AN ABSTRACT OF THE THESIS OF

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Title: Family Dental Health: Perspectives from Women Recovering from Methamphetamine Addiction

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This research focuses on the economic and social impacts to women's and children's dental health after methamphetamine abuse. Family oral health status, access to professional services, health literacy and home hygienic practices are evaluated in the frameworks of critical medical anthropology, applied anthropological praxis and matrix and bio-psycho-social addiction models from the standpoint that family oral health status is affected by a mother's changing perceptions of oral health care after an active addiction to methamphetamine. Utilizing a mixed methods approach (quantitative survey and grounded theory methods) the study finds that family oral health is situated in a framework of social inequity and power struggle, infrastructural insecurities in the OHP Medicaid system, and participants' personal experiences. Children's access to dental services and proper home care is dependant upon their mothers'/caretakers' personal experiences, health literacy and access to care.

Family Dental Health: Perspectives from Women Recovering from Methamphetamine Addiction

by

Melissa Anne Hanks

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APPROVED:

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Major Professor, representing Applied Anthropology

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Chair of the Department of Anthropology

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Dean of the Graduate School

I understand that my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

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Melissa Anne Hanks, Author

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Introduction

Summary

Methamphetamine (meth) addiction is the most costly and deadly substance abuse problem currently facing Oregonians. In other states, meth is disproportionately abused by men In Oregon, 47.5% of clients in treatment for meth use are women (Oregon DHS). To complicate matters, the majority of female users enter treatment between the ages of 21 and 45 when they are also likely to be bearing and caring for children. The children of Oregon mothers who suffer from meth addiction may be at risk for several addiction-related problems including deficiencies in comprehension, motor skills development, chronic abuse and neglect. While substantial research has addressed the effects of methamphetamine use on dental health in adult users, relatively little attention has been paid to the drugs' impact on the dental health of children of addicted parents. This research will begin to fill the gap in the existing literature by focusing on the dental health of children of addicted mothers, and examining how dental health status is affected by the mother's changing perceptions of oral health care after an active addiction to methamphetamine.

The purpose of this study is to examine how women's inclinations and abilities to seek out dental care for their children are affected by methamphetamine addiction (MAA). This research will help to clarify how the additional addiction factors of economic hardship, social/geographical isolation, and changes to the woman's own dental health status influence decisions to access dental care for her children. It will test the hypotheses that perceptions of the importance of dental care and the ability to

access family dental care change during and after methamphetamine addiction and that re-establishing dental care is a tool for a positive continued family recovery.

The information gained from this research lends a voice to a marginalized part of the larger Corvallis community. It sheds light on how the state and county insurance systems and the local dental care provider systems meet the needs of a part of the population who experiences a disparity in their dental health. Most importantly, it addresses how women who experience methamphetamine addiction re-orient themselves in a community and plan for their family's health care given their own experiences and levels of health literacy.

The study was conducted from August 2006 to February 2007 at Milestones Family Recovery in the Women's Residential, Transitional Housing Outpatient and Outpatient programs. Participants were recruited from the actively admitted clients in the programs, and asked to complete a survey, a semi-structured interview and a focus group to answer the research questions. They shared their life experiences with addiction and dental health, how they care for the children's oral health at home, and how they access professional dental services in the community for themselves and their families.

About the Research Site

The research sample is drawn from the Women's Programs at Milestones Family Recovery. This program is located in Corvallis. The Women's Program consists of one central counseling location (known commonly as "the House") and two residences that house the women's outpatient transitional apartments (Stronghold and Carrie's House). Clients who are in outpatient treatment provide their own living

space and attend counseling, classes and therapy sessions at the House. The House also serves as the living space for the residential clients. Residential clients may have one child under the age of six living with her, or staying with her on overnight or weekend visits as the Department of Health Services (DHS) allows if the children are in state custody. Almost every client in the Women's Program has at least one child or is pregnant with her first child; residential state-funded beds require that the client receiving funding has a child in treatment with her. The mean age of the clients sampled for this study is 31; the minimum age is 15, the maximum age is 44, and the modes are 23 and 28. Clients stay in treatment anywhere from two weeks to several months.

Residential clients are referred for treatment by a number of community resources, most often by DHS, courts and law enforcement. Some clients are referred by their families. Residential clients are in treatment on a voluntary basis; they choose to pursue treatment, and are free to terminate treatment. Residential clients follow House rules and schedules, and rotate House chores. Clients fill their days by attending daily scheduled group therapy sessions, one-on-one counseling sessions, classes on parenting, safety and anger management, written work peer presentation group, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), and church. They may also attend medical and dental appointments, classes at the local community college, vocational assistance programs, domestic violence programs, parenting enhancement programs, and GED classes during the week. Clients earn passes for afternoon, overnight and weekend unsupervised outings by progressing in their recovery and good citizenship in the House.

Outpatient clients who live in the Milestones program residences or on their own attend a once-weekly evening outpatient meeting, one-on-one sessions with the outpatient counselor, and may attend classes and additional group therapy sessions depending on their therapeutic needs. Both residential and outpatient clients have "staffings" scheduled once a month. During staffings, the clinical and counseling staffs jointly evaluate the client's progress, make recommendations for direction and address any needs the client may have.

Individual treatment outside of class and group consists of six progressive phases of treatment plans: Orientation, Stabilization, Phase I, II, III and IV. These phases (commonly referred to by clients and counselors as "phase work") are supplemented by treatment plans designed to address specific thought or behavioral patterns conducive to relapse. Clients work through their phase work on their own, and present their processing to their counselor or a facilitated group to complete the treatment plan. Once a necessary amount of progress is made in treatment, clients are either graduated completely or graduated to the outpatient program for further work.

The Researcher's Role at the Site

As an intern, I follow the basic guidelines for the counseling intern. This consists of many duties. My primary duty is to attend group therapy sessions led by a counselor, and to take notes on clients' check-in and processing during group. I type individual progress notes into a template to be signed and kept in the client's file. I also sit in on the Anger Management class once a week and take notes for that class. Every intern is expected to attend Tuesday staffings (see: About the Research Site) to observe the counseling process.

I began my internship in June of 2006, and spent 10-15 hours a week taking notes for groups, classes, and eventually taking notes during staffings. I took on the additional duty of facilitating the homework presentation group once a week, which consisted of listening to testimonial-style treatment assignments and initialing the assignment's completion. The internship has continued throughout the research project; I continue to take notes for one group each week and facilitate the homework group.

During my time at Milestones, I have built an excellent rapport with the clients, staff, and counselors. Between the staff, the counselors and I there has been a mutual exchange of trust, personal and professional growth. Where the clients are concerned, I have built appropriately professional relationships with almost all of them. This was attained mainly by becoming a fixture in groups, staffings and daily House life. When I began collecting data for this study, I found it beneficial to have spent a considerable amount of time in the internship. My relationships with the clients helped improve receptivity to my research questions. Participants considered the questions seriously and leapt to participate in the surveys and interviews with an overwhelming enthusiasm. Additionally, observation of negative client responses to certain topics introduced into common and therapeutic conversation (education level and significant others) prior to beginning research helped format interview and survey questions in ways that would not alienate potential participants.

Research Questions

The purpose of this study is to examine how women's inclinations and abilities to seek out dental care for themselves and their children in their care are affected by

methamphetamine addiction (MAA). This research will help to clarify how the additional addiction factors of economic hardship, social/geographical isolation, and changes to the woman's own dental health status influence decisions to access dental care for children. I approach the research question from the perspective that the population of meth users in Oregon constitutes a subculture, and seek to understand the relationship between mother's personal beliefs regarding dental care and the resulting dental care habits and dental health of her children. Recent research in the area of pediatric dentistry recognizes culture-based caries intervention programs as the most successful (Horowitz 1998). By addressing the individual beliefs of this subculture, their dental care needs can be better understood.

I will show through quantitative survey data and qualitative ethnographic data the similarities and differences between individual participant cases, their current dental health habits and accessibility patterns, their cumulative health literacy and commonly given reasons for the ability (or inability) to access adequate dental care. This includes asking questions about dental health, nutrition, income and lifestyle changes experienced during the women's meth use. I also ask about individual experiences during specific changes in individual participant's lives. This includes dental care experiences during childhood, active use, after entering recovery and the present.

The objective of this study is to determine how adult meth abuse influences family access to dental care. To do this, I examined the factors of economic changes to income and insurance, social isolation, geographic isolation, the addiction behaviors of neglect, abuse, binge-crash patterns, and the physical health effects of meth use. To

gather this information I conducted surveys and interviews with women who were currently enrolled in the Milestones Family Recovery Women's Programs and asked about their experiences with dental care during meth use and after seeking recovery. To best understand these experiences, I asked specifically about childhood influences, experiences while using and after seeking recovery, experiences with dental care and insurance providers, and their experiences taking care of their children's needs (Table 1). Additionally, participant perceptions of the children's dental health was assessed based on their mother's/care provider's experiences meeting dental care needs during addiction and after seeking recovery, specifically addressing nutrition, home care and dental office visits.

Project Goals and Expected Outcomes

The population sampled in this study can be defined as a vulnerable sample on three counts; they are recovering methamphetamine addicts, they are women, and they are either mothers or caregivers. Thus, it is important to acknowledge that the expected outcomes proposed at the beginning of this study will not be imposed via research bias in the results. This study does not intend to further contribute to the marginalization of the popular stereotype of the "meth mom." Instead, the goal is to shed light on real problems facing real individuals who are at a point in their addiction recovery where they are receptive to a positive direction for themselves and their families. I keep an open mind and constant willingness to be surprised by results, to ask questions that are important to this community and use results to address social action that this community desires.

I expect that few, if any, of the children of mothers in this study will have received dental care consistent with AAPD guidelines. This is not a judgment on the sample; it is equally unlikely that children of parents who do not experience substance addiction meet the AAPD guidelines. I also expect that the overall frequency of dental visits in the children's lifetimes to be low due to the economic and isolation factors of MAA. I do, however, expect that the sample will feel a maternal responsibility to care for their children and seek care despite their compromised ability to do so. I also expect that children's dental care habits at home will be encouraged, and that the mother's dental experiences will have some effect, positive or negative, on her perceived need to encourage her children's dental health care habits. Ultimately, I expect the experiences of addiction to play a stronger role in perceived dental health outcomes than the participants' perceptions of the dental care resources.

The Relevance of Applied Anthropology

Applied anthropology lends a unique praxis, method and theory to the questions and problems addressed in this study to make them more meaningful and applicable for the community in question. Anthropologists have sought answers to the problems of social patterns in addiction using ethnographic methods. Rosenbaum and Escamilla-Mondanaro (Campbell 2000) rejected the top-down policy approach and instead examined the individual experiences of addicted moms and the routine and structure of motherhood as a "sense of identity and pride" in the women's lives as a deterrent to drug use (Campbell 2000: 167). However, this study seeks to move beyond traditional ethnography by producing a narrative that is shared, and that may

be used to advocate desired changes in systems and policies with the overall goal of improving health outcomes.

This study utilizes critical praxis in medical anthropology (CMA) and applied praxis to address the more focused questions of how the women in this sample interact with their experiences, identities, peers, health-care resources, and families to address their perceived need for family dental care. The sample is comprised of women who share experiences in a spatially bound setting, qualifying them as a temporary sub-culture whose experiences and perceptions lead to a health outcome that is different than the community at large (Malkki 1997). Both critical medical anthropology and applied praxis rely heavily on working with and for communities to meet healthcare needs through community-based ethnographic research (Singer 1998; Erin 2005).

Singer (1998) highlights political economic ties to individual health and health care systems, Marxist critiques of the capitalist health care system, social action, and health care system transformation through system-correcting and system-challenging praxis. Ervin (2005) approaches applied praxis in anthropology from the perspective that anthropologists can and should become engaged with the main issues that affect humanity, and that challenging both system and policy to promote community-based improvement is both ethical and imperative to optimal outcomes (1). Ervin also promotes mixed methods as most appropriate due to their flexibility and pragmatism that can change to best address the variability in research questions and community-based outcomes (11). This study incorporates critical medical anthropology, applied praxis, and mixed methods with an objective methods approach and grounded theory methodology to engage the participants and the community to address the political

economic factors in their health care disparities and seeks to build community coalitions to correct and challenge their systems and policies.

How are women's inclinations and abilities to seek out dental care for themselves and their children in their care are affected by methamphetamine addiction?		
Do children receive adequate care?	Survey:	Age at first visit, frequency of visits
	Interview:	Examine current plans and home practices
Is social isolation a factor?	Survey:	Reasons for not accessing family dental care
	Interview:	Examine relationships with community, providers, family
Are economics a factor?	Survey:	Accessibility of insurance benefits past, present
	Interviews:	Examine income, insurance in decision making
How does the participant perceive of family dental care?	Survey:	Importance of family dental habits, practice of recommended hygiene
	Interviews:	Examine changes to participant's oral health and dental experiences, plans for children's oral health

Table 1: Research Questions and Testing Methods.

Literature Review

Family Dental Care Policy

Before proceeding to study how families access dental care, it is important to frame research questions in an understanding of current dental care policy. Guidelines specific to women and children and an examination of who creates and enforces policy are imperative to understanding how dental care in the United States is managed, who and what informs policies, and who they are created to serve.

National Level Oral Health Studies

The polices in existence today are the result of nation-wide data collection by the Dental, Oral and Craniofacial Data Research Center (DRC) on behalf of the National Institute of Dental and Craniofacial Research (NIDCR) and the Center for Disease Control (CDC), and by individual researchers in social health fields. This information is used by state-funded insurance programs like Oregon Health Plan (OHP) to manage insurance coverage for certain dental procedures. It is also used to educate dental practitioners about risk factors for oral health diseases and to tailor community resources to improve community oral health status. This includes biomedical and behavioral research, in large-scale and local epidemiological investigations. Much like a census, this information is gathered through standardized surveys and interviews administered by the NIDCR. It is then compiled into data tables and query systems accessible to the public. An annual report is created to summarize the yearly findings of the oral health status of demographic sub-samples of the United States population.

The American Academy of Pediatric Dentistry has a comprehensive policy on children's dental care. Early childhood caries (ECC) is one of the primary concerns of children's dental care. It is considered to be a disease, and affects more than 40% of preschool-aged children (AAPD Policy Statement 1113). Nearly 70% of dental caries are found in 20% of children in the national population, classifying ECC as an epidemic in certain high-risk groups (low socioeconomic status, special health needs, mother with high caries rate, child sleeps with bottle at night, etc.) in the United States. Prevention through parental education and behavioral changes has been the primary strategy to reduce ECC cases, but the approaches differ depending on barriers to educational models and the source of the research.

Public Health and Early Childhood Caries

Herschel Horowitz, a consultant in dental research and public health, composed a 1998 article reviewing recent research contributions and recommended research in the pediatric dentistry field. According to Horowitz, ECC is a disease that is passed from mother to child via both biological agents and behavioral patterns. ECC became a priority in public health in 1994 as a result of a CDC workshop, where it was determined to be the result of multiple risk factors, versus the previously held beliefs that ECC resulted solely from "baby bottle tooth decay" (67). Public health approaches to ECC attempt to understand individual manifestations of the disease from the risk factors of individual medical history, socioeconomic status, malnutrition, ethnic and racial background, and immigrant status. Dental professionals recognize the need to see children before they are of preschool age to provide proper parental counseling and, if necessary, early surgical intervention. The threshold for the initial

visit to a dentist is due to the colonization of cariogenic bacteria in the human mouth by the age of 19-26 months. Dentists do recognize that those children who are at the highest risk for having ECC never see a dentist. Parental inability to afford care can be based on a variety of factors, including the unwillingness of dental practitioners to examine very young children (68).

Horowitz (1998) argues that certain parental behaviors during their children's early years have been linked to a higher incidence of ECC. Cariogenic behaviors that have been studied for their relationship to ECC include prolonged nursing, improper bottle feeding and high concentrations of sweeteners, sugars and fermentable carbohydrates in the diet (69). One study by Tsubouchi showed a higher incidence of ECC in those children who bottle-fed at bedtime, had frequent between-meal snacks and had poor daily oral care habits. Children who consume high-sugar foods regularly in their diets more frequently develop caries by age 3, but those who were taught diet and dental hygiene habits in the home before one year of age were less likely to have caries (72). Some behaviors are specific to demographic groups. A 1995 study by Duperon indicated that sweeteners and improper bottle-feeding occurred more frequently in those U.S. families with lower socioeconomic status, two-career families, or families with outside caregivers. These studies have been repeated with a variety of demographic population variables, and the results are consistent -- human behavior in the form of feeding patterns, food choices, and pediatric oral hygiene are the main contributing factors to ECC.

The variables used in these studies have generated a set of predictors for ECC. Prevention is based on changing behaviors by participating in parental education and

using available services. Community-based preventative education studies recommend that models be made to specifically address the predisposing factors for individual communities based on factors which may influence their oral health status and their willingness to change behaviors (Horowitz 1998:78). Community education programs have demonstrated efficacy in reducing the incidence of ECC in small populations over 3-5 year periods (73). These programs are successful because of the focus on culturally specific beliefs and behaviors and community education instead of individual intervention. Horowitz gives preference to testing ECC prevention in community-based programs over controlled clinical experiments because such programs allow realistic assessments of program outcomes rather than idealistic researcher expectations (75).

To make programs for ECC prevention specific to a community, most programs first seek to identify barriers to changing behaviors (Horowitz 78). These barriers include differences between common understanding and professional standards and, inability to afford adequate nutrition and dental care. When populations of college-aged women were asked, they believed that the appropriate age for a first-visit to a dentist for a child was 2-3 years (73). This common understanding does not agree with the guidelines of the American Academy of Pediatric Dentistry; they recommend that children have their first dental visit before the age of one year. Additionally, professional guidelines differ in the consideration of oral health care as a part of general physical health. General pediatric practitioners do not always evaluate children's' dental health as part of health check-ups. Furthermore, many dental insurance programs are managed-care plans. When

referrals for pediatric dental care are at the mercy of a non-dental physician, it can be impossible for parents to obtain dental care when an unwilling pediatrician will not provide a referral (Horowitz).

Dental Professionals on Early Childhood Caries

The American Academy of Pediatrics (AAP) agrees that cases of early childhood dental caries are currently at epidemic proportions in the U.S. and research shows that it most frequently occurs in low-income populations. The AAP offers a four-component solution to the epidemic that includes: 1) decreasing transmission of cariogenic flora from parents to children; 2) early identification of at-risk individuals, 3) brushing and nutritional changes, and 4) the establishment of the dental home by one year of age for at-risk children (1113). The guidelines add parents with low education and low income levels as predictors of ECC. The AAP recognizes good oral hygiene practices as the "foundation for the ideal standard" of a dental home. This recognition is shared by the American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD). But the AAP requires high-risk children to have actual visits to a dental professional by the age of 6 months (or whenever the first deciduous teeth emerge) to provide the parents with educational information and to help avoid the potential for surgical intervention (1114).[1]

The AAP also includes the mother's oral health status as an independent correlate of her children's status (1114). The assignment of high-risk status to individual children is therefore assessed by a brief survey of the parents' dental history to identify what is termed the 'baseline decay potential' of the parents. This survey is

[1] Surgical intervention differs from routine cleaning and check-up. This could include procedures like dental caps and early removal of affected teeth.

performed as part of the Caries Risk Assessment Tool, and children are considered to be high risk if they have special health care needs, have a mother with a high caries rate, have current oral health issues, sleep with a bottle or breastfeed during the night, have older siblings, or are children whose family is of low economic status. The establishment of a dental home[2] is defined as "referring a child for an oral health examination by a dentist who provides care for infants and young children … and provides an opportunity to implement preventative dental health habits that meet each child's unique needs and keep the child free from dental or oral disease (1114-1115).

The AAP further recommends that all patients establish a dental home in the first two years of life. However, there is a grave disconnect between these policies and reality. How can parents with low education and low income levels be expected to know their child's true risk and afford quality dental care? The consideration of economic status as a component of dental health is especially important in Oregon, where 12% of the population lives in poverty and 25 counties have a higher percentage of the population living in poverty than the state average (State of Oregon, Economic and Community Development Department). This translates to about 420,000 individuals who lived in poverty in Oregon in 2003. Though Oregon's poverty rates are below both California and the national averages, there was an increase in poverty rates between 2000 and 2003. Oregon's unemployment rates are also telling: Oregon consistently has a higher unemployment rate than every other

[2] The American Academy of Pediatrics states, "the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care" (AAPD Oral Health Risk and Establishment of the Dental Home 1114). The same definition applies to dental care.

west-coast state and the national rate. Over the eleven-year average between 1995 and 2005, Oregon's average unemployment rate was 6.1%, and in 2003 was its highest at 8%. Several counties in Oregon have an eleven year unemployment rate average greater than 8.5%.

Medicaid, Oregon Health Plan and Dental Care

When the high-risk category of low socio-economic status (SES) is brought into consideration for establishment of a dental home, the main funding source of dental care must also be considered. OHP is the primary source of insurance coverage for low-income families and single mothers, and is divided into OHP Standard and OHP Plus coverage. Of the 372,002 individuals eligible for Dental Care Organization (DCO) coverage on the OHP Plus plans, only 347,283 individuals are enrolled. (Oregon Dental Care Organization Enrollment, September 2005). OHP Standard does not cover any preventative dental care, only paying for emergency dental care services. Additionally, not all OHP Plus programs have the same DCO: dental plans are provided by any of nine different care organizations, at least two of which are managed care programs.

Comparing the true risk for ECC that low-income Oregonian children face to the policies created by a government research center and professional dental practitioners, it becomes clear that the policies are not founded in a realistic assessment of community needs. The professional age-at first visit expectations do not agree with common beliefs about dental visits. Public health policies hold idealistic aims to eradicate ECC, but focus on the professional concerns rather than on community applications. By failing to consider the challenges low-income families

face in obtaining adequate dental care for themselves and their children, policies fail to aid their target populations. By neglecting to address why low-income families have poor nutritional habits, the policy is holding patients responsible for conditions outside of their control. By failing to address the additional factors that are associated with low-income populations and poor dental health, including multi-generational drug abuse, policy-makers are merely addressing the symptoms of larger social problems. To understand the specific circumstances affecting individuals addicted to substances and the larger social problems that impact health outcomes, it is necessary to approach their health-care issues with the perspective of the various approaches to understanding addiction and recovery.

Approaches to Addiction and Recovery

History of Addiction and Recovery Models

There is a wide range of variety in approaches to understanding and operationalizing solutions to addiction (Gorski 1986). In the moral model, addiction is thought of as a punishable personal choice (40). Drug use has been historically viewed as a moral issue; individuals were thought to choose use over sobriety, and because they would not cease use were considered to be faulty human beings by their own intentions. This model is still widely used among religious groups and in the legal system. Solving an addiction comes in the form of spiritual or legal intervention. Although the disease concepts and the moral model share a focus on character defects of choice, the placement of the choice is the pivotal identification of the paradigm. The moral model proposes that spiritual or personal deficiency is the cause of the

addiction, while the disease model includes the deficiency as a symptom of the progression of a disease (38).

The sociocultural model roots addiction in factors external to the individual. These include religion, culture, and family. The perspective explains addiction by examining the addicted individual's cultural and social background. Research shows that addiction is strongly socially situated, especially when one or both parents have experienced substance addiction and practice permissive parenting[3]. This is closely followed by having a drug-abusing peer group from a young age (Fisher 39). Psychological models borrow social factors from the sociocultural model, but propose that the external factors are internalized as psychological disorders. The psychological problem causes emotional pain, and drugs ease that pain. Proponents of this model coined the term "addictive personality" to explain the wide range of psychological and personality traits that are exhibited by addicted individuals.

Disease Concept and Critique

The most notable shift in the drug and alcohol counseling and treatment field was the introduction of the disease concept. The World Health Organization (WHO) recognized addiction as a medical problem in 1951. The APA used disease to describe addiction in 1965; soon after, addiction became defined as a "primary disease… [that] exists in and of itself and is not secondary to some other condition" (Fisher 42). As a disease, addiction progresses in stages, culminating in a loss of control in life. This concept became the foundation of Alcoholics Anonymous and the model for most treatment programs. Addiction is viewed as incurable (42). Evidence to support the

[3] Permissive parenting is defined by the failure to set limits and boundaries and inconsistent discipline. It is the opposite of authoritative parenting.

disease concept comes from research into genetic markers of addictive predisposition and psychological indices of addictive susceptibility (43).

Although groundbreaking, the disease concept has been critiqued on several counts. One criticism is founded in the research methods of the early proponents of the concept; some claim that only male alcoholics already in a recovery program were sampled, and that women and multi-generational addicts were left out (Fisher 44). Despite questionable research methods, the success of the concept is attributed to its "profitable and politically successful" application to a range of undesirable human behaviors. The idea that the process of addiction is unilinear is also questioned; Vaillant (1983) points out that a significant number of people who use substances defy the "loss of control" stage of addiction, and the progression of known stages are rarely uniform (Fisher 45). The disease model also results in a solely medicalized treatment program (47). Social and psychological contributors are neglected and the treatment method of personal empowerment is abandoned, resulting in the addict continuing detrimental health and social behaviors and eventual relapse.

Some studies rely only on the disease model concept that individuals have a heritable predisposition to addiction, and that an active addiction can be avoided by abstaining from the substance (Gorski 43). However, people can also become socially addicted to drugs to numb the pain of life events, relieve emotional tension in their thought processes, and connect with others. Substance dependency ruins healthy social relationships and replaces them with using friends, dealers and codependent significant others (44). Individuals can also become psychologically addicted to a

substance. Drug abuse replaces positive self talk[4] and coping skills with continued use. Psychological activity becomes destructive, drug-seeking thought.

Bio-Psycho-Social Models of Addiction and Recovery

The bio-psycho-social approach to drug addiction and recovery defines addiction as a three-fold biological, psychological and social addiction to a mood-altering substance (Gorski 38). The bio-psycho-social approach to drug and alcohol recovery places importance on treating the whole person, not just on the physical addiction. Conditions leading to addiction and relapse are viewed as a problem of social, psychological and biological function versus the common belief that individuals are solely responsible for the choice to engage in substance abuse. The most notable difference between this model and other commonly used approaches is the role of choice. According to the bio-psycho-social model, the use of drugs is a choice while addiction is a "lack of freedom of choice" (39). Other models define addiction as solely a physical dependency (complete absence of choice) or a continuous choice to use.

The Bio-Psycho-Social Model and Health

The bio-psycho-social model combines the medical disease model with the social and physiological models to address the individual's entire addiction. It treats addiction as a "multivariate syndrome" (Fisher 49). Initial use of a substance is due to sociocultural or psychological factors causing pain and weakening coping skills. Initial addiction is due to biological factors and the progression of the physical symptoms of the disease (50). Complete addiction is social, psychological and

[4] Positive self-talk is a counseling term used to describe an individual's inner dialogue and internal responses to external events. Self-talk is the basis of emotional well-being.

physical. Treatment is individualized and combines physical abstinence with social learning and personal empowerment. This model seeks to "explain" addiction in the three areas and replace learned survival habits with healthy habits. The bio-psycho-social model does not diagnose or fix the source of the addictive behavior (51).

The social and psychological effects combined with the physical dependency results in an addiction to feeling good at the expense of healthy living (Gorski 52). The resulting three-fold addiction further dulls the pain of living as a completely unhealthy person. Withdrawal symptoms are also bio-psycho-social. The body is chemically dependant on the cues of the substance. The primary physiological coping tool is removed with abstinence, and individual ability to socialize in healthy ways is destroyed. For an individual to successfully rehabilitate and continue recovery, all three contributing addictive areas must be simultaneously improved.

Most systems of diversion consider abstinence from the substance after a mandated detoxification period to be an adequate solution to addiction. A bio-psycho-social treatment model does begin with detoxification, but further rehabilitates the whole individual back to a healthy lifestyle. It teaches recovering clients new coping skills to handle the inevitable stressors they will encounter once out of supervised residential and transitional counseling. These stressors can come from any aspect of life, and, if left unmanaged, can build up to relapse (Gorski 53).

It is in these stressors that the bio-psycho-social model applies to family dental care. The addicted parent has a responsibility to take care of their health and provide for the health of dependant children (Gorski 80). Obtaining dental care for dependant children and the self is part of these responsibilities. By obtaining dental care, the

addicted mother is attending to the health of her family and planning for the future. Obtaining adequate dental treatment for herself relieves physical distress, thus reducing her own stressors and managing the balance necessary to her recovery.

Dental problems resulting from methamphetamine use lead to pain, guilt, low self-confidence and low self-esteem. The inability to address these health problems exacerbates the pain in all three areas. By actively seeking care and relieving herself of pain, she improves her self-esteem, can restore her self-worth and find empowerment. She can then continue to focus her energy on a successful continuing recovery.

Gender, Motherhood and Addiction

Women who are addicted to drugs or alcohol problems face specific types of problems due to expected gender roles and the concept of motherhood. Several bodies of political, ethnographic, and sociological studies have concluded that their problems with self-esteem, parenting, seeking recovery and supporting a family are magnified by external social conditions. Methamphetamine users are predominately white and almost equally male to female in ratio; nearly one-half of clients in treatment for meth use are female. One study conducted in Northern California examines why the incidence of female meth users is so high. Findings reveal that most women begin using in their late-teens to early twenties, and initial use is prompted by the user's belief that meth improves confidence, sexual and social performance, aids in weight loss, and promotes attractiveness and femininity (Anderson 1997). The study also concludes that the majority of these women perceive of themselves as powerless due to social influences (Anderson 187).

Addicted women have consistently been held to different standards than addicted men. Women who are addicted to substances violate gendered social role expectations in both addiction and recovery; they are expected to be pure and virtuous in character and action, and dependant on others for self-esteem (Campbell 2000). The role of 'mother' is frequently the center of treatment. Mothers who are addicted violate their expected social role and are accountable to it in the arenas of social addiction models and the legal system.

Women-Centered Addiction Models and Treatment

One specific area where women's roles are neglected is in addiction treatment models (Darnell 1999). Contemporary criminal justice and moral models suggest that women are responsible for their own addictions and those of their children. There is no regard for the social environment that leads to addictions in both generations. Feminist critics of these models include Nancy Campbell and numerous ethnographers who have explored addiction from emic points of view. They propose a dual change in the way women's addiction is viewed and the way it is treated. Instead of mother-as-pathogen, women should be seen as individuals robbed of their empowerment by external social conditions. The feminist solution to women's drug use is personal empowerment and recovery through relearning of self-sufficient behavior (Campbell 165).

Campbell's views of women and addiction critique two main paradigms in the regulation of substance addiction. One is criminalization, which treats addiction as a crime. The other, medicalization, treats addiction as a disease (Campbell 15). In the criminalization model, law enforcement seeks to curb drug use by reducing

availability and driving up the cost. By increasing the cost of illegal substances, criminal justice agents assume that demand will also be reduced. However, the criminalization model neglects to address other aspects of addiction. According to Campbell, the central criticism of the criminalization of addiction is that it is a top-down solution, and "public health aspects such as education, prevention and treatment remain under funded relative to law enforcement" (15). Campbell claims that current disease model policy focuses on controlling women's drug use, instead of questioning the role of women's personal empowerment in changing addictive behaviors. Disease and moral models are viewed as faulty because they do not target the structural violence that leads to addiction-causing behaviors. The feminist and critical models break from these shortcomings by centering on gender differences in addictive behaviors.

Feminist and Critical Views of Addiction and Treatment

The feminist and critical critiques also contribute to bio-psycho-social addiction models. Social addiction models have continuously focused on the mother as the source of behavioral indicators of addiction. Campbell claims that the contagious social disease model modified the pathogenic origins of social contagion and maladjustment to reflect relationship between mothers, families and children (166). The history of addiction-as-disease models used to create policy reflects an understanding that addiction is a symptom of a social pathogen. The goal of these models is to define and target the pathogen to reduce the symptoms. The contagious disease model, developed in the early 1970's, proposed that addiction be defined as "adjustment to intolerable stress for maladjusted people" as a result of a "maladjusted

upbringing" (Campbell 165). Because of social factors, especially the environment of childhood development, the external causes of maladjustment became associated with inadequate mothering.

One of the first ways the mother-as-pathogen approach was used against female meth addicts was pregnancy. A 1963 hospital study by Sussman highlights the roots of women's struggles to be heard, understood and treated for their addictions during the prenatal period. In his study on pregnancy and neonatal drug addiction, he examined several cases of young meth-addicted moms who had a history of drug use and showed withdrawal symptoms during labor (325). The infants' health after delivery was examined via physical symptoms of meth withdrawal. In all cases of infant withdrawal, the mother's lifestyle choices (including drug use, accessing prenatal care, marital status and STIs) were indicated as the source of her infant's poor health (327).

The bias arose from the suggestion that infants most at-risk were those whose mothers were unmarried at the time of the delivery, had contracted an STI, and lacked prenatal care (328). Sussman recommends withholding drugs during labor so that the mother can have an ideal "natural childbirth" (329). This study faults mothers addicted to methamphetamine for their social status and ability to obtain prenatal care, and uses meth addiction to place blame on the mother for violating her gender role by being unmarried, sexually impure and unable to get medical care for her family. It punishes women for their addictions by suggesting that women are responsible for their own backgrounds and deserve to a have painful childbirth.

Later studies focused on the child-care behaviors of both addicted and non-addicted mothers, and concluded that both groups had the potential to raise children who became addicts themselves (Campbell 168). Peer pressure was believed to be the catalyst for initial use, thus placing initial drug use in the "socially infectious" category. Continuous addiction, however, was thought to be the result of an over-controlling mother. Targeting the pathogen in this model took three forms: making broad social recommendations to correct both permissive and authoritarian parenting while simultaneously aiming school anti-drug programs at the effects of peer-pressure and boosting the importance of individual choice. Policy makers remain confused about the source of addiction as a social disease, and persistently view it from a theoretically etic perspective. Where should policy makers target the solution to the problem? Should there be massive social reform, or should the target of addiction prevention be young women and mothers?

Feminist Ethnographic Research among Drug Addicted Individuals

Ethnographic researchers rejected the top-down policy approach and instead focused on finding solutions by examining the individual experiences of addicted moms (Campbell 167). Researchers like Rosenbaum and Escamilla-Mondanaro have explored addiction at the individual level of the addicted women. In these studies, the responsibility to care for children is argued to be a deterrent to heavy use. The routine and structure of motherhood gives a "sense of identity and pride" to the women's lives that seriously lacks in their other social roles/connections.

Addicted women interact with criminal systems in similar ways to their male counterparts in all areas but one: the deterrence of drug use by taking away their

children. Losing children to the system means failure as a mother, and the loss of children as discipline for bad behavior. Women seek social relationships that are as emotionally battering as their relationship with their parents and are often raised to respond to addictive behaviors. Women's behaviors are most often in response to life-long social safeguarding from their families or male partners (cite). In order to survive abuse from those they are forced to rely on, women adopt personalities that are passive-aggressive, codependent, controlling and irresponsible to assert their identities.

The feminist critique criticizes American culture for holding women to unrealistic standards in both sobriety and addiction; they are a marginalized group. It further criticizes the government and policies for reinforcing these stereotypical roles by forcing women to conform in recovery to get the resources they need through their children. Campbell holds both culture and government responsible for changing these conditions (Campbell 222). When women are relieved of the burden of responsibility for the conditions of their addiction and considered individuals worthy of recovery outside of moral, family and social behavioral expectations, they will be able to truly recover.

The feminist approach to addiction criticizes US drug policy, public health and law enforcement because these approaches seek to modify drug-use behaviors without addressing the social conditions that lead to those behaviors. Campbell explains that the increasing reported rates of addiction among women, minorities and the poor indicates that drug abuse in these populations is rooted in the ultimate pathogen of "exclusion, disenfranchisement and marginalization" (16). She further states that

existing drug enforcement and addition treatment policies reinforce social disparities. These policies result in a perpetuation of substandard treatment of addiction in oppressed populations. Feminist solutions differ from others by framing the approach in policy change and personal and financial empowerment (17). The feminist model also calls for gender-specific treatment models informed by real experiences of female addicts to best address the specific needs of female addicts.

Funding Challenges and Women-Centered Treatment

However great the call for changes to women's addiction treatment may be, these changes must obtain the approval of funding sources. There remains a wide discrepancy between the Medicaid dollars used to fund recovery programs and state willingness to appropriate funds specifically for addicted women. According to Darnell's exploration of the relationship between funding and treatment possibilities, women face significant barriers to any form of treatment, let alone a gender-centered treatment program. Low-income addicted women without children are likely to be on the government funded health care systems that provide crisis and acute care, but are often not accepted by plans that cover rehab or preventative services (Darnell 169). When they are covered by these plans, these services are often considered optional. Both dental services and residential addiction rehabilitation were listed as "optional services" as federal matching payments for state Medicaid programs.

Oregon has a micro-allocation system to distribute optional coverage. This works by taking Medicaid dollars allocated to the state and dividing into counties depending on need (Darnell 181). These counties then determine who qualifies for certain services given their individual and family needs. For example, OHP Standard

does not include preventative dental care. Until mothers have custody of their children, they are covered by OHP Standard. Families are upgraded to OHP Plus (which does cover a wide range of dental care) when the children are in custody. Women are allocated resources for their children, not for themselves.

The funding for treatment also follows a sick-care model of treatment. Money is spent disproportionately on treatment of symptoms, rather than prevention. In 1995, 64% of the federal substance abuse budget was spent on criminal justice, 20% on treatment and only 14% on prevention. Medicaid services are also designed to fit the medical model. Financing is made available mainly for required medical substance abuse services. It is not considered medically necessary for women to attend a women-centered treatment program unless they are mothers. When women have children, it is acceptable to fund participation in these programs because women are learning parenting skills and benefiting their children. It becomes acceptable to fund addicted women in treatment, so long as they have dependant children in their custody (Darnell 191).

There is a call for including the vulnerable population of women in treatment plans. Meth abuse indicates an increased risk of fetal distress, fetal and maternal mortality (Comerford: Hoegeman and Wilson 1990). Mary Comerford has examined pregnancy and motherhood as part of treatment for substance addiction. She explains that women are more motivated to enter treatment when they are pregnant or have children out of concern for their family, but many treatment programs refuse pregnant women due to additional licensure and facility requirements (Comerford 187). In the relatively few women-centered treatment programs available, mothers are taught

parenting skills as central component of treatment. Bonding with children and building parenting proficiency are emphasized. Treatment plans highlight addiction as getting in the way of otherwise good parenting. Still, addicted women are treated as mothers first, individuals second.

History and Effects of Methamphetamine Abuse

There is a very specific set of bio-psycho-social effects of methamphetamine use. Some of the effects are on the individual user; other effects can influence the well-being of children, families and communities. Meth is the second most commonly used drug to marijuana (WHO 1997), and it has been an addictive substance of pandemic abuse since the mid 20th century. More common meth use began after World War II, when soldiers used it to stay alert. Various forms of the substance were used as medical therapies to treat ADD in children, suppress appetite, treat narcolepsy, and to severe depression. It was made illegal in 1970s after the negative effects were better understood, and groups considered subversive to American culture (biker groups, low-income communities and Hispanic populations) became the chief manufacturers and distributors of meth. Because the drug is easily manufactured in labs hidden in homes and vehicles, local law enforcement agencies became the primary controllers of manufacture and individual arrests. The burden placed on these agencies led to the Comprehensive Methamphetamine Control Act in 1996 (Anglin 225).

Methamphetamine is a central nervous system stimulant. Use affects dopamine and norepinephrine receptors, giving the user a temporary euphoria and general sense of well-being (Anglin 224). The high received from intake lasts longer

than other stimulants. Delivery of the drug to the central nervous system can be done one of many ways. Meth can be injected, snorted, smoked, or taken orally. The majority of contemporary users prefer the instant high received by smoking or injecting. Positive physical responses include “flight or fight” response and generation of therapeutic sympathetic stress responses. Immediate negative effects include increased blood pressure, body temperature, breathing and heart rate. Short-term consistent use results in arrhythmia, shaking, anxiety, insomnia, and aggressiveness. Prolonged use often results in paranoia, hallucinations, and stroke. Long-term chronic use leads to increased tolerance, structural brain damage and impaired neuronal endings. There are also long-term deficits in learning and memory (226).

Meth abuse affects both the user and society. There is a high correlation between meth use and crime rates on the West coast. In 2005, arrests for meth use or possession were up 100% in most West coast states, with 70% reporting increases in crime and 62% reporting increases in domestic violence related to meth use (Rhodus 29). Children of users are the primary recipients of negative effects. They are at risk for abuse and neglect; there is also evidence to support the assertion that pregnant women using meth can cause developmental problems and premature birth to their fetus (Anglin 226). Addicted parents leave children with no care, love, or role models (Comerford: Rosenbaum 1981). There is also an increased cost for addicted children to be removed from their mothers and raised with state funds (foster care, schools, health care) (188).

Family Health and Meth Abuse

Medical and emergency care research has examined the effects of parental methamphetamine abuse on children. In her discussion of emergency room protocol for treating children from meth homes, Nancy Mecham explains,

> "…there are many social issues involved that potentially put children from these environments at risk. As described previously, the binge-and-crash pattern of using this drug makes it difficult for parents who are users to meet even the basic needs of their children" (328).

Dental problems resulting from methamphetamine include dental caries, enamel erosions from bruxism, persistent low levels of saliva, and oral lesions Long-term use results in some or all of the adult teeth becoming infected and subsequently removed. The detrimental effects of meth use on dentition are a fact. However, the specifics of how the damage occurs vary depending on the research or dentist. The general consensus is that meth use causes caries (cavities) primarily at the cervical juncture of the enamel and gum line. Some professionals believe that the chemicals from smoking meth, grinding the teeth (bruxism), and reduction in salivary production causes the caries. Others stress user behaviors, referencing an assumption that meth users crave sugary soda-pop beverages and neglect their dental hygiene (Rhodus 36).

Dental problems from use lead to pain, and compound the guilt, low self-confidence and low self-esteem that are characteristic of the addicted individual. Dentists are frequently encouraged to refrain from dispensing drugs to meth patients suffering from dental problems and to hide prescription pads. They are also instructed to refrain from treating patients who have used meth in the six hours prior to treatment to avoid negative drug interactions and harmful physical side effects (Rhodus 35). This often leads to meth abusing dental patients being treated, painfully, without drugs or being refused services.

These physical ailments are often exacerbated by the lack of clinical familiarity with specific meth abuse related problems. Meth users are often stereotyped as bulimic, neglecting home oral health care, and eating large amounts of high-sugar foods (Rhodus 37). Their difficulty in obtaining services for their illnesses are compounded by the persistent social stereotypes of drug users perpetuated in medical and dental offices. To address these needs, it is imperative to educate practitioners about the needs of meth abusers and about the treatment of physical effects as part of treatment. If these needs are not addressed, the addict's primary coping tool is a return to substance abuse. Given that meth is easy to get in any community and relives pain, neglected medical needs lead to an easy relapse (Anglin 227).

Critical Medical Anthropology and Applied Praxis

The theories supporting this research come from critical praxis in medical anthropology (CMA) and applied praxis. Both approaches rely heavily on working with and for communities to meet healthcare needs through community-based ethnographic research. The goals, techniques, political approaches and challenges of critical and applied praxes are best exemplified in the works of Merrill Singer (1998) and Alexander Ervin (2005). Singer's 1998 article *Beyond the Ivory Tower: Critical Praxis in Medical Anthropology* summarizes political economic ties to individual health and health care systems, Marxist critiques of the capitalist health care system, social action, and health care system transformation through system-correcting and system-challenging praxis. Ervin's history of applied praxis outlines the history of the

applied discipline. Class struggle, power and class domination are the central themes to both critical and applied praxis.

Critical Medical Anthropology

Singer (1998) examines critical medical anthropology from the viewpoint that health care systems in stratified capitalist societies lead to an inevitable struggle between the working and dominant classes; the working class benefits from health care systems, but their overall health status is greatly impacted by the oppressive social conditions created by the dominant capitalist class (229). Social relations play a major role in determining who makes health policy, how it is enforced and funded, and who benefits from clinical medical practice. The role of the critical medical anthropologist is to improve social conditions by examining points of health disparity and transforming health problems into political issues (230). Anthropologists are best armed to make these changes because of the discipline's tendency to focus on the community. Anthropologists seek insider understanding, investigate the community's place as part of a larger system, and above all recognize human culture for its influence on the very concept of health, individual health status and health care systems created to address medical need (235).

According to Singer, there are two avenues by which critical praxis can be used. The first is system-correcting praxis, the second system-challenging praxis. System-correcting praxis seeks to "designate the conscious implementation of minor material improvements that avoid any alteration of the basic structure of social relations in a social system" (229). System-correcting praxis attempts to identify and fix immediate areas of suffering within an existing system. While it may address and

be successful at fixing problems to a degree, Singer claims that this praxis does not address sociopolitical conditions that are the ultimate cause of health disparities. Additionally, system-correcting praxis is often immediately successful but work is later used by those in policy-making power positions to further oppress the very community the critical medical anthropologist sought to help (228-29).

System-challenging praxis is "concerned with the unmasking of the origins of social inequity. Moreover, this type of praxis strives to heighten rather than dissipate social action and to make "permanent changes in the social alignment of power" (229). Singer gives preference to system-challenging praxis, additionally warning anthropologists away from generalizing all social problems to the world capitalist system and correcting with a focus on local social processes and community organization. To do this, Sanders (1985) recommends that system-challenging praxis be directed by enhancing democratization and eliminating mystification (Singer 229). These apply to the relationships between the community, the health care system and medical practitioners. Health is ultimately determined by social relations (230).

As Singer discusses anthropological contributions to the system-challenging praxis, he raises two areas that directly apply to this research. While anthropology recognizes culture as a primary influence on human behavior and social relations, it also considers contradictions and allows case studies to be examined for both proximate and ultimate causes of health status. Once these causes are determined, social relations in the form of community resources, existing systems and programs can be aligned. To offset the imbalance of social power inherent in these systems,

Singer recommends collaborations and coalition building across social groups, instead of dividing them (235).

Applied Praxis in Anthropology

Ervin (2005) details the history of applied praxis in anthropology, and current differentiations between types of applied anthropology. The history of the discipline of anthropology has been riddled with imperialism, ethnocentrism, co-opting of anthropological research and unethical applications of applied work. The era of structural functionalism is characterized by a study-down, colonial government direction of research. Anthropological research conducted from the 1930s to the end of World War II gave rise to organizational anthropology, which analyzed war-production factory activities in the US and culture patterns in Japan used to facilitate the occupation (6). Following the creation of the atomic bomb, anthropology took a decidedly theoretical turn, abandoning practice in the academy for fear of harming participants. For this reason, applied anthropology had its beginnings outside of the academic setting.

However, contemporary applied anthropologists recognize the mistakes of the discipline's past and work from the heart of applied anthropology: community-centered praxis (CCP). Ervin approaches applied praxis in anthropology from the perspective that anthropologists can and should become engaged with the main issues that affect everyone. He states specifically of academic anthropology that studying cultural phenomena that directly impact individual well-being without challenging the system and policy and promoting community-based improvement is incorrect (1). While academic anthropologists are challenged to avoid this trap, it is entirely possible

for anthropologists based in academic institutions to base their research in the community with community-driven applications, thus contributing to Ryan's (1985) vision of the decolonization of anthropology from purely academic pursuit to community-based practice (10).

The relationship between theory, practice and methodology in applied praxis is of enormous concern to Ervin. He questions whether applied anthropology should be concerned with the academic links between theory and practice, the applied links between methodology and policy analysis, or direct service to the community. The conclusion implicates the "values and visions" of the researcher, a healthy diversity of praxis in the discipline, and the generation of new theories from applied praxis to inform further research. Ervin upholds the view that mixed methods in theory, practice and methodologies are often best. He states of mixed methods, "it pays to be flexible in the choices of both method and theory and to have them pragmatically match the problem at hand" (11).

Literature Review: Conclusion

Society views women as the gatekeepers to their children's well-being. Studies of cultural behaviors contributing to children's oral health consistently find the behaviors of parents and caregivers as primary factors in the children's resulting dental health. Women receive a special scrutiny when they face substance addiction. Several addiction models focus on women as faulty people if they become addicted, and the root of their children's problems should they (or the children) become addicted to substances. They are held responsible for their own social and physical health and the well-being of their families.

Just how well women are able to take care of themselves and their families depends greatly on external factors. Women who are addicted to meth must find ways to access treatment, navigate the Medicaid system, and face the social stereotypes that health care providers and community members may hold. They coordinate their own health care resources and their children's to obtain health care services, and re-learn how to be the best people and mothers that they can be. Meeting these needs means finding financial and personal empowerment, freedom from physical pain, responsibility for children, and ultimately results in a recovery that has a good chance of lasting.

Methods

Methodology

This study combines qualitative and quantitative methods to best address the research questions and describe the sample's responses in the context of a unified system. The quantitative portion relies on a survey composed of questions from National Institute of Dental and Craniofacial Research (NIDCR) and the Centers for Disease Control and Prevention's (CDC) Division of Oral Health database of oral health questions included in national oral health surveys. The qualitative portion utilizes grounded theory methods to conduct interviews, analyze ethnographic data and present the findings to the original source for a check of validity. Reciprocal ethnography allows participants to review findings and facilitates the exploration of themes that contradict common findings. Reciprocal ethnography and the explicit discussion of counter examples are widely accepted methods for improving reliability and validity in qualitative analyses (Altheide 1998, Jayaratne 1991). By allowing participants to review the generated themes and to make recommendations or corrections to the ideas they have shared, the risk of misrepresenting an already marginalized population is reduced.

Recent trends in critical medical anthropology depend on reciprocal ethnography for validity and share the power of determining narrative with their study participants. Merely acknowledging the researcher's conscientiousness of the imbalance of power in the ethnography process can successfully balance that power. An active effort to share control of interpretation allows participants to lend their voice in their own representation, and recognizes the researcher's own positionality and subjectivity as a filter for the expressions of the participants. This approach decreases

further marginalization of the marginalized population. Abu-Lughod (2000) discusses the importance of this last awareness a reciprocal ethnography in reconstructing narratives in acknowledgment of the researcher's constant position of power in researcher/participant relationships. In her article "Locating Ethnography," Abu-Lughod states that anthropologists must constantly address their own power in research relationships, writing ethnography, and that the "critical" aspect of anthropology must be equally evaluative of the system and the researcher (261).

Abu-Lughod states in *Veiled Sentiments* that in producing a scholarly work on the Egyptian Bedouin community she identified her location in the ethnography as a woman, feminist and half-Arab (262). She examines how her ethnographic interpretation of the participants' lives is shaped by her own identities, and argues that there is no such thing as "life as lived," but only life as examined by a researcher and dialogue edited into text. Another aspect Abu-Lughod brings to light is the need to avoid writing about cultures (and sub-cultures) as "alien cultures because of the way such distinctions are inevitably hierarchical and tied to larger geopolitical structures of power" (262). The remedy for this problem is to counter the researcher's tendency to view the community of interest from the viewpoint of "social-scientific representation" with what Abu-Lughod calls the "discourse of familiarity," the active awareness that people are similar enough to warrant familiarity and subjectivity and are not populations void of humane and dignified consideration (263). Writing about populations through the lens of social-scientific representation causes them to be viewed as cold objects, rather than as human beings.

Developments in critical medical anthropology have addressed the topics of positionality, marginalization and subjectivity directly. According to Ervin (2005), medical anthropology has traditionally viewed researched populations through the lenses of both social scientific representation and western biomedical "orthodoxy and hierarchy" (51). Praxis in critical medical anthropology (Bauer, Singer and Susser 1997) promotes "advocating the policy needs of the marginalized, unions, communities and the impoverished" (Ervin 51). Critical praxis in research with these populations makes it crucial to evaluate the power positions of the biomedical system, economy and power from the effected population's viewpoint and to advocate for recommendations that the participants have specifically outlined.

In his article "Moral Models in Anthropology" (1995), Roy D'Andrade explains the recent conflict between the anthropological methodologies of objective models and moral models. Recognizing that "objectivity is not value free," an objective anthropological investigation is defined as an attempt to understand phenomena outside of the self, using ways to explain and understand the external phenomena (609). The results of objective models can be tested and replicated (610). A moral model is defined as one that assigns subjective ultimate values like "good" and "bad," explains "how things not in themselves good or bad come to be so," and attempts to correct those undesirable forces (610). Objective models can investigate subjective experiences, and as D'Andrade explains, can act as a moral model by "unmasking the symbolic hegemony that hides and legitimates oppression. The morally corrective act is denunciation. One can also act morally by giving a voice to

those who resist oppression; this at least identifies the oppression and the oppressors" (611).

It can be argued that objectivity, in the form of positivism, can be used as a tool by oppressors to "mystify" the true hegemonic causes of health disparities and maintain the disparities while appearing to attempt to fix them, thus reinforcing the oppressive relationship (613). However, D'Andrade argues that especially in the areas of anthropological health care investigation, it is necessary and beneficial to have "both moral and objective models, linked together" (613). He cites Rabinow's observation that it is necessary to have both moral and objective models to best practice anthropology, advocate for political concerns and contribute to an academic discourse (614).

Further, objective models and generalizations are not inherently "bad" of their own existence; rather, how they are used makes the difference between oppressive and helpful applications (619). D'Andrade's final stance takes a relativist viewpoint, that both models are useful, but must be kept separate to be most useful to the academic discipline of anthropology, individual anthropologists and the people they may seek to politically assist (624). Objective and moral models are tools best utilized to perform distinctly different tasks, cannot be effectively used to address the other's task, and neither is inherently better than the other.

Concerning the methodological implications of this study, I approach the research questions and hypotheses with an objective model intended to explore observable cultural phenomena external to myself. I do recognize that I am part of a community, that there is no positivist truth or true objective science that assumes

complete absence of researcher bias. However, the results of this study can be tested and replicated. They are a description of a reality.

Following D'Andrade's discussion of the distinction between objective and moral models, objective research should be conducted without a preexisting moral agenda, but moral recommendations can be made once observing subjective accounts of experiences, identifying the lines and sources of hegemony and oppression, and making recommendations and denunciations from a critical explanatory model of the observed phenomena. Because of this intentional joining of objective research model and moral action, this research can speak to both the growing body of anthropological and interdisciplinary social research and the application of the research to help advocate for the greater social good.

The methodological foundation for this study is a grounded theory approach that relies on theoretical sampling with concept saturation to explain participants' experiences of particular social phenomena. Grounded theory approaches have been widely used in anthropological analyses since it was first proposed in 1967 by Glasser and Strauss (Creswell, Morrow 1998). Because research is grounded in the participant's experiences with findings commonly returned to the community for assessment, grounded theory approaches have been argued to promote validity and reliability of qualitative assessments while being meaningful to participants (Raine 2001, Altheide 1998, Jayaratne and Stewart 1991).

Yvonne Lincoln's article "Emerging Criteria for Quality in Qualitative and Interpretive Research" explores quality in qualitative and interpretive research (Lincoln 2002). Current criteria for qualitative methods are less concerned with the

positivist aims of finding objective truth, focusing instead on the relationship between the researcher and the community of participants. It promotes a democratic understanding and sharing of knowledge between the researcher and the participants, thus denouncing academic elitism and addressing applied praxis concerns of directing research methods and applications towards the goal of informed social action (330).

According to Savage (1988), quality in research "integrates research, critical reflection, and action" (Lincoln 335). To ensure that the research is honest and valid, emerging criteria demands that the researcher recognize and validate the relationships between the inquirer and the subjects of inquiry. Positionality in relationship to the community is also required to ensure quality of research; this requires honesty about the degree of subjectivity in the interpretive approach while tempering the researcher's personal bias with critical reflexivity (334). The researcher must become a subjective part of the community, share their interests and directions in change, but critically evaluate both her own and other relationships as part of the group. Reciprocity from the researcher to the community, both personally and professionally, and the criteria to "create relationships that are based not on unequal power, but on mutual respect, granting of dignity, and deep appreciation of the human condition" directly engages the researcher and the work where it should be: with the community (339). Recognizing voice and appropriately crediting it to the community source empowers already marginalized populations against silence, disengagement and further marginalization (337).

The research design for this study is intended to pragmatically address the research questions. A mixed-methods approach provides a clear, contextual view of

the problem, the participants, and the information that they share. Mixed methods are supported in several bodies of literature (Ervin 2005, Jayaratne and Stewart 1991, Creswell 1998). Because this study deals directly with ideas of motherhood, gender and power, it is important to address use of various kinds of research methods from the perspective of feminist scholarship and reconcile criticisms of quantitative method with the preferred method of qualitative inquiry. Jayaratne and Stewart (1991) explore mixed-method inquiry from the historical perspective of feminist critique. Feminist social scientists currently recommend using mixed methods in community research. While quantitative methods have been evaluated in the past by feminist critics as sexist, biased, exploitative, overly simplistic and superficial, further inquiry into social science methodologies from the feminist perspective reveal that the creators and perpetuators of positivist methodologies have traditionally been "objective" male scientists (89).

Feminist criticism became heavily weighted against quantitative methods in favor of qualitative inquiries more in line with the values of feminism. Although qualitative methods spoke to feminist ideals of investing the self in research relationships, feminist scholars found their work in turn criticized by mainstream academia for bias and political application (90). Jayaratne and Stewart advocate for mixed methods in feminist scholarship citing methods as mere tools of researcher intent, stating that "both types of methods can be effectively utilized by feminists and can be implemented in ways which are consistent with feminist values" (91). Mixed methods are further supported by triangulation activities between methods, ensuring a

more contextual portrayal of the phenomena observed in results and their place in the holistic system.

Recruitment

Recruitment for this study took place at Milestones Family Recovery, in the Women's Residential and Women's Transitional Housing Programs. This population is vulnerable; individuals are in a voluntary substance addiction recovery program. The recovery program is guided by drug and alcohol counselors and managed by Milestones staff counselors and the individual's legal, judicial, and outside counseling staff. It is necessary to employ all possible methods to avoid coercion. Techniques to avoid coercion include removing all involvement of the clinic staff in recruitment, ensuring transparency of researcher intentions and non-affiliation with the clinic, and communicating to potential participants that clinic staff will not have access to information shared with the researcher during the data collection phase.

Phase I: Recruitment Survey

Phase I data collection consists of a recruitment questionnaire (Appendix 1), distributed by the researcher at group sessions and individuals as new clients enter the program. Potential study participants complete the survey and then self-identify if they are willing to meet for more extensive interviews. In addition to facilitating recruitment, phase one data collection is be used to generate a demographic profile of the study sample. It also provides basic information on oral health perceptions and practices that is comparable to national-level reported surveys. Questions for this survey are taken from the most recent surveys used by the National Institute of Dental Health (NIDH). The survey is divided into sections on access to dental care, mother's

dental health and children's dental health. Because of the tightly-knit community nature of this program it is not be possible to conduct completely anonymous surveys, and signed informed consent is be obtained before the survey is completed. Upon returning the survey, participants are compensated with a grocery voucher, and invited to participate in one-on-one, open-ended, semi-structured interviews with the researcher.

Phase II: Semi-Structured Interviews

To facilitate the privacy of these interviews, Milestones agreed to make a private space available at the residential program site (clients in both programs regularly attend functions at the residential site). There is an additional informed consent document for the interview phase of this research, which includes consent to audio record interviews. Participants have the option to decline audio recording, but still participate in the interview. Participants completing the Phase II interviews are compensated with a grocery voucher.

The interview questions are based on themes generated by the initial survey. Data analysis from the Phase I survey is used to generate common threads in participant's experiences that may be explored in more depth through the Phase II interviews. However, because of the nature of open-ended semi-structured interviews, themes introduced by the participant are included. Participants have the option to stop or postpone the interview process if they feel uncomfortable or distressed with the situation or the interview themes. When interviews have been thoroughly coded, the findings will be presented back to the participants to ensure validity of findings in Phase III.

Phase III: Focus Group and Validity

In Phase III, 10-15 participants who contributed interviews to Phase II and surveys to Phase I are asked to participate in a facilitated, non-recorded focus group meeting to discuss the findings from Phases I and II. An additional informed consent is obtained for Phase III. Participants are not asked questions of personal nature; are asked to verify or disagree with the presented findings, but participants are encouraged to openly discuss the findings and with one another.

Limitations

The individuals included in the sample for this study are not selected randomly. Selection is biased to target the perceptions and condition of a specific group of people who share a set of common life experiences. While their lives and personalities share have more in common with the population at large than differences, those differences are of significance to researchers in health literacy who seek to understand and improve health care conditions.

The number of individuals included in this study is not large enough to be representative of the entire population of methamphetamine-addicted mothers still using or in treatment. Therefore, this study cannot make statistical assumptions about the entire population; statements of statistical findings form the Phase I survey reflect only on the individuals in the sample. The nature of qualitative analysis in mixed-method approach also restricts the span of conclusions across a larger population, and the concerns, experiences, attitudes and perceptions of the topic can only be attributed to the sample.

Because of the nature of the power structure the participants find themselves in, they may express views that they perceive to be consistent with dominant social expectations. The source of power influencing participant behaviors may be DHS, a parole officer, pending legal matters, or a desire to project progress in recovery to get out. This limitation is discussed as the main theme across all interviews as Dominant Social Expectations. However I feel that most participants honestly shared their experiences, some may have self-censored their beliefs to project conformity to their perception of "correct" parenting practices. This limitation reflects behaviors that are commonly observed in the drug and alcohol recovery field.

Participants who make up this sample are also prone to relapse. While made up of no more than thirty individual participants, not all of those who completed surveys remained in treatment long enough to complete an interview. As a result, beds were opened and new participants became available. This is not an abnormal occurrence for any treatment program. Methamphetamine users are especially prone to relapse.

This makes it very difficult to maintain a sample composition of consistent individuals.

The relationship between the interviewer and the participant directly influences the resulting data. All data collected for this study involves personal exchange between the researcher and each individual participant. Several variables, including the tension in the house between participants at any given time, stress due to the behaviors of participant's peers, stage in recovery and rapport with the participant has an influence on the amount of information shared and how well it is conveyed in

interviews. For example, one participant was very defensive about her informed consent and interview process for confidential reasons not related to the personal affect of the researcher.

The relationship between the researcher and the participants is one of a power situation itself. To access the population, it was necessary to become a counseling intern and be associated with the counseling staff. My position of power, while not nearly as strong as those of staff or counselors, still involved some degree of alliance with those in power. Even without this position, I am a woman who has never experienced substance addiction or the social, biological or psychological conditions contributing to addiction. Thus, in the participants' eyes I am a member of the dominant social class. There is no doubt that this situation plays a part in the experiences and perceptions participants chose to share.

Finally, after spending several months with this sample before composing survey and interview questions, some limitations to the questions asked became clear. Participants' education levels were not questioned, because level of education is frequently regarded as a personal shortcoming. I felt it best to refrain from asking, to avoid inferring an attitude of judgment or marginalizing individuals by bringing out their personal insecurities. I also phrase interview questions from the perspective of the mother/caregiver's own experiences. The order of questions on the Phase II question guide (Appendix B) is intended to maximize the participant's personal reflection on their behavioral and attitude changes from active use to recovery, and give the participants more space for directing the interview to areas they consider important.

Data Analysis

The Phase I surveys are analyzed using Excel and basic descriptive statistics. Data is collected at the individual level, and depending on the nature of the question the survey ranks data at the nominal (yes/no, multiple factor questions), ordinal (number of times in treatment, ranking of overall health status and questions regarding periods of time) and some interval levels (children's ages, number of children). Responses to surveys are tallied, totaled and each answer is converted into a percentage of the responding population. For questions allowing the respondent to indicate more than one answer, the total numbers of answers are totaled and the percentage responding for each individual response is calculated.

The Phase I survey data then triangulated with survey data from the NIDCR national survey data tables. Such comparisons help to place this sample's reported health conditions in a broader contextual reference to national conditions for the same or similar demographic groups. The demographic groups referenced in the triangulation activity include age, gender, insurance status and income level.

Ethnographic Analysis

After completing both audio recorded and non-recorded interviews, interview transcripts or notes are coded by response themes to generate an analytical schema that maps common responses to interview questions (Charmaz 2004, Creswell 1998, Morrow 1998). Inductive or "open" coding of interview texts in grounded theory analysis requires allowing the participant's responses to generate their own themes (Bernard 444). To facilitate this method of analysis, I thoroughly read each individual interview and make notes in the margins regarding issues, feelings and experiences

brought up by the participants. Interviews are transcribed directly from the audio tape into Word documents, then uploaded as documents to NVivo. Based on the main themes generated by interviews, the text is first coded into the most common themes as free nodes. These themes are saturated with text from every interview. I then created a deductive coding scheme to test the hypothesis that the children's access to dental care is influences by mother's perceptions of care, social isolation and economic factors.

Initially coding the text into free nodes allows for the passages to be grouped by main theme, and divided into sub-themes. The use of sub-theme categories provides a multi-perspective view of responses, and highlights the range of responses to the main theme. Text passages from the main themes are divided into applicable categories (text may apply to one or more categories depending on content) and saturated with examples from all of the interviews. Once these categories are saturated, the most common themes mentioned in passages are selected and linked to one another in the context of common text passages.

Results

Phase I Survey

The entirety of the Phase I survey data results are given in Appendix E. An overwhelming 80% of participants indicate that they consider their teeth to be in fair or poor condition. Only 20% rated their teeth as ‘good’, and no one ranked their condition as excellent. These responses contrast sharply with the NIDCR data (Figure 1), which indicates that for the year 2002, 65.55% of female respondents reported their self-assessed oral health status as ’good to excellent’. This contrast indicates that the sample suffers greatly from a health disparity rooted in a social cause that differs from that of randomly-sampled female respondents in the greater national population. Not only is the sample percentage reporting at ‘good or better’ low for the female population, it is lower than any group, including those indicators of income, age and race in the 2002 national survey.

Following this trend in the survey data, of the 80% reporting a dental visit in the last three years, 46% report that the reason for their visit was for painful needs exceeding a regular cleaning or check-up. Participants had these visits for fillings (12%), to have teeth pulled (18%), or due to a toothache (16%). Only 24% report their last visit being for a regular cleaning and check-up. However, 100% of respondents reported brushing at least once a day, and 64% reported learning dental care from a parent or guardian during childhood. This indicates that the study’s sample is aware of the importance of dental care habits, practices home care regularly, and learned from an early age.

Of the participants responding, 60% could not access dental care they needed in the last year. This percentage jumps to 92% when expanded to lacking access in their lifetime, with 56% citing income, insurance or provider's accepted insurance as the main reason they could not access care (Figure 2). An additional 9.3% indicate that they could not access care due to transportation barriers. This suggests that most participants view insurance and income as the primary barriers to accessing the dental care they need for themselves, but feel that physical isolation from resources is also a barrier.

The majority (92.3%) of respondents are covered by some insurance plan. 84% of those are covered by Oregon Health Plan (OHP) dental plans, 11.5 % are covered a Native American tribal organization's insurance program, and 3.8% are covered by a private insurance plan. Only 56.5% report that they and all of their children are covered by the plan, with 26.6% reporting themselves and only some of their children are covered. This indicates that the majority of the sample is experiencing enough poverty to qualify for Oregon Medicaid-funded insurance programs, and that several mothers are currently separated from some of their children.

An overwhelming 79.4% of the sample report having two, three or four children, the majority (78.3%) of their ages between newborn and 9 years of age. This indicates that the most of the sample's children are at an age when they should be engaged in establishing lifetime dental care habits. Of those participants with children, 82.6% report their children's oral health status as 'good' or better. Additionally, 41.7% of participants report their children receiving preventative dental

services before the age of four; a further 16.7% report their children visiting the dentist after the age of four. The majority (62.5%) reported a children's dental visit in the last three years. According to the 2000 NIDCR survey data, only 26.5% of children under six had received any preventative dental services (Figure 3). These reports indicate that this sample's children have a higher reported level of access to dental care than most children. Ability to access care may be due to their mother's heightened awareness of their own oral health status, or the children's relatively high involvement with community resources due to their mothers' social status as recovering substance addicts. These phenomena will be discussed in the qualitative findings.

In regards to home care, 91.7% of participants report their children brushing at least once a day, and 54.3% of participants report home care as the best method for protecting children's teeth from cavities. This indicates that most of the sample feels that they closely monitor and care for their children's teeth at home, and feel that they are a greater influence over their children's oral health status than a dental care provider. Other responses further reflect this belief, as 66.7% of participants indicate that their children have not lacked a necessary dental visit in the last year, citing no problems (24%) or no teeth (16%) as the most frequently given reasons. Several participants did not answer this question if they indicate that their children had not lacked access to care. Those participants indicating that their children had not received a needed dental visit cite children's fear (8%), cost (8%), not having a dental provider (16%), or transportation issues (12%) as the barriers to access.

Based on the answers participants provide in the survey, the primary reasons for inability to access care differ for adult females and children. Insurance and income

are the primary barriers for participants, but not for children. In fact, few children lack access to necessary professional care. Everyone in the sample practices home care, but do not floss as often as most dentists recommend. It must be mentioned that participants are very honest regarding their own and their children's flossing habits. The majority of both participants and children (80.8% and 95.7% respectively) floss every few days or weeks, if ever. Participants rank their own oral health status as far lower than any other group at the national level, but their children receive better professional preventative dental care than any other group. This indicates that the sample of participants is acutely aware of their own oral health disparity but is equally aware of the importance of increasing their children's oral health status. These phenomena are discussed further in five main themes that emerge from the same sample's semi-structured interviews.

Phase II Interviews

The deductive coding of Phase II semi-structured interviews results in five main themes: Perceptions of Dominant Social Expectations, Insurance and Income, The Roles of Parent or Care Provider, Sources of Knowledge, Experience and Perception, and Navigating Non-Insurance Community and Family Resources**.** Aside from these main themes, I also tracked passages that directly referred to Children's Dental Status. These themes are then broken into sub-themes and further into categories. The sub-themes and categories are described in relation to the five main themes to best describe experiences that participants have in common, as well as the range of differences between participant experiences and perceptions.

The results of these interviews accurately explain the experiences and perceptions of the sample. All five of the main themes figure heavily into participants' abilities to access professional dental care for themselves and their children. The areas of economics, community connections and support, relationship with provider and perceptions of motherhood/care-provider roles are the outstanding areas where decisions to access and ability to access family dental care occur. These perceptions are influenced by interactions with providers and family members throughout the entirety of participants' lives. The level and sources of knowledge also factor heavily into participants' confidence about their abilities as parents/care-providers, pushing them either to care for children at home or seek care from a dental professional. Regardless of childhood experiences, participants' experiences of health and social use consequences result in a heightened awareness of the importance of their own dental health and that of their children.

Perceptions of Dominant Social Expectations (12 Categories in 5 Sub-Themes)

The main theme of Dominant Social Expectations is the obvious over-arching theme across all of the interviews, and is expressed in many forms. The source of these expectations come in the forms of external scrutiny (29 passages), internal scrutiny (30), in connection with "correct" motherhood roles (26), as a reflection of the disparity in social class between addicts and non-addicts (22), or a judgmental dental care provider (23). External scrutiny is characterized as "they" statements, in which the participant feels that others judge or have judged her. Participant T102, speaking about her feeling going to the dentist, states feelings of external scrutiny from a provider source:

> "I've never had a bad experience. All of my children's experiences have been good, but I don't like going. I let my teeth get so bad; they really harp on me about taking care of them. It affects my self-esteem and makes me not want to go." (T102)

Internal scrutiny, however, reflected a participant's judging of herself through the use of "I" statements. For example, R103 discusses the same situation as above, but the scrutiny is grounded in her own feelings of shame instead of the provider's judgmental expressions:

> "…I was really self conscious. They weren't rude to me, at the same time I was feeling so ashamed of stuff anyway. So I don't know… I don't remember a time when they were being rude. Even if they were rude I would be ok with it because I was ashamed." (R103).

In passages discussing social class disparity, participants directly recognize a difference between their social class and either a lower or higher class. Class status is mostly assigned between using and non-using individuals, and in a few instances between economic classes. In two examples, participants display a contrast in their views of their own social class, one economic and the other from use:

> "They don't care… all they care about is money. If you don't have money or insurance they won't help you anywhere. You'll have to deal with the horrible stuff that comes with having no money. They didn't know about my addiction… I'm not sure if they knew what I was doing. One dentist refused any care at all." (R105)

> "I see a lot of the women who have come through here who have lost all their teeth, who have had to have them all pulled or they have rotted out and that when I was using one reason I wanted to stop was because I was having dreams that I was losing all of my teeth, that they were just falling out, and it scared me really bad. So I'm very thankful that I've lost one, possibly two instead of all of my teeth." (R103)

Finally, T103 states that her social class is due to use consequences cutting off her access to community assistance:

> "I didn't have any income. They're not going to help people who are using drugs, and besides I was so busy getting high that I didn't try to get income help. There was no way to pay for dental care." (T103)

The role of motherhood is also a specific area where participants report aspiring to a "correct" social standard. These passages include statements of what a mother should do, what is considered by participants to be "proper" mother behavior, and either acting out those behaviors or intending to do so as part of recovery. For example, T101 explains her motherhood role as one of instruction and accessing care:

> "I've shown them brushing; they've seen me brush. But my oldest will try to get away with certain things, and he wasn't brushing them right. I'd look at him one morning, and I'd say "what? You brushed your teeth this morning and they still look like that?" I said, no, I'm going to teach you how to brush your teeth right. I'm shown him how four or five times, but I still make sure that he brushes them right every time because he doesn't feel it's important….They'll be going in the next 6 months, and the last time they went they got a fluoride coating. If they need a filling or a cleaning, they can get it. If they wait to go to the dentist, like I did, it's not good." (T101).

Another participant, R104, explains plans to address her children's dental care shortly after their return to her care from DHS:

> "I was going to call the dentist and ask them the age when they should have their first dental check-up; neither one has had a dental check. I'm sure my oldest is at the age when she needs one. As soon as their medical gets switched up here (OHP), I'll make one." (R104)

This sub-theme is discussed at greater length as part of the larger main theme of Motherhood and Care-giving Roles, but still falls under the Dominant Social Expectations Theme because of the overwhelming reports in interviews of social expectations of how mothers should act differing from their own using or current role behavior.

Some participants recognize experiences or feelings in which a provider has openly judged them or they felt judged. Often, this social isolation leads to barriers accessing care; these include Dentist Refusing Care (16 passages) due to use, method or lack of payment options, or child's age, and Fear and Social Isolation (13). These passages reflect feelings of being judged by a higher standard of behavior or member of a higher social class, and include a significant degree of guilt and shame for past or current behaviors.

In those passages referring to a dental care provider refusing care, the participant states that she sought care herself or her children and the provider refused care due to lack of insurance or participant's ability to pay for care, because the participant used drugs in the past or was high when she asked for care, or because the child in question was too young for a visit according to the provider's professional opinion. Participant's feelings are attributed to either an internal feeling of judgment projected onto a provider, or an outwardly judgmental attitude from a provider. These categories fit the main theme of Dominant Social Expectations because either a professional is placing a barrier between themselves and the patient, or the patient is placing internal feelings of dominant social expectations upon themselves. In either case, there is a general feeling of "us versus them", the source being either the participant or the provider. In the following examples, participants explain the range of their social isolation:

> "I never went to the dentist unless it was so painful that I couldn't… I had times I would try to get it out myself because I didn't want to have to go. I didn't go unless I needed an extraction. And even then I wouldn't make an appointment. I would just go in and demand…this is really sad, but it is true… I would say 'this tooth is hurting me so bad,' and my face would be swollen. I

> would really need it then, and they would get me in and extract it but I wouldn't go back." (T105)
>
> "I knew that I needed to do something about it, but I was afraid to go to the dentist because I was high. So I was afraid that if they caught me high I would get in trouble, so I just didn't go." (T112)
>
> "I tried to take my sons, both of them to the dentist before they were four, when they were two. And the dentist said that they would not see them before they were four. Not just one dentist; several dentists. Every one that I called in that area told me they had to be four. They probably didn't want to deal with the hassle of caring about children, because they're more difficult to settle down and a lot of kids are scared." (T101)

Dominant Social Expectations also appear in the sub-theme of Community Interactions. It is noticeable that most participants' interviews include passages mentioning a removal of children from the mother/caregiver's custody by a community source. Custody had either been removed in the past and has since been returned, or the mother/caregiver is currently experiencing the loss of custody. This fits the main theme of Dominant Social Expectations because these passages are examples of dominant social expectations of a higher social class being enforced through community agencies or members (Department of Health Services, law enforcement, or participant's immediate and extended family) on those with lower social class due to meth use. In discussing her plans to access dental services for her children, R111 explains:

> "It should be a regular thing. I don't have a dentist set up for my kids because I haven't seen them for so long and their dad isn't letting me see them, so I don't have any say over that right now." (R111)

Participant T103 experienced a similar situation from a community agency:

> "I didn't have them with me, but I was pregnant with my youngest. I was using certain parts of my second pregnancy. They took my daughter at the hospital, but my son was always with me. I've had them both since February." (T103)

Finally, dominant social expectations of appearance and self-esteem appear frequently throughout interviews independent of the questions asked. Fourteen passages cite mom's/caregiver's self esteem as a factor in improving her own dental health, indicating an internal submission to dominant standards of health. For example, T104 explains self-esteem as a part of her drive to have access to dental care:

> "When I take my dentures out, I feel naked. It affects my self esteem, it affects everything about me. Without teeth I can't eat or smile, and when they take them for a day to even realign, I hide. I won't go anywhere or talk on the phone because I sound so funny without them." (T104)

An additional seventeen passages state improvement or maintenance of physical appearance to be a motivating factor in seeking dental care, indicating awareness of aspiration to an external standard of beauty and health. According to R105, appearance plays an enormous part in her health care motivation:

> "It is important to me to have teeth. It means a lot to your appearance, so you need to have it. I am very concerned with what I look like and what my children look like; hygiene is important to us." (R105)

Insurance, Income and Provider Interaction (7 categories in 3 sub-themes)

Insurance, income and provider interaction are included in the same main theme because they are referenced as integral parts of one another in all of the interviews. With regard to obtaining care, having dental insurance coverage from OHP, UIHS or a private insurance program is considered to be a foundation to accessing care. As the survey data suggests, the main reason participants have not received the care they needed in the past is lack of insurance. Participants often reference insurance and income together as interchangeable methods of affording care, and other times having insurance despite a lack of income is stated to provide the continuation of care that cannot be afforded with income alone. For example, T104

discusses her recent transition to full-time employment and the gap in insurance coverage:

> "I have three more months before I get my dental [insurance was dropped from OHP because of income, with a 120 day wait until she can get insurance through employer]. Once you get a job, they tell you they'll wait but they don't. Like food stamps: they cut you straight off and it is hell. You pay all that deposit, you pay rent, and it is a struggle because I don't have a pot to piss in. All I have is the clothes on my back, two blankets and a pillow and I'm trying to move into my place. Worrying about insurance and all of that is hell." (T104)

In another example, T108 clearly gives the reason for her lack of access:

> "When my teeth started hurting, I knew I needed to take care of them, but I couldn't at the time because I didn't have OHP." (T108)

Finally, participants cite financial burden as a consequence of poor dental care for both the participant and her children. In two different examples, participants reflect on how they view the cost of care for themselves and their children:

> "I feel like, 'We are going to brush your teeth because I am not going to have the money for braces.' I'm trying to get her to let me brush them and I have a hard time with this because, and I don't want to set myself up for failure, but it will be hard for me if she ever needs braces for me to pay for them." (T103)

> "It's frustrating that there's a stipulation on what they will do. But I'm thankful that they will at least do fillings and cleanings. I've asked about an implant for here but I think it was some thing like $1500.00. And they don't do payments because once its done, if you don't pay on what are they going to do, take the tooth away? So it's kind of discouraging, but I'm thankful for what we do have." (R103)

One surprising and unexpected category emerged from the interviews; a mother's access to OHP Plus dental coverage is dependant on the custody status of her children. OHP Standard does not cover preventative dental work, and will only cover a narrowly defined scope of emergency dental problems. Sixteen passages made specific reference to insurance coverage for mom depending on obtaining custody of

children and caring for them according to a socially enforced standard, with mom's insurance being revoked with the removal of her children by a community agency. One participant, R104, states that her ability to access care for herself was directly dependant on the return of her children. This information is supported by the OHP Client Handbook. In an additional example, T101 discusses financial consequences of getting care while her insurance status was reduced by the same situation:

> "I was going to call the dentist and ask them the age when they should have their first dental check-up; neither one has had a dental check. I'm sure my oldest is at the age when she needs one. As soon as their medical gets switched up here (OHP), I'll make one. I've started getting my dental care done; now that I have OHP Plus, I'm going to go and get more work done than my dentist does with OHP Standard. OHP covers more work with that package." (R104)

> "I have a bill because I didn't have [insurance]. When I didn't have my kids I had OHP Standard, and it didn't cover dental. I had a temporary filling put in and now I owe them $94.00." (T101)

Negotiating the insurance system is referenced several times in the sub-theme Barriers to Care; negotiating with insurance sources to arrange appointments and payment makes up the majority of barriers to care. In 22 passages, participants make reference to several ways that navigating OHP bars their access to care. This includes refusing or delaying appointments, extending the waiting list more than two months for new patients, placing individual family members with different providers, gaps in coverage due to moving between counties, not providing coverage for the necessary level of care. Independent of one another, two participants explain their recent attempts to navigate the OHP system and encounter similar barriers:

> "I want to get my son to the dentist as soon as I can. I called the people on the first…my insurance is changing to certain doctors we can go to, and then it will be covered…somewhat covered [uncertainty in voice]." (R105)

> "On OHP, they're changing this guy that I go to over there. He's getting off [providing] OHP, and I wanted to reschedule our appointment so we could all go at once. I had it scheduled so all three of us could go on one day, I had worked that out [emphasis on "I"]. But I couldn't because they don't know who they're getting next. I wanted to get my oldest daughter in to have her teeth cleaned, because I just got her back. But they said they weren't accepting new patients and I would have to wait. It has been a couple months now, and it is OHP that is being like that. They should have somewhere she can go, even if it isn't the same dentist. I don't know how long it's going to be, so we can't schedule new appointments. Maybe after December, January. In Benton County, I have to go to them and they find my dentist. In Salem, it was different: they would give me a couple options to choose from. It was nice to have a list we can chose from, dentist who are accepting OHP. What I really don't like is having to have two of my kids go here and the third go over here. It gets confusing; I like to have them all in one spot." (T111)

The participants' relationships with providers are discussed often as part of accessing care. Building a supportive rapport with a dental care provider is an imperative community relationship to meeting dental health needs. Of the 16 passages referencing an empowering, holistic, understanding relationship with a dental care provider as a large factor in successfully accessing care, several participants credit meeting current needs and ensuring a more positive outlook on family dental care for both mom/care provider and children to these relationships. In two examples, participants explain their expectations of positive provider relationships for themselves and their children:

> "… the last time I went to the dentist it felt really good when she was working on my teeth. Part of it is knowing that my teeth are going to get fixed. I'm going to feel and look better, and it was soothing because she was so gentle and it helped. Her being gentle helped a ton. She was personally gentle and she knows my background of drug use and was nonjudgmental." (T103)

> "I am appreciating having a dentist now because I can take care of the teeth I have. I've gone to different dentists. The one I'm going to now is the only one who knows about my addiction, that I'm in treatment. When I got my tooth pulled, we talked about the Vicodin and abusing the pills. It wasn't like I was a maniac, "Give me pills!" [exaggerates aggravated behavior] or anything. He asked me, "are you going to be ok if I give you Vicodin for your pain?" He

> cared. My kids go to… I think an adult dentist, but they know how to work with kids, get on their level." (T111)

Speaking in general about the nature of experiences with dental providers, participants frequently discuss the difference between dental provider experiences during use and experiences occurring during recovery. Twenty passages reference satisfactory and empowering dental visits, while 34 passages reference dental visits that range from slightly negative perceptions of providers and visits to extremely physically and emotionally traumatic experiences. Of those negative experiences, some are linked to common concerns of dental visits, while other range from relapse triggers to traumatic surgical procedures:

> "I haven't had a bad experience, but I don't think that any dentist visits is typically fun. Nothing bad, just uncomfortable. The shot, when they give you the shots in the mouth, it's like "Oh, GOD!" I hate that. I really hate that. They tell you to relax and I feel like, 'you relax with a needle in your mouth' [laughs]. I feel comfortable doing it, and I wouldn't not go because I was scared, but it's just a little tense when they're numbing your mouth." (R111)

> "… I get triggered when I go to the dentist. It triggers me to go use; it isn't the fear, it is the shot they give me in my mouth." (R104)

> "I had 19 teeth pulled at one time. I was awake when they did it, I went in high when I had it done which I shouldn't have been. It took them more numbing stuff than normal to numb me because I was on drugs. I had taken aspirin before because I was so high I thought it would mellow me out. It didn't; instead it made me bleed more when they pulled my teeth. It took them hours to pull all of them and what they do is pull and twist the teeth out. But I was awake and I cried the whole time through the pulling because neither of my parents have false teeth, and here I am only 29 with false teeth today. My parents aren't even 55 yet. All due to using meth for 10 years." (T109)

This sub-theme of Mom's Dental Experiences is discussed at greater length as part of the Sources of Knowledge main theme, due to participants' experiences also serving as sources of knowledge of where to seek or avoid care and consequences of poor dental health.

The Role of Motherhood: Mom as Gatekeeper to Good Health and Nutrition (6 categories in 4 sub-themes)

Participants frequently mention ideals of motherhood behaviors throughout interviews. They consider making appointments, ensuring that they are kept, and teaching dental habits at home to be "correct" behaviors for moms and caregivers. Of the 31 passages mentioning mom/caregiver as the direct gatekeeper to dental care for children in her care, 13 of those reference successful instances of accessing care. In the following examples, participants discuss taking care of their children; the first speaks about when she was using, the second discusses her long-term recovery plan for her family:

> "I'd tell him to brush his teeth, and try to make sure he brushed his teeth, and I was a parent who did 'do as I say, not as I do' type, so I was still seeing to it, and he was going to the dentist." (R103).

> "Having insurance and care is definitely part of my long term plan. I want to make sure that if my children need dental care that they will be able to get it and won't have a hard time finding a dentist, or a specific insurance. I want to make sure that we have really good dental coverage and orthodontists in case they need that too. It has a lot to do with their self-esteem too, not just their physical health" (R106)

However, those participants who have experienced the temporary loss of their children defer the parental role a significant other (SO), family member or foster care. These cases are frequently mentioned (13 passages), and coupled with the participants' indications of their knowledge of motherhood roles regarding dental health:

> "I always knew that my kids brushed their teeth. Except for my oldest, his dad I and battled about him drinking a bottle after he was one. I would throw the bottles away and his dad would go buy more bottles, but my son had teeth at two months. So he had a full set of teeth by the time he was one year old and he drank a bottle until he was two and a half, so it messed his teeth up. Messed up like broken off, decayed, rotted out. But I took him to the dentists and he got them all fixed." (T101)

> "I didn't teach her; my mom was teaching her, her grandma. It ranked high. They had her at the dentist…I don't even know, because I would pop in and pop out. But I know that she went to the dentists a lot and they did the best they could. It ranked high with my mom and dad." (T104)

One surprising area where the theme of motherhood and responsibility emerged is under the sub-theme of Nutrition. When asked about their family's nutritional habits during periods of active use, participants frequently discuss their nutritional status with reference to caring for the children's needs while neglecting their own. This indicates a tendency of using moms and caregivers to maintain nutritional care for their children, but caring for their children's needs over their own. An additional 6 passages indicate that no one in the family, mom/caregiver included, ate appropriately and nine passages state that the entire family maintained adequate nutrition during the mom/caregiver's active use. In the following passages, R109 discusses her family's nutritional habits, and T113 explains how she obtained food for her children. In both passages, the participants explain what they know about correct nutrition and who had it:

> "I always cooked good meals for my kids at night. For breakfast there would be cereal. Lunch would be a sandwich. Dinner would be things like chicken, mashed potatoes, gravy, you know, green beans. They were eating nutritious meals on a regular basis. My kids were eating, but I wasn't eating at all." (R109)

> "I worked at the outreach church for homeless people, and I got a pick of varieties of food boxes and stuff. So I offset the price with my brother to feed the kids. I would fix them vegetables, open cans of peas and corn and fresh broccoli and cauliflower. They ate it because it was fixed for them. They were eating balanced meals, no sodas, but chocolate milk. They got their treats and snacks after school, a carrot or chopped up apple versus the candy, the easy quick-fix snacks." (T113)

Teaching Children in the Home is another sub-theme that includes several passages referring to the mom/caregiver's role in maintaining children's care. Several methods

of teaching children dental care in the home are directly linked to a mothering role, including 29 passages stating that mom/caregiver gives children direct instruction, supervision or brushes their teeth for them, 23 passages indicating feeling it best to enforce a home routine for children's dental care,16 passages referring directly to mom/caregiver showing her own health and an example to teach children, and eight passages stating that mom/caregiver uses play techniques to educate children at home. Several participants combine one or more teaching techniques, but all share a common expression of their mother/caregiver role being central to the children's home care:

> "I've shown them brushing; they've seen me brush. But my oldest will try to get away with certain things, and he wasn't brushing them right. I'd look at him one morning, and I'd say "what? You brushed your teeth this morning and they still look like that?" I said, no, I'm going to teach you how to brush your teeth right. I'm shown him how four or five times, but I still make sure that he brushes them right every time because he doesn't feel it's important." (T101)

> "When they're both in the bathtub, I get the stuff to brush their teeth. I brush my son's with my finger, and with my daughter she knows that when I get the toothbrush and paste that it's time to brush her teeth. I try to hold her from behind because it's easier that way. After we're done, she plays with the toothbrush and pretends to brush her own teeth, so she knows what brushing her teeth is." (T103)

Sources of Knowledge, Experience and Perception (12 categories in 3 sub-themes)

How moms/caregivers come by and use knowledge is often brought up in passages regarding the respondent's own childhood and adult dental experiences, as well as in passages expressing the breadth of the respondent's knowledge and applications of this knowledge to the children. Of these, nine passages express learning knowledge directly from a provider, 17 passages indicate learning from parent or immediate family members, four passages discuss learning knowledge at

school, and only two exceptions discuss not learning at all. The following passages display the range of knowledge sources:

> "I remember a lot, and my mom didn't teach us. We lived in a car for a long time, so brushing our teeth wasn't an option. My mom, she didn't care about her teeth, so she surely didn't tell us to brush our teeth. I didn't go to the dentist for the first time until I was 9 or 10, and when I did I had 6 fillings. They were teaching it at school, and I knew I was supposed to be brushing my teeth, but I couldn't because there was no where to brush my teeth." (T101)

> "To brush your teeth at least once a day. Usually we did it twice, and to floss. Both of my parents taught me that, and my mom's friend was a dental hygienist." (R106)

> "I spent a lot of time in the dentist office because I have a birth defect, and I had braces from 11-18. When I finally got my braces off, it was cool and I didn't want to go to the dentist. My upper mandible was too narrow so I had a spacer that hurt really bad, so I had a lot of painful experiences at the dentist and never wanted to go unless I had to go." (T112)

> "I don't think I never took care of my teeth. I didn't have a role model. My mom worked three jobs to support all of us, and my dad wasn't living at home at that time. I just had older brothers and they didn't care, so it wasn't a big thing with me. I was left in the dark. They did the best they could, but it wasn't a priority for our survival." (T104)

Another sub-theme that emerges in Sources of Knowledge is learning from use consequences. An overwhelming 56 passages indicate that respondents recognize physical health and nutritional detriment resulting conditions of their former drug use. Noticeably, 48 passages indicate almost equal reference to social consequences of use, including social isolation, guilt, fear, shame, embarrassment, and a reduction in social class status as a result of drug use:

> "It definitely wasn't a priority, but I still brushed my teeth at least once a day, and I probably didn't seek dental appointments and things like that. It did affect my teeth because I wasn't eating healthy." (R106)

> "I knew that using was going to hurt my teeth, but I wasn't taking care of them at all. They got worse when I was using." (R107)

> "I feel that if I don't get my teeth fixed, I don't know, it's not good it hurts. It hurts physically, and my self esteem now that I have a cavity in the front of my tooth. I look at it every day, and someone will say something like 'you have a piece of pepper stuck on your tooth' and it's embarrassing. I just lost half of my tooth this weekend, a back tooth. It hurts really bad." (R109)

> "I took my money elsewhere. I spent my money on the dope and I was looking for my next hit, not worrying about my kid's dental or anyone else's including my own. I wasn't eating; when I went into treatment the first time for meth, I weighed 87 pounds. I was a sick kid." (T104)

The most important factor of the sub-theme is the connection between use consequences and how those consequences lead to instruction by example for the children. Twelve passages in the sub-theme Learning and Knowledge mention the respondent learning from her use consequences, and an additional 16 passages included the respondent referencing herself and her lessons from use consequences directly effecting how she educates the children. Participant T109 best explains the connection between experiences and teach children:

> "It was hard for me to think of showing my child how to brush his teeth when I didn't have any teeth that looked like real teeth, because they were rotten. I wasn't going to smile in the mirror and say, 'Look, Momma brushed her teeth' when I didn't have any to brush. I was ashamed and embarrassed.… I would like to keep them on a schedule of every 6 months. That's really important to me from the experience I had with drugs and not taking care of myself right, that's what makes me motivated to keep them on a schedule of having regular check-ups." (T109)

Navigating Non-Insurance Community and Family Resources (7 categories in 3 sub-themes)

The last main theme emerging from the interviews is reliance on non-insurance community resources. In these passages, participants speak about accessing or learning from community or family members. Community support is divided into six distinct categories: foster care, family, culture group, recovery community, community services, and dental care providers. Twenty passages mention removal of the children

by the community; these incidents were mentioned in passing, never with blame or negatively. There is a general attitude of acceptance that this occurs as a use consequence. In six additional passages, participants reference the removal of the children as a support tool in teaching their children healthy home dental habits, and 11 passages directly reference the child's current care provider giving their children access to dental services outside of the home:

> "As far as my daughter goes, her dental and all of her medical is all up to date with her father. And my son, as soon as he gets here with me, I'm sure that he'll have all of his check-ups if he hasn't already had them in foster care. He's 5 months old and has already cut two teeth. His foster mom is a registered nurse." (R108)

A further 16 passages refer to family or culture group as a support system to help learn about dental health and nutrition and access care. These passages reference a culture group, family, or community agency in successful access to care:

> "I've always had [insurance] because I'm Indian. I had it though the tribe growing up, and when I moved up here I had it through Oregon Health Plan… the tribe that I'm from is in Northern California so I'd have to go there and I haven't had my license for three years. So I plan on doing that within the next year probably, and hopefully they can crown it so I won't lose that tooth. I have OHP Plus, but they won't cover it. I'll go this summer and stay for a couple weeks. I'll get whatever I need done and stay with my dad for however long it takes, get whatever I need done with my teeth. I'll take my older son because he needs braces and OHP won't cover braces either. So, we're going to have to figure out a way to go through them." (R103)

> "My kid's teeth are fair. My kids are brushing twice a day, morning and night. The younger ones in Head Start brush after they eat, too. They're learning that it is very important." (T111)

> "She (my daughter) always had medical. My mom pretty much took care of them. She had three square meals a day, and was taken care of." (R108)

An additional 12 passages refer to specific local provider or office that facilitates their dental care needs in a desirable manner. Most often, helpful traits in a provider

include non-judgment, knowledge of recovery and addiction factors in dental care, and a gentle personal affect. For children, these traits include an ability to be tolerant and gentle with children, humor, and an overall kid-oriented chair-side manner:

> "…since I've been in recovery I've had some really great dental experiences. I've had my teeth cleaned several times now, and they've patched a little chip I had. They're fixing my teeth and replacing a cap, because food particles get under the cap and the replacement will be tighter. Slowly, I'm getting more comfortable with my dental care. They know about my history and ask how I'm doing. Usually, it's the same dentist. They're really awesome at Willamette dental. If I call and say I need something, they get me in that day. I'm really grateful that I have been getting help." (T105).

> "My older son loves to go to the dentist, more than the doctor. It's his favorite thing. The dentist I took him to was a very good dentist. They called him Dr. Bill, and my son just loves him." (R109)

Summary of Results

These five main themes of Perceptions of Dominant Social Expectations, Insurance and Income, The Roles of Parent or Care Provider, Sources of Knowledge, Experience and Perception, and Navigating Non-Insurance Community and Family Resources accurately explain the experiences and perceptions of the sample. All of them figure heavily into participants' ability to access professional dental care for themselves and their children. The areas of economics, community connections and support, relationship with provider and perceptions of motherhood/care-provider roles are the outstanding areas where decisions to access and ability to access family dental care occur. These perceptions are influenced by interactions with providers and family members throughout the entirety of participants' lives. The level and sources of knowledge also factor heavily into participants' confidence about their abilities as parents/care-providers, pushing them either to care for children at home or seek care from a dental professional. Regardless of childhood experiences, participants'

experiences of health and social use consequences result in a heightened awareness of the importance of their own dental health and that of their children.

Most of the women in this sample have Medicaid (OHP) coverage and also have children. Because they are enrolled in OHP, this tells me that most of them live below the federal poverty level and raise their families on little to no income. Given that they experience poverty and drug addiction, their reports of feeling discrimination due to these two social markers is a significant marker of how much social status effects an individual's subjective perception of accessing health care services and addressing needs.

Children are universally important to the sample. Even the one participant with no biological children of her own viewed children as the future. The women in the sample are not only concerned with their children's health in the short term; they are also looking out for the distant future beyond the period of complete dependence on a parent. The most important feature of this awareness is the implication of the women's own childhood, use and recovery experiences in keeping children healthy. Several times, the women spoke of giving their children the tools of health, perspective, appearance and self-esteem that they themselves felt they had missed out on. The consequences of lacking these tools weigh heavily in the women's decisions to seek out dental care for the children, and into their vigilance over home care. Because the women do not always have health, perspective, appearance and self-esteem for themselves, they work hard to provide for the children to save them from the fate of repeating the cycle of poverty and drug addiction.

Keeping families together proves to be a barrier to accessing care. Although it is too large an issue to be addressed in the narrower scope of a pilot study, all of these women a social experienced separation from their own parents, significant others, and children. A point of frustration for most of the women is DHS removing children to another county, and the lag time between reinstatements of insurance benefits when the children moved between counties. OHP dental benefits on Plus plans differ between county administrations. Having the children back means the world to these women; it is a major (and tearful) life event when DHS returns physical custody of the children to their mother.

It follows naturally that a mom who has learned parenting and responsibility in recovery would desire to practice these tools with her children's health care, but navigating the OHP inter-county dental benefits when they are different for each family member is difficult if not impossible. The emergent theme of OHP benefits as helpful but antagonizing speaks to this characteristic of the sample. These women are mothers born anew, frustrated that they have learned how to take care of their children only to be faced with a health insurance system that does not facilitate the drive of mothers ensuring their children's health and well-being.

This sample is comprised of women who care a great deal for their children's health and future. They are determined mothers, but are also recovering methamphetamine addicts who face difficult lives in every aspect of the concept. Most have been alienated by a society they dually view as the cause of and solution to their family's health care needs. Because of the discrimination they feel from their communities, dental care providers and insurance systems, they are simultaneously

made painfully aware of the mistakes they have made and driven by a determination to give their children the best lives possible. The hurdles they overcome to take care of themselves and their families include stereotypes of meth moms and meth kids, the ability to afford dental care with money and insurance coverage, the workings of the state and county Medicaid policies, and their own fears of failure in recovery. Their aspirations to be better, healthier people and ensure optimal health outcomes for their children despite the handicaps of structural insecurities and structural violence (Farmer 2006) speak volumes to the strength and perspective the women in this sample carry into their family dental care decisions.

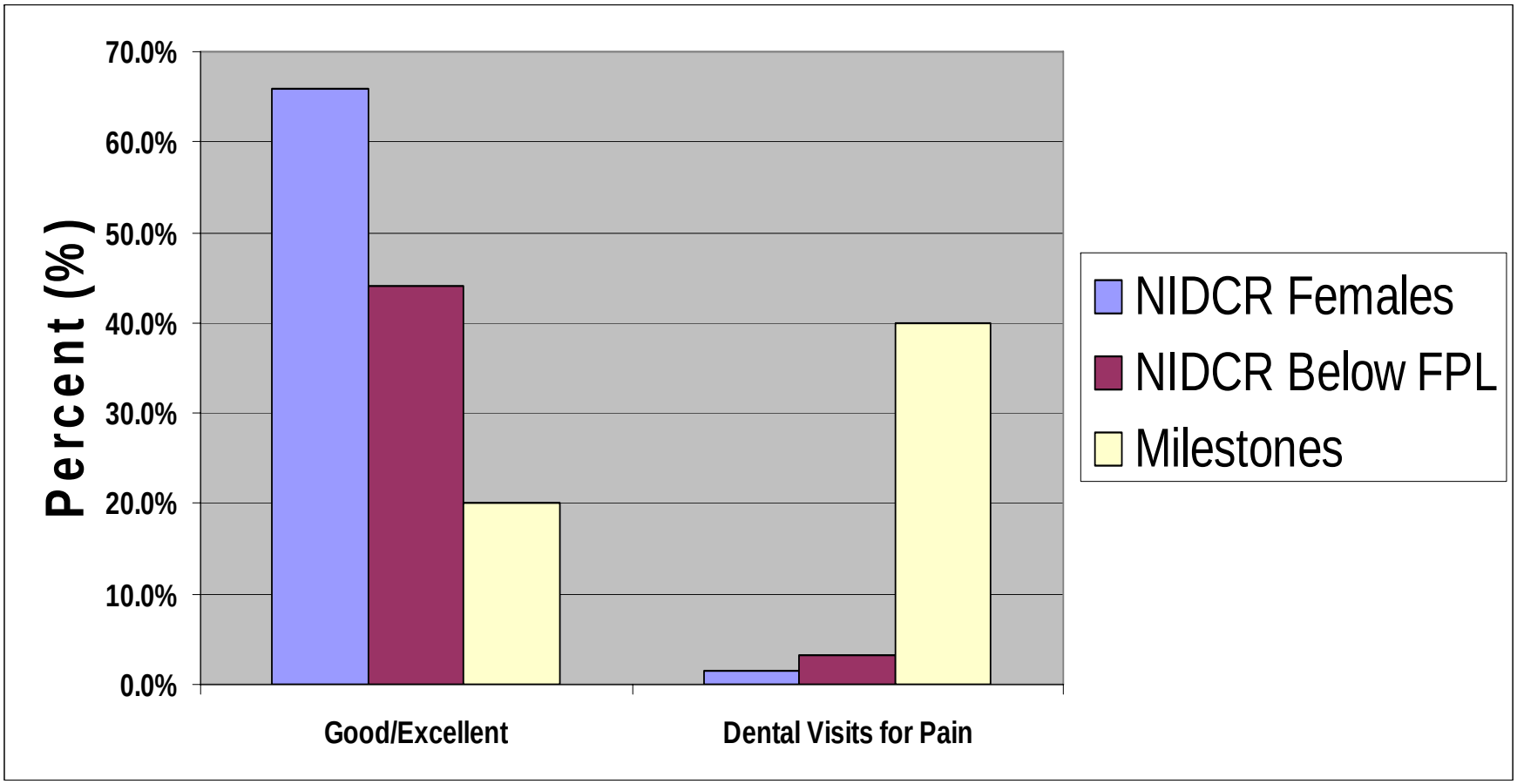

Figure 1 - Women's self-assessed dental health status and dental visits for pain. Self-Assessed Status – NHANES III 1994, Pain – NHANES III 1994

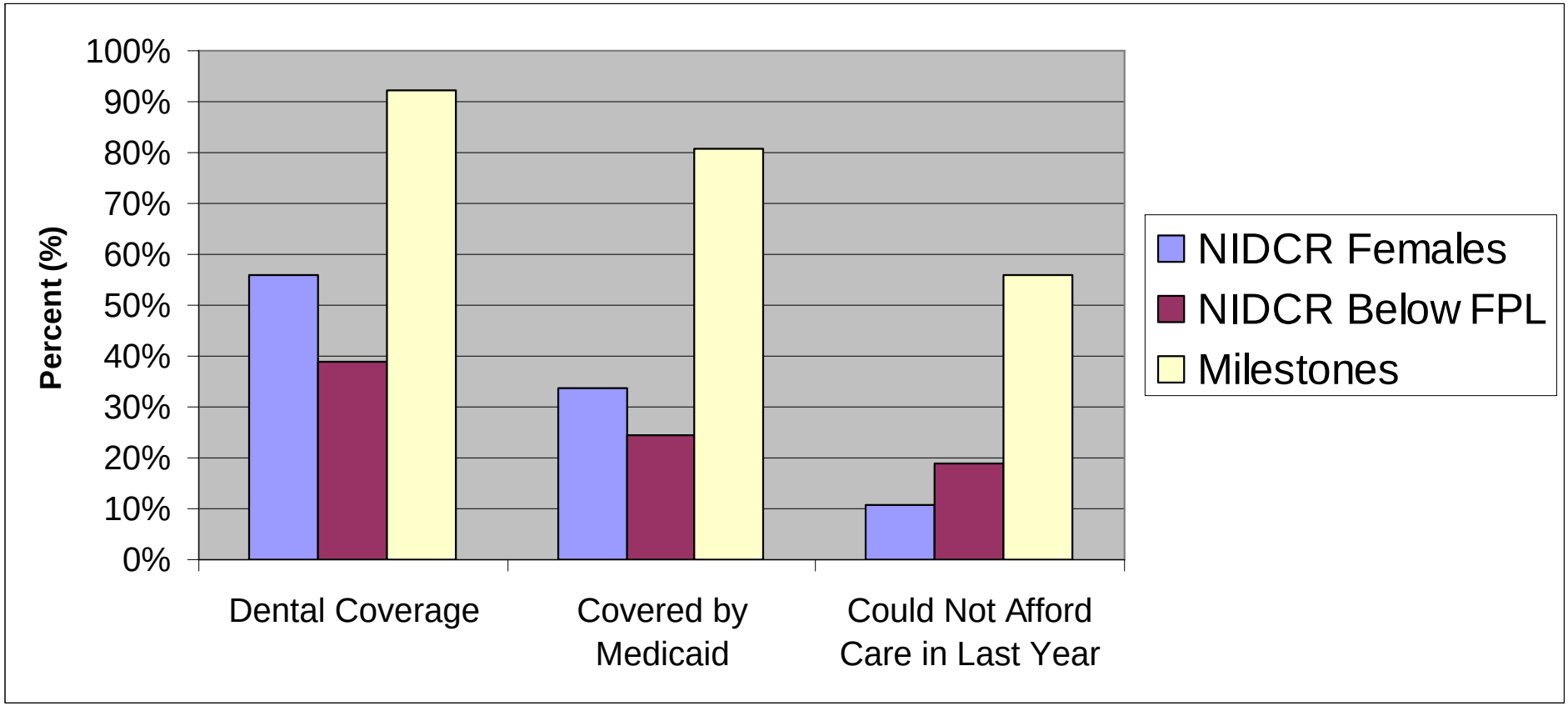

Figure 2 - Women's dental coverage, Medicaid coverage, and affordability of dental care. Dental Coverage – BRFSS 2001, Medicaid Dental Coverage – MEPS 2000, Could not Afford Care in Last Year – NHIS 2001

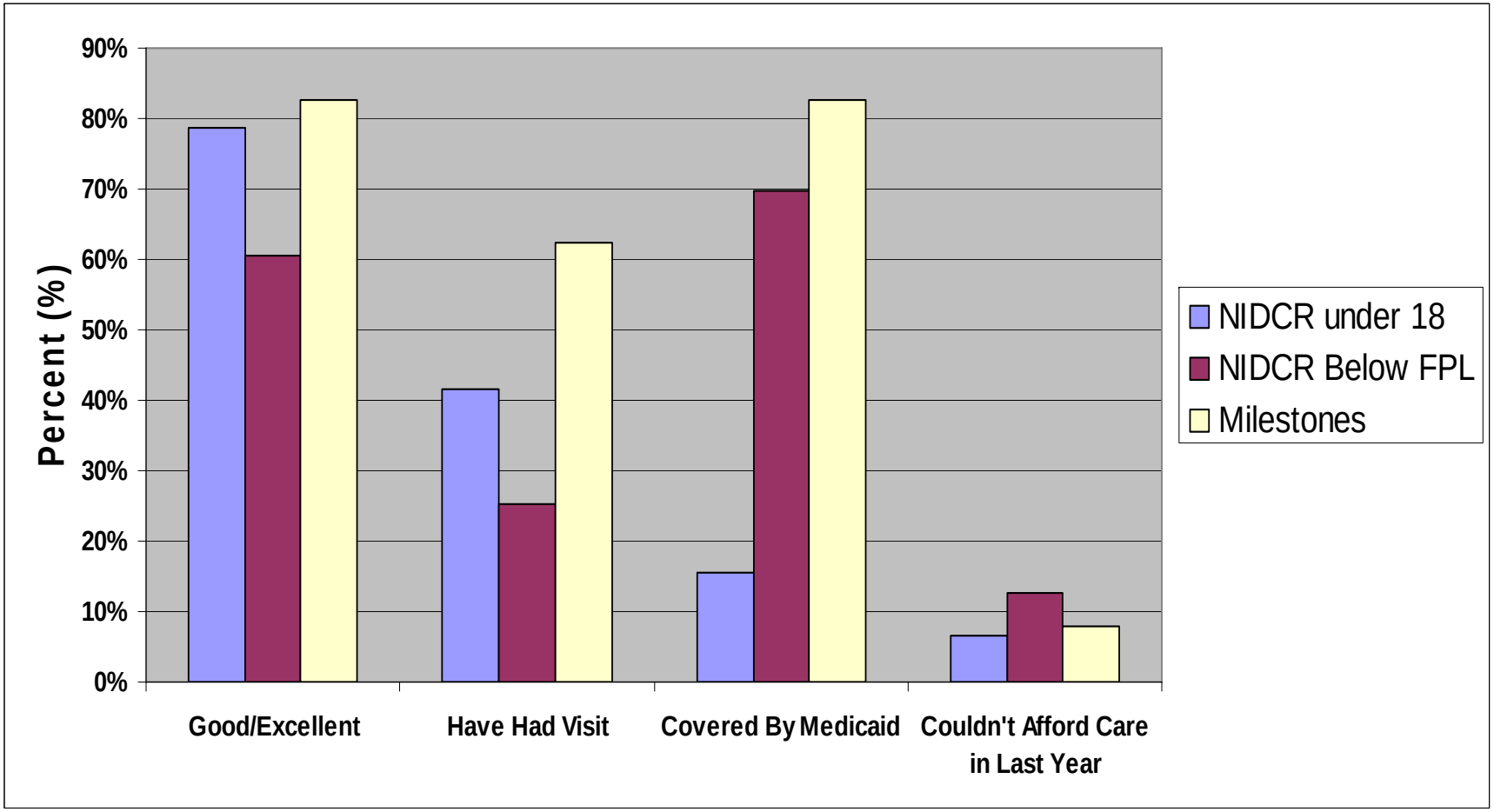

Figure 3 - Children's dental status as assessed by participants; ever had a dental visit, covered by Medicaid and affordability of care. Self-Assessed Status – NHANES III 1994, Dental Visit, Medicaid Coverage – MEPS 2000, Couldn't Afford Care in Last Year – NHIS

Discussion

Phase III: Validity and Reciprocal Ethnography Outcomes

An integral part of grounded theory and applied praxis is reciprocal ethnography. I presented the findings of this study to fourteen of the participants, sharing with them the entirety of the survey and coding results, a summary of each main theme, a theme map showing the process of participant's shared events and the relationships between themes (Appendix C), proposed recommendations and needs. The participants responded positively to the findings, agreeing with all of the themes, relationships, recommendations and theoretical applications.

Discussion focused on additional stories and struggles shared by those present. They shared that OHP no longer covers dentures. This is of enormous concern to most of the women because several were told by their providers that they had the option to fix their teeth, but that they would have to pay hundreds of dollars beyond the work that OHP would cover. Most providers do not allow payment plans, so the women must chose the only option that will alleviate their dental pain: complete removal of the affected teeth. One participant explained that her provider recommended repeated root planing[5] to save her four back teeth. OHP wouldn't cover the procedure, and the dentist's office would charge hundreds of dollars in difference. When she asked about the option of a payment plan, the dentist wanted half of the cost of the procedure up front. Feeling discouraged, the only other option was to have the teeth pulled completely (OHP would completely cover extraction). She went home to consider her decision, but the pain was so great that she went back for the extractions.

[5] Root planing is a dental procedure to prevent the progression of already advanced gum disease that cleans between the tooth and gum to the roots. It sometimes requires several visits and antibiotic treatments.

Another participant shared an opposite experience. She wanted her dentist to pull a tooth and asked several times, but the provider insisted on performing a root canal. The participant was understandably upset at the quality of care she received. She felt that if the dentist had listened to her needs, she would not be scheduling the visits necessary to monitor her pain.

Participants contributing to Phase III of the study also identified transportation as being more of a problem than they had previously identified in their surveys and interviews. They all agreed that when they were using, they could not drive themselves or children to appointments because they were high. Once they had made the decision to enter recovery they had lost their driving privileges, cars and children, and became reliant on public transportation or the availability of family and friends to get to appointments.

Another area that received further emphasis was community and family. All participants agreed that they could not have successfully obtained the care they and their children needed without the help of family and community resources. One participant stated that she credits her increased dental health status the Native American community that she belongs to. They provided transportation, services and insurance to herself and her children when she was using and early in her recovery. Other participants received help from family and church members arranging appointments and transportation. Several participants cited Head Start as an especially important community resource for their children's dental health education and habits.

Participants provided much feedback on the theme of social class. Several recognized that they had not considered themselves a social class until they had gone

through a period of active use and entered recovery. They had heavily felt the effects of using on their social status (hiding from those who may turn them in, avoiding dentists from shame, etc.), but further felt ostracized once they began to seek care during recovery. Several felt that dentists, doctors and their insurance plans did not match their efforts reach a standard pinnacle of physical health.

All of the participants felt that they constantly struggled against these entities to take care of themselves and their families. One participant stated that she made things more comfortable between herself and her provider by explaining recovery, her experiences with meth and the guilt she felt regarding her dental health status. By empowering herself with ownership and responsibility and presenting this to her dentist, she felt that she "disturbed the barrier" and "broke the ice" of social class she and the dentist felt between them. As a result, this particular participant built a lasting, therapeutic relationship with her dentist.

Regarding the children's dental care, all of the women felt that they do the best they can with respect to the limitations of economics, transportation and willing providers. All of the women agreed that they are good mothers and good people who previously made bad choices. They recognized modeling their dental care for their children, brushing with them and attending appointments as a family. Those women who had lost the majority of their teeth stated that they had held serious discussions with their children who did not like to brush, to explain the consequences of lax dental habits and drug use. Most of the women had successfully gotten their children in to see a local adult dental provider for preliminary checks before the age of three, and all planned to have their children see a dental provider in the next two months.

When providers do not agree to see their children, the women do ask about home care and practice that care vigilantly until the provider agrees to an appointment. One technique the women had been using at home was the use of plaque-indicating mouthwashes and toothpastes. Several of the women had the children practice brushing, use the mouthwash, then find the places they missed. They categorized this technique in both direct instruction and play, and explained that their children find it fun and independent to learn this way.

I found that the most interesting anthropological feature of this practice is the horizontal diffusion (from client to client) of vertically acquired knowledge (from dental professionals or community classes) among women who house together in the recovery population. This is what Malakki and Meyerhoff (1997 have described as an "accidental communitas," a group of people who have experienced a common situation together in space and time that unites them after their dispersal from that space. When one house resident learns a new technique from Head Start or a provider, she shares it with others and all of the children learn together. This pattern continues when new women enter the house, creating a self-maintained current of health literacy between participants, houses and recovery generations. This pattern also applies to finding a dental provider, and avoiding those providers who are not helpful**.**

Structural Violence: Social Class and Health Disparity

Brendan Kelley (2006) describes the ways that structural violence leads to health disparities among individuals with mental illnesses. He describes structural violence as attributable to the "systematic exclusion" of the mentally ill from their own communities and political participation, and the resulting "difficulties the

mentally ill may experience recognizing or articulating their own needs in the absence of effective health-care systems, and the absence of knowledge about alternative systems" (2118). Paul Farmer (2005) also describes structural violence at the national and social levels in his work *Pathologies of Power*, in which human-rights abuses, AIDS, and HIV infection rates are discovered to be "localized and nonrandom" due to "social process that are embedded… in the inegalitarian social structures" of globalization, nations and local communities throughout the world (230).

This is precisely the way that women in this sample experience structural violence. Because of sociopolitical stereotypes of meth users, they are stripped of their political weight and social importance. Few (if any) recovering methamphetamine users are able to contribute to dental health policy at the community and state levels, and they are rarely consulted about ways to improve their health conditions. OHP has rigorous rules of who receives dental coverage and how much dental work will be covered do not consider the greater level of need those recovering methamphetamine users require. The recovering population suffers more frequently as a result, at a greater level than non-users because they cannot access care. Stereotyping of methamphetamine addicts results in blaming the mother/addict/victim, and the actual contributors to the health disparity are covered up, perpetuating the cycle of structural violence.

These stereotypes and the blaming that systematically excludes recovering meth users from communities are present in ways that stigmatize former users for life. The Oregon Partnership and target Meth materials made available by the Oregon Medical Association (2007) prompts community educators to instruct communities

about methamphetamine users and their drain on the community. These presentations present all meth users as violent, abusive, neglectful, hypersexual[6], unhealthy, dangerous individuals who abuse children, destroy property, and cost Oregonians tax dollars and property values because of the problems they cause. The stereotype of hypersexuality is especially harmful for women. Increased libido is one of the known effects of using meth. The common stereotype of meth users proposes that adult users experience an increase sex drive and heightened pleasure, resulting in promiscuous and unsafe sexual practices. Thus, the predominant social attitudes on the morality of women's sexual behaviors are applied to female users in addition to beliefs about substance abuse. A series of slides in one presentation clearly state that everyone who isn't using meth is a victim of those who do. Meth users are blamed for nearly every problem in every community in Oregon.

The culture of addiction is further a determinate of social class and health. As explained in the literature review, drug addiction is still viewed by the most powerful agencies as a choice. Addiction is seen as a personal shortcoming, and a sign of being a "bad" person. When women are addicts, they are viewed as counter to "normal" definitions of the female roles of "woman" and "mother". As indicated in the stereotypes perpetuated by the media, drug addicts (meth addicts especially) are seen as wanton non-human creatures who do not care about themselves or others, are a drain on the economy, stealing medical and dental resources from non-users, and above all neglectful parents who focus all of their money and time on seeking and purchasing drugs. Law enforcement and religious groups are proponents of the moral

[6] Being excessively active in and/or concerned with sexual activity

model, which frequently relies on publicly de-humanizing drug addicts as a prevention strategy.

The women who participated in this study emphasize disparity between social classes as an indicator of health. They frequently discuss losing teeth and experiencing decreased dental health status as a result of their social status as a "drug user". While they recognize that their teeth would be healthier if they had not used drugs, they cite a combination the social stereotype of meth users and their own feelings of guilt because of experiences with this stereotype as the reasons they could not be as healthy as they want to be in recovery. The main areas of disparity that the sample identifies are economics, drug use, and those agents of the community who enforce dominant expectations (dentists, doctors, social service workers, etc). These women need help for themselves and their children, but are afraid to ask for it because of the stereotype set forth by people with power.

Economics is also an exclusionary factor to dental care. These women cannot afford care for themselves or their children without insurance, and because of their income level most of the women utilize OHP for dental and health care access. The sample views dental care as a luxury for people who have jobs, money, or a private insurance program. Access to dental care signifies greater political status in the community and higher social class, resulting in "nice" teeth being an indicator of social status. The women also feel that they would have more leverage in negotiating care decisions if they were of a higher economic class. These women lose the key elements of choice and autonomy; having no money or insurance and a very limited

dental insurance plan robs them of upward sociopolitical mobility and forever condemns them to an obvious visual marker of their place in society.

The way that the general population views drug addicts continues when their health care is considered. OHP rarely covers residential drug and alcohol treatment, preferring to place clients in less-expensive but often less-effective outpatient counseling programs. Oregon is currently ranked 49th in the nation for access to drug and alcohol treatment for 18-25 year olds, and 45th overall (OMA 2007). OHP does not commonly cover dental care, and preventative and intermediate dental visits are not covered under OHP Standard at all. The OHP Client handbook further states that OHP Standard will cover emergency dental needs, including "severe" tooth pain and "serious" dental infection. Non-emergent (and thus not covered) dental needs include "a toothache" and swollen gums.

Two questions emerge from this policy. First, most methamphetamine users are also living in poverty. They must get dental care to completely rehabilitate. How can this portion of the population avoid relapse without assistance? Second, every participant in this sample who experienced tooth pain classified it one way: the worst pain they had ever experienced. How should they determine the difference between "severe" tooth pain and a tooth ache, swollen gums from a serious infection, without consulting a dentist? OHP standard policy should allow covered preventative visits to avoid these situations and to facilitate the correct diagnosis of those conditions as "emergencies" or not.

Power and Health Literacy

The women in this sample experience relationships with their health care providers that are unique to their sub-culture. Power in these relationships and the health literacy of the sample are key to understanding how those relationships function and how they can be improved to reach a desirable health outcome. Health literacy is a relatively recent consideration in the medical and dental professions. According the American Medical Association, health literacy is defined as

> "the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions and follow instructions for treatment. A recent government study estimates that over 89 million American adults have limited health literacy skills... Compounding the problem is the fact that most patients hide their confusion from their doctors because they are too ashamed and intimidated to ask for help" (AMA 2006).

Specifically in regards to oral health literacy, the American Dental Association issued a statement in February of 2007 that details the need for oral health literacy, and lists limited health literacy as a major barrier to adequate dental health and access to preventative dental care (ADA 2007). The ADA further outlines specific needs of improved provider/patient communication, reduction in professional jargon in patient instruction, and a baseline of cultural competency in care to improve oral health outcomes.

Power is a key component of health literacy. Often patients feel intimidated or ashamed if they cannot understand instructions. This imbalance leads to a communication barriers between patient and provider, and can lead to an undesirable health outcome (ADA 2007). The women in this sample are especially prone to experiencing this imbalance of power, but feel the effects at the point of accessing professional prevention and intervention. The levels of health literacy they report on

surveys and in interviews suggested a strong grasp of information necessary to make health decisions, but not the power to obtain services. They express feeling that they have little (if any) power over their own access to dental health care. Without income, adequate insurance, or social standing, they cannot afford or ask for care from a dental professional. They frequently mention not understanding where they should go for dental care, how they should advocate for their needs if the dentist holds all of the knowledge, or the clear details of their dental procedures as communicated by insurance programs and providers. The nature of this imbalance indicates that the women themselves are not the source of low health literacy; rather, those in power create structural barriers to their acting on knowledge they already have.

One area where all of the women agree that they have no power was with OHP and their dental care providers. They concur that OHP helps them somewhat, helps their children all the time, but that OHP policies governing where they can go for care, how much of their care is covered, and when they can access care robs them of personal empowerment in their own care and their abilities to act as gatekeepers for their children's care. While they are trying their best to create healthy lives for themselves and their children, they are not able to achieve this because they have no autonomy in planning their own health care. OHP, other insurance companies and dentists are the ultimate holders of power because they delegate which services are accessible and which are not.

Dentists are in a special position to improve this problem with intervention. However, the dental profession faces its own position of power and stereotypes of meth users. As meth use becomes wide-spread, so do the dental problems it is

associated with. Dentists are forced to confront the treatment of this problem by the nature of their work. While some dentists care appropriately for their patients as people and display a high degree of understanding, others do not. This is emphasized by the women when they discuss their personal experiences with their dentists; some have established understanding and open communication, while others have been mistreated and openly judged. The two extremes are most often brought to light.

While they cannot always access professional care, they recognize having power inside their own homes and over their children's care. The women may not have power in their *own* care, but do have power to supervise their children, access care for their children, and manage those resources to facilitate their power as mothers and caregivers to support the health of their children. These women showed a fairly high knowledge of dental recommendations for home care. They indicate on the survey and in their interviews that they know to brush and floss at least once a day, and that this helps prevent further dental health problems. They all knew that using methamphetamines would harm their teeth and health. They all knew that their children should see a dentist at some point in their childhood, and felt that if they had not seen a dentist early in life themselves that it was a failing on their own parents' behalf.

Some of the knowledge that the women shared with me was incorrect. Several shared with me that they believe that women lose calcium from their teeth when they are pregnant. Several also felt that children should not see a dentist and did not need dental hygiene care until they have teeth. Others believed in "street knowledge," beliefs about dental care and meth that are specifically transmitted cultural beliefs

within the drug-using community. These ideas range from meth sapping calcium from enamel, to supplementing a poor diet with vitamins to save teeth. None of these theories have been clinically tested, but the participants' clinging to any knowledge they can get shows that they seek to empower themselves with knowledge from any source in an attempt to save their teeth while using. They apply this knowledge to their children in an effort to prevent them from perpetuating poor dental health in the next generation. By seeking power through gathering knowledge, these women are attempting to save their children and lift them out of the cycle of addiction and low oral health status.

Conclusions

The findings of this study are grounded in participants' experiences with dental health care and their perceptions of the importance of dental health care for their children, relationships with dental care providers, community and family, and perceived need of care to maintain healthy families and selves. In the Phase I surveys, participants' collective responses suggest that the majority of the participants are insured but still cannot afford dental care to the level they feel would ensure expected health outcomes. Most of these participants are covered by Oregon Health Plan, and individual family members are sometimes covered by different plans in different counties. Not surprisingly, most of the participants had their last dental visit for pain (versus a regular check-up), and cited a lack in insurance, income, and dental provider as barriers to accessing care.

The sample overwhelming ranks their own dental health status lower than national survey samples, but rank their children's dental care better than samples of birth to 18 year olds in the national samples. Most of the children had seen a dentist recently. For those who had not, participants cited a lack of fully emerged dentition, lack of a pedodontist, or a lack of transportation as reasons for not yet having a child's first dental visit. Participants' children noticeably did not face the income/insurance barrier their mothers reported for themselves. Additionally, the ages for first visit ranged from early infancy to late toddler-hood, with very few of the children having their first visits after the age of 4.

In Phase II, the participants highlighted economics, community connections and support, relationship with provider and perceptions of motherhood/care-provider

roles as the prevalent realms where decisions to access and ability to access family dental care occur. Participant's descriptions of interactions with providers and family members throughout the entirety of participants' lives lend perspective to their immediate dental health care decisions. How much care they access and their perceived levels of health literacy directly reflect confidence about their abilities as parents/care-providers, leading them to either prefer caring for children at home or driving them outside the home to seek care from a dental professional. Regardless of individual childhood experiences, participants' experiences of both health and social consequences of methamphetamine result in a heightened awareness of the importance of their own dental health and that of their children in both the present and future.

Anthropological Theoretical Applications

Sociobiology

Jerome Barkow's article "The Elastic Between Genes and Culture" (1989) explains that adaptive cultural traits can change in response to environmental alteration, changes in expense for fitness payoff, incorrect information, and the unequal distribution of wealth and power in group decision-making. Culture is defined by Barkow as "a pool of at least some-what organized information of various kinds, social transmitted within and across generations" (440). He explains,

> "If socially transmitted information does at times tend to be fitness-reducing, then under certain circumstances we may expect selection to favor individual-level mechanisms that permit the individual not only to perform functions analogous to the editing and revising of received information, but to create new information as well" (440).

The women in this study perform a revision in the maternal transmission of information in health literacy both between themselves and to their children, resulting

in adaptive biological health outcomes for themselves and their offspring. In the scope of pure biological fitness, dental health is a somewhat necessary component to producing fit offspring; maternal dental health effects birth weight, transmission of potentially fitness reducing oral microorganisms, and the health of larger physiological systems (Horowitz 70-71; AAPD 1113-1114)). In the scope of social fitness, visible dental health status is equivocal to success accessing monetary resources and acquiring the power to pass adaptive knowledge on to offspring, thus increasing the social and physical viability of offspring. According to Barkow, socially transmitted information can be maladaptive when

> "wealth and power are unequally distributed, and the teachings of a dominant group may tend to enhance the relative fitness of its members at the expense of that of others. It can be argued that culture is an arena for social conflict, and deception and misinformation are powerful weapons" (441).

If this sample is considered in Barkow's latter category of those whose expense is taken to enhance the fitness of the dominant group, their experiences fit this theoretical model. The women follow socially transmitted information (information from providers, OHP, and other community dental programs) because the costs appear to be low for the higher biological and social fitness return, but in actuality the returns are low for them. In terms of freeing up scare health care resources, they become a non-dominant social group whose lack of returns benefits other groups and the elite. Deception and misinformation, in the broadest sense appearing in the form of stereotypes of "meth moms" and "meth kids," benefit the dominant group by protecting them from and defining them against the sterotype. Misinformation keeps the dominant class in the dominant, and more fit, position.

When examining the role that elite status decision makers play in determining cultural fitness outcomes, Barkow states “the transmission of culture involves conflict over information, ” and concludes that in regards to advantages entailing expenses, “…it is common for the benefits of an innovation to be enjoyed by one segment of society and the costs carried by another”(447). This theoretical model could be applied to this study in two ways. First, some Oregonians carry the cost by missing out on OHP dental benefits to free resources for others. The result is that technological dental innovations for preventative and restorative care are reserved for one segment of society that the elite deem worthy (under 19, pregnant, TANF families, those on SSI, over 65), and others who otherwise qualify for benefits don’t receive the benefits of any technologies to fund those who do.

This segment of sociobiology theory could also be considered in terms of meth prevention programs using stereotypes to deter new cases; the elite use these strategies in schools to transmit cultural knowledge (that meth use is unacceptable) to children with scare tactics and stereotypes of users, while those users pay the social costs (reduced health care choices, reduced employment options, health disparities) to keep the elite’s children off of the drugs.

Barkow states of revising maladaptive cultural information into adaptive traits that “…mechanisms that already revise socially transmitted information specifically in our own fitness interest also tend to revise culture, often eliminating fitness-reducing information,” for example, “deliberate socialization of children by parents wishing to transmit a revised culture to their offspring” (442). This sample of women revises the previously mentioned fitness-reducing socially transmitted information when they act

as gatekeepers to the children's dental health. They socialize the children to hold certain beliefs that differ from their parent's beliefs and take care of their health in certain ways to avoid what the mothers themselves found maladaptive, thus revising cultural information for the sample and their offspring to improve the fitness of both. This revision of information and resulting increase in fitness occurs in spite of the continuation of the purposefully maladaptive information of the unequal wealth/power distribution.

Intimation and prestige also play a role in Barkow's exploration of cultural transmission/revision in children. Parents, in this theory, are most likely to be the sources of information for children (449). Paired with "deliberate socialization," Barkow makes a case for the revision of maladaptive culture traits in the parent to child socialization relationship. He states, "culture revision involves conscious, deliberate decision-making as well as nonvolitional processes. These points can be illustrated by "parental child training decisions" (451). Barkow further states, "Many parents do not simply attempt to replicate themselves in their children: They try to prepare them for the future. During times of change, that may mean deliberately socializing them in a new manner or deliberately exposing them to socializing influences absent during their own youth.

In this sample, it is important to consider who assumes the role of teaching children when they are removed from their mothers. Children learn from their fathers, relatives or foster care. Once they are returned from their mothers, they reinitiate an information transmission relationship that is based on banishing the "meth mom" stereotypes the children may have been taught while away from mom to revise

maladaptive culture traits, and continuing beneficial learning behaviors surrounding dental care that began either with mom before removal or that began with another learning source.

The idea that parents transmit culture revisions to their children deliberately to improve fitness is obviously apparent in this sample. The transmission of information about proper dental care, where to access resources, the social and physical consequences of meth use, and the importance of dental health to personal self-esteem and appearance that most participants state they strive to give their children matches this theoretical approach. Fitness for the children improves both socially and biologically, as they gain prestige and earning potential by safe-guarding their dental health. I would argue against Barkow's generational caveat, however, because the women in this sample don't necessarily expose the children to influences absent in their own youth. Rather, they expose them to the lessons the women felt were absent in their adult lives. They are essentially passing on what they know now to keep their children from falling into the same lack of personal respect and care that the moms faced as adults, recognizing themselves in positions of power and prestige in their children's eyes.

Symbolism and Interpretive Anthropology

Symbolic and interpretative anthropological theory helps to explain the phenomena of the "meth mom" stereotype both for the dominant members of the community and for the women themselves, and explains how the symbols and rituals surrounding women's gendered roles serve as a marker for enforcing correct social behaviors and unifying communities. Turner explains in his work "Symbols in

Ndembu Ritual" (1967), "Symbols instigate social action. In a field context they may even be described as 'forces,' in that they are determinable influences inclining persons and groups to action" (546). Symbolic meaning is defined by "what it does and what is done to it and for whom" (552). Turner describes dominant symbols as those which are at the center of ritual, are meaningful to the participants and unite them as groups, and are "ends in themselves" (551). Interpreting the symbols comes both from the anthropologist's field perspective of situating the meaning of both symbol and ritual in the structure of the observed culture and, in this study's case, narratives, experiences and perceived roles of the participants (551-52).

The women's social positions in this study, especially the stereotype that they feel both within themselves and from others, are dominant ritual symbols of culture. Several of the women recognize that there is a stereotypical meth user: one who has no teeth, has permanently lost custody of her children, has no clean friends, will go to any length to be high, and will hurt anyone in her path on her quest for the drug. This symbolic woman is both abused and abuses, she is a community menace and a drain on resources, and she has no hope. She does not care for herself or other people outside of meth-seeking connections. She is not a contributing member to society, and is easy to spot on the street.

Symbolism occurs for the women at two places; they are simultaneously the symbol for the dominant social classes and recognizing their opposition to the same symbol, which they themselves have metamorphosed from to become recovering women. When the women discuss their identification with this symbol, it is either as a person they were who, as Turner explains, drives them to take action and go to

recovery, or a person they had not yet become who they rejected before arriving at that point in their addiction. Turner discusses this feature as the polarizing, community-dividing features of a symbol. Recognizing the symbol, women become opposed to one community group to join another, thus placing them in the recovery community. The symbol has meaning to them as their future or their past. They take action because of the symbol, inciting the rituals of re-arranging the family, resources, and personal values to reject one social group and join another. The community split occurs between the actively using group and the group who is in recovery.

At another level, the same stereotype of "meth mom" is utilized by the dominant social group who creates policy, law, and the standards of womanhood, motherhood, and personhood. They define themselves and the rules for society in opposition to the stereotype symbol. This can be observed in the OMA's Methamphetamine Taskforce community education presentations, in DHS policy, and in law enforcement action. The "meth mom" becomes a symbol of the dangers of drug use and what kinds of people to avoid. The symbol is used in educational tools to unify the dominant group against the meth-using community, and the "us versus them" mentality conveyed in the educational materials cannot be denied for its potency in polarizing communities against the seemingly necrotic group. Instead of unifying the society, the dominant group seeks to completely separate the meth-using group by using the rituals of taking the children, placing users in correctional facilities or drug treatment programs, drive them out of communities, and take away the materials they use to make the drug. The stereotype of "meth mom" and "meth user" acts as a dominant symbol to drive this social action and either expel users who will

not change or bring users back to the dominant class with reform programs and punishment.

Turner goes on to explain that in constructing “those ideal prototypes of behavior” that ritual and symbols seek to uphold, the amount of time spent reinforcing the conflicts between groups opposed by the symbol feeds directly into the maintenance of the ideals of proper conduct (548). He states that some types of ritual are “situated near the apex of a whole hierarchy of redressive ad regulative institutions that correct deflections and deviations from customarily prescribed behavior” (551). For this study, the “meth mom” symbol instigates conflict between the dominant class and meth users, and between the women and various permutations of their identities to uphold a unification of the entire community’s ideals of gender, motherhood and human social behavior.

Geertz’s article “Deep Play: Notes on the Balinese Cockfight” (1973) explores the contextualizing of identity and unspoken vertical hostility in symbolic conflicts between social groups of differing vertical status. He views Balinese cockfights as symbolic of the conflict between status positions, expressing conflicts between the groups who embody opposing values and reconciling identities from the conflict’s outcome. Groups in conflict within a locale will unify against an invading group, but in the absence of an invading group will align with the next hierarchical group that is in opposition, or between individuals. Conflicts that post vertical status positions against of another are deeper than conflicts between horizontal status positions and have more serious wager risks.

Conflict, in Geertz' view, reinforces alliance with a group. Individuals take one side or another and place their values in opposition to the other group to show solidarity and status (567). Status, however, doesn't really change with conflict results; the conflict is symbolic of the ongoing inner hostility of immobile relegation to a status place. Real conflict makes intangible hostility tangible, and thus a malleable medium to reaffirm identity (569). Status is important because it invades every aspect of an individual's life and, in some cases, fitness, as it restricts or allows participation in and access to social life and economic well-being (570).

For this study, conflict between social groups of unequal status is symbolic of accepting or rejecting the status marker of "meth addict." In Geertz's terms, some women identify with the "meth mom" group and will "bet with" them. They identify with the values and behaviors, and seek to advocate fro themselves in the social arena from this position. Other women, who are closely related to the opposing group within the recovery community much like nearby but opposing kin relationships in Geertz' work, oppose ever having been "meth moms" and identify themselves in opposition to that identity, thus placing their values in conflict with the other closely related group. These values are rarely in conflict because, much like the neighboring or common local groups, they share a locale and status in comparison to a larger population. Value conflicts are mostly individual and have little wager attached to them.

However, when the conflict becomes vertical, the women in the neighboring groups align their identities to advocate for themselves against a dominant value system. The women "bet with" the entire recovery community, for in the sights of the

dominant social classes and rule makers the women are united under the stereotyped symbol of "meth mom." The conflict occurs in the women advocating for their families' access to healthcare resources. Both the women and dominant classes recognize the difference in status, and both realize that their status positions will never change. Because of their uniting experiences, the two groups will never switch places. In the struggle for health care resources, the women reaffirm their status as addicts and the dominant class reaffirms their place as rule makers, resource rationers, and enforcers of acceptable social behavior.

As with Geertz's cockfights, every conflict has a different outcome. Sometimes the women win the conflict with OHP and dental care provider and get resources. Sometimes they lose and accept either inadequate resources or none at all. In either case, the outcome is not as important as the constant affirmation that the women are of lower economic and social class status than dentists when meeting for conflict on the "floor" of the clinical setting, law enforcement when meeting for conflict on the "floor" of child custody, and the community at large when meeting for conflict on the "floor" of employment, insurance benefits, and basic community interaction (568).

Further, Geertz mentions that a singular conflict is a "particulate burst of form," while a string of conflicts is the statement of reality in "spurts," thus "rendering ordinary, everyday experience comprehensible by presenting it in terms of acts and objects…" (568-69). For this study, the conflicts between the women and the many manifestations and locations of dominant social class are the same. The underlying acknowledgements of status are constantly present, but only in arranged meetings

between the two groups do the components of the relationship take on a tangible form. When the many isolated conflicts are added together and shared among the groups, collective notions of the other take a testable form.

Meetings between members of the dominant class and addicted individuals occur with law enforcement, dentists and community members to create a picture of "meth moms." For the women, they share their meetings with dentists, law enforcement and community members to create not only pictures of each of these sections of the dominant class, but to position themselves as *not* members of the dominant class. Participants explain this theoretical construction of culture as they describe recognition of both external scrutiny and equal internal scrutiny, both occurring as a result of conflict with the dominant social class. Geertz explains this as a feature of the Balinese cockfight, that an individual conflict participant "forms and discovers his temperament and his society's temper at the same time" (573). In the same way, the women in this study reaffirm their identities in response to the status created both for them and, eventually, by them.

Critical Medical Anthropology

In revisiting Critical Medical Anthropology, it is defined by Singer (1998) as

> "a theoretical and practical effort to understand and respond to issues and problems of health, illness, and treatment in terms of the *interaction* [sic] between the macrolevel of political economy, the national level of political and class structure, the institutional level of the health care system, the community level of popular and folk beliefs and actions, the microlevel of illness experience, behavior, and meaning, human physiology and environmental factors" (225-26).

CMA approaches health as a political issue, includes power as an imperative variable in health care policy and programs, and attempts to change "culturally inappropriate, oppressive, and exploitative patterns in the health arena" (226).

This research demonstrates that this sample of women who are either mothers or children's care givers and are in recovery for addiction to methamphetamines experience health disparities as a result of structural violence surrounding their drug use. They are subject to the stereotypes of "meth moms," which places them in a lower political, economic, and class position than people, especially mothers, who do not use methamphetamines.

Substance Addiction and Critical Medical Anthropology

In the case of this research, methamphetamine use is the proximate cause of poor dental status among using mothers, and their behavior patterns during use contributes to their children's dental health status. Use also contributes significantly to their education levels, employment, and decision-making behaviors. However, the ultimate cause of their own suffering and their children's suffering is the *social prejudice and policy* surrounding their drug use, during both active use and all phases of recovery. Their places in the community are determined to be "drug addict", "addicted mother", and inevitably "bad mother." These roles are not self-determined; they are handed down by law enforcement, the media, and the very creators of dental health policy who represent Medicaid-funded insurance programs in Oregon's counties, public health, community oral health coalitions and dental practices. Women are allowed or denied resources for themselves based on their choice to have children, the custody status of their children, and their decisions to seek financial

empowerment through employment. Children receive dental care only so far as their mothers are able to secure insurance and keep appointments in a dental insurance system that constantly delays appointments, changes providers, and denies payment.

Infrastructural Insecurity in Insurance and Community Systems

Most of these women directly interact with the Oregon Health Plan because of their decreased economic status, and face the structural violence that OHP system creates for families. When these women lose their children, they also lose their OHP Plus coverage and their access to dental care services. As their dental care declines due to continued drug use, they are unable to access dental care that may have saved their teeth because of the lack of insurance coverage and an attitude of disdain from those in power (dentists and policy makers). In the end, they are stripped of their personal power and health care choices as they take what they can get from OHP and dental providers once they regain their children, and are punished for a dental health condition that they only partially contributed towards. If these women could access dental care without stigma for their social class, scorn for their poverty status, and fear of excessive scrutiny, their oral health condition would greatly improve.

At the community level, the sample's beliefs and actions empower them in their homes so that they can care for their children. The women at Milestones realize that their choices led to their own decreased dental status. They also realize that they have some knowledge to help their children avoid the same situation, and take action to either care for the children themselves throughout use and recovery periods. If they cannot do this they rely on family or community agencies to ensure that their children get the care they need. The women's folk beliefs are enhanced by the health care

experiences that result from their disparity, and result in a heightened awareness of where to access services, how to enforce home dental care habits, what they envision for their children, and how to achieve it. These women's experiences empower them to care for their children despite a system that oppresses the women themselves.

The women in this sample face structural violence from the Medicaid insurance system they must rely upon for basic access to care. The program judges the female drug users by their ability to meet "correct" standards of motherhood; if they cannot keep their children, they cannot keep their access to health care. Their health care status decreases as a result. When they do gain back physical custody of their children and their insurance status, the dental insurance on OHP Plus often isn't enough to cover the degree to which their dental condition has deteriorated. The structural violence occurs in the trap of being in enough poverty to be eligible for OHP, and by the same requirements not having enough income to pay for necessary dental procedures beyond OHP coverage. The result is unnecessary extractions and the added oppression of OHP administration's recent decision to cease paying for dentures. OHP policymakers force dentist's hands to perform "inevitable" extractions, and then decline denture coverage. The combined power of OHP and the provider's payment policy takes the women's teeth and leaves them toothless, both literally (in the physical sense) and figuratively (of their social capitol, self-esteem and autonomy).

All of this power functions under the stereotype that health care resources should not be wasted on those whose choices have led them to decreased health status. The children in this sample are well cared for and have a high rate of receiving adequate preventative and surgical interventions via their mothers, the community,

and overt OHP health care resource rationing strategy of including all persons under the age of 19 among the eligible population. The children did not choose their conditions, and so they are cared for by state allocated Medicaid funds. Their mothers, however, are seen as individuals who have made choices and "deserve" to be where they are. This belief is so powerful that most of the women internalize it as self-criticism. Public health care benefits are always available to the children. But the full use potential of those resources is not always met because of the systematic rationing against individual women. The creation of an insurance coverage dichotomy results in decreased health literacy for the family decision-maker and a consequential reduction in positive health outcomes for the dependants.

Multi-Disciplinary Theoretical Applications

Biomedical Ethics: Ethics in Health Care Resource Allocation

A large part of addressing the problem of access to dental care is the ethics of allocating scarce health-care resources. This issue has been addressed by many biomedical ethicists (Veatch 2003, Pence 2004) and there are various schools of thought on how resources should be allocated. It is generally accepted that the cost of covering every physical health need for every American is out of the question, and that as a result resources will always need to be rationed and there is inevitable debate over who does and does not deserves resources (Veatch 2003:127).

In Oregon, the funds for public dental health benefits are sparse and extremely limited. Not everyone who qualifies for OHP also qualifies for dental benefits. According to the OHP Client Handbook, only Oregonians who are "pregnant, under the age of 19, receiving SSI, receiving Temporary Assistance to Needy Families

(TANF), Age 65 or older, blind, or disabled with income at or below the SSI standard, Age 65 or older, blind or disabled receiving, state-paid long-term care services" can qualify for the OHP Plus benefits that cover dental care, residential drug and alcohol treatment, and mental health and medical transportation (16). On the OHP Standard plan, only emergency dental care, outpatient drug and alcohol and outpatient mental health services are covered beyond basic medical benefits. It is clear that OHP allocates scarce resources based on social worth (families not experiencing separation, pregnancy, the elderly and disabled) and the ethical principle of social utility.

Additionally, treatments are covered based on a moveable "line" of coverage. Federal Medicaid funds requires state programs to cover certain mandatory services, but leaves decisions to cover additional services up to the state (OHP Client Handbook 1). In Oregon, OHP has a Prioritized List of Health Services that are covered depending on which conditions and corresponding services are deemed most important to Oregonians. The list was first created by the Oregon Health Services Commission (HSC) and based on public input. Procedures are ranked in order of importance to Oregonians, and the list is updated regularly.

Because of the limitations on funds, procedures that fall above the "line" of importance are covered, and those below the line are not (2). The full range of dental care is not considered a condition that is important enough to be a basic health care need in OHP plans, and so preventative dental services are only available on the OHP Plus plan. Non-emergent dental services are not covered on OHP Standard. Dental care services for the general population above the age of eleven are classified as once a year routine checks ups, brushing and flossing (January 2007 OHP Prioritized List of

Health Services). Dental care services for non-pregnant women are not provided at all, and there is no mention of a connection between covered systemic diagnoses resulting from dental conditions.

The participants and their children are in need of dental health care services above the line of basic healthcare and preventative visits. This applies to most of the women who are already facing dire dental conditions and their children, who fall into the AAPD high risk category based on their parent's income levels and their parent's struggle to access dental care. All children in Oregon are eligible to receive dental care benefits from the federal State Children's Health Insurance Program (SCHIP), which allocates federal funds that are administered by DHS through OHP. Thus, children may not face the same source of structural violence and health disparities as their mothers, but do suffer from a form of covert rationing.

The sample reported on the survey that one of the main reasons their children could not get dental care in the last month was for lack of a dentist. This indicates that either dentists are unwilling to see young children (and families able to use their health care resources), or their mother cannot act as a gatekeeper to the child's dental needs because of confusing health care benefits. The crucial aspect of this situation is the disintegration of the family, and the unique situation that the women in the sample describe occurring when their children are removed from their custody and the resulting cut to their own health benefits and community connections.

At the individual level, the principles of the dental care professionals conflict with the autonomy of the patients. In the view of the ethical principle of subjective Hippocratic utility, the dentist could use his/her best judgment to best benefit the

patient. However, the ethical principle of patient autonomy directly conflicts with Hippocratic utility. As Veatch states, "Patients may rationally differ from their physicians on what counts as medical benefit" (130). Some participants in this sample report their dentists determining directions for individuals' dental care without considering the patient's autonomy or the holistic needs of the patient. This ethical conflict of treatment is occurring with their current provider, or with a past provider. The women in the sample do state that the provider often trumps their autonomy with professional decision and power. Because patient autonomy in health care is often thought of in libertarian principles, people who have the funds to pay for their services privately often have more choice in accessing care, and those who are reliant upon public or "charity" benefits have little say in their treatment options. Because of their poverty status, most of the women in this sample must rely on public Medicaid system funds for dental care, and as a result must rely on the dentist's professional recommendation for direction. In ethical terms patient autonomy principles should takes precedence over provider judgment for the best health outcomes; however, this debate is less about individualized health care outcomes and more about the power, politics, policy and money that are hallmark of state health care programs.

Because of this situation, the ethical conflict of resource allocation for this particular sample of women falls under the area of social ethical principles. While the individual patients desire care, and the dentists may want to provide that care for the patient's dental health benefit, social views on public health care expenditures differ. When resources are used for what Veatch calls "marginally beneficial" but expensive procedures to improve the health of one person, those resources are diverted from

other areas that society may deem more beneficial (132). The stereotype of who "deserves" health care plays heavily into how social ethics in Oregon are determined. Why should the public have to pay to fix the dental problems of a population who chose to ruin their teeth and are assumed to endanger their families? Social utility diverts potential funds to expenditures that better benefit society in areas where the beneficiaries are seen to produce more for society than they are thought to take.

The ethical principles guiding the OHP resource allocation are in so much conflict that both Veatch and Pence cite the OHP rationing ethics as examples of sacrificing social justice ethics in favor of social utility. Pence explains that OHP "democratically developed a public policy about medical financing," placing emphasis on socially-determined definitions of morally acceptable health care expenditures (451). The decision-making power behind OHP coverage was placed in the hands of the voting public in 2002 when they voted against universal coverage for all Oregonians. Pence further explains that OHP has historically denied coverage to Oregonians with disabilities and individuals with conditions that exceed previously agreed-upon expenditures.

Veatch expands upon these exclusions, explaining that OHP initially ranked the most efficient use of state Medicaid funds by excluding the needs of patients deemed inefficient; patients who would survive without the benefits and patients who would suffer even if the benefits were used on them. Depending on what is included in the category of "suffering", the women in this sample suffer personally, socially, physically and psychologically for want to treatment, but still live without it. Even if they receive the OHP level of treatment they will likely suffer, but can also survive

without the benefits. In the end, their health outcomes remain grim because of the duality of their exclusion from benefits.

The ultimate deciding factor in allocating resources for recovering addicts' dental care is patient blame. Individuals are viewed to have a duty to take care of their physical bodies. Teeth of meth users are equated with liver transplants for life-long drinkers who suffer cirrhosis of the liver, and neither is a health care priority because of the view that the patient's substance use lead to the health condition as a consequence of poor choices. Social justice principles of caring for those individuals suffering the most can and should be considered alongside the current social utility principles considered in OHP resource allocation.

Preventative and basic intervention dental care should be a priority for all OHP recipients. Those cases that require the expenditure of a large amount of health care funds (dentures, caps, etc.) should be considered on the basis of a combination of dentist/patient consultation, the amount of lifestyle improvement the procedure could generate, and the likelihood that the patient would relapse or fail to take care of her teeth given that lifestyle improvement. Providing at least preventative care and educational instruction at office visits would contribute greatly to reducing the need for expensive surgical interventions, and would significantly contribute to a reduction in relapse and repetitive rehabilitation admits. It is in the best interest of social ethical principles and public expenditure to support these women so that they can rehabilitate themselves and improve the health outcomes for the children.

Bio-Psycho-Social Addiction Theory and Matrix Model Treatment Programs

Accessing dental care to these women means recovery. Adequate dental care means freedom from the physical pain that triggers them to escape to an all-too-convenient relapse. It means success at realigning their lives and coordinating health care for themselves and their children that was derailed in addiction. It means that their children have what they need to avoid the trap of substance addiction, and the tools they need to find success in the world without the physical and emotional pain that their mothers and caregivers have experienced. Giving their children self-confidence and health means that they are successful contributors to society, and they have saved their children from the cycles of poverty and health disparity that they themselves could not avoid.

The Matrix Model of drug and alcohol treatment promotes self-esteem, dignity, and self-worth. This study shows that for this sample, recovery is an important part of their lives and they view dental care as an integral part of their recovery for just these reasons. It also shows that the Matrix Model of drug and alcohol therapy empowers these women and gives them hope. Through community and family involvement with individual recovery, they build the social capitol necessary to access dental care for themselves and their children.

The dangers of continuous poor oral health status for these women are clear. Without a positive self-assessed dental status, they will continue feeling the low-self esteem and external social scrutiny they have described as barriers to care. The emotional pain combined with the physical pain and failing health of dental deterioration will lead to an increased risk of relapse. Several of the women in this

study described their parents' behaviors, positive and negative, contributing to the foundation of their dental care habits. If the moms relapse, their children will be without a gatekeeper to access their care, and the cycle of disparity will likely continue.

Recommendations

System-Correcting Versus System-Challenging Praxis

Although Singer (1998) claims that system-correcting praxis in Critical Medical Anthropology fail to alter the "basic structure of social relations" that lies at the root of health disparities, it is important to address the immediate needs of a population while simultaneously challenging that structure at a higher level (229). It violates the ethical principles of applied praxis to work with an underserved population and not attempt to address the immediate needs that they have directed attention to addressing. Because it is important to challenge both the ultimate structural violence in a social structure and address the proximate harms that contribute to health disparity, I have collaborated with the women who participated in this study to arrive at immediate needs (Table 2) and a set of long-term needs (Table 3) that the women felt could help them immediately, help them in the future and eventually improve the system both for younger generations of recovering women and their children.

System Correcting (Short Term) Recommendations

Several of the women emphatically stated that they had requested visits for children younger than twenty-four months, but the provider told them to wait until the child was two or older. According to AAPD recommendations for high-risk children,

they should establish a dental home before the age of twelve months. The women who had difficulty finding a dentist to examine their younger children also state that they had previous experience with pediatric dentists in other counties. These same women identified high expectations of their children's dentist and dental experiences. Currently, Benton County does not have a pedodontist. Benton County needs to obtain a pedodontist or a dentist who is willing to see children younger than twenty-four months to allow parents who realize the importance of their children's dental care to access those services they are expected to obtain.

In addition to a pedodontist, participants frequently stated that judgmental providers were a main reason they had not gotten dental care for themselves. Those women who had a supportive provider identified their provider's understanding of recovery and addiction, gentle nature, concern for their patient's personal well-being, and openness to the patient's desired treatment outcome as the main characteristics contributing to a therapeutic provider/patient relationship. Women who did not have a supportive provider identified both verbal and non-verbal judgment, disregard for patient fears or needs, disregard for the recovery process and possible triggers[7], and the provider's focus on money and teeth instead of the whole patient as signs of an unsupportive provider. Dentists need to be educated about the specific health implications of recovery, and practice an understanding of the disparities this population of patients may face in improving their health outcomes. A sensitivity and cultural competency training curriculum for dentists would be most beneficial.

[7] A "trigger", commonly referred to in Matrix Model therapy, is an event, object, or situation that reminds the recovering client of using and trips the client's coping skill of using that substance to escape discomfort or pain.

Educational resources to empower recovering women are another way that their access to family dental care can be improved. This needs to occur on two levels. First, the women identified in interviews that they would like to receive classes early in recovery about how to take care of their own and their children's oral health. While about half of the information that they shared with me was street knowledge about women's teeth, how meth affects teeth and the benefits of nutrition, it showed me that these participants hold on to any knowledge in attempts to improve their own and their children's health. Only one participant, who had a background in nursing, identified nutrition and infant oral health care as the primary contributors to healthy teeth.

Milestones, Benton County Public Health and local dental providers need to collaborate on a healthy mom/healthy kids educational series to inform recovering women about the changes they see happening to their own teeth, how to keep their kids' mouths healthy and where to access community resources for dental care. This should include a listing of dentists who accept OHP, dentists who are willing to see younger children and pregnant women, and who understand recovery. It should also include information about transportation options to appointments, free/low-cost community dental programs, who to call if there is a dental emergency, methods for teaching children of all ages about dental care and how to recognize potential problems with children's teeth. A module on nutrition's contributions to health should also be included.

The older children should receive an education session of their own. Some of the participants felt that a class to introduce their children to a dentist, dental tools, exams, and basic oral hygiene would be helpful. One mom explained that her children

listen to her, but it would mean more to them if information came from a professional. All of the participants' requests for information should be included in a children's class, as well as a module about understanding the oral health effects of drug use in the context of lifetime health goals. Milestones and Benton County Public Health need to arrange a day when the women can take the children to have a brief check-up and a fluoride varnish at the Public Health offices at a reduced or lower cost, to break the ice for accessing resources and begin a foundation of health literacy for both adults and children while in recovery.

System Challenging (Long Term) Recommendations

According to the women whose lives and children are affected by these disparities the insecurities include popular stereotypes of drug users that result in blaming the user, the lower social class of "drug addict," the reduction or complete absence of patient autonomy, and structural violence in the OHP Medicaid system. In order to improve the overall oral health status for this sample of women and children, it is absolutely necessary to improve the systems of dental care and insurance. This is achieved by examining the infrastructural insecurities that contribute to these women's health disparities.

Popular stereotypes of drug users, especially methamphetamine users, result in blaming the user. According to Join Together, a program of the Boston University School of Public Health, "Rampant discrimination against people with addictions restricts their access to education, housing, employment, financial assistance, and health care, which often discourages people from seeking treatment" (2007). Join Together further explains that "unequal and inadequate insurance policies" are forms

of discrimination against good people who have the unfortunate condition of substance addiction.

Banishing stereotypes can best be addressed by stopping them at the source: the Oregon Medical Association's Amphetamine Task Force. A quick review of the website shows a collection of PowerPoint presentations and literature promoting the grandiose misinformed generalizations and, this study shows, false assumptions about the features of methamphetamine users that contribute to social prejudice and structural violence. Of more importance is the rapid rate at which these stereotypes infect communities; the OMA's 2007 January agenda promotes social marketing campaigns in medical clinics and businesses, CME training from medical professionals, and hospital broadcasts of the PowerPoint presentations. While it understandable that a community would seek to protect its members from the potentially harmful behaviors of a small group of people, it is equally (if not more) important to understand that the "ounce of prevention" approach, in this case, inhibits the cure and predisposes the social recovery piece for recovering addicts to relapse.

By polarizing Oregon communities against helping and understanding a human condition, the OMA propaganda poisons communities against effective rehabilitation of mothers and children by banishing them from community participation. The findings of this study can be used to speak to the reality of women addicted to methamphetamine; they are hopeful and determined women and mothers who are conscientious of their families' needs, struggle against a health care system that is turned against them because of economics and social status, and seek better futures for both their children and themselves. To genuinely address the endemic of

methamphetamine use, the OMA must be open to informed research outside of medical and law enforcement information and be willing to work in the best interest of entire communities, including recovering addicts and their families.

While some users do neglect and abuse their children, and some users do have severe dental consequences due to oral health and nutritional neglect, this is *not true for all users* (Oregon DHS, SAMHSA 2006). Media and law enforcement agencies display broad stereotypes of meth users to prevent new first-time use, but these campaigns result in misconceptions and depersonalized views of a portion of the community population. These stereotypes lead to discriminations in housing, employment, and most importantly in health care. In a 2005 open letter to the media, more than thirty physicians state clearly that:

> "Experience with similar labels applied to children exposed parentally to cocaine demonstrates that such labels harm the children to which they are applied… leading to policies that ignore factors, including poverty, that may play a much more significant role in their lives…. Similarly, we are concerned that policies based on false assumptions will result in punitive civil and child welfare interventions that are harmful to women, children and families rather than in the ongoing research and improvement and provision of treatment services that are so clearly needed" (Lewis 2005).

The reduction or complete absence of patient autonomy is often masked by blame laid on the women for creating their own dental health circumstances and contributing to their children's supposed neglect. There is an absence of choice, shown in the women's inability to choose tooth-saving dental options because of a lack of income or insurance coverage. Dentists further limit mothers' autonomy in seeking care for children by denying visits due to the child's age or status as a patient with Medicaid coverage. To address this barrier, researchers must "study up" and examine the dental providers' views and those of OHP Dental Care Organization (DCO) administrators.

As several of the women mentioned, their options for dental care after use are usually limited to extraction of their teeth with no coverage for partial or full prosthetics. While I understand that OHP faces funding cuts in its dental programs, it is equally important for dentists and insurance administrators to consider the value of human quality of life in all aspects of their health care access, including dental care.

One piece of concern for quality of life for recovering addicts is also economic. Appearance and self-esteem play a significant role in obtaining and maintaining employment. If the women in this sample lose their teeth because of treatment insecurities and are not able to replace them, how can they get jobs? The loss or poor appearance of dentition is an increasingly recognized sign of meth use; the women in this sample all acknowledge that dental problems are a marker of their low social status. Employment is a key part of recovery and self-empowerment, and is also of enormous concern for Oregon's economy. Without positive dental outcomes, this population will remain in poverty, remain powerless, and their children will repeat the cycle. If Oregon policymakers want to give their constituents the best chance at economic self-sufficiency, they should consider visible dental health disparities as a point of intervention.

Structural violence in the OHP Medicaid system creates a dichotomy of coverage among the population. Some individuals are completely covered, while others are cut off from health care completely based on their social worth. OHP needs to address the policy of determining individual women's health care coverage by pregnancy or custody of children, and the termination or reduction of benefits after delivering a child, losing custody of children, or obtaining barely gainful employment.

First, this policy discriminates against women who chose not to have children. It also discriminates against men. It forces women to choose between using their reproductive bodies and resulting children to obtain health insurance. While this may be defendable for private insurance companies, it is not acceptable for a federally-funded public health insurance program.

The women in this study's sample identified increased health disparity, higher costs for their dental health, and problems accessing care for their children because of the policy of reducing mothers' insurance coverage when she loses her children. This policy punishes women who are deemed "unfit mothers" by removing their children and allowing dental health to shift from treatable condition to dire surgical intervention. Once their children are removed, mothers lose track of their children's health status and face gaps of several months while regaining custody and coverage for themselves and the children. Often when children are removed, they go to different counties in Oregon with different OHP regulations, resulting in confusion of benefits when they are returned to their mothers. OHP eligibility policy has reduced women to bodies of physical and cultural reproduction, a situation that they face throughout other agencies of American culture, and simultaneously caused a barrier to access for the reunited family (Campbell 2000).

The disparities caused by structural violence in the state Medicaid systems across the nation have recently been addressed due to a casualty caused by the very structural violence discussed in this study. On February 25th, 2007, twelve-year-old Deamonte Driver died in a hospital in Maryland of a brain infection resulting from untreated dental disease. His mother was uninsured, his family lost their Medicaid

coverage because of homelessness, local dentists would not accept Medicaid, and his mother worked endlessly to find a dentist who would see children and accept Medicaid. What could have been as simple as a low-cost in-office dental procedure became a nearly $250, 000 hospital bill. Dentists cite low Medicaid reimbursement rates, frustrations with Medicaid bureaucracy, and high frequency of dental decay among populations in poverty as the mains reasons they feel that they cannot provide adequate services (Washington Post, February 28th 2007).

The American Dental Association (ADA) released a statement on March 2nd, 2007, explaining that

> "We need state and federal public officials to stop shortchanging dental programs, which costs all of us heavily in the long run. We need water fluoridation and the universal availability of preventive care, both of which are surefire investments that produce healthier, more productive young people. And we need to educate all parents about taking care of their children's oral health."

The American Academy of Pediatric Dentistry (AAPD) also released a statement on March 2nd, 2007 stating that "Oral health is central to overall health. The mouth, as a part of the body, has long been ignored… The AAPD is working hard to support an infrastructure that can help families who need it most." The AAPD definition of a dental home is "children's oral health care… delivered in a comprehensive, continuously accessible, coordinated and family-centered way by a licensed dentist" (AAPD 2007). Parents need to be reincorporated into family health care. Their stories and frustrations support my assertion that family dental care for Medicaid patients in Oregon is not comprehensive, accessible, well-coordinated or inclusive of parents. While it is a step in the right direction to provide adequate preventative dental

care to children, it is equally important to provide the same standard of care for low-income parents. These women see themselves as the gatekeepers to their children's dental care. Neglecting the mothers but caring for the children harms families, creates unnecessary disparity, and ultimately results in barriers to dental care access for entire families like Deamonte Driver's.

Oregon Health Plan, treatment facilities, and a handful of dental providers in Benton County do occasionally help support the efforts of mothers recovering from methamphetamine addiction. However, addressing and repairing sources of structural violence in the OHP dental care system, breaking-down unwarranted stereotypes of users and reuniting the family unit in every aspect of their healthcare will increase their chances of improved overall health in the present and the future. Ultimately, the women feel that they need to protect their children's health to prevent another generation of substance addiction. Supporting recovering women, instead of discriminating against them, will help support the entire families' recovery from substance addiction. Collaboration, care, and community supported healing are the greatest chance these courageous women and their children have of success in life, health and recovery.

Receptive Dental Community	Pedodontist
	Family Dentist
	Recovery Competency (non-judgmental providers)
Educational Resources for Women in Recovery	Parenting and Dental Health
	Recovery Dental Health and Health Literacy
	Children's Dental Health Education

Table 2: System Correcting Short-Term Recommendations

Address Infrastructural Insecurities	Erase common stereotypes of "Meth Addicts" and their children (OMA)
	Further study policy-making processes and provider attitudes
Promote Patient Autonomy	Create community dental programs for the uninsured and underinsured to ensure access and choice in treatment
Address Structural Violence in OHP	Abolish the link between pregnancy, custody and women's OHP coverage
	Provide continuous health care for women (and men) regardless of their life events and reproductive capabilities
	Improve benefit and provider accessibility for OHP clients and families in habitation transitions and recovery

Table 3: System Challenging Long-Term Recommendations

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Appendix

Appendix A Phase I Survey

Project Title:	**Family Dental Health: Perceptions of Women in Substance Dependency Recovery, Phase I**
Principal Investigator:	**Melissa Cheyney, Ph.D., Department of Anthropology**
Co-Investigator(s):	**Melissa Hanks, Department of Anthropology**

How many times have you been in a substance addiction treatment program?
This is my first time
Twice
Three or more times

Is anyone in the family covered by an insurance plan that pays for dental care?

1 Yes
2 No

a. What is the name of the plan? Is there more than one?

b. Who in the family is covered by this plan?

Access to Services

During the past 12 months, was there ever a time when you needed dental care but could not get it?

1 Yes
2 No

Has there ever been a time in your life when you needed dental care but could not get it?

1 Yes
2 No

The last time you could not get the dental care you needed, what was the main reason you couldn't get care?

1 Could not afford it
2 No insurance
3 Dentist did not accept Medicaid/insurance
4 Not serious enough
5 Wait too long in clinic/office

6 Difficulty in getting appointment
7 Don't like/trust/believe in dentists
8 No dentist available
9 Didn't know where to go
10 No way to get there
11 Hours not convenient
12 Speak a different language
13 Health of another family member
14 Other reason
15 Don’t know or don't remember

Your Dental Health

How would you describe the condition of your teeth and gums?
1 Excellent
2 Good
3 Fair
4 Poor

Have you ever had your teeth cleaned by a dentist or dental hygienist?
1 Yes
2 No

During the past 3 years, have you been to a dentist?
1 Yes
2 No

What was the main reason for your last visit for dental care?
1. No visit
2. Regular checkup
3. To have teeth cleaned
4. To have teeth filled
5. To have teeth pulled or other surgery
6. Toothache
7. Adjustment or repair of a denture
8. To have a denture made
9. For a prescription
10. Bleeding gums or periodontal disease
11. Loose teeth
12. Problems with 3rd molar (wisdom teeth)
13. Some other reason (please specify) _____

How often do you brush your teeth?

1 More than once a day
2 Once a day
3 Every few days
4 Every few weeks

How often do you use dental floss?

1 More than once a day
2 Once a day
3 Every few days
4 Every few weeks
5 Never

When you were growing up, did parent or guardian teach you about healthy dental habits?

1. Yes
2. No

Your Children's Dental Care

How many children do you have?

How old are they?

How would you describe the condition of your children's teeth and gums?

1 Excellent
2 Good
3 Fair
4 Poor

How old were your children when they first saw someone for dental care?

1 under 4 yrs. old
2 4 yrs. old or older
3 Don't know
4 Never

During the past 3 years, have your children been to the dentist for routine check-ups or cleanings?

1 Yes
2 No
3 Don't know

How often do they brush their teeth?

1 More than once a day
2 Once a day
3 Every few days
4 Every few weeks

How often do they use dental floss?

1 More than once a day
2 Once a day
3 Every few days
4 Every few weeks
5 Never

In your opinion, which of these is the BEST method for protecting your children's teeth from cavities?

1 Limiting sugary snacks
2 Using fluoride
3 Chewing sugarless gum
4 Brushing and flossing the teeth
5 Visiting the dentist every 6 months

Have your children ever had their teeth cleaned by a dentist or dental hygienist?

1 Yes
2 No

In the past 12 months, has there been a time when one of your children has needed to see a dentist but didn't go?

1 Yes
2 No

Why didn't they go?

1 Afraid
2 Nervous
4 Cost
5 Don't have a dentist
6 Dentist too far
7 Can't get there
8 No problems
9 No teeth
10 Not important
11 Didn't think of it
12 Other (specify) _____
13 Don't know

Appendix B Phase II Semi-Structured Interview Questions

How do you feel about your teeth?

When did you get dental insurance for yourself? For your children?

When you were growing up, what did an adult teach you about taking care of your teeth? What feelings did you have about this time?

During the time of your addiction when you were actively using, where did your dental care rank in your life? What were the outcomes?

During this same time, how did your children's dental health rank? What were your feelings about teaching and/or role modeling good dental health to them?

When you were using, did your income affect your children's or your own dental health?
Did it affect your nutrition? Your children's nutrition? Could you pay for food?
Did your income changes affect your ability to get dental care?

Now that you are in recovery, what do you feel you have learned about your and your children's health care? How do you think dental care for your family ranks as part of your recovery? What outcomes do you see happening if you can't get good dental care?

What is your plan for your family's dental care?

How do you feel about the dentist? How do your children feel about the dentist? Have your experiences been positive, neutral or negative?

If there were classes offered in making a plan for family dental care as part of your recovery, would you use them? What advice would you offer new clients about their family's dental care?

Appendix C Qualitative Results by Theme, Passage Saturation

Experiences of Dominant Social Expectations

(29) External Scrutiny; feels others judging her, "they"
(31) Internal Scrutiny; judges self, "I" statements
(27) Parenting Role; recognizes "correct" parenting practices
(22) Social Class; recognizes her own class disparity
(23) Provider Scrutiny; felt dentist judged them

Attitude Towards Circumstances

(14) Positive outlook, satisfaction or thankful for health
(14) Negative outlook, embarrassment or dissatisfaction with health

Barriers to Accessing Care

(16) Dentist's Opinion; dentist refused care to adult (use, payment) or child (age)
(13) Fear, Social Isolation; fear of dentist, embarrassment, shame

Importance of Self Esteem and Appearance Factors

(14) Adult Self Esteem; cites her self esteem as important
(05) Kids Self Esteem; cited her kids' self esteem as important
(17) Adult Appearance; cites her own appearance as important
(05) Kids Appearance; cites her kids' appearance as important

Insurance, Income and Provider Interaction

(16) Insurance Dependant on Custody; mother's insurance revoked with custody
(17) Insurance as Barrier; insurance (program or lack of) inhibits care
(19) Income as Barrier; lack of income negatively affects care access

Barriers to Accessing Care

(16) Dentist's Opinion; dentist refused care to mom (use, payment) or child (age)
(23) Insurance; OHP or insurance program is refusing appointments, payment
(08) Income; can't afford necessary procedures w/o insurance
(02) Transportation; can't get transportation to/from appointments
(06) Insurance benefits, appointments difficult to coordinate

Success Factors in Accessing Care

(16) Good Provider Relationship

The Role of Parent or Care Provider

Dominant Social Expectations

(27) Parent Role; you recognize "correct" parenting practices

Motherhood and Gender

(32) Mom as Gatekeeper to Dental
(14) No Custody or Defer to SO, Family

Nutrition Factors

(07) Mom as Gatekeeper to Nutrition

(10) Whole family ate healthy during addiction
(06) No one in family ate healthy during addiction
(12) Poor nutrition contributed to mom's poor dental health
(12) Mom cared for kids, neglected herself

Sources of Knowledge: Experiences and Perceptions

(09) Learned from Provider
(10) Correct Knowledge; knowledge compliant with current professional info
(09) Incorrect Knowledge; knowledge is not correct
(18) Learned from Parents or Community
(04) Learned at School
(13) Learned from Use Consequences
(01) Didn't Learn

Consequences of Use for Mom

(57) Health; dental and nutritional
(48) Social; isolation, guilt, fear, shame, embarrassment, reduces social class status.

Your Dental Experiences (during and after active use)

(20) Good; dental experiences satisfactory
(35) Less than Satisfactory; vary from negative perceptions of dentist's attitude to physical trauma.

Teaching Kids in the Home

(08) Play; mom uses play to teach children
(16) Adult as Example; mom cites herself, use experiences in teaching kids.
(29) Direct Instruction; adult directly instructs, performs and supervises care.
(06) Kids not with Mom
(23) Routine; adult uses routine to train kids
(02) Not teaching at all

Success Factors in Accessing Care

(31) Adult as Gatekeeper to Dental

Navigating Non-Insurance Community and Family Resources.

Community Support

(20) Removal of Children; community has removed children from custody
(08) Food Stamps; mom has utilized food stamps
(02) Head Start; mom references kids attending Head Start
(02) Milestones; mom references Milestones as support
(16) Family and Culture; mom references her family or culture group as support
(12) Specific Local Provider; reference to a helpful local dental provider

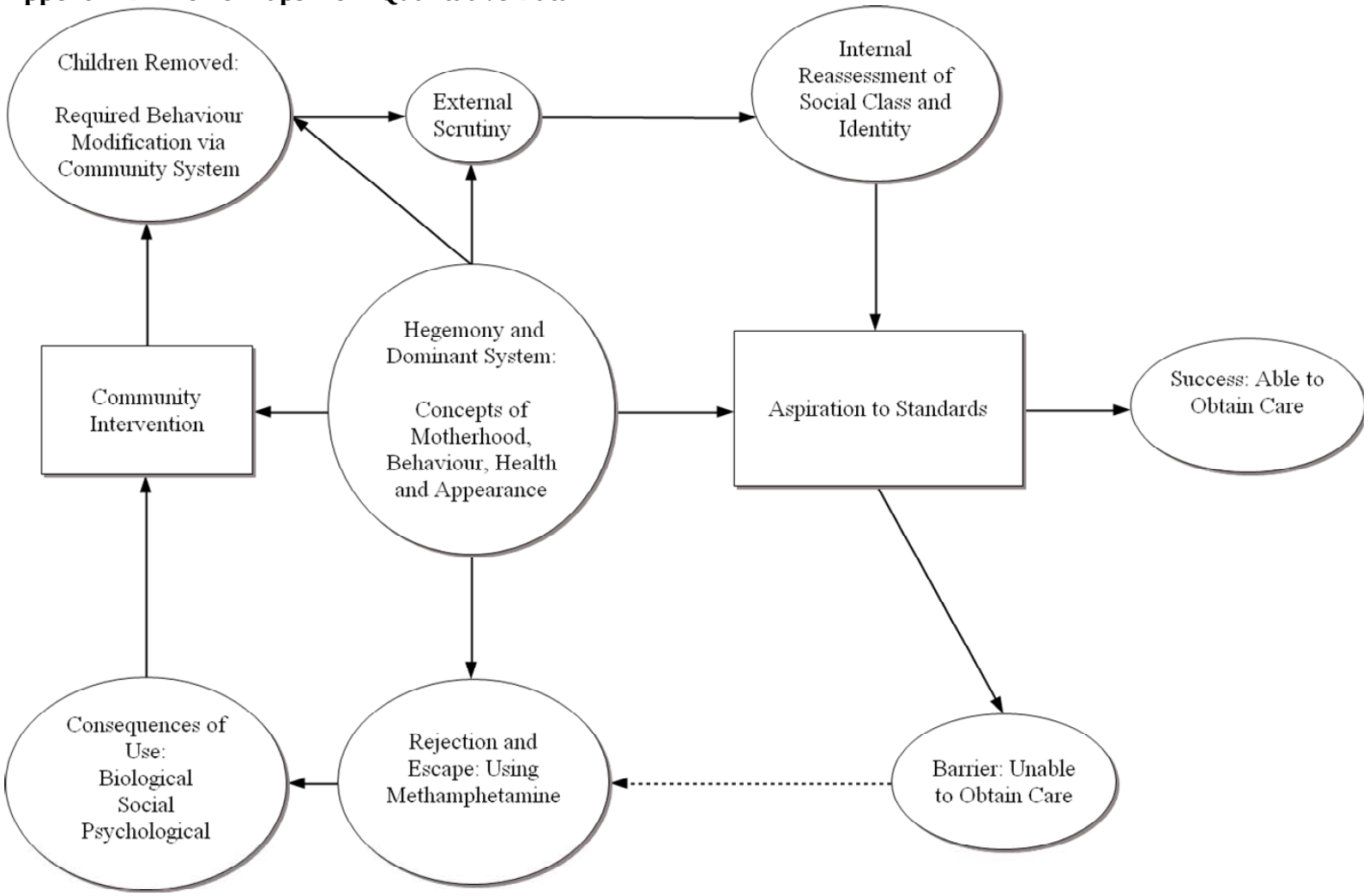
Success Factors in Accessing Care

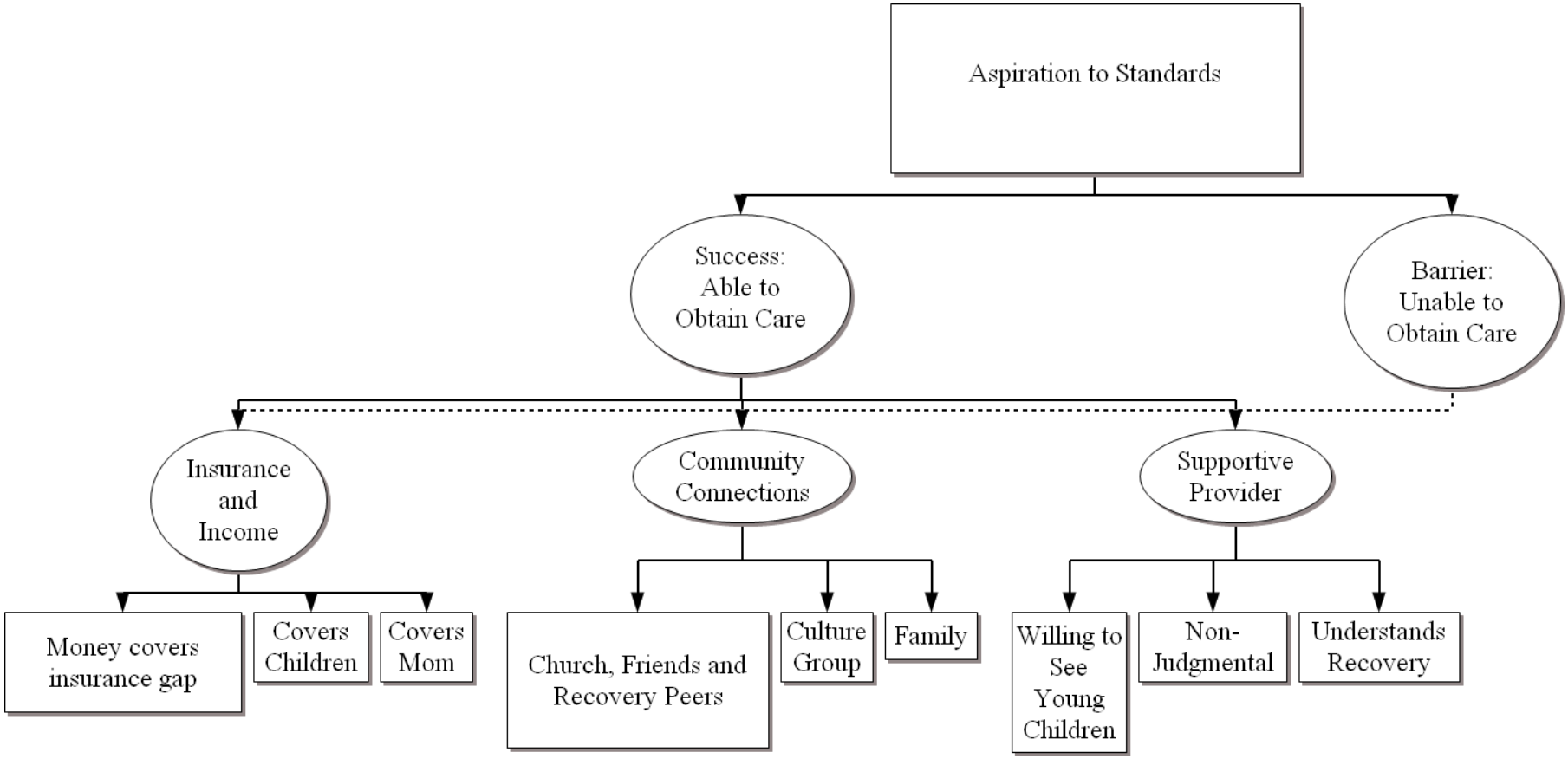
(16) Good Provider Relationship
(12) Community Support

Children's Dental Status

(11) Healthy Teeth; teeth are in good condition, don't need care
(21) Need Dental Attention; participant feels child needs immediate dental visit, cannot get
(19) Care in Home; child receives adequate care in home
(12) Not in Mom's Custody; care from foster care, grandparents or SO
(10) Has Had Major Procedure; child has had surgical procedure
(04) Too Young for Care per Adult
(05) Too Young for Care per Dentist
(13) Expectations of Provider; mom desires certain traits in dentist

Appendix D Theme Maps from Qualitative Data




Aspiration to Standards
Success: Able to Obtain Care
Barrier: Unable to Obtain Care
Insurance and Income
Community Connections
Supportive Provider
Money covers insurance gap
Covers Children
Covers Mom
Church, Friends and Recovery Peers
Culture Group
Family
Willing to See Young Children
Non-Judgmental
Understands Recovery

Appendix E Phase I Survey Results

Demographics			Percentage of Total		
How Many Times in Treatment Program?					
	1. First Time	8	30.8%		
	2. Twice	7	26.9%	Total	
	3. Three or more times	11	42.3%		26
Is Anyone in the family covered by an insurance plan that pays for dental?					
	1. Yes	24	92.3%	Total	
	2. No	2	7.7%		26
What is the name of the plan?					
	1. OHP	21	80.8%		
	2. Private	1	3.8%		
	3. UIHS	3	11.5%	Total	
	4. Other	1	3.8%		26
Who is covered?					
	1. Self	4	17.4%		
	2. Self and all Children	13	56.5%		
	3. Self and some children	6	26.1%	Total	
	4. Children Only	0	0.0%		23
Access to Services					
In the past 12 months, has there been a time when you needed dental care but could not get it?					
	1. Yes	15	60.0%		Total
	2. No	11	44.0%		25

Has there ever been a time in your life when you needed dental care but could not get it?

1. Yes	23	92.0%	Total
2. No	3	12.0%	25

The last time you could not get dental care you needed, what were the main reasons you couldn’t get care?

1. Could not afford it	18	24.0%
2. No insurance	16	21.3%
3. Dentist did not accept medicare/caid	8	10.7%
4. Not serious enough	2	2.7%
5. Wait too long at clinic/office	2	2.7%
6. Difficulty getting to appointment	5	6.7%
7. Don't like/trust/believe in dentists	3	4.0%
8. No dentist available	4	5.3%
9. Didn't know where to go	2	2.7%
10. No way to get there	7	9.3%
11. Hours not convenient	1	1.3%
12. Speak a different language	0	0.0%

	13. Health of another family member	0	0.0%	
	14. Other reason	7	9.3%	Total
	15. Don't know or remember	0	0.0%	75

Your Dental Health

How would you describe the condition of your teeth and gums?

1. Excellent	0	0.0%	
2. Good	5	20.0%	
3. Fair	8	32.0%	Total
4. Poor	12	48.0%	25

Have you ever had your teeth cleaned by a dentist or dental hygienist?

1. Yes	22	88.0%	Total
2. No	3	12.0%	25

During the past 3 years have you been to a dentist?

1. Yes	20	80.0%	Total
2. No	5	20.0%	25

What was the main reason for your last visit for dental care?

1. No visit	3	6.0%
2. Regular check-up	7	14.0%
3. To have teeth cleaned	7	14.0%
4. To have teeth filled	6	12.0%
5. To have teeth pulled or other surgery	9	18.0%

	6. Toothache	8	16.0%	
	7. Adjustment or repair of denture	1	2.0%	
	8. To have a denture made	1	2.0%	
	9. For a prescription	0	0.0%	
	10. Bleeding gums or periodontal disease	0	0.0%	
	11. Loose teeth	0	0.0%	
	12. Problems with 3rd molar (wisdom teeth)	3	6.0%	Total
	13. Other	5	10.0%	50
How often do you brush your teeth?				
	1. More than once a day	12	46.2%	
	2. Once a day	14	53.8%	
	3. Every few days	0	0.0%	Total
	4. Every few weeks	0	0.0%	26
How often do you use dental floss?				
	1. More than once a day	0	0.0%	
	2. Once a day	5	19.2%	
	3. Every few days	6	23.1%	
	4.Every few weeks	11	42.3%	Total
	5. Never or no answer	4	15.4%	26
When you were growing up, did a parent or guardian teach you about healthy dental habits?				
	1. Yes	16	64.0%	Total
	2. No	9	36.0%	25

Your Children's Dental Health

How many children do you have?

1. One or pregnant with first	3	12.5%	
2. 2-4	19	79.2%	Total
3. 5-6	2	8.3%	24

What are their ages?

1. Not Yet Born - 12months	9	15.0%	
2. 12 - 24 months	7	11.7%	
3. 24 months - 3 years	6	10.0%	
4. 3 - 5 years	9	15.0%	
5. 5 - 7 years	9	15.0%	
6. 7 - 9 years	7	11.7%	
7. 9 - 11 years	2	3.3%	
8. 11 - 13 years	3	5.0%	
9. 13 - 15 years	1	1.7%	
10. 15 - 17 years	3	5.0%	Total
11. 17 years or older	4	6.7%	60

How would you describe the condition of your children's teeth and gums?

1. Excellent	5	21.7%	
2. Good	14	60.9%	
3. Fair	4	17.4%	Total
4. Poor	0	0.0%	23

How old were your children when they first saw someone for dental care?

1. under 4 years old	10	41.7%	
2. 4 years or older	4	16.7%	

	3. Don't know	5	20.8%	Total
	4. Never seen a dentist	5	20.8%	24
During the past 3 years have your children been to a dentist for routine check-ups or cleanings?				
	1. Yes	15	62.5%	Total
	2. No	9	37.5%	24
How often do they brush their teeth?				
	1. More than once a day	9	37.5%	
	2. Once a day	13	54.2%	
	3. Every few days	0	0.0%	
	4. Every few weeks	1	4.2%	Total
	5. Never or no answer	1	4.2%	24
How often do they use dental floss?				
	1. More than once a day	1	4.3%	
	2. Once a day	0	0.0%	
	3. Every few days	2	8.7%	
	4. Every few weeks	14	60.9%	Total
	5. Never, don't know or no answer	6	26.1%	23
In your opinion, which of these is the BEST method for protecting your children's teeth from cavities?				
	1. Limiting sugary snacks	6	17.1%	
	2. Using fluoride	2	5.7%	
	3. Chewing sugarless	1	2.9%	

	gum			
	4. Brushing and flossing the teeth	19	54.3%	Total
	5. Visiting the dentist every 6 months	7	20.0%	35
Have your children ever had their teeth cleaned by a dentist or dental hygienist?				
	1. Yes	14	60.9%	Total
	2. No	9	39.1%	23
In the past 12 months, has there been a time when one of your children needed dental care but could not get it?				
	1. Yes	8	33.3%	Total
	2. No	16	66.7%	24
Why didn’t they go?				
	1. Afraid	2	8.0%	
	2. Nervous	0	0.0%	
	3. Cost	2	8.0%	
	4. Didn't have a dentist	4	16.0%	
	5. Dentist too far	1	4.0%	
	6. Can't get there	2	8.0%	
	7. No problems	6	24.0%	
	8. No teeth	4	16.0%	
	9. Not important	1	4.0%	
	10. Didn't think of it	1	4.0%	Total
	11. Other (specify)	2	8.0%	25