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Parents who use drugs: Accounting for damage and its limitation

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Parents who use drugs parent in a context of heightened concern regarding the damaging effects of parental drug use on child welfare and family life. Yet there is little research exploring how parents who use drugs account for such damage and its limitation. We draw here upon analyses of audio-recorded depth qualitative interviews, conducted in south-east England between 2008 and 2009, with 29 parents who use drugs. Our approach to thematic analysis treated accounts as co-produced and socially situated. An over-arching theme of accounts was ‘damage limitation’. Most damage limitation work centred on efforts to create a sense of normalcy of family life, involving keeping drug use secret from children, and investing heavily in strategies to maintain ambiguity regarding children’s awareness. Our analysis highlights that damage limitation strategies double-up in accounts as resources of child protection as well as self protection. This illuminates tensions in the multiple functions that accounts of damage limitation can serve. We draw a distinction between accounts in which damage is qualified and those in which damage is accepted. Accounts of damage qualification highlight a theme of ‘good enough’ parenting. Accounts of damage acceptance highlight a theme of ‘recovery’. We find that the interview accounts operate in response to a regulative norm of ‘good parenting’ in which one strives to deflect damaged identity through narratives of damage qualification and to seek understanding and acceptance through narratives of recovery. Noting the absence of space for parents who use drugs to openly reflect or talk about the challenges they face, we identify the need for social change interventions to create enabling environments for earlier help seeking and talking.

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Introduction

Harm reduction, a mainstream feature of European public health and drug policies, emphasises efforts to reduce the health, social and economic harms of drug use to individuals, communities and societies. The reduction of harm to children and young people affected by parental drug use has become a prominent feature of current drug policy in the UK (HM Government, 2008), based on the premise that parental drug use is potentially harm producing to children “at every age, from conception to adulthood” (ACMD, 2003). With as many as 5 million people in the UK dependent upon alcohol or drug use, estimates suggest that at least 8 million people, and over 2 million children, are living in families affected by substance use (Manning, Best, Faulkner, & Titherington, 2009; Velleman & Templeton, 2007). A recent growing body of research has sought to map the impact of parental problem drug use on the lives of children and young people and other family members (Barnard, 2007; Barnard & McKeganey, 2004; Kroll & Taylor, 2003; Velleman & Orford, 1999; Velleman & Templeton, 2007). Whilst acknowledging potential for risk moderation (Backett-Milburn, Wilson, Bancroft, & Cunningham-Burley, 2008), if not ‘resiliency’ to harm (Velleman & Orford, 1999), this literature largely documents the impact of drug use on parenting and of parental drug use on the family as overwhelmingly damaging. Reviews of the literature have linked parental drug use with household instability, child neglect, compromised child care and safety, detached parent–child relationships, and in turn, ‘problem’ behaviours and psychological harm among affected children (Barnard & McKeeganay, 2004; Kroll & Taylor, 2003). Kroll and Taylor note that “for most children living with chronic substance-misusing parents, life can be very painful, difficult, frightening or dangerous” (Kroll & Taylor, 2003). Noting the “heavy toll” exacted by parental drug use on children’s lives, Barnard argues that “it is only under conditions of stringent and controlled drug use that children are not negatively affected” (Barnard, 2007: 61). This has led some to propose that there should be greater policy emphasis on enabling parents towards recovery from their addictions and on preventing drug users from parenting:

For far too long services and policy have entertained the notion that children can remain under the care of drug-addicted parents and remain unharmed. Parental drug addiction is
incompatible with providing a safe and nurturing environment for young people. Drug-addicted parents need to understand that they are harming their children. Services need to force them to make a decision between continuing with their drug habit or taking on the legitimate responsibilities of being a parent. Drug-addicted parents should be given 12–18 months to get drug-free or lose their children. [Neil McKeganey, quoted in Children and Young People Now, 2009, August 27]

Similar statements have been reflected in media reporting on parenting in the face of problematic alcohol use:

It is almost certainly the case that a child in a home with parental alcohol abuse is not being well looked after. If a parent cannot change their behaviour, they cannot be allowed to continue to harm their children. More should be removed from their homes, where parental alcohol use is affecting their health, than is currently the case. [Neil McKeganey, quoted in Daily Record, February 19, 2007]

Such proposals may alternatively be viewed as overly "simplistic” (Children and Young People Now, 2009, August 27), for they may neglect the harm potential linked to removing children into care (Forrester & Harwin, 2006), the potential impact of parent and family-level interventions (Copello, Velleman, & Templeton, 2005; Copello, Templeton, & Velleman, 2006), the strategies parents may employ to moderate risk linked to their drug use (Kearney, Murphy, & Rosenbaum, 1994; Klee, 1998; Richter & Bammen, 2000), the presence of drug use as a complex feature, even moderating response, of broader social-structural vulnerabilities (Bourgois & Schonberg, 2009: pp. 183–208), and the possibility that not all people who use drugs make ‘bad parents’. The trope that ‘drug users make bad parents’ (especially those addicted to illicit drugs) nonetheless prevails in discourses framing policy and popular debate. In the UK, it is highly visible in the light of recent national television documentaries featuring the damage of problem drug use on family life (for example, Channel 4 Television's My Mum Loves Drugs, Not Me), and bubbles under the surface in the light of heightened concerns surrounding the adequacy of strategies of child protection following a number of high profile cases of improperly managed child neglect. National policy has placed increasing emphasis on parenting capacity and responsibility, including tackling parenting deficits through parenting orders and contracts, and even a national parenting academy (Furedi, 2008). Some have suggested that a ‘culture of fear’ surrounds an unprecedented preoccupation with risk, including abuse, to the child, alongside heightened anxieties concerning the ‘toxicity’ of modern parenting (Furedi, 2006, 2008). Once “taken-for-granted as something you just got on with”, parenting "has become a minefield", wherein the family has come "to be seen as a dangerous site where many of the participants are held to be continually at risk" (Furedi, 2006: 75).

Accounts of parents

There are few qualitative studies exploring how parents who use drugs account for harm and harm reduction (of their drug use to their children). Klee (1998) found most parents (of poly drug and amphetamine use) to reflect upon the potential dangers of their drug use to their children, and many to engage, to varying extent, in strategies of damage limitation. She also found that an acute awareness of prevailing negative constructions of drug using parents (as selfish, uncaring, irresponsible, distracted, neglectful) acted as a highly effective deterrent to parents seeking help. A fear of having children removed from their care was paramount. In a similar thematic analysis, Richter and Bammen (2000) developed a descriptive typology of harm reduction strategies from the semi-structured interview accounts of 22 opioid dependent mothers. Harm reduction strategies included efforts to: shield children from evidence of drug use; keep the home environment stable, safe and secure; maintain a stable small habit; stay out of jail; enter drug treatment; stop using; and in the event of children’s needs not being met, placing their children in the care of trusted others.

In an ethnographic portrayal of the lives of homeless injecting drug users in San Francisco, Bourgois and Schonberg document the experiences of those “dead-beat dads’ and ‘crack monster mothers’ vilified in the press for failing to support and nurture their children” (2009: 184). They focus on the stories of drug users who are living a harsh street-life dominated by the everyday business of scoring and using heroin or crack, and who have long abandoned regular contact with their children. They locate the break-up of family life and the perpetuation of harms linked to drug use as one feature of a cycle of broader structural and inter-generational violence which frames the lives of the socially marginalised. They argue that:

The psycho-affective component of family violence and neglect is not solely psychologically bounded or interpersonally driven. It is structurally overdetermined by poverty, unemployment, household evictions, incarcerations, dysfunctional social services, and the criminalization of drug and alcohol consumption.” (Bourgois & Schonberg, 2009: p. 207: pp. 183–208).

For the homeless drug users of their ethnography, the “nuclear family ideal has never been an option”, and thus there is painful “dissonance between their valuation of traditional kinship roles and the reality of their lives”. Though abandoning family life and their children, parents’ accounts nonetheless portray a sense of pride in their children, love for them, concern that their basic needs are covered, and sometimes, the hope that one day they might recover the relationships they once had with them.

Hardesty and Black seem more explicit in their envisaging of the narratives of Puerto Rican mothers who use drugs as techniques to help bridge “the chasm” between being a drug user and a parent (1999: 602). Generating life history interviews among 20 Latino mothers addicted to heroin or crack cocaine, they find a narrative of ‘good motherhood’ to underscore attempts to avoid becoming a ‘bad mother’ through managing the potential harms of drug use to their children (especially shielding them from drug use) and through creating impetus for recovery when addiction had become overwhelming. They write:

Notwithstanding the devastation of poverty, marginalisation, and other forms of oppression, women can and do mother. Despite problem histories and abusive partners, despite the absorption into the anesthetising world of drugs, and despite the damage caused to their children and other family members, these addicts moved into the frightening world of recovery where they confronted the consequences of their past failures. They did so because of their children. Motherhood is their life-line. (1999: 618)

These findings have parallels with an earlier qualitative interview study of 68 mothers who were heavy users of cocaine, mostly crack, in San Francisco (Kearney et al., 1994). Their accounts were found to challenge “popular images of ‘crack mothers’ as amoral, heartless drug fiends” (359) through their emphasis on “defensive compensation”. This process comprised strategies deployed by mothers to simultaneously protect their children from harm and to protect their highly valued identities of motherhood. Defensive compensation involved “defending children from drugs and the drug life” at the same time as “shielding one’s identity as a mother” in an effort to maintain “mothering standards while using crack” (Kearney et al., 1994: 355). But defensive compensation became
more difficult over time, especially given unforeseen disruptions generated by a harsh socio-economic environment, resulting in the voluntary placement or forcible removal of children into alternative care for some. Women who maintained a sense of their integrity and capacity as mothers took steps to regain custody and care of their children.

Barnard and colleagues undertook thematic analyses of qualitative interviews with 62 parents in Scotland involved in current drug use, drug treatment or former drug use (Barnard, 2007). These studies find that drug use routines “necessarily impinge upon the care and wellbeing of children”, and that this is the case “even despite the efforts of the parent to protect them from exposure to drugs and the associated lifestyle” (Barnard, 2007: 61). In documenting fundamental conflicts of interest between the compulsions and routines of drug use and parental duty, alongside exposure to risk as an integral feature of the lives of children of parents who use drugs, she finds that the “prevalent operational presumption of the recent past not to anticipate problems with childrearing just because the parent has a drug problem runs counter to the conclusions” of her research (Barnard, 2007: 78).

Method

Between 2008 and 2009 we undertook depth qualitative interviews with parents who use drugs. This research was part of a mixed method qualitative study investigating children’s experiences of family life affected by parental drug use. We sought to capture the lived experiences of parenting in the context of drug use from the perspectives of parents and how they narrated their experiences.

Sampling and recruitment

We recruited 29 parents. These comprised people currently using drugs dependently or problematically (25) and people having stopped using in the last year (4). We adopted a purposive sampling strategy which was revised throughout. Key sampling dimensions included: age; gender; and form of substance use (specifically, problem illicit drug use, alcohol, polyuse). Initial recruitment was via snowballing within social networks of problem drug users (20), who were largely dependent users of heroin and crack cocaine with little or no contact with drug-related helping services. This was supplemented by recruitment via specialist drug services (9), including for dependent users of alcohol. Transcription and coding of data were undertaken throughout, informing the focus of ongoing recruitment and data collection. Most (27) were recruited in a large metropolitan city in the south of the UK, and the remainder (2) in the south-east of England.

The approximate average age of participants was 41 (range 35–55), and there we interviewed roughly equal numbers of men (14) and women (15). Table 1 summarises the 29 participants (and their pseudonyms). All but three were primary users of opioids and/or crack, and most of these had experience of injecting drug use. Around half (12) were currently in contact with methadone substitution treatment services. Most (14) were at least weekly users of their primary drug. A minority (6) described themselves as in a process of recovery from their drug use, and were either conscious to reduce their use, or had recently stopped (4). Participants had 59 children between them, aged between six months and 36 years (most were between 5 and 18 years), of whom 34 were male. A minority (2) had had their children removed into alternative care.

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Drug use</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zed</td>
<td>41</td>
<td>Heroin chaser</td>
<td>1 boy</td>
</tr>
<tr>
<td>Carlo</td>
<td>38</td>
<td>Former heroin injector</td>
<td>1 boy</td>
</tr>
<tr>
<td>Ali</td>
<td>36</td>
<td>Crack, heroin, alcohol</td>
<td>1 boy</td>
</tr>
<tr>
<td>Mary</td>
<td>43</td>
<td>Crack (former injector)</td>
<td>1 boy</td>
</tr>
<tr>
<td>Rob</td>
<td>41</td>
<td>Heroin chaser</td>
<td>1 boy</td>
</tr>
<tr>
<td>Kirsty</td>
<td>36</td>
<td>Crack, heroin (former injector)</td>
<td>5 boys, 2 girls</td>
</tr>
<tr>
<td>Barbara</td>
<td>42</td>
<td>Former alcohol, crack</td>
<td>1 boy</td>
</tr>
<tr>
<td>Nanu</td>
<td>35</td>
<td>Methadone (former injector)</td>
<td>1 boy, 1 girl</td>
</tr>
<tr>
<td>Carmen</td>
<td>36</td>
<td>Heroin, crack, methadone (former injector)</td>
<td>1 boy, 1 girl</td>
</tr>
<tr>
<td>Jack</td>
<td>36</td>
<td>Heroin chaser (former injector)</td>
<td>2 boys, 1 girl</td>
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<tr>
<td>Rich</td>
<td>47</td>
<td>Heroin injector, methadone</td>
<td>1 boy</td>
</tr>
<tr>
<td>Dan</td>
<td>47</td>
<td>Heroin injector, buprenorphine</td>
<td>1 girl</td>
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<td>Kate</td>
<td>36</td>
<td>Cocaine</td>
<td>5 boys, 2 girls</td>
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<td>Ziggy</td>
<td>54</td>
<td>Heroin and crack injector</td>
<td>1 boy</td>
</tr>
<tr>
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<td>35</td>
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<td>1 girl</td>
</tr>
<tr>
<td>Nadine</td>
<td>41</td>
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<td>1 girl</td>
</tr>
<tr>
<td>Lou</td>
<td>51</td>
<td>Heroin, methadone (former injector)</td>
<td>2 boys</td>
</tr>
<tr>
<td>Mwansa</td>
<td>49</td>
<td>Crack, cocaine</td>
<td>2 boys</td>
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<tr>
<td>Erico</td>
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<td>Subutex (former heroin, crack)</td>
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<td>Adio</td>
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<tr>
<td>Stef</td>
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<td>Former heroin and crack</td>
<td>2 girls</td>
</tr>
<tr>
<td>Jenni</td>
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<td>Heroin, crack, injector, methadone</td>
<td>1 boy</td>
</tr>
<tr>
<td>Larry</td>
<td>49</td>
<td>Methadone, heroin (former injector)</td>
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</tr>
<tr>
<td>Jan</td>
<td>48</td>
<td>Methadone</td>
<td>1 girl</td>
</tr>
<tr>
<td>Ebbe</td>
<td>50</td>
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<td>1 boy, 2 girls</td>
</tr>
<tr>
<td>Jon</td>
<td>50</td>
<td>Methadone</td>
<td>2 girls</td>
</tr>
<tr>
<td>Ingrid</td>
<td>39</td>
<td>Heroin, crack, methadone</td>
<td>2 girls</td>
</tr>
<tr>
<td>David</td>
<td>42</td>
<td>Alcohol</td>
<td>2 girls</td>
</tr>
<tr>
<td>Sue</td>
<td>43</td>
<td>Alcohol</td>
<td>1 boy</td>
</tr>
</tbody>
</table>

Data collection

The study involved an audio-recorded in-depth interview, facilitated by a simple topic guide designed to explore participants’ narratives of their experiences of parenting in the context of drug use. Interviews were as non-directive as possible. Key areas of discussion included: drug use experience; family life and parenting; harms related to drug use; damage limitation and acceptance; help seeking; and recovery. Interviews generally lasted between 60 and 90 min, were conducted by the authors, with most taking place in participants’ homes. All participants received a supermarket voucher valued at £20 for their participation.

Analysis of accounts

Our focus is mapping key emerging themes in the personal narratives of parents who use drugs. All interviews were transcribed verbatim for coding and analysis. Key emerging themes included; damage; damage limitation; damage acceptance; secrecy; ambiguity; normalcy; recovery. This level of data categorisation enabled us to explore emerging relationships between accounts of damage limitation, acceptance and recovery, as well as distinctions between accounts of damage limitation and acceptance. In our analyses, we treat interview data as co-produced and relational to context (Dingwall, 1997; Ricoeur, 1981). We see the interview as a moment in identity work (Riessman, 1993), wherein personal narratives present, perform and negotiate a self or an identity in relation to a situated context of meaning (Butler, 1993; Goffman, 1963). In this way, accounts of harm and its reduction at once provide stories of experience and scripts for an ethic of the self or its recovery. Interview narratives act as a ‘technology of the self’ (Foucault, 1988), as a practice of self-formation, whereby individuals are enjoined through various discursive practices (including research) to find, shape and describe themselves (Tamboukou, 2008). This means narratives can be seen as transformative, with
the interview occasion acting as one moment in the creation or restoration of self according to surrounding aesthetic values. What is at stake in the context of this study is the performance of self and bridge the cultural divide between ‘drug user’ and ‘parent’.

Ethics

The study had ethical approval from the National Health Service Research Ethics Committee (Oxford) and the London School of Hygiene and Tropical Medicine University Ethics Committee.

Findings

The interview accounts of parents who use drugs placed strong emphasis on damage limitation regarding the potential adverse effects of their drug use on family life. In addition, we identified two main forms of narrative in the accounting: damage qualification; and damage acceptance.

Damage limitation

Three main forms of damage limitation strategy can be identified in accounts: the maintenance of “normalcy” in family life; the prevention of disruption and “chaos” to family life through controlling drug use; and the creation of a safety-net of support should disruption occur. The prevention of disruption through controlling the effects of drug use on family life included efforts to maintain regular income, prevent drug withdrawal (through maintaining regular and sufficient access to drugs), and resist a “chaotic” pattern of drug use (characterised, for example, by frequent injecting and/or use of crack). The creation of a safety-net of support in the event of disruption occurring included support provided by partners, especially non-using ones, family and friends, often in the form of child care, as well as support provided by care and social services. However, we found that most damage limitation work centred on efforts to create a sense of normalcy of family life. We concentrate this analysis on these accounts of damage limitation.

Normalcy of family life in a context of regular parental problematic drug use was only ever articulated in accounts as an appearance. Accounts did not attempt to appeal to the idea of drug use as a normative feature of family life, instead readily accepting that “it’s not the normal thing to do”. Nadine, a long-term user of heroin, envisages normalcy as something to strive for, and as determined by externally visible or verifiable indicators of what constitutes a norm:

I always try to keep it as normal as possible. You know, there was, the bills were always paid first. The shopping was always done. You know, I always tried to make sure that there was always electricity and gas and food and trips to the park. [Nadine]

Zed, also a long-term and daily user of heroin, likewise characterises normalcy as inevitably to varying extent a mask, whereby parents knowingly invest in creating an appearance of normalcy. The aim of such damage limitation strategy is to pass as normal by “covering up”:

We did our best to maintain a kind of normalcy. You know, celebrate birthdays, you know, the whole thing… Just the business of living, you know… We would go to his parent’s evenings and stuff, and, you know, try and maintain this kind of front, really… But we could do it, we could do all those sorts of things, even if we were pinned. […] We were living a family life, and bringing up [Simon], and it wasn’t a lie but there was a certain amount of covering up inevitably. [Zed]

Keeping drug use hidden from children, as well as from outside others, was a primary technique of damage limitation. The object here was to separate out the worlds of drug use/users from that of children/family life, at least as far as children’s knowledge of the situation was concerned:

We didn’t want him to be brought up in an environment where hard drugs were, you know, being used… We didn’t want him to be conscious of that, because it might, you know, it might affect his behaviour at a later date I suppose. And that’s, that’s the kind of ongoing, kind of theme I suppose, is trying to keep it a secret you know, from [Simon] primarily, but from everybody else too. [Zed]

Strategies to separate out the parent’s world of drug use from the child’s world of family life are mobilised around time and space. Opportunities for drug use, or heavier use, arose at certain times of the day: “I’d always do it in the night when my boys were in bed”; “When he’d finally go to sleep that’s when I would start smoking”. In the home, all parents we interviewed talked of creating separated space in which to use, away of their children’s view, usually behind closed doors:

I used to go to the bathroom. We’d lock ourselves in the bathroom… Yeah, “Why can’t I come in, Mummy?” “No, I don’t want you to see. I want to see Daddy.” “But Daddy is on the toilet.” “So why can’t I go in?” [Ebbe]

We’d park him in front of the box [television], and go into the bedroom, close the door, barricade the bloody door, put something in front of it, and use… He’d call through the door, and we’d go “Yeah, yeah, hold on”. [Zed]

While children were said to become accepting of parents having their separate space to “do their thing”, the above extracts also acknowledge attempts made by children to seek attention of their parents when behind closed doors. In addition to separated space, homes would be routinely cleaned up of evidence of drug use, both visual (“I used to wash the worktop off with bleach”; “I had to hide my paraphernalia”); and sensory (“I’d spray the house”; “I’d always put a bucket in the hallway with bleach in it so it would help take the smell away”). When separated time or space was not available in the home, the time and space for drug use would be made: “Try to distract them” – “I would give them money to get them out the house, to go, and get some takeaway”.

Separating out the worlds of drug use and family life is thus contingent on keeping drug use hidden. Such a strategy offers a rationale of that which can not be seen can not do harm for it can not be known. Being seen to do drugs or to be a drug user was positioned by parents as a critical threshold to their children knowing their parents’ as people who use drugs. Accounts gave repeated emphasis to the “fact” that children had “never” seen evidence of drug use:

He’s walked into a room a couple of times when there’s quickly been some shuffling around, and I know he must have thought “What the, what’s Dad doing?”. But he’s never actually, no, I’ve never allowed Jack to actually see me taking drugs. [Rob]

I’d hide the stuff, but no, he never saw me taking anything. I can say for a fact, he never saw me taking it. […] I think he sensed that I was doing something, but he never saw. He didn’t see me do it. [Mary]

The only voiced exception to the rule of keeping drug use hidden from view was when children were judged not old enough to know
what they were seeing: “It was easy to use around him without it affecting him really, that’s how we saw it at the time”; “He wouldn’t have known what a piece of foil was when we was 3 years old”; “I think once he got to 6, 6ish, I think we made efforts… you know, he was now conscious of his environment”.

Maintaining drug use as ‘unseen’ places primary emphasis on drug use being known through children engaging directly with visible evidence (of activities, substances, users, paraphernalia). This enables an investment in, and appeal to, ambiguity; that keeping things visibly concealed maintains sufficient uncertainty to protect a parent’s hope or belief that their drug use remains undiscovered, at least unconfirmed. Mary, a long-term user, emphasised that she was never seen by her son to smoke crack. She makes an important distinction: “I think he sensed that I was doing something, but he never saw”. Knowing requires seeing. Even in situations in which parents suspected their children knew of “something” – which was not unusual – accounts invest heavily in the idea that drug use is hidden from view. This is even while acknowledging that strategies of concealment are fragile and open to disruption. Here, Ziggy, a long-term injector of heroin and crack, characterises his risk management of drug use in the home as a form of ‘edgework’ in the face of liminal knowledge: his son ‘knows’ a certain amount, always wants to know more, but never gets to see (and thus, know) enough: “You have to be careful. When I’m trying to do my thing, he’s always trying to get a look at it”. Ziggy and Mary claim that their drug use is sensed but unseen, and thus ambiguous.

There are also accounts of disruption to risk management intention, such as when parents’ drug use is ‘accidently’ seen or discovered. Most parents acknowledged the fragility of their strategies of secrecy in a context of regular drug use, accepting that these were open to exposure: “He waited in, and we tried to hide it, but he sort of sussed out, ‘What you doing? I know you’re hiding something’”; “I’d take him to school and I’d be in a real state [withdrawal]… I knew I was in a real state, and he looked at me like I was a state”. Every parent we interviewed reflected upon the dilemma that their children may know more than they have actually seen, or that they have seen enough to know more than their parents hoped. Yet even in such cases, the illusion of secrecy appeared important to uphold. Here, Mary reflects upon the fragility and personally situated nature of strategy, revealing that strategies of secrecy are at once serving of self and child protection: My son would say, “Who was this?” And I’d say it was a friend, like, everyone was a friend. May be, in his head, he might have had an inkling, I don’t know. But as far as I was concerned, no, they were just friends, and he didn’t know anything else. He was none the wiser as far as I was concerned. [Mary]

Parents might pursue strategies of ambiguity concerning their drug use even in the face of their children communicating to them that they know:

We had a special draw for all the needles and the drugs, and one day I opened up the draw and there were two plastic skeletons in there, you know, rubber skeletons. [Larry]

I didn’t want them to actually catch me doing it, I didn’t want them to see my paraphernalia. But then, there has been three occasions where I [have] come home and found my paraphernalia plonked right in the middle of whatever’s gone on, where they’ve thrown things all over the place with their anger and frustration. [Mwansa]

We can begin to appreciate the ‘double-edged’ function of damage limitation accounts. They are presented as serving the interests of child protection through concealing and containing parental drug use. But they at once serve the interests of parents who place considerable personal investment in keeping their drug use hidden. This means that strategies of secrecy and ambiguity may not serve parents and children equally well. Mary, who is interested to reduce her drug use, presents an account which captures these tensions, accepting an appearance of normalcy through knowledge ambiguity as ultimately illusory:

I don’t know if he knew, but, to me, he seemed, it was like he was confused what was going on. And that’s the way I wanted to keep it. He didn’t know what was going on… That’s the way I wanted to keep it.

I always wanted to have the illusion that I was alright. It was an illusion that I was okay. […] For me, that was very important, yeah, for him to see me looking normal. Yeah, and not high, or not, you know, like a ‘crack head’. [Mary]

Mary’s account is revealing for it tells us that investing in strategies of secrecy and ambiguity in the face of knowledge about their illusory potential exposes a basic problem in coming clean to self. Narratives of apparent normalcy protect against exposing the self as not normal. More than this, they act to resist entertaining that image of self most feared — the ‘junkie’ or ‘crackhead’ mum or dad — that is always at risk of being uncovered, and by one’s own children. Coming clean to self necessitates undoing, and questioning, one’s account of oneself. Coming clean to self is difficult and risky, especially given normative representations of parent drug users as child damaging.

The dilemma of whether and when parents should ‘come clean’ to their children illustrates this investment in ambiguity and denial of disclosure. Most parents repeatedly postponed this conversation, usually to an imagined time when they were clean of drugs:

Jack and I have actually never talked about it. We have never had a conversation about my drug addiction. Never. I’ve always kept it quiet from him[…] If I am successful in cleaning up, then I’m sure I would, I’m sure I would have a conversation with Jack, six months, a year down the line. [Rob]

I know we’re going to have the conversation, I know we will. But right now, I mean, I’m not ready for it now. And I think he’s, kind of, like, I think he’s waiting for me, to me, to actually come to him. [Mary]

Our data suggests that parents tend to disclose their drug use only once their children indicate (unambiguously) that they know or when they are about to find out by some other means. The process of coming to terms with the idea that their children know — or know enough — is a gradual yet critical one towards accepting the illusory status of a narrative of damage limitation, and the potential denial of damage caused. This leads us to consider parents’ accounts of damage acceptance.

Damage acceptance

If parental drug use is known, related damage cannot be denied. All parent accounts engage with the idea that drug use is damaging to their family life in some way. But there is variation, and ‘damage’ is open to multiple situated interpretations. We have identified two main forms of damage accounting, which participants may shift between. First, that drug use makes bad parents. Here, accounts emphasise that drug use and parenting can bring about fundamental conflicts of interest, which can be seriously damaging. Second, that drug users need not make bad parents. Here, accounts seek to neutralise the pejorative quality associated with the idea of drug users as necessarily bad parents who cause damage to their children. In these accounts, the acceptance of damage is qualified. Let us consider these first.
Qualification

Damage qualification accounts seek to resist popular ‘stereotypical’ depictions of drug users as bad parents. Mwansa makes direct reference to the “stereotype”, claiming that it is not like this, and that drug using parents are doing the same “everyday business” as other parents, and thus striving towards a sense of normalcy:

You've got this stereotype, that all drug users are dirty, and it's not like that at all. You know, there's hundreds of women out there that are going about their everyday business, taking their children to school, and then they're going home and using, you know. They're going back and picking up their children and trying to engage in what we think is the norm. [Mwansa]

Zed’s account captures many core features of the damage qualification account. He tackles head on expectations of accusations of ‘neglect’ and ‘abuse’. He draws attention to this being the context framing his accounting (“We’re probably quite defensive about it”). He resists association with one-dimensional or worst-case depictions of the drug user by emphasising that drug users are a “mixed bag”. He appeals that, like any parent, they are doing their “best” given their circumstances. And importantly, he invokes the notion of resilience, that the “kids are pretty together”. His is a depiction of ‘good enough’ parenting:

We're doing what, as best we can. OK, we've got a drug problem. But, you know, we're not abusing him, we're not neglecting him. We're probably quite defensive about it really in some ways, but with, there is, you know, an argument that um, it's, it's not necessarily, it doesn't necessarily mean that the children, the child is neglected, or you know, not looked after properly. I know other people who are junkies or were, and have got children, you know, it's a mixed bag really. But most of, in fact, all, the kids are pretty together. You know, they've grown up in to be very nice young adults. [Zed]

The key features of damage qualification accounts are that they emphasise parents as trying their best to be good enough, having got their priorities right, to ensure that their children's basic needs are covered, thereby limiting the damage: “They were fed, they were clothed, I loved them”; “He's always got clean clothes and food at home. He gets to school on time”; “We did our, our best, giving him”. For Kirsty, dependence on narcotics serves to cushion the self from the unbearable pain of coming to accept that damage was not as severe or apparent as popularly imagined (physical, neglect, violence, abuse), but was emotional in nature:

They've always eaten, and they've always had good meals, and they've always had the best of the best. They've been at school. They never missed out because I still made sure those things were okay. But they're not okay, because mentally I've harmed my children. You know, I have harmed my children. [Mwansa] Drug addiction makes you a very selfish person, very self-centred, very me, me, me, very insular. When you're a drug addict, you're not emotionally available. [Rob]

Confession

In contrast to damage qualification, accounts of damage acceptance more readily accept rather than deflect responsibility for damage caused. Even in the face of long-term addictions, they emphasise agency. These accounts enable coming clean to self and others, and accept blame for what has happened:

I messed up for a very crucial time for my eldest son… I wasn't there because I was so zoned out in my head. I chose what I wanted to do over my children. [Mwansa] It was a choice, and I chose crack cocaine for ten years. I was not in his life properly for ten years. [Mary]

She [her daughter] says I've ruined her life. And she is right. I hate to admit it, but she is right… They're being neglected in one way or another. [Kirsty]

While damage qualification accounts emphasise the situated relativity of damage pointing to the existence of others worse than them, damage acceptance accounts emphasise the rarity, even impossibility, of ‘good enough’ parenting in the context of problem drug use. As Carmen, a long-term user of heroin, indicates: “It can't work… It's impossible”; explaining that “all the people I know who had kids and who are still using, lost the kids [to social services]”. Accounts of damage acceptance acknowledge both the illusionary potential and the psychical comfort afforded by narratives of damage qualification. Far from holding on to the idea that their children may not know or do not know enough about their drug use, damage acceptance requires coming clean about the potential for injury and the permeability of the mask of normalcy. Damage acceptance requires giving-up on denial. Kirsty, for instance, makes clear that children “pick up on everything”, that “they are in tune with what is going on around them”. For Kirsty, dependence on strategies of secrecy is an act of self-deception necessitating an assumption of “stupidity” on behalf of children regarding their awareness of their situation. Ebbe, looking back, accepts that she acted as if her children were unaware, whilst under the surface knew that they knew:

I knew deep down inside me, and I just, you know, you're trying to sort of like [whispering] ‘They don't know, they don't know’. You try and shield them, but really they ain't stupid… They want to know everything, and they do. [Ebbe]

Likewise, Nadine, a regular heroin chaser, envisages appeals to normalcy through secrecy as an “excuse”, as a pretence which serves to cushion the self from the unbearable pain of coming to terms with the damage addiction might be causing:

It's all excuses… You find excuses, and you find ways to make yourself feel better about it… You have to, you just blank it out. You just, it becomes normal, so you just hide it away, and just think ‘That's alright, she doesn't know what I'm doing', so it doesn't matter. [Nadine]
Accepting damage thus re-positions damage limitation as a reflexive product of denial to self and others. Damage acceptance involves coming out of hiding to confess and face-up. While distinct from each other, participants can shift simultaneously in an attempt to fashion an alternative subjectivity, by which parents seek to protect their children from the harms of knowing and experiencing their drug use. Here, most damage limitation work centred on efforts to create a mask of normalcy of family life, largely by keeping evidence of drug use hidden from children's view. We found that this strategy was predicated on a rationale of that which cannot be seen cannot do harm for it cannot be known. Yet we also found this strategy to be inherently fragile; for that which cannot be seen by children may nonetheless be sensed, and in fact, known.

Second, interview narratives themselves are a technique of damage limitation. They act to restore participants' presumed damaged self/identity in relation to an ethics of practice of parenting. Interview narratives resist a normative depiction of drug users as necessarily 'bad parents' through emphasising an alternative personal experience of parenting and parenting values, emphasising the protection of their children from the world of drugs. Accounts of 'damage limitation' and 'damage qualification' are techniques of resistance, deflecting the inculcation of self as a damaged parent (see Scott & Lyman, 1968).

Yet accounts of damage qualification overlap with those of damage acceptance, highlighting the fluidity of damage limitation accounting. A narrative of 'good enough' parenting may coexist with one of damage acceptance. A narrative which seeks to resist the portrayal of self as 'bad parent' in an attempt to fashion an alternative subjectivity may also portray the self as damaged in relation to parenting and in need of repair. Parents' narratives operate in response to a (co-produced) regulative norm of 'good parenting' in which one strives to seek understanding and recovery through narratives of damage acceptance whilst deflecting damaged identity through narratives of damage qualification. Parents' narratives do not simply represent a fixed or binary vision of good/bad parent or damage acceptance/limitation. Narratives are at once accounting to self and to others, with multiple selves and forms of parenting represented, including through the liminal concept of 'good enough' parenting.

Our analysis thus highlights a constant duality in accounting: between 'private' and 'public' accounting; between narratives for self and for others; between speech acts which do something for the person (illocutionary) and which 'square' the person with their audience (perlocutionary) (Scambler, 2002; Scott & Lyman, 1968). Narratives of parenting should not merely be interpreted in terms of their relationship to the reconstruction of 'spoiled identity' (Goffman, 1963; McIntosh & Mckeganey, 2000; Waldorf, 1983) and presentation of a moral self (Riessman, 1993), but as reflections of a dialectic between internal and external discourses. The accounts of parents who use drugs must bridge private-public divides; between the self as 'drug user' and as 'parent'; between the self as primarily responsible to itself and limited to the sphere of its own perceived self-interest and the self which is governed by the ethical impulse to live for and be understood by others (Bauman, 1992; Frank, 1997).

What is distinct about accounts of damage acceptance is that they have more of a confessional quality, acting as techniques of recovery, which seek a personal ethical truth about recovering from drug use and addiction in search of a 'true self'. These accounts thus engage with various 'myths of addiction' (Keane, 2000; Valverde, 1998, 2002), especially the trope of 'addict liar' and 'sobriety as truth', in which addiction has led to the loss of true self through deception. With the addict "possessed of a disordered or diseased self" (Keane, 2000: 324), recovery necessitates 'coming clean' about 'living a lie', such as the mask of denial afforded by parents' narratives of parenting in the face of drug use

Discussion

We found that the interview accounts of parents who use drugs place strong emphasis on damage limitation. Strategies of damage limitation were primarily focused on maintaining an appearance of familial normalcy and on accomplishing 'good enough' parenting. We identified two main forms of narrative in the accounting of damage linked to parental drug use. Damage qualification accounts resisted the idea that people who use drugs necessarily make bad parents. Damage acceptance accounts were more readily accepting of parental drug use as harmful to family life. These latter accounts emphasised the illusionary potential of damage limitation strategies and a need to re-build family relationships in a process of self recovery. We discuss our findings for what they tell us about how parents narrate their situation, and for what implications they have for interventions.
narratives of damage limitation. An authentic self is marked by transparency and consistency between inner/private and outer/public representations (Valverde, 2002). Keane notes that in a ‘healthy’ person appearance and reality coincide with nothing hidden from self or others, but an addict acts, saying things that are not meant and pretending feelings which are not felt (Schaef, 1992: 50 – 51). The recovering parent-addict must come out from behind the mask (Hughes, 2007).

The function of narratives of recovery is therefore that they ‘talk away’ damage to self and others in search of realising and representing a ‘true’ parenting self. In qualitative interviews, we enjoin ‘troubled’ individuals to account for themselves, as ethical and responsible, inviting moments of reflection towards the realisation of this true self (Rose, 1996: 4). This is why, we believe, there are also moments of unrehearsed ‘discovery’ within interview conversation, such as Kirsty’s self realisation of the illusionary quality of her attempts to keep secret her crack and heroin use from her son for over a decade.

The recovered self is at once in a process of discovery and in the making, with recovery accounts inevitably a mix of experience and performance. Such identity work is probably never done. Narratives of self repair are only ever momentary, made of their particular situation. This means that the hope of pinning down a true self is likely illusory. Confessional narratives of truth-telling and of ‘coming clean’ do not reveal a true self but are a strategy with no fixed end point which promotes provisional truths. Moreover, regulative social norms in relation to good parenting may need to change before parents who use drugs or do damage to their children can accomplish redemption. The transformative project towards redemption as a good parent is relational, dependent upon others, and situated in practices and actions, not merely discourses. This means transforming identity is not simply about ‘talking things away’ or changing minds but is established through participation and doing (Hughes, 2007). Unpacking the interactional processes of recovery, and of how identity migration from drug user to good parent is secured, requires further qualitative investigation that will help inform interventions that can better support parents in their recovery efforts.

**Damage limitation intervention**

Evidence suggests that parents who use drugs will engage in targeted helping interventions where they are offered, and that behavioural and family therapeutic interventions can reduce child welfare risk and improve familial relationships, especially when drug treatment is also offered (Copello et al., 2005). Our findings suggest that parents who engage with narratives of damage acceptance may be readily accepting of interventions to help support a process of recovery. We also found that the occasion of the qualitative interview may act as one moment in a process of self-realisation and narration towards recovery or change, suggesting an applied role for forms of motivational interviewing alongside other interventions (Miller & Rollnick, 2002). Interventions providing support in relation to parenting, and the management of drug use in the context of family life, are likely to reinforce the effects of drug treatment interventions, and vice versa (Copello et al., 2005; Liddle, 2004). Parenting relationships should thus be a key focus of drug treatment initiatives, which otherwise tend towards a focus on the individual drug user alone.

Parents engaging with narratives of damage qualification may also be readily accepting of interventions to support damage limitation efforts. Even while accepting these accounts as ‘perlocutionary’, they indicate how parents who use drugs (perhaps like most parents) may reflect upon their parenting practices against a (variably defined) benchmark of ‘good enough’ parenting. This suggests potential for intervention engagement. But we also see that some parents engage in a process of postponement, and even by their own definitions denial, deferring the opportunity to ‘face-up’ to their situation. This suggests the need for earlier intervention. Low threshold interventions might give greater emphasis to creating the opportunity and space for parents who use drugs to talk about the challenges they face as parents. Harm reduction services – such as syringe exchange, outreach, and opioid substitution treatment programmes – offer unrealised potential for initiating dialogue with parents to foster reflection about their drug use in relation to family life as well as how to minimise potential damage. Harm reduction services often act as a conduit towards entry into drug treatment, with concerns to protect family life also acting as an incentive towards treatment or recovery (Copello et al., 2005). A harm reduction approach to parental drug use actively concentrates attention towards identifying and minimising the harms of drug use to family life, including through maximising access to drug treatment, whereas primary reliance upon drug treatment and child welfare services may miss opportunities for earlier intervention.

But we have to be realistic about what is possible. In a climate in which parenting is a “minefield” and parents are “continually at risk” (Furedi, 2006), especially drug using ones (who parent in an atmosphere of increasing pressures concerning alternative care plans for their children), there is a fine line between service efforts being feared as unwanted surveillance or as harmful and services being perceived as helpful. Talking about the challenges of parenting in the face of drug use is not an easy thing to do, and needs to be made much easier. That our interview conversation with parents seemingly precipitated moments of self-realisation about damage potential hints at the limited opportunities that parents who use drugs may have for such talk. There is little public space – including within helping services – encouraging of open talk and reflection about what constitutes good parenting in the face of problem drug use. This lack of public talking space – arguably contracting even further in the light of emerging cultures of panic surrounding modern parenting and child protection – heightens the social and other harms of parental disclosure, in turn reinforcing strategies of damage limitation which emphasise secrecy, ambiguity and denial. Moreover, a lack of dialogue among interventionists concerning the potential role of damage limitation regarding parental drug use betrays a tendency for ‘harm reduction’ to be constructed as potentially damaging in itself, for it forecloses services which do not necessarily encourage abstinence, tolerating continued parental drug use. At the same time, and given a primary focus on the individual drug user, the harm reduction movement has been slow to acknowledge the collateral damage potential of parental drug use. In our view, harm reduction may be tolerating of drug use, but is discouraging of damage. A lack of harm reduction dialogue space concerning parental drug use indicates the need for social interventions to open up, confront and reduce the hidden harms of drug use in the family.

The ‘hidden harm’ policy agenda in the UK (HM Government, 2008) has given rise to an abundance of policy commitment and research focused on protecting children from the harms of drug use. The predominant focus of interventions has been the delivery of behavioural, cognitive and psychosocial therapeutic interventions targeting individuals, and more recently, parenting couples, ‘whole families’, and the social networks of drug using parents (Copello et al., 2005; Copello, Templeton, et al., 2006; Velleman & Templeton, 2007). Emerging evidence suggests that interventions which involve partners, couples, family members (including children) and the social network members of the drug using parent tend to do better that those which target the individual drug using parent alone (Stanton & Shadish, 1997; Liddle, 2004; Kidorf, King, Neufeld,