchange].

Element 6. Experienced multiple attempts at treatment and staying clean.

All of the women had attempted and had been previously unsuccessful in recovery. Four shared early attempts with clean time ranging from five days to one month. One woman stated, “I went in COMPASS [local drug treatment center] for five days. I didn’t listen and I was back out there” [using drugs]. Another identified herself as, “I’m a thirty-day woman.” While a third said, “Thirty days is the most I stayed clean”.

The final two elements identified by the women describe the women’s activities as they entered and continued in the recovery process. All of the women shared with enthusiasm the change in behaviors and the pleasure they were experiencing.
Element 7. Improved personal care in recovery.

Improvement in personal care was described by all of the women. The actions taken included keeping physically clean, eating right, clean clothing, exercising, and getting adequate rest. None of the women spoke specifically about routine professional healthcare for themselves; however, healthcare for their children was seen as being a responsible parent.

- Today I’m taking care of myself. I get plenty of sleep…I eat right…I feel good.
- I keep my clothes clean…I cook my dinner…keep myself up.
- I watch my weight…watch what I eat…walk a lot.

Element 8. Assumed increased responsibility for self and family.

The women were proud of their progress in the roles of adult and parent. All of the women described themselves currently as responsible. As an adult and parent being responsible means to take care of your “business.” The responsible adult as described by the women, pays bills, cares for children, cleans house, goes to work, gets medical care for her children, and attends school functions with her children.

- They [children] eat…kids get plenty of sleep…I can keep a roof over our heads.
- I’m responsible about taking care of myself…responsibility for me and my household [family]…I have good feelings and I pay my bills…I haven’t missed any payments.
• I take care of my babies...I get the kids to school, clean house, go to the store, budget everything...I have a clear brain...I think better.

• I’m responsible. I’m stable. I show up at the schools....whatever medical attention they need...I’m on top of things.

• I work....go to school...I have my daughter. [This participant had three children removed from her care and adopted. This daughter was scheduled to be adopted but due to a foul up in paperwork it did not take place. Today mother and daughter are together.]

Research question 3

Finally, the participants were asked, “What have you had to call upon to keep you in recovery?” The women quickly and confidently answered the third research question, “What do African American women recovering from crack cocaine addiction identify as reasons facilitating their remaining in recovery?” Four elements were identified as maintaining their continued recovery. (See Table 1)

Element 1. Identifying and utilizing a sponsor.

Despite the fact that all of the women were addicted to crack cocaine and two identified themselves also as alcoholics, all of the women had engaged in Alcoholics Anonymous (AA). All five of the women stated that meeting and engaging a sponsor was the primary reason they remained in recovery. A primary principle of AA is the adoption of a sponsor by the member. A sponsor acts as a mentor for the alcoholic as she progresses through the program. Regular, often-daily, contact with a sponsor was
reported. My sponsor...I call my sponsor sometimes everyday, sometimes two or three times a day.

Element 2. Connecting with God or a Higher Power.

The women shared that turning the struggles of recovery over to God or their Higher Power was very important to them. The contact in the form of prayers was frequent and often daily, in the morning to ask for help during the day and at night to thank Him: “I thank God at night…and when I get up in the morning;” “I pray every night…my Higher Power;” “I pray a lot…God, help me.”

Element 3. Multiple sources of long-term support are essential.

The women expressed strong value for a support group, adopting a home group and speaking daily with other recovering women. Each woman regularly attended twelve-step AA meetings, AA Big Book Studies, and participated in the Fellowship. This participation is valuable for the long-term support it provides. A home group is one particular recovery group the participant attends, usually weekly. All five of the women reported the importance of their home group. In addition to AA groups, the women also attended Cocaine Anonymous (CA) and Narcotics Anonymous (NA) groups that offered contact with other recovering people and broadened their circle of support.

- A support group...I talk to somebody in recovery everyday.
- I have a home group...regularly attend meetings....the Fellowship.
- I talk with a recovering woman everyday.

Element 4. Adopting the Alcoholics Anonymous (AA) premises of keeping the focus of recovery on self, looking back, and remembering what it was like while using.
The women shared that recovery was selfish in that the “focus is on you and never forget where you have been or what it was like when you were using.”

- I focused on what it is that I need to be doing for me
- do this for me….keeping the focus on myself
- You use because you want to….its all about me
- looking back, calling upon memories, what it was like being out there
- never forget where you came from.

Paradigm of the Experience

The analysis of the data continued with the final phase (van Kaam, 1966, 1987) and development of a paradigm of the experience.

What is the experience of the African American woman using crack cocaine?

Feelings of not fitting in and being alone even when they were with their families were eased by substance use. Early and frequently, first experiences with alcohol and crack cocaine use were with a family member or friend, and even their mothers were users of alcohol and drugs. The women felt a mixture of anger, sadness, frustration, and forgiveness for the poor to non-existent relationships with their mothers. Criminal behaviors resulting in incarceration and abusive relationships with men were part of the life style. There was a feeling of craziness related to the behaviors associated with the feeling of paranoia experienced while smoking crack. The women expressed a great sense of guilt and remorse for the hurt their children experienced because of the drug use.

Near the end of active using there were thoughts of self-destruction and intense feelings of being too tired to continue.
Is there a difference in the self-care activities reported by African American women during active crack cocaine use and during recovery?

The drive to meet the demands of their addiction to crack cocaine kept the women from taking care of their most basic needs such as food, clean clothing, personal hygiene, and health care. Additionally, their addiction kept the women from fulfilling their responsibilities as adults and parents. Bills were not paid. Utilities were frequently turned off. Evictions and frequent moves were common. The children were left alone or with others often for long periods of time, missing school and medical appointments while the mothers were in pursuit of the drug. In desperate attempts to pay bills and obtain the drug, the women engaged in behaviors generally considered unacceptable, such as sex for money or drugs and stealing from family. There was a sense of sadness in the previous failed attempts at recovery. These feelings were sharply contrasted to the pride and excitement the women took in their accomplishments since entering recovery. In recovery the women maintained their physical health by eating right, exercising, getting adequate rest, and keeping clothing clean. There was a sense of success as the women assumed control of their homes and the responsibility for their children.

What do African American women addicted to crack cocaine identify as reasons facilitating their remaining in recovery?

Maintaining sobriety and continuing recovery were embraced as key to continued success. The women extolled the role of sponsors and professed the part God or their Higher Power played in recovery. Equally valued by the women was the development of multiple long-term supports in the community as a part of their recovery plan. The
women adopted the beliefs of keeping the focus on self and never forgetting what it was like when they were using.

Active crack cocaine use has roots in their early life. Family relationships and the use of alcohol and drugs by family members with the acceptance even the expectation of using to be a part of the family are the basic conditioning factors (bcf) of family systems and pattern of living that directly lead to a self-care requisite of keeping the body free of harmful substances. Crack cocaine abuse negatively impacts the bcf of health state by leading to addiction. Two self-care requisites, one developmental and one health deviation arise as a result of the addiction. The first requisite is to correct the social-emotional-developmental arrest precipitated by addiction. The second is a health deviation requisite to maintain sobriety and enter long term recovery. The bcf's of the crack cocaine addicted woman impair her self-care agency and her self-care activities are reduced to basic survival. This survival mode severely limits the woman’s ability to meet the therapeutic self-care demands created by the impact of the crack cocaine use on her self-care requisites. Thus, well being is not attained. These concepts are presented in Figure 2.

Validity

The final paradigm was prepared and presented to the participants by the investigator in private individual meetings for confirmation as described in the analysis as the last activity. All participants were in agreement with the description.
Figure 2. Relationship of SCDTN components during active crack cocaine abuse.

Basic Conditioning Factors
- Health state
  - experienced multiple attempts at treatment
- Family systems factors
  - feelings of being out of place & alone
  - previous experience of drinking & using with family
  - missing a positive mother/daughter relationship
- Pattern of living
  - minimal to nonexistent ability to care for self
  - unable to fulfill responsibilities as an adult or parent
  - engaged in risky behavior of multiple sex partners
  - violence from abusive relationships

Self-care Requisites
- Universal
- Prevention of hazards (safety)
- Developmental
- Stagnation in late childhood with delayed entry into adulthood (social – emotional - developmental arrest)
- Health Deviation
- Awareness of and attending to the effects & results of a pathologic condition (addiction)

Therapeutic
- Self-care Demand
- TSCD

Well Being
- Health
- Life
- Human Development

Self-care Agency (Impaired) → Self-care Activities (Survival)
Summary

The results of the data analysis using van Kaam's (1966, 1987) psychophenomenological method were presented. Essential elements were described for the three research questions. There were eight essential elements for questions one and two and four elements for question three. Finally, a paradigm of the experiences of the African American woman recovering from crack cocaine addiction and her self-care activities was presented.
CHAPTER V

Discussion

This chapter is a discussion of the data describing the experiences of African American women recovering from crack cocaine addiction and their self-care activities before and during recovery. The information was organized to encompass the experiences of the African American woman recovering from crack cocaine addiction including self-care activities and what keeps her in recovery. Eight essential elements were identified for both the experiences and the self-care activities and four elements for maintaining recovery. Conclusions, limitations, implications for nursing, and recommendations for future research are discussed.

Findings

The participants describe eight essential elements, answering the first research question: What is the experience of the African American woman using crack?

Feelings of being out of place and alone. Drinking and using crack was described by the women as a means to be accepted by family or friends. One vividly described smoking cigarettes and drinking beer at the age of seven to make her mother’s other children like her. Four of the women stated using was a means of easing feelings of loneliness. There was a sense of pain and hurt expressed by the women, as they described not “fitting in” in environments that typically always accept an individual, home, school, and family. The same hurt and pain was felt as they shared how lonely they were. The feelings of loneliness the women expressed supports Zlupko et al.’s (1995) study of addicted women who reported having few or no friends and a very limited social network. Additionally, Lindenberg et al.’s (1994) study reporting social
pressure or peer influence as a factor in drug use is also supported by the findings of this study.

Previous experience of drinking and using with family. All of the women reported drinking and using with family members. Two women stated that their first use of crack was with a family member, and four identified their mothers as addicts or alcoholics. The information shared by the women regarding family drug use was presented without emotion until they began to describe the drug using behaviors of their mothers. Two became teary eyed as they described their mothers’ drinking and drug use. One angrily described her mother as an intravenous drug user and drug addict who overdosed and died while she as a child was present. The importance of the parent being a drug addict or alcoholic supports the findings of Wallace (1990) who concluded being the adult child of an alcoholic may be etiologic in the development of crack cocaine dependence. Active substance use with partners and close family members, particularly mothers, was reported in a study by Dore and Doris (1998). Additionally, the Lindenberg et al. (1994) study found social pressure or peer influence to be a trigger to use drugs.

The relationship of first time using with other family members was not found in the literature. Henderson et al. (1994) reported a woman’s first experience with illicit drugs occurred during an intimate or sexual encounter, and this was not the finding of this study. The two who described their first crack use reported it to be with family members. None of the women shared using with a significant other or in a mutually romantic encounter as described by Zlupko et al. (1995). Crack cocaine use with men in sexual scenarios was reported by four of the women to procure the drug, not as a part of a romantic encounter.
**Missing a positive mother/daughter relationship.** Next to the relationship with their children, the relationship discussed by the women in the greatest detail was with their mothers. All of the women described difficulty in their relationships with their mothers. The range was from being hurt for not having a mother/daughter relationship to deep feelings of anger, even hate. This supports the finding by Wallace (1990) who reported disrupted relationships or traumatic losses such as the early death of a parent may be etiologic in the development of crack cocaine dependence. Additionally, the findings support Lindenberg et al.’s (1994) report of perceptions about drug use by inner city Hispanic women, one resiliency factor deterring drug use to be the positive socializing of parental and childhood experiences.

**Violence from abusive relationships.** The women shared experiences of being hurt, physically, and verbally but only the physical abuse by men, other than family members, was identified specifically as abuse. One woman minimized the abuse by her boyfriend when she said, “I never went to the hospital for it so I guess it wasn’t too bad.” These findings support those of Dore and Doris (1998), Wallace (1990), and Wright (1995) that one quarter to one third of those entering a detoxification unit had experienced domestic violence or sexual abuse. None of the women reported being sexually abused, but one reported having sex with her siblings at the age of seven and had her first child at thirteen years old. A second described behaviors of other women in “crack houses...engaging in unusual sexual acts” for drugs or money and soon she was doing it too.

**Feelings of paranoia while using.** All of the women spoke of the intense feelings of paranoia that were experienced while using. The paranoia appeared to be related directly to using and was not spoken about except while seeking the drug, actually using, or
immediately after an episode of smoking. Paranoia was described by the women as running from window to window looking for the police, walking backwards down the street because someone may be following them, or hearing noises and seeing shadows in their homes. No literature in nursing research was found to report paranoia in crack cocaine using African American women. Smith et al. (1993) did report on the overrepresentation of psychiatric diagnoses including substance abuse in homeless women but did not identify paranoia as one of the diagnoses.

**History of incarceration.** Four of the women shared the experience of spending time in jail or prison for a variety of charges. All of the women had felony convictions but none were violent crimes. This appears to support the U.S. Department of Health and Human Services (1990) report that drug abuse in the United States, for both men and women, results in an increase in the rate of severe crimes with incarceration.

**Loss of children to county protective services.** The relationship most often spoken about by the women was between them and their children. All five of the women spoke about abuse and neglect of their children. Four of the women had the experience of having their children removed from their care for various levels of neglect and the fifth was not clear why the authorities had not taken her children. There was no nursing research found that discussed the involvement of children’s protective services in the lives of crack cocaine addicted women, but (Jaudes, Ekwok, and Van Voorhis, 1995) reported that estimates indicate 50% to 80% of families brought to the attention of child welfare authorities are involved with alcohol or other drugs.

**Self-destructive thoughts and wishing to die.** The women in the study described feelings of self-destruction and suicide related to being tired of using crack cocaine and
the life style that supported the addiction. No literature reported a relationship between crack cocaine use and suicide but Smith et al. (1993) reported, in a study of homeless women in St. Louis, one third had a history of substance abuse. The Smith study further reported depression to be twice as frequent in the homeless group; 49% of those reporting depression had attempted suicide.

The second research question, "Is there a difference in the self-care activities reported by African American women during active crack cocaine use and during recovery?" generated eight essential elements, six of which reflected the time during active using and two behaviors since entering recovery.

Minimal to nonexistent ability to care for self. The women all described their attention to personal needs as poor to nonexistent while they were actively using crack cocaine. This included personal hygiene such as bathing, oral care, eating properly, and sleeping regularly. The only attention to health care shared by the women was for pregnancy and that was minimal. One woman stated she did not have any prenatal care and another said she only had prenatal care with the last two children and that was at the end of her pregnancy. This supports the work of Nyamathi (1991) and Smith et al. (1993) who reported that addicted individuals took few or no preventive measures, rarely recognized or sought care for medical conditions, and frequently failed to follow through on prescribed therapies.

Unable to fulfill responsibilities as an adult or parent. The women described how the desire for crack cocaine overruled the sense of responsibility expected of an adult and parent. Those responsibilities were reported as caring for their children and providing a safe appropriate place for them to live. The perceived resiliency factors of personal
competence reflected the ability to make positive life choices, adult developmental roles of having children and being a role model, and economic participation with access to community resources as reported by Lindenberg et al. (1994) are supported by this study.

Engaged in the risky behavior of multiple sex partners from prostitution and daily soliciting. Although all of the women reported prostituting for money and drugs, none reported that their children were unwanted or unplanned. Two reported having acquired a sexually transmitted disease (STD). This supports the works of Edlin et al. (1994), DeHovitz et al. (1994), Hser, Chou, Hoffman, and Douglas (1999), and Nyamathi (1991) who reported that women who smoke crack cocaine frequently have multiple sex partners or exchange sex for drugs and are at high risk for STD’s including HIV infection and unplanned or unwanted pregnancies. Additionally, the findings support the work of Muller and Boyle (1996) that maintaining sexual relationships with men and obtaining drugs were higher priorities for most crack cocaine using women that protecting themselves from HIV infection.

Left family for long periods of time. All of the women reported going on “missions” to obtain or to use drugs, while only three described the absences. The women spoke of these missions in very matter of fact tones but express deep sympathy for others who are still engaging in that lifestyle. Several works described study participants as homeless but there were none that described women as leaving home and families as a part of their crack cocaine using lifestyle.

Stole from family and loved ones. All of the women shared that prostitution and exchanging in sexual favors was not the only way they supported their addiction. Another behavior in which the women engaged was stealing from their families. This took the
form of taking money, food stamps, clothing, food items, toys, and anything else that
could be sold or traded. There was a very strong sense of shame but an underlying tone
of "I did what I had to do." The U.S. Department of Health and Human Services (1990)
reports that drug abuse in the United States, for both men and women, results in an
increase in the rate of severe crimes with incarceration but there was no documentation
found regarding stealing from family.

**Experienced multiple attempts at treatment and staying clean.** Four of the women
described failed attempts at treatment for their cocaine addiction. One of the women
described an early attempt at treatment as just something she had to do to get people out
of her life. Three stated that this time they were just plain tired of the life and wanted to
quit. Although there were no nursing references related to crack cocaine addicted women
and repeated attempts at treatment, Dahlgren and Willander (1989) investigated alcoholic
women's responses to a women-specific treatment program in an attempt to respond to
the high incidence of treatment failure in women who entered traditional programs or
programs that were not gender specific. This finding also supports the work of Nelson-
Zlapko et al. (1995, 1996) that found women in general had a higher rate of treatment
avoidance, a lower rate of retention in treatment, and a higher incidence of relapse.

**Improved personal care in recovery.** To have confidence and to be satisfied with
oneself is to have self-esteem. The women enthusiastically described their personal care
habits of eating right, exercising regularly, keeping clean, and getting adequate sleep.
This supports Nyamathi (1991) who reported that women with high self-esteem and a
sense of coherence reported less emotional distress and engaged in fewer high-risk
behaviors such as drug use. Additionally, this finding supports the resiliency factor,
personal competence reflected by the ability to make positive life choices, reported by Lindenberg et al. (1994)

**Assumed increased responsibility for self and family.** All of the women expressed that they were now responsible for their own life and that of their children. As an adult and parent, being responsible means to take care of your "business." The responsible adult as described by the women, pays bills, cares for children, cleans house, goes to work, gets medical care for her children, and attends school functions with her children. Success in fulfilling the developmental roles of an adult (i.e. having children, being a role model, establishing personal goals, and establishing enduring emotional relationships) and economic participation with access to community resources are two resiliency factors described by Lindenberg et al. (1994) and supported by this finding.

Four elements were identified to answer the third research question, "What do African American women recovering from crack cocaine addiction identify as reasons facilitating their remaining in recovery?"

**Identifying and utilizing a sponsor.** All five of the women identified their sponsor as a major factor in their recovery. This positive life choice supports the resiliency factor of personal competence as described by Lindenberg et al. (1994) as the ability to make positive life choices and the development of the adult roles of establishing personal goals and enduring relationships.

**Connecting with God or a Higher Power.** The second element unanimously reported by the women was making the connection with their Higher Power. The use of one’s Higher Power is a major premise of the philosophy of Alcoholics Anonymous. All
used the term Higher Power interchangeably with God. No specific literature reference to a Higher Power or God was found.

Multiple sources of long-term support are essential. This finding supports the works of Nyamathi (1991) and Lindenberg et al. (1994). Nyamathi reported the strong relationship that coherence, self-esteem, and support availability has on emotional distress. Lindenberg et al. describe one aspect of adult role development, the establishment of enduring emotional relationships, as one of six resiliency factors to resist drug use.

Adopting the Alcoholics Anonymous premises of keeping the focus of recovery on self, looking back, and remembering what it was like while using. All five of the women reported the need to keep the focus on themselves and never forget the past. This finding supports the suggestion made by Zlupko et al. (1995) that a woman specific treatment program would best serve the woman by having a philosophy that focuses on the individual’s strengths and uses their past experiences as learning tools rather than sources of grief and shame.

Theoretical Implications

The self-care deficit theory of nursing (Orem, 1995) appears to be a very useful framework for nurses working with crack cocaine addicted African American women. The theory provides for an assessment of what the individual needs to maintain a state of well-being, their self-care ability, and directs the nurse to support or enhance the individual’s self-care abilities or to directly meet the needs when a deficit is identified. Crack cocaine addiction has a profound effect on the African American woman’s ability to meet the therapeutic self-care demands for herself or her family by impacting her basic
conditioning factors. Nurses use the assessment of the addicted woman's basic conditioning factors to guide the plan of care to meet the self-care demands. The relationship that crack cocaine abuse leading to addiction has on the individual's wellbeing can be assessed by utilizing the SCDTN. The universal self-care requisites are often negatively impacted by the pattern of living described by the addicted woman. This pattern of living brings environmental factors into her life that place her health state at risk for poor nutrition, alteration in sleep-wake patterns, STD's, unwanted pregnancy, injury, and possibly death. Addiction appears to negatively impact the developmental requisites by delaying or halting the developmental process of an individual and disrupting one's decision-making abilities. Nurses need to be aware of the delay and faulty decision-making abilities of the crack cocaine addicted woman. An assessment of where the woman is in her decision-making abilities is essential in assisting her to set goals and establish boundaries for herself and her family. The health deviation requisites are influenced by the sociocultural orientation of the addict and the community toward the addict and addiction. This attitude will set the tone for availability and adequacy of resources in the community and whether or not the addict will access the resources. Nurses and other health care providers need to be aware of their own beliefs and prejudices as well as those of the community to best assist the addicted woman in recognizing a need for assistance, seeking services, carrying out prescribed treatment, and learning to live with the changes in lifestyle the condition has made necessary.

Conclusions

Crack cocaine addiction for the African American woman is a long term, progressively disabling condition. Environments that typically accept an individual,
home and family only afforded the women a sense of belonging when they participated in alcohol and drug use. The women described how substance use eased the intense feelings of not fitting in and loneliness even in their homes with their families present. The women shared that they were using to be a part of their family’s life. The women reported alcohol and cocaine use with family members, for one as early as seven years old. Each woman spoke of a poor relationship with her mother and many stated their mothers were alcoholics or drug addicts. The loss and disruption of the mother-daughter relationship for the women produced a mixture of anger, sadness, frustration, and forgiveness. The women expressed a great sense of guilt and remorse for the disruption in their mother-child relationships with their children and the hurt their children had experienced because of the drug use. Although none of the women reported sexual abuse, one described having sex with siblings at the age of seven and had her first child at thirteen. Another described being in the “crack house” engaging in sexual activities that early in her addiction she said was degrading and she would never do. The women experienced abuse by others but only the abuse by men other than family members was viewed to be abuse, and in one case it was minimized and rationalized as being deserved. Incarceration was an accepted part of the life style. Many of the women had served time in prison for felonies such as prostitution, destruction of property, resisting arrest, and possession of drugs and drug paraphernalia. The women described situations that indicated that their mental health was at risk. Feelings of paranoia experienced while smoking crack were reported. Near the end of active using the women described thoughts of suicide, an intense feeling of being too tired to continue and the belief that it was not worth fighting for life.
The addiction to crack cocaine kept the women from taking care of their most basic needs such as food, clean clothing, personal hygiene, and health care. One woman, when asked how she cared for herself while she was using simply stated, “I didn’t.” The women were unable to fill the roles of adult or mother. In desperate attempts to pay bills and obtain crack cocaine the women engaged in behaviors, generally considered unacceptable, such as sex for money or drugs and stealing from family. Bills were not paid. Utilities were frequently turned off. Evictions and frequent moves were common. The instability of the households dramatically affected the families. The children were left alone or with others often for long periods of time. Missing school and medical appointments while the mothers were in pursuit of the drug was so frequent that many of the women had the experience of having their children removed from their custody. The women reported failed attempts at recovery or trying to stop using. Several of the women stated simply that they failed because they were not done using. Since entering recovery, the women expressed pride and excitement as they described their abilities to care for themselves and their families. During recovery the women reported maintaining their physical health by eating right, exercising, getting adequate rest, and keeping clothing clean. The criteria or the abilities expected of an adult and a successful parent were described by the women as being employed, taking care of the medical needs of their children, assuring that their children attend school, and maintaining a stable home environment.

Maintaining sobriety and continuing recovery are the keys to continued success. The principles of Alcoholics Anonymous were embraced by all of the women. Sponsors, God or their Higher Power, attending regular AA meetings, and sharing their experiences,
strength and spirit played an important role in their recovery. The women adopted the beliefs of keeping the focus on self and never forgetting what it was like when they were using. The development of multiple long-term supports in the community was also an important part of their recovery plan. Interestingly, none of the women identified the treatment program or the transitional recovery program as important to their recovery.

Limitations

Several limitations of this study were identified. First, the small number of participants, five, makes it hard to generalize the findings to all African American women however the intent of the study was to obtain in depth data. Second, all of the participants were recruited from the same transitional residential program and their recovery experiences were similar due the program’s uniform expectations of all participants. Finally, the women in the study not only experienced an addiction to crack cocaine but also presented a history of alcohol abuse, which makes it difficult to attribute all of the findings to their crack cocaine use.

Implications

Implications for nursing practice. Crack cocaine addiction for the African American woman affects the woman to the core of her being. For the five women in this study, the path to addiction started in early childhood with poor family dynamics, especially in their relationship with their mothers. The participants were unable to identify a time when a nurse could have intervened to stop the progression of the addiction. Nurses and other health care providers however had opportunities to evaluate the basic conditioning factors, the self-care agency, and the self-care activities of the women both as children and adults. Nurses who work with families need to be aware of
how family relationships can impact a child’s state of health and long term success or failure and the negative influence that crack cocaine has on the health of an African American woman’s relationship with her family. The information that sexual and physical abuse by family members may not be identified as abuse by the African American woman addicted to crack cocaine is important to the nurse practicing in an arena where African American women seek services. The nurse’s efforts should support the African American woman to develop strong healthy family bonds and assist her to feel good about her roles of adult and mother within her family.

The experiences of these five women should alert those who encounter African American women actively using crack cocaine or entering recovery programs that a successful recovery is more than to stop using. Utilizing the past as a learning experience and enhancing the individual’s resiliency factors increases the likelihood of success. Recognizing the woman’s need to maximize her ability to care for herself and her family is critical. Techniques and learning experiences that increase self-image, encourage healthy relationships, provide information regarding family growth and development, support efforts to change or add new behaviors, acknowledge successes, and recognize the need to seek assistance elsewhere in the community should be a part of a recovery program that admits African American women.

Long term, the African American woman recovering from crack cocaine addiction needs to have support from many sources in the community. The woman’s circle of support should include participation in self-help groups such as AA or CA, treatment and healthcare providers, church, family and friends, or other individuals who are committed to be available to the woman.
Implications for nursing education. Nursing educators need to provide information to students and nurses on the impact crack cocaine addiction has on the African American woman's ability to care for herself, her family, and ultimately her sense of well being. Conversely, the role of family life in the development of addiction needs to be shared with nurses whose practice includes women of childbearing age and families. Strategies for presenting this information would include videos, role modeling, and clinical experiences at sites frequented by the women such as homeless shelters, free clinics, and community drug treatment programs. Nurses who understand how complex addiction to crack cocaine is for the African American woman will be better able to assist the woman to develop a short and long-term plan to meet her and her family's requisites.

Implications for theory development. Addiction and recovery is very personal and varies individual to individual. The SCDTN effectively supports the crack cocaine addicted African American woman and the nurse working with the woman by recognizing the uniqueness of each woman's experiences and the impact of the addiction on her basic conditioning factors, self-care requisites, and her self-care agency. Additionally, the theory dictates that the woman directs the plan of care and is an active participant in its development and implementation. The ability to direct the plan ensures an increase in meaning to the individual thus increasing the chance for success. If the addict does not feel this control the plan will fail.

Recommendations for further research

This study has identified factors from the childhood of the women that appear to have impacted their addiction and their recovery. Further study to generalize the results to all women would be beneficial in development of education and prevention programs
that will assist addicted women to stabilize their lives and improve the living experiences for their children with the goal of breaking the cycle of family addiction. Qualitative studies that investigate women in various treatment programs, women of other ethnic backgrounds, and women of other socioeconomic groups would help to generalize the findings to all women. Studies that follow the children to determine how their mother’s experience with addiction and recovery impacts their behaviors would provide information to the nurse and other health care providers for prevention efforts aimed at the children of crack cocaine addicted women. Finally, there is a need for studies identifying the best practices for the successful recovery of women addicted to crack cocaine which include long term results, three to five years and beyond.

Summary

The experience of the crack cocaine addicted African American woman, prior to addiction through her early recovery, was presented. The findings presented included a discussion of each essential element and the impact the addiction has on the self-care abilities of the woman. This psychophenomenological study has presented information that will assist nurses and other health care providers to more effectively identify the needs and barriers to recovery for the African American woman. As recovery to addiction is personal and requires the individual to actively participate, the self-care deficit theory of nursing (Orem, 1995) guides the nurse’s practice to identify the individual’s basic conditioning factors, self-care agency, and therapeutic self-care demands to reach a state of well being. Finally, limitations and areas for further research were presented.
REFERENCES


Year Book.


Appendix A

You are being asked to participate in a research study that will look at the self-care behaviors used by women who are recovering from crack cocaine addiction. The study is part of my requirements to complete my masters degree in nursing at the Medical College of Ohio. You are selected as a possible participant because you are currently enrolled in the recovery program at Harbor House.

If you decide to participate, you will be asked to participate in an interview with me. This interview will be audiotaped and you will be asked to discuss your experiences with your addiction, specifically, how it has affected your self-care activities. During the interview I will be asking you about your experiences with your addiction to crack cocaine and how you have taken care of yourself. The sharing of your experiences will help nurses and other health care providers understand the needs of women who find themselves in the same situation. The interview will take place in a private setting and all the information will be kept confidential. Your name will not appear on the tape or any written documents.

I will be returning to your next meeting if you are interested in participating in my study, you may let me know at that time. Your decision to participate or not participate in this study will in no way affect any of your services from the Harbor House.

Thank you for considering participation in this study.

Sincerely,

Jean Brandt, RN, BSN
Graduate Student
Medical College of Ohio
School of Nursing
Appendix B

Informed Consent Form
Experiences of the Recovering Crack Cocaine Addicted African-American Woman Within a Self-Care Framework
Principal Investigator: Judith Anderson, RN, PH.D. 383-5893
Jean Brandon, RN, BSN 251-2563

Purpose
You are being asked to participate in a research study to identify the self-care behaviors used by recovering crack cocaine addicted women. The purpose of this study is to determine whether addiction to crack cocaine affects a woman’s ability to care for herself. Five women will be participating in the study. You were selected as a possible participant in this study as you are currently engaged in a recovery program.

Procedures and Duration
If you decide to participate, you will complete a short questionnaire and take part in an interview that will last approximately 60-90 minutes. The interview will take place in a private setting agreed upon by you and Mrs. Brandon.

Risks and Discomforts
There should be no risks or discomfort to you. However, there may be some discomfort in talking about your drug use and its impact on your life. If you should experience feelings of discomfort or distress and you wish to talk with someone you may speak with Ms. Brandon or call her at 251-2563 or her advisor Dr. Judith Anderson at 383-5893.

Benefits and Compensation
We cannot and do not guarantee or promise that you will receive any benefits from this study. However, there is the possibility that talking about your experiences may provide you with some insight and aid in your recovery process. The information may be useful for nurses and other health care professionals who work with recovering women.

Confidentiality
If you indicate your willingness to participate in this study by signing this document, the findings from this study will be published in Mrs. Brandon’s thesis. All information will be reported as group data; no participant names will ever be used. Any information that is obtained in connection with this study that can be identified with you will remain confidential and will be disclosed only with your permission. Only Mrs. Brandon and her advisory committee will have access to the study data which will be stored in a locked file and destroyed after data analysis is completed. Under some circumstances, the Institutional Review Board and Research and Grants Administration may need to review patient records for compliance audits.

Approved by MCO IRB
06/16/99
In the Event of Injury
In the event of injury from your participation in this study, treatment can be obtained at Medical College Hospital. You may also contact Mrs. Brands, at 251-2563 or her advisor Judith Anderson, at 385-5935 or you may utilize the services at Rescue Crisis, at 255-9585. You should understand that the cost of treatment will be your responsibility. Financial compensation is not available.

Voluntary Participation
Participation in this study is strictly voluntary. If you decide not to participate in this study, it will not in any way affect your relations with your treatment program, the Medical College of Ohio or their personnel. If you decide to participate, you are free to withdraw at any time without penalty.

Questions
Before you sign this consent, please ask any questions regarding the study that are unclear to you. You may take as much time as necessary to think this over.

AUTHORIZATION
YOU ARE MAKING A DECISION WHETHER OR NOT TO PARTICIPATE IN THIS STUDY. YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE INFORMATION PROVIDED ABOVE. HAVE HAD ALL YOUR QUESTIONS ANSWERED, AND HAVE DECIDED TO PARTICIPATE.

"The date you sign this document to enroll in this study, that is, today's date, MUST fall between the dates indicated on the approval stamp affixed to each page. These dates indicate that this form is valid when you enroll in the study but do not reflect how long you may participate in the study. Each page of this Informed Consent Form is stamped to indicate the form's validity as approved by the MCO Institutional Review Board (IRB).

Date ____________________________ Time ____________________________

Name of Subject (please print) ____________________________

Signature of Subject ____________________________

Signature of Investigator Jean Brands, RN, BSN 251-2563

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP

If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research subject or research-related injuries, please feel free to contact Douglas Willkerson, Ph.D., Associate Vice-President for Research, Medical College of Ohio at (419)837-4221.
Appendix C

Experiences of the recovering crack cocaine addicted African American woman within a self-care framework.

Basic Conditioning Factor Information

Participant Number: __________
Date: _______________________

1. What is your age today? ____________________________________________

2. Education (highest grade completed): _________________________________

3. What is your sobriety date? _________________________________________

4. Do you have health care coverage? _________________________________
TO: Judith A. Anderson, R.N., Ph.D.
School of Nursing
MCOD

FROM: Eric Schub, M.D.
Chair, Institutional Review Board
Research and Grants Administration

DATE: November 5, 1998

SUBJECT: IRB 999-303 - Experiences of the Recovering Crack Cocaine Addicted African-American Woman within a Self-care Framework

The above project was reviewed and approved by the chairman of the Institutional Review Board as an expedited review. The full board will review it at its meeting on 11/19/98.

APPROVAL DATE: 10/26/98
EXPIRATION DATE: 10/27/99

NOTE: THE ATTACHED CONSENT FORM WITH THE IRB APPROVAL STAMP IS THE ONLY VALID VERSION AND MUST BE COPIED AND USED FOR ALL STUDY PARTICIPANTS.

It is the Principal Investigator’s (P.I.’s) responsibility to:

1. Ensure that all subjects, or their legal representatives, sign the informed consent form at the time they sign the form to give consent to participate in the study. When applicable, a copy of the signed and dated informed consent form must be placed in each patient’s medical record.

2. Notify promptly the IRB at 383-4251 of any unoward incidents or unanticipated adverse reactions that develop in the course of the research on human subjects. Please make copies of the attached form and use it for ALL SUCH REPORTS for this protocol. The Principal Investigator is also responsible for submitting to the MCOD IRB forms of adverse events that occur at other sites conducting this study.

3. Report promptly all changes in key personnel and obtain prior IRB approval for any changes required in the informed consent/assent documents.

4. Obtain prior IRB review and approval for changes in procedures, inclusion/exclusion criteria, source of participants, new or additional advertising materials, and for any and all changes to the informed consent/assent documents.

5. Report promptly new information affecting the risk/benefit ratio and obtain prior IRB approval for any changes in the informed consent/assent documents that may be required by the new information.

6. Obtain prior IRB review and approval for all modified and/or added incentives going to the P.I., study coordinator, other study personnel, and/or the institution. These incentives may be in the form of money or other items of value, including, but not limited to, equipment, such as computers, and intangibles, such as frequent flyer miles.

Approval of changes may be requested by sending a memo with a copy of all materials relevant to the requested change and revised consent/assent documents, if applicable, with the revisions highlighted, to me.

IRB protocols must be reviewed and reapproved no less than once per year. Research and Grants Administration will try to remind you when reapproval is due. However, your office should have a reminder system in place to initiate the reapproval process at least a month prior to the expiration date shown above.

Enclosures: Stamped consent/assent document(s); Attachment: forms and guidelines.

EHSS MPA #41338
Medical College of Ohio

INSTITUTIONAL REVIEW BOARD

MEMORANDUM

TO: Judith A. Anderson, R.N., Ph.D.
Department of Acute and Long Term Care
MCO

FROM: Eric Schauh, M.D.
Chair, Institutional Review Board
Research and Grants Administration

DATE: October 11, 1999

SUBJECT: IRB #99-303 - Experiences of the Recovering Crack Cocaine Addicted African-American Woman within a Self-Care Framework

The above protocol was reviewed and reapproved by the Chairman of the Institutional Review Board and this action will be reported to the committee at its meeting on 10/21/99. This reapproval is only for data analysis. The project is reapproved for a period of up to one year.

CONTINUING REVIEW DATE: 10/08/99
EXPIRATION DATE: 10/07/00

It is the Principal Investigator's (P.I.'s) responsibility to:
1. Notify promptly the Institutional Review Board at 383-4251 of any untoward incidents or unanticipated adverse reactions that develop in the course of your research on human subjects. Please make copies of the attached form and use it for ALL SUCH REPORTS for this protocol.
2. Report promptly all changes in key personnel.
3. Report promptly new information affecting the risk/benefit ratio and obtain prior IRB approval for any short addendum to the consent/assent documents that may be required to inform participants of new information regarding the study.
4. Obtain prior IRB review and approval for all modified and/or added incentives going to the P.I., study coordinator, other study personnel, and/or the institution. These incentives may be in the form of money or other items of value, including, but not limited to, equipment, such as computers, and intangibles, such as frequent flyer miles.

Approval of changes may be requested by sending a memo with a copy of all materials relevant to the requested change and revised consent/assent documents, if applicable, with the revisions highlighted, to me.

IRB protocols must be reviewed and reapproved not less than once per year. Research and Grants Administration will try to remind you when reapproval is due. However, your office should have a reminder system in place to initiate the reapproval process at least a month prior to the expiration date shown above.
CONCONDITION OF AGREEMENT

1. It is understood that Harbor House/300 Beds, will decide which residents Ms. Brandt may solicit participation from.

2. Procedures are to be followed as detailed in Ms. Brandt's letter.

3. Harbor House/300 Beds, will be informed in writing of any changes in the forms, procedures or interview process prior to resident participation and that any changes in the procedures will need to be approved by Harbor House staff.

4. It is understood that strict confidentiality procedures will be used so that no resident's name will be connected with this study with the exclusion of the consent to participate form and that no identifying information will be on the questionnaires or the audio tapes.

5. It is understood that no resident is under any obligation to participate in this study by virtue of residency status at Harbor House and that residents are free to withdraw their participation at any time without penalty.

6. It is understood that neither Harbor House/300 Beds nor any of the agencies employees can be held liable for any injuries, breaches or other incidents that may occur as a result of resident participation in this study.

7. The signatures below indicate that Ms. Brandt and others associated with this study agree to the above conditions and that permission has been granted for Ms. Brandt to solicit resident participation.

Dr. Judith Anderson 7-2-98

Jean Brandt 6/13/98

Dorothy Cooper Executive Director/ Harbor House 4/2/98

Gretchen Thomas Program Advisor/ Harbor House 6/2/98
ABSTRACT
Experiences of the recovering crack cocaine addicted African American woman within a self-care framework.

The purpose of this study was to explore the experiences of women recovering from crack cocaine addiction with a secondary purpose to explore how the addiction affected their ability for self-care. The psychophenomenological study examined the recovering African-American woman’s ability to meet her requisites utilizing Orem’s (1995) Self-care deficit theory of nursing as a framework. Five African-American women, 18 to 45 years of age, addicted to crack cocaine and in recovery six months to two years, were selected as a convenience sample from women enrolled in the aftercare phase of a recovery program. Participation was strictly voluntary and confidentiality was maintained at all times. After obtaining the informed consent from each participant, a self-administered biographical questionnaire was completed, followed by an audio taped interview consisting of three questions. Van Kaam’s (1966, 1987) Psychophenomenological Method was used for data analysis.