



ST. MARY'S
UNIVERSITY

Digital Commons at St. Mary's University

Theses & Dissertations

Counseling & Human Services Theses and
Dissertations

9-2017

The Mother's Experience : A Phenomenological Study of Maternal Self-Efficacy Among Mothers Attending Outpatient Treatment for Substance Abuse

Lisa Witkowski

Follow this and additional works at: <https://commons.stmarytx.edu/dissertations>



Part of the [Counseling Psychology Commons](#)

Recommended Citation

Witkowski, Lisa, "The Mother's Experience : A Phenomenological Study of Maternal Self-Efficacy Among Mothers Attending Outpatient Treatment for Substance Abuse" (2017). *Theses & Dissertations*. 12. <https://commons.stmarytx.edu/dissertations/12>

This Dissertation is brought to you for free and open access by the Counseling & Human Services Theses and Dissertations at Digital Commons at St. Mary's University. It has been accepted for inclusion in Theses & Dissertations by an authorized administrator of Digital Commons at St. Mary's University. For more information, please contact egoode@stmarytx.edu, sfowler@stmarytx.edu.

THE MOTHER'S EXPERIENCE: A PHENOMENOLOGICAL STUDY OF
MATERNAL SELF-EFFICACY AMONG MOTHERS ATTENDING OUTPATIENT
TREATMENT FOR SUBSTANCE ABUSE

A DISSERTATION

Presented to the Faculty of the Graduate School of
St. Mary's University in Partial Fulfillment
of the Requirements
for the Degree of

DOCTOR OF PHILOSOPHY

in

Marriage and Family Therapy

by Lisa Witkowski, M.A., L.P.C., L.M.F.T.

San Antonio, Texas

September 2017

ProQuest Number: 10639723

All rights reserved

INFORMATION TO ALL USERS

The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if material had to be removed, a note will indicate the deletion.



ProQuest 10639723

Published by ProQuest LLC (2018). Copyright of the Dissertation is held by the Author.

All rights reserved.

This work is protected against unauthorized copying under Title 17, United States Code
Microform Edition © ProQuest LLC.

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 – 1346

APPROVAL PAGE

THE MOTHER'S EXPERIENCE: A PHENOMENOLOGICAL STUDY OF
MATERNAL SELF-EFFICACY AMONG MOTHERS ATTENDING OUTPATIENT
TREATMENT FOR SUBSTANCE ABUSE

APPROVED:

Jason Northrup, PhD

Dissertation Adviser

Carolyn Tubbs, PhD

Dissertation Committee Member

Nicholas Wilkens, PhD

Dissertation Committee Member

APPROVED:

Christopher Frost, PhD

Dean of the Graduate School

Date

DEDICATION

*To the mother figures in my life – Mom and Nana,
Devoting your lives to my care,
Showing me love, kindness and the art of listening,
You gave me the strength to accomplish my dreams.*

ACKNOWLEDGEMENTS

As I reach the end of this unsteady, rugged path, I look back of the distance I traveled in these last few years. It was an incredible journey that tested my endurance. The path was unfamiliar with many divots and unmarked signs. I always felt a bit shaky from the rocky foundation and my underlying uncertainty. I frequently found myself asking, "Is this right?" However, I kept myself moving forward. Encouraging myself to place one foot in front of the other. I continued to walk even when I feared I was lost, merely walking in circles, or the darkness of clouds filled the sky. I promised myself I would not start without an inner certainty of making it to the end. To myself, I was indebted. Now, I stand here reflecting on my journey while tears of joy swell up in my eyes. I have reached the end. Yet, this was not a sole achievement. I owe a great deal of gratitude to the individuals who made this possible.

First, the brave women of this study. My research would be nonexistent if you were unwilling to voluntarily share your personal stories. To Adriana, Brenda, Cynthia, Gina, Jaime, Jenny, Judy, Leah, Maria, Sammy, Sonia, and Vanessa –Thank you so very much (Emoji Hug)!!! You all have such touching stories that will stay with me.

Next, I would like to thank Rhonda Wade for believing in the credibility of this study and assisting me with recruitment efforts. You were so kind and went beyond to help with my research. It is easy to see how you continue to touch the lives of these women everyday with your natural empathetic and compassionate abilities. I am so grateful to have met you on this journey.

Dr. Northrup, I don't believe I could ever thank you enough. You have been so encouraging throughout this entire journey of mine. You have spent countless hours

analyzing my data, reading through my work, and listening to me ramble. You are always so positive and uplifting. I felt like a priority to you with your availability to answer my questions, calm my anxiety, and advising me on future endeavors. You've helped me find my footing when fell. I feel so blessed to have had you as my chair. I truly thank you for your time, encouragement, and insightful feedback through this entire process. You were my compass pointing me north!

Dr. Tubbs and Dr. Wilkens, you helped build my endurance before heading out on this journey. Dr. Tubbs, you seemed to know how to push me further than I thought I was capable of when considering this form of research. You introduced me to qualitative research and gave me the inspiration to conduct this type of study. During my writing, you helped me spot angles that could cause hiccups along the way. I would recall the ethical considerations you shared as I prepared myself to interview the participants and utilized the methods of analysis I practiced in your class. Your expertise on qualitative research was incredibly useful during this study. Dr. Wilkens, you always seem to know how to bring humor to a situation while still giving thoughtful recommendations. Your humor helped ease some of my anxiety as I traveled down my path. Images of your nonchalant and calm demeanor during course instruction reminded me to relax when I was beginning to stress. Your clinical experience when working with this population helped me see potential issues and develop precautions to my research. You informed me of research grants regarding this research topic that I could apply for. Your clinical expertise and approach assisted me through the course of this study. To my committee – Dr. Tubbs and Dr. Wilkens, thank you for preparing me for this endeavor.

Next, I would like to thank Mary Telisak for taking the time to peer debrief with me. During our conversations, you assisted me by playing devil's advocate and advising similar thinking-strategies on which direction to go along my path. I appreciate the time you voluntarily gave with the understanding that you may have lost time with your own research and family. Mary, thank you for meeting me along my journey and making me thoroughly evaluate the path before proceeding.

To my mom, you inspired me to conduct this research. Over the years, you've supported my decisions and inquired on my progress. We have shared many laughs, some cries, and learned to watch for synchronicity in life. Our relationship has grown to a better place. I am thankful for the unconditional love and support you have given me.

To my dad, you have supported me in every way possible to make this journey accomplishable. Your words of encouragement stuck with me through all the obstacles. You kept pushing me to finish and checking in on my progress. You've been an amazing role model that has shown me how to overcome life's hardest challenges. I am thankful for your endless love, support, and listening ear you were always able to provide.

To all my family and friends, thank you for surrounding me with constant adoration and support during this process. Bryan, Jeff, and Matt – you have been the most amazing brothers, and I appreciate the arrangements you all made to spend family time together especially during the roughest moments in the last year. Nana – I know you would be so proud. I miss your presence every day, but know you are with me in spirit. Thank you for being the light from above to guide me through the fog.

To my fiancé, your patience and ongoing support motivated me to finally reach the end of this long journey. I appreciate how understanding you have been through this

entire process. You financially supported us these last six months to allow me to fully concentrate. You even made writing a game – as you work, I work. Brad, I love you so much and thankful you are in my life. Now, we can finally go tie the knot!

LIST OF TABLES

Table 5.1 Demographics of Participants	73
Table 5.2 Category: What It Means to Be a Good Mother	81
Table 5.3 Category: Consequences of Addiction on Motherhood.....	91
Table 5.4 Category: Being a Mother During Recovery	103
Table 5.5 Category: Risk Factors.....	115
Table 5.6 Answering the Research Questions	123

ABSTRACT

THE MOTHER'S EXPERIENCE: A PHENOMENOLOGICAL STUDY OF
MATERNAL SELF-EFFICACY AMONG MOTHERS ATTENDING OUTPATIENT
TREATMENT FOR SUBSTANCE ABUSE

Lisa Marie Witkowski

St. Mary's University, 2017

Dissertation Adviser: Jason Northrup, Ph.D.

The purpose of this study is to better understand the perceptions of maternal self-efficacy among mothers in substance abuse recovery. A phenomenological research design using face-to-face, semi-structured interviews captured the lived experiences of mothers attending outpatient drug and alcohol treatment. For this study, the researcher distributed approved flyers to designated outpatient treatment centers to voluntarily recruit mothers for purposeful sampling. Eligibility requirements include women at least eighteen (18) years or older, at least one living child, attended prior rehabilitation services, and display good mental status after assessed by the researcher with the Mini Mental Status Exam. During the interview, the researcher collected demographical data and audio-taped the interview. Once interviews were completed, the researcher transcribed the audio-recorded interviews into a digital format and checked for accuracy. The researcher uploaded the digital transcriptions into a qualitative data analysis software

program. Moustakas' (1994) modified Stevick-Colaizzi-Keen method assisted in analyzing the transcriptions and identifying emerging themes. During data analysis, the "essence" evolved suggesting the lived experiences of mothers in outpatient substance abuse treatment: The integration process between good mothering beliefs and practices with sober living. The depicted essence formed from four identified categories: *What It Means to Be a Good Mother*, *Consequences of Addiction on Motherhood*, *Being a Mother During Recovery*, and *Risk Factors*. Within these categories, 11 themes emerged – *Providing a Stable and Safe Environment*, *Nurturing the Relationship*, *Being a Good Role Model*, *Impact of Addiction on Me*, *Impact of Addiction on My Children*, *Hitting Rock Bottom*, *Treatment's Role in Staying Sober*, *Fixing the Damage*, *Discovering My Purpose*, *Types of Trauma*, and *Life Stressors*. Also, an additional 39 integral subthemes were identified. Member-checking with participants and peer debriefing was conducted to validate results. From the confirmed data, a depiction of the essence of the phenomenon is portrayed. This study concludes by discussing limitations, implications to clinical practice for mental health professionals, and recommendations for future research.

TABLE OF CONTENTS

Title Page	i
Approval Page.....	ii
Dedication.....	iii
Acknowledgements.....	iv-vii
List of Tables	viii
Abstract.....	ix-x
Table of Contents	xi-xix
CHAPTER 1	
THE PROBLEM AND JUSTIFICATION OF THE STUDY	1-13
Statement of the Problem.....	1-2
Purpose of the Study	2-3
Rationale for the Study	3-6
Research Questions.....	6
Theoretical Framework.....	6-11
Self-Discrepancy Theory	7-8
Attachment Theory	8-9
Social Cognitive Theory	10-11
Definition of Terms.....	11-13
Summary	13
CHAPTER 2	
REVIEW OF THE LITERATURE	14-51
Ideology of Mother	14-18

Historical Development of Intensive Mothering Ideology	15-17
1930's – 1950's	15-16
Post WWII	16-17
1970's to Current	17
Self-Discrepancy Theory	18-19
Contradicting Lifestyles to Intensive Mothering	19-25
Careers	19-21
Single and Low-Income	21-23
Minority	23-25
Sexual Orientation	25
Maternal Identity and Becoming a Mother	26-27
Guilt and Shame in Motherhood	27-29
Maternal Deprivation and Caregiving Knowledge	29-30
Child Maltreatment and Risk Factors	30-31
Prevention of Child Maltreatment	31-33
Social Cognitive Theory Applied to Self-Efficacy	33-35
Maternal Self-Efficacy	35-40
Task Mastery	35-36
Remembered Experiences and Vicarious Learning	36-37
Verbal Persuasion	37-38
Physiological and Affective States	38-39
Stigmatized Lifestyles and Impact on Mothering	40-45
Mothering through Mental Illness	40-42

Mothering through Prison	43
Mothering through Prostitution.....	44
Mothering through Addiction	44-45
Women, Addiction, and Maternal Self-Efficacy	45-49
Women with Addiction.....	45-46
Characteristics of Mothers with Addiction	46-47
Substance Abuse Treatment Programs for Mothers	47-48
Maternal Self-Efficacy in Mothers with Addiction	48-49
Summary	49-51
CHAPTER 3	
RESEARCH METHODS	53-66
Research Design.....	52-54
Characteristics of Qualitative Research	52-53
Benefits to Qualitative Research.....	53
Approaches to Qualitative Research.....	53-54
Phenomenology.....	54-56
Transcendental Phenomenology	54-55
Moustakas' Phenomenological Method.....	55-56
Assumptions and Rationale for Design.....	56-57
Participants, Setting, and Role of the Researcher	57-61
Participants.....	57-58
Setting	58-60
Role of the Researcher	60-61

Data Collection Procedures.....	61-63
Data Analysis Procedures	63-64
Methods of Verification.....	64-66
Confirmability.....	64-65
Dependability.....	65
Credibility.....	65-66
Transferability.....	66
Summary.....	66
CHAPTER 4	
SELF OF THE RESEARCHER	67-71
Personal Experience.....	67-68
Clinical Experience.....	68-69
Presumptions.....	69-71
CHAPTER 5	
RESULTS	72-125
Meet the Participants.....	72-76
Adriana.....	72
Brenda.....	72-74
Cynthia.....	74
Gina.....	74
Jaime	74
Jenny	75
Judy.....	75

Leah.....	75
Maria.....	75-76
Sammy	76
Sonia	76
Vanessa	76
Categories, Themes, and Subthemes	76-78
Category: What It Means to Be a Good Mother	78-89
Theme: Providing a Stable and Safe Environment	79-82
Subtheme: Providing Basic Needs.....	79-80
Subtheme: Having Structure	80
Subtheme: Safety	80-82
Theme: Nurturing the Relationship	82-86
Subtheme: Being Physically and Emotionally There	83-84
Subtheme: Bonding Through Activities	84
Subtheme: Approachability	84-85
Subtheme: Showing Affection.....	85-86
Theme: Being a Good Role Model	86-89
Subtheme: Demonstrating Communication Skills.....	87-88
Subtheme: Teaching My Children Responsibilities	88
Subtheme: Modeling Self-Care.....	88-89
Category: Consequences of Addiction on Motherhood.....	90-101
Theme: Impact of Addiction on Me.....	90-94
Subtheme: Relational Impact.....	92

Subtheme: Emotional Impact.....	92-93
Subtheme: Cognitive Impact.....	93
Subtheme: Physical Impact.....	93-94
Theme: Impact of Addiction on My Children	94-97
Subtheme: Relational Impact.....	95
Subtheme: Emotional Impact.....	95-96
Subtheme: Awareness.....	96
Subtheme: Physical Impact.....	96-97
Theme: Hitting Rock Bottom.....	97-101
Subtheme: Family Members Caring for My Children.....	98-99
Subtheme: Negative Consequences	99
Subtheme: CPS Involvement	99-100
Category: Being a Mother During Recovery	101-111
Theme: Treatment's Role in Staying Sober.....	101-105
Subtheme: Learning to Cope	102-104
Subtheme: Protecting Sobriety	104
Subtheme: Choices.....	104-105
Theme: Fixing the Damage.....	105-109
Subtheme: Not Going Backwards.....	106
Subtheme: Making Amends.....	107
Subtheme: Taking Time to Repair Relationships	107-108
Subtheme: Reuniting with My Children	108-109
Theme: Discovering My Purpose	109-112

Subtheme: Wanting to Be a Mom.....	110
Subtheme: Finding Direction.....	110-111
Subtheme: Finding Myself.....	111
Category: Risk Factors.....	112-118
Theme: Types of Trauma.....	112-116
Subtheme: Family History of Addiction.....	113
Subtheme: Childhood Abuse	113-114
Subtheme: Sudden Grief and Loss.....	114
Subtheme: Abandonment.....	114-116
Theme: Life Stressors	116-118
Subtheme: Single Parenting	116-117
Subtheme: Managing Responsibilities Without Help.....	117
Subtheme: Having Multiple Children.....	117-118
Subtheme: Marital Problems.....	118
Composite Description of Textural-Structural Analysis.....	118-121
Core Essence.....	121
Discussion.....	121-125
 CHAPTER 6	
SUMMARY, IMPLICATIONS AND RECOMMENDATIONS	126-149
Summary	126-128
Supporting the Literature	128-131
Enhancing the Literature.....	131-135
Unresolved Guilt and Shame	132-133

Meaningful Life	133-135
Adding to the Literature.....	135-137
Defining a Good Mother.....	136
Implications to Theory	137-140
Implications to Clinical Practice.....	141-143
Mentorship Programs.....	141
Attachment-Based Activities	142
Identifying Meaningful Direction.....	142
Wraparound Services	142-143
Limitations	143-145
Recommendations.....	146-148
Conclusion	148-149
REFERENCES	150-180
APPENDICES	181-261
Appendix A Consent Form.....	181-184
Appendix B Recruitment Flyer.....	185-186
Appendix C Site Permission Council for Alcohol and Drugs Houston.....	187-188
Appendix D Site Permission INNOVATIONS	189-190
Appendix E Demographic Data Form	191-194
Appendix F Interview Protocol.....	195-196
Appendix G Mini Mental Status Examination.....	197-198
Appendix H Textural-Structural Description: Adriana.....	199-202
Appendix I Textural-Structural Description: Brenda	203-206

Appendix J Textural-Structural Description: Cynthia	207-211
Appendix K Textural-Structural Description: Gina.....	212-215
Appendix L Textural-Structural Description: Jaime.....	216-219
Appendix M Textural-Structural Description: Jenny	220-223
Appendix N Textural-Structural Description: Judy	224-228
Appendix O Textural-Structural Description: Leah	229-233
Appendix P Textural-Structural Description: Maria.....	234-238
Appendix Q Textural-Structural Description: Sammy	239-243
Appendix R Textural-Structural Description: Sonia.....	244-247
Appendix S Textural-Structural Description: Vanessa.....	248-251
Appendix T Member Checking Log	252-254
Appendix U Peer Debriefing Feedback	255-257
Appendix V Sample Analytic Memos Excerpt.....	258-261

CHAPTER I

THE PROBLEM AND JUSTIFICATION OF THE STUDY

Mothers in addiction treatment settings often experience impediments to their recovery when access to their children becomes limited. Western culture often teaches women to identify themselves as a primary caregiver. Women often experience high levels of guilt and shame when they neglect their roles as mothers due to their relationship with addiction (Ehrmin, 2001). Chemically dependent women display reduced self-esteem and self-efficacy levels along with experiencing frequent devaluation by others (CSAT, 2009). This creates emotional challenges for women to seek or feel deserving of help (CSAT, 2009; Ehrmin, 2001).

Statement of the Problem

The stigma of “bad mother” haunts a woman as she engages in drug-seeking behavior and potentially avoids treatment to escape labeling herself. Mothers become fearful that admitting to alcohol or drug use will create custody issues too (CSAT, 2009; Finkelstein, 1994). Most mothers desire to be “good, competent and caring mothers,” including chemically dependent women who pass up treatment options to escape critical judgments of their parenting skills (Brudenell 2000). However, mothers do seek treatment when referred by the criminal justice system and/or child protective services (CSAT, 2009; Brady & Ashley, 2005). Grella and Joshi (1999) found women enter and utilize treatment more frequently than men due to women’s pressing concerns over custody and responsibility of care for their children. Additionally, women attending treatment with their children demonstrate better life outcomes (e.g. abstaining from drugs and/or alcohol, holding employment, retaining custody of their children, involvement

with support groups, and evasion to arrests/incarceration) than women without children in treatment (Stevens & Patton, 1998). Connors et al. (2006) and Saunders (1993) note that women demonstrated improvements in living skills (i.e. independent living, parenting, employment, and relationships) and recidivism in treatment when mother-child programs were offered. The women also displayed lower levels of psychological distress. For many women, motivation and retention in treatment involves sustaining strong connections with their children. However, many women in substance abuse treatment struggle to find treatment facilities where children can accompany them. Interference with successful treatment completion and sustaining sobriety occurs when pre-existing barriers remain (Finkelstein, 1994).

Purpose of the Study

The purpose of this study is to contribute to a better understanding of perceived maternal self-efficacy in mothers who are in outpatient treatment for substance abuse. Chemically dependent mothers often display reduced perceptions in self-efficacy towards their ability to parent, which magnifies unresolved feelings of guilt and shame (Ehrmin, 2001). Intense guilt and shame can perpetuate drug and alcohol use, foster denial of problems, and display neglectful parenting practices (Brady & Ashley, 2005). Simmons and colleagues (2009) report approximately two percent of mothers from two nationally representative surveys meet the clinical criteria for drug abuse or dependence have misused prescription or illicit drugs with children under the age of 18 in the home. In strategies to improve treatment outcomes in substance abuse, Coon et al. (1998) found that when perceived self-efficacy increased during the recovery process, sobriety sustained following treatment. Further, high self-efficacy levels correlate with low levels

of shame (Baldwin, 2006) suggesting improvements on perceived maternal self-efficacy during treatment will reduce negative beliefs in self and produce positive treatment outcomes in mothers. Most chemically dependent mothers want to become “caring and competent parents” and maintain or regain custody of their children (Brudenell, 2000). The study focuses on women’s perceptions in maternal self-efficacy and the importance of motherhood as she progresses through recovery in outpatient substance abuse treatment.

Rationale for the Study

The existing literature on substance abuse treatment for women focuses mainly on child welfare issues regarding parental abuse and neglect. Few studies related to mothers’ impediments to recovery and accessibility to their children exist in the literature. Much of the existing research is quite dated (over ten years old). One rationale for this study is that it would help keep the field current and add to the previous base of knowledge.

Studying women’s perspectives of motherhood in outpatient treatment would also be important to the field of substance abuse treatment because it would address the Substance Abuse and Mental Health Administration’s (SAMSHA) mission to “reduce the impact of substance abuse and mental illness on America’s communities” (SAMSHA, 2013). SAMSHA strives to improve the lives of youth and families who are impacted by addictions and substance abuse. The Department of Health and Human Services (1999) and Child Welfare League of America (1998) reports the child welfare system for suspected parental abuse or neglect refers children most frequently due to maternal substance abuse.

This study could also be useful for improving mental health care for substance-abusing mothers, as women show an increased risk for additional psychiatric diagnoses when chemical dependence is present (Zilberman et al., 2003). In combination with substance abuse disorders, women commonly meet criteria for anxiety and affective disorders more so than men (DiNitto et al., 2002; Agrawal et al., 2005). Various literature (Gil-Rivas, V. & McWhorter, 2013; Worcester, 2008; Khantzian, 2003, 1997) on Co-Occurring Psychiatric and Substance Disorders (COPSD) highlight their distressing effect on individuals and the tendency to self-medicate. In response to stress and caregiver responsibilities, women commonly alter their “state of mind” by participating in activities that allow them to “temporarily escape” (Baker & Carson, 1999). Literature reveals that stress may arise in women from physical discomfort during pregnancy, anxiety surrounding the health and well-being of the fetus, caring for the baby, and feelings of societal shame for using of substances while pregnant (Daley et al., 1998).

This study would be relevant to the field of MFT because research suggests that women show higher rates of engagement, retention, and recovery when children are included as part of the treatment process (CSAT, 2009; Lungren et al., 2003; Szuster et al., 1996). During substance abuse treatment, women learn parenting skills as well as strategies to improve the mother-child interaction (Peterson et al., 1996). Relationships, in general, build on a woman's identity, self-esteem, support system and rational for decision-making (CSAT, 2009). Miller's (1976) publication discusses a woman's overall life pursuit towards psychological connection with others. Connections form from the relational process and develop a woman's sense of self and self-worth (Covington, 2000). With relationships as an essential component to women's lives, the inclusion of children

supports her overall growth and development in day-to-day activities (Covington & Surrey, 1997; Finkelstein 1993, 1996; Miller, 1984). Conversely, disconnections or broken relational bonds between a mother and her children result in psychological problems (e.g. addiction, anxiety, depression, etc.) for the woman. A mother's ability to function in a parental role becomes impaired and her children endure potential risk for maltreatment. Young, Boles, and Otero (2007) reviewed existing prevalent studies on the Child Welfare System and substance abuse treatment estimated that approximately 408,460 mothers receiving treatment for substance use had one or more children removed by child protective services. Children that enter the child welfare system due to parental substance abuse experience longer retention rates, and a greater chance of developing mental and physiological health problems leading to significant costs (Child Welfare Information Gateway, 2009). In 2001, The National Center on Addiction and Substance Abuse at Columbia University reported the U.S. spent \$24 billion dollars towards substance abuse with \$5.3 billion contributed to the child welfare costs (The Substance Abuse and Mental Health Services Administration, 2013). At this time, the United States spends significant amounts of expenditures towards substance use and the child welfare system (Child Welfare Information Gateway, 2009).

This study is important to marriage and family therapists because it offers insight into treatment needs of mothers in substance abuse recovery. In 2013, the American Association for Marriage and Family Therapy (AAMFT) decided to emphasize "raising vibrancy in children and enhancement for long term gains." Marriage and Family Therapists (MFTs) understand the relational component that engages women to seek substance abuse treatment, and the importance relationships play in the healing process

(CSAT, 2009). Relationships with children serve as a primary motivation source for women to initiate and utilize treatment services (Duffy & Baldwin, 2013; Tracy, 1994). Improved relationships between mother-child interactions not only impact the woman's recovery, but produce long term effects on a child's overall emotional, physical and intellectual development (National Scientific Council on the Developing Child, 2004; CSAT, 2009). The relational development between mothers and children is emphasized in this research. Developing and maintaining positive relationships can enhance self-esteem and heighten self-efficacy in women (CSAT, 2009; Finkelstein et al., 1997).

Research Questions

The primary research question for the current study is: *What is the lived experience of mothers in outpatient substance abuse treatment?* The answer to this question informs treatment programs on potential needs of mothers when developing gender-specific services. In particular, the lived experiences of mothers may provide insight into adapting current trends of treatment, determining barriers to treatment, and/or eliminating stigma attached to substance abusing mothers. A secondary question in this study answers: *What do mothers in outpatient substance abuse treatment believe makes for a good mother?* In answering this question, mental health professionals and researchers further advance therapeutic approaches, interventions, and resources when assisting mothers in treatment. The approach best suited to examine the research questions involves a qualitative phenomenological research design.

Theoretical Framework

A theoretical framework provides a lens when examining a phenomenon of interest. The lens compiles a system of concepts, assumptions, beliefs, and theories to

guide the research. Past literature surrounding this research area combines several disciplines – psychology, education, and communication. The three main theories shaping this study include Self-Discrepancy Theory, Attachment Theory, and Social Cognitive Theory. Although concepts differ, the intertwining of practices in each theory describes the foundations of perceptions in mothering in women recovering from substance abuse.

Self-Discrepancy Theory. Higgins' (1987) developed self-discrepancy theory to explain the sense of consistency between an individual's desired beliefs and self-perceptions. Applying a systemic lens to theory allows for a shift in attention from a part (individual) to the whole (society). To fully grasp an understanding on a phenomenon, systems theory reviews the global functioning rather than examining the separate parts (Mele, Pels, & Polese, 2010). The constant interaction between people and their external environment influence an individual's belief system (Sutphin, McDonough, & Schrenkel, 2013; Amagoh, 2008).

With systems perspective in mind, self-discrepancy theory transitions from evaluating individual beliefs to beliefs developed by society (Mele, Pels, & Polese, 2010). Self-discrepancy would evaluate the consistency between societal-based beliefs and self-perceptions. For example, exposure to media encourages beliefs set by society. Groups and individuals use the standardized images from media as a comparison when evaluating ability to fulfill role (Nabi & Oliver, 2009). Harrison's (2000) research on self-discrepancy demonstrated emotional distress (i.e. symptoms of anxiety and depression) in adolescents when exposed to media promoting ideal-body through television programs. The results of the study support Higgins' (1987) prediction that

when people exhibit conflict between beliefs about the self in relation to societal standards, emotional discomfort arises. Higgins (1987) further explains the relationship between various selves (*actual*, *ideal*, and *ought*). The *ideal* and *ought* selves serve as “guides” or standards to fulfilling specific duties that are cultivated by westernized worldviews. The two differ as the *ideal* self focuses on attributes an individual hopes or dreams to possess (i.e. an image of “good mother” attributes a woman dreams to possess) while the *ought* self focuses on the attributes an individual believes she should possess (i.e. the minimum of duties and obligations a mother believes she should perform) (Liss, Schiffrin, Rizzo, 2013; Higgins, 1987)). The *actual* self refers to one’s current self and compares against the “self-guides” established by society. If an individual’s actual self fails to match the ideal or ought selves, the individual may elicit feelings of anxiety, shame, and guilt (Adams, 2015). The magnitude of discrepancy between the beliefs of self determine the level of negative affect the individual experiences (Higgins 1987). Self-discrepancy theory helps to explain the maternal guilt and shame women often experience when attempting to “live up” to the societal standards of intensive mothering. The fear of negative evaluation and being judged as a “bad” mother by others fuels the unhealthy cycle of self-discrepancy (Liss, Schiffrin, Rizzo, 2013).

Attachment Theory. John Bowlby (1973) describes the mother-child bond as a warm, intimate, and continuous relationship with the mother as an essential component for establishing positive mental health in children. Attachment theory also describes the patterns of bonding and connection people form with others. The attachment provides a safe and secure base for a child to actively explore during development while in a protected environment (Benoit, 2004; Bowlby, 1973). Bowlby also noted the importance

of the mother's attitude and availability to the child when sustaining a healthy relationship (Benoit, 2004). Attachment theory assisted in forming standards for westernized, intensive mothering practices along with identifying potential deficits (maternal deprivation and child abuse/neglect) when the continuous mother-child bond breaks (Leupp, 2010; Bowlby, 1969).

Systems theory views attachment and relationships with others as separate parts to the entirety. By looking at wholeness, systems theory examines the interconnections that generate patterns of behavior over time. Consistent behavior patterns communicate through a feedback loop, a self-regulating system (Meadows, 2009). This means patterns of bonding continuously repeat unless new adaptations are introduced that force change (Farber, 2007; Cordon, 2013).

Emotionally Focused Therapy (EFT) applies attachment theory to a systemic perspective. This approach to therapy focuses on the disruption patterns between mother and child. It also emphasizes the maladjustments that may manifest as the child grows into adulthood. Broken attachments hinder relationships with others (Hattery, 2001). Maladjusted adults will struggle to maintain successful relationships with friends, family, colleagues, and significant others (Fraley & Davis, 1997). Enactments of disconnections from the mother-child bond emerge within intimate relationships and/or intergenerational family members as a way to repair past injuries. However, continuous negative emotional interactions with family members and partners will cause damaging repetitive cycles of emotional distress and disconnection (Efron & Bradley, 2007). Attachment theory highlights the importance of the mother-child relationship, discusses barriers that may

interfere with forming attachment, and the impact in children's mental and physical health outcomes.

Social Cognitive Theory. Bandura explains the inherent need for humans to establish control over their lives to obtain beneficial gains (Benight & Bandura, 2004). Humans watch others and apply similar actions or behaviors to achieve successful outcomes (Coleman & Karraker, 1998). Applying social cognitive theory to a systemic perspective, observation occurs during social interactions or through media sources (Nabi & Oliver, 2009). Systems theory examines "wholeness" from multiple interacting elements or the socio-cultural messages that inform behavior in humans. A group of people come together to develop a set of rules, culture beliefs, and ideals (Cordon, 2013). These developed standards are communicated through forms of interaction. For example, social norms depict an ideal through media and influence behaviors demonstrated in the community (Nabi & Oliver, 2009). Institutions, organizations, and leaders embrace the portrayed behaviors. Community members learn and demonstrate promoted behaviors to others through social interactions (Graf et al., 2012). Social context assists in shaping learned behaviors in humans (Reed et al., 2010).

Social cognitive theory further discusses the process of learning, motivation and self-efficacy (Bandura, 1997). Learning also shows systemic components as the process involves the flow of communication between multiple structures. When new structures emerge, the learning system needs to adapt, change, respond, or attend to the information introduced (Cordon, 2013). Observing another relatable individual perform a task successfully introduces new structures. The process of learning occurs when the observer identifies with the model, adapts inner flow structures, and exhibits high self-efficacy

(Ardelt & Eccles, 2001; Cordon, 2013). Self-efficacy describes one's belief in mastering a specific skill (Bandura, 1997). Motivation to participate in an activity increases when a person believes she can be successful (Pajares, 2002). Social cognitive theory applied to mothering practices discusses the perceptions mothers hold regarding parenting capabilities and motivation towards caretaking.

Definition of Terms

Child(ren) refers to any dependent individual, under the age of 18, with a mother currently attending outpatient treatment for illicit drugs or alcohol use for this study.

Intensive mothering refers to the socially constructed, westernized standards of adequate caregiving currently accepted by society as the norm. The ideal emphasizes a mother's complete devotion of time, money and energy to her child's physical and emotional well-being (Hays, 1996). For this study, mothers may indicate societal influence and compare ideals to their caregiving practices.

Lived Experience refers to an individual's description of a common phenomenon (Creswell, 2013). For this study, the researcher explores the mother's journey through recovery.

Maternal self-efficacy refers to a mother's perceived capability to successfully complete caregiving tasks in the parental role. Four contributors (task-mastery, vicarious learning, verbal persuasion, and physiological/affective states) measure levels of maternal self-efficacy perceptions (Troutman et al., 2012). For this study, mothers discuss their experiences of mothering and perceptions of maternal self-efficacy while recovering from substance abuse (Leerkes & Crockenberg, 2002).

Mother refers to a female participant, 18 years or older currently seeking outpatient treatment for substance abuse with at least one (1) living child during the time frame of the study.

Motherhood for this study pertains to the restructuring of goals, behaviors, and responsibilities within women. Mothers encounter an identity transition during the major developmental life event and construct a new "maternal identity" (Mercer, 2004). Stressors such as personal emotional and physical well-being, cultural beliefs, socioeconomic status, environmental conditions, and caregiving experience/ knowledge impact the maternal identity development (Elliot et al., 2015; Mercer, 2004).

Outpatient Substance Abuse Treatment refers to non-residential or non-hospitalized treatment setting that provides services for chemically dependency. Services in outpatient treatment include individual and group therapy, psychoeducational classes, medication management, case management, and support groups - 12 Steps AA or NA (CSAT, 2006).

Phenomenology consists of deeper understanding and attributes meaning among a phenomenon by examining the descriptions of several individuals who encountered the event (Creswell, 2013). The researcher examines a collection of descriptions from mothers attending outpatient substance abuse treatment for this study.

Stigma refers to the negative or scrutinized judgements by society on differences among ideal mothering. Mothers using illicit drugs or alcohol struggle with associated labels of "Unfit or Bad Mothers" regardless of actual caregiving practices (Reid, Greaves, & Poole, 2008). For this study, mothers recovering from substance abuse participate in

alternative lifestyles that deviate from the “norm” or socially acceptable environment for raising children.

Substance use and/or abuse demonstrates a pattern of harmful consumption in illicit drugs or alcohol and increase in tolerance which may negatively impact the woman or others. The repeated acts of drug and alcohol misuse deteriorate a woman's physical, psychological and relational well-being (World Health Organization. International, 2015).

Summary

Numerous barriers impede treatment services for mothers recovering from substance abuse. Women encounter stigmatizing labels such as “unfit or bad” when they neglect their role as mothers (CSAT, 2009). The negative impact of society's devaluation lowers women's self-esteem and self-efficacy causing severe feelings of guilt (Ehrmin, 2001). The haunting stigma of “bad mother” potentially hinders women from seeking substance abuse treatment (Brudenell 2000).

However, most mothers strive to sufficiently care and nurture their children (Brudenell 2000). Services that allow for children to accompany mothers show improvements in engagement, retention, and recovery during the treatment process (Lungren et al., 2003; Szuster et al., 1996). Women learn parenting skills as well as strategies for improving the mother-child interactions while attending substance abuse treatment (Peterson et al., 1996). The improved relationship between mother and child build on the women's self-efficacy (CSAT, 2009; Covington, 2000). The paucity of knowledge surrounding the experiences of maternal self-efficacy in chemically dependent mothers remains limited and the study hopes to contribute to the gap.

CHAPTER II

REVIEW OF THE LITERATURE

This chapter focuses on providing an overview of the literature surrounding the ideology of mothering in chemically dependent women. The chapter also describes the development of motherhood along with barriers that impact maternal identity, including guilt and shame, maternal deprivation, caregiving knowledge, and maternal self-efficacy in women with substance abuse disorders. The existing literature relevant to this review includes dated research from over a decade ago. Unfortunately, very little recent research examines this phenomenon, something this study hopes to correct.

Ideology of Mothering

The Western, socially-constructed ideology of mothering oppresses women to maintain extensive care for their children while fighting off implicit or explicit judgments on “bad mothering practices” (Johnston, Swanson, 2006; Ong, 1985). According to Arendell (2000), mothering is a conditioned, ongoing relationship that involves instilling social values and practices into new generations of life through nurture and care. The prevailing North American ideology of mothering established by Sharon Hays, a sociologist specializing in Motherhood and Gender Studies, coined the term “intensive mothering.” Hays (1996) describes intensive mothering as an “all-encompassing female activity that is child-centered, emotionally absorbing, labor intensive and financially expensive for which the maternal devotion nurtures the development of the sacred child’s needs” (p. 46).

Historical Development of Intensive Mothering Ideology

1930's – 1950's. During the 1930's, the intensive mothering ideology began to emerge. Child rearing beliefs started to shift in focus. Children, previously viewed as evil, sinful beings in need of discipline in the seventeenth and eighteenth centuries, were now being considered innocent and vulnerable (Biese, 2017). Hattery (2001) discusses the movement towards nurturance and devotion in parenting practices. Mothers adjusted their behaviors to be warm, child-centered, and completely devoted to meeting the needs of their children (Biese, 2017; Hattery, 2001). When mothers lacked attention and nurturance towards their children, they were accused of depriving their children of essential elements of motherly love and devotion. The mothers were considered by society as engaging in acts of maternal deprivation (Hattery, 2001). This change in parenting style influenced the practices of intensive mothering.

Models of child development were becoming popularized. Theorists, Erik Erikson and Sigmund Freud, were publicizing their work on the psychosexual model of child development (Hattery, 2001; Leong, 2008). This model contributed to intensive mothering ideology by focusing on involvement of parents. The psychosexual model discusses the need for parental guidance as a child encounters stages of conflict. Erikson and Freud theorized that children able to resolve conflicts would grow up to be happy, well-adjusted adults, whereas; maladjusted adults would have struggled to attain resolution in childhood (Hattery, 2001). This theory emphasized a mother's lack of involvement would contribute to the maladjustment in her child's development (Biese, 2017; Hattery, 2001). Another theorist, Jean Piaget, developed his model of cognitive development (Leong, 2008). He suggested that children learn cognitive abilities in a

series of predetermined stages by conducting “little experiments” to master object permanence and abstract reasoning. Parents played a crucial role in cognitive development of children by encouraging “little experiments” and providing environments where cognitive growth could occur (Hattery, 2001). A mother's inability to provide a conducive environment risks optimum growth in cognitive development in the child (Hattery, 2001; Hays, 1996). The models brought forth by Erikson, Freud, and Piaget encouraged the high demanding commitment of intensive mothering ideals.

With changes in child-rearing beliefs, a new manual for parenting was written by pediatrician, Benjamin Spock. His parenting guidelines in his popular book, *Baby and Child Care*, emphasized maternal affection and flexibility over punishment when rearing offspring (Hattery, 2001). His writing encouraged mothers to stay at home with their children as best practices to parenting. Spock's expertise and recommendations contributed to the ideals associated with intensive mothering practices (Douglas & Michaels, 2004).

Post WWII. Intensive mothering standards continued as the norm in the United States after World War II. Women who entered the workforce to support war efforts were encouraged to return home to tend to their children. By middle-class women returning home, jobs opportunities increased for men. The transition in the workforce promoted the economic growth (Biese, 2017; Hattery, 2001). The rising economy promoted the societal importance of women staying at home and their role as mothers (Biese, 2017). Theorists Harry Harlow and John Bowlby also were focusing on the importance of the mothering role and mother-infant attachment (Hayes, 2009). Harlow's research noted the social and cognitive deficits occurring in youth when maternal separation occurs in caregiving with

primates. Bowlby formulated the theory of attachment where mother-child bonding is essential during the early years of life and disruptions to the attachment contribute to developmental problems in children (Douglas & Michaels, 2004). The booming economy and new advancements in caregiving research continued to uphold the intensive mothering beliefs induced by the westernized culture.

1970's to Current. The feminist movement in the 1970's encouraged gender equality and allowed women to re-enter the workforce. However, women with children were still being depicted by media as stay-at-home mothers (Douglas & Michaels, 2004). Magazines and television shows portrayed dominant images of the traditional stay-at-home mothers (Kuperberg & Stone, 2008). Celebrities endorsed intensive mothering practices by providing narratives of the joyous devotion to their children (Douglas & Michaels, 2004). Finally, numerous articles ran that shared horror stories over child care incidents in working mothers (Kuperberg & Stone, 2008). The motherhood images and stories increased attention to intensive mothering practices and capitalizing on the powerful ideology still in existence today.

The ideology of "intensive mothering" developed from White, middle-class, domesticated women who primarily stayed at home full-time and later, the ideology became associated with societal expectations on good mothering practices (Boris, 1994). Adams (2015) suggests mothers place high value on meeting societal representation of "good" mother. When incongruity exists between expectations and realities of motherhood, mothers experience self-discrepancies and emotional discomfort (Adams, 2015; Liss, Schiffrin, & Rizzo, 2013). Liss, Schiffrin, and Rizzo (2013) discusses the impact of emotional discomfort (i.e. a sense of shame) perceived in mothers when failing

to meet “ideal” caregiving practices. Mothers equate “not ideal” as “bad” in their minds lowering self-efficacy levels in mothers. The low maternal self-efficacy and negative self-evaluations in mothering practices disrupts the attachment process between the mother and child (Leerkes & Crockenberg, 2002). The lack of secure attachment in the mother-child relationship potentially causes physiological and health concerns in children (Boursnell, 2007; Oyserman et al., 2005). The negative child outcomes emphasize mothers' self-discrepancies and their inability to obtain “good” mother status by society.

Self-Discrepancy Theory

Self-Discrepancy Theory proposes the notion that emotional discomfort arises when discrepancies occur between an individual's actual self and the ideal self created by society (Higgins, 1987). The actual self or one's “sense of self” consists of attributes an individual already possesses while the ideal self depicts an image of how a person, family, group, or institution “ought-to-be” (Adams, 2015; Higgins, 1987). Systems theory suggests the image generated develops from societal messages. Parents reinforce societal messages by communicating ideal images in the home (Adams, 2015). The generated images or “self-guides” internally compares one's attributes to the attributes in the “ought-to-be” image. When mismatch occurs between actual and ideal self, a person experiences a negative emotional reaction (Adams, 2015). The level of emotional discomfort potentially causes mental health issues in the individual resulting in feelings of guilt and shame (Liss, Schiffrin, & Rizzo, 2013).

Self-discrepancy theory applied to mothering explains guilt and shame often experienced in women who differ in the actual sense of self compared to the ideal “intensive mothering” practices. The “ought-to-be” societal standards set extremely high

demands of care for mothers, and women internalize these messages. When a mother struggles to attain ideal standards, she perceives herself as “inadequate” or “bad” mother (Liss, Schiffrin, & Rizzo, 2013). Underprivileged mothers, who do not fit into the dominant cultural expectations, undergo chastising treatment for failing in their maternal duties.

Contradicting Lifestyles to Intensive Mothering

Mothers already struggle with meeting societal expectations of “good mother” ideals and maternal role transition. However for some mothers, external strains amplify stress and inhibit effective mothering. Low-income, single, minority, and/or lesbian mothers seldom fit the hegemonic view society has construed. These women experience feelings of frustration, isolation, exhaustion and depression. The balancing act of attempting to sustain a lifestyle and living up to society's expectations becomes overwhelming (Johnston & Swanson, 2006).

Careers. Career-invested women find many challenges in meeting the ideology of “good mother.” According to the U.S. Bureau of Labor Statistics (2015), 69 % of mothers with children under the age of 18 years of age participate in the labor force. Even with married men documenting more time spent with their children from 1965 to 2000, employed full-time women still perform a majority of the housework and child-rearing (Leupp, 2010). The United States in comparison to European social welfare states provide little assistance for mothers in paid parental leave or subsidized childcare (Gornick & Meyers, 2004). Full-time employed mothers experience tension between work responsibilities and parenting (Johnston & Swanson, 2006). Mothers describe cognitive dissonance over time spent working and lack of attention with their children.

Full-time working women often find separation of work and family roles difficult, resulting in greater unhappiness and stress (Johnston & Swanson, 2006). Work-family balance complicates women's employment, and result in women reconsidering employment decisions (i.e. occupation, working from home options, and/or returning to the workforce).

Doctors, social workers and childrearing experts utilize Bowlby's attachment theory to encourage women to stay home with children rather than returning to work after childbirth (Murkoff & Mazel, 2016; Weissbluth, 2015; Sears, 2013). Devoting self to the all-encompassing needs of her children still holds as the dominant ideal cultural model of child-rearing despite criticisms on actual childrearing practices apparent in the United States (Leupp, 2010). Approximately 23 million children ranging from pre-school to school-age in the U.S. attend substitute caregiving options (i.e. care by family or friends, hiring babysitting services, and utilizing child care facilities) while the mother works (Encyclopedia of Children's Health, 2015). Even with the abundance of mothers utilizing child care options during work hours, women are still evaluated by society in their mothering practices and arrangements by society through the standardized norm of intensive mothering ideals (Leupp, 2010).

Living up to "good mothering" practices demonstrate only one of the competing family-work struggles for women. Mothers often face pressures on work performance ideals (Williams & Cooper, 2004). Similar to intensive mothering, the ideal worker completely devotes herself to the demands of work regardless of the family caretaking responsibilities (Crowley, 2013). The conflict for women heightens as taking time off or maternity leave present threats to professional advancement (Williams & Cooper, 2004).

Women employed in highly competitive professions reluctantly dismiss opportunities to reduce workloads or schedules to steer away from titles associated with poor dedication, lack of job commitment, or low performance attainment compared to peers (Crowley, 2013). The pressures of ideals from both mothering and work performance cause mental and physical health problems (MacDonald, 2009). Women often reports high levels of stress, anxiety and fatigue when attempting to meet societal expectations in motherhood and professional advancement (Bar & Jarus, 2015). MacDonald's (2009) study revealed that inadequacies and anxiety about not fulfilling the needs of her children presented as a norm among mothers who attempt to implement strategies for work-family balance. Essentially, employed mothers experience inevitable inadequacies in at least one of life's domains.

"The inherent contradictions between the ideals of intensive mothering and the unencumbered worker make it impossible for employed women with children to meet workplace and mothering expectations simultaneously" (Leupp, 2010).

Single and Low-Income. With married women in United States already struggling to meet the high societal standards intensive mothering places on mothers, the challenges for the single, low-income mothers becomes especially straining when attempting to fulfill multiple roles. In the United States, approximately 80% of the 12 million single-parent families are headed by women. (U.S. Consensus Bureau, 2013). Making 1 in 4 children raised without a father, and nearly 4.1 million single-mother households living below the poverty line (U.S. Consensus Bureaus, 2013). The common maternal characteristics among low-income single mothers include young (under age 34), lack previous marriages, less educated, and unemployed (Mather, 2010). Financial instability for mother-headed households serves as a significant barrier when attempting to embrace

and perform intensive mothering practices. Low-job wages or unemployment for mother-headed households place children at-risk. Single, low-income mothers have limited financial resources to provide sufficient education, child care and health care for their children. Austin et al. (2004) discusses how children in single-mother, low-income families often face exposure to harsh environments including random neighborhood crime, violence in the community, gang presence, and unlivable home conditions (i.e. lack of nutritional food, physically inadequate dwellings, utilities disconnected due to unpaid bills). Coley et al. (2013a) report the behavioral, cognitive, and emotional disturbances children encounter when growing up in poor quality housing. Coley and colleagues (2013b) revealed children exposed to residences with leaky roofs, broken windows, rodents, peeling paint, non-functioning appliances, exposed wiring, or uncleanly environments displayed higher rates of emotional/behavioral problems and lower academic functioning. Murry et al. (2001) describes prevalent emotional/behavioral problems as temper tantrums, fighting, cheating, lying, depression, academic problems, gang-related involvement, and teenage pregnancy among children from single-mother families. For low-income, single-mothers, family survival becomes an essential focus.

Mothering practices in low-income families involves combatting the potential internal and external problems their children's well-being may encounter. To assist low-income families, federally-funded child care facilities known as Head Start Centers developed nationwide to provide child care arrangements for parents facing poverty (Deming, 2009). Head Start Centers promote the mission of "school readiness" by providing an environment where cognitive and social development can grow in each

child. The federal guidelines of the Head Start program regulates standards in education, physical and mental health, nutrition, and social development that often lacks in children from low-income families (Aikens et al., 2010). The professional care provides a safe learning environment for children and facilitates the needs towards counteracting the potential hardships children face in homes and communities of poverty (MacDonald, 2009). The professional child care option allows for single, low-income mothers to work and eliminate concerns on the child's well-being (Deming, 2009). MacDonald (2009) emphasizes the importance "to work" and place children in professional child care rather than stay-home with children for mothers with children under age five receiving public assistance. However, the dominant mothering ideology scorns mothers for using such alternative parenting practices or promotes a sense of guilt, inadequacy, and uneasiness for "opting out" as the primary caregiver in child-rearing.

Minority. Although most mothers in the United States embrace some form of the ideology of intensive mothering, the interpretation differs among cultures, races, and ethnicities. MacDonald (2009) discusses cultural adaptations to Western standards of mothering in the United States as a result of differences between racial and ethnic child-rearing practices (i.e. mother's reliance on friends or family – kinship and variations to concerted cultivations) or unrealistic expectations of mothering ideals (i.e. staying home regardless of insufficient income). In the African American culture, a mother relies on extended family for assistance in child care. Another cultural variation to the stay-home mother occurs in Hispanic families. Hispanic mothers access assistance through household residents (i.e. partners, other adults or older children in the home) while Anglo American mothers often rely on neighbors or friends for child-rearing assistance (Steidel

& Contreras, 2003). Anglo American mothers usually receive less aid in child rearing than mothers of minority (Arendall, 2000). The practices and arrangements of “Othermothering” developed out of a survival strategy for child rearing. Mothers of low-income and color adopted “Othermothering” or the use of kin networks due to necessity rather than convenience. Extended child care from the “other mothers” allows the custodial parent an opportunity to fulfill essential obligations while children are supervised (Taylor, 2011).

Variations in concerted cultivations developed from US mothers with limited resources. Lareau (2002) describes concerted cultivations as organized leisure activities or extensive reasoning that fosters the child's development and talents (i.e. sports, music lessons, and tutoring). Working mothers or low-income mothers focus more on providing the “essentials for natural growth” including love, food, shelter, and safety due to limited resources. Mothers of African American decent incorporate other essentials into childrearing including teachings on coping mechanisms toward inequality in their children, ensuring family and racial survival, and developing a positive ethnic identity in children (MacDonald, 2009). Natural growth differs from culture to culture, immigrant Muslim mothers place importance on religious and cultural traditions in childrearing practices which varies greatly from the “White, middle-class American” mothering. Many Muslim mothers who immigrated to the United States “hold on” to their cultural beliefs and encourage their children to learn the traditions by attending Islamic Schools, learning the native language, devoting time to frequent prayer, and requesting daughters to wear the hijab (head cover) in early adolescence (Al-Jayyousi et al., 2014). Elliot and colleagues (2015) interviewed Black, single, low-income mothers on the notion of

mothering practices. For these mothers, "Being a Good Mom" involves fending off dangers, injustices, and unpredictable encounters with poverty, racism, and sexism. Cultural differences to mothering practices find the intensive mothering practices to be excessive as parents shuttle their children from one activity to another. Instead, mothers spread their limited resources by centering on basic developmental needs and rule setting.

Sexual Orientation. Herrera's (2009) study on Chilean, lesbian mothers explores the perceptions of motherhood achievement. The women report reconciling the two identities of mother and lesbian becomes challenging. The women hid their sexual orientation in fear of losing their children or family. Lesbian women often refrain from identifying as homosexual due to potential legal discrimination towards the child custody decisions (Hequembourg, 2007). Pearson (2012) notes changes in child custody decisions regarding sexual orientation and unfit parenting. Most states require a nexus test by the court which "blinds" homosexual orientation and focuses primarily on factors predicting harm to the child. However, the question of harm relates only to homosexual couples since the court considers role-modeling and community inclusion as critical components in "normal" child development (Pearson, 2012). Understanding Pearson's (2012) recent contributions, lesbian mothers still experience stigmatization for both their sexual preference along with an alternative family structure (Bos, 2004; Goodman, 1980).

Lifestyle alters ideals on "good mothering" practices. Many mothers struggle to live up to societal expectations of "completely devoting oneself to the overall well-being of their children." Mothers contradicting intensive mothering ideals (i.e. career-invested, single and low-income, cultural differences, and sexual orientation) exhaust themselves

to meet the westernized standards of mothering. Yet, these mothers face conditions that essentially ensure failure and negatively impact the maternal identity development.

Maternal Identity and Becoming a Mother

Research efforts on maternal identity development established theories on “Becoming A Mother” (BAM). Life transition into motherhood includes a restructure of goals, behaviors and responsibilities that forms a new role in one’s self conception (Mercer, 2004). The spiraling, ongoing process of maternal identity continues throughout a woman’s psychosocial development whereas physical development demonstrates a more direct progression (Mercer, 2004; Kegan, 1982; Rubin, 1984). Mercer’s (1981, 1985) research characterized maternal identity as a sense of harmony, confidence, satisfaction, and attachment to infant in her role as mother. The woman’s maternal identity shapes her self-system. Her ideal image, self-image, and body image encompass her self-system. The woman compares her ideal self to both the self and body images she currently holds. Lower self-esteem and risk for role-failure in maternal identity status attributes to women who lack in reflection of desirable qualities, traits, attitudes, and achievements of motherhood (Mercer, 2004). However if a mother acquires new skills even when challenges present, a mother experiences congruence in her self-system and regains confidence in her maternal identity.

Despite the taxing role of mothering, the favorable outcomes of higher competence and satisfaction levels can produce a gratifying experience for a parent (Coleman & Karraker, 1998). Rogers and White (1998) conducted a panel analysis on previously collected data on marital quality and family life from the late 1980’s to the early 1990’s to identify factors on parenting satisfaction. Mothering as an identity role

was found to be more influential than marital status or occupation. Ross and Van Willigen (1996) concluded that women with children exhibit greater meaning in their lives than women without children (Arendell, 2000). Yet, conflicting research on parenting and well-being still remains. Young parents and parents with young children in the home report lower satisfaction levels combined with higher stress levels than those without children (Nelson et al., 2012; Mirowsky & Ross, 2002; Nomaguchi & Milkie, 2003). Nelson and colleagues (2012) investigated the controversial debate of reduced well-being in parents as they evaluated life satisfaction between parents and nonparents. The study revealed that parents reported higher levels of happiness, positive emotion, and meaning in their lives than nonparents. Both Kearney et al. (1994) and Coyer (2003) utilized qualitative research designs to depict stresses of addicted mothers and found motherhood to be a central social role amongst this population. Kearney, Murphy and Rosebaum (1994) found addicted mothers would make every attempt to continue her mothering role and give custody only as a last resort. Coyer (2003) determined that mothers in recovery wanted to maintain sobriety to fulfill a nurturing, dependable presence in their children's lives. When threats of custody towards their children and role as mothers presented, the women reconsidered the drug life and pursued immediate changes (Coyer, 2001; Kearney et. al, 1994).

Guilt and Shame in Motherhood

Mothers often experience guilt and shame due to perceived discrepancies between one's ideal self and actual self (Arendell, 2000). The fear of judgment from others contributes to one's negative evaluation of self (Liss et al., 2012). Qualitative, phenomenological research describes women envisioning the "motherhood myth" as the

norm, which leads to guilt when mothers cannot live up to the myth (Liss et al., 2012; Wall, 2010; Seagram & Daniluk, 2002). The descriptions of the myth include completely devoted mothers responsible for the development of their children. Liss et al. (2012) conducted a study utilizing a cross-sectional, self-report of on-line surveys in mothers with children ages five years and younger regarding feelings of maternal guilt, shame, fear of negative evaluation and maternal self-discrepancies. The research indicated that guilt and shame correlated with maternal self-discrepancy and negative evaluation. Higher fear in negative evaluation showed elevated levels in guilt, shame, and maternal self-discrepancy. The excessive investment and high standards of society to be a "good mother" can ultimately create feelings of depletion, inadequacy and sense of guilt (Liss et al., 2012).

The motherhood myth identifies women in various situations, including substance-abusing mothers, as the societal expectation. Women who use or are in recovery for substance abuse must often place their children with relatives or state-funded foster care (Baker & Carson, 1999). With this in mind, the negative beliefs toward self exacerbate. She begins to doubt her mothering capabilities and experiences greater levels of guilt and shame (Liss et al., 2012). Kearney et al. (1994) found that substance abusing women who lost custody of their children demonstrated an increase in frequency towards drug use. The mothers would drug-seek to deal with the feelings of loss. High risk, vulnerable women often lean on the effects of drugs and alcohol to deal with difficult emotions. Substance dependent women, in general, already encounter societal stigmatization due to their lifestyle choices. For mothers, the shame and guilt intensifies.

The community and media not only label her a social misfit, but an “unfit mother” as well (Brady & Ashley, 2005; Hardesty & Black, 1999; Kearney et al, 1994).

Unfortunately, mothers often go into “hiding” due to fear of negative evaluation and stigma avoidance. Women make attempts to balance their parenting and drug habits. Recovery pushes to the side and the vicious addiction cycle continues. Even with the mother's best intentions to care for her family, the challenge often becomes too great and neglect appears in the woman's caregiving (Liss et al. 2012). The research from Grossman and Schottenfeld (1992) recognized both feelings of guilt and shame in addicted women along with feelings of insufficient task mastery and perceived helplessness in their role as caregivers.

Maternal Deprivation and Caregiving Knowledge

John Bowlby and James Robertson discovered an interesting element to human life when observing the effects of maternal separation in hospitalized children (Bowlby, 1973). Bowlby's findings led him to theorize the importance of adequate mothering towards children's mental health. Children restrained from a warm, intimate, and continuous relationship with their mothers displayed at-risk potential for personality development damage. Bowlby suggested that a neglected child would grow up to be a neglectful psychopathic parent (Bowlby, 1969; 1973). Insufficient mothering practices or Bowlby's term “maternal deprivation” demonstrates long-term negative effects on a child including a wide range of anxiety disorders, depression, cognitive impairment or sociopathic characteristics (Bowlby, 1973).

The impact of addiction in parents contributes to adverse caregiving problems and poses risks to children. Bijure et al. (1992) studied exposure to danger in children whose

parents used drugs. The findings concluded that parents may have difficulty creating a safe environment for their children. Kumpfer and Turner (1990, 1991) examined relationships in substance dependent parents towards their family. The study showed that the families of drug users may lack essential components to relationships including bonding and attachment. Inciardi, Lockwood, and Pottieger (1993) researched drug dependent parents and priorities. The study indicated that the parent's drug seeking habit may surpass the child's basic physiological, safety, and social needs (i.e. love, attention, supervision, food, and clothing) (Baker & Carson, 1999).

Child Maltreatment and Risk Factors

Multiple studies have noted the link between child maltreatment and potential risk factors. The National Center on Child Abuse Prevention Research conducted surveys with child protection agencies within the 50 United States and found substance abuse to be the one of the two leading problems in 85% of the states displayed by families who reported child maltreatment (Wells, 2009). Another interesting report on child maltreatment was indicated by the National Clinical Evaluation Study, a collection of data compromising of 19 nationwide demonstration projects. The study reveals substance abuse and neglect in more than half the families (Berkeley Planning Associates, 1983). Dubowitz et al. (2011) notes Child Protective Service reports are often generated due to the mother's substance use. Of the mothers receiving substance abuse treatment, approximately 50% lost custody to at least one of their children (Canfield et al., 2017). Maternal substance use causes significant deficits on parenting through lack of involvement, limited responsiveness, inconsistency, controlling acts of discipline, harsh criticism, and extreme punishments (Suchman & Luthar, 2000). CASAColumbia (1998)

reports approximately five children a day die from abuse and/or neglect per year.

Unfortunately, child maltreatment leads in all trauma-related deaths in children under the age of five.

Volatile environments arise when stressful, routine caregiving and substance abuse combine. The appropriate responses when attending to a child's cues or providing adequate nurturing becomes impaired when a mother abuses substances. Many times, judgment, priorities, and/or consistent caretaking suffer when a mother becomes intoxicated or withdraws from substances. Drugs and alcohol often create a person to show aggression, paranoia, or anger. The situation fuels potential for child abuse and neglect to occur (Wells, 2009). Chemically dependent mothers who maltreat their children also suffer from a variety of perpetuating problems. Gustavsson and Rycraft (2008) noted several factors in mothers that coincide with child maltreatment – risky living arrangements, financial strains, domestic violence, and involvement with the criminal justice system. When high levels of stress, poverty, and lack of child care accompany maternal substance abuse, child neglect becomes evitable (Cash & Wilke, 2003).

Cash and Wilke (2003) studied the ecological model of maternal substance abuse and child neglect for women entering treatment. The study found a mother's family of origin, mother's substance abuse, mental health, risk factors in the family, and community risk factors predict increased likelihood for child neglect. In addition, the research suggests that mothers with greater levels of family interaction and positive perceptions in parenting display considerably lower signs of neglect. Supportive

resources that reduce or prevent parental abuse and neglect become extremely helpful when developing treatment options for mothers.

Prevention of Child Maltreatment

The United States Advisory Board on Child Abuse and Neglect recommends substance abuse treatment programs for preventing child abuse and/or neglect. Also, the U.S. Advisory Board (1995) promotes parenting classes as an intervention strategy to prevent child abuse and neglect by teaching basic parenting skills (Peterson, Gable and Saldana, 1996).

Coyer's (2003) research on mothers recovering from cocaine addiction also supported the data on adverse effects of drug use towards parenting. In the qualitative study, the investigator interviewed a sample of eleven (11) women discussing their perceptions of engaging in "good parenting" behaviors. Five themes emerged from the data analysis. Lack of a constant, structured household for the children and adequate parental presence (abandonment) were commonly expressed in the mothers. However, all the women identified poor parenting activities they sought to change from when they were using cocaine.

Ehrmin (2001) conducted a study with a sample of African American women in residential treatment for substance abuse. The study revealed potential barriers to treatment including unresolved feelings of guilt and shame surrounding perceived failure in the maternal role for women in recovery. Parents also demonstrated higher rates of self-blame when negative effects of their addiction impacted their children's health. Unfortunately, the emotional distress in the parents appeared to lead to frequent relapse and a continuation of the addiction cycle (Bennett, 1995; Coyer, 2001; Ehrmin, 2001).

Even though addicted mothers show specific areas of deficiency in parenting practices (Velez et al., 2004), Lief (1985) provides evidence that when a mother receives the necessary support and guidance, she can become an adequate parent. Aside from the children receiving valuable services that strengthen the attachment and developmental needs from the parenting classes, the mother also benefits from newly acquired knowledge which enhances her self-esteem. As levels in her self-esteem rise, she begins to feel a sense of empowerment in her role as mother. As mothers progress through treatment, she faces challenges when balancing recovery and motherhood. She must address her children's needs while concentrating on her own treatment concerns. Comprehensive gender-specific treatment programs recognize the potential risks to children when mothers experience psychological distress (Nicholson, 2010). Accessibility to children throughout the program becomes dispersed as children attend school, child care, group, and/or participate in residential family-oriented activities during the day while mothers focus without distraction on treatment (Graham et al., 1997). Also, the programs are monitored twenty-four (24) hours for security purposes and staff supervises mother-child interactions to offer support when necessary (Suchman et al., 2008). Regardless, mothers are required to maintain full responsibility of children as this fosters quality parent-child interactions (Graham et al., 1997).

Social Cognitive Theory Applied to Self-Efficacy

Parenting alone challenges many regardless of the impact of substance abuse. Challenges in parenting may create stress, doubt, uncertainty and other unexpected events (Kuhn & Carter, 2006). However, human beings desire a sense of control over their lives (Bandura, 2001). Social cognitive theory explains the innate need for control in one's

environment to produce beneficial gains for an individual (Benight & Bandura, 2004). As so, parents exercise this control (e.g. a parent requesting for the child to complete a chore) for the beneficial outcomes (the child responding by following through on task) (Teti & Gelfand, 1991). When a parent encounters adversity such as a temper tantrum in a child, an inability to exercise control or reluctantly “gives in” to the child results in diminished feelings of competency toward childrearing and future predicted instances of “loss of control” or failures (Coleman and Karraker, 2003). Lack of control lowers perception in self-efficacy causing parents to give up more quickly during hardship (Kuhn & Carter, 2006). Avoidance in activities also pertains to low self-efficacy since parents with less-efficacious perceptions on parenting maneuver around difficult tasks such as disciplinary action (Coleman & Karraker, 2003). Unfortunately, parents with lower self-efficacy derive less pleasure in parental experience and anticipate low beneficial gains (Ardelt & Eccles, 2001). Social cognitive theory, in regards to parenting, discusses parental motivation in caretaking and introduces the importance of self-efficacy.

Bandura (1982) theorized that self-efficacy, an individual's belief in ability to complete a specific task successfully, is fundamentally necessary in order for an individual to learn a specific behavior and make a change. (Coleman & Karraker, 1998) applies the same concept towards parenting (e.g. a mother who is confident in her parenting capabilities demonstrates effective parenting behaviors).

Bandura's social cognitive theory further explains self-efficacy development and mechanisms for intrinsic interest and personal satisfaction in activities (Coleman & Karraker, 2000; Bandura, 1997). Social cognitive theory suggests individuals become

personally invested in activities when they feel successful in activity outcome (Pajares, 2002; Coleman & Karraker, 2000). Achievement or activity success reinforces self-satisfaction in pursuing the activity and derives personal fulfillment in task completion (Pajares, 2002; Bandura, 1997). However, Bandura (1997) suggests not all behaviors toward task completion produce enjoyment. An example includes a mother who demonstrates high efficacious beliefs in her parenting, but engages in disciplinary actions when appropriate (Ardelt & Eccles, 2001). The disciplinary behaviors for the mother may not always create a sense of pleasure, but necessary in child-rearing practices (Coleman & Karraker, 2003). Parents perceiving themselves as worthwhile and essential to the child's life, form a sense of accomplishment (Ardelt & Eccles, 2001). Social cognitive theory in relation to self-efficacy emphasizes the notion that people continuously engage in activities that create self-satisfaction, personal fulfillment, and a sense of accomplishment regardless of the unpleasant associated behaviors (Bandura, 1997).

Maternal Self-Efficacy

Maternal self-efficacy refers to the mother's perceived ability to perform the tasks associated in the parental role. Perceived parental self-efficacy differs from "parental confidence" and "parental competence" by four distinguished contributors - successful task-mastery experiences, past childhood memories on parenting, verbal persuasion and cues on affective and physiological states (de Montigny & Lacharite, 2005). By targeting and intervening on any of the four contributors, one's perceived self-efficacy is likely to improve (Pennella et al., 2012).

Task-Mastery. The first component of perceived maternal self-efficacy involves a mother's task-mastery experience. She evaluates her efforts in a relatable experience and

consider her performance level. For example, mothers' with past experiences in a childcare setting prior to becoming a mother demonstrate higher levels of self-efficacy in infant care than those without among women with toddlers (de Montigny and Lacharite, 2005). However, prior practice in a task does not guarantee mastery or higher self-efficacy levels. An individual continuously participating in similar simplistic tasks or avoiding difficult, unfamiliar tasks may struggle to form a strong sense of self-efficacy (Bandura, 2006). An individual must step out of his or her comfort zone and attempt challenging tasks to increase self-efficacy (Brown et al., 2013). Working through obstacles with success leads an individual to view future situations as achievable challenges (Troutman et al., 2012). Williams and Williams (2010) report "individuals with high levels of self-efficacy approach difficult tasks as challenges to master rather than as threats to be avoided" (pp. 455) when studying the relationship between self-beliefs and performance. Of the four, task mastery experience provides the most significant source of information regarding one's capabilities and limitations in comparison to the others.

Remembered Experiences and Vicarious Learning. Past childhood experiences serve as a reference point for parents. A mother judges her ability to succeed in caretaking situations by transmitting old memories of childrearing from childhood that she observed and her capacity to model the behavior (Coleman & Karraker, 1998). She transmits the same experiences of love and acceptance or rejection and devaluation from her parents to the relationship with her child (Mercer, 2004). During childhood, sense of self develops (Bandura, 1997). Children with parents that demonstrate affection, acceptance, and sensitivity develop a sense of self exhibiting competence, worthiness,

lovable, and expectations that others respond to their needs (Leerkes & Crochenberg, 2002). Childhood memories and the emotional experiences attached serve as a model of how to perceive and interpret the world, predict future outcomes, and plan behavior in relation to goals during adulthood (Nicols et al., 2007). Positive childhood experiences promoting a well-developed sense of self influence maternal self-efficacy (Leerkes & Crochenberg, 2002).

By observing others (models) succeed or fail, a mother determines her own capabilities by comparing similarities between the model and herself (Coleman & Karraker, 1998). For example, a mother watching another woman accomplishing a child-rearing practice determines her own competence in the same task (McCarter-Spaulding & Kearney, 2001). The vicarious experience influences the mother's belief that she, too, has the capability to accomplish the observed behavior. The more the mother associates with other women, the more she finds herself successful in the task (Abarashi et al., 2014). A familiar expression "If you can do it, so can I" often accompanies the influence to partake in the activity (Brown et al., 2013).

Vicarious learning increases self-efficacy. Educational materials including books and videos or hearing from other mothers provides as vicarious learning (Brown et. al, 2013). Mothers enrolled in a prenatal class for breastfeeding watch videos with an instructor that demonstrate breastfeeding mechanics with a doll. Women attending a breastfeeding intervention program during the prenatal period displayed increases in their self-efficacy (Hatamleh, 2012).

Verbal Persuasion. Building self-efficacy involves reinforcing through verbal persuasion. Mothers, who struggled with breastfeeding preterm babies in a neonatal unit,

showed enhanced maternal perceptions of parental self-efficacy when nurses encouraged and supported the women (Swason et al., 2012). Bandura (1997) found an individual's level of self-efficacy maintains when their significant other verbally expresses beliefs in the partner's capabilities. Social support from a partner boosts a mother's recognition of her maternal performance. Positive verbal feedback such as "You're doing a great job" from a partner reinforces the mother's efforts in parenting. Also, a partner advising the mother to brush aside discouraging failed attempts (i.e. discussing how temperament may influence the child's response and not mother's fault) increases the mother's beliefs in her maternal duties. Pennella and colleagues (2012) found providing positive feedback as an intervention to mothers with preterm infants improves her conception in parental self-efficacy. Redmond (2010) suggests that a credible source (i.e. partner, health care workers, nurses, other mothers) offering verbal persuasion increases one's self-efficacy beliefs compared to disputable source. Verbal encouragement and support from a reliable source assists in developing a mother's perceived self-efficacy.

Physiological and Affective States. When people judge their capabilities, individuals pay close attention to somatic cues in their body. Somatic symptoms convey one's physiological and affective states (Bandura, 1997). Individuals rely on information gathered from somatic indicators to communicate signs of dysfunction and contemplation on one's success or failure in a specific situation (Brown et al, 2013). Feelings of stress, anxiety, worry and fear negatively impact self-efficacy and produce a self-fulfilling prophecy that "one will fail" at a fear-induced task (Pajares, 2002). Stressful situations often activate physiological arousal in individuals (Bandura, 1997). The emotional arousal from stress may negatively affect perceived self-efficacy and alters one's ability

to cope with the situation. Difficult temperaments in infants or behavioral problems in children create stress in a parent's physiological well-being. The stress response acts as a reinforcer in one's ability or inability to parent (de Montigny & Lacharite, 2005).

Frequent fluctuations towards affective and physiological states cause self-efficacy to reduce in individuals according to Reece and Harkless (1998) who studied self-efficacy, stress and parental adaption in childbearing families. The stress response cues a mother to evaluate her abilities to successfully complete the task or potentially fail.

Parents either rise to the occasion or assume failure and flee task participation. Highly efficacious mothers persevere during challenging child-rearing moments and display less negative emotional arousal (Coleman & Karraker, 2000). However, mothers feeling doubtful, sensing high anxiety in adverse situations, predicting task failure, receiving challenges as threats, or avoiding difficult child-rearing moments display lower self-efficacy (Weaver et al., 2008). Parenting encounters many complex, unpredictable situations especially in early childhood (Coleman & Karraker, 2000; 1998). Mothers struggling low self-efficacy report higher rates of problematic behavior in their young children (Weaver et al, 2008).

The four contributors of self-efficacy impact an individual's belief that she maintains control over events in her life. When self-efficacy beliefs begin to form, Strecher and colleagues (1986) suggest an individual has a foundation for what she chooses to participate in, investment of efforts towards specific activities, and a set amount of time the individual retains interest despite obstacles and failures. Bandura (1982) revealed that low levels of efficacy result in poor persistence, depression and self-

blaming attributes in individuals. This means that self-efficacy has a major influence on parenting practices.

Parental self-efficacy beliefs significantly influence the quality of care provided to children according to growing research on parent practices. Teti and Gelfand (1991) describe parenting tasks among mothers with first year infants in the home environment. The study elaborated on several areas of self-efficacy and provided a description of the maternal behavior in each parenting task. Responsive parenting includes facilitation a child's cognitive development, nurturance and emotional growth in a child, providing adequate structure and discipline, and maintenance of physical health (Laundry et al, 2008; Eshel, 2006). Landry et al. (2008) further explains the description of maternal behavior. A mother involved in developing cognitive abilities in her child encourages exploration, play, and other stimulating learning activities in the child (Laundry et al. 2008). A mother demonstrating warmth, sensitivity, and attentively listening to her child's needs facilitates the child's emotional growth (von Suchodoletz, 2011). Routine, structure, and discipline provided by mothers will set age-appropriate rules, maintain consistent routines, and apply necessary discipline for child's understanding of safety and limitations (von Suchodoletz, 2011, The Canadian Paediatric Society, 2004). Finally, responsive maternal behavior involves a mother attending to annual physical exams, providing proper nutrition, and detecting signs of illness when maintaining the physical health in her child (Eshel, 2006). Coleman and Karraker (2003) note the mother's ability to respond and provide quality parenting towards her child's overall well-being impacts the maternal self-efficacy beliefs.

Stigmatized Lifestyle and Impact on Mothering

Mothering through a socially unacceptable lifestyle only adds to the multitude of chronic stress many mothers face on a daily basis and negatively influence the maternal self-efficacy beliefs.

Mothering through Mental Illness. Mothers with mental illness struggle with recognition as a mother and ability to parent successfully. The stigma attached to mental illness portrays individuals as crazy, dangerous, or sick (Phelan et al., 1998). Health care professionals often criticize mothers with serious mental illness due to genetic considerations. Having a parent with mental illness compromises the genetic vulnerability and increases the likelihood of psychiatric illness in the child (Montgomery, 2005). A child may develop developmental or health complications from deficits in parenting caused by the mother's mental illness (Boursnell, 2007). Parental deficits often associated with mothers with mental illness include emotionally unavailable, disorganized, inconsistent, and competing for the "child role" versus being a parent towards the child. According to Oyserman and colleagues (2005), a parent's lack of responsiveness and ability to meet parental demands becomes compromised when episodic mental illness arises. The mother may display limitations in her capacity to parent through her mental illness risking the child's fundamental needs (Oyserman et al., 2000).

Much of the past research on women with mental illness focuses on the attachment bond between mother and her child (Boursnell, 2007). Mothers with depression interact for shorter durations of time and provide less social contact impacting the parent-child attachment. Families with major affective disorders show more insecure attachment styles especially in mothers who experienced depression for a majority of the

child's life (Oyserman et al., 2000). Studies with mothers diagnosed with schizophrenia, borderline, bipolar, and substance abuse may exhibit challenges with maternal reflective attunement, an essential component related to sensitive caregiving, since the disorders struggle to understand and reflect the thoughts, feelings and motivations of others (David, 2011). In addition, Oyserman et al. (2005) report mothers with serious mental illness display lower confidence in child-rearing abilities, extreme forms of discipline (permissive or harsh), and lower levels of academic achievement in their children. Unfortunately, children with parents suffering mental illness often end up in alternative settings (i.e. foster care), show more behavioral concerns, and exhibit more psychiatric disorders (Mowbray et al., 2001).

Negative stigma continues to surround mental illness. Lacey et al. (2015) discusses the harsh criticisms parents with mental illness face regarding abilities to care for oneself in conjunction with further demoralizing judgments on caring for another (child). Mothers with mental illness often fear losing their children over the pre-conceived notations of inadequate parenting in the mentally ill (Boursnell, 2007). Yet despite the negative societal attitudes, mothers with mental illness experience similar meaningfulness and fulfillment from the parental role (Lacey et al, 2015). Diaz-Caneja and Johnson (2004) note that the parenting role among parents with severe mental illness provides a sense of purpose and incentive towards recovery. Boursnell (2007) suggests mothers with mental illness face barriers to the ideology of "good enough parents" and choose to parent alone to avoid potential negative attitudes. The overwhelming demands of parenting alone produce stress and strain on mothers with mental illness. Without outside support, motherhood may exacerbate mental health issues (Davies & Allen,

2007). The capacity to adequately parent becomes limited and the child's optimal developmental growth suffers (Mowbray et al., 2001). The mother's self-efficacy and competence lowers over problematic parenting practices (Oyserman et al., 2000; Davies & Allen, 2007). The agonizing stigma attached to mothers with mental illness becomes self-fulfilling as her mental issues impair her function to parent while she isolates herself to avoid harsh criticisms from society risking her child's developmental needs.

Mothering through Prison. Mothers in prison defy cultural norms related to mothering and ideal child-rearing practices. Incarcerated mothers face harsh criticisms in their role as mothers, and challenge the perspective on families, parenting, and caretaking (Kennedy, 2011). Society views women in prison as "more pathological" than men since a majority of incarcerated women struggle with histories of mental illness, drug use and abusive relationships (ShIPLEY & Arrigo, 2004, Kennedy, 2011). The stereotypes surrounding incarcerated women include psychological instability, a fixed addict, and continued victimization in abusive relationships (ShIPLEY & Arrigo, 2004). The preceding stereotype on women criminals only heightens the negative messages towards incarcerated mothers (Kennedy, 2011).

Ideal mothering standards require women to devote most of their time and energy to their children. Imprisoned women devote a majority of their time behind bars and child-rear at a physical distance. Visitations, telephone calls and physical contact with their children remains limited due to constraints in the prison, funding for phone calls or travels, and inconsistent communication efforts with children. Mothers in prison may make attempts to connect with their children by sending cards and letters to their children, but the emotional expression of feelings becomes ineffective (Bernstein, 2005).

The failure in communication between children and incarcerated mothers signals parenting deficiencies. The deficiencies may question a mother's fit or suitability as a parent. The underlying doubt manifests as a mother's lack of devotion and commitment to her children, which inadvertently; suggests insufficient mothering practices for mothers in prison (Kennedy, 2011).

Mothering through Prostitution. Another alternative lifestyle with limited research focuses on mothers that engage in prostitution. Dalla (2004) describes these mothers' painful experiences of not meeting the ideal maternal role. The women discuss the impact and neglectful nature of the sex industry on their children. Mandiuc (2014) found living conditions, housing stability and child supervision arrangements potentially harmful to the child's safety among mothers in prostitution. The risk factors including drugs and/or alcohol presence, exposure to strangers (clients) in household, and witnessing violence pose safety concerns towards the child's growth and development (McClelland & Newell, 2008; Mandiuc, 2014). McClelland and Newell (2008) discuss how parental responsibilities and involvement in prostitution promote stress in mothers. Mothers involved in prostitution often negatively cope by consuming alcohol and drugs to relieve feelings of shame and low self-esteem (Mandiuc, 2014; McClelland & Newell, 2008). With more focus being placed on deviant behavior patterns and job roles of her lifestyle, society fails to even accept women involved in prostitution as mothers (Dalla, 2004).

Mothering through Addiction. Mothers who use illicit drugs demonstrate an alternate view to the "Good Mother" hegemonic model. Children of drug-using parents become exposed to high risk and chaotic lifestyles that can negatively impact the child's

development (Denton et al., 2002). Banwell and Banner (2006) describe the environment conditions such as criminal behavior, drug-dealing, witnessing overdoses, financial strains, domestic violence, inconsistent schedules, frequent moves, and child protective services involvement. In the eyes of Western society, drug-using mothers appear as “a passive parent with an inability to cope.” Chemically dependent mothers lack the ideals of intensive mothering and unfortunately prove their “poor parenting” by raising less-than-perfect children (Barnard, 2004). In Hardesty and Black's (1999) study on addicted Latina women, the women discuss living a dual life. The mothers juggle everyday drug activities with their maternal requirements in child-rearing. The women actively seek to “do it all” and make every attempt to meet the intensive mothering ideology. Eventually, drug activities consume most of their time, and the negative evaluations from others create unbearable tension.

Mothers that deviate from societal expectations and encounter frequent stressors demonstrate perceived impairments in confidence and comfort in her caregiving abilities (Coyer, 2001)

Women, Addiction, and Maternal Self-Efficacy

Women with Addiction. Even though males outnumber females in substance abuse issues, one in five American women will abuse or exhibit dependency on drugs and/ alcohol at some point in her life (The National Center on Addiction and Substance Abuse, 1996). Approximately, 6 million women in the United States abuse alcohol, over 2.5 million women abuse illicit drugs, and an outstanding 7.5 million females misuse or abuse prescription drugs (NCASA, 2006). The trends of primary substances across ethnic and racial groups include Caucasian and American-Indian/Alaska-Native: alcohol, Asian

and Pacific: methamphetamine, African-American: crack/cocaine, and Hispanic/Latina: heroin (CSAT, 2009). Sadly, women typically begin using substances around the age of twenty (20), and the introduction to drugs and alcohol for females often comes from outside sources (i.e. alcohol and marijuana from peers; illicit drugs from a partner or spouse). Women initiating in substance use report influence from relationships, negative affect, and stress (CSAT, 2009). Women present with higher rates of co-occurring psychological factors such as mood and anxiety disorders. Women use substances as a way of regulating affect to depressed mood, anxiousness, and trauma-induced stress (Covington et al., 2008). History of sexual and physical trauma in women show higher rates of substance abuse disorders and initiate use as a means to self-medicate (NCASA, 2006). Women report stress as the primary problem rather than chemical dependency when entering substance abuse treatment (CSAT, 2009). Stressors identified by women in addiction treatment that promote relapse include unprocessed trauma, unemployment, problems with the legal system, health problems, housing/ homelessness issues, and caring for dependent children (CSAT, 2009; Covington et al., 2008; Wallen, 1998). The act of caring for children may serve as a mental resource or mental burden.

Characteristics of Mothers with Addiction. Many women abusing alcohol and drugs fall within the child-bearing age. Mothers who use illicit drugs or alcohol struggle to supervise, provide nurturance, and assist their children with daily life needs. Mothers often find themselves facing custody issues regarding their children. Children become a motivating force with mothers struggling with chemical addiction (Wallen, 1998). Pregnant women reduce or refrain from chemical use during pregnancy and initiate treatment efforts to “get clean” (Hardesty & Black, 1999; CSAT, 2009). According to

CSAT (2009), pregnant women ranging from 15 to 44 years of age showed only 5 percent of illicit drug use compared to non-pregnant women who reported a significantly higher rate of use at 53.2 percent. Yet, sobriety after childbirth and treatment retention seems to decline. Due to women socialized as caregivers, mothers focus more energy on caring for others (i.e. children) and place less attention on recovery needs (Hardesty & Black, 1999). Unfortunately perpetuating the cycle of addiction, the mother relapses and child protective services removes children from the household (Kearney et al., 1994). Mothers endure abundant feelings of shame and guilt which lowers the women's self-esteem and self-efficacy.

Substance Abuse Treatment Programs for Mothers. With maternal substance abuse on the rise, mothers benefit greatly from effective treatment interventions. The development of gender-specific treatment programs in recent years focuses on the comprehensive needs of women in recovery (Milligan, 2010). Niccols and colleagues (2012) discuss the services provided to women including “group and individual addiction treatment, maternal mental health services, trauma treatment, parenting education and counseling, life skills training, prenatal education, medical and nutrition services, education and employment assistance, child care, children's services, and aftercare” (pp. 2). Milligan et al. (2010) conducted a meta-analysis on integrated treatment programs for chemically dependent women. Findings from the analysis suggest gender-specific programs offering prenatal care, child care, and parenting report greater abstinence rates and reduction in substance use (Milligan et al, 2010; Ashley et al., 2003). However, Barnard (2004) reports mothers attending parent trainings when in treatment show higher levels of self-esteem, parenting knowledge, and attitudes. Mothers learning parenting

skills during treatment show improvements in child outcomes (i.e. reduction in impairments towards the child's physical growth, health, cognitive functioning, and school performance). Niccols et al. (2012) notes mothers retain custody 5 times as much at the end of treatment when children reside at the facility. Integrated treatment programs show effectiveness in decreasing substance abuse among mothers, but research remains limited due to small comparison groups, missing data, and quality of study. However, the positive outcomes (i.e. increased self-esteem, parenting knowledge, and attitudes) for mothers benefiting from the integrated treatment programs positively influences their overall maternal self-efficacy (Sanders & Woolley, 2005; Barnard, 2004).

Maternal Self-Efficacy in Mothers with Addiction. Understanding the impact of efficacious caregiving practices, research has begun to explore the concept of maternal self-efficacy. Mothers evaluate their own abilities to successfully manage tasks and situations in parenting (Sanders & Woolley, 2005). She also applies caregiving memories from childhood into her mothering practices. Women with childhood experiences filled with love and acceptance report higher levels of self-esteem and confidence. Positive childhood experiences contribute to a positive sense of self. Maternal self-efficacy influences the mother's overall sense of self (Leerkes & Crockenberg, 2002). Highly efficacious mothers frequently engage in maternal behavior to soothe their distressed child's needs. When efficacy lowers, mothers become easily discouraged, lack persistence, and become unable to adapt in difficult situations (Bandura, 1999; Leerkes & Crockenberg, 2002).

Teti and Gelfand (1991) support the findings that demonstrated mothers with higher perceived efficacy display more adequate parental practices (de Montigny &

Lacharite, 2005). Later in 1996, MacPhee and colleagues conducted a similar study to Teti and Gelfand (1991), but across all ethnic groups of 500 low-income parents. The findings indicate perceived parental efficacy displayed strong relational links to child-rearing practices as well. Teti and Gelfand (1991) determined that high maternal self-efficacy was linked to maternal sensitivity and warmth while Stifter & Bono (1998) added one other attribute – responsiveness (Sanders & Woolley, 2004) . Maternal self-efficacy is essential as it directly impacts the quality of care towards children.

Improvements in self-efficacy can rebuild the quality of mother-child interactions. Baldwin and colleagues (1999) noted that chemically dependent women often expressed the desire to nurture positive interrelationships including the relations with their children. Coyer (2001) notes that women often focus solely on the basic needs of their children rather than the emotional support. The chemically dependent women found mothering to be explained as a list of caregiving tasks, rather than, a relationship. The sample of women in the study described wanting to “be there” for their children and witness significant life events in their children’s lives (Banwell & Bammer, 2006).

In numerous studies, recovery meant more than “getting clean” to female addicts (Pursley-Crotteau & Stern, 1996; Hardesty and Black, 1999). It involved “creating a new life.” For mothers in treatment, it meant recreating their roles as mothers. Treatment and sobriety were steps into reclaiming their children whether the children were given up voluntarily or removed by a state agency. Children motivate women to attend treatment and maintain sobriety (Hardesty and Black, 1999). In addition, Coyer (2003) suggests that length of sobriety displays improvements in parenting beliefs and behaviors of women in substance abuse treatment, whereas, addiction leads to negative outcomes (i.e.

incompletion of tasks, meddling behavior, and unpleasant disposition when intoxicated) in parenting behaviors (Raynor, 2013).

Summary

With substance abuse addiction on the rise in mothers living in the United States, an alarming 15 percent of all American women between the ages of 15 and 44 years of age will abuse alcohol or illicit drugs (Connors et al, 2003). Of those women, most hold an important role in their families as mothers (Watson & Parke, 2009). Mothers often encounter challenges when attempting to balance their addiction and the responsibilities of parenthood placing their children at-risk. Yet, only about one-third of women access treatment services for substance abuse disorders (O'Reilly, 2010).

Chemically dependent mothers face stigma as both "Societal Deviants" and "Unfit Mothers" (Watson & Parke, 2009) Past research on child maltreatment focuses on the lack of caregiving abilities among addicted mothers, dangerous living environments for children, and the deficits in the child's physical, socio-emotional, and cognitive development (Wells, 2009; Coleman & Karraker, 2003). Child protective services often become involved and remove children from home (Baker & Carson, 1999). Mothers abusing alcohol and drugs experience immense guilt and shame which perpetuates the cycle of addiction (Liss et al., 2012).

The recent developments in women's addiction and gender-specific treatment identified needs for mothers and children. Treatment programs that offer integrated services show higher entry and retention rates among women (Lungren et al., 2003). The integrated treatment programs provide services for children, child care, and parenting skills (Niccols, 2012). The inclusion of children improves self-efficacy in mothers and

the mother-child interaction (Graham et al., 1997). Maternal self-efficacy influences her quality of care towards her children (Teti & Gelfand, 1991).

Existing research focuses on parenting practices, specialized treatment programs, and retention among mothers who abuse alcohol and illicit drugs. Limited research explores mothers at various stages of recovery and the influence of children when in treatment. This study addresses the role of mothering at various stages of recovery and the perceptions on maternal self-efficacy. The findings of the study contribute to a deeper understanding of a mother's journey through recovery while identifying potential needs in women's treatment programs for substance abuse.

CHAPTER III

RESEARCH METHODS

The purpose of this study is to gain a better understanding of the lived experiences of women mothering through recovery. Moustakas's (1994) transcendental phenomenological approach explores the rich descriptions of mothering for women attending outpatient services for substance abuse.

Research Design

Qualitative research captures and brings forth the world. The development of qualitative research forms from social inquiry - how people interpret and make sense of their experiences (Yin, 2011). The inquiry leads researchers to gather information and generate an understanding of social reality from individuals, groups, and cultures (Daly, 2007). By using qualitative approaches, researchers explore the behavior, perspectives, and experiences of the people they study (Creswell, 2013). For this study, the researcher explores the lived experiences of motherhood through women in recovery and make this portion visible to the world.

Characteristics of Qualitative Research. Qualitative research offers a unique approach to social inquiry varying from quantitative research methods. The researchers examine human life in its natural setting (Willig, 2008). Meanings and interpretations appear surrounding the participants' experiences and behaviors. The researcher examines the multiple realities of participants to convey an essence (Daly, 2007). The multiple perspectives form a definition of this particular essence allowing the researcher to use thick, rich descriptions to educate the rest of the world (Creswell, 2013). Education

provides knowledge. Knowledge produces power. Power from knowledge transforms the world.

Benefits to Qualitative Research. Qualitative research offers advantages when looking for a complex, detailed understanding of the issue. The researcher gathers detail by talking directly with people in their natural setting (Creswell, 2013). This allows for individuals and groups to disclose stories that may expand knowledge on past literature or assumptions. The qualitative approach empowers individuals to share stories that may be silenced or unmeasurable in quantitative research (Anderson, 2010; Creswell, 2013). Quantitative measures and statistical analyses struggle to capture the complexity of a problem (Creswell, 2013). However, the researcher utilizes unrestricted flexibility and appropriate sensitivity to uncover the context in qualitative research. Also, qualitative research provides explanations to given responses in quantitative research (Anderson, 2010). Theory development may evolve from the acquired data collection in qualitative research. Another benefit includes elaborating on past theories that are often general with limited descriptions (Choy, 2014; Creswell, 2013). By providing deeper thoughts and behaviors of those who have experienced the issue first hand, a fuller understanding develops. Qualitative research provides depth while displaying openness to generate a detailed picture of why people behave in certain ways and their feelings associated with these actions (Choy, 2014).

Approaches to Qualitative Research. To study qualitative inquiry, five main methodological approaches assist in the understanding of a problem or issue. Creswell (2013) notes the five strategies – narrative, phenomenology, grounded theory, ethnographic, and case studies. The methodological approach justifies the selection

process of the researcher on approaching data collection in a particular fashion (Wertz, 2005; Creswell, 2013). This research study utilizes a phenomenological approach to explore the lived experiences of mothers in outpatient substance abuse treatment.

Phenomenology

Diamond (2000) states, “a phenomenological, subjective perspective is required to understand the meaning of addiction, the self, and the world” (p. 14).

Phenomenology focuses on understanding the experiences of consciousness and asks “What is this or that kind of experience like?” (van Manen, 1990, p.9). By using phenomenology, the researcher describes the commonality of the phenomenon of all the participants. Phenomenology has two main approaches – transcendental and hermeneutic. Transcendental (descriptive) phenomenology involves the researcher removing prior knowledge and personal experiences while studying the lived experiences. The researcher attains transcendental subjectivity by utilizing techniques to bracket bias and remain neutral (Lopez & Willis, 2004). Hermeneutic (interpretive) phenomenology differs by including the researcher’s interpretation, refutes bracketing, and looks for the hidden human experience. Both approaches to phenomenology seek to construct the lived reality of participants as well as searching for a universal meaning of the phenomenon (van Manen, 1990). This study utilizes a transcendental phenomenological approach.

Transcendental Phenomenology. The core of transcendental relies on meaning, design inquiry, and data collection portraying the human experience. Transcendental means “everything is perceived freshly, as if for the first time” (Moustakas, 1994, p. 34). In order to accomplish openness on human experience, researchers must place aside prejudgments or brackets their experiences as much as possible. This provides a fresh look and collection of wholeness on the particular phenomenon of interest (Moerer-

Urdahl & Creswell, 2004). Transcendental phenomenology fixates on the descriptions of experiences from the participants while following systematic steps to data analysis (Creswell, 2013).

Moustakas' Phenomenological Method. Moustakas (1994) describes the methodological structure of transcendental phenomenological research as “a series of methods and procedures that satisfy the requirements of an organized, disciplined, and systematic study” (p.103). The phenomenological method intertwines four processes (i.e. the Epoché, Phenomenological Reduction, Imaginative Variation, and Synthesis) when understanding the nature, meaning, and essences of lived experiences (Moustakas, 1994).

Gazing upon a phenomenon in a fresh and open consciousness while suspending prior reference to knowledge and experience involves the epoché process (Willig, 2008). The epoché process relates similarity to a “clearing space” for the mind (Moerer-Urdahl & Creswell, 2004). Yet, not all elimination of reality occurs. Moustakas (1994) discusses another dimension of epoché. Reflective-meditation invites the researcher's thoughts of preconceptions and prejudgments to enter the consciousness while allowing the ideas, biases, and presumptions to leave freely (Moustakas, 1994). The researcher writes out invading thoughts until the consciousness freed and a fresh approach to the situation established (Lin, 2013). In the epoché process, the researcher frees herself from positioning a stance and perceives the phenomenon in pure form.

Following epoché, the researcher engages in Phenomenological Reduction. The process of Phenomenological Reduction involves describing the textual qualities of the experience. For the researcher to fully grasp the nature of the phenomenon, a reflective process of “looking, noticing, and looking again” offers possible shifts in a perspective

(Lin, 2013; Moustakas, 1994). The researcher assumes all layers of information contain equal value in portraying the phenomenon through *horizontalization* (Moustakas, 1994). As the researcher examines the statements regarding the experience, the researcher deletes repetitive, irrelevant, or overlapping information (Moerer-Urdahl & Creswell, 2004). Thus, remaining statements or horizons attributes the purest, precise textual meaning to the phenomenon (Moustakas, 1994). The researcher proceeds to cluster the horizons into themes and meaning emergent may begin to evolve.

Meaning evolvment from textual description develops through the use of imagination in multiple perspectives. The researcher considers varied possibilities through the process of Imaginative Variation (Moustakas, 1994). The structural descriptions illustrate the essential structure to phenomenon and answers "How did the experience of the phenomenon come to be what it is?" (Moustakas, 1994, p. 98).

The researcher gathers the textual and structural descriptions into an integrated statement revealing the essences and meanings of the phenomenon (Creswell et al., 2007). The final process in the phenomenological method utilizes synthesis to explain the entire experience of a phenomenon (Moustakas, 1994). The Synthesis of Meanings and Essences establish knowledge on the phenomenon. Phenomenological research demonstrates the researcher's best attempts through imaginative and reflective processes to capture the essences of a phenomenon at a particular time and place.

Assumptions and Rationale for Design

Thus, a transcendental phenomenological approach is well suited for this study investigating the lived experiences of mothers attending outpatient substance abuse treatment. The purpose of transcendental phenomenology involves understanding of the

human experience in its whole totality through in-depth and multiple interviews between the researcher and participants (Creswell, 2013). The researcher implemented bracketing, thick descriptions from the participants, and the researcher's intuition suggested in phenomenological studies. The researcher engaged in bracketing to remain open and abstain from pulling in personal knowledge, scientific facts, explanations, and predictions on subject content (Wertz, 2005). Rich, thick descriptions explaining the participants' experiences assisted the researcher in unraveling the phenomenon being investigated. Also, Creswell (2013) suggests utilizing the researcher's intuition, imagination and universal structures to assist in conception when attaining a picture of the experience. For example, my intuition guided my clinical judgment when questioning a client to reveal underlying suffering that needs addressing during session. The new information brought forward by my client assists in conceptualizing the problem and developing a beneficial treatment plan.

Participants, Setting, and Role of the Researcher

Participants. The selection of participants for this study included mothers who attend outpatient treatment services for chemical dependence. Creswell (2013) recommends purposeful sampling as a strategy for selecting participants in phenomenology. The criterion for phenomenological research requires participants to have experienced the phenomena of interest. Mothers attending outpatient alcohol abuse treatment met the criteria for this research study.

The eligibility requirements for the sample consisted of women, eighteen (18) years or older, attending outpatient treatment services for alcohol abuse. Also, the women had at least one living child during the time frame of the study with a prior history of

rehabilitation services or three (3) counseling sessions for alcohol, but not excluding other substances. Due to the continuum of motherhood, time restraints, and convenience sampling, the researcher recruited mothers with children varying in age to participate in the study. Also, the recruitment for racial and ethnic backgrounds included all groups. For this study, exclusion factors remained limited due to a relatively small sample size. Exclusion factors included intoxication at time of interview, non-English speaking, without children, and poor mental health status determined by researcher. The researcher performed a mini mental health status examination to assess participant's orientation, attention, calculation, recall, language, and motor skills in functioning (Ramirez et al., 2010) (See Appendix G).

This study conducted interviews with twelve (12) female participants reaching saturation. The recommendations for three (3) to ten (10) participants from Creswell (2013) allows for the researcher to collect extensive detail on each participant while providing multiple perspectives that generate themes identified in a cross-case theme analysis. For the study, purposely sampled women (i.e. adult females with at least one living child, proficient in English, attending outpatient treatment for alcohol abuse, and consented to voluntarily participate in study) offered insight on the perspectives of motherhood and competency.

Setting. The sites allowing the researcher to draw a sample from for the study included The Council on Alcohol and Drugs Houston and UT Physicians Innovations in Addictions Treatment Clinic both located in Houston, Texas. The researcher determined the selection of sites by the services offered by each organization. The organizations offered outpatient services to recovering addicts in the community of Houston, Texas.

The researcher established preliminary contact with the Chief Operations Officer, Mary Beck, at The Council for Alcohol and Drugs on permission to conduct study at the organization. The Council on Alcohol and Drugs Houston provided a letter of support (See Appendix C) agreeing to place approved flyers (See Appendix B) in locations within the facility. Individuals interested in the study contacted the researcher through the contact information communicated on the flyer. During interaction, the researcher developed rapport by explaining the purpose of the study and discussing the criteria with the interested individual. At that time, the researcher determined if individual met criteria for the study along with time and confidential place for interviewing.

For the UT Physicians INNOVATIONS in Addictions Treatment Clinic, the researcher currently works with UT Physicians Clinics. The researcher established access through preliminary contact with the Medical Director, Dr. Michael Weaver, to permit the researcher to conduct study at the clinic. The Medical Director provided a letter of support (See Appendix D) granting the researcher permission to distribute approved flyers (See Appendix B) in locations around the clinic for individuals to review. Interested individuals contacted the researcher through contact information communicated on the flyer. The researcher built rapport with the individual by explaining the purpose of the study and determine if interested party met criteria to participate. If individual met criteria, the researcher established a time and confidential location to conduct the interview.

The Council on Alcohol and Drugs Houston. The Council on Alcohol and Drugs Houston provides residential and outpatient services for individuals suffering with addiction (Council-houston.org, 2015).

UT Physicians Innovations in Addictions Treatment Clinic. The UT Physicians Innovations in Addictions Treatment Clinic offers outpatient treatment services for addiction in alcoholism, illegal substances, and prescription medication (UTHealth Medical School, 2015).

During data collection, the researcher contacted an additional facility, Santa Maria Hostel, to recruit participants for the study as a contingency plan. With the added site, the researcher achieved a point of saturation.

Santa Maria Hostel. Santa Maria Hostel offers outpatient treatment services that encourages relapse prevention and the use of community in recovery efforts for mothers (Santa Maria Hostel, 2016).

The researcher established contact with Santa Maria Hostel by meeting face-to-face with the current Outpatient Counselor, Rhonda Wade, to build rapport and discuss purpose of the study. The outpatient counselor agreed to act as a gatekeeper to facilitate recruitment of eligible participants for the study. A gatekeeper is an identified individual that has a trusted relationship and access to the population of interest (Namageyo-Funa et al., 2014). The outpatient counselor utilized the approved flyers (See Appendix B) during outpatient treatment classes to explain the study and identify potential volunteers interested in participating in the study. The outpatient counselor provided the interested individuals with contact to the researcher. The researcher and potential participant decided on a mutual time and location to meet for the initial interview.

Role of the Researcher. The researcher plays a critical and unique role that extends further than interactions with participants during the interview when investigating a phenomenon. To fully grasp the understanding of the participant's

experience, the researcher utilized bracketing to remain open by acknowledging her experiences, assumptions and prior knowledge on the phenomenon in a written section known as Self-of-the-Researcher before conducting interviews (Wertz, 2005). The open stance continued into analysis as the researcher refrained from invading impositions by consciously reviewing her inner thoughts, ideas, perceptions, attitudes, sensations and emotions that entered her mind (Marshall & Rossman, 2010; Moustakas, 1994). The researcher proceeded to document her inner experiences in analytic memos (See Appendix V).

Also, the researcher maintained conscious awareness to bracket her own perceptions as she provided rich descriptions of the participants' perceptions in written section known as Results when bringing forth the deeper understanding of the phenomenon (Creswell, 2013; Marshall & Rossman, 2010). The bracketed information from the researcher remains available for the researcher to reflect on, and discuss potential conflicts in the researcher's ability to extract the "essence" of the phenomenon (Moustakas, 1994). Finally, the researcher linked her interpretations to past literature developed by others in a section known as Summary, Implications, and Recommendations when analyzing the gathered lived experiences. By connecting interpretations to supporting literature, the researcher reduced the risk of making construed interpretations, and remains bracketed in data analysis (Creswell, 2013; Moustakas, 1994). The researcher's role influences the entire research process and guides the study from the beginning "overarching question" to the final interpretation of results (Moustakas, 1994).

Data Collection Procedures

To capture the essence of maternal self-efficacy, the mothers at the outpatient facility shared their experiences through face-to-face, semi-structured interviews (See Appendix F) conducted by the researcher. The researcher reviewed the consent form, discussed the limits of confidentiality, and obtained consent with each participant. The researcher assessed each participant utilizing the Mini Mental Status Examination. The researcher collected demographic information (See Appendix E) on each participant (Creswell, 2013). Demographic information obtained included participant's age, race, marital status, number of children, age of onset for substance use, number of treatment programs attended, reason for past relapses, frequency of contact with participant's child, medical and behavioral health problems, and support systems. The researcher ensured confidentiality by assigning a unique number to demographic information to conceal their identities (Moerer-Urdahl & Creswell, 2004). Then, the researcher proceeded with the semi-structured interview by asking open-ended questions (See Appendix F). The researcher attended each interview with two audio-recorders and charging device to prevent equipment failure. Also, the researcher tested equipment prior to the interviews to ensure proper functioning. The length of interviews lasted no longer than one (1) hour and thirty (30) minutes (Daly, 2007). In this time, participants had the opportunity to discuss experiences and perspectives on motherhood and addiction.

After each interview, the researcher documented thoughts, feelings, reflections and insights in analytic memos (Marshall & Rossman, 2006). Also, the researcher transported the audio-recordings to an outside agency specializing in transcription. The transcription service reformatted the audio-recorded interviews into a digital format. The researcher assigned the same unique number from the participant's demographic

information to the digital audio file. During data collection, the researcher developed an identity key assigned unique numbers to participants. The researcher uploaded the audio file of the interviews into MAXQDA, a qualitative data analysis software program. The researcher reviewed the digital format of documented interviews checking for accuracy. After review, the researcher carefully de-identified digital transcriptions within 48 hours. Then, the researcher destroyed audio recordings and the identity key within 24 hours of de-identification. The reviewed digital format assisted the researcher in the next process – data analysis.

Data Analysis Procedures

Phenomenological data analysis provides the researcher with a set of phases to guide structure, order, and reveal patterns in the participants' lived experiences (Daly, 2007). The focus of analysis consists of identifying and separating descriptions into components. To assist the researcher in identifying descriptions, the researcher utilized a qualitative data analysis software program – MAXQDA. The computer-assisted software tool, MAXQDA, allowed the researcher to upload the digital transcriptions and facilitate with data coding, memoing, and data management. Moustakas' (1994) modified Stevick-Colaizzi-Keen method of data analysis aided the researcher in organizing and analyzing the collection of data. The step-by-step process began after the researcher engaged in the epoché process and bracketed her presumptions. Then, the researcher started reviewing the verbatim transcriptions and maintaining a receptive attitude towards every statement.

Reading through the data, the researcher noted significant statements, sentences, and quotes by creating a list depicting each thought relevant to the concerning phenomenon (Creswell, 2013). Listing each statement by verbatim or *horizontalization*

allows equal value in the participant's view of the experienced phenomenon (Moerer-Urdahl & Creswell, 2004). When statements become overlapping or repetitive, the researcher started to eliminate. Then, the researcher illustrated each participant's experience through a narrative description known as a *textual description*. Rich textual descriptions depict the "what happened" in the lived experience (Moustakas, 1994). Using textual descriptions as a foundation, the researcher utilized imaginative variation to elicit "how one experienced" the phenomenon (Moustakas, 1994). The researcher generated *structural descriptions* discussing the underlying and precipitating factors surrounding the essential structures of the phenomenon (Moerer-Urdahl & Creswell, 2004). For each participant, the researcher integrated textual and structural descriptions constructing a *textural-structural description*. The researcher gathered all the textual-structural descriptions and composited a group description of the experience known as the *composite textural-structural description* (Lin, 2007). Finally, the researcher compiled integrated meanings and essences to evolve the underlying phenomenon.

Methods of Verification

Establishing trustworthiness in qualitative research becomes essential when evaluating the quality of findings. Guba and Lincoln (1989) substitute trustworthiness for reliability and validity to ensure rigor in qualitative inquiry. The criteria of trustworthiness incorporated four concepts – 1) *Confirmability*, 2) *Dependability*, 3) *Credibility* and 4) *Transferability* (Morse et al., 2002). The researcher implemented methodological strategies to verify rigor in the research process.

Confirmability refers to the researcher remaining neutral and presenting accurate data (Houghton et al., 2013). To control for bias, the researcher engaged in bracketing --

putting aside past knowledge about the phenomenon encountered (Husserl, 1964). The researcher demonstrated bracketing and reflexivity by discussing personal experiences and identify aspects that relate to the phenomenon prior to interviewing participants. A written section in the research, known as epoché, contains the researcher's bracketed, shared experiences (Creswell, 2013; Moustakas, 1994). The researcher referenced literature and findings that support interpretations from the study and strengthen quality maintenance (Williams, 2011). The process of *Confirmability* closely overlaps *Dependability* in qualitative rigor.

Dependability refers to the stability and consistency of the data. By checking, confirming, and re-checking, the researcher demonstrates certainty in qualitative research (Morse et al., 2002). The researcher used the process of inquiry audit to maintain dependability when interpreting results from the study. To assess for consistency in the study, an independent auditor (Dr. Jason Northrup, a faculty member in an accredited Marriage and Family Program) reviewed documented memos, transcriptions, and reports related to theme emergence. Memos included the researcher's observations made during interviews, learned information, inner thoughts, ethical concerns, and potential proceedings in the study.

Credibility ensures the researcher's findings demonstrate believability and truth value (Houghton et al., 2013). To support the validity of the study, triangulating analyst (Dr. Jason Northrup) also analyzed and coded portions of data (Patton, 2002). Triangulation in qualitative researchers refers to multiple perspectives reviewing and verifying findings in the study (Creswell, 2013; Williams, 2011). The researcher also engaged in peer debriefing with a disinterested party (Mary Telisak, a doctoral student

enrolled in an accredited Marriage and Family Program trained in qualitative, quantitative, and mixed-methods analysis) to keep the credibility of the study. Peer debriefing involves meeting with an outsider, an unattached peer to the study, who asks unbiased, probing questions to further analysis on the researcher's methodology and conclusions (Williams, 2011). Finally, the researcher used a technique known as member checking. The process of member checking involves participants from the study reviewing the collection of data, interpretations, and reports by the researcher to clarify if the participants' experiences have been accurately portrayed.

Transferability refers to whether findings apply to other similar contexts or situations outside the researcher's study while sustaining the collected meanings and inferences of participants (Houghton et al, 2013). The researcher utilized rich detailed descriptions from the participants known as "thick descriptions" (Williams, 2011).

The study's inquiry audit upholds confirmability, dependability, credibility, and transferability standards necessary for qualitative research (Guba & Lincoln, 1989).

Summary

The purpose of this transcendental phenomenological study is to explore the experiences of women recovering from substance abuse and the viewed perceptions on motherhood. At this time, limited research exists on this particular phenomenon. The approach of the study fills the gap of knowledge and verifies the accuracy of data through a series of steps regarding maternal self-efficacy among women attending outpatient substance abuse treatment.

CHAPTER IV

SELF OF THE RESEARCHER

To obtain an attitude and mindset of openness, the researcher must set aside preconceptions, and prejudgments (Moustakas, 1994). In this section, the researcher brackets her own experiences to refrain from influencing the participants' understanding of the phenomenon. I disclose a self-dialogue of personal and professional experiences that motivated my research interest. I also discuss my preconceived assumptions and bias which have formed that influence my consciousness. The disclosure begins the process of epoiché as I state my influences and allow myself to clear a clouded mind.

Personal Experience

The researcher recalls her childhood and the issues her family encountered surrounding substance abuse. The researcher recounts the moment she realized dysfunction in her household. She was watching a film in her high school health class to describe the impact substance abuse creates on individuals and families. The researcher began to relate to much of the story line in the movie. The film is about a mother struggling with alcoholism and her family's efforts to get her help. The researcher acknowledged the hardship her own family had endured in the past year. Her parents were in the process of a divorce and her mother's drinking had escalated. The researcher remembers this period for her life being emotional difficult.

The researcher often experienced painful feelings of sadness, embarrassment, anger, rejection, and abandonment related to her mother's alcoholism. The hardest part for the researcher was losing the close relationship with her mother. The researcher began to distance herself to keep painful feelings from overwhelming her. The researcher made

attempts to keep busy by involving herself in sports and class assignments to reduce the emotional impact. Now, the researcher believes she missed many years from the mother-daughter relationship due to underlying her fears of emotional hurt and lack of communication.

As years went by, the relationship between the researcher and her mother evolved. Her mother revealed past events and the debilitating impact alcohol has caused on her life. Past hurt had narrow-minded the researcher, but her mother's sharing assisted the researcher in understanding and truly hearing her mother's perspective. Empathy and compassion entered the researcher's heart while fear and emotional hurt dissipated. A new, reformed relationship developed between her mother and the researcher.

Clinical Experience

As a Marriage and Family Therapist (MFT), the researcher works with a variety of families. One type of family dynamic that often enters her office for services is families with substance abuse addictions. MFTs take a systems perspective by focusing on family relationships and relational patterns between members of the family. Much of her clinical work involves educating families on destructive family interactions and intervening on relational patterns for productive change. By changing one part of the system, the other parts compensate by rearranging and forming new, healthy interactions. The new relational patterns assist in eliminating old patterns that maintained addictive behaviors in the family.

During her clinical experience, the researchers has encountered mothers recovering from substance abuse, as well as their children. Mothers describe the involvement of Child Protective Services and the negative evaluation by society for

making substance abuse a priority over motherhood. The mothers often discuss the immense shame and guilt for choosing addiction over the relationship with their child. Rebuilding relationships and repairing damages within their children is a common concern for mothers recovering from substance abuse. Many children display behavioral and emotional problems at school and in the home. The mothers seek guidance for helping their children through this challenging time as the added stress is impacting the recovery process. Mothers report how the behavioral and emotional challenges in the children is creating an urge for mothers to use substances again. The tears, pleading and misunderstandings are commonly shown amongst mothers with history of substance abuse. The researcher's clinical role involves educating mothers on the impact of addiction on families, changing parental approaches, and creating more positive interactions with their children. Stigma of "Unfit" Mother decreases, levels of guilt and shame reduce, and parenting perceptions improve when mothers attend counseling sessions. The mothers have an outlet and receive helpful suggestions for repairing destructive family interactions. The researcher's clinical work has given her a closer look at the recovery process in mothers with substance abuse issues and the impact on families.

The experiences from the researcher's clinical work and personal life motivated her to pursue research in substance abuse and families. In order to fulfill the pursuit, the researcher must abstain from presumption. Continuing in the epoché process of clearing her mind and bringing awareness to her own biases, the researcher discloses her presumptions.

Presumptions

Given her clinical and personal background, the researcher feels necessary to discuss pre-assumptions that may have formed prior to interviewing the mothers. The first presumption is that mothers in substance abuse treatment will experience guilt and shame over their substance abuse and their perceptions of their parenting. Both in the researcher's personal and clinical experience, mothers have expressed moments of guilt and shame. The researcher has encountered mothers expressing shame in their drug-seeking behavior and missing out on memories with their children. The mothers also noted how they felt inadequate as mothers and guilty for prioritizing substance abuse over motherhood. During sessions, mothers often address the need to repair the mother-child relationship.

The researcher's second presumption is that mothers experience low self-esteem and see themselves as "Unfit Mothers." The researcher believes chemically dependent mothers struggle with negative labels by society due to either Child Protective Services involvement or relatives assisting the mother as she struggles with her addiction. The negative messages impact her self-esteem and self-worth. The mothers internalize these degrading labels and have difficulty removing the invisible "stamped" label across her forehead. She continues to move through her life fulfilling the prophecy of "Bad" Mother. Her recovery process involves rebuilding her sense of self by offering acceptance, empathy, and challenging distorted messages society may have cast on her during her addiction.

The researcher's final presumption she finds important to acknowledge is the mother's ability to parent. The researcher believes mothers in substance abuse treatment have negative evaluations in their own parenting skills. Many mothers in session have

discussed their limitations and frustrations when dealing with parenting issues. Much of the sessions revolve around the mother's childhood memories. She opens up and discusses the ineffective parenting she received while growing up. When a mother attempts to soothe or discipline her child, she has limited knowledge on how to proceed. The researcher's counseling sessions are spent processing the mother's childhood experiences, providing parenting tips, and reassurance when faced with stressors. The researcher believes mothers have lower levels of perceived maternal self-efficacy.

Now that the researcher has discussed relevant experiences in her professional and personal life along with acknowledging her own biases, pre-judgements, and influences on the research, the researcher suspends and brackets her experiences. This section allows the researcher to fully capture the lived experiences of mothers in substance abuse recovery in a clear, fresh state of mind.

CHAPTER V

RESULTS

This chapter provides a description of the participants and explanation of the categories, themes, and subthemes interpreted from the data. Twelve mothers participated in my study. Of the participants, four were Hispanic, seven were Caucasian, and one was African American. The average age of the participants was 36.6, ranging from 28- 62 years old. The average age of the participants' children was 8.9 years old, ranging from 10 months to 32 years of age. The average number of children for the mothers was 2.6, ranging from 1 to 6 children. Three of the mothers were married, eight were single, and one was separated. The average start age of use was 15.75, ranging from 13 – 18 years of age. The average number of treatment programs attended was 2.1, ranging from 1 – 4. Detailed textural-structural descriptions of the participants have been included in Appendices: H - S.

Meet the Participants

Adriana. Adriana is a 46-year-old Hispanic female with graduate level education. She is divorced with two daughters (24-year-old and 23-year-old). She began drinking at the age of 13 and had used for approximately 33 years. Her length of sobriety is 2 months and 18 days. She has attended 4 treatment programs. Adriana reports her reason for prior relapse was due to experiencing relationship failure. She reports having daily contact with her children.

Brenda. Brenda is a 28-year-old Hispanic female who is currently employed as a housekeeper. She is single with four children (two daughters – 6-year-old and 5-year-old; two sons – 3-year-old and 2-year-old). She started using at the age of 18 and had used for

Table 5.1

Demographics of Participants

Pseudonym	Age	Marital Status	Race	Number of Children	Substances Used
Adriana	46	Divorced	Hispanic	2	Alcohol, Cocaine
Brenda	28	Single	Hispanic	4	Alcohol, Cannabis
Cynthia	44	Divorced	Caucasian	1	Alcohol, Opioids
Gina	31	Single	Hispanic	6	Alcohol, Cannabis
Jaime	28	Married	Caucasian	4	Alcohol, Cannabis
Jenny	30	Single	Caucasian	1	Alcohol, Opioids
Judy	62	Single	Caucasian	1	Alcohol, Cannabis
Leah	34	Married	Caucasian	2	Alcohol, Methamphetamine
Maria	45	Married	Hispanic	2	Alcohol, Cocaine
Sammy	30	Separated	Caucasian	3	Alcohol, Methamphetamine
Sonia	28	Single	Caucasian	3	Alcohol, Amphetamine
Vanessa	33	Single	African American	2	Alcohol, Opioids

approximately 1 to 2 years. Her length of sobriety is 7 months. She has attended 2 treatment programs. Brenda reports her reason for prior relapse was due to stress. She reports having visits with her children once every 2 weeks since February 2016.

Cynthia. Cynthia is a 44-year-old Caucasian female who is currently a student with occupational background in the real estate industry. She is divorced from her 14-year-old year son's father and currently engaged to her fiancée, Jacob. She began using at age 15 and has approximately used for 27 years (on and off). Her length of sobriety is 14 months and attended 1 treatment program (Memorial Herman PaRC). She reports no relapses at this time. Cynthia reports having constant contact with her son during recovery.

Gina. Gina is a 31-year-old Hispanic female with a GED certificate. She is single with six children (four sons – 13-year-old, 11-year-old, 10-year-old, and 8-year-old; two daughters – 16-year-old and 7-year-old). She started using at the age of 14 and had used for approximately 17 years. Her length of sobriety is 6 months. She has attended 1 treatment program. Gina reports her reason for prior relapse was life stressors. Gina has been in contact with her children about 3 times or less during her recovery.

Jaime. Jamie is a 28-year-old Caucasian female with some high school level of education. She is married with four children (three daughters – 13-year-old, 11-year-old, and 2 ½-year-old; 1 son – 10-month-old). She started using at the age of 16 and had used several times over the years. Her length of sobriety is 1 year. She has attended 1 treatment program. Jaime reports her reason for prior relapse was due to the death of her son. She reports having daily contact with her children during recovery.

Jenny. Jenny is a 30-year-old Caucasian female with some college education. She is single with an 18-month-old daughter. She began using at the age of 16 and had used for approximately 14 years. Her length of sobriety is 9 months. She has attended 2 treatment programs. Jenny reports her reasons for prior relapse was not continuing the maintenance of her recovery. Jenny reports having daily contact with her daughter during her recovery.

Judy. Judy is a 62-year-old Caucasian female who is currently employed as a resident tech at a transitional living facility for women. She is divorced and a single parent to her 32-year-old son. She started using at the age of 17 and had used for approximately 40 years. Her length of sobriety is 2 years and 4 months. She has attended 3 treatment programs. Judy reports her reasons for prior relapse was due to several factors – money, relationship issues, and being an addict. She reports having limited contact with her son during her recovery.

Leah. Leah is a 34-year-old Caucasian female who has a high school education. She is married with two sons (14-year-old and 11-year-old). She started using at the age of 15 and had used for approximately 15 years. Her length of sobriety is 102 days. She has attended 2 treatment programs. Leah reports her reason for prior relapse was due to not being ready. She reports daily contact with her children during her recovery.

Maria. Maria is a 45-year-old Hispanic female with some high school education. She is married with 2 children (8-year-old daughter and 6-year-old son). She started using at the age of 18 and had used for approximately 20 years. Her length of sobriety is 1 month. She has attended 3 treatment programs. Maria reports her reason for prior relapse

was due to marital problems. Maria reports having daily contact with her children during recovery.

Sammy. Sammy is a 30-year-old Caucasian female who is currently employed as a fabrication welder. She is separated with 3 sons (10-year-old, 2-year-old, and 1-year-old). She started using at the age of 15 and had used for approximately 15 years (off and on). Her length of sobriety is 1 1/2 years. She has attended 2 treatment programs. Sammy reports her reasons for prior relapse was not maintaining her recovery. Her youngest son resides with family and her eldest son was placed into Foster Care. Sammy maintains daily contact with her eldest son and monthly visits with the youngest.

Sonia. Sonia is a 28-year-old Caucasian female with some college education. She is single with three children (6-year-old son, 2-year-old daughter, and 1-year old son). She began using at the age of 14 and had used for approximately 14 years. Her length of sobriety is 6 months. She has attended 3 treatment programs. Sonia reports her reasons for prior relapse was due to interacting with friends that use and influence her. Sonia reports having daily contact with her children during her recovery.

Vanessa. Vanessa is a 33-year-old African American female with some college education. She is single with 2 daughters (12-year-old and 2-year-old). She began using at the age of 18 and had used for approximately 10 years. Her length of sobriety is 3 1/2 months. She has attended 1 treatment program. Vanessa reports no prior relapse. She reports having daily contact with her children during her recovery.

Categories, Themes, and Subthemes

Once the interviews were transcribed into digital format, the transcriptions were uploaded into MAXQDA and checked for accuracy. I engaged in the epoché process by

bracketing by bias, presumptions, and judgements each time before proceeding with data analysis. With a fresh mindset, I reviewed each participant's transcription and highlighted segments relevant to the experience during the horizontalization process. Each participant's highlighted segments were exported from MAXQDA to an individual Microsoft Word document. Next, I listed all the significant statements and eliminated any repetitive, overlapping statements. Then, I merged thematic meaning units into themes. Again, I reviewed the transcriptions and identified each listed segment as either structural or textural for each participant. I modified Moustakas' method for descriptions of textures and structures by creating two separate tables – structural table of themes with supporting subthemes and textural table of themes with supporting subthemes. Finally, I constructed a textural-structural description of each participant's experience using verbatim examples.

I contacted each participant to read aloud the participant's individual narrative for member-checking purposes. Nine of the twelve participants took part in the member-checking process. Few modifications (if any) were made to the individual narratives. I modified (if needed) and emailed the participant's narrative for a second review. Participants were given the opportunity to send additional feedback to their individual narratives through email for a second set of revisions. No further revisions were sent by the participants. The member checking process lasted approximately one month. Once the individual analysis was completed, I created a composite table for all the participants. Initially, I identified 3 categories, 10 themes, and 39 subthemes. I engaged in peer debriefing with Mary Telisak, a disinterested party trained in qualitative data analysis. From her thought-provoking questioning and insightful feedback, an additional

category was identified. The new category was labeled Risk Factors. Originally, I had placed *Growing Up in a Dysfunctional Family* under the theme *Impact of Addiction on Me* which fell under the Category – *Consequences of Addiction on Motherhood*. After further review and consideration of the data, *Growing Up in a Dysfunctional Family* was merged with other potential risk factors for substance abuse and renamed to *Types of Trauma*. *Types of Trauma and Life Stressors* were placed under the newly developed category - *Risk Factors*.

Adjustments were made to the composite table regarding categories, themes, and subthemes. Previous themes and subthemes were combined, discarded, or shifted into an alternative category. For example, my initial theme of *Being Physically and Emotionally There* was collapsed into a subtheme under the newly emerged theme *Nurturing the Relationship*. During the composite table review, several initial themes were discarded due to low numbers in participant responses. The final composite table of responses from all the participants concluded with 4 categories - *What It Means to Be a Good Mother*, *Consequences of Addiction on Motherhood*, *Being a Mother During Recovery*, and *Risk Factors* (Tables 1, 2, 3, and 4). From the four categories, 11 themes emerged - *Providing a Stable and Safe Environment*, *Nurturing the Relationship*, *Being a Good Role Model*, *Impact of Addiction on Me*, *Impact of Addiction on My Children*, *Hitting Rock Bottom*, *Treatment's Role in Staying Sober*, *Fixing the Damage*, *Discovering My Purpose*, *Types of Trauma*, and *Life Stressors*. Within in the 11 themes, 39 subthemes were identified and labeled. Detailed information in the following sections depict the categories, themes, and subthemes for further understanding.

Category: What It Means to Be a Good Mother

The category *What It Means to Be a Good Mother* (Table 5.2) portrays the views of good mothering practices in recovering chemically dependent mothers. All twelve participants describe important duties in motherhood when caring for children. The mothers discuss participating in many of the essential mothering tasks. Each participant acknowledges the importance of establishing a healthy, positive relationship with their children. From the participant's perspective, "Being a Good Mother" means promoting an atmosphere of safety and stability while displaying a positive influence on their children. Many mothers note participating in good mothering tasks throughout the course of their children's lives regardless of substance use. Three themes emerged within this category including *Providing a Stable and Safe Environment, Nurturing the Relationship, and Being a Good Role Model.*

Theme: Providing a Stable and Safe Environment

The theme *Providing a Stable and Safe Environment* describes how the mothers believed consistency and security assist in shaping the healthy development of their children. Ten of the twelve participants discussed providing a safe and predictable environment as an essential task for motherhood. Within this theme, three subthemes emerged – *Providing Basic Needs, Having Structure, and Safety.* *Providing Basic Needs* describes the fundamental physiological and educational needs including food, shelter, clothing, and education. *Having Structure* describes a consistent schedule and routine followed on a daily basis. *Safety* describes the financial security and protection of an individual's well-being.

Subtheme: Providing Basic Needs. Nine of the twelve participants stated Being a Good Mother means providing essential necessities to their children. Many of the women

discussed preparing meals, supplying clean clothing, providing shelter, and meeting the educational requirements for their children. Jaime states, "I make sure they always have what they need and I make sure they have a roof over their head. I make sure that they have clean clothes and that they went to school." In some cases, the mothers discussed addiction becoming a distraction towards meeting their children's educational needs. Leah discusses the addicted mindset, "You don't get them up. You don't participate in school activities." However, most of the mothers reported providing food, clothing and shelter with limited issues.

Subtheme: Having Structure. Six of the twelve participants noted the importance of having a structured schedule and routine. The women noticed smoother days, reduced behavioral issues in their children, and less chaos when following a daily routine. Vanessa discusses staying on a schedule "Preparing meals on a schedule. Keeping them on a schedule. School is coming up, so we are going to have to rise early. Go to bed at a good time, so [the children] can be refreshed." For some of the mothers, addiction caused disruption and disorganization to schedules. Sonia explains, "Well, basically, there's no structure because if it's bath time – 8:00 p.m. – but you're out of alcohol at 8:00 p.m., you're not going to say oh, let me stop doing this and get my kids in the bathtub. You're going to say let me get my alcohol. And then I'll be able to function to give them a bath, which may not be until 11:00 that night." It is apparent that structure and routine provided a predictable schedule for the mothers to follow when raising their children.

Subtheme: Safety. Six of the twelve participants believed *Safety* was an important aspect of Being a Good Mother. The mothers discussed different types of safety including

Table 5.2

Category: What It Means to Be a Good Mother

Theme	Subtheme	T/S	Segment	<i>n</i>
Providing a Stable and Safe Environment		S	Safety is the most important, and just trying to make sure that they have a healthy nutritious meal here that means you have to plan because everything is fast foods – McDonald's. (Vanessa)	10
	Providing Basics Needs	S	Being a good mother means to me making sure my children are happy, have clean clothes and good nutrition and meals for them to eat and activity. (Vanessa)	9
	Having Structure	T	If you're sober, they take a bath at eight. They eat dinner at 8:30. It's structure. (Sonia)	6
	Safety	T	So to me it was to take them to the Memorial Mall where I know they're safe. There's no cars. There's nothing and I play with them right there. (Brenda)	6
Nurturing the Relationship		S	Oh, I wake her up every morning. And I love on her. I don't just wake her up. But I've always done that 'cause I want her to know that I care. They can feel it. My kid can feel it. (Jenny)	12
	Being Emotionally and Physically There	T	Now [my son] gets all my time. If he calls... If I'm at work, I stop. They understand I'm a single mother. I need to talk to my child. He obviously needed something right now. I make sure I call him every day. We see each other every time that we can. I'm interacting with him. I'm doing what he's doing. (Sammy)	10
	Bonding Through Activities	T	They love the -- they call it Thomas the Train by the zoo. They love going to the zoo and get on the Thomas Train. We'll be riding on the little boats and we go see the ducks around the pond. (Brenda)	8
	Approachability	T	I kept telling my little girl that anything she can talk to me. Anything, I'm not going to get mad or anything. If somebody is bullying or abuse and stuff like that, I don't want them to go through that. (Maria)	7
	Showing Affection	T	I just gently rub her back, give her a kiss – wake her up, and she smiles. I've never had a bad day with my kid ever, not even when I brought her home. It was all good. She's awesome. (Jenny)	5
Being a Good Role Model		S	I think that's what being a good mother is It's teaching how to live successfully by themselves or teaching them how to take care of themselves in a healthy way without hurting others and maintaining healthy relationships. (Adriana)	11
	Demonstrating Communication Skills	T	The way that I participate in being a good mother is when the kids are talking to me, I will actually listen. Versus if I'm washing dishes, just saying, "Uh-huh, uh-huh..." (Vanessa)	10
	Teaching My Children Responsibilities	T	They're little. Everything I do, my daughter does it. She copies me – everything. It's crazy. I just laugh at her. I don't let her know I'm watching her. But if I sweep, she's sweeping. That's how it should be. (Sonia)	6
	Modeling Self-Care	T	For example, being in outpatient – I took parenting today. We talked about self-care. When I learn that by taking care of yourself, you're actually modeling that, and they're actually watching that I take pride and joy in doing that. (Adriana)	5

Note. T/S, Textural/Structural

physical well-being and financial security. Brenda discusses being a protective parent, “And my kids know that whenever something's done to them they can come and tell me and I will be sure to follow up with whoever hurt them or whoever told them anything. I'm very over protective like that with them.” For some of the women, protection was essential since they experienced in lack in safety growing up. Maria expresses her philosophy on protection, “I tell them “Anything – if you're out there playing or anything and some man comes by or a woman comes by and start asking questions, never get close to that person. Just come running and talk to me.”” The women also noted the importance of being employed and saving money. Brenda states, “And now that I'm able to save the money up I have two/three months in advance on my rent. So I'll be able to go to work after [the children] all got to be in school.” Protection and security were obvious essentials in parenting for these mothers.

As I read through the responses from the mothers, I noticed the bottom two levels of Maslow's Hierarchy of Needs being discussed. Basic needs, structure, and safety seem to be necessities of human life when I think of providing for another human being. It was easy for me to understand the women referencing this portion of mothering. However, the responses that grabbed my attention was the reflection by the mothers. Many of the women would compare mothering while using to sober mothering practices. It was interesting to watch the mothers reflect in the moment on chaotic vs structured schedules. The mothers understood the impact of inconsistent and unsafe environments from their own life experiences. The next section describes how the mothers nurture the relationship with their children.

Theme: Nurturing the Relationship

The theme *Nurturing the Relationship* describes the warm, supportive emotional interactions that strengthen bonds between mother and child. All twelve mothers discussed the importance of nurturing the relationship with their children. Jenny shares her beliefs, "Being a good mom to me is taking your kid with unconditional love." Many of the mothers reported engaging in acts to increase the bond with their children. Sammy shares her way to strengthen the bond with her son, "I'm interacting with him. I'm doing what he's doing. We went to Jumpy World, and I was jumping with him. I'm getting in there and doing whatever he's doing." From the participants' responses, four subthemes emerged – *Being Physically and Emotionally There*, *Bonding Through Activities*, *Approachability*, and *Showing Affection*. *Being Physically and Emotional There* describes a mother's ability to be within physical reach and emotionally available to recognize the feelings of her children. *Bonding Through Activities* describes the quality time a mother spends with her children by engaging in activities to strengthen the attachment. *Approachability* describes the warm and inviting communicative atmosphere a mother creates with her children. *Showing Affection* describes the tender and caring actions a mother engages in to display love for her children. It was apparent the deep-seated love all the mothers' felt towards their children.

Subtheme: Being Physically and Emotionally There. Ten of the participants describe the importance of Being Physically and Emotionally There for their children. Jaime shares, "Being there emotionally, physically whenever they need someone to talk to." The women felt being physically around for their children assisted in providing essential needs and security for their children. Gina expresses her thoughts on physically being there, "Well, for me, that's like the main, main thing because I would always put

my children to sleep and be like I'll be here. I'll be back, just don't worry. And then when they wake up, I wouldn't be there. So just being at home and being a sober mother is the biggest thing right now." Emotional availability was also noted in the women. Jenny shares, "I think it's better 'cause I'm paying attention. I've gone through treatment. You learn to recognize your feelings and your kid as well." The mothers believed physical and emotional presence added depth to the relationships with their children.

Subtheme: Bonding Through Activities. Eight of mothers in the study describe *Bonding Through Activities*. The mothers strengthened the bond by engaging in activities that their children enjoyed. The mothers noticed an increase in their child's self-esteem when spending quality time with their children. For example, Leah explains, "I like when we have -- me and my son, my oldest son, I like the part where we bond. I like the bonding parts. He teaches me how to workout because it makes him feel good. So he shows me what I can do working out and then my other son, movie time with him or playing Legos with him." The mothers wanted to create positive memories with their children. Brenda states, "[My children] really are going to remember more the things that -- oh, she went to my soccer game. She took us to the park. [My children] love going to the Memorial Mall, the castle, the play castle they have there. So we always be going there and they love going there." By participating in activities with their children, the mothers enhanced the parent-child attachment and benefited their child's relational development.

Subtheme: Approachability. Seven of the twelve participants noted Approachability to be a key aspect of mothering when creating a loving relationship with

their children. Many of the mothers discussed providing a supportive, calm, open-minded environment for their children. The mothers wanted to create a close relationship with their children. I recognized the mothers hoped their children would come talk to them during difficult situations. Brenda shares, "To me that's something they know that they're not afraid of me too if they did something wrong. It's a mistake. Everybody makes it. They can tell me anything. That's one of my main things with them, that I have open conversations with them." Some of the mothers discussed creating an approachable stance with their children due to a lack of relationship with their own mothers. Maria shares, "My mom was never talking to us. I had to learn the hard way. What I've gone through, what I've been through, what happened to me as I was growing up, I don't want them to go to the same." The calm demeanor and nonjudgmental attitude by the mothers provided trusted relationships with their children.

Subtheme: Showing Affection. Five of the twelve participants describe *Showing Affection* when engaging in important mothering practices. The mothers showed affection by providing tender touch, cuddling, encouraging with words, and giving hugs and kisses. Jenny describes her morning routine of affection, "Oh, I wake her up every morning. And I love on her. I don't just wake her up. But I've always done that 'cause I want her to know that I care. They can feel it. My kid can feel it. I want her to know that I'm there no matter what." Some of the mothers noted having difficulty finding a healthy balance with appropriate levels of affections. For example, Sammy states, "You have to nurture them. You have to love them. I over-love, and I will wait on my kids hand and foot and coddled them. If anything happens, I will overdo all that." It was evident that the mothers felt a high need to provide nurturing affection towards their children. The

mothers' recognized affection attributes to a child's sense of security and provides the message "You are loved."

Reviewing the responses of the mothers, they seemed to understand the importance of attachment with their children. They would engage in several types of nurturing to build a strong bond with their children. I had to wonder if the information the mothers learned during parenting classes encouraged similar responses or if the mothers' responses were from an innate drive to attach with their children. Needless to say, I enjoyed hearing the bonding experiences of the mothers. I noticed many of the women's faces would light up with joy when describing the particular ways love and affection was shown towards their children. I was surprised to learn none of the participants discuss the grueling demands of meeting the nurturing needs of their children. However, it was nice to hear the efforts the mothers were making to establish a healthy and deep bond with their children. The next section describes how the mothers participate in being a good role model.

Theme: Being a Good Role Model

The theme *Being a Good Role Model* describes mothers demonstrating positive life skills to their children. The mothers recognized their children were watching and repeating the same behaviors. Jenny says, "She's to the point now where she's watching everything I do. And she's copying." Understanding the influence the mothers had on their children, the woman sought to engage in positive behaviors for their children to mimic. The learned behaviors assist in developing healthy, happy, and well-adjusted children. Sammy explains, "Like me – I want my sons to grow up, and I want them to be happy and productive and not have the problems that I've had and have the setbacks that

I've given myself. I want them to learn the right way. That's being a good mom."

Demonstrating Communication Skills, Teaching My Children Responsibilities, and Modeling Self-Care are three subthemes that emerged under this theme. *Demonstrating Communication Skills* describes conveying a message in calm and appropriate tone with the ability to effectively listen to another. *Teaching My Children Responsibilities* describes mothers showing their children tasks including household chores, cleaning, and independent living skills. *Modeling Self-Care* describes a mother's ability to practice and implement calming techniques during stressful situations, mindfulness, and upkeep in health needs.

Subtheme: Demonstrating Communication Skills. Ten of the twelve mothers discussed demonstrating effective communication skills when Being a Good Role Model. Many of the mothers would monitor their tone and use appropriate language when speaking to their children. For example, Adriana explains, "And then [my daughter] gave me the chance to explain myself, and I did without raising my voice and being respectful and respecting those communication boundaries without crossing the line, insulting." For other mothers, listening was an important aspect of communication. Vanessa shares, "I'm actually listening and giving feedback to what they are asking me – whether it's just "Mommy, come here look at this." I'm actually their present with them, versus just saying I'm there or acknowledging when my mind is somewhere else." The mothers noted effective communication skills assist when sharing feelings and discussing difficult topics in families. Cynthia shares her conversations with her son, "I talked to Danny. I told him "Look, mommy made mistakes. I want you to go and listen and participate in family counseling so that you are smarter than I am and you don't decide to drink or use

drugs when somebody offers it to you.” I just tell him straight out.” The mothers felt demonstrating effective communication skills allowed for feelings to be shared, acknowledged, and heard. Their children would benefit from establishing healthy relationships by implementing learned communication from their mother.

Subtheme: Teaching My Children Responsibilities. Six of the participants discussed teaching responsibilities to their children. The mothers would perform and teach daily chores to their children. Maria says, “Especially my little boy, he’s six. He loves doing the dishes. Sometimes I let him. Sometimes I have to look and see if they were scrubbed okay. I teach them. I tell them “When you finish eating or something, your cereal or something – don’t just put the plate. At least put some water in there and let it soak,” because they get dry.” Many of the mothers noticed their children mirror cleaning activities alongside them. Sonia explains, “I don’t let her know I’m watching her. But if I sweep, she’s sweeping. That’s how it should be. It’s a good feeling.” The mothers were teaching their children to be competent individuals while participating in family activities – doing chores together. Many of the mothers felt rewarded by contributing to their children’s learning.

Subtheme: Modeling Self-Care. Five of the participants discussed modeling and practicing self-care acts. The mothers recognized the importance of taking care of yourself, in order; to successfully care for their children. Jenny states, “Ya have to take care of yourself to be a good mom. Like the uptake medicine, take it if you’re prescribed it so you can be there.” Many of the mothers found that relapse was attributed to neglecting personal self-care. The mothers would see a downward spiral when not meeting their emotional and physical needs. For example, Sammy shares her experience

with ignoring self-care acts, "If I don't take care of myself, I can't go to work for my children. I can't do any of these things. I didn't do that the first time I went to treatment. I didn't do that. I didn't care about self-care." Understanding the benefits of self-care, the mothers hoped their children would watch and participate in similar acts to becoming healthy, functional adults. Adriana explains, "Because they are learning to take pride in taking care of themselves, which is my job as a mother to teach them how to learn to live without me...successfully without me. And they're able to do that by watching me." Routinely engaging in self-care, the mothers are demonstrating proper physical and mental health care to their children.

As I reviewed the participants' responses on role modeling, it was interesting to hear the positive influence the mothers were trying to instill in their children. The mothers wanted their children to learn independence and task completion. I felt the mothers were attempting to build their child's self-esteem through responsibilities. The self-care practices and communication skills seemed new to the mothers. Many of the mother discussed not participating in prior self-care and struggled with emotional regulation when communicating. I believe these skills were acquired through treatment and have taken some time to implement. I would not be shocked if the women continued to struggle with communication skills and modeling self-care during stressful times in motherhood. It is not always easy to give yourself a "mommy time out" or "let me take a few deep breaths" when facing multiple demands throughout the day. I was impressed by the efforts of the women to influence their children in a positive life direction. It was apparent the mothers wanted to best possible outcome for their children. The next section discusses the consequences of addiction on motherhood.

Category: Consequences of Addiction on Motherhood

The category *Consequences of Addiction on Motherhood* (Table 5.3) describes the havoc addiction creates on the lives of the participants. All twelve participants discuss addiction interfering with mothering practices. Many of the mothers prioritized addiction over their duties as a mother. Addiction clouded their judgement and sent the mothers into a downward spiral. The impact on the lives of the mothers and her family were extensive due to the negative consequences of addiction. Some of the mothers discuss losing everything in their life due to substance use. Three themes emerged within this category – *Impact of Addiction on Me, Impact of Addiction on My Children, and Hitting Rock Bottom.*

Theme: Impact of Addiction on Me

The theme *Impact of Addiction on Me* describes the impairments in functioning due to substance use on the participants. Eleven of the twelve participants discuss the negative impact addiction caused on their daily functioning. Judy shares, “It’s hard to go do things when all you want to do is your addiction. You know?” The participants noticed their relationships deteriorating, enhanced emotional turmoil, impairments in their cognition, and physical sides effects from substance use. However, the strength of addiction overpowered the women. Sonia describes the intense force, “It’s almost like chains on your feet that just hold you down.” Life became more challenging when attempting to balance motherhood and addiction. Four subthemes emerged from the participants’ responses including *Relational Impact, Emotional Impact, Cognitive Impact, and Physical Impact.* The next section provides more details on the impairments of addiction on the participants.

Table 5.3

Category: Consequences of Addiction on Motherhood

Theme	Subtheme	T/S	Segment	<i>n</i>
Impact of Addiction on Me		S	I didn't want to leave the house. I would rather just sit, unless I was going to get what I needed and wanted. That's pretty much how it got to be. (Judy)	11
	Relational Impact	T	I never wanted to spend time with [my children] or do special things with them. I would take them to "You can watch TV. Just watch TV. Mommy wants to go over here. Mommy wants to listen to some music." Because I just didn't want to. (Maria)	8
	Emotional Impact	T	After I had my children, I just felt guilty. It was just a wall of guilt, pretty much, 'cause I know they deserved better. (Sonia)	7
	Cognitive Impact	T	You know, at the time, the only thing I thought about was my substance use. I didn't think about... I couldn't actually go do things without having it with me. It's hard to go do things when all you want to do is your addiction. You know? (Judy)	5
	Physical Impact	T	If I drink too much, I've got this headache. I would sleep all day. I've got children. (Maria)	5
Impact of Addiction on My Children		S	You know, when you get into an addiction, you think that you're only hurting yourself, and you don't really see how you're hurting other people – especially your children. (Judy)	10
	Relational Impact	T	My oldest one in particular probably suffered the most. So she has difficulty with relationships. And I think that was a result of watching my struggles. (Adriana)	8
	Emotional Impact	T	There is one time where I was using, and my oldest son, George, wanted me to read "Clifford the Big Red Dog" to him. He kept asking me and he kept asking me. Because I was under the influence, I kept telling him no because I was too busy doing something else it didn't matter. I will never forget that. He went to bed crying, and that's not something I would do as a mother. I always think about that. (Sammy)	7
	Awareness	T	When we got back to Texas, we both were using and made [my husband and I] ugly with each other. As my kids got older, they started understanding stuff. They knew when we were using. (Leah)	6
	Physical Impact	T	I didn't even mind if my kids went to school. I was late waking them up and I stopped going to functions with them. I wouldn't participate in any of my kid's stuff. (Leah)	5
Hitting Rock Bottom		S	I had to hit my rock bottom, which was going to jail again and have my grandma die. (Jenny)	8
	Family Members Caring for My Children	T	So I kind of pushed them away. They stayed with my mom for three months and we never came back. We were going to go back for them but we fell to use. (Leah)	8
	Negative Consequences	T	And when I say worse, we lost everything. My car, my house, everything. We were on the streets. (Leah)	5
	CPS Involvement	T	CPS came in one day, and I wasn't home. And my children were outside playing with a fire. And they took them, about a year and a half ago, and that was it. (Gina)	5

Note: T/S, Textural/Structural

Subtheme: Relational Impact. Eight of the mothers in the study discuss their relationships suffering during their substance use. The women recognized the escalation of discord with their intimate partners, parents, in-laws, friends, and children when using. Judy explains her relational decline with her son, "When I really got into my addiction, yeah, it affected our relationship really bad and our relationship started going downhill." For some mothers, the intensity of addiction caused a gap in interaction with their children. Adriana explains, "I didn't even speak to my children during that time." Also, the women discussed the relational issues with their significant others. Leah shares, "When [my husband and I] got back to Texas, we both were using and made us ugly with each other." Relationships with family members would deteriorate due to lack of trust from previous actions. "[My ex mother-in-law] thinks I went out partying all that time," says Judy. Relationships were only one of the areas significantly being impacted by the mothers' substance use.

Subtheme: Emotional Impact. Seven of the twelve mothers discuss the emotional impact addiction caused on their lives. Denial allowed the women to continue to participate in their addiction without having to make lifestyle changes. Cynthia explains, "As long as you don't want to see it, you don't have to make a decision about whether or not it's acceptable to you. It's a constant denial." Also, fear attributed to the cycle of addiction in the mothers. "It got to the point where I was scared to open the door. I was just afraid that my world was going to close in on me. I was afraid that somebody was going to find out, take him away from me, or get arrested." says Cynthia. Some of the mothers mentioned feelings of anger and inability to regulate emotions while using. Vanessa explains, "Then when I needed to use again, it started to get kind of shaky,

mean, yelling and angry toward the kids.” The majority of responses by the mothers focused on the feeling of guilt. Many of the mothers reflected on past actions and felt intense remorse for the pain caused to their children. Jaime says, “I shouldn't have been always in my room. I should have been spending more time with my children.” Gina further elaborates on feelings of guilt, “It’s already breaking me down and tearing me apart.” The painful feelings were the most notable impact on the mothers.

Subtheme: Cognitive Impact. Five of the participants discuss the cognitive impairments due to engaging in their addiction. Many of the mothers would prioritize their substance abuse over daily tasks and motherhood. Maria describes her mindset, “I was in my world, and I just wanted to sit and listen to music and drink.” The convincing argument of the addictive mind would blur the mothers’ realities. Sonia explains, “But you are stuck in this mentality where you feel like you need the substance.” The strength of the addiction would capture the immediate focus of the women. Sonia says, “You’re going to say let me get my alcohol. And then I’ll be able to function to give them a bath, which may not be until 11:00 that night. At least I’m getting it done. You’re trying to rationalize and justify it – at least I’m getting it done.” The mothers noticed the power addiction held over their mindsets.

Subtheme: Physical Impact. Five of the participants discussed the physical side effects of substance use. Headaches and increased need for sleep were mentioned by the women when using. Brenda explains, “And whenever I come home from work I had really bad hangovers. My head hurt so I just wanted to get some sleep.” The women discussed decline in daily functioning due to the physical symptoms. Leah shares, “I literally laid in bed and did nothing. Nothing. I could not move or do nothing. I

wouldn't do anything for my kids." The physical impact of substance abuse caused disruption to the participants' lives and perpetuated the downward spiral of addiction.

To me, it felt like the women were struggling to keep their heads above water. They were attempting to juggle two large demands at once – addiction and motherhood. Both of those demands continuously occur throughout the day without any defined end. It was interesting to learn about the strength of fear and denial. The strength of denial and fear seemed comparable to addiction in the psychological, emotional, and physical aspects. All three – denial, fear, and addiction contributed to continued use of substances. Guilt was two-sided as it would be a motivating factor to question lifestyle and make changes, but also attributed to additional use. I was surprised by the length of time the women could keep functioning in this manner before the effects of addiction truly set in. However, the relational breakdowns with the participants' families did not shock me since the participants were focusing primarily on their addiction. The addiction was obviously not only impacting the lives of the mothers. The next section discusses the impact of addiction on the participants' children.

Theme: Impact of Addiction on My Children

The theme Impact of Addiction on My Children describes impairments caused on the children due to the women's substance use. Adriana says, "[My children] do have difficulties because of my substance use." Ten of the twelve participants discuss the relational, emotional, and physical impact endured by their children. The mothers describe situations where their children exhibit distress or a developed understanding of addiction. Gina shares, "Your kids know what you're doing even though they may not know exactly what it is you're doing. They know that you're not their mother at that

point in time.” Four subthemes emerged under this theme including *Relational Impact*, *Emotional Impact*, *Awareness*, and *Physical Impact*. *Relational Impact* describes the disruption in interactions and healthy development in relationships on the children due to their mother's addiction. *Emotional Impact* describes the psychological effects and painful feelings displayed in the children. *Awareness* describes the early acquired knowledge and understanding of addiction in the children. *Physical Impact* describes the lack in structure and safety experienced by the children from their mother's substance use.

Subtheme: Relational Impact. Eight of the twelve participants discuss the relational issues their children experience due to their mother's substance use. Adriana's daughter struggles to develop and maintain healthy relationships due to the dysfunctional relational interactions she experienced from childhood. Adriana says, “My oldest one in particular probably suffered the most. So she has difficulty with relationships. And I think that was a result of watching my struggles.” Some of the mothers noticed a strained relationship with their children from engaging in substance use. Judy shares, “[My son] won't talk to me. He's not ready to reconnect with his mother.” Judy's son has become distant towards his mother and implemented the cut off method he experienced from Judy when previously using. Judy explains, “We were like really close, so close we were like twins. Then all of a sudden I just cut him off basically.” The children were repeating the acquired relational patterns they learned from their mothers.

Subtheme: Emotional Impact. Seven of the twelve participants discuss the emotional impact of addiction on their children. The mothers express their children showing anger, crying spells, and worry. Sammy shares, “[My son] said he cries almost

every night because his brother is in foster care.” Sammy’s son often experiences sadness due to the family being separated. Child Protective Services had intervened and placed Sammy’s eldest son in foster care when she was using. Judy shares the anger her son displayed from her lack of follow-through on promises. She says, “He started talking back. Like one time he told me I was liar, when I would tell him I was going to do something for him. Like I was going to go get him a CD, and he’s like “Oh, mom, you are a liar.” Judy’s son was deeply hurt and angry over the years of broken promises. It seems that many of the children were trying to communicate the painful feelings they experienced from their mother’s addiction.

Subtheme: Awareness. Six of the participants discussed their children developing knowledge and adverse effects of addiction on their mother. The awareness occurred after the children experienced repeated negative situations with their mothers. Maria says, “My little girl is like “Mommy, I like it when you don’t drink. I don’t like it when you drink because when you drink you’re mean.” And then she says “You punish us.”” Maria’s daughter was understanding the changes in emotional reactivity when Maria was under the influence. Leah’s son observed his mother often not being home when he wakes up. Leah says, “My son -- we talk still every night has to say, "I love you, mom" or begs me to stay because he thinks I'm not going to be there. It's not a good life.” Leah’s son learned addiction would lead to his mother abandoning him. He attempts to change the outcome by expressing his love or plead with his mother. The children were grasping the concept of addiction and the impact is caused on their mothers.

Subtheme: Physical Impact. Five of the participants discuss the physical impact of addiction endured by their children. Many of the women expressed chaotic lifestyles

when under the influence. The children would miss school, events, and activities. Leah explains, "I stopped going to functions with them. I wouldn't participate in any of my kid's stuff. I didn't even mind if my kids went to school. I was late waking them up." For some of the women, the lack of supervision and unstructured setting allowed the children to roam without boundaries. For example, Brenda shares, "[My son's] all over the place I had to be watching him all the time. The other one is three. So they're always getting into trouble trying to play with things around the house." With the mothers distracted by their addiction or side effects, their children's safety and education were being neglected.

After listening the responses, it was heartbreaking to hear the women discuss how their behaviors and actions effected their children during addiction. It was especially difficult to read the examples the mothers gave regarding the emotional hurt caused to their children. Many of the mothers showed remorse and broke down in tears when discussing their past actions during the interview. I felt torn – As a person, I wanted so badly to reach out and comfort the women, but as a therapist, I knew it was important for the women to process their experience and regulate difficult emotions. The mothers seemed to grasp the pain they were causing on their children's lives, but it is also apparent that addiction minimizes, denies, and makes one avoid from having to change no matter what the consequences are including the negative impact on their children. The next section will discuss the situations and circumstances the mothers faced at rock bottom.

Theme: Hitting Rock Bottom

The theme Hitting Rock Bottom describes the lowest, distressing moment the participants encountered when in their addiction. Eight of the twelve participants discuss

reaching a point of rock bottom and the associated circumstances. "I became self-aware that I felt depressed, and I was like... Every day was worse than the one before" Cynthia shares, "To a lot of people, that's a softer rock bottom, but believe me, it was painful." The despair Cynthia felt in that moment was so terrifying that she started questioning her lifestyle. Jenny's rock bottom was the moment she no longer had the assistance of grandmother. Jenny says, "I think that's when it hit me. I have nobody to help me anymore. It's only me on my own." Her grandmother had passed away and Jenny was facing arrest charges. She realized she would have no one to care for her daughter while in jail. Rock bottom was extremely painful, but life-changing for many of the women. Three subthemes emerged from this theme – *Family Members Caring for My Children*, *Negative Consequences*, and *CPS Involvement*. *Family Members Caring for My Children* describes the mothers placing their children with of family to provide primary caretaking needs while the participants were in active use. *Negative Consequences* describes the unfortunate circumstances that simultaneously occurred when the mothers were in their addiction. *CPS Involvement* describes the experiences of the mothers regarding Child Protective Services intervening to prevent potential harm on the children.

Subtheme: Family Members Caring for My Children. Eight of the participants discuss placing their children in the care of other family members when using substances. Jenny gave her daughter to her grandmother while she was in the midst of her addiction. She says, "My grandma had my kid at the time." Gina says, "Well, I used to leave my children with my dad. And I would go out and party. And then I wouldn't come home until I was ready to come home." Gina leaned on her father to be the primary caregiver during her addiction. Vanessa also utilized family members to care for her children and

assumed this was their role. She recalls, “putting the responsibilities off on the grandparent or another family member, thinking that they are supposed to do it.” Leah placed her children with her husband’s parents during her use. She says, “So I sent my kids to go to my in-laws. I was pretty much on the streets just so I can use.” At this point, the participants were highly invested into their addiction. The women were willing to set aside their role mother and give family members the authority to make decisions on the care of their children.

Subtheme: Negative Consequences. Five of the participants discuss the harsh consequences they encountered during their addiction. Some of the women spent time in jail while others lost personal possessions. Jenny states, “[I] didn’t do aftercare. So then I went back to using again. Then I got put in jail.” Jenny ended up in jail after ignoring the maintenance of her sobriety. Judy encountered both – she went to jail for six months and lost her personal identification documentation when released. Judy shares, “I was in jail, and the person I was staying with – a bunch of us were staying there – got kicked out. I lost all my IDs.” Judy recalls being homeless and unemployed without any supportive paperwork to identify herself. Leah’s experience was similar with being unemployed and losing her possessions due to engaging in her addiction. “I knew that we weren’t going to be able to pay our bills because neither one of us was working because we were using at the time.” Leah shares, “we lost everything. My car, my house, everything.” The consequences the women endured due to their addiction assisted in hitting rock bottom.

Subtheme: CPS Involvement. Five of the twelve mothers share their experiences with CPS intervening. Some of the mothers are familiar with the Child Protective Services after experiencing the system during their childhood. Brenda shares, “I never,

ever, ever imagined my kids would go through what I went through but everything's happened. I just hope they don't have to stay there that long.” Other participants were shocked by CPS intervening and removing their children. Gina shares, “CPS came one day, and I wasn't home. And my children were outside playing with a fire. And they took them, about a year and a half ago, and that was it.” Sammy felt appreciative for CPS intervening and helping her become accountable for her actions. Sammy shares, “Over time of using a substance, it changes your judgment. I'm not the person that I am. How can I be a mom at all? I'm so grateful that CPS intervened and removed my child.” Leah was surprised for the lack of involvement by Child Protective Services in her situation. She states, “I've never had CPS. I should have had them called on me.” Even though the participants experienced a variety of feelings towards CPS, it was clear that their lives were falling apart and on the verge of losing their most valuable asset – their children.

Hitting rock bottom seemed to be a significant moment for the participants when hearing their responses. The women seemed to recognize their life crumbling apart as some lost their homes, cars, jobs, and children. It makes sense that their worlds would start to dismantle when the women were placing most of their energy into their addiction and neglecting other life demands. I was shocked at how many women gave their children to family members to care for when they were using. I am spilt three ways on this decision. First - confused, “How could she just give her child away like that.” Second - pitied, “Wow, that must have been a very low point in her life to give up care of her children. Third, impressed, “She knew she could not appropriately care for her children, and placed them in a better situation.” Losing their jobs and homes were difficult for the women, but CPS intervening and losing custody of their children seemed to be the lowest

point for the mothers. They were trying so hard to prevent this situation from happening and even avoided treatment with fears of CPS involvement. The mothers questioned their lifestyles and decided to make different choices in their lives. The next section discusses the role of motherhood in recovery.

Category: Being a Mother During Recovery

The participants describe their experiences during treatment and the impact recovery played on their role as a mother. Jenny says, "Sobriety actually impacts me being a good mom every day." The third category, *Being a Mother During Recovery* (Table 5.4), discusses specific changes the women have made to their lives. The women are implementing learned strategies to reduce relapse, mending relational damage, and discovering meaning in their lives. Gina shares her changes: "Right now, I believe I'm being a good mother by staying sober, coming to my classes, completing everything that CPS wants me to complete, keeping in contact with them, having negative drug test and right now fixing my house so that my children have a bed to sleep in and food on the table, taking care of bills, taking care of business." Three themes emerged within this category – *Treatment's Role in Staying Sober, Fixing the Damage, and Discovering My Purpose*.

Theme: Treatment's Role in Staying Sober

The theme *Treatment's Role in Staying Sober* describes the integration of knowledge and strategies the mothers acquired during treatment into their regular lives. Seven of the twelve participants discuss approaches to maintaining a life of sobriety. Sammy explains, "Two words are committed and application. I'm really focused on that in outpatient. I have to stay committed to my recovery, and I have to apply it to my day

every second.” The participants notice when life becomes challenging outpatient treatment can assist. Leah says, “And then my outpatient helps me, my recovery. I love that. I love being at my meetings because when I'm having a bad day and I feel like I'm stuck.” Under this theme, three subthemes emerged – *Learning to Cope, Protecting Sobriety, and Choices*.

Subtheme: Learning to Cope. Seven participants discuss a variety of ways to cope when handling difficult situations and emotions. Some of the women discuss seeking assistance from sponsors or listening to the recommendations of supportive others when dealing with hardships. Vanessa says, “My sponsor was telling me that it was going to take a long time to actually schedule. I thought it was going to be – bam, bam, bam. I was going to have to sit down and think about, what I'm going to actually schedule for the kids, and make sure it happens.” Vanessa reached out to her sponsor when feeling overwhelmed with responsibilities. Her sponsor supported Vanessa in sitting down every day and developing a schedule. Sammy receives support from staff and individuals in Sober Living. Sammy shares, “I want to be monitored so that I can get that feedback and have that accountability. Right now that's what I'm doing to be a good mom. I'm moving to a Sober Living House, so that I have supported people around me, helping me live the right way as a family.” Other methods of coping can be implemented solely by the participants. Gina explains, “Right now I just take one day at a time, one problem at a time. I don't let everything pile up on me. So if I can, I'll deal with a few at a time.” Gina breaks down responsibilities to reduce stress. Similarly, Vanessa completes as many responsibilities as possible then leaves the rest for the following day. She says, “I've also

Table 5.4

Category: Being a Mother During Recovery

Theme	Subtheme	T/S	Segment	<i>n</i>
Treatment's Role in Staying Sober		S	It feels good to still be in outpatient because I'm still working towards staying sober. (Sonia)	7
	Learning to Cope	S	So I try not to think about everything that I have to pay. I just take on one [problem] at a time and try to manage the rest. (Gina)	7
	Protecting Sobriety	T	Sometimes you have to just walk away. It sucks, and it's not fair, but it's really sometimes as simple as "You know what? This is a threat to my sobriety." (Cynthia)	7
	Choices	S	I made a different choice to go to sober living instead of going back out in the world and even going home to my grandma's house. (Jenny)	5
Fixing the Damage		S	Because I'm able to kind of look at my behavior in retrospect and kind of see where things went wrong. (Adriana)	8
	Not Going Backwards	T	I don't ever want to go back to being that person because my children have been without me for a year and a half. (Gina)	6
	Making Amends	T	I apologized to him for "You remember when this happened when mommy was angry and ..." I basically took responsibility and told him that it was because I had this problem, and "I'm doing all these things so that I can heal from this, and I'm sorry for what I did or what I didn't do." I was specific with him and told him "It was not your fault. You did a good job. I'm sorry." (Cynthia)	5
	Taking Time to Repair Relationships	T	I know it's by living in by action, especially with my children, but it's scary. It takes time, and you're going through a grieving process. It's a lot. (Sammy)	5
	Reuniting with My Children	T	And now I'm trying to get everything good in place so whenever they come back home they're going to come back home to the same environment they used to be in. (Brenda)	5
Discovering My Purpose		S	When I had my children, this is what I felt like I was meant to do, ya know, my calling. (Sonia)	6
	Wanting to Be a Mom	T	I just want to be a mom in my life and my life back with my kids. (Jaime)	7
	Finding Direction	T	I'm an after-care facilitator now ever since I graduated. I have a sponsee. Somebody else asked me to sponsor them today, too. (Cynthia)	6
	Finding Myself	T	So sobriety has made me -- I found out who Leah really was because I've lost myself. So I'm becoming the person I want to be and it's helped me so much. I have energy, just everything. I got myself back. (Leah)	5

Note. T/S, Textural/ Structural

been realizing if I don't get everything done, I try to get as much done as possible. I would kind of cheer myself up to keep going, and I can just do it tomorrow." By coping with challenging feelings and events, the mothers are mentally and physically stronger to fight off cravings and reduce potential triggers to relapse.

Subtheme: Protecting Sobriety. Seven of mothers discuss engaging in practices to protect their sobriety since thoughts of use and triggers still exist. Cynthia explains, "You have to shield yourself from that to protect your sobriety." The mothers vocalized fighting off potential threats to their sobriety. Leah elaborates, "And it's a struggle everyday fighting for your life because when you're sober you have the devils already waiting for you out there. [Addiction is] always waiting for you. Even on things you used to do, it will sneak up on you." Some mothers protect their sobriety by developing an encouraging mindset when surrounded by triggers. Judy says, "Just do the next right thing. That's all you have to do. Do not put any substance in your body, and do the next right thing. Everything will work out." Judy tells herself to focus on making the next step that supports her sobriety. Other participants changed their surrounding environments. Sammy shares, "I'm surrounding myself with good people. I'm around somebody that's doing the right thing." By changing the people, places, and things in their lives, the mothers protect their sobriety.

Subtheme: Choices. Five of the twelve participants discuss making healthy choices to continue a route of sobriety. The women discuss reintegrating to their lives after treatment and the positive choices that assist in staying sober. Gina shares "I'm refraining from my addiction. I'm staying away from people that I used to go out with. I come to my outpatient classes. I talk to my counselor. I do regular drug tests. I mean,

I'm just really, really trying to stay away." Cynthia adds to making a conscious choice to stay sober. She says, "I don't want to be surrounded by that anymore. I recognize how getting caught up in somebody's tornado whips me into a tornado. I now see that I have a choice as to whether or not to going to that tornado, and I choose not to." The participants discuss how poor choices lead to relapse. Jenny shares, "I thought it was a game and I could go talk to the same people and go do the same things. And you can't because we don't change those things. You're going to have the same result...put it that way." The women recognized they hold the power to maintain sobriety by participating in healthy decisions.

After hearing the responses from the women, it makes sense on how life can be challenging when trying to transition back into their lives with numerous triggers still present. When in treatment, an individual is removed from potential threats, but reintegration causes many to relapse. I felt the mothers were making significant changes, putting in a great deal of effort, and engaging in activities that promote sobriety. I have no doubt that the women face challenges every day and rely on coping mechanisms when they can. I feel society believes that going to treatment is the answer to sobriety. However, the women did an excellent job explaining how their journey of recovery is merely just starting. They work to maintain their sobriety on a daily basis which seems to be a heavy load in itself along with caring for their children. The mothers also have to repair portion of their lives that were impacted by their addiction. The next section focuses on *Fixing the Damage*.

Theme: Fixing the Damage

Fixing the Damage is a theme describing the participants' motivation to mend areas of their life impacted by their substance abuse. Eight of the twelve mothers discuss eagerness accompanied by uncertainty on how to repair damage. Sammy says, "I've caused so much damage. I'm trying to figure out how to fix that." Similarly, Gina says, "Right now I'm trying to focus on what needs to be fixed." Many of the women had time to reflect on past behaviors and actions that negatively impacted their lives when in treatment. Sammy shares, "With parenting and outpatient, I'm reflecting on my parenting now." Four subthemes emerged within this theme including *Not Going Backwards*, *Making Amends*, *Taking Time to Repair Relationships*, and *Reuniting with My Children*.

Subtheme: Not Going Backwards. Six of the twelve mothers discuss not falling back into their previous unhealthy lifestyles. Some of the participants still have an unnerving fear of relapse that never seems to dissipate. Leah states, "I will never go back to using, but everyday I wake up and I pray and I pray that I never go back to that lifestyle again." The participants seem to move forward by remembering their blessings and what could be lost when relapsing. Gina says, "Not letting anything take the place and all the positive things that are going on and not letting anybody take my children or anything take my children away from me ever again." Gina stays determined by recalling what she could lose if she slips. Likewise, Jenny stays sober by thinking of her daughter as her most value asset. She says, "But I make the choice not to because why would I come this far to go backwards when I have the most precious gift sitting right in front of my face." The participants seemed to not fall off the wagon by identifying the improvements in their lives and reminding themselves of what could be lost. Even with years of sobriety, the continuous fear of relapse is always lurking in the mothers.

Subtheme: Making Amends. Five of the participants discuss taking ownership for the harm caused and providing apologies for their actions. Many of the mothers made amends to their children. Cynthia says, "Most of my amends to my son are what they call living amends. One example of that is just me being sober. I'm essentially making amends to my son every day I am clean." Cynthia took responsibility for her past mistakes and apologized to her son. Other participants engage in activities to rectify their past actions. Sammy explains, "What I've done is I bought Michael, my youngest son, that same book. I found it at Sam's. Whenever we're all together again, I let George read it to Michael. We can all be in there, tucking him into the bed. That's just the best that I can do to make up for what I've done. It's my way of making amends." Some mothers were shocked by the responses they received when mending relationships with family and friends. Gina shares, "One of these girls that I had problems with, about two weeks ago, I said that I was sorry to her for everything that happened in the past. And she just turned around and looked at me and started laughing. She was like, I've been wanting to tell you the same thing. So my amends have been going okay." For the participants, making amends was emotionally difficult. The mothers directly faced their mistakes which kept them accountable and allowed for an opportunity to apologize for past actions.

Subtheme: Taking Time to Repair Relationships. Five of the twelve participants discuss the process of repairing relationships with family and friends. The mothers recognized that healing would evolve over time especially rebuilding trust. Judy wrote a letter to her son hoping to reconnect their relationship. She says, "I have written my son a letter, asking for forgiveness. I know in his time, he will come around." Sammy shares, "I

know it's by living in by action, especially with my children, but it's scary. It takes time, and you're going through a grieving process. It's a lot." Sammy understands her children are still hurting by is making attempts to follow through on her words and demonstrate reliability. Leah's children are cautious when rebuilding their relationship with her.

"Right now, [my children are] just broken because we broke too many promises." says Leah, "I think that they're excited but then they're like, "Okay, we're been through this before because we've done this before."" Judy fears rushing the relationship with her son due to excitement over her granddaughter. She says, "It's going to be very hard to stand back and stand up and not try and just rush it. I just want a relationship with my granddaughter so bad." It was apparent that the mothers were still in the process of repairing and rebuilding trust with family and friends.

Subtheme: Reuniting with My Children. Five of the participants discuss reuniting with their children after being separated for a lengthy period of time. Some of mothers are separated from their children by Child Protective Services. The mothers express the hardship of being without their children. Brenda says, "So it's been really hard and now I'm trying to get everything good in place so whenever they come back home they're going to come back home to the same environment they used to be in. I just hope it goes good." Brenda is hopeful that her children will return to the home soon. Gina is also still in the process of reuniting with her children. She says, "Well, 'cause [my children are] without me. We haven't had visitation. I know that's terrifying to them. I promised them that they'd come home. I really want them home." Gina desperately wants her children home and to make up for lost time during the separation. Sammy is going through the reunification process with CPS. She explains, "I am going to get Michael

back, but it's a process – unsupervised visitations, weekend visitations. Then they give them back to me. It's a long process.” For Jaime, she has completed the recommendations by CPS and reunited with her children. Jaime says, “I just got children back three weeks ago.” However, state agencies are only reason for separation. At times, estrangement occurred due to the choice of the children. Judy's son cut off his relationship with his mother. She says, “Right now it's really kind of difficult because, like I said earlier, my son is not ready to reconnect with me. I have a granddaughter that will be three in September that I've never seen.” Judy hopes to reunite with her son and meet her granddaughter someday soon. Being separated from their children has been extremely difficult for these mothers, but they are hopeful to reunite in the future.

Considering all the possible damage compromised by addiction, the participants were up against a challenging road of repair. The women were working hard to rebuild the foundation that was destroyed from broken promises, hurt feelings, and deception. I understood the mothers wanting their relationships to return to previous levels of closeness and trust especially their children. For many, their children seemed receptive to rebuilding the relationship. However for others, the process of repair would take a very long time. This theme highlighted the underlying hope the participants held that encouraged them to keep making efforts to fix the damage. I believe the hope would assist these women in overcoming the obstacles and stay motivated in their sobriety. The next section discusses the purpose and meaning the women derived during recovery.

Theme: Discovering My Purpose

The theme *Discovering My Purpose* describes the revelations the mothers uncovered during the recovery process. Six of the twelve participants discuss discovering

meaning in their lives and experiencing true happiness. With a clear mind from sobriety, the women could access parts of themselves that gave them direction. Adriana states, "Being sober allows me to grow. And I can't grow as a mother if I'm using. When I'm using, I can't grow as a person much less grow as a mother. Whenever I'm using, there's really no growth going on." Some mothers found purpose from helping others in need. Cynthia shares, "I just feel like part of my purpose is to help people figure out how to [find help]. I think that's part of the reason I've been through what I've been through." Other participants recognized the joy and fulfillment from motherhood. Sonia says, "[Motherhood] gave me purpose in life." Three subthemes emerged – *Wanting to Be a Mom, Finding Myself, and Finding Direction*.

Subtheme: Wanting to Be a Mom. Seven of the twelve participants describe the meaningfulness of motherhood. Judy says, "Having children was really the big thing for me. It was so important." For many of the women, motherhood brought a sense of purpose to their life. "I think [motherhood] was my calling." says Sonia, "It's a good feeling. It's better than getting wasted. It's way better." The joys of motherhood created a pleasant feeling in the mothers. Maria says, "It does feel good. It feels awesome. It feels good to be a mom while I'm staying sober." For many of the mothers, their children played an essential role in perpetuating change. Jenny says, "I can tell [my daughter] what I went through so she will know how she changed me." It seems motherhood contributed to the women discovering their purpose in recovery.

Subtheme: Finding Myself. Five of the participants discuss the journey of self-discovery when in treatment. Jenny says, "You're learning yourself, and you're learning about your kid." The mothers had time to focus on themselves and engage in soul-

searching. Leah says, "So I'm becoming the person I want to be and it's helped me so much." The women noticed an increase in their self-esteem and happiness when getting in touch with their inner selves. Judy explains, "I'm happy. I'm upbeat. Let's see. What else? I'm probably more loving and caring and open, especially... That is a lot. I'm just a totally different person, totally different." Leah relates, "I am a better person. I am confident. I feel amazing. I feel like a whole new woman." Self-discovery and introspection also benefits their children. Adriana explains, "It also allows my kids to see me. Because I think that they learn a lot about themselves by learning who their mother is. And if I'm using, they don't know me. They don't know who I am. They don't know the real mom." Looking deep inside, the mothers seem to bring forth their "real self" during recovery process.

Subtheme: Finding Direction. Six of the mothers discuss finding direction in their lives during recovery. When in addiction, the mothers felt lost and depressed. Jenny says, "You don't know what you're doing from day-to-day." The mothers felt their lives were chaotic and empty. "I felt depressed, which causes the using." says Sonia, "I had no direction in life." After entering treatment, the mothers started to pull meaning out of their past experiences. Cynthia shares, "The reason why I said this is because I feel like I have a purpose. I think that's part of the reason why I've gone through a lot of the adversity that I have in my life." The purpose extracted directed the mothers in new life pursuits. Judy says, "Yeah, so just one person helping me has just opened the doors into the area I want to be in, which is helping people. I like to help people, especially the homeless." The mothers engaged in new passions seem to experience greater life satisfaction.

As I reviewed the responses from the participants, I was really captivated by their introspection and revelations. The mothers showed deep insight when exploring their inner selves. I could tell the women worked hard during their recovery to learn about themselves and how to move forward. To me, it made sense that the women would find meaning and direction through self-analysis. It was also understandable that the women would want to help others and give back to the community. By doing so, an individual evokes a sense of altruism. I could easily relate to that feeling by being a therapist and wanting to improve the lives of others. Motherhood seemed to also elicit a gratifying feeling in the women and provide meaning into their lives. The women wanted to be the very best mothers they could for their children which ignited change. The next section describes the Risk Factors in the participants that likely assisted in development of addiction.

Category: Risk Factors

The participants describe Risk Factors that increased their likelihood for developing an addiction. The fourth category, Risk Factors (Table 5.5) identifies the exposure of adverse events on the women. The mothers endured a variety of biological, psychological, and family vulnerabilities making them more susceptible to negative outcomes. Maria shares, "Yeah, I remember my childhood was rough for me and my brother." Two themes emerged within this category – *Types of Trauma and Life Stressors*.

Theme: Types of Trauma

The theme *Types of Trauma* refers to the traumatic events that occurred influencing the participants' development towards addiction. Eight of the twelve mothers

discuss experiencing some form of trauma including physical, emotional, sexual abuse, and/ or neglect. For some of the participants, trauma was experienced in childhood. Cynthia shares, "I grew up in a lot of dysfunction." For others, trauma occurred during the participant's substance abuse. Brenda explains, "One of my friends got killed because she was really, really drunk. She fell asleep in the car and she drove onto the 59th wall and she killed herself. She had four little kids." From the responses, four subthemes emerged including *Family History of Addiction, Childhood Abuse, Sudden Grief and Loss, and Abandonment*.

Subtheme: Family History of Addiction. Four of the twelve mothers discussed their family history of addiction. Leah says, "[Addiction] runs in the family." The women were often genetically predisposed and raised in environments that promoted substance abuse. "My family history," says Cynthia, "My genetics plays a part." Cynthia recalls the interactions in her family as being very dysfunctional. She says, "That combination of variables led to me having a problem." Similarly, Gina's family would often engage in substance use. She says, "I thought [using] was just a way of life. That's the way I grew up around my family." The family history of addiction placed the mothers at risk for substance abuse.

Subtheme: Childhood Abuse. Three of the participants discuss suffering from physical, emotional, and sexual abuse as children. The distressing childhood abuse continued to impact the women into adulthood. Sonia shares, "I mean like my traumatized childhood, stuff like that kind of gives me no purpose in life." Recalling the childhood abuse lead to past depressive states for Sonia. Her depression would often trigger Sonia to use. Maria relates to Sonia's experiences by engaging in substances to

mask her feelings. Maria shares, "I know it's got to do with my childhood. As I was growing up and the stuff that happened, it drove me to drink and cover the pain that I feel." The mothers were at risk to develop an addiction after experiencing childhood abuse.

Subtheme: Sudden Grief and Loss. Three of the participants discuss the traumatic sudden loss of a close family or friend. For some mothers, the loss was a family member. Jenny says, "[My grandma] passed in March...a couple months ago." Losing her grandma was a difficult loss for Jenny. Jenny's grandma had filled the role of "mom" when Jenny's mother abandon her. Jaime's sudden loss was even more traumatic. She shares, "I had twins back in October. In December one of them passed away for SIDS." For Brenda, she lost a close friend. She says, "[My friend] fell asleep in the car and she drove onto the 59th wall and she killed herself. She had four little kids." The sudden and intense grief responses in the mothers made them vulnerable to using substances.

Subtheme: Abandonment. Two of the participants discuss being traumatized from childhood abandonment. Both the women faced abandonment issues in relation to their mothers. Brenda shares, "Yeah, because my mom was never there." At only 11 years old, Brenda was removed from her home and placed into shelters by CPS. For Brenda, she felt deserted by her family. She says, "Since I have no family -- well, I have my family but it's like I didn't have them at all." Jenny related to Brenda's childhood experiences. She shares, "My mom left me in the hospital when I was born in Phoenix, Arizona." Jenny's mother abandoned Jenny shortly after her birth. Jenny says, "My mom was just a person who had me." The lack of physical presence by their mothers and endured

Table 5.5

Category: Risk Factors

Theme	Subtheme	T/S	Segment	<i>n</i>
Types of Trauma		S	Since I have no family -- well, I have my family but it's like I didn't have them at all. I haven't been home since I was 11 years old. I grew up in CPS custody. So I know how it works out, the shelters are, and I don't want that for my kids really bad. (Brenda)	8
	Family History of Addiction	T	I thought it was just a way of life. That's the way I grew up around my family. I thought I could manage it, too, but I can't. And I don't want my kids to grow up the way I grew up. (Gina)	4
	Childhood Abuse	T	I know it's got to do with my childhood. As I was growing up and the stuff that happened, it drove me to drink and cover the pain that I feel. (Maria)	3
	Sudden Grief and Loss	T	I had twins back in October. In December one of them passed away from SIDS. That day CPS took all my kids from me and then they were gone for seven months. But they had to make sure that we didn't [hurt] the baby or whatever. The autopsy came back that it was SIDS, natural death or whatever. (Jaime)	3
	Abandonment	T	My mom left me in the hospital when I was born in Phoenix, Arizona. My mom was just a person who had me. I don't call that a good mom. (Jenny)	2
Life Stressors		S	I have a husband that I have to cook, clean, take care of my children. I have a lot of stuff to do and it's just...[stressful]. (Jaime)	10
	Single Parenting	T	We got divorced, no kids. I really got basically screwed. I didn't get anything out of the divorce. But I wanted out bad enough I just went. I said "Okay, whatever" and signed the papers. (Judy)	6
	Managing Responsibilities without Help	T	Before the treatment, it was really hard because you had to deal with everyday things like taking the kids to school, being able to drive them to school, feeding them and being -- always being able to watch over them because -- since they were so small. (Brenda)	5
	Having Multiple Children	S	It's just really hard whenever you try to do everything by yourself, especially when you've got so many kids and they're so small. (Brenda)	4
	Marital Problems	T	I know it's hard because my husband and I are having little arguments and marriage problems, so that got me off the track. (Maria)	3

Note. T/S, Textural/ Structural

emotional hurt caused significant abandonment issues in the women. Trauma involving childhood loss seems to have contributed to the development of addiction.

Listening to the various trauma the mothers endured was terribly disheartening. I felt the women were placed at an unfair advantage in their lives due to their childhood experiences. Many of the women grew up in dysfunctional families where they were exposed to child abuse and neglect. My heart broke when I heard a couple of the participants discuss being abandoned by their mothers. As a therapist, I understand the importance of attachment and attunement between mother-child relationships. That bond was damaged and left the mothers in a vulnerable position. The emotional and relational development in the women was hindered early-on from childhood abuse and neglect. It makes sense that the women would seek substances to emotionally-regulate. The mothers were not shown appropriate ways to cope from traumatic life events.

Theme: Life Stressors

Ten of the twelve participants describe stressful life situations that contributed to the development of addiction. The mothers discuss experiencing a variety of hardships that added stress to their lives. Gina says, "The more stress I get, the more I'll think about using." When life stressors would pile on the women, they struggled to cope. Many of the women would revert to substance abuse during difficult situations. Judy says, "I would have used this as an excuse to go out and get drunk and do whatever." Several common life stressors were identified as subthemes – *Single Parenting, Managing Responsibilities Without Help, Having Multiple Children, and Marital Problems.*

Subtheme: Single Parenting. Six of the twelve participants discuss the stress of single parenting. The mothers attempted to care for their children, but were limited due to

finances or support. Judy says, "Being a single parent with no child support, it was hard." For some of the women, they took on the role of both mother and father. Jaime says, "I've always been mom and dad. I mean it was hard but I did it." Some of the mothers had to find other avenues to support their children including returning to the workforce. Brenda shares, "So whenever [my husband] left and things went down and I had to work and would drink at work." It seems the stress of single parenting wore the mothers thin and made them susceptible to developing an addiction.

Subtheme: Managing Responsibilities Without Help. Five of the participants discuss the stress of managing responsibilities with little assistance. Vanessa shares, "As a person, I really don't like to be overwhelmed with responsibilities." The women would care for their children, pay bills, maintain their household, and work without support. Brenda explains, "Before I had to pay a babysitter. I had to pay my car. I had to pay the rent. I had to pay the light. I had to pay the phone bill. I had to do everything." The piles of responsibility seemed daunting to the women. Sammy says, "I would look at all these things that needed to be done. I would get overwhelmed. I let my stress overwhelm me." Unfortunately, the women had no choice, but to tackle the responsibilities on their own. It seems the mounting stress of responsibility placed the women in a vulnerable position especially towards addiction.

Subtheme: Having Multiple Children. Four of the participants discuss the stress of having multiple children. Jaime says, "Very stressful because I have four children." For Jaime, she was raising four children which became overwhelming at times. Brenda experienced similar stress raising her four children. She says, "It's just really hard whenever you try to do everything by yourself, especially when you've got so many kids

and they're so small." Maria would attempt to manage requests by her children. "If [my daughter] said "Mommy, can we play? Can you fix this for me?"" explains Maria, "James broke it, or James messed it up. I need for you to help me put it back together." Having to tend to multiple children and being pulled in various directions caused high strain on the mothers.

Subtheme: Marital Problems. Three of the participants discuss enduring relational strain in their marriages. Leah says, "[My husband and I] were arguing." Leah admits her marriage was becoming toxic. The women noticed frequency and intensity of arguments rising with their significant others. The issues in the marriage would build causing significant tension in the mothers. Maria explains, "My husband and I are having little arguments and marriage problems, so that got me off the track." The discord between Maria and her husband was impacting her stress levels. It seems some of the mothers were dealing with marital problems causing high levels of stress.

After listening to the responses, the mothers were obviously under a great deal of stress. It was troubling to hear the daily struggles of the women. I felt my own anxiety rising as they described tending to multiple children as a single parent while juggling all the responsibilities. It made sense that the women would feel pressured by the stress. Many of the mothers had limited (if any) support to unwind after a series of difficult days. I empathized with the mothers and wanted to point out their strengths as a therapist. Also, it is understandable the mothers could only function for so long under extreme stress before needing some type of break. Unfortunately, this need for a break placed the women in a vulnerable position to develop an addiction.

Composite of Textural-Structural Analysis

Being a Mother in Outpatient Treatment for Substance Abuse encompasses a variety of experiences and views on motherhood while dealing with an addiction. The mothers share the meaning of good mothering as they reflect on consequences of their addiction. They also describe the process of recovery in motherhood while acknowledging attributing risk factors to the development of addiction. The combination of structures and textures attempts to describe the essence of motherhood in outpatient treatment for substance abuse to capture this phenomenon in the following narrative.

Being a Mother in Recovery means navigating life on a new road. You construct an ideal of good mothering to self-reflect on. You recognize the impact your addiction played on yourself and your loved ones. You make changes to your life to keep yourself sober while trying to heal past damages. You discover your inner self and find meaning to your life. You acknowledge the obstacles that contributed to your development of addiction. You learn to stop taking the same previous rocky path of addiction.

As a mother, you want to give your children the very best. You try your hardest to protect your children from danger and stick to a schedule. "Kids need a lot of stability." You show your children love by offering kisses and having cuddle time. You spend time with your children, participate in their activities, and make sure to always be there for them. You show them how to cook, clean, and live independently. "You teach them everything they know." You talk to your children about life so they feel they can talk to you. Most importantly, you make sure you take care of yourself. "It's kind of like you can't love someone if you don't love yourself."

However, addiction blinds you from being a good mother. "I knew I was capable of better." The relationships with your children, family, and friends suffer. Your focus

becomes your addiction. "You love the substance more than you love yourself or the child because of the intoxicated feeling or whatever the escape." You are tormented by feelings of guilt and shame. "But then it makes me feel bad because I feel like I have neglected them at times when I would drink." You notice your children are starting to understand something is off. They get upset when you leave and act out for your attention. Your children miss school and functions. "You don't participate in school activities. You leave your kids. You forget about them. You just stop being a mother." It keeps getting worse. You spend time in jail or CPS intervenes. Life spirals downward until finally you hit your rock bottom and lose everything.

With your last bit of hope, you go to treatment. You learn new ways to cope, recognize the power of choices, and ways to protect your sobriety. When you leave treatment, you realize the "real" fight for your life begins. "And it's a struggle everyday fighting for your life because when you're sober you have the devils already waiting for you out there. It's always waiting for you." At any moment, you might slip. "Everything is new. It's the scariest thing right now because I used for so long." That fear pushes you to keep going to your outpatient classes for support. You continue to "work the steps" and slowly repair your relationships especially with your children. During the process, you start feeling like yourself again. You discover meaning to your life and the passion to be a good mother.

With a clear mind, you recognize how your addiction developed. You can see the dysfunction you grew up in and the traumatic events that left you vulnerable. "I understand the dynamics of it, and I can label the dynamics of the situation." You are also more aware of the stress you were constantly under. "It's just really hard whenever

you try to do everything by yourself, especially when you've got so many kids and they're so small." Now, you work hard to reduce the load of stress. "I just take one day at a time, one problem at a time. I don't let everything pile up on me." You learn to express yourself more and forgive those that have hurt you in the past. "Along the way, I was able to kind of make amends to my mother who unfairly carried a lot of the blame when it reality, it wasn't her. So I was able to forgive her. And our relationship has been strengthened." Life seems to be better as long as you remember: "Whatever you put above your sobriety you're going to lose."

Core Essence

The composite textural-structural description helps reveal the core essence of mothers in outpatient substance abuse recovery. Mothers describe the merging of two significant domains – sobriety and motherhood. The categories *What It Means to be a Good Mother* and *Being a Mother in Recovery* combine to form a new identity. A “good mother” involves women incorporating positive changes to their lives that promote sober living while fulfilling the responsibilities of motherhood. The essence provides an understanding of what it is like to have experienced outpatient substance abuse treatment as a mother.

Discussion

The findings assist in uncovering the “essence” of this phenomenon and answer the proposed research questions of the study. The composite textural-structural description of the participants helps to form an understanding of the first question: *What is the lived experience of mothers in outpatient substance abuse treatment?* The mothers describe reconstructing their lives since being in treatment. They shift between the

consequences of their addiction and the changes being implemented to support their recovery. The participants undergo a continuous fight as they battle daily triggers, cope with painful emotions, and engage in choices that protect their sobriety. Outpatient treatment provides an environment where the participants can watch others, learn new behaviors, and apply similar actions to their lives for a successful outcome. The lifestyle changes in the women are consistent with Bandura's Social Cognitive Theory. A central focus for the women involves repairing the relationship with their children. The mothers recognize the process to mend the damage takes time, but they strive to reunite and rebuild the bond with their children. The women fear relapse as they return to their previous lifestyle of addiction and neglect their role as mothers. The results affirm addiction in mothers interferes with the essential mother-child bond discussed in Bowlby's Attachment Theory. Also, the women discuss self-reflecting and soul-searching during recovery. The women discovered meaning in their lives and a sense of happiness. As the women came to terms with their "actual" selves, they moved closer to their perceived "ought" selves. This finding affirms Self-Discrepancy Theory where one experiences emotional discomfort when confliction occurs between beliefs of the self.

Further, the data provides valuable information on beliefs about good mothering practices to answer the secondary question: *What do mothers in outpatient substance abuse treatment believe makes for a good mother?* The participants discuss their beliefs on attributes and practices a "good mother" should possess. The women believe mothers should provide a secure and consistent environment, promote a loving relationship, and model positive life skills to their children. Many of the women noted engaging in actions

Table 5.6

Answering the Research Questions

Research Question	Category	Explanation
Question # 1: <i>What is the lived experience of mothers in outpatient substance abuse treatment?</i>	Consequences of Addiction on Motherhood <i>Example Themes:</i> Impact of Addiction on Me, Hitting Rock Bottom	The mothers discussed the impairments addiction caused on their lives during substance abuse treatment
Question # 1: <i>What is the lived experience of mothers in outpatient substance abuse treatment?</i>	Being a Mother During Recovery <i>Example Themes:</i> Treatment's Role in Staying Sober, Discovering My Purpose	The mothers discussed their experiences in outpatient substance abuse treatment and the positive changes they are making that promote a sober lifestyle
Question # 1: <i>What is the lived experience of mothers in outpatient substance abuse treatment?</i>	Risk Factors <i>Example Themes:</i> Types of Trauma, Life Stressors	The mothers reflected on factors that put them at-risk for developing an addiction when in substance abuse treatment
Question # 2: <i>What do mothers in outpatient substance abuse treatment believe makes for a good mother?</i>	What It Means to Be a Good Mother <i>Example Themes:</i> Nurturing the Relationship, Being a Good Role Model	The mothers believe providing a safe and secure environment, fostering the relationship with their children, and being a good role model make for a good mother

or activities that displayed good mothering practices, and the fulfilled sensation when performing these tasks. They also referenced times when they were distracted due to their addiction and the associated guilt when failing to meet mothering obligations. The results are consistent with Higgin's Self-Discrepancy Theory that an individual's experiences cause feelings of anxiety, shame, and guilt when exhibiting discrepancy in oneself.

The results from this study support the literature by confirming risk factors to mothers in recovery. The participants were at-risk for developing an addiction due to past trauma and chronic daily stressors. The women endured a variety of trauma including family history of addiction, sudden loss, childhood abuse, and neglect. The unrelenting stressors of single parenting, multiple children, lack of support when managing numerous responsibilities and marital problems contributed to substance abuse in the mothers. Both trauma and life stressors exist in the research as vulnerabilities to the development of addictions in females. This study supports previous knowledge on child welfare issues associated with parental substance abuse. The participants often described the deficits to their parenting when under the influence. The mothers had strained relationships, experienced physical side effects and emotionally distressed due to their focus being captivated by their addiction. Much of the research presents similar findings on maternal substance use.

This research better informs services and clinical practice with mothers in substance abuse treatment. First, mothers seem more apt to engage in coping skills, healthy choices and parenting classes when observing positive changes in others. Mentorship programs would allow peers to share stories, encourage skill implementation, and guide newly enrolled mothers in treatment. Second, bonds between mothers and their

children have been damaged due to her substance use. Promoting attachment-based activities in family therapy would reestablish the mother-child bond during treatment. Third, self-esteem and self-worth can be increased in women by identifying her purpose in life. Interest inventories and job placement opportunities would provide direction for mothers in treatment. Finally, the research affirmed risks factors and child welfare issues for mothers with substance abuse issues. Wrap-around services can assist mothers that are susceptible to relapse due stress and past trauma. Working closely with child welfare workers, goal-setting towards family reunification, and engaging children in treatment services can increase the chances for mothers to regain/retain custody of their children. The next chapter elaborates on the major findings of the study, address limitations, and provide recommendations in clinical practice and future research.

CHAPTER VI

SUMMARY, IMPLICATIONS, AND RECOMMENDATIONS

This study provides a deeper understanding to the experiences of mothers in outpatient substance abuse treatment. The results contribute to potential implications in clinical practice for mental health professionals and treatment services for chemically dependent mothers. Limitations are addressed along with recommendations for future research to advance substance abuse treatment for mothers.

Summary

The purpose of this study was to answer the proposed research questions: *What is the lived experience of mothers in outpatient substance abuse treatment? What do mothers in outpatient substance abuse treatment believe makes for a good mother?* The in-depth answers explore the journey of mothers through outpatient treatment for substance abuse and provide updates to current trends of gender-specific treatment services for women. Most of the relevant literature is outdated or focused on child abuse and neglect regarding maternal substance abuse. The findings from this study reveal rich, full descriptions of the struggles, changes, and benefits the mothers encountered when in recovery.

The literature review provided an in-depth analysis of past research on motherhood in substance abusing women. The overview considers Self-Discrepancy, Attachment, and Social Cognitive Theories when applied to the ideology of motherhood. The research addresses barriers and stigmatized lifestyles that impact mothering. Additionally, the background analysis reviews research on maternal self-efficacy in chemically dependent mothers.

The methodology of the research study is discussed. The researcher utilized a transcendental phenomenological approach, which attempts to describe the lived reality of the participants from a fresh, open perspective. Openness was achieved by bracketing the researcher's own experiences and knowledge. By implementing this qualitative research method, the researcher fully explored the experiences of mothers in recovery. Purposeful sampling was utilized to target sites with the population of interest, mothers attending outpatient substance abuse treatment, for the study. Flyers were distributed around three facilities to recruit mothers for the study. Twelve semi-structured, in-depth interviews were conducted by the researcher. The face-to-face interviews were audio-recorded to capture the experiences of the women. The researcher transcribed audio-recordings into digital format and uploaded transcriptions into a qualitative data analysis program, MAXQDA. Using Moustakas' modified phenomenological method, the researcher identified categories, themes, and subthemes. The use of analytic memoing throughout the data collection and analysis process assisted in reconstruction of merging data. Major themes and subthemes were organized under categories to capture the essential "essence" of the phenomenon.

Self of the researcher section provides space for the researcher to bracket experiences that may influence the study. The researcher set aside preconceptions regarding guilt and shame in women for prioritizing addiction over motherhood, feel labeled by society as an "Unfit Mother" due to her substance abuse issues, and have lower perceived maternal self-efficacy prior to conducting interviews. The disclosure of personal and professional experiences allowed the researcher to attend to information with a fresh outlook.

The results section provides a description of the participants and the major findings of the study. Demographic information and overview of the participants is initially discussed followed by the development of 4 categories, 11 themes, and 39 subthemes. The first category, *What it Means to Be a Good Mother*, had three themes emerge - *Providing a Stable and Safe Environment*, *Nurturing the Relationship*, *Being a Good Role Model*. The next category, *Consequences of Addiction on Motherhood*, had three themes emerge - *Impact of Addiction on Me*, *Impact of Addiction on My Children*, *Hitting Rock Bottom*. The third category, *Being a Mother During Recovery, and Risk Factor*, identified three themes *Treatment's Role in Staying Sober*, *Fixing the Damage*, *Discovering My Purpose*. The last category, *Risk Factors*, had two themes emerge *Types of Trauma and Life Stressors*. The emerging themes and subthemes in this qualitative study are broken down into detail. Finally, the findings are combined to reveal a composite narrative explaining the phenomenon.

This chapter summarizes and note implications to the findings while connecting this study to previous literature. First, I discuss how the study supports current research on child maltreatment when parental substance abuse is involved, shame and guilt associated with motherhood ideals, and risk factors associated with addiction. Next, I provide a better understanding at what recovery is like for mothers in outpatient substance abuse treatment by adding to the research. Finally, I discuss implications for clinical practice and treatment services for mothers.

Supporting the Literature

The mothers in the study indicate the negative effects addiction caused on their lives. The theme *Impact of Addiction on Me* discusses relational, emotional, cognitive,

and physical impairments when engaging in substances. My study supports Cash and Wilke's (2003) findings noting emotional distress, relational issues, and difficulty fulfilling the role as mother when abusing substances. Wells (2009) focuses on substance abuse and child maltreatment, particularly the impairments in caregiving abilities with lack of supervision and consistent care. Similarly, the mothers in my study struggled to provide adequate care to their children by neglecting emotional needs and missing school. Also, many of the mothers experienced hardships including arrests, homelessness, and financial strains due to substance abuse. These findings support Wells (2009), who identifies environmental dangers (i.e. unstructured settings, unsafe living conditions, and frequent strangers entering the household) to children when parents engage in substance abuse. The subtheme, *CPS Involvement*, supports the research in the child welfare system becoming involved due to threats of abuse, neglect and unsafe environments for children with parental substance abuse.

My study affirms Liss et al.'s (2012) findings on the difficult emotions, including guilt and shame, mothers expressed for not living up to their potential as mothers during their substance abuse. For example, the subtheme *Emotional Impact* discusses the mother becoming depressed when recalling past behaviors in their addiction and internalizing guilt. My study shows similar findings between guilt and shame linked to depression in mothers.

Female substance abuse often is a result of traumatic events. Brady and Ashley (2005) support the theme *Types of Trauma* from my study that describes the variety of traumatic events the women endured that preceded to their development of addiction. The participants recount past child abuse, abandonment from caregivers, sudden loss, and

growing up in a family with addiction problems. The mothers' responses support existing literature of self-medicating to cope with their exposure to trauma.

Center for Substance Abuse Treatment (2009) addresses stressors women encounter that trigger initial use. The research recognizes hardships including relationship discord, marital status, and caring for others as precipitators to substance use in women. My research findings agree with previous literature in the theme *Life Stressors*. The participants revealed stress associated with marital problems, single parenting, caring for multiple children, and managing responsibilities without assistance as risk factors towards developing addiction.

The theme *Fixing the Damage* supports Covington's (2000) theoretical overview of treatment models for women. The participants discussed their efforts to rebuild relationships with their loved ones especially their children. Further, the theme *Discovering My Purpose* revealed the positive self-worth the participants attained from recovery. As the women learned about themselves in treatment, a desire was evoked to rebuild the lost connection with their children which is discussed in the subtheme *Wanting to Be a Mom*. By reforming the relationship with substances, the mothers reconnected with their families. The existing research suggests disconnection and disruptions in relationships create psychological distress in women. The subthemes *CPS Involvement* and *Family Members Caring for My Children* describe the disruption in their relationships with their children. The mothers in the study experienced high levels of distress when they were separated from their children. Maintaining the relationship with their children seems to be an essential piece when working mothers in substance abuse treatment.

Much of the shared lived experiences by the mothers in recovery confirms past research and existing literature. This information is useful, but ignores the purpose to expand knowledge and trends in the field. For this, the rich descriptions assist in adding insight to lives of mothers while in outpatient treatment for substance abuse. The detail gathered in this study provides valuable information on shortcomings and advances in treatment for maternal substance abuse.

Enhancing the Literature

Past research has been beneficial in identifying approaches to working with mothers in substance abuse treatment, but lacked depth into the continued struggles and needs of women. This study paints a vivid portrait of the theme *Impact of Addiction on Me* that aid clinicians' approaches to treatment interventions on maternal guilt and shame. The women suffer from painful emotions of guilt and shame regarding their past parenting actions. As Gina says, "And I'm thinking about all the bad things that I did when I was in my addiction." The mothers learn parenting skills while in treatment, but are constantly reminded of old memories where they fell short from being under the influence. Sammy shares, "Because I was under the influence, I kept telling him no because I was too busy doing something else that didn't matter. I will never forget that." The women harbor those negative feelings. They attempt to reduce the emotional distress by engaging in believed proper mothering practices. However, the strained relationship with children only signifies their past parenting mistakes and underlying feelings of guilt and shame emerge again. "I have a son that's still struggling with [anger] because he's seen a lot more than the other one has but they don't have that mom they used to have."

Leah explains, "I was like the perfect mom until I started using." The women lose confidence in themselves and their abilities to be an ideal "good mother."

Current approaches embrace spirituality and self-discovery in treatment (Robinson et al., 2007). This research refines previous research on spirituality and self-discovery by highlighting the importance of purpose in the theme *Discovering My Purpose*. By identifying core values and unique gifts in treatment, women can pursue interests that provide direction in their lives. Meaning gives women a reason to stay sober. Jenny explains, "Something to look forward to." Meaningful acts for women include volunteer service work, careers in the helping profession, and motherhood. Judy shares, "I like to help people, especially the homeless." Fulfilling her role as mother restructures her sense of self and builds on her self-worth. "[Motherhood's] a good feeling. It's better than getting wasted. It's way better." Sonia explains, "I think that was my calling." A mother's psychological and spiritual well-being is strengthened. She has a higher likelihood of counteracting negative feelings of guilt and shame with life purpose.

Unresolved Guilt and Shame. Mothers in recovery for substance abuse experience a great deal of unresolved guilt and shame. The mothers rehash their negative past behaviors and actions as they work on their sobriety in treatment. The emotional toll weighs heavy on the mothers when they notice the impact on their children. They recall past situations where their addiction took priority over their children. Listening to their stories and watching the women break down tugged at my heart. The women were in enormous pain regarding regrettable decisions of the past and failing to live up to their capabilities as mothers. How does one effectively cope with feelings of guilt and remorse? Many of the mothers tried making up for past mistakes by following

recommendations by the treatment program, but the pain still lingered. Feelings would be stirred up again when attempting to restore relationships with their loved ones. The slowly evolving relationship with their children was difficult for the mothers. The mothers mourned for the close relationships they once had with their children and reflected on how their life got to this point. The women were in a constant battle of inner turmoil with themselves.

Guilt and shame can be paralyzing especially in motherhood when a woman is caring for innocent children. Her moral compass is torn when she engages in wrongful acts and puts her children at risk. She evaluates her behavior and attempts to make right of her wrongs, but outstanding wrongs leave her feeling shameful. The mothers held countless wrongs that were left uncorrected. Self-forgiveness was certainly a challenging area for the mothers in recovery.

Guilt and shame have been areas addressed in past research and treatment services (Ehrmin, 2001; Parolin & Simonelli, 2006; Baker & Carson, 1999; Rotkirch & Janhunen, 2010; Liss et al., 2012). This study illuminates guilty wrongdoings and lingering feelings of shame in mothers. Letting go seems to be a process especially when encountering future situations that trigger these distressing feelings in women. The mothers appear to have difficulty moving forward with their lives and maintaining sobriety when guilt and shame continue to hold the women in the past.

Meaningful Life. Finding meaning and purpose in their lives was an essential component to the mothers in substance abuse treatment. Prior to being sober, the women felt like they lacked direction with little hope, dreams, and goals. They often neglected their obligations as mothers and established a faulty sense of meaning which caused

distressing feelings of anxiety and depression. To fill that void, substances are used to escape emotional pain. Eventually, the women lost their sense of self. Life no longer had meaning and the vicious cycle of addiction continued. However, treatment interrupted this cycle. The mothers began finding themselves through activities that encouraged soul-searching and introspection in treatment. By rediscovering themselves, the women were learning about their own unique abilities. Some found meaning through helping others. Others discovered purpose from motherhood. The mothers noticed reconnections occurring with their children as they engaged in their fulfilling role as mother. This provided motivation and hope for the women. The women noticed positive changes in their attitude and outlook on life. New life pursuits were being explored and meaning was being attributed to their lives.

Hearing the women share their aspirations and the joyous fulfillment of motherhood, I could see the excitement in their faces. The mothers had found direction which filled the emptiness. This passion would help in recreating their sense of self. It is understandable that constructing meaning in one's life provides excitement and hope for the future. The women felt they were being pulled towards a calling. By satisfying this need, the women were redefining their selves. They would identify in positive roles such as mother, employee, and volunteer. These roles encourage connections with others. Again, connection is motivating factor for women in recovery. It builds her confidence and sense of self.

I want therapists, mental health professionals, and treatment services to know that motherhood seems to provide a sense of meaning and purpose in a woman's life. The rewarding fulfillment from being a mother fills a woman's directional gap when

substances are removed from her life. She rediscovers core values and explores strengths that she offers as a mother. She engages in mothering practices toward her children that delivers deep satisfaction. Motherhood appears to promote sobriety and helps to keep women committed to the path of recovery. Mental health professionals can utilize a strengths-based approach by identifying strong attributes a mother already possesses in her parenting capabilities and incorporate meaning from motherhood.

Meaning and purpose keep a mother moving forward in her recovery. She reforms her identity and reconnects to others. She is better equipped to handle difficult emotions including shame and guilt. These negative feelings can distract women by focusing on past hurt. However, life purpose can offset the emotional distress and refocus the mothers. She engages in positive acts that build on her self-worth. She feels valuable to society. Meaning enriches a mother's life and promotes commitment to recovery.

Adding to the Literature

This study provides deeper insight into the beliefs and perceptions of "good mothering" in women attending substance abuse treatment. Previous literature describes intensive mothering practices and the barriers many women face from achieving ideal standards of motherhood. Couvrette et al. (2016), Reid et al. (2008), Baker and Carson (1999), and Hardesty and Black (1999) are a few of the relevant studies that have been conducted on views of chemically dependent women regarding motherhood ideals. Couvrette et al. (2016) and Reid et al. (2008) identify "good mother" essentials that support my category *What It Means to Be a Good Mother*. Baker and Carson (1999) describe the deficits in parenting when the mothers were under the influence affirming my category *Consequences of Addiction on Motherhood*. Incongruity can be seen

between the perceived mothering ideals and expressed discrepancies in the mothers. Hardesty and Black (1999) describe the process of reconstructing mothering ideals by incorporating recovery into the role of mother which supports my third category, *Being a Mother During Recovery*.

Defining a Good Mother. Couvrette et al. (2016) and Reid et al. (2008) reveal views on good mothering ideals in chemically dependent women. My study shows similar views on "Being a Good Mother." From the responses, a good mother was defined as providing a secure and safe environment, fostering a relationship with her children, and demonstrating life skills that promote success. The women shared their individual experiences in supporting their ideals to good mothering practices. Some women established schedules and routine in the household while others taught their children responsibilities. Most of the mothers acknowledged the importance of being physically and emotionally present with their children. The mothers could articulate the impact good mothering practices had on their children's well-being. Each of the expectations described in the mothers seemed to be accomplishable daily tasks.

Baker and Carson (1999) discuss neglectful parenting behaviors in substance-abusing mothers and the potential harm caused upon their children. My study shows similar findings as the women reflected on their shortcomings in motherhood during their addiction. The mothers recall living in a chaotic, unstructured household and often emotionally unavailable. Many of the mothers felt self-care to be a selfish act and limited their engagement in self-maintenance behaviors due to their misconceptions prior to receiving treatment. When using substances, distance grew between the mother's ideal standards and her actual practices of mothering. The mothers saw their relationships

crumbling and their functioning being impaired. The mothers would become overwhelmed with distressful feelings for not living up to her mothering capabilities. It seems the longer the women used, the further they moved from achieving their views of good mothering practices.

Hardesty and Black (1999) discuss recreating the role of mother in recovery. My research supports the renegotiation process of a mother's identity and new set of expectations to the role of mother that was introduced during treatment. Outpatient treatment encouraged the mothers to engage in self-care practices. The mothers learned and practiced new coping strategies that they would model to their children. Also, the women would participate in recovery maintenance by attending meetings and avoiding situations that would threaten their sobriety. The mothers had to reconstruct previous ideals of mothering to incorporate their current lifestyle practices. This means a "Good Mother" in women attending treatment would involve her tending to her recovery on a daily basis.

Motherhood for women in recovery differentiates from societal ideals. These mothers have additional expectations to their role as mother. The mothers need support from mental health professionals and treatment programs in forming a maternal identity that includes recovery maintenance. The next section addresses implications to theory and clinical practice.

Implications to Theory

This research was guided by three main theories - self-discrepancy theory, attachment theory, and social cognitive theory. My findings are consistent with

intertwined theories addressed in this study. I discuss how my findings closely support the current concepts relating to each of the theories in this study.

Higgins (1987) explains self-discrepancy theory as the emotional consequences for conflicting beliefs about the self. My research illustrates self-discrepancy theory by acknowledging the discrepancy in the mother's known capabilities toward parenting and her actual parenting practices when using substances. The women explain the emotional discomfort endured when reflecting on past caregiving to their children during their substance use. The mothers would neglect mothering obligations and struggle to function properly when using. Emotional availability was limited along with physical presence for several mothers. Yet, their actions and behaviors were much different than their beliefs on being a good mother. The mothers identified three essential areas on good mothering practices. They noted providing a safe and secure environment, nurturance, and positive role modeling. The mismatch in actions versus beliefs caused discrepancies in the women. The women were facing an internal battle between their actual self and ought-to-be self. The discrepancies would lead to feelings of anxiety, depression, guilt, and shame for not living up to their ideal mothering capabilities.

Bowlby's (1973) theory on attachment describes a necessary need for an infant to bond with a caregiver, and the adverse impact to a child's development when disruptions occur in the mother-child relationship. My work depicts attachment theory by identifying interruptions to the mother-child bond when the participants were abusing substances and negative effects on the child's well-being. Many of the mothers describe focusing more on the relationship with their addiction than the relationship with their children. They describe the overpowering strength of the addiction as dysfunctional type of love. The

women would “nurture” the relationship with their addiction with continual use. As they prioritized their love for addiction, their role as mother slowly diminished. The women noticed the impact addiction was causing on their mothering practices. The women’s households were often chaotic and disorganized. Their daily functioning was impaired by hangovers or increased need for rest. The mothers would struggle to get their children to school on time or attend functions. Basic essentials including food, clothing, and shelter were provided, but emotional availability was often lacking. Some of the mothers even confessed to being physically absent. Quality time and bonding moments with their children significantly decreased when the mothers were engaging in substance use. The limited emotional connection and physical presence hindered the attachment process with their children.

The mothers noticed the developmental effects on their children’s well-being. The children began to show signs of socioemotional disturbances. The mothers recognized the trust issues that often occurred in their children due to the inconsistencies as a mother. The children struggled to form healthy relationships with others due to severed bond with their mother. Also, the children would often have emotional outbursts and difficulty regulating emotions. The mothers attributed emotional pain, hurt, and anger in their children to their unavailability when using. The children seem to be experiencing emotional and relational distress due to the formation of insecure attachments with their mothers.

Bandura (2001) explains social cognitive theory as the process of learning through watching others. My research illustrates social cognitive theory by identifying the new learned approaches for handling every day stress and triggers in the mothers.

Parenting classes and outpatient treatment demonstrate techniques for emotional regulation and stress reduction. Parenting classes demonstrated positive skills for the mothers to use to assist with child-rearing. The classes taught self-care practices and scheduling techniques to maintain routine in the home. The mothers learned new ways to relax and manage difficult emotions by observing self-care demonstrations by the group facilitator and listening to success stories of women in group sessions. Watching and listening encouraged the women to attempt the techniques on their own with their children. The parenting classes allowed the women the opportunity to feel comfortable taking on similar tasks. Mothers described sitting down and writing out daily schedules while others discuss staying consistent with their medication regimen. Some of the mothers learned the benefits of patience when dealing with behavioral challenges with their children.

In outpatient treatment, the mothers learned new strategies for coping with life stressors. Again, the mothers watch and observe others triumph through hardships. This encourages the women to engage and continuously practice outside of treatment. The mothers discuss breaking down problems to reduce stress loads. Also, the mothers discuss managing emotions when faced with situations that may trigger a relapse. The women noticed their confidence raising when successfully engaging in coping and parenting skills. The successful outcomes for mothers promoted future attempts in the learned practices. Her perception on her ability to handle life stressors and mothering practices raised. Maternal self-efficacy in the women improved during treatment and parenting classes. The next section discusses the implications to clinical practice and treatment services.

Implications to Clinical Practice

This research informs mental health professionals on helpful treatment approaches when working with mothers in substance abuse recovery programs. Suggestions are offered to improve the quality of services provided to women in treatment. Suggestions to clinical practice are established from the gathered data and the main guiding theories in this study.

Mentorship Programs. Mentorship provides increased opportunities for connection with women in substance abuse treatment. Mentorship programs allow mothers to gain additional support with newly acquired parenting skills. Mothers can attend parenting training classes and be supplied with an individual mentor. The mentor is a safe and non-judgmental peer who can assist with child-rearing practices. The mentor has successfully completed the parenting training program and supervised by a clinician (Tracy et al., 2011). This would allow the mentor to assist mothers with challenges, skill implementation, and guidance. Women can speak individually to mentors on personal hardships in mothering tasks. Mentors can share similar stories of motherhood to create an empathetic relationship with their mentee while offering helpful suggestions that demonstrate successful outcomes in child-rearing (Murphy et al., 2008). The mutual relationship of sharing promotes connection and community in treatment services. Mothers reflect on the information provided by their mentors (Tracy et al., 2011). When mothers believe they have the capability to perform effective strategies in parenting, they are more willing to engage in the recommendations. Mentorships programs can assist in building maternal self-efficacy and a women's sense of self.

Attachment-Based Activities. The bond in mother-child relationships has been disrupted during a mother's addiction. Bond rebuilding can occur during family therapy sessions. Promoting attachment-based activities during therapy can assist in the repair process. Interactive activities supporting reconnection between mother and child involve physical closeness, smiling, eye contact, soft tones, and touch. Some activities to promote attachment include - thumb wrestling, feather blowing, rubbing lotion on skin, balancing objects on head, cooking together, clapping in rhythmic pattern together, sharing snacks, and having the child teach an interest to the adult (Munns, 2009; Booth & Jernberg, 2010). These activities create opportunities for mothers to attune, empathetically respond, and playfully engage with their children. The interactions in attachment-based family therapies generate healthy socio-emotional development (Booth & Jernberg, 2010).

Identifying Meaningful Direction. Many women lack purpose and meaning in their lives when struggling with addiction. Treatment services that offer opportunities for women to discover career options and interests provide direction in her life. Career counseling is useful in identifying one's personal strengths, skills, and talents. During sessions, the women engage in assessments and inventories to pinpoint satisfying occupations that closely match their unique attributes. Job placement opportunities can be offered as well to encourage women to begin utilizing their specialized talents. The new direction reconstructs the woman's sense of self and gives value to her life (White et al., 2006). Her self-esteem and self-worth rises. Successful recovery maintenance occurs due to established life goals, participation in self-fulfilling acts, and gained hope.

Wraparound services. Wraparound services provide mothers with added support that improve treatment outcomes. Many women encounter chronic stress that place them

at-risk for relapse. Mothers are often raising multiple children in single parent homes with limited external support. Wraparound services that offer therapeutic child care, housing options, employment assistance, and family reunification plans with child welfare workers aid mothers in relapse prevention (Osar et al., 2009; Marsh & Smith, 2011). Trauma is another area that often perpetuates relapse in women. Women experience emotional distress from past traumatic events without knowledge on coping mechanisms to self-soothe. Many trauma survivors self-medicate with substances to avoid feeling anxious or depressed (Covington, 2008). Wraparound programs in treatment that provide primary and behavioral health care assist women in managing difficult emotions. Women learn to cope with symptoms and triggers related to trauma by engaging in activities that self-soothe (i.e. exercising, meditating, listening to music, reading, and taking medication) (Covington, 2007). Wraparound services offering support to reduce daily stressors and trauma symptoms assist women in relapse prevention.

Mentorship programs, attachment-based activities, identifying meaningful direction, and wraparound services can improve overall care to gender-responsive treatment programs. The provided suggestions to clinical practice guide mental health professionals in helpful approaches when working with women in substance abuse treatment. The next section discusses the limitations to this study.

Limitations

There are several limitations that need to be addressed in my study. This study included some anticipated limits while also encountering a few unexpected. Anticipated limitations sample size, and sampling strategy. Unexpected limitations include participant

demographic, openness in interviews, and length of time between initial interviews and follow-up meetings. These issues may have restricted my findings in this study.

Qualitative research in nature is smaller in sample size. Even with recommended sample sizes to meet saturation needs, qualitative research has significantly less participants than quantitative research due to time constraints and available resources. In-depth interviewing provides the researcher with rich descriptions of the participants' experience. However, data collection and analysis is time-consuming. When saturation was met, the researcher concluded recruitment. Future studies increasing sample size may alter findings from this study.

Purposeful sampling is an effective strategy for identifying and selecting knowledgeable participants in a particular phenomenon of interest. For this study, I recruited adult mothers that were currently attending outpatient treatment services. Another limitation of this study was not including teenage mothers. This population may offer differences or additional insight into the perspectives of motherhood while attending outpatient treatment. Capturing the views of teenage mothers in recovery could enhance the findings and potential recommendations for clinical practice.

I had prepared myself for the anticipated limitations, but was surprised by the unpredicted issues that occurred. The first being the demographics of my participants. My sample of participants included four Hispanic, seven Caucasian, and one African American females. Even though there was some diversity in the recruitment sample, my study consisted of mainly of Caucasian and Hispanic mothers. I am uncertain to why my race diversity was scarce since addiction impacts all cultures, races, and socioeconomic statuses. Also, Houston is known to be one of the most diverse cities in the United States.

My initial thought would be the social stigma surrounding mental health and substance abuse issues. Other cultures and races may struggle to seek assistance for substance abuse issues due to cost, available resources, and cultural practices towards healthcare. Another consideration for racial disparities in my study may be due to willingness to participate for research. Volunteer rates in minorities are often low due to distrust, lower education levels, and access to care where research occurs (Fisher & Kalbaugh, 2011).

Another unexpected limitation was the openness during interviews. Most of the participants were forthcoming in describing their experiences. However, a few participants were more reserved to share. This could be attributed to the limited time I had in building a rapport with my participants. Some participants may have experienced past trauma resulting in trust issues. Discussing sensitive information may have been challenging for these participants. More time or multiple interviews with these mothers may have improved the researcher-participant relationship encouraging the willingness to openly express experiences.

The final unanticipated limitation involves the length of time between initial interview and follow-up meeting. The follow-up meetings were completed eight months after the initial. Even though the mothers that participated in the member-checking process confirmed their personal narratives, time may have altered their perceptions. Length of time between initial interviews and follow-up meetings should be reduced to provide accurate recall on information shared.

Some of the limitations were expected while others occurred during the research process. These limitations provide valuable information in developing and expanding future recommendations. The next section focuses on recommendations for research.

Recommendations

The rich data gathered from this research study provided insight into the lived experiences of mothers attending outpatient substance abuse treatment. The use of phenomenology allowed the researcher to explore this phenomenon of interest and affirm much of the past research conducted. It also contributed to the base of knowledge regarding perceptions of good mothering practices in chemically dependent mothers. The in-depth interviews assisted in determining areas of research that may further understanding of this population in future studies.

Potential future qualitative studies examining the experiences of motherhood in other substances and addictions may contribute additional information to this phenomenon. This study focused primarily on the experiences of mothers recovering from alcohol abuse. Studies on illicit substances in mothers may provide insight into parenting practices when engaging in criminal behavior. Also, studies focusing on alternative addictions (i.e. gambling, sex, shopping, exercise, etc.) may provide valuable information on the perceptions of motherhood when in recovery.

Future studies can utilize quantitative approaches and compare findings against the themes of this study. Quantitative research has the advantage of being repeatable and analyzed quickly. Researchers can survey larger pool of participants in less time than qualitative studies. Utilizing the Parental Sense of Competence Scale (PSOC) or similar surveys that measure satisfaction and efficacy in parents may assist in identifying significant variables (Gilmore & Cuskelly, 2009). Results acquired from the quantitative studies may verify and quantify findings from this study. The results have potential for generalizability. Broad inferences can be drawn about the perceptions of motherhood

during recovery. Quantitative studies may further enhance the understanding and provide a closer representation of the phenomenon.

Qualitative research assists in developing a hypothesis that can be tested through quantitative studies. This qualitative study identified the integration process between sobriety maintenance and proper child-rearing practices in mothers. The mothers had to establish balance and reconstruct former good mothering ideals. Intensive mothering practices would cause painful feelings and unnecessary stress in the women which puts them at-risk for relapse. Instead, I propose future research focus on examining balance between one's personal, sobriety-related needs with the responsibilities of parenthood. Brudenell (2000) found the process of balance being an essential component when substance-abusing mothers were integrating recovery into their lifestyles. Ratnapalan and Batty (2009) suggest implementing the concept of "Good-Enough Mothering" approaches where the child's needs are still met, but with a softer method of tiering down in care as the child grows. Good-enough mothering approaches would assist in incorporating balance rather than complete devotion concepts from intensive mothering practices. Treatment programs would promote standards of sufficient attunement, emotional regulation, and protection without sacrificing the mother's own needs. Having therapists and psychoeducational settings trained in and implementing good-enough mothering practices would also help in diminishing skewed messages by society. The interventions steer away from being an "outstanding" mother, but rather provide guidance in performing at the best capacity she can in a moment. Societal ideals of mothering are misaligned with the recovery process. Chemically dependent mothers need to establish boundaries, balance, and stability. Good-enough mothering approaches encourage a

lifestyle that is beneficial to recovery by emphasizing structure, balance, and limits, but will need to address faulty messages of maintaining sobriety through one's children. Intensive mothering neglects those essential aspects. Future quantitative studies may implement a factorial survey to examine variables contributing to the formation on good-enough mothering practices. Results from the studies may assist in dismantling the impossible demands of intensive-mothering ideals and portray a closer representation of parenting that is comparable to various motherhood lifestyles.

The addressed areas can add to the literature and improve current treatment trends to chemically dependent mothers in outpatient services. Continuing to examine the perceptions of motherhood in variety of addictions would enhance current knowledge on addiction treatment modalities when working with mothers.

Conclusion

This study explored the lived experiences of mothers attending outpatient substance abuse treatment. Much of the findings validate previous research on the impairments and child welfare issues that occur when using substances. It also confirms risk factors for addiction development. This phenomenological study enriched the literature by providing the perspectives of good mothering practices and the impact of treatment services in chemically dependent mothers. The mothers identified important aspects of parenting that contribute to positive child development and how addiction hindered their ability to carry out these tasks. The mothers incorporated skills learned in treatment to their daily lives and acknowledged the benefits occurring due to these changes. It was evident on the deep love these women had for their children. The mothers were working hard to making positive changes for a better life for both themselves and

their children. The women understood the damage addiction caused, but were trying every day to repair pieces of their lives. This study reaffirms the negative impact addiction can instill in a mother's life and the challenging process to restore the broken aspects.

Treatment services and mental health professionals working with mothers should integrate meaning and purpose attained from motherhood. This seems to provide direction and hope in women when recovering from addiction. The rewarding fulfillment of motherhood can boost a woman's self-worth and self-efficacy. She has the psychological, physical, and spiritual strength to fight off potential threats to her sobriety. Her solid sense of self propels her to continue participating in good mothering tasks while reducing discrepancies between her actual and ideal self.

This has been an extremely rewarding and healing journey for myself. I have been pushed past limits that at one time I thought were impossible. These incredible women from my study have helped heal pieces of me by opening up my perspective on motherhood during addiction. They allowed me to walk side-by-side with them and share their unique stories. By hearing their struggles, accomplishments, and dreams, empathy and compassion grew in my heart. I admire their willingness to share such personal experiences. The women have expanded my thinking on this phenomenon and made me a better clinician for the future families I will assist in my profession. A deep-hearted thank you to the women of this study and the impact you will serve towards future research.

REFERENCES

- Abarashi, Z., Tahmassian, K., Mazaheri, M. A., Panaghi, L., & Mansoori, N. (2014). Parental self-efficacy as a determining factor in healthy mother-child interaction: A pilot study in Iran. *Iranian Journal of Psychiatry and Behavioral Sciences*, 8(1), 19–25.
- Adams, M. (2015). Motherhood: A discrepancy theory. *Research and Theory for Nursing Practice: An International Journal*, 29(2), 143-157.
- Agrawal A, Gardner CO, Prescott CA, Kendler KS. (2005). The differential impact of risk factors on illicit drug involvement in females. *Social Psychiatry and Psychiatric Epidemiology*. 40(6):454–466.
- Aikens, N., Tarullo, L., Hulse, L., Ross, C., West, J., & Xue, Y. (2010). ACF-OPRE Report: A year in head start: Children, families, and programs. Washington, DC. US Department Health and Human Services, Administration for Children and Families, Office of Planning, Research, and Evaluation.
- Al-Jayyousi, G.f., Roy, R.N., & Al-Salim, F. (2014). Muslim Mothers and Migration. *International Journal of Education and Social Science*, 1(4), pp. 41-49. Retrieved from February 21, 2015 www.ijessnet.com
- Amagoh, F. (2008). Perspectives on organizational change: Systems and complexity theories. *Innovation Journal: The Public Sector Innovation Journal*, 13(3), Article 3.
- Anderson, C. (2010). Presenting and evaluating qualitative research. *American Journal of Pharmaceutical Education*, 74(8), 141.
- Ardelt, M., & Eccles, J. S. (2001). Effects of mothers' parental efficacy beliefs and

- promotive parenting strategies on inner-city youth. *Journal Of Family Issues*, 22(8), 944-972.
- Arendell, T. (2000). Conceiving and investigating motherhood: The decade's scholarship. *Journal Of Marriage & Family*, 62(4), 1192-1207.
- Ashley, O.S., Marsden, M.E., Brady, T.M. (2003). Effectiveness of substance abuse treatment programming for women: A review. *American Journal of Drug Alcohol Abuse*. 29:19–53.
- Austin, M.J., Chow, J., Hastings, J., Taylor, S., Johnson, M., Lemon, K., Leer, E. (2004). Serving low-income families in poverty neighborhoods using promising programs and practices: Building a foundation for redesigning public and nonprofit social services. Retrieved February 21, 2015 from <http://cssr.berkeley.edu/pdfs/lowIncomeFam.pdf>
- Baker, P. L., & Carson, A. (1999). 'I take care of my kids': Mothering practices of substance-abusing women. *Gender & Society*, 13(3), 347-363.
- Baldwin, D. H., Rawlings, A., Marshall, P. S., O'Neill Conger, P., & Abbott, B. A. (1999). More Empowerment, Too! (ME2): A Program for Young Mothers Involved in Substance Abuse. *Public Health Nursing*, 16(6), 376.
- Baldwin, K. (2006). The Relationship among Shame, Guilt, and Self-Efficacy. *American Journal Of Psychotherapy*, 60(1), 1-21.
- Bandura A. (1982). Self-efficacy mechanism in human agency. *American Psychologist*, 37 (2), 122-147.
- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.
- Bandura, A. (1999). Self-efficacy: Toward a unifying theory of behavioral change. In R.

- F. Baumeister (Ed.) , *The self in social psychology* (pp. 285-298). New York, NY, US: Psychology Press.
- Bandura, A. (2001). Social Cognitive Theory: An Agentic Perspective. *Annual Review Of Psychology*, 52(1), 1.
- Bandura, A. (2006). Guide for constructing self-efficacy scales. In F. Pajares & T. Urdan (Eds.). *Self-efficacy beliefs of adolescents*, (Vol. 5., pp. 307-337). Greenwich, CT: Information Age Publishing.
- Banwell, C., & Bammer, G. (2006). Maternal habits: Narratives of mothering, social position and drug use. *International Journal Of Drug Policy*, 17(6), 504-513.
- Bar, M. A., & Jarus, T. (2015). The effect of engagement in everyday occupations, role overload and social support on health and life satisfaction among mothers. *International Journal Of Environmental Research And Public Health*, 12(6), 6045-6065.
- Barnard, M. N. (2004). The impact of parental problem drug use on children: what is the problem and what can be done to help?. *Addiction*, 99(5), 552-559.
- Benight, C. C., & Bandura, A. (2004). Social cognitive theory of posttraumatic recovery: the role of perceived self-efficacy. *Behaviour Research And Therapy*, 42, 1129-1148.
- Bennett L. A. (1995). Accountability for alcoholism in American families. *Social Science & Medicine*, 40 (1), 15-25.
- Benoit, D. (2004). Infant-parent attachment: Definition, types, antecedents, measurement and outcome. *Paediatrics & Child Health*, 9(8), 541–545.
- Berkeley Planning Associates (1983). The exploration of client characteristics services,

- and outcomes. Evaluations on of the clinical demonstration projects on child abuse and neglect (Contract No. 105-78-1108). Washington, DC: National Center on Child Abuse and Neglect.
- Bernstein, N. (2005) *All Alone in the World: Children of the Incarcerated*, New York: The New Press.
- Biese, I. (2017). *Opting out and in: on womens careers and new lifestyles*. Abingdon, Oxon: Routledge, an imprint of the Taylor & Francis Group.
- Bijur, P., Kurzon, M., Overpeck, M., and Scheidt, P. (1992). Parental alcohol use, problem drinking, and children's injuries. *Journal of the American Medical Association* 267, 3166-71.
- Booth, P. and Jernberg, A. (2010). *Theraplay: Helping Parents and Children Build Better Relationships through Attachment-Based Play* (3rd edition). CA: Jossey-Bass.
- Boris, E. (1994). Mothers are not workers: Homework regulation and the construction of motherhood, 1948–1953. In E. Glenn, N. Glenn, G. Chang, & L. Forcey (Eds.), *Mothering: Ideology, experience, and agency* (pp. 161–180). New York: Routledge.
- Bos, H. (2004). *Parenting in planned lesbian families*. Amsterdam: Amsterdam University Press.
- Bournsnel, M. (2007). The silent parent: Developing knowledge about the experiences of parents with mental illness. *Child Care In Practice*, 13(3), 251-260.
- Bowlby, J. (1982). *Attachment and loss: Vol. 1. Attachment* (2nd ed.). New York: Basic Books.

Bowlby, J.M. (1973). *Attachment and Loss: Vol. 2*. London: Hogarth Press.

Bowlby, J.M. (1969). *Attachment and Loss: Vol I*. London: Hogarth Press.

Brady, T. M., & Ashley, O. S. (Eds.). (2005). Women in substance abuse treatment: Results from the Alcohol and Drug Services Study (ADSS) (DHHS Publication No. SMA 04-3968, Analytic Series A-26). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Brady, K.T., Sinha, R., 2005. Co-occurring mental and substance use disorders: the neurobiological effects of chronic stress. *American Journal of Psychiatry* 162, 1483–1493.

Brown, L.J., Malouff, J.M., & Schutte, N.S. (2013). Self-efficacy theory. Retrieved May 31, 2015 from <http://samples.jbpub.com/9781449689742/Chapter2.pdf>.

Brudenell I. (2000). Parenting an infant during alcohol recovery. *Journal of Pediatric Nursing*.15(2):82–88.

Burns KA, Chethik L, Burns WJ, Clark R. (1997) The early relationship of drug abusing mothers and their infants: An assessment at eight to twelve months of age. *Journal of Clinical Psychology*. 53:279–287.

Canfield, M., Radcliffe, P., Marlow, S., Boreham, M., & Gilchrist, G. (2017). Maternal substance use and child protection: a rapid evidence assessment of factors associated with loss of child care. *Child Abuse & Neglect*, 70, 11-27.

Cash, S. J., & Wilke, D. J. (2003). An ecological model of maternal substance abuse and child neglect: Issues, analyses, and recommendations. *American Journal of Orthopsychiatry*, 73(4), 392-404.

Center for Substance Abuse Treatment (CSAT). (2009). Substance Abuse Treatment:

- Addressing the Specific Needs of Women. Treatment Improvement Protocol (TIP) Series 51.* HHS Publication No. (SMA) 09-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment (CSAT). (2006) *Center for Substance Abuse Treatment. Substance Abuse: Clinical Issues in Intensive Outpatient Treatment.* Treatment Improvement Protocol (TIP) Series 47. DHHS Publication No. (SMA) 06-4182. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Child Welfare Information Gateway. (2009). *Parental Substance Use and the Child Welfare System.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.
- Child Welfare League of America. (1998). Alcohol and other drug survey of state child welfare agencies. Washington, DC.
- Choy, L. T. (2014). The strengths and weaknesses of research methodology: comparison and complimentary between qualitative and quantitative approaches. *IOSR Journal of Humanities and Social Science*, 19(4), 99-104.
- Coleman, P. K. and Karraker, K. H. (2003), Maternal self-efficacy beliefs, competence in parenting, and toddlers' behavior and developmental status. *Infant Mental Health Journal*, 24: 126–148.
- Coleman, P. K., & Karraker, K. H. (2000). Parenting self-efficacy among mothers of school-age children: Conceptualization, measurement, and correlates. *Family Relations*, (1). 13.
- Coleman, P. K., & Karraker, K. H. (1998). Self-efficacy and parenting quality: Findings

- and future applications. *Developmental Review*, 18(1), 47-85.
- Colten, M. E. (1982). Attitudes, experiences, and self-perceptions of heroin addicted mothers. *Journal of Social Issues* 38:77-92.
- Coley, R.L.,Leventhal, T., Lynch, A.D., Kull, M. (2013a). Poor Quality Housing Is Tied to Children's Emotional and Behavioral Problems. (Policy research brief 1-4). Retrieved from May 31, 2015
http://www.macfound.org/media/files/HHM_Research_Brief_September_2013.pdf.
- Coley, R. L., Leventhal, T., Lynch, A. D., & Kull, M. (2013b). Relations between housing characteristics and the well-being of low-income children and adolescents. *Developmental Psychology*, 49(9), 1775-1789.
- Conners, N. A., Grant, A., Crone, C. C., & Whiteside-Mansell, L. (2006). Substance abuse treatment for mothers: Treatment outcomes and the impact of length of stay. *Journal Of Substance Abuse Treatment*, 31(4), 447-456.
- Coon, G., Pena, D., & Illich, P. (1998). Self-efficacy and substance abuse: assessment using a brief phone interview. *Journal Of Substance Abuse Treatment*, 15(5), 385-391.
- Cordon, C.P. (2013). System theories: An overview of various system theories and its application in healthcare. *American Journal of Systems Science*, 2(1), 13-22.
- Council-houston.org. (2015). *The Council on Alcohol and Drugs Houston*. Retrieved April 15 2015 from <http://www.council-houston.org/>.
- Couvrette, A., Brochu, S., & Plourde, C. (2016). The "deviant good mother":

- motherhood experiences of substance-using and lawbreaking women. *Journal of Drug Issues*, 46(4), 292-307.
- Covington, S. S., Burke, C., Keaton, S., & Norcott, C. (2008). Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment. *Journal of Psychoactive Drugs*, 387-398.
- Covington, S. S. (2007). Working with substance abusing mothers: A trauma-informed, gender-responsive approach. *The Source*, 17 (1), 1-6.
- Covington, S. S. (2000). Helping women recover: A comprehensive integrated treatment model. *Alcoholism Treatment Quarterly*, 18(3), 99-111.
- Covington S.S., Surrey, J.L. (2000). The relational model of women's psychological development: Implications for substance abuse. In: Wilsnack RW, Wilsnack SC, editors. *Gender and Alcohol: Individual and Social Perspectives*. New Brunswick, NJ: Rutgers Center of Alcohol Studies; 1997. pp. 335–351.
- Coyer S. M. (2001). Mothers recovering from cocaine addiction: Factors affecting parenting skills. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 30 (1), 71-79.
- Coyer S. M. (2003). Women in recovery discuss parenting while addicted to cocaine. *The American Journal of Maternal Child Nursing*, 28 (1), 45-49.
- Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches (3rd ed.)*. Thousand Oaks, CA, US: Sage Publications, Inc.
- Creswell, J., Hanson, W., Clark Plano, V., & Morales, A. (2007). Qualitative research designs: Selection and implementation. *The Counseling Psychologist*, 35(2), 236-264.

- Crowley, J. E. (2013). Perceiving and responding to maternal workplace discrimination in the United States. *Women's Studies International Forum*, 40, 192-202.
- Daley M, Argeriou M, McCarty D. (1998) Substance abuse treatment for pregnant women: A window of opportunity? *Addictive Behaviors*. 23(2):239–249.
- Dalla, R. (2004). "I fell off [the mothering] track": Barriers to "effective mothering" among prostituted women. *Family Relations*, 53(2), 190-200.
- David, D. H., Styron, T., & Davidson, L. (2011). Supported parenting to meet the needs and concerns of mothers with severe mental illness. *American Journal Of Psychiatric Rehabilitation*, 14(2), 137-153.
- Davies, B., & Allen, D. (2007). Integrating 'mental illness' and 'motherhood': The positive use of surveillance by health professionals. A qualitative study. *International Journal Of Nursing Studies*, 44. 365-376.
- Deming, D. (2009). Early childhood intervention and life-cycle skill development: Evidence from head start. *American Economic Journal: Applied Economics*, (3). 111.
- de Montigny F, Lacharite C. (2005) Perceived parental efficacy: Concept analysis. *Journal of Advanced Nursing*. 49(4):387–396.
- Denton, B., O'Malley, P., Bammer, G., & Banwell, C. (2002). Improving the effectiveness of family-based interventions for drug-using parents in prison and the wider community. Unpublished final report for NHMRC.
- Department of Health and Human Services, Administration for Children and Families. (1995). A Nation's Shame: Fatal Child Abuse and Neglect in the United States. U.S. Advisory Board on Child Abuse and Neglect.

- Department of Health and Human Services. (1999) Blending perspectives and building common ground: A report to congress on substance abuse and child protection. Washington, DC: U.S. Government Printing Office.
- Diamond, J. (2000). *Narrative means to sober ends: Treating addiction and its aftermath*. New York: Guilford Press.
- Diaz-Caneja, A., Johnson, S., 2004. The views and experiences of severely mentally ill mothers. *Social Psychiatry and Psychiatric Epidemiology* 39 (6), 472–482.
- DiNitto, D. M., Webb, D. K., & Rubin, A. (2002). Gender differences in dually-diagnosed clients receiving chemical dependency treatment. *Journal of Psychoactive Drugs*, 34(1), 105-17.
- Doody O, Noonan M (2013) Preparing and conducting interviews to collect data. *Nurse Researcher*. 20, 5, 28-32.
- Douglas, S. J., & Michaels, M. (2004). *The mommy myth: The idealization of motherhood and how it has undermined women*. New York: Free Press.
- Dubowitz, H., Kim, J., Black, M., Weisbart, C., Semiatin, J., & Magder, L. (2011). Identifying children at high risk for a child maltreatment report. *Child Abuse & Neglect*, 35(2), 96-104.
- Duffy, P., & Baldwin, H. (2013). Recovery post treatment: plans, barriers and motivators. *Substance Abuse Treatment, Prevention & Policy*, 81-12.
- Efron, D., & Bradley, B. (2007). Emotionally focused therapy (EFT) and emotionally focused family therapy (EFFT): A challenge/opportunity for systemic and post-systemic therapists. *Journal of Systemic Therapies*, 26(4), 1-4.
- Ehrmin J. T. (2001). Unresolved feelings of guilt and shame in the maternal role with

- substance-dependent African-American women. *Journal of Nursing Scholarship*, 33 (1), 47-42.
- Elliott, S., Powell, R., & Brenton, J. (2015). Being a good mom: Low-income, black single mothers negotiate intensive mothering. *Journal Of Family Issues*, 36(3), 351-370.
- Encyclopedia of Children's Health. (2015). *Working mothers*. Retrieved February 21, 2015 from <http://www.healthofchildren.com/U-Z/Working-Mothers.html>
- Eshel, N., Daelman, B., de Mello, M. C., & Martines, J. (2006). Responsive parenting: interventions and outcomes. *Bulletin Of The World Health Organization*, 84(12), 991-998.
- Farber, S. K. (2007). Dissociation, traumatic attachments, and self-harm: Eating disorders and self-mutilation. *Clinical Social Work Journal*, 36(1), 63-72.
- Farkas, D., Duffett, & Johnson, J. (2000). *Necessary Compromises: How parents, employer and children's advocates view childcare today*. New York: Public Agenda.
- Finkelstein N. (1996) Using the relational model as a context for treating pregnant and parenting chemically dependent women. In: Underhill BL, Finnegan DG, editors. *Chemical Dependency: Women at Risk*. New York: Harrington Park Press/Haworth Press; 1996. pp. 23–44.
- Finkelstein N. (1993) Treatment programming for alcohol and drug-dependent pregnant women. *International Journal of the Addictions*. 28(13):1275–1309.
- Finkelstein N, Kennedy C, Thomas K, Kearns M. (1997) *Gender-Specific Substance Abuse Treatment*. Rockville, MD: Center for Substance Abuse Prevention.

- Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, 12(4), 531-545.
- Fisher, J. A., & Kalbaugh, C. A. (2011). Challenging assumptions about minority participation in u.s. clinical research. *American Journal of Public Health*, 101(12), 2217–2222.
- Fraley, R. C., & Davis, K. E. (1997). Attachment formation and transfer in young adults close friendships and romantic relationships. *Personal Relationships*, 4(2), 131-144.
- Gilmore, L., & Cuskelly, M. (2009). Factor structure of the parenting sense of competence scale using a normative sample. *Child: Care, Health and Development*, 35(1), 48-55.
- Gil-Rivas, V. and McWhorter, L. (2013). Chapter 24 - Self-Medication. In *Principles of Addiction*, edited by Peter M. Miller, Academic Press, San Diego, 235-241.
- Gil-Rivas, V. and McWhorter, L. (2013). Chapter 24 - Self-Medication. In P. M. Miller (Ed.), *Principles of addiction: Comprehensive addictive behaviors and disorders* (pp. 235-241). San Diego, CA: Academic Press.
- Given, L. M. (2008). *The SAGE encyclopedia of qualitative research methods*. Thousand Oaks, CA: SAGE Publications Ltd
- Gornick, J., & Meyers, M. (2004). More alike than different: Revisiting the long-term prospects for developing "european-style" work/family policies in the united states. *Journal Of Comparative Policy Analysis: Research And Practice*, 6(3), 251-273.
- Goodman, B. (1980). Some mothers are lesbians. In E. Norman & A. Mancuso

- (Eds.), *Women's issues and social work practice*. Itasca, IL: F. E. Peacock.
- Graf, A., Bar-On, H., Henin, T., Piotrowski, R., von Raggamby, A., & Lang, S. (2012). Literature Review & Research Survey. InContext Project: Supportive Environments for Sustainable Living. Retrieved September 30, 2017 from http://www.incontext-fp7.eu/sites/default/files/D2.2_Final_DeliverableResearchSurvey.pdf
- Graham, A., Graham, N., Sowell, A., & Ziegler, H. (1997). Miracle village: a recovery community for addicted women and their children in public housing. *Journal Of Substance Abuse Treatment, 14*(3), 275-284.
- Grella, C. E., & Joshi, V. (1999). Gender differences in drug treatment careers among clients in the national drug abuse treatment outcome study. *The American Journal Of Drug And Alcohol Abuse, 25*(3), 385-406.
- Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods, 3*(1). Article 4. Retrieved May 16, 2015 from http://www.ualberta.ca/~iiqm/backissues/3_1/html/groenewald.html
- Grossman, J., & Schottenfeld, R. (1992). Pregnancy and women's issues. In T. R. Kosten, H. D. Kleber (Eds.). *Clinician's guide to cocaine addiction: Theory, research, and treatment* (pp. 374-388). New York, NY, US: Guilford Press.
- Guba, E.G. & Lincoln, Y.S. (1989). *Fourth generation evaluation*. California: Sage Publications.
- Gustavsson, N., & Rycraft, J. R. (2008). Chemically dependent mothers and their children. *Journal of Social Service Research, 20*(1-2), 55-71.
- Hans, L.L, Bernstein, V.J, Henson, L.G. (1999) The role of psychopathology in the

- parenting of drug-dependent women. *Development & Psychopathology*, 11:957–977.
- Hardesty, M., & Black, T. (1999). Mothering through addiction: A survival strategy among puerto rican addicts. *Qualitative Health Research*, 9(5), 602.
- Harrison, K. (2000). The body electric: Thin-ideal media and eating disorders in adolescents. *Journal of Communication*, 50, 119– 143.
- Hatamleh, W. (2012). Prenatal breastfeeding intervention program to increase breastfeeding duration among low income women. *Health*, (3), 143.
- Hays, S. 1996. *The cultural contradictions of motherhood*. New Haven, CT: Yale University Press.
- Hayes, M. O. (2009). The lived experience of mothering after prison. *Journal of Forensic Nursing*, 5(4), 228-236.
- Herrera, F. (2009). Tradition and transgression: Lesbian motherhood in chile. *Sexuality Research & Social Policy: A Journal Of The NSRC*, 6(2), 35-51.
- Hequembourg, A. L. (2007). Becoming lesbian mothers. *Journal Of Homosexuality*, 53(3), 153-180.
- Heidegger, M., & Stambaugh, J. (1996). *Being and Time: A Translation of Sein Und Zeit*. Albany: State University of New York Press.
- Hiersteiner, C. (2004). Narratives of low-income mothers in addiction recovery centers: Motherhood and the treatment experience. *Journal of Social Work Practice in the Addictions*, 4(2), 51-64
- Higgins, E. T. (1987). Self-discrepancy: A theory relating self and affect. *Psychological Review*, 94(3), 319–340.

- Higgins, E. T., Klein, R., & Strauman, T. (1985). Self-concept discrepancy theory: A psychological model for distinguishing among different aspects of depression and anxiety. *Social Cognition, 3* (1), 51-76.
- Houghton, C., Casey, D., Shaw, D., Murphy, K. (2013) Rigour in qualitative case-study research. *Nurse researcher, 20*(4), 12-17.
- Holloway, I., & Wheeler, S. (2002). *Qualitative research in nursing*. Oxford, UK: Blackwell Science.
- Husserl, E. (1964). *The idea of phenomenology*. (W. P. Alston & G. Nakhnikian, Trans.). The Hague. Nijhoff.
- Inciardi, J., Lockwood, D., and Pottieger, A. (1993). *Women and crack cocaine*. New York: Macmillan.
- Johnson, B., & Christensen, L. B. (2013). *Educational research: Quantitative, qualitative, and mixed approaches*. Thousand Oaks, Calif: SAGE Publications.
- Johnston, D., & Swanson, D. (2006). Constructing the “good mother”: The experience of mothering ideologies by work status. *Sex Roles, 54*(7/8), 509-519.
- Kearney, M.H., Murphy, S., & Rosenbaum, M. (1994). Mothering on crack-cocaine: A grounded theory analysis. *Social Science Medicine, 38*(2), 351-361.
- Kegan, R. (1982). *The evolving self*. Cambridge, MA: Harvard University Press.
- Kennedy, D. A. (2011). Good mother: Mothering, feminism, and incarceration. *William & Mary Journal Of Women And The Law, (2)*, 161.
- Khantzian, E.J., 2003. Understanding addictive vulnerability: an evolving psychodynamic perspective. *Neuro-Psychoanalysis 5*, 5–21.

- Khantzian, E.J., 1997. The self-medication hypothesis of substance use disorders: a consideration and recent applications. *Harvard Review of Psychiatry* 4, 231–244.
- Leong, F. T. (2008). *Encyclopedia of counseling* (Vol. 2). Thousand Oaks, Calif: SAGE Publications.
- Kumpfer, K., and Turner, C.W. (1990; 1991). The social ecology model of adolescent substance abuse: Implications for prevention. *International Journal of Addictions*. 25(4A), 435-64.
- Kuperberg, A., & Stone, P. (2008). The media depiction of women who opt out. *Gender & Society*, 22(4), 497-517.
- Landry, S. H., Smith, K. E., Swank, P. R., & Guttentag, C. (2008). A responsive parenting intervention: The optimal timing across early childhood for impacting maternal behaviors and child outcomes. *Developmental Psychology*, 44(5), 1335-1353.
- Lacey, M., Paolini, S., Hanlon, M., Melville, J., Galletly, C., & Campbell, L. E. (2015). Parents with serious mental illness: Differences in internalised and externalised mental illness stigma and gender stigma between mothers and fathers. *Psychiatry Research*, 225723-733.
- Lareau, A. (2002). Invisible inequality: social class and childrearing in black families and white families. *American Sociological Review*, (5), 747.
- Leerkes, E. M., & Crockenberg, S. C. (2002). The Development of Maternal Self-Efficacy and Its Impact on Maternal Behavior. *Infancy*, 3(2), 227-247.
- Leong, F. T. (2008). *Encyclopedia of counseling* (Vol. 2). Thousand Oaks, Calif: SAGE Publications.

- Leupp, K. M. (2010, April). Why Do Women Opt out? The Ideological & Economic Determinants of Women's Employment Status. Paper presented in Poster Session at the meeting of Population Association of America 2010 Annual Meeting Program, Dallas, TX.
- Levy, E. F. (1989). Lesbian motherhood: Identity and social support. *Affilia: Journal Of Women & Social Work*, 4(4), 40-53.
- Lief, N. R. (1985). Parenting and child services for drug dependent women. In R. Brotman, D. Hutson, & F. Suffet (Eds.), *Pregnant addicts and their children*. New York: Center for Comprehensive Health Practice. New York Medical College.
- Lin, C. (2013). Revealing the "essence" of things: Using phenomenology in LIS research. *Qualitative And Quantitative Methods In Libraries (QQML)*, 4, 469 – 478. Retrieved from http://www.qqml.net/papers/December_2013_Issue/2413QQML_Journal_2013_ChiShiouLin_4_469_478.pdf
- Liss, M., Schiffrin, H., & Rizzo, K. (2013). Maternal guilt and shame: The role of self-discrepancy and fear of negative evaluation. *Journal Of Child & Family Studies*, 22(8), 1112-1119.
- Lundgren LM, Schilling RF, Fitzgerald T, Davis K, Amodeo M. (2003) Parental Status of Women Injection Drug Users and Entry to Methadone Maintenance. *Substance Use & Misuse*. 38(8):1109–1131.
- Macdonald, C. (2009) "What's culture got to do with it? Mothering ideologies as

- barriers to gender equity." In *Gender Equality: Transforming Family Divisions of Labor*. Janet C. Gornick and Marcia K. Meyers, eds. London: Verso.
- MacPhee, D., & And, O. (1996). Ethnic variations in personal social networks and parenting. *Child Development*, 67(6), 3278-95.
- Mandiuc, A.M. (2014). The impact of a prostitute mother on the child life circumstances. *European Journal of Research on Education*, 2(2), 1-9.
- Marsh, J. C., & Smith, B. D. (2011). Integrated substance abuse and child welfare services for women: a progress review. *Children and Youth Services Review*, 33(3), 466-472.
- Marshall, C., & Rossman, G. B. (2006). *Designing qualitative research*. Thousands Oaks, Calif.: Sage Publications, c2006.
- Mather, M. (2010). U.S. children in single-mother families. PRB data brief. Washington, DC: Population Reference Bureau. May 2010.
- McCance, T. & Mcilfatrik (2008). Phenomenolgy In R. Watson, H. McKenna, S. Cowman, & J. Keady (Eds.), *Nursing Research: Designs and Methods E-Book*. (pp. 231-242). Edinburgh, London: Elsevier Health Sciences.
- McCarter-Spaulding, D. E. and Kearney, M. H. (2001), Parenting self-efficacy and perception of insufficient breast milk. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 30: 515-522.
- McClelland, G. T., & Newell, R. (2008). A qualitative study of the experiences of mothers involved in street-based prostitution and problematic substance use. *Journal Of Research In Nursing*, 13(5), 437-447.
- Meadows, D. H. (2009). *Thinking in systems. A primer*. London, UK: Earthscan.

- Mele, C., Pels, J., & Polese, F. (2010). A brief review of systems theories and their managerial applications. *Service Science*, 2(1-2), 126-135.
- Mercer, R. T. (2004). Becoming a mother versus maternal role attainment. *Journal Of Nursing Scholarship*, 36(3), 226-232.
- Mercer, R. T., & Ferketich, S. L. (1995). Experienced and inexperienced mothers' maternal competence during infancy. *Research in Nursing & Health*, 18(4), 333–343.
- Mercer, R. (1981). A theoretical framework for studying factors that impact on the maternal role. *Nursing Research*, 30(2), 73-77.
- Mercer, R. (1985). The process of maternal role attainment over the first year. *Nursing Research*, 34(4), 198-203.
- Miller, J. (1990). The development of women's sense of self. In C. Zanardi (Ed.). *Essential papers on the psychology of women* (pp. 437-454). New York, NY, US: New York University Press.
- Miller, J. B. (1976). *Toward a new psychology of women*. Oxford, England: Beacon.
- Milligan, K., Niccols, A., Sword, W., Thabane, L., Henderson, J., Smith, A., & Liu, J. (2010). Maternal substance use and integrated treatment programs for women with substance abuse issues and their children: a meta-analysis. *Substance Abuse Treatment, Prevention, and Policy*, 5, 21.
- Mirowsky, J., & Ross, C. E. (2002). Depression, parenthood, and age at first birth. *Social Science & Medicine*, 54, 1281–1298.
- Moerer-Urdahl, T., & Creswell, J. (2004). Using transcendental phenomenology to

- explore the “ripple effect” in a leadership mentoring program. *International Journal of Qualitative Methods*, 3 (2). Article 2. Retrieved January 24 2017 from http://www.ualberta.ca/~iiqm/backissues/3_2/pdf/moerercreswell.pdf
- Montgomery, P. (2005). Mothers with a serious mental illness: A critical review of the literature. *Archives Of Psychiatric Nursing*, 19226-235.
- Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal Of Qualitative Methods*, 1(2), 1-19.
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.
- Mowbray, C. T., Oyserman, D., Bybee, D., MacFarlane, P., & Rueda-Riedle, A. (2001). Life circumstances of mothers with serious mental illnesses. *Psychiatric Rehabilitation Journal*, 25(2), 114-123.
- Munns, E. (2009). *Applications of family and group therapy*. Lanham, MD: Rowman & Littlefield.
- Murkoff, H. E., & Mazel, S. (2016). *What to expect when you're expecting*. New York: Workman Publishing.
- Murphy, C. A., Cupples, M. E., Percy, A., Halliday, H. L., & Stewart, M. C. (2008). Peer-mentoring for first-time mothers from areas of socio-economic disadvantage: A qualitative study within a randomised controlled trial. *BMC Health Services Research*, 8(1).
- Murry, V. M., Bynum, M. S., Brody, G. H., Willert, A., & Stephens, D. (2001). African American single mothers and children in context: a review of studies on risk and resilience. *Clinical Child And Family Psychology Review*, 4(2), 133-155.

Nabi, R. L. & Oliver, M. (2009). *The SAGE handbook of media processes and effects*.

Thousand Oaks, Calif: SAGE.

Namageyo-Funa, A., Rimando, M., Brace, A. M., Christiana, R. W., Fowles, T. L.,

Davis, T. L., Martinez, L. M., & Sealy, D. (2014). Recruitment in Qualitative

Public Health Research: Lessons Learned During Dissertation Sample

Recruitment. *The Qualitative Report*, 19(4), 1-17. Retrieved June 10, 2015 from

<http://nsuworks.nova.edu/tqr/vol19/iss4/3>

National Center on Addiction and Substance Abuse (NCASA). (2006). *Women under the influence*. Baltimore: John Hopkins University Press.

National Scientific Council on the Developing Child. (2004). *Young children develop in an environment of relationships*. Retrieved May 10, 2015 from

<http://www.developingchild.net>.

Nelson, S., Kushlev, K., English, T., Dunn, E. W., & Lyubomirsky, S. (2013). In defense of parenthood: Children are associated with more joy than misery. *Psychological Science*, 24(1), 3-10.

Nichols, J., Schutte, N. S., Brown, R. F., Dennis, C., & Price, I. (2009). The impact of a self-efficacy intervention on short-term breast-feeding outcomes. *Health Education & Behavior: The Official Publication Of The Society For Public Health Education*, 36(2), 250-258.

Nicholson, J. (2010). Parenting and recovery for mothers with mental disorders. In B. Levin, M. Becker (Eds.). *A public health perspective of women's mental health* (pp. 359-372). New York, NY, US: Springer Science + Business Media.

Nomaguchi, K. M., & Milkie, M. A. (2003). Costs and rewards of children: The effects

- of becoming a parent on adults' lives. *Journal of Marriage and Family*, 65, 356–374.
- Ong, B. (1985). Understanding child abuse: Ideologies of motherhood. *Women's Studies International Forum*, 8(5), 411-419.
- O'Reilly, A. (2010). *Encyclopedia of motherhood*. Thousand Oaks, CA: Sage Publications.
- Oser, C., Knudsen, H., Staton-Tindall, M., & Leukefeld, C. (2009). The adoption of wraparound services among substance abuse treatment organizations serving criminal offenders: The role of a women-specific program. *Drug and Alcohol Dependence*, 103(Suppl 1), S82–S90.
- Oyserman, D., Mowbray, C., Meares, P., & Firminger, K. (2000). Parenting among mothers with A serious mental illness. *American Journal of Orthopsychiatry*, 70(3), 296-315.
- Oyserman, D., Bybee, D., Mowbray, C., & Hart-Johnson, T. (2005). When mothers have serious mental health problems: Parenting as a proximal mediator. *Journal Of Adolescence*, 28(4), 443-463.
- Pajares (2002). *Overview of social cognitive theory and of self-efficacy*. Retrieved May 31, 2015 from <http://www.emory.edu/EDUCATION/mfp/eff.html>
- Parolin, M., & Simonelli, A. (2016). Attachment Theory and Maternal Drug Addiction: The Contribution to Parenting Interventions. *Frontiers in Psychiatry*, 7, 152.
- Patton, M. (2002). *Qualitative research and evaluation methods 3rd ed.*: Sage Publications.
- Pearson, K. H. (2012). Sexuality in child custody decisions. *Family Court Review*, 50(2),

- 280-288.
- Pennella, C., Whittingham, K., Boyd, R., Sanders, M., & Colditz, P. (2012). Prematurity and parental self-efficacy: The preterm parenting & self-efficacy checklist. *Infant Behavior And Development, 35*(678-688).
- Peterson, L., Gable, S., & Saldana, L. (1996). Treatment of maternal addiction to prevent child abuse and neglect. *Addictive Behaviors, 21*(6), 789-801.
- Phelan, J. C., Bromet, E. J., & Link, B. G. (1998). Psychiatric illness and family stigma. *Schizophrenia Bulletin, 24*(1), 115-126.
- Pursley-Crotteau, S., & Stern, P. (1996). Creating a new life: Dimensions of temperance in perinatal cocaine crack users. *Qualitative Health Research, 6*(3), 350.
- Ramirez, D., Wood, R. C., Becho, J., Owings, K., & Espino, D. V. (2010). Mini-mental state exam domains predict falls in an elderly population: Follow-up from the hispanic established populations for epidemiologic studies of the elderly (H-EPESE) Study. *Ethnicity & Disease, 20*(1), 48-52.
- Ratnapalan, S., & Batty, H. (2009). To be good enough. *Canadian Family Physician, 55*(3), 239-240.
- Raynor, P. A. (2013). An exploration of the factors influencing parental self-efficacy for parents recovering from substance use disorders using the social ecological framework. *Journal Of Addictions Nursing, 24*(2), 91-99.
- Reece, S. M., & Harkless, G. (1998). Self-efficacy, stress, and parental adaptation:.. *Journal Of Family Nursing, 4*(2), 198.
- Redmond, B. F. (2010). *Self-Efficacy Theory: Do I think that I can succeed in my work?*

- Work Attitudes and Motivation. The Pennsylvania: State University, World Campus.
- Reed, M. S., A. C. Evely, G. Cundill, I. Fazey, J. Glass, A. Laing, J. Newig, B. Parrish, C. Prell, C. Raymond, and L. C. Stringer. (2010). What is social learning? *Ecology and Society*. 15(4): r1. [online] URL: <http://www.ecologyandsociety.org/vol15/iss4/resp1/>
- Reid, C., Greaves, L., & Poole, N. (2008). Good, bad, thwarted or addicted? Discourses of substance-using mothers. *Critical Social Policy*, 28(2), 211-234.
- Ritchie, J., & Lewis, J. (2003). *Qualitative research practice: a guide for social science students and researchers*. London; Thousand Oaks, Calif. : Sage Publications, 2003.
- Robinson, E. A., Cranford, J. A., Webb, J. R., & Brower, K. J. (2007). Six-Month Changes in Spirituality, Religiousness, and Heavy Drinking in a Treatment-Seeking Sample*. *Journal of Studies on Alcohol and Drugs*, 68(2), 282-290.
- Rogers, S. J., & White, L. K. (1998). Satisfaction with Parenting: The Role of Marital Happiness, Family Structure, and Parents' Gender. *Journal Of Marriage & Family*, 60 (2), 293-308.
- Rosenbaum, M. (1979). Difficulties in taking care of business: Women addicts as mothers. *American Journal of Drug and Alcohol Abuse* 6,431-46.
- Ross, C. E., & Van Willigen, M. (1996). Gender, parenthood, and anger. *Journal of Marriage and Family*, 58, 572-584.
- Rotkirch, A., & Janhunen, K. (2010). Maternal Guilt. *Evolutionary Psychology*, 8(1), 90-106.

- Rubin, R. (1984). *Maternal identity and the maternal experience*. New York: Springer.
- Saunders, E.J. (1993). A new model of residential care for substance-abusing women and their children. *Adult Residential Care Journal* 7(2),104–117.
- Sanders, M. R., & Woolley, M. L. (2005). The relationship between maternal self-efficacy and parenting practices: implications for parent training. *Child: Care, Health & Development*, 31(1), 65-73.
- Santa Maria Hostel. (2016). Outpatient Services. Retrieved July 5, 2016 from <http://www.santamariahostel.org/the-road-to-recovery/outpatient-services/>
- Seagram, S., & Daniluk, J. C. (2002). 'It goes with the territory': The meaning and experience of maternal guilt for mothers of preadolescent children. *Women & Therapy*, 25(1), 61-88.
- Sears, W. (2013). *The Baby book: everything you need to know about your baby from birth to age two*. New York: Little, Brown.
- Shipley, S. L., & Arrigo, B. A. (2004). *The female homicide offender: serial murder and the case of Aileen Wuornos* / Stacey L. Shipley, Bruce A. Arrigo. Upper Saddle River, N.J.: Pearson : Prentice Hall.
- Simmons, L., Havens, J. R., Whiting, J. B., Holz, J. L., & Bada, H. (2009). Illicit Drug Use Among Women with Children in the United States: 2002–2003. *Annals Of Epidemiology*, 19(3), 187-193.
- Spillett, M. A. (2003, September 22). Peer debriefing: who, what, when, why, how. *The Free Library*. Retrieved May 19, 2017 from [https://www.thefreelibrary.com/Peer debriefing: who, what, when, why, how.](https://www.thefreelibrary.com/Peer+debriefing:+who,+what,+when,+why,+how.)
- Steidel, A. G., & Contreras, J. M. (2003). A New Familism Scale for Use with Latino

- Populations. *Hispanic Journal of Behavioral Sciences*, 25(3), 312-330.
- Stevens, S. J., & Patton, T. (1998). Residential treatment for drug addicted women and their children: Effective treatment strategies. *Drugs & Society*, 13(1-2), 235-249.
- Stifter, C. A., & Bono, M. A. (1998). The effect of infant colic on maternal self-perceptions and mother–infant attachment. *Child: Care, Health And Development*, 24(5), 339-351.
- Substance Abuse and Mental Health Services Administration. (2013). National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986–2009. (HHS Publication No. SMA-13-4740). Retrieved from <http://store.samhsa.gov/shin/content/SMA13-4740/SMA13-4740.pdf>
- Substance Abuse and Mental Health Services Administration. (2004) *Results from the 2003 National Survey on Drug Use and Health: National Findings*. Rockville, MD.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2014, Sept. 23). About the Agency. Retrieved 2014 September 23 from <http://www.samhsa.gov/about/>.
- Suchman, N., DeCoste, C., Castiglioni, N., Legow, N., & Mayes, L. (2008). The Mothers and Toddlers Program: Preliminary findings from an attachment-based parenting intervention for substance-abusing mothers. *Psychoanalytic Psychology*, 25(3), 499-517.
- Suchman, N. E., & Luthar, S. S. (2000). Maternal addiction, child maladjustment and socio-demographic risks: implications for parenting behaviors. *Addiction (Abingdon, England)*, 95(9), 1417–1428.

- Sutphin, S., McDonough, S. and Schrenkel, A. (2013) The role of formal theory in social work research: Formalizing family systems theory. *Advances in Social Work, 14*(2), 501-517.
- Swanson, V., Nicol, H., McInnes, R., Cheyne, H., Mactier, H., & Callander, E. (2012). Developing maternal self-efficacy for feeding preterm babies in the neonatal unit. *Qualitative Health Research, 22*(10), 1369-1382.
- Szuster, R.R., Rich, L.L., Chung, A., Bisconer, S.W. (1996) Treatment retention in women's residential chemical dependency treatment: The effect of admission with children. *Substance Use and Misuse, 31*(8):1001–1013.
- Taylor, T. (2011). Re-examining Cultural Contradictions: Mothering Ideology and the Intersections of Class, Gender, and Race. *Sociology Compass, 5*(10), 898.
- Taylor, J., Lauder, W., Moy, M., & Corlett, J. (2009). Practitioner assessments of 'good enough' parenting: factorial survey. *Journal of Clinical Nursing, 18*(8), 1180-1189.
- Teti, D. M., & Gelfand, D. M. (1991). Behavioral competence among mothers of infants in the first year: The mediational role of maternal self-efficacy. *Child Development, 62*: 918-929.
- The Canadian Paediatric Society. (2004) Effective discipline for children. *Paediatrics & Child Health, 9*(1), 37–41.
- The National Center on Addiction and Substance Abuse at Columbia University. (1999). *No safe haven: Children of substance-abusing parents*. New York: The National Center on Addiction and Substance Abuse at Columbia University. Retrieved on

- March 14, 2015 from <http://www.casacolumbia.org/addiction-research/reports/no-safe-haven-children-substance-abusing-parents>
- The National Center on Addiction and Substance Abuse (CASA) at Columbia University. (1996). *Substance abuse and the american woman*. New York: CASA.
- Tracy, E. M. (1994). Maternal Substance Abuse: Protecting the Child, Preserving the Family. *Social Work*, 39(5), 534-540.
- Tracy, K., Burton, M., Miescher, A., Galanter, M., Babuscio, T., Frankforter, T., Rounsaville, B. (2011). Mentorship for Alcohol Problems (MAP): A Peer to Peer Modular Intervention for Outpatients. *Alcohol and Alcoholism*, 47(1), 42-47.
- Troutman, B., Morgan, T. E., Arndt, S., Johnson, R. F., & Chmielewski, M. (2012). Development of parenting self-efficacy in mothers of infants with high negative emotionality. *Infant Mental Health Journal*, 33(1).
- U.S. Advisory Board on Child Abuse and Neglect. (1995). *A nation's shame: fatal child abuse and neglect in the United States*. Fifth report. Washington, DC: Department of Health and Human Services.
- U.S. Department of Labor, Bureau of Labor Statistics. (2015). *Employment characteristics of families: Families with children*. Retrieved on February 22, 2015 from <http://www.bls.gov/news.release/famee.nr0.htm>
- U.S. Census Bureau, "Table FG10. America's Families and Living Arrangements, Family Group: 2013." Retrieved February 22, 2015 from <http://www.census.gov/hhes/families/files/cps2013/tabFG10-all.xls>.
- U.S. Census Bureau, "Table C8. Poverty Status, Food Stamp Receipt, And Public

- Assistance For Children Under 18 Years By Selected Characteristics: 2013.”
Retrieved February 22, 2015 from
<http://www.census.gov/hhes/families/files/cps2013/tabC8-all.xls>.
- University of Texas Health Science Center (UTHealth Medical School). (2015).
INNOVATIONS in Addictions Treatment. Department of Psychiatry and
Behavioral Sciences at UTHealth Medical School. Retrieved May 10, 2015 from
<https://med.uth.edu/psychiatry/patient-care/innovations/>.
- Velez, M. L., Jansson, L. M., Montoya, I. D., Schweitzer, W., Golden, A., & Svikis, D.
(2004). Parenting knowledge among substance abusing women in
treatment. *Journal Of Substance Abuse Treatment*, 27(3), 215-222.
- von Suchodoletz, A. T. (2011). Linking maternal warmth and responsiveness to
children's self-regulation. *Social Development*, 20(3), 486-503.
- van Manen, M. (1990). *Researching lived experiences: Human science for an action
sensitive pedagogy*. Albany: State University of New York Press.
- Wall, G. (2010). Mothers' experiences with intensive parenting and brain development
discourse. *Women's Studies International Forum*, 33(3), 253-263.
- Wallen, J. (1998). Need for services research on treatment for drug abuse in women. In
National Institute on Drug Abuse, Drug Addiction Research and the Health of
Women (NIH Publication No. 98-4290, pp. 229-236). Rockville, MD: US
Department of Health and Human Services, National Institutes of Health.
- Weaver, C. M., Shaw, D. S., Dishion, T. J., & Wilson, M. N. (2008). Parenting self-

- efficacy and problem behavior in children at high risk for early conduct problems: the mediating role of maternal depression. *Infant Behavior & Development*, 31(4), 594-605.
- Weissbluth, M. (2015). *Healthy sleep habits, happy child: a step-by-step program for a good nights sleep*. New York: Ballantine Books.
- Wells, K. (2009). Substance abuse and child maltreatment. *Pediatric Clinics of North America*, 56(2), 345-362.
- Wertz, F. J. (2005). Phenomenological research methods for counseling psychology. *Journal Of Counseling Psychology*, 52(2), 167-177.
- White, W.L., Laudet, A.B. & Becker, J.B. (2006). Life meaning and purpose in addiction recovery. *Addiction Professional*, 4(4), 18-23.
- Whiting, L. S. (2008). Semi-structured interviews: guidance for novice researchers. *Nursing Standard*, 22(23), 35-40.
- Williams, D. (2011). Qualitative inquiry in daily life: Exploring qualitative thought. Retrieved May 10, 2015 from <https://qualitativeinquirydailylife.wordpress.com>
- Williams, J. C. & Cooper, H.C. (2004). The Public Policy of Motherhood. *Journal Of Social Issues*, 60(4), 849-865.
- Williams, T., & Williams, K. (2010). Self-efficacy and performance in mathematics: Reciprocal determinism in 33 nations. *Journal of Educational Psychology*, 102(2), 453-466..
- Willig, C. (2008). *Introducing Qualitative Research in Psychology: Adventures in Theory and Method*. Maidenhead, England: McGraw Hill/Open University Press.
- Wimpenny, P., & Gass, J. (2000). Interviewing in phenomenology and grounded theory:

- is there a difference? *Journal Of Advanced Nursing*, 31(6), 1485-1492.
- Winnicott, D.W. (1953). Transitional objects and transitional phenomena; a study of the first not-me possession. *Int J Psychoanal.* 34(2):89–97.
- Worcester, S. (2008). Three groups more likely to self-medicate. *Clinical Psychiatry News*, 36(3), 28.
- World Health Organization. International (Who.int). (2015). *WHO; Substance abuse*. Retrieved June 10, 2015 from http://www.who.int/topics/substance_abuse/en/.
- Yin, R. K. (2011). *Qualitative Research From Start to Finish*. New York: Guilford Press.
- Young, N. K., Boles, S. M., & Otero, C. (2007). Parental Substance Use Disorders and Child Maltreatment: Overlap, Gaps, and Opportunities. *Child Maltreatment*, 12(2), 137-149.
- Zilberman ML, Tavares H, Andrade AG, el-Guebaly N. (2003) The impact of an outpatient program for women with substance use-related disorders on retention. *Substance Use and Misuse.* 38(14): 2109–2124.

Appendix A
Consent Form

CONSENT TO PARTICIPATE IN THE RESEARCH STUDY

What is the study about?

You are asked to participate in a research study. This study is about a mother's journey through recovery from substance abuse. Much research has focused on substance abuse recovery, but little information is known on the mother's view of recovery. I am interested in hearing your experience. The title of this study is *The Mother's Experience: A Phenomenological Study of Maternal Self-Efficacy among Mothers Attending Outpatient Substance Abuse Treatment*.

Participation in this study is voluntary. You may withdraw at any time. There is no penalty for withdrawing from the study and your outpatient treatment services. Questions will NOT be asked about child abuse, child neglect, probation or active relapse during the interview. Please feel free to ask any questions you may have.

Who are the Researchers?

My name is Lisa Witkowski. I am a doctoral student at St. Mary's University in San Antonio, Texas. I will be the person meeting and talking with you during the interview. However, faculty members of the Marriage and Family Therapy Program at St. Mary's University will be helping me in this study. Their names are Dr. Jason Northrup, Dr. Carolyn Tubbs, and Dr. Nicholas Wilkens. They will not be at the interviews.

What is the purpose for this study?

The purpose of this study will be to explore the experiences of mothers and views of parenting while attending outpatient services for substance abuse. My hopes are to gain a deeper understanding of motherhood among women in recovery.

What will I have to do?

Today, you will fill out a short form on contact information and background history on yourself. Then, you will participate in an estimated 90 minute interview that will be recorded.

Later, the researcher will contact you to schedule a second meeting to talk about findings from the study. During this 60 minute meeting, you will have the opportunity to change, add, or take out any information to accurately reflect your view and protect your privacy.

Is it private?

All information collected during the interview process will be kept private. The researcher will protect your identity by assigning a random number to the information collected during the interview. The researcher will make an identity key connecting random numbers and identities. The identity key will be stored in a locked file cabinet

within a locked office. Consent forms and demographic information will be locked in a separate filing cabinet within the researcher's locked household. The information collected for this study will be stored for 5 years and then destroyed. The researcher will secure information uploaded on the computer with a password.

What are the risks?

You may find some of the information uncomfortable to talk about during your interview. You may ask to not discuss certain things or not go into great depth on specific topics. If you become too uncomfortable, you may ask to stop at any time. At the end of the interview, the researcher will provide you with a referral list for counseling. If you would like to participate in counseling, you are responsible for all costs.

What are the benefits?

You will have the opportunity to reflect on your parenting skills and potential desire to seek assistance in parenting. Your help with the research may also contribute to changing substance abuse recovery for mothers.

What are the costs?

No costs besides time, 90 minute interview and 60 minute meeting, will be experienced for participating in this study.

How will I be compensated?

The researcher will provide a healthy meal at the end of the interview. This is to thank you for your time. If you withdraw from the study, the healthy meal will still be available to you.

Can I quit the study?

Participation in the study is completely voluntary. You may withdraw at any time. Withdrawing from the study will not interfere with your outpatient treatment services.

Why might the interview stop?

The researcher will immediately stop the interview if you disclose information regarding child abuse, child neglect, probation violations and/or active relapse. The researcher is mandated by law to report child abuse and neglect. The researcher will not report probation violations unless contacted by probation officer.

Questions:

If you have any questions or concerns, you may contact the researcher, Lisa Witkowski, at her cell number: (908) 268-1590 or personal email: lwitkowski@stmarytx.edu.

If I have any questions about your rights as a participant in the research study, you may contact the St. Mary's University Institutional Review Board Chair, Dr. Dan Ratliff, at 210-436-3736 or email at IRBCommitteeChair@stmarytx.edu.

ALL RESEARCH PROJECTS THAT ARE CARRIED OUT BY INVESTIGATORS AT ST. MARY'S UNIVERSITY ARE GOVERNED BY THE REQUIREMENTS OF THE UNIVERSITY AND THE FEDERAL GOVERNMENT.

Acknowledgement:

- I have read and understand the Informed Consent Form.
- I believe I understand the purpose and my role as a participant of the study.
- I understand I have the right to withdraw from the study at any time.
- I understand the researcher has the responsibility by law to report information regarding suspected child abuse and child neglect.
- I have been given a copy of the Informed Consent Form.

Your signature below means that you voluntarily agree to participate in this research study.

Signature of Participant

Signature of Researcher

Printed Name of Participant

Printed Name of Researcher

Date

Date

You will be given a copy of this form to keep

Appendix B
Recruitment Flyer



TAKE PART IN A RESEARCH STUDY

- ◇ Are you 18 years or older?
- ◇ Do you have at least 1 living child?
- ◇ Have you been to rehab or counseling?
- ◇ Are you currently receiving Outpatient Treatment for Alcohol?

If you answered YES to these questions, you may be eligible to participate in the following research study:

“The Mother’s Experience: A Phenomenological Study of Maternal Self-Efficacy Among Mothers Attending Outpatient Substance Abuse Services”

Purpose:

To better understand what it’s like to be a mother going through substance abuse recovery.

Interviews:

1 Interview & 1 Follow-up Meeting
1 hour & 30 minutes in a Length for Interview
Confidential setting for interview selected by participants

Healthy Nutritious Meal:

Participants will receive a healthy nutritious meal at the conclusion of the interview.

If you are interested in participating in this study or have any questions, please contact the researcher from the provided information below.

Lisa Witkowski, MA, LPC

Doctoral Student at St. Mary’s University

Phone: (908) 268-1590

E-mail: lwitkowski@stmarytx.edu

Appendix C

Site Permission Form - Council on Alcohol and Drugs Houston



February 11, 2015

Institutional Review Board for the Protection of Human Subjects
St. Mary's University
One Camino Santa Maria
San Antonio, Texas 78228

Principal Investigator: Lisa M. Witkowski, M.A., L.P.C.
Marriage and Family Therapy Ph.D. Program
St. Mary's University
(908) 268-1590

Dear Members of the Committee:

On behalf of The Council on Alcohol and Drugs Houston, I am writing to formally indicate our awareness of the research proposed by Ms. Lisa Witkowski, a student at St. Mary's University. We are aware that Ms. Witkowski intends to leave flyers in our waiting areas at the facility to recruit participants for her research study. I give Ms. Witkowski permission to leave flyers at our facility.

If you have any questions or concerns, please feel free to contact my office by telephone at (281) 200-9331 or e-mail: mbeck@council-houston.org.

Sincerely,

Mary H. Beck, LMSW, CAI
Chief Operations Officer
The Council on Alcohol and Drugs Houston
Mailing Address: PO Box 2768 Houston, Texas 77252
Physical Address: 303 Jackson Hill St. Houston, Texas 77007
Office: 281-200-9331
www.council-houston.org



303 JACKSON HILL STREET, HOUSTON, TEXAS 77007 • P.O. BOX 2768, HOUSTON, TEXAS 77252
281.200.9302 • FAX 713.400.6369 • WWW.COUNCIL-HOUSTON.ORG • A SUPPORTER OF NCADD

Appendix D

Site Permission Form – INNOVATIONS



Medical School
Department of Psychiatry and Behavioral Sciences
Center for Neurobehavioral Research on Addiction

Michael Weaver, MD, FASAM
Professor
Medical Director

June 1, 2015

Institutional Review Board for the Protection of Human Subjects
St. Mary's University
One Camino Santa Maria
San Antonio, Texas 78228

Re: **Site Permission Form**

Principal Investigator: Lisa M. Witkowski, M.A., L.P.C.
Marriage and Family Therapy Ph.D. Program
St. Mary's University
(908) 268-1590

Dear Members of the Committee:

On behalf of INNOVATIONS in Addiction Treatment Clinic in the UT Department of Psychiatry, I am writing to formally indicate our awareness of the research proposed by Ms. Lisa Witkowski, a student at St. Mary's University. We are aware that Ms. Witkowski intends to distribute flyers to our clinic regarding her research study to recruit participants for her study. I give Ms. Witkowski permission to distribute flyers to our clinic.

If you have any questions or concerns, please feel free to contact my office by telephone at (713) 486-2558 or e-mail: Michael.F.Weaver@uth.tmc.edu.

Sincerely,

Michael Weaver, MD, FASAM

713.486.2558 Fax 713.486.2618
Michael.F.Weaver@uth.tmc.edu
1941 East Road, BBSB 1222
Houston, Texas 77054

Appendix E
Demographic Data Form

Number ____ (To be completed by researcher)

Age_____

Marital Status_____

Race_____

Age of First Substance Use_____

Number of years using: _____

Number of attended treatment programs: _____

Reasons for relapse?

Programs you participated in while in recovery (i.e., NA, AA, parenting programs, educational programs)

Length of Sobriety? _____

How often have you been in contact with your children during recovery?

How is contact maintained? (i.e. phone calls, visits, emails)

Who has been the primary caregiver for your children during your recovery?

Number of children _____ Age _____ Sex _____
Age _____ Sex _____
Age _____ Sex _____
Age _____ Sex _____
Age _____ Sex _____
Age _____ Sex _____
Age _____ Sex _____

Do you have any physical health problems? Yes _____ No _____

If yes, what physical health problems do you have?

Do you have any mental health problems? Yes _____ No _____

If yes, what mental problems do you have?

Are you currently taking any medications? Yes _____ No _____

If yes, what type of medications are you currently taking?

Highest level of education? _____

What helps you maintain your sobriety?

What type of support system do you have as you process through recovery?

Are you currently employed? Yes_____ No_____

If yes, what is your work occupation?

Appendix F
Interview Protocol

Interview Guide

1. What is it like to mother prior to receiving substance abuse treatment?
2. What is it like to be a mother in outpatient recovery for substance abuse?
3. What does "Being a Good Mother" mean to you?
4. What tasks are involved in "Being a Good Mother?"
5. Please describe the ways you participate in "Being a Good Mother?"
6. How does sobriety impact or not, your ability to be a "Good Mother?"

Appendix G

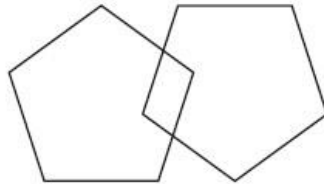
Mini Mental Health Examination

The Mini-Mental State Exam

Patient _____ Examiner _____ Date _____

Maximum Score

- | | | |
|---|-----|--|
| 5 | () | Orientation |
| 5 | () | What is the (year) (season) (date) (day) (month)?
Where are we (state) (country) (town) (hospital) (floor)? |
| 3 | () | Registration
Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all 3. Count trials and record.
Trials _____ |
| 5 | () | Attention and Calculation
Serial 7's. 1 point for each correct answer. Stop after 5 answers.
Alternatively spell "world" backward. |
| 3 | () | Recall
Ask for the 3 objects repeated above. Give 1 point for each correct answer. |
| 2 | () | Language
Name a pencil and watch. |
| 1 | () | Repeat the following "No ifs, ands, or buts" |
| 3 | () | Follow a 3-stage command:
"Take a paper in your hand, fold it in half, and put it on the floor." |
| 1 | () | Read and obey the following: CLOSE YOUR EYES |
| 1 | () | Write a sentence. |
| 1 | () | Copy the design shown. |



_____ Total Score
ASSESS level of consciousness along a continuum _____
Alert Drowsy Stupor Coma

Appendix H

Textural-Structural Description: Adriana

Adriana is a 46-year-old Hispanic female with graduate level education. She is divorced with two daughters (24-year-old and 23-year-old). She began drinking at the age

of 13 and had used for approximately 33 years. Her length of sobriety is 2 months and 18 days. She has attended 4 treatment programs. Adriana reports her reasons for prior relapse was due to relationship failure. The programs she participated in while in recovery include Alcohol Anonymous, Narcotics Anonymous, and Sex and Love Addicts Anonymous. Adriana reports a diagnosis of Depressive Disorder NOS. She reports Insomnia, Back Pain, and reflux disease as physical health problems. She is currently on Lexipro and Seroquel for medications. She reports having daily contact with her children.

Adriana recalls the impact of addiction on her life. She felt she was deriving her own “emotional needs and spiritual feelings of self-worth” from her children. Adriana experienced a “high degree of guilt and shame” for the unfair burden she placed upon her children. Adriana struggled with establishing a strong self-love and a clear identity for herself. She believes the traumatic events from her childhood contributed. She explains, “For example, my parents divorced. I was told as a child that it was the blameless fault of the children.” Adriana believes the negative messages conveyed by her parents hindered her self-esteem development as a child. Her low self-worth added to the many challenges she faced balancing addiction and motherhood. She states, “When I was drinking and raising them, it was a struggle.”

Adriana notices the impact of her addiction on her children. “My oldest one in particular probably suffered the most. So she has difficulty with relationships.” she explains, “And I think that was a result of watching my struggles.” Adriana believes her children have difficulty due to her substance use. She discussed her addiction escalating after her children entered college. During this time, she hardly spoke to her children. Adriana noticed her inability to function when she was actively using. “But when I fell

hard into my addiction, they were already out of the house and independent,” explains Adriana. Even though Adriana’s children were grown, her daughters still had worries regarding Adriana’s distant behavior and decided to contact Adriana. “But they ended up reaching out to me later on.” she says, “My oldest one kind of rescued me off the streets and said, “I need my mom back.”” Adriana felt her child saved her life by communicating her concern over her mother’s addiction. She shares, “That’s why they came to my aid because they said they wanted their mom back. They need me for themselves. We need you. We love you, and we want you to be happy.” Adriana entered treatment.

During treatment, Adriana learned the importance of modeling for her children. She realized her children have been watching and mirroring Adriana’s behavior. She says, “For example, being an outpatient – I took parenting today. We talked about self-care. When I learn that by taking care of yourself, you’re actually modeling that, and they’re actually watching that. I take pride and joy in doing that.” Before recovery, she believes self-care would have been considered a selfish act. Now, she enjoys taking care of herself and understanding the benefits self-care has on her children’s well-being. “Because they are learning to take pride in taking care of themselves, which is my job as a mother to teach them how to learn to live without me...successfully without me. And they’re able to do that by watching me.” Also, she feels children “learn a lot about themselves” by learning who their mother is. Adriana discusses her daughter’s curiosity in learning about herself. “My youngest daughter’s been thinking a lot about who she takes after. She’s starting to learn about herself. She knows she’s independent. She’s

strong.” she says, “And she is kind of looking at both her dad and myself, looking at qualities in us and trying to find herself in us.”

She is also utilizing open communication with her daughters. “And I allow her the chance to explain herself and the way she felt.” she says, “And then she gave me the chance to explain myself, and I did without raising my voice and being respectful and respecting those communication boundaries without crossing the line, insulting.” She believes the change in communication patterns is rebuilding and making for closer relationships with her daughters. She states, “And [my daughter] did get involved with drugs and alcohol herself. But she is also in recovery. And I’m in recovery as well. So we’re able to kind of talk to each other. We understand each other and are able to talk to each other.”

Her daughters, sponsors, and sober friends assist Adriana as a support system during her recovery process. She maintains her sobriety by implementing 12-Step Programs, getting sleep, and keeping contact with her children.

Appendix I

Textural-Structural Description: Brenda

Brenda is a 28-year-old Hispanic female who is currently employed as a housekeeper. She is single with four children (two daughters – 6-year-old and 5-year-old; two sons – 3-year-old and 2-year-old). She started using at the age of 18 and had used for approximately 1 to 2 years. Her length of sobriety is 7 months. She has attended 2 treatment programs. Brenda reports her reasons for prior relapse was due to stress. The programs she participated in while in recovery include Parenting Classes, Alcohol Anonymous, Narcotics Anonymous, and Counseling. At this time, Brenda reports no physical or mental health problems. She is currently on Butalbital, Acetaminophen, and caffeine medications. She reports having visits with her children once every 2 weeks.

Brenda explained the difficulty of raising four children without the assistance of her husband while using. Brenda's husband was deported back to Mexico. Brenda believes her husband leaving was a major contributor in her use. "Well our daily routine was I get up at 5:00 or 6:00 in the morning. I fix him his lunch and then after he's gone [to work] I wake the kids up and -- the ones that go to school. I wake them up and I get them ready." she says, "Since their dad was with us, he got them used to sleeping over him and always sleeping in our bed and they're really used to being in my room." Life significantly changed and "went down" for Brenda when her husband left the home. To support her family, Brenda took a job at a local bar. She states, "So I ended up having to go to work at a bar and at the bar you had to drink with the customers." Brenda followed the bar motto of "this is what you have to do at work. You drink." to fit in with her new position. However, Brenda experienced side effects from drinking when returning home. "And whenever I come home from work I had really bad hangovers." She says, "My head hurt." She was attempting to balance motherhood with her addiction. Lacking prior

help from her husband, Brenda was handling the “every day things” such as driving her children school and watching over them on her own. Brenda’s stress was rising from managing all the daily tasks. Brenda’s addiction soon worsened and was impacting the lives of her children. Brenda lacked patience due to low-quality sleep from her nightly drinking at work. She would often react out of frustration with her children for “kicking and screaming” with one another. Brenda confesses, “I wasn't trying to be after them. I was trying to just go to sleep.”

Brenda faced traumatizing events when CPS intervened and placed her children in foster care. She was shocked by the repeated events of her children going through what she went through as a child. This saddens Brenda since she grew up in CPS custody. She says, “I haven't been home since I was 11 years old.” Brenda remembers the CPS system and shelters she stayed in. She hopes she will regain custody as the separation has been extremely “hurtful for all of us.” In the meantime, she is allowed visitations. She says, “Well really all I see them is once time every two weeks and besides when I see them, I work all day.”

From reflecting on her own difficult childhood experiences, she understands the importance of “being there.” Brenda mentions, “My mom was never there.” Providing a different experience for her children, Brenda is creating positive memories and spending quality time with her family. She believes children remember more of the time spent with their parents than material possessions. “They really are going to remember more the things that –oh, she went to my soccer game.” she says, “She took us to the park.” She recounts memories with her children. She says, “They love the -- they call it Thomas the Train by the zoo. They love going to the zoo and get on the Thomas Train.” Brenda

believes protecting her children is another approach to “being there” for her children. She keeps her children safe by watching over and following up with their concerns at school. “So to me it was to take them to the Memorial Mall where I know they’re safe.” she explains, “There's no cars. There's nothing and I play with them right there.”

Brenda is determined to fix the damage caused to her family. She keeps to a schedule, has complimentary job hours to her children’s school, has been saving money, and paying her bills. “And now that I'm able to save the money up I have two/ three months in advance on my rent.” she says, “So I'll be able to go to work after they all got to be in school.” With hope to reunite, Brenda is working hard create the “same environment” her children are familiar with.

Brenda’s support system that has assisted in her recovery process includes her counseling and family. She maintains her sobriety by the faith and love for her children desiring to have a better life for them.

Appendix J

Textural-Structural Description: Cynthia

Cynthia is a 44-year-old Caucasian female who is currently a student with occupational background in the real estate industry. She is divorced from her 14-year-old year son's father and currently engaged to her fiancée, Jacob. She began using at age 15 and has approximately used for 27 years (on and off). Her length of sobriety is 14 months and attended 1 treatment program (Memorial Herman PaRC). She reports no relapses at this time and participates in programs such as Alcohol Anonymous, Narcotic Anonymous, Co-Dependents Anonymous, Al-Anon, Rehab, and Aftercare services. Cynthia reports a diagnosis of Generalized Anxiety Disorder, and Major Depressive Disorder – mild. She also has physical health issues regarding her thyroid. Currently, she is on two medications for her thyroid and three medications for mental health issues.

Cynthia believes addiction significantly impacted her life. She recalls living in a state of “constant denial.” She explains her mindset, “The way that I thought about it at that time is “How could I have an addiction that’s taken over my life?” She feels denial prevented her from “seeing the problem and having to make a decision about whether or not it’s acceptable.” Cynthia attributes learning denial from her dysfunctional childhood upbringing. She says, “I was raised in a family where I could look at you and say “The candle is red,” and my mother would go “That’s purple. What’s wrong with you?” That messed me up. I’m telling you. It raised me into a person that didn’t even know what was right in front of me. Somebody would say “No, that’s purple.” I would go “Oh, okay. It’s purple.” As Cynthia’s using continued, she became “self-aware she felt depressed.” Her depression worsened more every day until finally experienced a “depression crash.” Cynthia believed her guilt was catching up with her. She says, “That was probably the most tormenting aspect of my addiction for me, was “Oh my God, God has given me this

precious child, and what are you doing?" She believes she was not "being as good as a parent as her son deserved."

Cynthia noticed the impact her addiction was causing on her child. Her life appeared normal as Cynthia was "around a lot," but lacked in emotional presence. "You wouldn't have known it. I was around," she explains, "He had dinner. He was fed. He was going to school. The house – the house didn't look that good, but you know." She neglected to assist with homework or engage in conversations about her son's day. She says, "During my heavier addiction, I wasn't as attentive to him in school and stuff like that – helping with homework and staying around about things." During her addiction, Cynthia saw time drifting with son as "weeks would go by and then months would go by and then years would go by."

Cynthia recalls the constant state of fear during her use. She experienced intense paranoia over her powerlessness to addiction. She feared others finding out about her use and potentially taking her child away. "It got to the point where I was scared to open the door. I was just afraid that my world was going to close in on me," she says, "I was afraid that somebody was going to find out, take him away from me, or get arrested." The endless paranoia was overwhelming for Cynthia, but resisted treatment due the "scarlet letter" of shame attached to her once admitting she had a problem. She explains, "It pisses me off that society – like 98 percent of society looks at us like we are bad people trying to be good or we have a moral issue or a weakness. I get pissed off because – you know what? I am a tough chick, and I'm smart, and it took me there." However, Cynthia recognized her life would crumble without help. She says, "I was like "Okay, if I continue on this road, eventually something is going to happen. It's inevitable. I'm going

to run out of luck.” She forced herself to overcome the fear. She admits, “Scariest damn thing I’ve ever done in my entire life, driving to rehab. I had a panic attack in the car.”

Cynthia enrolled in treatment. “I spent two weeks in-patient, and they offered what they call PHP. You know what that is? Partial hospitalization. So I did two weeks inpatient, where I lived there for 14 days.” she says, “Then I switched and transitioned, and I did another month of PHP. I would basically go until 4:30 Monday through Friday for four weeks.” She leaned on the support of others to assist with her as she attended treatment. She says, “I gave my bank accounts and my credit cards to my girlfriend and the dogs to people” and “I basically gave my kid to my ex-husband for two weeks. I did two weeks in-patient.” Cynthia believes the time and money spent on treatment was worth the cost due to the detrimental consequences addiction causes. Cynthia explains, “Perhaps a criminal attorney would have been on my plate down the road or treatment, so I spent \$18,000 for 6 weeks of treatment.” She remembers feeling ashamed entering, but walked out with a sense of pride when leaving treatment.

Cynthia made considerable changes to her life since attending treatment. She willingly surrendered and “handed her will over to care of God.” With a clearer mind and spiritual development, she engages in a healthy lifestyle. She lives life in moderation by finding her own understanding of balance and practices proper self-care. She says, “So my recovery has very much been about what they call self-care, being true... To thine own self be true. It’s not selfishness. That’s “I’m worthy of more than that.” She continues working the program and implementing the “Big Book” principles to her daily life. She says, “The big book says “You have a daily reprieve based on the fitness of your spiritual condition.” She makes “living amends” to her son. “I apologized to him for

“You remember when this happened when mommy was angry and...” she says, “I basically took responsibility and told him that it was because I had this problem, and “I’m doing all these things so that I can heal from this, and I’m sorry for what I did or what I didn’t do.” I was specific with him and told him “It was not your fault. You did a good job. I’m sorry.”” Cynthia talks with her son about her addiction, the family genetics, and peer pressure to use as a teenager. To better understand, Cynthia’s family attended counseling sessions. She says, “I told him “Look, mommy made mistakes. I want you to go and listen and participate in [family counseling] so that you are smarter than I am and you don’t decide to drink or use drugs when somebody offers it to you.” I just tell him straight out.” Cynthia feels her “life has gotten much better” and determined to maintain the positive changes.

Cynthia discovered her purpose from her life events. She feels “there is a reason” she experienced adversity. “I think that’s part of the reason why I’ve gone through a lot of the adversity that I have in my life. I left an abusive marriage with no job and no family and a two-year-old child,” she says. She believes her purpose is to assist women suffering from domestic violence and mothers with addiction. Cynthia enrolled in school to further her knowledge, but in the meantime; has already taken steps towards helping others. “I’m an after-care facilitator now ever since I graduated. I have a sponsee.” she says, “Somebody else asked me to sponsor them today, too.”

Cynthia acknowledged several supports – fiancé, sponsor, sober friends, Alcohol Anonymous Group, outpatient rehab, and therapist. She maintains her sobriety by attending AA meetings, working the Big Book Steps, reading literature, upholding a sober home, completing aftercare, and participating in therapy.

Appendix K

Textural-Structural Description: Gina

Gina is a 31-year-old Hispanic female with a GED certificate. She is single with six children (four sons – 13-year-old, 11-year-old, 10-year-old, and 8-year-old; two daughters – 16-year-old and 7-year-old). She started using at the age of 14 and had used for approximately 17 years. Her length of sobriety is 6 months. She has attended 1 treatment program. Gina reports her reasons for prior relapse life stressors. The programs she has participated in while in recovery include Alcohol Anonymous, Narcotics Anonymous, and Parenting Classes. Gina reports a diagnosis of Major Depressive Disorder and Anxiety Disorder Unspecified. She is currently on Seroquel, Zoloft, Doxipen, and Prazosin. She reports having Insomnia as current physical health problem.

Prior to treatment, Gina struggled to “be there” for her children. She says, “I wasn’t worried if they were eating or they were inside the house or if they were okay playing outside.” she explains, “I was just worried about me and what I wanted and what I wanted to get.” Gina reflected on past experiences that were emotionally difficult regarding her children. Gina would leave her children in her father’s care while she went out at night. “I used to leave my children with my dad. And I would go out and party.” she says, “And then I wouldn’t come home until I was ready to come home.” Gina felt at ease with her father caring for the children since he always a reliable support to her family. She says, “We used to live with my dad. I always thought that my dad would take care of them anyways ’cause he always took care of us. I wasn’t really too worried about it.” Gina truly wanted to “be there” and would even make promises to be home when her children wake. “I would always put my children to sleep and be like I’ll be here. I’ll be back, just don’t worry.” she says, “And then when they wake up, I wouldn’t be there.”

Over a year ago, Gina lost custody of her children. Child Protective Services (CPS) intervened and removed Gina's children. Gina reports, "CPS came one day, and I wasn't home. And my children were outside playing with a fire. And they took them, about a year and a half ago, and that was it." Gina noted the intense "hurt" felt inside her due to the absence of her children, but believes her children suffered the most from the circumstances. "I can only imagine what it's doing to them and them not knowing their father." she says, "They only have their mother. So I know it's devastating to them." CPS restricted Gina's contact with her children. "We haven't had visitation." She says, "But now that they're not with me, I think about them more." Gina notices her children are constantly on her mind along with the guilt for prioritizing addiction over her family. She states "I think about how much time I need to make up to them that I lost when I was in my addiction." Gina finds her guilt "breaking [her] down and tearing [her] apart." She often ruminates about "all the bad things" she did while using.

Gina hopes to fix the damage caused to her family. She wants to amend trust by fulfilling promises to be there for her children when she tells them she will be home. She is learning to repair relationships through her 12 Step Program . "And I'm on my eighth step, which is making amends. It's hard." She explains, "My amends have been going okay because I didn't know so many people actually wanted to apologize to me too." Gina finds apologizing to family members to be a challenging aspect of her eighth step. She says, "So my amends have been going okay – making amends with family members that I don't really like. They're my family. So I had to make amends to them, too. But it's going okay."

Gina is doing her best to “stay away” from potential triggers. She refrains from “going out with people” she would use with. Gina supports her efforts to stay sober by attending outpatient classes, engaging in regular drug tests, and talking with her counselor. Gina works hard to not “fall off the wagon” and has a sponsor to assist with challenging moments. By staying away from substances, Gina has noticed positive changes in her life.

Gina has learned to slow down when handling stress. She no longer allows “everything to pile up” and will deal with “one problem at a time.” She recognizes stress from finances puts her at risk for a relapse. She limits her worry on financial burdens by focusing on “one day at a time.”

Her support system consists of her sponsor, Ms. Rhonda – Santa Maria Hostel, and sober friends. Gina maintains her sobriety by missing her children and learning to live life without an addiction.

Appendix L

Textural-Structural Description: Jaime

Jamie is a 28-year-old Caucasian female with some high school level of education. She is married with four children (three daughters – 13-year-old, 11-year-old, and 2 ½-year-old; 1 son – 10-month-old). She started using at the age of 16 and had used several times over the years. Her length of sobriety is 1 year. She has attended 1 treatment program. Jaime reports her reasons for prior relapse was due to the death of her son. The programs she participated in while in recovery include Parenting, Seeking Safety, Group Therapy, Life Skills, and Relapse Prevention. Jaime reports a diagnosis of Anxiety Disorder NOS. She reports Seizures and Chronic Pain as physical health problems. She is currently on Gabapentin, Norco, and Effexor for medications. She reports having daily contact with her children.

She attempts to balance motherhood with treatment. Jaime feels outpatient classes can be stressful on her and her family. She drives a long distance to attend classes while still managing to care for her four young children, maintaining her household, and cooking for her current husband. Jaime finds herself becoming irritated from the stress of driving to treatment and raising her children.

Jaime believes “mothering is all she knows” since being a mother has been a predominant role in her life. She became pregnant at 14 years old and went on to marry the father of her children. A year later, Jaime and her husband divorced. Jaime currently functions as a single parent and tries her best to provide for her family. She says, “I manage to take care of four at all different ages and I've always been there.” Due to her circumstances, Jaime feels she has always played the role of both mother and father with her children.

Last year, CPS became involved in Jaime's life. She suddenly lost one of her children. "In December, one of them passed away from SIDS," she says, "The autopsy came back that it was SIDS, natural death or whatever." During the investigation of her child's death, Child Protective Services intervened and removed the children from the home. "CPS got involved in my life was whenever I had twins," she says, "That day CPS took all my kids from me and then they were gone for seven months." The children were removed for seven months and placed with her pastor and his wife. CPS required Jaime to attend outpatient treatment while the investigation was completed. She believes she attends treatment due to her history of substance abuse. She says, "The only reason pretty much that I am in these classes is because of my background, because I have a substance charge in my past." Jaime was determined to retain custody of her children. Jaime is doing everything she can. She states, "I told them, I said I'll do whatever to get my kids back home." Jaime desperately wanted her children back and her life to return to the usual. She says, "I just want to be a mom in my life and my life back with my kids." Jaime's children returned three weeks ago while Jaime completes the remaining classes for treatment. She says, "I just got them back three weeks ago. So I should be able to be at home with them instead of [outpatient treatment]."

Jaime reflects on the impact of her addiction towards her children. When she was using, she would spend more time in her room than with her children. "I guess whenever I did use I would stay in my room and at times -- this was years ago, though." She says, "I shouldn't have been always in my room. I should have been spending more time with my children." As a result, Jaime experienced feelings of shame for her neglectful

behavior. Jaime believes being under the influence changes her ability to be a good mother.

Jaime believes “being there” for children is essential for parenting. When her children need someone to talk to, Jaime feels she should be both physically and emotionally present. Jaime believes she has always made her children a priority. She feels she should be a mother figure rather than a friend. She believes her children “need her being mom.”

Jaime works at being a good role model for her children. She intends to set a good example by implementing structure. However, applying discipline is still a struggle for Jaime. She says, “I'm kind of bad on sticking to discipline. That's my only problem is -- I'll be like, "You're grounded." And then two days or a day later I'm like whatever.” Jaime strives to stay firm to discipline and maintain routine in her household. Jaime makes sure she provides everything her children would need – roof over their heads, clothes, food, education, and financially supported.

Jamie's support system that has assisted in her recovery process includes her pastor, church, husband and counselor. Jamie maintains her sobriety from her children and herself.

Appendix M

Textural-Structural Description: Jenny

Jenny is a 30-year-old Caucasian female with some college education. She is single with an 18-month-old daughter. She began using at the age of 16 and had used for approximately 14 years. Her length of sobriety is 9 months. She has attended 2 treatment programs. Jenny reports her reasons for prior relapse was not continuing her recovery maintenance. The programs she has participated in while in recovery include Alcohol Anonymous and Narcotics Anonymous. Jenny reports a diagnosis of Major Depressive Disorder and Attention Deficient Hyperactivity Disorder – Inattentive Type. She is currently on Strattera, Buspar and Elavil. She reports no current physical health problems.

Jenny struggled to “be there” for her child when she was using. Her life prior to treatment was stressful and disorganized. She would tend to “everything else” besides paying attention and being with [her] child. Addiction had blurred Jenny’s vision into “thinking [she] was a good mom,” however; she was often moving through the motions of “day-to-day” life without any emotional involvement. She remembers being “physically” present, but “mentally” shut off from her child. Using prevented Jenny from “feeling [her] emotions.” Jenny experienced guilt due to the emotional abandonment toward her daughter. Jenny reflects on her own childhood experiences and the impact of her mother not being there. “My mom left me in the hospital when I was born in Phoenix, Arizona.” She says, “My mom was just a person who had me. I don’t call that a good mom.” Jenny discusses her mother abandoning her at the hospital and her grandmother stepping in to raise Jenny. She explains, “And my grandma raised me. So she was always there. I knew her as my mom, not my mom.” She views her grandmother as a mother figure rather than her own mother since her grandmother was “always there.”

Jenny's grandmother was extremely influential in her life and provided "unconditional love" to Jenny. Jenny further describes "unconditional love" as 'being there through thick and thin.' Jenny models the love and affection she learned from her grandmother towards her daughter. "I just gently rub her back, give her a kiss – wake her up, and she smiles," says Jenny. Every morning, she spends time "loving on" her daughter to provide emotional security. Jenny wants her child to know she cares. Jenny believes children can feel the love shown by parent.

Unfortunately, Jenny "hit rock bottom" shortly after her grandmother passed away. Her grandmother was caring for Jenny's daughter due to Child Protective Services involvement. Jenny had attempted treatment programs in the past, but never followed through on after-care. Jenny's life significantly changed when she returned to jail and no longer had her grandmother to watch over her daughter. Jenny begged to re-enter treatment for substance abuse.

Jenny sought treatment and chose to surround herself with a supportive environment unlike previous attempt at recovery. She decided to make a "different choice to go to sober living" with her daughter than returning to her grandmother's house. Jenny believes "going backwards" to the same environment would cause a high likelihood of relapse. Jenny focused on "doing what's best" by placing her daughter and herself first in priority instead of "what was going on around [her]." Jenny recognizes her sobriety is maintained by a conscious decision every day. She makes an active choice to change her lifestyle by not engaging with "the same people and same things." Otherwise, she believes "you'll have the same result."

Outpatient treatment has educated Jenny on aspects of being a good role model. She has learned to recognize feelings she had been avoiding when using along with the feelings of her daughter. Also, she understands the significance of “taking care of yourself” as a mother by upkeeping her medication to be present for her daughter. Jenny notices her daughter is “watching and copying everything she does.” By modeling self-care and choosing positive life paths, she hopes her daughter will have a better outcome. Jenny’s strong love for her child assists in maintaining her sobriety along with wanting a better life for herself and her daughter. Her main support system while in recovery was Jenny’s family.

Appendix N

Textural-Structural Description: Judy

Judy is a 62-year-old Caucasian female who is currently employed as a resident tech at a transitional living facility for women. She is divorced and a single parent to her 32-year-old son. She started using at the age of 17 and had used for approximately 40 years. Her length of sobriety is 2 years and 4 months. She has attended 3 treatment programs. Judy reports her reasons for prior relapse was due to several factors – money, relationship issues, and being an addict. The programs she has participated in while in recovery include AA meetings, inpatient at Houston Recovery Center and WHO-A, and outpatient at Houston Recovery Center. Judy reports a diagnosis of Major Depressive Disorder and Bipolar Disorder II. She is currently on Wellbutrin and Abilify and reports no physical health problems.

Judy recalls the impact addiction caused on her daily functioning. She states “I didn’t want to leave the house. I would rather just sit, unless I was going to get what I needed and wanted. That’s pretty much how it got to be.” Judy struggled to accomplish everyday tasks without having the substance on her. Her mind was constantly thinking about using. She believes her primary focus was on her addiction. As she fell further into her addiction, Judy encountered a series of negative consequences in her life. “When I went to jail [for six months], I lost all my IDs.” she says, “I had to learn how to get a referral to go to Operation ID to get what I needed, like my license and Social Security card. Everything. All my important papers were at the house, and the guy got kicked out because he couldn’t pay his rent, so everybody had to leave.” Judy struggled to rebuild her life after prison. She became homeless, unemployed, and lacked personal identification documents.

Judy's relationship with her son suffered due to her addiction. Judy feels her relationship changed from being "really close, like twins, to basically cutting [my son] off." Judy remembers spending most her time with her son before she was heavily using. Judy and her son would travel to many places. She says, "We went all over, going to Six Flags, but I was into my addiction, too." However, Judy's addiction started escalating and her time with her son diminished. She would also tend to break promises to her son. "Like one time he told me I was liar, when I would tell him I was going to do something for him," Judy explains "Like I was going to go get him a CD, and he's like "Oh, mom, you are a liar."'" She attributes her relationship going downhill with her son from the lack of time spent together and broken promises.

Judy believes her addiction was impacting her son as well. Judy raised her son until his 8th grade year. After that time, she admits she was barely able to her requirements as a mother. She recognizes the difficulty her son has as viewing her as a mother figure. She says, "He doesn't accept and recognize that I raised him up their eighth grade before he went to boarding school." Even though her son addresses Judy as "Mama," she feels her son became so angry with her that he considers "his grandparents as his parents." Her son developed intense anger and distanced himself from Judy for many years. Judy attempted to reconnect with her son. She explains, "I have written my son a letter, asking for forgiveness." Judy feels her son is not completely ready to reconnect yet. "I have a granddaughter that will be three in September that I've never seen." Judy says, "I'm allowed to get pictures. I'm allowed to send presents, but I go through his grandmother to do that." Judy still has limited contact with son and restricted relationship with her granddaughter.

As Judy became more involved with her addiction, she needed support from others. Judy's ex mother-in-law assisted her in caregiving duties on the weekends with her son. Judy says, "She would pick him up Friday night at daycare or after school, and I would come over on Sunday. They would do their church, piano practice, all that stuff, and they had a pool. They had all the toys." As time went on, her son and his paternal grandmother developed "their little connection." Judy's son was gradually spending more time with his grandmother. She believes her ex mother-in-law wanted custody, but Judy refused to give him away. She thinks her son's grandmother developed misconceptions about Judy's lifestyle. "She thinks I went out partying all that time" she explains, "I didn't have the money to go partying. There again, three times from him being born up through eighth grade did I make enough money that I to do those things."

Judy learned to follow the next right step during her recovery. "Just do the next right thing. That's all you have to do. Do not put any substance in your body, and do the next right thing." Judy believes she was serious about "getting straight and getting her life together." Judy had sought out assistance from community resources where she was connected to a transitional living center providing treatment. Others in the program noticed Judy's drive for sobriety and commended her efforts in treatment. Her hard work was paying off as she noticed significant improvements in her life. "I got a job." she says "The LCDC helped me get a job. It was transitional living for men."

Judy feels like a totally different person since treatment. She explains, "Oh, man. It's wonderful. I cannot believe that I'm straight. I have nothing in my body that's not supposed to be there." She feels more than a "night and day difference." She says, "It's almost like going to heaven, but knowing heaven is going to be even so much more than

this.” She believes she is more loving, caring, and open individual. Judy feels sobriety is “better than she ever expected.”

Judy emphasized the importance of a support system during recovery. She acknowledged several supports – STAR Court, Paternal grandparents, Son’s father, friends, church, job, probation officer, sponsor and attending her regular AA meetings. Judy has a strong desire to help others in the community, has attained certificate from a community college, and is known as the “Resource Queen.” She maintains her sobriety through her faith in God, supportive family members, hope to reconnect with her son, and developing a relationship with her granddaughter.

Appendix O

Textural-Structural Description: Leah

Leah is a 34-year-old Caucasian female who has a high school education. She is married with two sons (14-year-old and 11-year-old). She started using at the age of 15 and had used for approximately 15 years. Her length of sobriety is 102 days. She has attended 2 treatment programs. Leah reports her reasons for prior relapse was due to not being ready. The programs she participated in while in recovery include Alcohol Anonymous, Narcotics Anonymous, and Outpatient Services. Leah reports a diagnosis of Anxiety Disorder NOS, Attention Deficit Hyperactivity Disorder, and Depression Disorder NOS. At this time, she reports no physical health problems. She is currently on Concerta, Celexa, and Klonopin medications. She reports daily contact with her children.

Leah believes “using only gets worse” after reflecting on her acceleration with addiction. Three years ago, she moved back to Texas for military services with her family. The move triggered a relapse for Leah and her husband. Leah and her husband had been sober until slipping back into use. She explains, “We were doing right and then that one time we slipped and used.” She describes how the “slip” escalated the relapse quickly. “When we use, we don't just use a little bit.” she says, “We have to use a whole lot.” Leah and her husband's addiction caused financial issues for the family. “I knew that we weren't going to be able to pay our bills because neither one of us was working,” she says, “because we were using at the time.” As Leah's use got worse, her family faced detrimental consequences. “And when I say worse, we lost everything. My car, my house, everything. We were on the streets.” she explains, “I was pretty much on the streets just so I can use.”

Leah's relationships started suffering with her husband and children. With her husband, she remembers frequent arguments occurring. “So it was constantly [the kids]

would hear arguing,” she says, “we both were using and made [my husband and I] ugly with each other.” Leah felt the relationship was “toxic” and “so hateful” with her husband. With her children, they started to understand when Leah and her husband would use. “I was angry all the time because I was like the perfect mom until I started using” explains Leah. Her children would notice the changes in her when she was under the influence. She explains, “When I'm using I slept a lot. I literally laid in bed and did nothing. Nothing. I could not move or do nothing.” She was becoming neglectful in her caregiving duties as well. “I didn't even mind if my kids went to school. I was late waking them up,” says Leah, “and I stopped going to functions with them. I wouldn't participate in any of my kid's stuff.” Leah's addiction was impacting her daily life functioning.

Leah struggled to “be there” for her children during her addiction. Leah sent her children to live with their grandparents while her and her husband continued using on the streets. She says, “They stayed with my mom for three months and we never came back.” Leah had planned on “going back” for her children, but she admits she fell to use. Due to her absence, Leah's children need reassurance that Leah will be there. “My son -- we talk still every night because he has to say, "I love you, mom" or begs me to stay.” she explains, “because he thinks I'm not going to be there. It's not a good life.” Leah recognized and developed guilt over the pain her children experienced from her inability to be there for them. She believes “holding onto the guilt” trapped her in the vicious cycle of addiction.

Leah was “sick and tired of being sick” and made the choice to come to treatment on her own. “That's the first thing you do in treatment is they say you write your yets.”

she says, "And you're like what do you mean write your yets? What has not yet happened to you? I've done a lot of things. Have you lost your kids yet? Have you died yet?" During treatment, Leah noticed many mothers had lost custody of their children. She believes CPS should have intervened and removed her children due to her neglectful behavior. She says, "I've never had CPS. I should have had them called on me."

Leah is working hard to strengthen the bond with her children. "Now it's like my focus is on having them ready for school or getting them ready for school, seeing what they want to do, spending time with them," she says, "having mommy time with them." She focuses on spending time with her children by engaging in activities they enjoy. "He teaches me how to workout because it makes him feel good. So he shows me what I can do working out." she says, "and then my other son, movie time with him or playing Legos with him." She shows love and affection towards her children. "I enjoy waking every morning and they're still laying down and I sneak into bed with them," she says "and give them a kiss."

Leah fights for her life every day by battling her addiction. She states, "because when you're sober you have the devils already waiting for you out there. It's always waiting for you." She remembers the hardship of leaving treatment from prior experiences and the immediate triggers that surround her. "Even on things you used to do, it will sneak up on you, and you have to be willing to -- because when the first day that I was released and I got to go out there, I couldn't do it." Leah feels she will struggle daily, but continues the fight for the family she once had. "So I want us to be that family we were because we were a good family."

Leah's support system while in process of recovery includes her Recovery Coach, Sponsor, Sober Friends, and Family. Leah maintains her sobriety by loving herself, loving her children, and utilizing her coping skills.

Appendix P

Textural-Structural Description: Maria

Maria is a 45-year-old Hispanic female with some high school education. She is married with 2 children (8-year-old daughter and 6-year-old son). She started using at the age of 18 and had used for approximately 20 years. Her length of sobriety is 1 month. She has attended 3 treatment programs. Maria reports her reasons for prior relapse was due to marital problems. The programs she has participated in while in recovery include Alcohol Anonymous and Parenting Classes. Maria reports having mental health problems, but did not specify. She reports no current physical health problems.

Maria recalls the impact addiction caused on her life. She says, "I wanted to be in my little world, and the kids would say "Mommy, I want to eat." I'm like "Let me get up, and let me go fix it. Let me go fix you something." Maria was attempting to meet the demands of her children while experiencing the sides effects of drinking. "If I drink too much, I've got this headache. I would sleep all day." she explains, "I've got children." The stress of handling both addiction and motherhood would wear on Maria. She says, "I was in my world, and I just wanted to sit and listen to music and drink." Maria noticed the painful feeling of guilt from engaging in her addiction rather than her children. She says, "I would look at them and just look at their faces. It would make me feel bad, and I would think "Gosh, I need to quit drinking."" Maria believes the guilt motivated her to interact with her children. She explains, "If [my daughter] said "Mommy, can we play? And then I would tell them "I'm sorry, baby. I'm sorry. Okay, I will play with you for a little while."" Maria feels she would disregard her children due to her drinking.

Maria admits her addiction impacted the lives of her children as well. She believes she lacked concern for her children's well-being. She says, "I'm able to tell my own self "Gosh, you're drinking, but you don't know how to drink just a few and that's

it. Pay attention to the kids. The kids need you.” She noticed she spent more time drinking than meeting the needs of her children. She states “I never wanted to spend time with them or do special things with them. I would take them to “You can watch TV. Just watch TV. Mommy wants to go over here. Mommy wants to listen to some music.” Because I just didn’t want to.” She struggled to find the time to play with her children. “Like for instance, they wanted to play. I didn’t feel like playing, and then I would say “Gosh, okay. Let’s play for a little while, and then mommy has to go to do some other stuff.” Her patience would dwindle and would react harshly to her children. “When I would be drinking and doing my own thing and just want to do whatever I’m doing, they would come and want something,” she responded, “Go to timeout.” “You never listen.” “Don’t talk to me about that. Go to timeout.” Maria felt she was often irritable when using. “I was always complaining, you know what I mean?” she says, “Instead of being fine with it, I was like “No, gosh. You always want something. If it’s not one thing, it’s the other.”” Maria feels her children noticed her short temper from the comments made. She explains, “My little girl is like “Mommy, I like it when you don’t drink. I don’t like it when you drink because when you drink you’re mean.” Maria believes her mindset prioritized addiction over her children.

When in treatment, Maria began opening up about her rough childhood. “I know it’s got to do with my childhood.” she explains, “As I was growing up and the stuff that happened, it drove me to drink and cover the pain that I feel.” Maria learned the dysfunction patterns of communication in her family. She says, “I remember my childhood. I wanted to tell my mom, and I thought I could never tell her.” Due to the poor communication in Maria’s family, Maria learned valuable lessons by experiencing the

hardships of life. She says, "My mom was never talking to us. I had to learn the hard way." Maria believes she needs to "break the chain" for her children to experience a fulfilling childhood.

Since entering treatment, Maria believes she is making changes in her parenting by modeling life skills to her children. She encourages everyone in the family to help when completing chores. She says, "When they're cleaning, I'm like "There's still too many toys. Monica doesn't want help me." And Monica says "Those are your toys. Those are mine. I picked up mine. The ones that are mostly spread out are yours." I tell them "Let's do one thing. Let's all help." As she teaches her children to clean, she monitors her children for activities that still may be challenging. "When my son is sweeping or helps out sweeping, I tell him "Okay, if you can't do that, I'll do that." Maria explains. She wants to teach her children to live independently by demonstrating chores and having her children watch. "Even laundry, they like to do. I tell them "These are your clothes. One of these days you're going to get older. You're little, but you need to look and watch because one day you're going to do it." She says, "I can't be doing it all the time. You're going to grow up, and you can do your own clothes."

Maria notices improvements in her self-esteem since being sober. When she was drinking, she became apathetic to daily upkeep. She says, "If I'm a drunk, I don't even wake up. For what? Who wants to visit? I don't want to see nobody. I have to go buy groceries. I don't have to pretty myself up and stuff." Her lack of care from drinking would deteriorate her self-esteem. "Drinking was just... I looked at myself like "Gosh, you're terrible." Then my self-esteem would just be down. It does have a vague impact." Maria explains. Since treatment, Maria makes a conscious effort to maintain her body

and notices a heightened self-esteem in herself. “Just to feel better, you want to smell good. You want to look good. At least put a little powdered... It doesn't have to be like you're going to the mall. At least maintain your body.” she states, “That has lifted up my self-esteem.”

Maria identified current stressors - marital issues and difficulty finding a job. However, church, family, friends, and her husband assist as support systems in her recovery and maintain her sobriety.

Appendix Q

Textural-Structural Description: Sammy

Sammy is a 30-year-old Caucasian female who is currently employed as a fabrication welder. She is separated with 3 sons (10-year-old, 2-year-old, and 1-year-old). She started using at the age of 15 and had used for approximately 15 years (off and on). Her length of sobriety is 1 1/2 years. She has attended 2 treatment programs. Sammy reports her reasons for prior relapse was not maintaining her recovery. The programs she has participated in while in recovery include Alcohol Anonymous, Narcotics Anonymous, and Faith-based services. Sammy reports a diagnosis of Anxiety Disorder NOS, Obsessive Compulsive Disorder, and Attention Deficit Hyperactivity Disorder – Inattentive Type. She reports no current physical health problems or medications. Her youngest son resides with family and her eldest son was placed into Foster Care. Sammy maintains daily contact with her eldest son and monthly visits with the youngest.

Sammy noticed the impact addiction was causing on her life. She believes her addiction was “clouding her judgement” on the important aspects of life. She says, “Over time of using a substance, it changes your judgment. I’m not the person that I am.” Sammy remembers ruminating on everything she needed to complete when using. She says, “In my addiction, I would worry about “I have to get this done. I have to get that done. Things have to be perfect.” Her perfectionate mindset would often “overwhelm” her. “I would get overwhelmed.” Sammy explains, “I let my stress overwhelm me. I let my anxiety overwhelm me.” Her life was unraveling and causing “unmentionable damage” to her family.

With her addiction distracting Sammy, she felt she was not giving the “undivided attention” her children deserved. She recalls ignoring her son’s request to read him a story. “There is one time where I was using, and my oldest son, George, wanted me to

read “Clifford the Big Red Dog” to him. He kept asking me and he kept asking me.” she says, “Because I was under the influence, I kept telling him no because I was too busy doing something else that didn’t matter. I will never forget that.” Sammy remembers the emotional impact that caused on her son. She shares, “He went to bed crying, and that’s not something I would do as a mother. I always think about that.” Her past actions continue to haunt Sammy.

CPS intervened with Sammy’s family and removed her oldest son. Her son was placed in foster care and Sammy is in the process of getting him back. Her younger son was placed with Sammy’s mother. Sammy notices her younger son struggles with separation from his brother. She says, “He said he cries almost every night because his brother is in foster care.” However, Sammy understands the process for regaining custody and determined to get her child back. “I am going to get Michael back, but it’s a process – unsupervised visitations, weekend visitations. Then they give them back to me.” she says, “It’s a long process.” Sammy keeps in close contact and notifies her caseworker when needed. “I stay in daily contact with my caseworker, almost every day. I let her know everything.” she explains, “That’s all that matters, because she’s the one that I do need to prove something to her right now. I need to provide documentation.”

To regain custody, Sammy must apply and commit to a lifestyle change. She says, “When it comes to my children, I’m trying to make our lives right. The therapy – I follow all the recommendations. But I find my own things. I’m giving CPS things to give me recommendations on.” Living by action, Sammy is surrounding herself with positive individuals and finding a supportive environment to reside in as she recovers. She says,

“I’m moving to a Sober Living House, so that I have supported people around me, helping me live the right way as a family.”

Learning as much as she can, Sammy is desperate to acquire new skills and hear feedback from others. She explains, “If somebody notices something, like “It would probably be better if you did this...” Constructive criticism is what I want.” Prior to treatment, Sammy recognizes she lacked knowledge in coping and nurturing skills. Sammy hopes the knowledge gained from treatment will assist in mending the hurt caused to her family. “What I’ve done is I bought Michael, my youngest son, that same book. I found it at Sam’s.” she says, “Whenever we’re all together again, I let George read it to Michael. We can all be in there, tucking him into the bed. That’s just the best that I can do to make up for what I’ve done. It’s my way of making amends.” Sammy attempts to fix the damage, but uncertain on the repair process for earning trust back with her children. She says, “I understand the dynamics of it, and I can label the dynamics of the situation, but I don’t know what I do to make these [feelings] go away and to mend everything and to gain trust back.”

Treatment has taught Sammy to focus more on her children and herself than the perceptions of others. She says, “I took anger management, and I learned that I cared too much about perception to other people.” Sammy acknowledged she was concerned about the judgements of others and would attempt to mask her reality to others. “I’m worried what other people are going to think, so I’m like “No, my kids come first.”” She explains, “I wanted to appear like my kids come first, but in reality I was putting on a show.” Now, she realizes to slow down and focus on what is truly important in her life such as engaging in self-care practices. She says, “This time around, it’s like “No, I’m going to

take care of myself.” Last time Sammy attended treatment, she neglected to take care of herself. She says, “I didn’t do that the first time I went to treatment. I didn’t do that. I didn’t care about self-care.”

In the past, Sammy was not as receptive to treatment. She explains her mindset, “It was “I’m going to get this checklist done.” However, she believes she is dedicated to her sobriety this time. She says, “This is the first time I wanted to be sober my whole life since I went into treatment May 26. I want to be sober definitely. Everything is new.” Sammy notices her outlook on treatment and life is much different than in the past. “I’m 30 years old, and I don’t want to use drugs or alcohol – nothing. First time.” she states, “It’s like a light switch. Life is this way, not stopping. So it’s good.”

Recovery Services, Santa Maria Hostel, Church and Family have assisted as her support system during recovery. Sammy maintains her recovery by utilizing self-care and exercise.

Appendix R

Textural-Structural Description: Sonia

Sonia is a 28-year-old Caucasian female with some college education. She is single with three children (6-year-old son, 2-year-old daughter, and 1 year old son). She began using at the age of 14 and had used for approximately 14 years. Her length of sobriety is 6 months. She has attended 3 treatment programs. Sonia reports her reasons for prior relapse was due to interacting with friends that use and influence her. The programs she has participated in while in recovery include Alcohol Anonymous, Narcotics Anonymous, and Parenting Classes. Sonia reports a diagnosis of Major Depressive Disorder and Bipolar Disorder Unspecified. She is currently on Latuda and Celexa. She reports no physical health problems at this time.

Sonia believes addiction had a significant effect on her life. She recalls the strength of her addiction. "It's almost like chains on your feet that just hold you down." says Sonia. She felt "stuck in the mentality" of needing the substance. She admits her addiction became a priority over her children. "When you're using, everything goes to that substance." she says, "It's like your child. It's a great impact." The infatuated feeling of addiction created an intense hold on Sonia. "You love the substance more than you love yourself or the child because of the intoxicated feeling or whatever the escape" says Sonia. Sonia feels she was "giving all her love to the substance." Sonia struggled to balance her obligations as a mother with her addiction. She cared for basic needs including bathing, feeding, and protecting her children, but lacked in emotional presence. She felt "no emotional attachment" towards her children while using. She believes she was rationalizing her behavior to give her an excuse to keep using. Sonia explains, "At least I'm getting it done. You're trying to rationalize and justify it – at least I'm getting it done." Sonia noticed a "wall of guilt" building inside of her regarding her use. "After I

had my children, I just felt guilty.” She says, “It was just a wall of guilt, pretty much, ’cause I knew they deserved better.” She knew deep down that she was capable of more as a mother. She felt ashamed for quality of care her children were receiving due to her use. Sonia feels she was neglecting the emotional needs of her children. To prevent her from focusing on the guilt, she placed an invisible wall up to avoid thinking about her use. She believes she placed the barrier due to her selfish mindset. As long as the wall held, Sonia could continue using. “That wall was just to protect myself, which is selfish.” she says, “But it’s selfish all the way around for using.”

Sonia’s addiction impacted the lives of her children. Her addiction would distract Sonia from giving undivided attention to her children. “And if I’m using, they don’t have that at all because my mind is like where can I get my next whatever.” she says, “My children need all my attention.” Unfortunately, her attention would be focused on meeting her craving rather than fulfilling the needs of her children. Sonia noticed her children would misbehave when attempting to get her attention. Sonia believes her children were communicating their unfulfilled needs. She says, “But sometimes they need that extra attention. I might say pick up your toys. And he’ll act like he doesn’t know what I’m talking about. But he wants me to interact with him.”

With a clearer mind from treatment, Sonia recognized her purpose in life. She feels motherhood was her calling. When Sonia was using, she felt “no direction in her life.” The trauma she experienced from childhood gave her little purpose in life. She remembers “how low she would let herself get” and stopped caring for herself. Sonia felt she was depressed which would cause her using. However, Sonia’s children “take all that

away” from her. She “feels good” fulfilling her role as a mother. She believes motherhood is “a much better feeling than getting wasted.”

Sonia believes being a good role model is essential in satisfying her role as a mother. Influencing her children in the right direction, Sonia teaches her children more than the basics. She teaches her children “everything they need to know” including structure, cleaning, love, and communication. “I teach them to clean and pick up their toys and stuff like that.” She says, “I just gotta show them everything.” Sonia recognizes her children are watching and learning from her. She says, “They’re little. Everything I do, my daughter does it. She copies me – everything. It’s crazy. I just laugh at her. I don’t let her know I’m watching her. But if I sweep, she’s sweeping.” She understands that maintaining her sobriety is important on influencing her children in the right direction. When Sonia uses, she lacks structure and “her children are chaotic.” Sonia explains, “Because if it’s bath time – 8:00 p.m. – but you’re out of alcohol at 8:00 p.m., you’re not going to say oh, let me stop doing this and get my kids in the bathtub. You’re going to say let me get my alcohol. And then I’ll be able to function to give them a bath, which may not be until 11:00 that night.” Sonia believes children need stability, and when she is sober, Sonia has routine.

Her support system assisting Sonia during her recovery include counselors, Narcotics Anonymous Group, and friends. She maintains her sobriety by her children and her will to stop using.

Appendix S

Textural-Structural Description: Vanessa

Vanessa is a 33-year-old African American female with some college education. She is single with 2 daughters (12-year-old and 2-year-old). She began using at the age of 18 and had used for approximately 10 years. Her length of sobriety is 3 1/2 months. She has attended 1 treatment program. Vanessa reports no prior relapse. The programs she has participated in while in recovery include Alcohol Anonymous at The Council on Recovery, Parenting Classes, Church Services, Self-help Tutorials. Vanessa reports no current physical or mental health problems at this time. She reports having daily contact with her children.

Vanessa recalls the impact addiction had on her life. She remembers life being easy-going until she needed to use again. Suddenly, she would become angry and start yelling. "Then when I needed to use again, I started to get kind of shaky, mean, yelling and angry toward the kids." says Vanessa. Unfortunately, she would lash out on "whoever" was around if she was unable to engage in her substance. Many times, Vanessa would find herself releasing her frustrations out on her children. Feeling guilty, Vanessa would apologize for taking her anger out on her children. Even though Vanessa's children would forgive her, she continued to hold onto the guilt since her children "weren't really doing anything" to her. Vanessa recognized her cyclic pattern during her use. She would react inappropriately by yelling then follow-up apologies to her children during her use. If she took the time to "think before reacting," Vanessa feels situations between her and her children would have been "smoother." However, the distraction of addiction inhibited her ability to attain control over her actions. She believes reacting differently would have reduced the number of apologies.

Vanessa struggled with managing multiple responsibilities. She would often become overwhelmed by taking on several tasks at once. When feeling overloaded, Vanessa would place the responsibilities on other family members. She felt family was “supposed to” handle the responsibilities she was unable to complete. However, treatment encouraged Vanessa to find an outlet to manage her distressed feelings. Vanessa started listening to motivational speakers to better understand her own philosophy on life. “I’ve been listening to some motivational speakers.” She expresses, “One of my favorites during my outpatient was Jim Rohn.” Vanessa feels the motivational speakers emphasized the importance of breaking down responsibilities. She recognized giving tasks a set time assisted, rather than; attempting to “rush, rush, rush” to complete each one. If unable to finish her responsibilities, Vanessa is allowing herself to leave to the task for tomorrow. Vanessa takes on more responsibilities with this new strategy. She recognizes the burden she placed upon her family by distributing responsibilities on to them. Now, she appreciates help “on the simple things” from her family members.

Vanessa learned the benefits of having a schedule when in treatment. She notices that scheduling leads to a smoother day. Despite the monotonous nature of having to sit and write her daily events, Vanessa feels scheduling works for her. She explains, “In the morning, I’m like “Get up kids. Eat breakfast. Put your clothes on.” They can wake up – not slowly, but it’s not “Got to get up. You got to go. Mom is going to do...” It’s more that they get to get up, unwind in the bed for about six minutes.” She believes giving activities a certain amount of time keeps her on schedule. Vanessa feels the preparation and set-up of a schedule creates for an overall smooth day.

Treatment helped Vanessa recognize the importance of “being there” as a mother. Vanessa pays attention to details and the simple aspects of life being sober. “The way that I participate in being a good mother is actually [when the kids are talking to me] I will actually listen.” she says, “Versus if I’m washing dishes, just saying “Uh-huh, uh-huh...” Before treatment, she missed the important details her children were attempting to convey to her. Now, Vanessa listens and provides feedback to her children. She says, “I’m actually listening and giving feedback to what they are asking me – whether it’s just “Mommy, come here look at this.” She believes she is capable of being “present in the moment” with her children.

Also, Vanessa is learning to deal with differences in others. Prior to treatment, she would ignore her child’s interest and attempt to persuade her daughter to engage in activities Vanessa enjoyed. She says, “I wanted my daughter to play basketball, and she didn’t want to play basketball. She wanted to play volleyball. Years back when I was using, I would have convinced her that “You can play basketball.”” Vanessa believes she is learning to accept and deal with the different preferences of her children. “But when she told me she wanted to play volleyball, I was like “Okay, that’s fine. If that’s what you want to do is a sport...”” she says. Vanessa believes she accepts her daughter’s choices without conviction.

Family and church members assisted as her support system while in the process of recovery. Vanessa maintains her sobriety by staying busy exercising, reading, and being involved.

Appendix T

Member Checking Log

Member Check Phone Log				
Participant #	Date	Time	Attempt #	Notes
1	4/11/2017	11:21 AM	1	Left Voicemail
	4/11/2017	3:07 PM	-	Member Check Completed
2	4/11/2017	11:26 AM	1	Left Voicemail
	4/19/2017	5:13 PM	2	Left Voicemail
	4/25/2017	3:15 PM	3	Left Voicemail
	5/3/2017	11:43 AM	-	Member Check Completed
3	4/11/2017	11:30 AM	1	Member Check Completed
4	4/11/2017	11:45 AM	1	Member Check Completed
5	4/12/2017	10:58 AM	1	Rescheduled for 3:00 pm
		3:07 PM	-	Left Voicemail
	4/19/2017	5:21 PM	2	Left Voicemail
	4/25/2017	3:29 PM	3	Left Voicemail
6	4/12/2017	11:00 AM	1	Left Voicemail
	4/19/2017	4:08 PM	2	Left Voicemail
	4/25/2017	4:33 PM	3	Rescheduled for Next Week
	5/3/2017	4:10 PM	-	Left Voicemail
7	4/12/2017	11:04 AM	1	Left Voicemail
	4/19/2017	4:11 PM	2	Left Voicemail
	4/25/2017	4:06 PM	3	Left Voicemail
8	4/12/2017	11:17 AM	1	Member Check Completed
9	4/12/2017	11:30 AM	1	Left Voicemail

	4/13/2017	6:30 PM	-	Member Check Completed
10	4/12/2017	6:15 PM	1	Left Voicemail
	4/19/2017	3:34 PM	2	Member Check Completed
11	4/12/2017	4:01 PM	1	Rescheduled for Next week
	4/21/2017	3:49 PM	2	Member Check Completed
12	4/12/2017	6:04 PM	1	Call Attempted
	4/19/2017	2:50 PM	2	Call Attempted
	4/25/2017	9:08 AM	3	Member Check Completed

Appendix U

Sample Peer-Debriefing Feedback

Peer Debriefing - Cynthia

Main document changes and comments

Page 4: Commented [MT1] **Mary Telisak** **4/21/2017 12:29:00 PM**

Might you consider making a sub-theme of "support" under this theme? Cynthia talked about her fiancé, her sponsor, sober friends, AA, rehab, therapist, the big book, and after care.

Page 4: Commented [LW2R1] **Lisa Witkowski** **5/2/2017 11:27:00 AM**

I think some of what you are mentioning came from her narrative which included her demographic information. She did write about her support systems. I'll merge Working the Program, Developing a Spiritual Life and Family Counseling. I'll make a subtheme of Support.

Page 4: Commented [MT3] **Mary Telisak** **4/21/2017 12:21:00 PM**

Maybe clarify – "making amends to my child." In fact, maybe "parenting post-addiction" is another Theme all together and "Making amends" and "talking to my child about addiction" are sub-themes?

Page 4: Commented [LW4R3] **Lisa Witkowski** **5/2/2017 2:02:00 PM**

Making Amends applies to many areas of her life – not only her child. This segment is discussing an example with her child, but she has other segments that discuss general amends to others. I think this is a good thought, but will keep Making Amends.

Page 5: Commented [MT5] **Mary Telisak** **4/21/2017 12:20:00 PM**

Not sure this fits under choices in my mind. To me it belongs more under "changing my life" – recognizing that addiction will trick you.

Page 5: Commented [LW6R5] **Lisa Witkowski** **5/2/2017 11:00:00 AM**

Yes, I was going back and forth on placing this theme under Choices Vs Changing My Life. I think this will fit better under "changing my life."

Page 6: Commented [MT7] **Mary Telisak** **4/21/2017 12:28:00 PM**

Yes – I wrote this down just as you did. Nice.

Page 6: Commented [LW8R7] **Lisa Witkowski** **5/2/2017 11:02:00 AM**

Great we agree. Thank you for your feedback!

Page 7: Commented [MT9] **Mary Telisak** **4/21/2017 12:32:00 PM**

To me the subcategory of "stigma" and this quote falls under the category of "the impact of addiction on me", as opposed to related to fear as a subtheme. Maybe "fear" is part of "the impact of addiction on me?" Just thinking outloud. Hmmm

Page 7: Commented [LW10R9] **Lisa Witkowski** **5/2/2017 11:39:00 AM**

Yes, I understand your perspective. I think I will place Stigma under Impact of Addiction on Me. I'll place Fear under Painful Feelings

Page 7: Commented [MT11] **Mary Telisak** **4/21/2017 12:17:00 PM**

Other "feelings words" I noted were: Fear, Powerlessness, and Shame. Would it be helpful to quote those here too in different subthemes or as a category – "painful feelings".

Page 7: Commented [LW12R11] **Lisa Witkowski** **5/2/2017 11:05:00 AM**

Yes, I see your train of thought. At first, I was hesitant to make painful feelings a separate subtheme. I thought I would lose some of the important information in her experience by merging into one theme, but I think you are on to something with this. I won't be able to make Painful Feelings an individual theme since is linked to Impact of Addiction on Me

Page 7: Commented [MT13] **Mary Telisak** **4/21/2017 12:25:00 PM**

I really like "fear" as a theme. Good catch.

Page 7: Commented [LW14R13] **Lisa Witkowski** **5/2/2017 1:22:00 PM**

Thanks! I'm going to move Fear under Painful Feelings as you suggested

Page 7: Commented [MT15] **Mary Telisak** **4/21/2017 12:19:00 PM**

LOVE this as a theme. Great catch.

Page 8: Commented [MT16] **Mary Telisak** **4/21/2017 12:16:00 PM**

I see this more as a cause or "road to" addiction, as opposed to a result of addiction or an impact of addition on her.

Denial was also part of Cynthia's road to addiction. She talked about "a world closing in" – maybe that is could be a sub-theme of a broader "road to addiction" theme.

Page 8: Commented [LW17R16] **Lisa Witkowski** **4/24/2017 5:04:00 PM**

Wow great thoughts Mary! I think I'm going to make this a separate new theme - Risk Factors. I feel Denial might fit better into your other idea about Painful Feelings.

Header and footer changes

Text Box changes

Header and footer text box changes

Footnote changes

Endnote changes

Appendix V

Sample Analytic Memo Excerpt

November 30, 2016

I have been breaking down the horizontalizations further after reading Dr. Northrup's feedback. I think this is a good idea because I am seeing multiple themes in larger segments. I noticed in Judy's horizontalization she was discussing multiple ideas in one segment. She discussed her child developing anger towards her, her son developing a close relationship with his grandparents, and Judy not being a mother-figure for her son. With Judy's horizontalization broken down more, I can go through the entire document and better identifying structural and textural themes. Dr. Northrup suggested I color code my structural and textural segments to for easy identification. This has been helpful to review the segments and decide whether I'm accurately identifying a segment as textural or structural. I notice I have identified some textural segments as structural and vice versa. Looking over this segment from Judy, I have identified the previous themes – anger developing in her son, her son's close relationship with grandparents, and not being a mother-figure into textural and structural themes. To me, anger developing in her son was a condition that occurred due to her substance use. I felt the same about the theme not being a mother-figure. However, I did debate this segment because it describes her beliefs on what her child is thinking, but felt the information in the segment added context to her involvement as a mother until he went to boarding school. Lastly, the close relationship with his grandparents describes Judy's beliefs on her son. She was discussing how her son considers his grandparents' as parents. Judy believes this to be true, but may not be the reality of her son.

December 8, 2016

I went through Brenda's horizontalization and added in the interview questions. I'm wondering if I should eliminate tangential information she mentioned that did not seem relevant to question I was asking. However, I feel she was expressing her thoughts, beliefs, and views on her experience. I feel this is something that was meaningful to her when answering the question. I remember thinking during the interview if I should re-ask the question, but I felt that might be my own bias in how she answered the question. In her eyes, she may have answered the question and I'm potentially looking for some other meaning. I feel I should keep what I see to be "tangential" in the horizontalization for now. If little meaning has been gathered after completing the remaining participants' horizontalizations, I will potentially eliminate this information. I feel off-topic information may still be relevant to Brenda's experience. I think I'm trying to assess whether the horizons are non-repetitive meaning units or stand out in her experience.

December 15, 2016

I'm reviewing Dr. Northrup's suggestions and revisions to labels of Textural and Structural themes. I seem to mix up Textural and Structural themes often. I have my comments to the side of each segment to address why I made each horizon either structural or textural. Some of my theme names need to be changed. For Brenda's horizontalization, I had labeled a Textural theme as "Being a Good Mother." After reviewing Dr. Northrup's suggestions, he felt I should be more specific. I agree that the theme could be more specific. I thought the theme name was to be broad to incorporate other relating themes. I decided to change the

Textural theme name to Being a Good Mother Means Playing With My Children. Brenda expressed her beliefs on what is an important aspect of parenting which is playing with her children. Thinking about other participants' horizontalizations, I notice a common pattern with mothers on playing with their children. Maybe, I was too broad thinking I have to incorporate more under a theme than potentially necessary. I have a few other theme names that need to be changed in Brenda's chart. Revising my work, I need to target more of the meaning in the statements rather than paraphrasing the statement made in the interview.

December 23, 2016

Honestly, I'm going to be spending much of my time with my family for the next two weeks. Not sure I'll look much at my research. I feel so much has happened this year that I want to be near my family. It's hard being so far away. I need to reconnect with myself. I feel I'm trying to take on too much at once. This week, I moved to Austin after my fiancé was offered a job opportunity. My fiancé and I discussed me taking the next several months to finish my research to complete my dissertation. I was juggling too much with working full-time and attempting to focus on my research after counseling clients all day. I was feeling emotionally depleted. The stress was overwhelming at times.